Statement of compliance

For year ended 30 June 2017

HONOURABLE ROGER COOK MLA DEPUTY PREMIER, MINISTER FOR HEALTH AND MENTAL HEALTH

In accordance with section 83 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 2017. This Annual Report has been prepared in accordance with the provisions of the Financial Management Act 2006.

Ian Smith PSM
Board Chair
East Metropolitan Health Service

Peter Forbes
Board Member
East Metropolitan Health Service
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Average cost per emergency department attendance
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East Metropolitan Health Service

Executive summary
On behalf of East Metropolitan Health Service (EMHS), we are delighted to present the 2016–17 Annual Report, which provides an insight into our key achievements, performance review and areas of focus during our first year of operation.

Following a significant program of reform across the Department of Health, EMHS was established as a board-governed statutory authority on 1 July 2016, providing greater responsibility and accountability for the delivery of health services within our community.

The hospitals and services which have come together to form EMHS have a long and proud history and have continued to perform at a high level during the last 12 months, as we build our health service to meet the needs of the community we serve, both now and in the future.

Our focus during this last year has been centred around seven service delivery principles: high performing systems and teams, supporting cultural diversity, consumer-centred care, intellectual curiosity, active partnerships, doing the right thing and of course, valuing our staff. EMHS staff have embraced these principles, establishing solid foundations for the organisation which will see us excel for years to come.

With the patient experience at the forefront of everything we do, we have explored a range of initiatives to engage with consumers in new and more accessible ways, to gain their feedback on the care we provide so that we can continually improve our services. Use of social media platforms such as Patient Opinion has proven to be an excellent tool to listen and respond to consumer feedback in ‘real time’, using this information to improve the quality of our services and directly engage with our consumers.

In line with the continued focus on service improvement, we have implemented several programs which are already producing positive results in areas such as safety and quality, patient flow and performance. We have made great progress in the relatively short time since we were established and will continue to build on this momentum and seek out opportunities to further improve our systems and processes.

We are also working hard to develop positive and productive relationships with our communities and partner organisations, in order to facilitate better health outcomes for our consumers. With a significant Aboriginal population in our catchment area, our Community and Population Health team have excelled in their efforts to strengthen our links with the Aboriginal community and service providers, to achieve our aim of providing a safe and culturally appropriate health care environment for Aboriginal consumers.

During this past year, we have continued to strive for excellence across all areas of our service, which is demonstrated on a daily basis through the compassion, dedication and professionalism of our hard working staff. We place a strong emphasis on encouraging our team members to do the right thing within their workplaces and have a range of support in place to aid our staff to achieve their professional goals. Our diverse group of staff bring an energy and vibrancy to the workplace and their achievements have been recognised across the country.

We are immensely proud of the work that each and every EMHS staff member does to ensure we deliver the best care possible to our patients and the community we serve.

Lastly, the Board would also like to acknowledge the tremendous work of EMHS Executive, led by Liz MacLeod, for their exceptional leadership, diligence and support over the last 12 months, which has seen EMHS develop into the high-performing organisation it is today.
Statement from the Aboriginal Health Community Advisory Council

We are committed to working alongside EMHS to achieve the best health outcomes for the Aboriginal community. We are representing the community to create a health service that is built on respect and culturally appropriate care that meets the needs of Aboriginal people. Together we are working towards Closing the Gap in Aboriginal health.

(Noongar translation)
EMHS strategic intent 2017-2020

Our Vision: Healthy people, amazing care
Koorda moort, moorditj kwabadak (Noongar translation)

OUR VALUES

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

Service delivery principles

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

Supporting cultural diversity
Partnering with Aboriginal and culturally diverse communities to provide healthcare 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.

Valuing our staff
Standing out in our field as an employer of choice.

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

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

194,733 emergency presentations
135,477 inpatients admitted
5025 babies born
47,904 operations performed
278 patients transferred to the hospital by helicopter (average of 5 patients per week)

146,733 emergency presentations
125,477 inpatients admitted
75 babies born
45,904 operations performed
280 patients transferred to the hospital by helicopter (average of 5 patients per week)

On average, patients stayed 4.99 days

Over $1.2 million in research grants awarded
81 newly conducted research studies
7 EMHS Finalists
2 EMHS Winners!

Provided inpatient health care to 12,523 Aboriginal patients (average of 240 patients per week)
66 Aboriginal people employed

see data table in appendix
First year milestones

July
EMHS is established as a statutory authority under a Board governance structure.

October
Royal Perth Bentley Group achieved periodic review for accreditation against the National Safety and Quality in Health Service Standards.

December
Established Aboriginal community advisory groups for Armadale, Bentley, Swan Hills/Midland and Inner City.

November
St John of God Midland Public Hospital celebrates its first birthday and becomes the first hospital in the Perth metropolitan area to appoint a Director of Aboriginal Health onto its Executive Board.

February
St John of God Midland Public Hospital achieved organisation-wide accreditation for the National Safety and Quality in Health Service Standards.

April
Bentley Hospital celebrated its 50th anniversary.

May
EMHS awarded runner-up for the Most Outstanding City Hospital in Australia in the inaugural Australian Patients Association awards.

June
Royal Perth Hospital achieved Accreditation with the Royal Australasian College of Physicians, maintaining its status as a premier teaching hospital.

August
Aggression Prevention Initiative launched to improve staff safety.
East Metropolitan Health Service

Governance/Overview
Enabling legislation
The Health Services Act 2016 WA (HSA 2016) introduced changes to the governance of the Western Australian health system by clarifying roles, responsibilities and accountabilities and by devolving decision making to the local level.
Section 32 of the HSA 2016 provides for the establishment of health service providers (HSPs). EMHS was established as a HSP by the Minister for Health under section 32(1)(b) of the HSA 2016 on 1 July 2016.
Section 70(1)(b) of the HSA 2016 stipulates that the Board is the governing body of the statutory authority and is to perform or exercise all of the functions of EMHS under this act or any other written law.

Administered legislation
EMHS as a statutory authority is governed by a range of legislation, including the following acts which were administered as at 30 June 2017:
- Anatomy Act 1930
- Blood Donation (Limitation of Liability) Act 1985
- Cremation Act 1929
- Fluoridation of Public Water Supplies Act 1966
- Food Act 2008
- Health (Miscellaneous Provisions) Act 1911
- Health Legislation Administration Act 1984
- Health Practitioner Regulation National Law (WA) Act 2010
- Health Professionals (Special Events Exemption) Act 2000
- Health Services (Quality Improvement) Act 1994
- Health Services Act 2016
- Human Reproductive Technology Act 1991
- Human Tissue and Transplant Act 1982
- Medicines and Poisons Act 2014
- National Health Funding Pool Act 2012
- Nuclear Waste Storage and Transportation (Prohibition) Act 1999
- Pharmacy Act 2010
- Private Hospitals and Health Services Act 1927
- Prostitution Act 2000 (except s.62 and Part S, which are administered by the Department of the Attorney General)
- Public Health Act 2016
- Radiation Safety Act 1975
- Royal Perth Hospital Protection Act 2016
- Surrogacy Act 2008
- Tobacco Products Control Act 2006
- University Medical School, Teaching Hospitals Act 1955
- Western Australian Health Promotion Foundation Act 2016

Acts passed during 2016–17
- Royal Perth Hospital Protection Act 2016

Bills in Parliament as at 30 June 2017
There were no bills in Parliament as at 30 June 2017.

Amalgamation and establishment of Boards
EMHS Board was established as a result of the HSA 2016.

Accountable authority
EMHS is a board governed statutory authority, where the Board is directly accountable to the public and the Minister for Health and works with the Director General of the Government of Western Australia Department of Health.
The EMHS Chief Executive is employed by the Director General as the ‘chief employee’ of the health service and is accountable to the Board.
Note: see WA Health governance structure roles and responsibilities on page 9 for additional information.

Responsible Minister
EMHS is responsible to the Deputy Premier, Minister for Health and Mental Health, the Honourable Roger Cook MLA.
WA Health governance structure, roles and responsibilities

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

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

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

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

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

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

EMHS provides a comprehensive range of surgical, emergency, mental health, ambulatory and primary health services to over 708,000* people living within Perth’s eastern corridor. This includes the provision of both hospital and community-based services with the East Metropolitan catchment area, in addition to statewide services such as the adult major trauma unit, based at Royal Perth Hospital.

EMHS comprises the following health groups and hospitals:

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

**Royal Perth Bentley Group (RPBG),** which consists of:
- Royal Perth Hospital (RPH)
- Bentley Health Service (BHS)

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

**Population health programs:** provides a range of community services to people both within the EMHS catchment and in the wider Metropolitan area including rehabilitation, health promotion and public health services. This includes multiple health programs, such as:
- Walypup Kworpading Koort (healthy heart)
- Mooridi Maarman (men’s health)
- Diabetes and podiatry care
- Aboriginal youth health
- Smoking prevention
- Living Improvements for Everyone (LIFE) – management of chronic disease
- Statewide Aboriginal Mental Health Service
- Mobile Clinical Outreach Teams (mental health)

Note: This is not an exhaustive list. For more information, please see www.eastmetropolitan.health.wa.gov.au.

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

* 2017 estimated resident population based on ABS census 2011.
EMHS Board

(Back row, from left)
Peter Forbes
Ross Keesing
Debra Zanella
Stephanie Trust
Richard Gut
Geraldine Ennis
Kingsley Faulkner

(Front row, from left)
Hannah Seymour
Ian Smith
Suzie May
Mr Ian Smith PSM
EMHS Board Chair

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

Mrs Suzie May
EMHS Board Deputy Chair
Chair, EMHS Board Consultation and Engagement Committee

Suzie May is a lawyer and a trained welfare officer, working initially in psychiatric and rehabilitation hospitals before establishing a private legal consultancy specialising in law reform and legal policy. Mrs May has experience in prison reform, court diversion, therapeutic jurisprudence and judicial case management. She brings a diverse range of skills and expertise to the Board and is an active consumer advocate and advisor, motivational speaker, university guest lecturer, board member, mentor and author of a non-fiction book on pregnancy and musculoskeletal disease.

Ms Debra Zanella
Chair, EMHS Board Audit and Risk Committee

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

Mr Peter Forbes
Chair, EMHS Board Finance Committee

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

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

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

Professor Kingsley Faulkner
Chair, EMHS Board Safety and Quality Committee

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

Ms Geraldine Ennis PSM

Geraldine Ennis has over 30 years experience improving the delivery of health services in rural and remote communities. A registered nurse and midwife, Ms Ennis has been the Goldfields Regional Director of WACHS for the last 10 years and was formerly Director of Nursing and Health Service Manager of Katanning Hospital, where she was actively involved in establishing and working with the Board of Management for Katanning Health Service. Ms Ennis was also previously Chair of St Patrick's Catholic School Board in Katanning. Ms Ennis was awarded a Public Service Medal in 2013 for outstanding public service in the provision of health services in rural and remote Western Australia.

Dr Stephanie Trust
Chair, EMHS Board Planning and Service Delivery Performance Committee

Stephanie Trust is a Kidja woman, born and raised in the East Kimberley where she is currently a general practitioner at Kununurra Medical. Initially trained as an enrolled nurse, Dr Trust went on to work as an Aboriginal health worker in the Kimberley and Pilbara for nearly 12 years before becoming a doctor. Dr Trust has been an integral member of boards such as the Australian Indigenous Doctors’ Association, the Kimberley-Pilbara Medicare Local and the Kimberley Stolen Generation Aboriginal Corporation.

Mr Richard Guit
Chair, EMHS Board Safety and Quality Committee

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

Dr Hannah Seymour
Chair, EMHS Board Safety and Quality Committee

Hannah Seymour is the Medical Co-Director for rehabilitation, mental health services and the women, children and newborn service at Fiona Stanley Hospital (FSH), where she played an instrumental role in the commissioning of these areas including the State Rehabilitation Service. With a clinical background in geriatric medicine, Dr Seymour has also held leadership roles in various health areas including falls, rehabilitation, aged care, models of care service delivery and workforce planning and brings with her extensive experience in WA Health. Dr Seymour currently works clinically in orthogeriatrics and cares for patients with hip and other fractures at FSH.
EMHS Area Executive Group

Chief Executive
Liz MacLeod

Area Director
Maha Rajagopal
Area Director of Allied Health and Health Sciences
John Buchanan
Area Director of Clinical Services
Mark Platell
Executive Director Corporate Services and Finance
Brad Sebbes
Executive Director Safety, Quality and Consumer Engagement
Sandra Miller
Director Office of the Chief Executive
Anne-Marie Presho
Executive Director Clinical Service Planning and Population Health
Karen McMenamin
Executive Director Procurement and Contract Management
Philip Aylward*
Executive Director Armadale Kalamunda Group
Shae Seymour
Executive Director Royal Perth Bentley Group
Aresh Anwar

Clinical Coding
Facilities Management and General Services
Workforce
Finance
Business Intelligence Unit
Library
Health Technology Management Unit
Clinical Governance
Consumer Engagement
Audit and Risk
Policy
Ministerial and Parliamentary Liaison
Program Management Office
Executive Support Board
Legal (contracted out - liaison only)
Communications
Research and Ethics
Population Health
Aboriginal Health
Clinical Planning (includes Emergency Department, inpatient and outpatient)
Workforce Planning
Mental Health

* The occupant of the position of Executive Director Procurement and Contract Management is not an employee of EMHS. This function is a bureau service provided by North Metropolitan Health Service (NMHS).

Click here to view EMHS Executive Group professional biographies (external site).
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 Western Australian Department of Health (WA Health). 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 greater focus on achieving results in key service delivery areas for the benefit of all Western Australians.

WA Health’s 2016–17 KPIs measure the effectiveness and efficiency of EMHS in achieving the following health outcomes:

Outcome one:
1. Provide quality diagnostic and treatment services that ensure the maximum restoration to health after an acute illness or injury.
2. Provide appropriate after-care and rehabilitation to ensure that people’s physical and social functioning is restored as far as possible.
3. Provide appropriate obstetric care during pregnancy and the birth episode to both mother and child.
4. Provide appropriate care and support for patients and their families during terminal illness.

Outcome two:
1. Increase the likelihood of optimal health and wellbeing by:
   • providing programs which support the optimal physical, social and emotional development of infants and children
   • encouraging healthy lifestyles (e.g. diet and exercise).
2. Reduce the likelihood of onset of disease or injury through:
   • immunisation programs
   • safety programs.
3. Reduce the risk of long-term disability or premature death from injury or illness through prevention, early identification and intervention, such as:
   • programs for early detection of developmental issues in children and appropriate referral for intervention
   • early identification and intervention of disease and disabling conditions with appropriate referrals (e.g. breast and cervical cancer screening; and screening of newborns)
   • programs that support self-management by people with diagnosed conditions and disease (e.g. diabetic education).
4. Monitor the incidence of disease in the population to determine the effectiveness of primary health measures.
5. Provide continuing care services and programs that improve and enhance the wellbeing and environment for people with chronic illness or disability.

Performance against these activities and outcomes are summarised in the Summary of KPIs section and described in detail in the KPI section.
Whole-of-government goal: greater focus on achieving results in key service delivery areas for the benefit of all Western Australians.
Changes to outcome based performance management framework

The Outcome Based Management Framework in 2016–17 was updated to reflect the implementation of the HSA 2016 and the nine legal entities that now comprise WA Health. In order to comply with this change, a new outcome (outcome three*), services and key performance indicators were introduced to align the Department as the System Manager, HSPs and Health Support Services to the State Government goal.

*Outcome three is only reported on by Health Support Services and the Department of Health.

Shared responsibilities with other agencies

EMHS works closely with the System Manager, other HSPs and a large number of Government and non-Government agencies to deliver programs and services to achieve better health outcomes for the community of the eastern metropolitan region.
East Metropolitan Health Service
Service delivery and performance
Developing high performing teams is a crucial driver to achieving our vision as a high performing health service, with a range of initiatives already underway to develop teams and staff to achieve better outcomes for patients and the health of our population in general.

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

High performing teams

In order to drive the level of focus and accountability required, EMHS has established five executive level committees to provide oversight of performance relating to safety and quality; finance; clinical planning and service delivery; risk and audit; and consumer and community consultation and engagement. Each of these committees reports to the Chief Executive via the Area Executive Group and ultimately assists to inform the Board.

A dedicated team development program has been established in EMHS to develop skills in teamwork, leadership and decision making; and across the organisation, targeted leadership and management training has been provided to a number of key staff through organisations such as the Australian Institute of Management (AIM), Institute for Health Leadership and the Australian Institute of Company Directors.

A program of regular leadership breakfasts has seen approximately 90 senior managers and executives attend presentations from industry leaders to learn more about the attributes of high performing organisations. These included presentations from Professor Hugo Mascie-Taylor from the United Kingdom’s National Health Service who spoke to staff about how senior clinical leaders can lead by example in creating a culture of safety and quality in the workplace; while Michael Utser from Woodsite provided senior leaders with his insights on how to lead teams in an environment of adversity, developing resilience and improving performance.

EMHS is committed to ensuring positive, high quality clinical outcomes for its patients. To assist with this, EMHS is in the process of planning a portfolio of work comprising area wide led activities that aim to improve patient care through the adoption of rigorous, consistent and transparent practices for clinical audit and response to lessons learned.

Results from the ‘Voice of the Staff’ survey, undertaken in May 2017, will be used to celebrate successes, as well as identify opportunities for improvement that are highlighted from our staff, which will foster the positive culture that EMHS desires.

Enhancing systems and processes

An Internal Audit Charter and Internal Audit Plan in place to evaluate the effectiveness of systems, processes, governance and risk management arrangements throughout the organisation and provide assurance to the EMHS Audit and Risk Committee.

At a local level, a comprehensive audit was undertaken relating to patient falls assessment and management at AKG and Bentley, in recognition of falls being the largest cause of injury related hospitalisations amongst older people. The audit found comprehensive falls prevention activities, guidelines and action plans existed throughout the hospital which were well supported by staff and the Executive. The audit provided a small number of recommendations to better support falls prevention and management at the hospital, which are in the process of being implemented.

In 2016-17, each of the EMHS hospitals participated in either a Periodic Review or Organisation Wide Survey, conducted by the Australian Council on Healthcare Standards (ACHS). This survey measures performance against a range of healthcare standards, including the National Safety and Quality Health Service (NSQHS) Standards.

EMHS hospitals were commended by the ACHS surveyors for staff commitment to patient-centred care, improvement in strengthening governance and compliance, excellent consultation with consumers through active partnerships and achievement in transitioning to the EMHS governance structure.

Financial performance

The 2016-17 year was a challenging but ultimately financially successful one for the health service. EMHS was able to turn around an opening deficit position of $1,372,000 to finish the year with a financial surplus of $50,304,000.

This was achieved through good governance, sound financial management and a focus on expenditure and cost control, without compromising clinical safety and quality. This result has enabled the health service to establish a solid financial foundation and platform for launching future programs of investment and growth within the health service.
Supporting cultural diversity
Partnering with Aboriginal and culturally diverse communities to provide healthcare networks that are free from prejudice and are culturally informed.

Celebrating diversity
Diversity is celebrated within EMHS, not only through our consumers, but also with our staff, who on a daily basis care for people from a variety of backgrounds and countries. Approximately 16 per cent of the total workforce was born overseas and this diversity within our team allows our patients, consumers and carers to feel welcome, understood and supported. Each EMHS site and service offers consumers from culturally and linguistically diverse (CALD) backgrounds access to professional and confidential interpreting services. The provision of this service enables EMHS to facilitate communication between CALD consumers and clinicians and was accessed more than 13 200 times in 2016-17.

Investing in Aboriginal health
Across the Perth metropolitan area, Aboriginal people represent approximately 1.6 per cent of the total population, whilst within the EMHS catchment area Aboriginal people comprise approximately 2.2 per cent of the total population, with more than 12 700 Aboriginal people residing in the area.* As such, EMHS continues to support and invest in the delivery of services and programs that strive to close the gap in the health and wellbeing of Aboriginal people.

In 2016-17, more than 40 dedicated Aboriginal health staff worked to improve the health of Aboriginal people in our catchment area through the provision of healthy lifestyle education programs, consumer and community engagement and partnering with health professionals to inform the delivery of culturally appropriate service delivery.

To ensure the provision of health care services is culturally appropriate, a significant program of work to engage with internal stakeholders to embed Aboriginal health in the development of strategies, frameworks and policies at all levels of the organisation has been undertaken. This will be supported by the development of a Cultural Respect Framework, which will provide a greater level of accountability throughout the organisation in implementing culturally appropriate care.

In the development of these strategies and programs, EMHS formed four Aboriginal Health Community Advisory groups and an Aboriginal Health Advisory Council, which provide advice on service, program and policy development impacting Aboriginal consumers. These groups have enabled the health service to develop stronger partnerships with the community and improve coordination between health services for Aboriginal people.

EMHS healthy lifestyle and health promotion programs
EMHS healthy lifestyle and health promotion programs have been developed to specifically meet the needs of the Aboriginal community and are delivered by trained Aboriginal staff members. In 2016-17, more than 12 800 occasions of service were recorded for these programs, which include:

- Walup Kworpading Koort (Healthy Heart): providing health education sessions to consumers in the southern suburbs through an exercise program facilitated by an exercise physiologist, podiatry services, walking groups and healthy food preparation.
- Moorditj Maarman (Males Yarning Group): held in Middle Swan, this group provides Aboriginal males the opportunity to have health checks, discuss health issues and provide support for the spiritual, emotional and physical wellbeing of participants. WA Police and the Department of Corrective Services have recently commenced referring paroled and released prisoners into this program.
- I’m Moorditjtabi (Becoming strong): a healthy lifestyle and nutritional education program designed to help community members change unhealthy lifestyles, improve fitness and make healthy food choices. The program includes exercise, education and cooking sessions.
- Journey of Living With Diabetes (JLWD): culturally appropriate program delivering diabetes prevention, education and self-management skills.
- JIWD and Perth Diabetes Care: a holistic diabetes health education program incorporating individual health assessments and education sessions. Participants in the program have access to trained exercise physiologists, diabetes educators, dieticians and Aboriginal health professionals.
- Bibra Lake Men’s Group: promotes exercise, diabetes education and health checks for participants.
- Moorditj Dena (Strong feet): a mobile community outreach service providing chronic disease assessment, diabetes education and podiatry services.
- Aboriginal Youth Health: providing culturally appropriate health programs at schools. This program gives young people the opportunity to improve their knowledge of the harms related to alcohol and tobacco use and risky sexual behaviour. In addition, it increases their knowledge of how to access appropriate health services.
- Yarning it Up (Smoking prevention): aims to reduce tobacco related harm in the adult Aboriginal population. It includes community workshops and training for health professionals. This program promotes culturally appropriate services including referral to nicotine replacement therapy.
- Living Improvements for Everyone (LIFE): this six week program provides a holistic, general model of care for the management of chronic conditions, which has been adapted to be culturally appropriate for local Aboriginal communities. The LIFE program recognises cultural, language and life differences, grief and loss, alternative communication methods, problem solving and action plans.

*Based on 2011 census data.
Active partnerships
Working with our partners to build and facilitate health and wellbeing in our communities

EMHS is working closely with a wide range of health care, community care and education providers in order to build better health and wellbeing in our community. We are seeking to develop collaborative relationships with partner organisations to ensure the best outcomes for our consumers.

Partnering to deliver outstanding health care to the Midland community
St John of God Midland Public Hospital (SJGMPH) is operated under a 20 year contractual Public Private Partnership agreement between St John of God Health Care (SJGHC) and the State Government. This 307-bed public hospital provides a comprehensive range of clinical services including emergency, critical care, surgical, general medical, maternity, paediatric, aged care, cancer care and mental health services.

SJGMPH provides safe, high quality care and works collaboratively with EMHS to participate in health care reform initiatives that are implemented across the public health system. A comprehensive suite of KPIs monitor the overall quality of the service provided.

SJGMPH celebrated its first birthday in November 2016, heralding one year of providing high quality care to the people of Midland and surrounding areas.

Partnering to achieve better outcomes for mental health patients
EMHS has partnered with the Mental Health Commission (MHC) to deliver a range of mental health inpatient and non-admitted services under a service level agreement. This agreement also covers specific projects such as the mental health police co-response project, ongoing funding for the individualised community living strategy and the mobile clinical outreach team, which provides mental health care for homeless people.

EMHS manages two statewide mental health services – the State-wide Specialist Aboriginal Mental Health Service (SSAMHS) and the Mental Health Emergency Response Line (MHERL).

SSAMHS provides culturally appropriate mental health care to Aboriginal people throughout the State, while also developing and maintaining inter-agency partnerships aimed at the development of a more holistic approach to Aboriginal mental health.

MHERL provides a rapid response for individuals, families, carers and health professionals involved in a mental health emergency, with 24 hour, 7 day a week assessment, specialist intervention and clinical support.

EMHS partners with a range of community organisations such as Headspace, Helping Minds and Red Cross to contribute to planning and service delivery, promote community based care, support patients and their carers and assist them to navigate the system.

Cultivating partnerships within EMHS
As a newly established health service, EMHS has placed a significant emphasis on working collaboratively and breaking down silos throughout all levels of the organisation, to share lessons learned and provide support. One example is the establishment of the EMHS Winter Collaborative Program, which saw representatives from each EMHS site and service, in addition to several external organisations, work together to improve the journey and outcomes of patients presenting to EMHS services during the traditionally busy winter period.

Partnering to support students and graduates
EMHS has partnered with education and research institutes to provide opportunities for staff and students to develop their skills and experience through clinical placements, internships, quality initiatives and research projects. All EMHS hospitals host nursing, medical and allied health students from Perth’s major universities and TAFEs for clinical placements and internships throughout the year.

In November 2016, EMHS participated in the Targeted Nursing Transition Program – a 26 week pilot program coordinated in collaboration between NurseWest, the Nursing and Midwifery Office and RPH. This program aimed to provide an alternative employment pathway for newly qualified registered nurses who did not obtain a placement in a traditional graduate nursing program. Nine participants completed this program at RPH and were provided with support to develop their professional practice, in addition to employment opportunities upon completion of the program.
Institute for social inclusion strategy

Due to its inner city location, RPH treats significant numbers of people who are homeless or of no fixed address who “sleep rough” in Perth’s central business district and inner suburbs, or who are otherwise insecurely housed. While homeless patients comprise only a small percentage of RPH Emergency Department (ED) attendances, individual homeless patients are high users of the ED.

The health needs of this patient group do not exist in isolation and are often co-dependent on the patient’s increased need for support in other areas of life, including housing and accommodation and are often impacted by multiple co-morbidities.

RPH is working with a number of external partners, including the City of Perth, Ruah (50 Lives 50 Homes project), WA Primary Healthcare Alliance and Homeless Healthcare General Practitioners (GP), to implement the Institute for Social Inclusion (ISI) strategy. This strategy aims to ensure optimum continuum of care and reduce hospital presentations through a transition programme from hospital, to community based healthcare and social support (including mental health, social welfare, drug/alcohol rehabilitation and domestic violence) and providing accommodation and employment opportunities.
Intellectual curiosity
Exploring and leading the translation of research into evidence based practice and innovations that will deliver excellent health outcomes

EMHS recognises that the provision of excellent clinical care can be supported through fostering intellectual curiosity amongst the workforce. In alignment with this, EMHS has sought to develop a culture where all staff are encouraged to be creative, progressive and forward thinking. Research and innovation is promoted throughout all levels of the organisation, through the provision of ongoing access to education and professional development and assistance in accessing research grants.

Innovations and service improvements
At a local level, health service staff are constantly seeking opportunities to improve the way services are delivered, as well as enhancing the patient experience. Programs such as RPH’s ‘Safety After Hours for Everyone (SAFE)’ initiative, which was recognised as a finalist in the WA Health Excellence Awards, identified that a discrepancy in the staffing levels between ‘in-hours’ and ‘after-hours’ care was contributing to the quality of patient health outcomes. Through this program, RPH developed and implemented an innovative after-hours model of care, enabling patient care to be monitored, progressed and escalated in a timely and appropriate manner. This was achieved through improvements such as ward-based resident medical officers, a task tracking system, earlier recognition of deteriorating patients and a centralised handover focussing on patients of concern.

In order to support better health outcomes for patients in regional areas, or those unable to travel to hospital to attend clinics, EMHS hospitals make use of video technology to enable patients to communicate with health care professionals. RPH partnered with WACHS to deliver more than 6500 appointments via Telehealth in 2016-17, which enables regional patients to attend a central clinic or hospital closer to their home and have an appointment with a RPH clinician via video link. In 2016, RPH also commenced a trial of Video Call, which is based on a similar concept to that of Telehealth, but is available to both metropolitan and regional patients to have a face-to-face appointment with a RPH clinician using their home computer, phone or tablet device, without being required to travel to a hospital or clinic for the appointment. To date, this technology has been used predominately in diabetes, gastroenterology and plastic surgery clinics.

Research
More than 80 research studies across EMHS in a diverse range of fields including nursing, allied health and clinical trials were approved during the 2016-17 financial year. These included:

- 32 investigator-initiated studies conducted by local staff and sites within WA Health
- 12 studies conducted in collaboration with not for profit organisations and institutions
- 9 clinical trials investigating new drugs and devices (sponsored by pharmaceutical companies)
- 28 studies performed in collaboration with Western Australian universities.

EMHS was awarded over $1.2 million in research grants which were allocated to more than 35 studies.

Improving mental health services
The Armadale Mental Health Service (AMHS) Discharge Clinic is a WA-first initiative aimed at improving patient care by providing consumers with appropriate follow up within seven days of discharge from an inpatient service. The clinic was developed as part of a clinical redesign of mental health services at AHS in July 2016. It was identified that adult and older adult community mental health services were not meeting the national target of 75 per cent in providing seven-day follow up to consumers post discharge.

This gap in timely follow-up after discharge posed significant risks for consumers with severe mental illness. To address this need, AMHS reconfigured its existing resources to expand the AMHS GP Liaison (GPL) team and commenced a dedicated Discharge Clinic in October 2016, operating three days a week. This ensured consumers discharged from an inpatient ward can access timely follow-up care.

The clinic is led by the GPL team which includes a psychiatrist, a clinical nurse specialising in GP/Primary Health Liaison and administrative staff. Since implementation of the Discharge Clinic, seven day follow-up has improved considerably for both older adult and adult community patients.

AHS Mental health team
(Left to right)
Pey Bin Ho, Kezia Higham, Michelle Cafano, Steven Fu, Vanessa Turner, Rijo Joseph, Deborah Luntie, Lynn Osborn, Cheryle McLachlan
RPH researcher in cell bid to stem blood disorder

RPH researcher, Dr Melita Cirillo, was one of seven WA Health staff awarded fellowships in the Department of Health's inaugural Registrar Research Fellowships in early 2017.

Dr Cirillo is investigating the potential of using adult stem cells to treat one of the most common blood disorders in the elderly. Myelodysplastic syndrome (MDS) is a disorder of the bone marrow that can progress to leukaemia in up to a quarter of cases.

Dr Cirillo says research has shown MDS patients can benefit from various immune therapies but none has been used routinely due to side effects including increased risk of infection.

"We're investigating whether Mesenchymal Stromal Cells (MSCs) - adult stem cells that, while not an immune therapy as such, have been found to modulate the immune system - might be a safer alternative" Dr Cirillo said.

She described MSCs as versatile cells with special properties including being universal donor cells (meaning they can be taken from anyone and given to anyone else without the need for tissue matching) that homed to sites of inflammation. MSCs being infused into participants in Dr Cirillo’s project are obtained from the bone marrow of healthy donors and culture-expanded in RPH’s cell and tissue therapies manufacturing unit, Cell and Tissue Therapies WA.

Dr Cirillo said this preliminary "phase one" study was recruiting patients who had been identified as being in the early stages of MDS.

If the analysis of this initial phase shows positive results, then a larger phase two study will be undertaken.

While MDS is not curable for most patients, blood transfusions and treatment for infection are the most common of the currently available therapies for patients with early MDS.

Dr Cirillo said the ultimate goal of the research team was to save lives by finding a simple and effective treatment that could slow the progression of MDS and improve patients’ quality of life by limiting hospital visits and transfusions.
Consumer-centred
Providing consumer centred healthcare that empowers individuals to optimise their health and wellbeing

The provision of consumer and community-centred care is at the forefront of everything we do in EMHS and many initiatives have been launched in 2016-17 to help the organisation achieve this goal.

Engaging with our consumers
In late 2016, EMHS commenced a trial subscription of Patient Opinion - a social media platform that allows consumers to provide feedback about their experience with a hospital or health service. Patient Opinion subscribers are notified when a consumer posts a comment about them and can listen and respond in real time to patient experiences, using this feedback to improve the quality of their services. This 12 month trial is aimed at engaging with our consumers in a contemporary and more accessible way, to gain their feedback on the care we provide so we can continually improve our services. 36 stories have been received through Patient Opinion since the trial commenced and as a result, EMHS was nominated for the ‘Most Outstanding City Hospital in Australia’ award at the Australian Patients Association’s inaugural patients award night in recognition of the commitment EMHS has made to receiving and responding to patient feedback.

In 2016-17, EMHS received feedback from more than 5400 patients through Press Ganey, which benchmarks the health service against comparable hospitals around the world. These surveys collect data from inpatients, mental health, day surgery and emergency departments and provide feedback on a range of areas including waiting times, communication, staff attitudes as well as food service and facilities, which can be used for quality improvement initiatives. Additionally, dedicated Consumer Engagement departments at both RPBG and AKG received more than 2800 consumer feedback contacts.

Individual departments within EMHS also seek out different ways to collect feedback and engage with their consumers. The RPBG Outpatients Department collated feedback from more than 13,000 patients in 2016-17 through surveys distributed via text message and online. The survey assesses areas such as wait times, communications and accessibility and is used to inform service delivery and improvements. This data is collated on a quarterly basis, with responses received in the last quarter of 2016-17 indicating 86.4 per cent of respondents nominating the outpatient service as good or excellent.

Collaborating with our community
Recognising the significant input our consumers can play into the design and delivery of EMHS health care services, the organisation works with a number of consumer advisory councils and community advisory groups. Members of each of these committees provide invaluable advice to hospital and health service leaders on service delivery and consumer information and ensure the organisation is able to continue to work towards better health outcomes for our consumers.

Improving palliative care services
As the provision of palliative care services across EMHS was known to be limited, in February 2017 a 28 bed specialist palliative care service for all EMHS hospitals and patients in the catchment area was launched at Kalamunda Hospital. By providing this specialist service at Kalamunda, EMHS was able to provide an enhanced model of care for patients, including an expanded palliative care medical team with 24 hour on-call access, nursing, allied health and chaplaincy staff with specialist palliative care experience, in addition to dedicated on-site family and carer facilities.

Health Consumer Excellence Awards
In April, an impressive group of EMHS staff and programs were recognised for their achievements in the 2017 Health Consumer Excellence Awards.

Moorditj DjeNa, an EMHS Population Health program, was awarded the Health Organisation Award, which recognises organisations that demonstrate an ongoing partnership with health consumers to improve health outcomes. The Moorditj DjeNa program is a high-risk foot and diabetes education service for Aboriginal people, which focuses on the prevention and management of foot complications.

Elaine (Ellie) Newman, from RPBG, was awarded with the Health Professional Award, which recognises individuals demonstrating excellence in patient care. Ellie coordinates the Cognitive Impairment Project within EMHS, which identifies a better way to care for patients with dementia and delirium through their healthcare journey.

The Aboriginal Health Liaison Program at RPBG was awarded the Aboriginal/Torres Strait Islander Health Award for their excellent work in providing a coordinated, culturally responsive service for Aboriginal and Torres Strait Islander patients within the hospital. This program was commended for their role in ensuring patients and their families have an improved hospital experience through advocacy, linkages with community services, meeting the diverse cultural needs of patients and educating staff, patients and family.

Fatima Edward was awarded the Compassionate Care Award for her work as an assistant in nursing in acute geriatrics and subacute ortho-geriatric care at RPBG. Fatima was recognised for her ongoing commitment to compassionate care by consistently going above and beyond her duties, providing patients with a consistent high standard of care while also seeking to better engage with her patients wherever possible.

Petrina Lawrence from the RPH Consumer Advisory Council, and the Boodjari Yorgas Family Care Program at AKG were also highly commended for their work towards better outcomes for health consumers.

Supporting our patients, families and carers. Dr Mathake Mmoloki and Ka Yan Cooper, Kalamunda Hospital
Developing our leaders

Our staff working in leadership roles throughout the organisation have had the opportunity to participate in a range of leadership programs to enhance skills and develop more effective teams. 24 middle managers throughout EMHS completed a course through AIM in 2017 covering subjects including coaching, performance development, difficult conversations and resilience. Committees focussed on employee wellbeing have been established at a number of EMHS sites and services, providing staff with access to counselling, training, fitness and peer support. More than 200 AKG staff have participated in initiatives developed by the AKG Employee Wellness Program, such as training on how to manage stress and improve resilience, meditation, mindfulness, healthy eating, yoga and self-care for health professionals.

An employee wellness committee is also active throughout RPBG, promoting nutrition and active lifestyles amongst the workforce, by providing staff with increased access to healthy food options and fitness programs. Additionally, all EMHS staff are provided with access to employee assistance programs and support networks such as pastoral care and employee support officers.

Valuing our staff

Standing out in our field as an employer of choice

As an employer of more than 7100 staff spanning a range of professional fields, EMHS prioritises the safety, wellbeing and professional development of our staff in all levels of the organisation. Note: Staff at SJGMPH are not included in staff information and data. (See important note in the disclosure and compliance section).

Supporting our staff

EMHS has a commitment to supporting our staff through the provision of professional development opportunities, employee wellbeing and assistance programs and staff safety.

Committees focused on employee wellbeing have been established at a number of EMHS sites and services, providing staff with access to counseling, training, fitness and peer support. More than 200 AKG staff have participated in initiatives developed by the AKG Employee Wellness Program, such as training on how to manage stress and improve resilience, meditation, mindfulness, healthy eating, yoga and self-care for health professionals.

An employee wellness committee is also active throughout RPBG, promoting nutrition and active lifestyles amongst the workforce, by providing staff with increased access to healthy food options and fitness programs. Additionally, all EMHS staff are provided with access to employee assistance programs and support networks such as pastoral care and employee support officers.

RPBG have focused on strengthening non-technical skills (such as teamwork, leadership, situational awareness, decision making and error management), by developing workshops in:

- handover – addressing failures in communication between clinicians and teams (ED and State Major Trauma Unit)
- leadership in the context of clinical care
- leading through uncertainty
- difficult conversations and leading quality care and service improvement
- mindfulness
- growing capacity in teams
- leadership development.

Supporting our workforce diversity

EMHS is committed to development of a workforce representative of the community and continues to work towards the outcomes of the WA Health Equity and Diversity strategy 2015-2020. A range of ongoing strategies exist to support this, including:

- ensuring recruitment processes and job descriptions are inclusive and non-discriminatory
- flexible work arrangements
- trained employee support officers to provide support and information to employees with equal opportunity related concerns
- EMHS Disability Access and Inclusion Plan which provides strategies to ensure people with a disability have the same opportunity as other people to obtain and maintain employment within EMHS.

Supporting our Aboriginal workforce and developing strategies to attract, retain and recruit Aboriginal people is an identified priority for EMHS. This will ensure that we are able to provide more culturally appropriate care to our Aboriginal consumers. Initiatives such as the establishment of an Aboriginal Workforce Engagement Group will continue to ensure our Aboriginal workforce are given the opportunity to provide feedback in the development of strategies and programs to support our growing Aboriginal workforce.

As part of a commitment to growing our Aboriginal workforce, a 12 month pilot program has commenced to increase the recruitment of Aboriginal people within EMHS. The pilot program enables recruiting managers to apply Section 51 of the Equal Opportunity Act 1984 to their recruitment process, which will allow Aboriginal applicants who meet the selection criteria to be prioritised for shortlisting and appointment.

Engaging with our staff

In May 2017, EMHS launched its inaugural ‘Voice of the Staff’ survey, which enabled all staff to provide feedback on all aspects of the organisation, including job satisfaction, workplace safety, leadership, work-life balance and engagement. 30 per cent of staff responded to the survey and results will be used to develop action plans to address areas for improvement for the year ahead.

Throughout the year, EMHS Board and Executive have taken opportunities to meet with staff, visit each of the sites and services and continually encourage two-way dialogue between staff and senior leaders.

Recognising and celebrating the successes of our staff is a key focus of EMHS and in 2016-17, a large number of EMHS staff and programs were commended in a number of high profile awards including the WA Nursing and Midwifery Awards, WA Health Excellence Awards and Consumer Excellence Awards.
Valuing EMHS junior doctors

EMHS intern, Dr Michele Delacretaz was awarded the Momentum Most Inspiring Woman of the Year Award in March. Dr Delacretaz joined the 2017 intake of 85 interns at the age of 54, following a 30 year career as a midwife where she developed a passion for improving outcomes in women’s health.

While progressing through the internship program, Dr Delacretaz and her fellow interns are provided with high quality teaching, supervision and support in addition to a comprehensive orientation, skill based training including clinical simulations, staff development seminars and mentoring.

Additionally, in recognition of some of the pressures new doctors face when commencing a career in healthcare, RPBG launched a wellbeing program for junior doctors as they rotate throughout EMHS sites. The program provides tailored support to junior clinicians through peer support, a dedicated wellbeing officer and targeted strategies including a weekly peer group session, workshops and training, to help support both the mental and physical health of this staff group.

Initiatives such as these have seen EMHS become a desirable place to work, attracting a high calibre of students who recognise the emphasis the health service places on attracting, retaining and supporting staff. In 2017 more than double the number of medical graduates applied for roles at RPH when compared with previous years.
Doing the right thing

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

EMHS has developed a range of initiatives to support and empower staff and patients to achieve the best health outcomes.

Strategic Intent 2017-2020

EMHS has developed a strategic intent, which encompasses a vision for EMHS, values and service delivery principles, which will later be supported by operational plans. This document will be used to guide the EMHS strategic direction over the next two to three years while the organisation completes a comprehensive consultation process for a longer term strategic plan.

Encouraging transparency and ethical practice

The senior leadership team of EMHS have worked hard to build a culture of transparency across all levels of the organisation. One example is the release of a monthly “balanced scorecard” to staff, providing up-to-date data on performance indicators such as Western Australia Emergency Access Target (WEAT), The Western Australia Elective Services Target (WEST), hand hygiene, safety and quality and net cost of service to budget. This information is supported by regular updates from Executive to all staff about organisational performance, current programs and future strategies.

EMHS strives to support a culture of ethical practice and substantive equality in the workplace, through adherence to WA Health Code of Conduct and Public Sector Standards, development of a Disability Access and Inclusion Plan and a range of initiatives to contribute towards substantive equality. Further information on specific actions towards each of these outcomes is included in the disclosure and compliance section.

Ensuring essentials

In 2017, EMHS launched its ‘Ensuring Essentials’ program, which recognises the need to improve the quality of patient care and reduce the cost of health care by eliminating unnecessary tests, treatments and procedures that do not add value to patient care.

This program aims to improve transparency, evidence based practice and patient empowerment across EMHS by focusing on practices that reduce clinical variation, eliminate or minimise waste, improve efficiencies, enhance value and ensure sustainability for EMHS in the future.

The two year program will measure the outcomes of current practices to improve decision-making and achieve greater value for our patients and will ultimately see practices and processes embedded into the organisation to achieve long lasting impacts.

Building collaborative care with community services

As part of a $225,000 Innovation and Evidence Grant from the WA Primary Health Alliance, a project called Building Collaborative Care with Community Services was launched at AKG in January 2017.

This 18 month project focuses on shared care pathways and aims to achieve better health outcomes for consumers through a greater level of involvement with patients and carers and collaboration with community health and social care providers.

The Building Collaborative Care project is a sub-set of an overall model of care implemented at AKG for patients with chronic diseases and/or complex care needs. This model of care includes four core elements:

1. Implementation of a screening tool to identify at-risk patients;
2. Case management of these patients by the Complex Care Coordination (CCC) team, which facilitates holistic and collaborative care by developing action and management plans incorporating medical, allied health, GPs, specialist and community services input, working together with the patient, carers and families. The goal is to achieve patient centred, agreed health goals and safe discharge planning;
3. Shared care planning through regular communication and liaison with community services and;
4. Partnering with patients, carers and family to educate them regarding self-management strategies and activating the individual action plans during deterioration, which has been critical in minimising re-presentations to hospital.

This shared care approach is expected to improve patient satisfaction and care through improving health care workers’ knowledge of community based health and social care services, while also ensuring patients are linked in with the right service at the right time.
Financial overview

EMHS total cost of providing health services in the 2016-17 financial year was $1.4 billion. Full details of the 2016-17 financial performance are included in the financial statements section.

Our results in 2016-17 against initial estimates of financial targets are included in Table 1 below.

<table>
<thead>
<tr>
<th>Financial</th>
<th>2016-17 target $000</th>
<th>2016-17 actual $000</th>
<th>Variation $000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cost of services (expense limit) (sourced from Statement of Comprehensive Income)</td>
<td>1,251,317</td>
<td>1,401,209</td>
<td>149,892</td>
</tr>
<tr>
<td>Net cost of services (sourced from Statement of Comprehensive Income)</td>
<td>662,208</td>
<td>720,517</td>
<td>58,309</td>
</tr>
<tr>
<td>Total equity (sourced from Statement of Financial Position)</td>
<td>1,047,817</td>
<td>1,236,561</td>
<td>188,744</td>
</tr>
<tr>
<td>Net increase in cash held (sourced from Statement of Cash Flows)</td>
<td>0</td>
<td>113,219</td>
<td>113,219</td>
</tr>
<tr>
<td>Approved salary expense level</td>
<td>732,353</td>
<td>744,622</td>
<td>12,269</td>
</tr>
</tbody>
</table>

Total cost of services (expense limit) variation of $149.9 million
- The 2016-17 initial target was subsequently adjusted as a result of budget increases for increased activity, additional expenditure associated with high cost drugs, transfer and revaluation of land and building assets and charges for the provision of shared service. In addition, there were services received free of charge from PathWest not included in the initial target.

Net cost of services variation of $58.31 million
- Primarily related to additional expenditure above initial target, partially offset by additional Commonwealth revenue and patient charges.

Total equity variation of $188.7 million
- Attributed to net assets transferred to EMHS, an improved operating result and increase in the asset revaluation reserve.

Net increase in cash held variation of $113.2M
- The increase in cash held was a result of an improved operating position, additional Commonwealth revenues and increased revenues from patient activity.

Approved salary expense level variation of $12.3 million
- There was an increase in salary expense due to the additional costs associated with increased activity.

Summary of key performance indicators

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

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: Tables 2 and 3 should be viewed in conjunction with detailed information on each key performance indicator found in the key performance indicators (KPIs) section of this report.

<table>
<thead>
<tr>
<th>Variation data legend</th>
<th>Please note the following legend for KPI variation data:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variation figure = undesired result</td>
<td>Variation figure = desired result</td>
</tr>
</tbody>
</table>

Table 2 – Outcome one: Actual results vs. KPI targets

Outcome one: Restoration of patients’ health, provision of maternity care to women and newborns, and support for patients and families during terminal illness.

Key performance indicator (KPI) | 2016-17 target | 2016-17 actual | Variation
--- | --- | --- | ---
Percentage of patients discharged to home after admitted hospital treatment* | 97.3% | 97.7% | 0.4%

Age (years) | 97.3% | 97.0% | 0.3%
0 to 39 | 97.3% | 98.0% | 0.7%
40 to 49 | 97.3% | 98.7% | 1.4%
50 to 59 | 97.3% | 98.0% | 0.7%
60 to 69 | 97.3% | 96.3% | 1.0%
70 to 79 | 97.3% | 97.6% | 0.3%
80 and above | 97.3% | 97.6% | 0.3%

* Data period: July – December 2016.
Outcome one: Restoration of patients’ health, provision of maternity care to women and newborns, and support for patients and families during terminal illness.

Key performance indicator (KPI) 2016-17 target 2016-17 actual Variation

Table 2 continued – Outcome one: Actual results vs. KPI targets

Key effectiveness indicators

Survival rates for sentinel conditions*

Stroke by age group (years)
- 0 to 49: 95.3% 100% 4.7%
- 50 to 59: 92.8% 100% 7.2%
- 60 to 69: 93.3% 93.2% 0.1%
- 70 to 79: 90.6% 90.8% 0%
- 80 and above: 83.3% 87.5% 4.2%

Acute myocardial infarction by age group (years)
- 0 to 49: 99.5% 97.3% 2.2%
- 50 to 59: 99.2% 100% 0.8%
- 60 to 69: 98.4% 97.4% 1.0%
- 70 to 79: 96.7% 97.9% 1.2%
- 80 and above: 92.7% 90.9% 1.8%

Fractured neck of femur by age group (years)
- 70 to 79: 99.0% 97.8% 1.2%
- 80 and above: 96.4% 99.3% 2.9%

Proportion of elective wait list patients waiting over boundary for reportable procedures
- % category 1 over 30 days: 0.0% 24.6% 24.6%
- % category 2 over 90 days: 0.0% 21.6% 21.6%
- % category 3 over 365 days: 0.0% 3.7% 3.7%

*Data period: July – December 2016.

Unplanned hospital readmissions within 28 days for selected surgical procedures (per 1000)*

- Knee replacement: 22 8.3 13.7
- Hip replacement: 21 30.6 9.6
- Tonsillectomy and adenoidectomy: 71 28.1 42.9
- Hysterectomy: 47 66.7 19.7
- Prostatectomy: 34 34.5 0.6
- Cataract surgery: 1 0.5 0.5
- Appendicectomy: 39 34.4 4.6

Rate of unplanned readmissions within 28 days to the same hospital for a mental health condition (per 1000)**
- 66 81.9 15.9

Percentage of liveborn term infants with an Apgar score of less than seven at five minutes post-delivery*
- 1.8% 0.82% 0.98%

Key efficiency indicators

- Average cost per casemix adjusted separation for tertiary hospitals: $6789 $6415 $374
- Average cost per casemix adjusted separation for non-tertiary hospitals: $6451 $6172 $279
- Average cost per emergency department attendance: $714 $858 $144
- Average cost per public patient non-admitted activity: $277 $382 $105

*Data period: July – December 2016.
**Data period: September - November 2016.
Table 3 – Outcome two: Actual results vs. KPI targets

Outcome two: Enhanced health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care.

Key performance indicator (KPI) | 2016-17 target | 2016-17 actual | Variation
--- | --- | --- | ---

Key effectiveness indicators

Percentage of contacts with community-based public mental health non-admitted services within seven days prior to admission to a public mental health inpatient unit* | 70% | 57.1% | 12.9%

Percentage of contacts with community-based public mental health non-admitted services within seven days post-discharge from public mental health inpatient units* | 75% | 72.4% | 2.6%

Key efficiency indicators

Average cost per capita of population health units | $39 | $22 | $17

Average cost per bed-day in specialised mental health inpatient units | $1379 | $1586 | $207

Average cost per three month period of care for community mental health | $977 | $1752 | $775

*Data period: July – December 2016.

Other performance indicators

Western Australia Emergency Access Target (WEAT)

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

When patients arrive in the ED, they are assessed by specialty trained nurses on how urgently their condition requires treatment. This process, which is known as triage, ensures treatment is provided within the appropriate time, which assists in prevention of adverse outcomes which may arise as a result of deterioration in the patients condition. The triage process and scores are recognised by the Australasian College for Emergency Medicine and Table 4 below articulates the triage category and targets for treatment activity to occur. A result equal to or above target is desired.

Table 4 - Triage category, treatment acuity and WA performance targets:

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

Monitoring the indicators related to treatment occurring within clinically recommended timeframes assists to manage the demand on ED services. This measures the effectiveness of service provision and assists in the facilitation of decision making for our clinical teams in order to determine the most appropriate location for ongoing treatment and care, whether that be within the hospital facility or within the community setting.
Table 5 demonstrates our performance against WEAT in 2016-17 and includes all health services with an ED, namely RPH, AHS and SJGMPH. In 2016-17 81.7 per cent of all triage category two and 90 per cent of all triage category five were seen within clinically recommended times, above the targets of 80 per cent and 70 per cent respectively. In 2016-17 the Australasian College for Emergency Medicine targets for patients categorised as triage one, three and four were not met. This remains consistent with reporting from previous years.

Table 5 - Percentage of patients seen within recommended times by triage category.

<table>
<thead>
<tr>
<th>Triage category</th>
<th>Target (per cent)</th>
<th>2016-17 actual (per cent)</th>
<th>Variation (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>100</td>
<td>99.90</td>
<td>0.1</td>
</tr>
<tr>
<td>2</td>
<td>80</td>
<td>81.7</td>
<td>1.7</td>
</tr>
<tr>
<td>3</td>
<td>75</td>
<td>45.2</td>
<td>29.8</td>
</tr>
<tr>
<td>4</td>
<td>70</td>
<td>62.3</td>
<td>7.7</td>
</tr>
<tr>
<td>5</td>
<td>70</td>
<td>90</td>
<td>20</td>
</tr>
</tbody>
</table>

Data source: Emergency Department Data Collection.

Learning from clinical incidents

It is an unfortunate reality that no system which delivers complex health care is free from risk or error. It is globally recognised (World Health Organisation, 2017) that errors in healthcare delivery are the cause of unintended harm and at times, associated with poor outcomes for patients.

Ensuring patient safety and the delivery of high quality care at all times is the number one priority for EMHS. To support this, EMHS has a proactive and transparent patient safety culture that uses a non-punitive approach to the reporting of and learning from, clinical incidents or errors.

During the 2016-17 year, there were more than 135,000 patients admitted to EMHS hospitals. In addition, more than 190,000 patients were seen in our EDs and another 480,000 patients were seen in an outpatient clinic or setting. The overwhelming majority of these patient interactions occurred without incident and this is a testament to the dedicated, highly skilled professionals that are the foundation of the health service, supported by processes and systems that are in place to mitigate error arising from human factors. However, for a very small percentage of patients errors did regretfully occur during their care and in some cases, these errors resulted in unintended harm.

To ensure that EMHS learns from the events and takes appropriate action to prevent similar events occurring in the future, a clinical incident management process is undertaken in accordance with the WA Clinical Incident Management Policy and the WA Open Disclosure Policy. The principles of Open Disclosure ensure that the patient, their family and/or carers are provided with information about the incident in a timely, open and honest manner and that they receive an apology for any harm that may have resulted, as early as possible.

So that the health service can adequately investigate the causes of clinical incidents, each incident is assigned a rating known as a Severity Assessment Code (SAC) score that guides staff in the type of investigation method to be applied to each event. Clinical incidents that result in serious harm or death (SAC 1) require a very detailed, rigorous investigation facilitated by an expert panel, members of which may at times, be completely independent to the health service.

In the interests of transparency and in support of the recent WA Health Safety and Quality Review led by Professor Hugo Mascie-Taylor, EMHS is sharing the number of serious clinical incidents that occurred in 2016-17 at our hospitals and services.

During 2016-17, 184 SAC 1 clinical incidents were reported by EMHS employees (Table 6). At the time of reporting, investigation of 182 of these incidents had been completed, with two in progress. Following investigation, 49 of the 182 incidents were ‘declassified’, meaning that the healthcare provided to the patient was determined not to have contributed to the incident or its associated outcome for the patient.
The total number of SAC1 incidents for 2016-17 is further defined in Table 6.

Table 6 - SAC 1 incidents 2016-17:

<table>
<thead>
<tr>
<th>SAC1 Incident</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notified</td>
<td>184</td>
</tr>
<tr>
<td>Investigated</td>
<td>182</td>
</tr>
<tr>
<td>Ongoing investigation</td>
<td>2</td>
</tr>
<tr>
<td>Declassified*</td>
<td>49</td>
</tr>
<tr>
<td>Total confirmed</td>
<td>135</td>
</tr>
<tr>
<td>Confirmed with patient outcome of death**</td>
<td>25</td>
</tr>
<tr>
<td>Confirmed with patient outcome of serious harm</td>
<td>65</td>
</tr>
<tr>
<td>Confirmed with patient outcome of moderate harm</td>
<td>4</td>
</tr>
<tr>
<td>Confirmed with patient outcome of minor harm</td>
<td>14</td>
</tr>
<tr>
<td>Confirmed with patient outcome of no harm</td>
<td>27</td>
</tr>
</tbody>
</table>

* Declassification of a reported SAC 1 clinical incident may occur following thorough investigation if it is identified that no healthcare causative factors contributed to the incident. Declassification requests are reviewed by two independent senior clinicians who have extensive experience in the area of safety and quality in healthcare. Declassification means that the event is no longer considered to be a clinical incident.

** For some of these incidents, other factors may be involved and therefore healthcare was not the only contributing factor or direct cause of the patient's death.

EMHS acknowledges the distress to patients and their loved ones that is brought about from any event that was unintended and regrettable, could have been prevented. To this end, the open and active reporting and investigation of SAC1 clinical incidents which do occur in EMHS are treated as critical learning opportunities to make our health care systems and processes safer into the future.

EMHS empowers its staff to be open, transparent and unswerving in the identification, reporting and management of clinical risks. The reliance on staff to report on unsafe practices or systems is vital to this process and high numbers of incidents can be associated with a healthy reporting and patient safety culture. Placing less emphasis on total numbers, EMHS places great value on the recommendations and actions that arise from each and every incident.

Example: Learnings from a serious clinical incident

Situation:
An elderly patient fell while they were walking to the toilet in a hospital emergency department and suffered a broken bone as a result of the fall.

Clinical incident:
The Incident Investigation Panel conducted a thorough investigation of the incident and concluded that the patient’s risk of falling had not been assessed or documented by staff on admission to the emergency department. Staff were therefore not appreciative of the fact that the patient was likely to fall while under their care.

Contributory factors:
The panel determined that processes were not in place for patients to be routinely assessed for their level of risk of falling, on admission to the department. In addition, some staff were not aware of the side effects of a particular medication that the patient was on, which made them at an increased risk of falling.

Recommendations:
1. The introduction of a tool in the emergency department that would mean that staff are prompted to routinely assess patients when they are admitted to the department, for their risk of falling.
2. To provide staff with training to support the implementation of the risk assessment tool, including training on the side effects of medications that may place a patient at an increased risk of falling.

Lessons learned:
All areas that care for patients must have ways to ensure that patients are assessed for their risk of falling. Staff training and education is vital to remaining aware of matters that may place patients at an increased risk of falling.
Infrastructure

With the exception of the newly built SJGMPH, many EMHS sites and services are housed within ageing facilities requiring significant maintenance and ongoing investment.

Established in 1855, RPH is Western Australia’s oldest public hospital and as such requires significant works to ensure that the infrastructure is maintained and compliant with building codes. EMHS is working on a site-planning exercise which is anticipated to provide options for the consolidation of land and buildings on the RPH site for consideration.

RPH was allocated $19.5 million from the 2015-16 capital works budget for upgrades to plant and equipment, lifts, central cooling towers, roof, emergency generators and air conditioning chillers. As buildings on the RPH campus continue to age, the implementation of minor works to keep the buildings useable will not be sustainable and significant increased investment is required.

At AKG $1.564 million of capital funding has been allocated for future redevelopment of both Armadale and Kalamunda Hospitals. In early 2017 Kalamunda Hospital commenced planning a program of capital works to upgrade major hospital infrastructure including the roof, hospital air conditioning, electrical switchboards, fire barriers, reception area and removal of asbestos cladding, with works commencing in July 2017.

An additional $550,000 of minor works was undertaken throughout EMHS during 2016-17.

Significant issues impacting EMHS

Establishment of EMHS as a new entity

The establishment of EMHS as a new board-governed statutory authority in 2016 generated a significant program of work to define and clarify roles and responsibilities between the health service and system manager, as well as the transition of services from SMHS and NMHS. This process was ongoing throughout 2016-17, with the gradual devolution of some system manager functions to the health service occurring throughout the year, such as audit and industrial relations.

Within EMHS, departments delivering area wide services including corporate, administrative, security, engineering and clinical coding were impacted by a range of changes to their functions. With many EMHS staff hailing from other health services, particularly NMHS and SMHS, a large focus of 2016-17 was to establish an EMHS-specific culture by acknowledging and supporting staff throughout these changes. This was achieved by defining roles and responsibilities within these amalgamated teams, focusing on team building and capitalising on the benefits the area health service model presented in terms of organisational effectiveness and efficiency. Throughout this process, the Board and Executive sought to ensure that each EMHS site and service held onto their unique identity, dictated by the significant history of the hospitals, while embracing the integration into and formation of an the area model.

Ensuring appropriate staffing levels and skill mix was a challenge in many areas of the organisation. System-wide shortages of some clinical staff has proven to be an issue, however has been mitigated to an extent by EMHS hospitals taking a collaborative approach to explore co-appointment of registrars to work across both the tertiary and general hospitals. In addition, EMHS has explored opportunities to use allied health staff to support the increased demand on medical staff, restructured the nursing workforce to encourage more nurses into frontline care and recruited nationally and internationally for those specialties where a significant shortage is experienced within WA.

Staff safety

Aggression and occupational violence was identified as a key issue in 2016-17 in recognition that frontline healthcare staff are one of the groups most likely to face aggression in the workplace.

In 2016-17, EMHS staff reported 3733 aggressive incidents. This included situations where staff members felt threatened, duress alarms were activated, violent altercations occurred, verbal or physical abuse was experienced and self-harm attempts or threats were made.

Staff are provided with training in aggression management to equip them with the skills to identify and manage aggressive behaviour in the workplace. Security cameras and highly trained security personnel are in place across key areas of each hospital, while duress alarms and personal protective equipment such as gloves and glasses are available to staff as requested.

As part of our continued focus on staff safety, EMHS has launched its Aggression Prevention Initiative (API). This is led by a steering committee of internal and external stakeholders (including WA Police) who are focused on a number of actions to reduce aggression across all EMHS sites. These actions include staff training and awareness, an increased focus on workplace reporting, driving cultural and workplace changes, more proactive community engagement and education and reviewing current governance processes and management of aggressive patients.

The API committee is also working closely with WA Police to develop a collaborative approach to aggression management. This will include developing a process to better support staff in reporting violent incidents to police and linking with the Perth Watch House to improve management of aggressive clients requiring medical assistance.

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An additional $550,000 of minor works was undertaken throughout EMHS during 2016-17.
Meeting community demand
Upon the establishment of EMHS, the Board and Executive worked tirelessly to obtain a sound understanding of the organisation’s demands, seeking to quickly assure themselves that services were being delivered in the most appropriate setting. This aims to ensure that patients who require hospital treatment have access to hospital based services and that patients who are able to be managed in the community in partnership with their GP have the appropriate supports as required.

The population of EMHS continues to grow and the demand for services remains significant. In 2016-17:
- more than 194,700 were treated in our emergency departments
- more than 135,400 people were admitted as inpatients to our hospitals
- more than 5,000 babies were born
- more than 47,900 operations were performed.

In order to meet the ongoing demand, a number of governance changes came in to effect in 2016-17 with continued work towards integration of Royal Perth and Bentley hospitals into the combined Royal Perth Bentley Group and establishment of Armadale Kalamunda Group, which better facilitates patient transfers across the two groups and more broadly across the health service.

Elective surgery wait lists
The establishment of EMHS also saw the inheritance of significant elective surgical wait lists with approximately 10,000 patients waiting for elective surgery (reportable/non-reportable and excluded procedures) at the commencement of the 2016-17 financial year. A number of key initiatives were completed throughout the year which included a targeted program aimed at reducing plastic surgery wait list, whereby 276 patients received their operation via additional funding from the Department of Health. The completion of additional gastroenterology procedures and a change in the patient pathways to ensure that patients receive timely access to care also assisted in reducing the elective surgery wait list.

Emergency departments
Managing demand via the ED is viewed of highest priority to all teams in EMHS. Comprehensive plans from all sites with EDs, namely RP, SJGMPH and AHS, were formulated in response to weakening performance in late 2016, in particular related to performance of the Western Australia Emergency Access Target (WEAT). Further detail on WEAT performance is available on page 30. A performance intervention notice was placed on the EMHS from the Department of Health requesting the development of recovery plans related to WEAT performance which aimed to address strategies to ensure sustained performance, and most importantly, timely access and equity to patient care via the emergency department. These strategies have been implemented and performance is tracked daily, weekly and monthly.

Peak winter period
Demand for hospital services traditionally peaks during winter months, placing significant pressure on the health care system. In 2016, the winter period was significant and extended, resulting in a significant volume of patients admitted from ED’s into inpatient beds. SJGMPH reported an increase in activity during the 2016 winter period, driven strongly by unplanned admissions from respiratory infections and exacerbated airway diseases.

In order to proactively improve the patient experience during the 2017 winter period, EMHS established a Winter Flow Collaborative Committee to develop strategies to address known pressure points during the winter demand period. This Committee comprised representatives from EMHS hospital and services, along with St John Ambulance and WA Primary Health Alliance, who together reviewed a number of areas including admission and discharge, referral and transfer pathways, staffing and public awareness.

Mental health
High demand for community mental health services has been experienced across EMHS, with a reported 26.5 per cent increase in occasions of service at community mental health services from 2015-16 to 2016-17. The increase in community mental health demand is impacted by a reduction in inpatient mental health admissions, with the mental health unit at Bentley Hospital noting a shift from the traditional inpatient model of care to a more community based focus.

EMHS commenced a significant program of work towards the establishment of a 12 bed inpatient youth mental health unit at Bentley Hospital, which will provide inpatient mental health services for patients between 16-24 years. This will further support existing youth mental health inpatient beds across the system. The existing Bentley Adolescent Unit (BAU), operated by the Child and Adolescent Mental Health Service (CAMHS), will relocate their inpatient child and adolescent mental health service to Perth Childrens Hospital upon its opening. At this same time, EMHS will open the East Metropolitan Youth Unit (EMyU) in the building currently occupied by the BAU at Bentley Hospital, under a new model of care. The EMyU will provide a safe and therapeutic youth service that delivers effective early intervention to support younger patients with mental health conditions.
East Metropolitan Health Service

Key Performance Indicators (KPIs)
Certification of KPIs

EAST METROPOLITAN HEALTH SERVICE
CERTIFICATION OF KEY PERFORMANCE INDICATORS FOR THE YEAR ENDED 30 JUNE 2017

We hereby certify that the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess East Metropolitan Health Service's performance and fairly represent the performance of the health service for the financial year ended 30 June 2017.

Ian Smith PSM
Board Chair
East Metropolitan Health Service
27 September 2017

Peter Forbes
Chair, EMHS Board Finance Committee
East Metropolitan Health Service
27 September 2017

Audit opinion

Please see the full audit opinion in the financial statements section.

Outcomes

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

Outcome one: Restoration of patients' health, provision of maternity care to women and newborns, and support for patients and families during terminal illness.

Outcome two: Enhanced health and well-being of Western Australians through health promotion, illness and injury prevention and appropriate continuing care.

Variation data legend

Please note the following legend for KPI variation data:

Target
Achieved data is undesired result

Achieved data is desired result

Actual
Percentage of patients discharged to home after admitted hospital treatment

**Rationale**
The main goals of health care provision are to ensure that people receive appropriate evidenced-based health care without experiencing preventable harm and that effective partnerships are forged between consumers, healthcare providers and organisations. Through achieving improvements in the specific priority areas that these goals describe, hospitals can deliver safer and higher-quality care, better outcomes for patients and provide a more effective and efficient health system.

Measuring the number of patients discharged to home after hospital care allows for the monitoring of changes over time that can enable the identification of the priority areas for improvement. This in turn enables the determination of targeted interventions and health promotion strategies, aimed at ensuring optimal restoration of patients’ health.

**Target**
The 2016 target is 97.3 per cent.

**Results**
During 2016 a total of 97.6 per cent of EMHS patients across all ages were discharged home following admitted hospital treatment.

Figure 2 demonstrates performance against age ranges, which when segmented demonstrates that the 40 to 49 and 80+ age groups failed to reach the target of 97.3%.

**Outcome one** Effectiveness KPI

Survival rates for sentinel conditions

**Rationale**
Hospital survival indicators should be used as screening tools, rather than being assumed to be definitively diagnostic of poor quality and/or safety.

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

These three conditions have been chosen as they are particularly significant for the 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 that include the diagnosis, the treatment given or procedure performed, age, co-morbidities at the time of the admission and complications which may have developed while in hospital.

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

**Results**
The performance of EMHS in the survival rate for stroke was met or exceeded in all age ranges with the exception of ages 60 to 69 years.

Figures 3a to 3c demonstrate performance against each age range.

**Outcome one** Effectiveness KPI

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**Data period:** July – December 2016.
**Data source:** Hospital Morbidity Data System.
Survival rates for sentinel conditions (continued)

The performance of EMHS in the survival rate for acute myocardial infarction varied amongst age range groupings.

Figure 3b - Survival rate for acute myocardial infarction by age group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Target</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-49</td>
<td>99.5%</td>
<td>97.3%</td>
</tr>
<tr>
<td>50-59</td>
<td>99.2%</td>
<td>100%</td>
</tr>
<tr>
<td>60-69</td>
<td>98.4%</td>
<td>97.4%</td>
</tr>
<tr>
<td>70-79</td>
<td>96.7%</td>
<td>97.9%</td>
</tr>
<tr>
<td>80+</td>
<td>92.7%</td>
<td>90.9%</td>
</tr>
</tbody>
</table>

Data period: July – December 2016.
Data source: Hospital Morbidity Data System.

Survival rates for sentinel conditions (continued)

The performance of EMHS in the survival rate for fractured neck of femur patients was under target in the age range 70 to 79 years and exceeded the target for age range 80+ years.

Figure 3c - Survival rate for fractured neck of femur by age group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Target</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>70-79</td>
<td>99%</td>
<td>97.8%</td>
</tr>
<tr>
<td>80+</td>
<td>96.4%</td>
<td>99.3%</td>
</tr>
</tbody>
</table>

Data period: July – December 2016.
Data source: Hospital Morbidity Data System.
Proportion of elective wait list patients waiting over boundary for reportable procedures

Outcome one  Effectiveness KPI

Rationale
On 1 April 2016, WA Health introduced a new state wide performance target for the provision of elective services. The new target requires no patients (0 per cent) on the elective waiting lists wait longer than the clinically recommended time for their procedure, according to their urgency category.

Reportable cases are defined as all waiting list cases that are not listed on the Elective Surgery Wait List Data Collection (ESWLDC) Commonwealth Non-Reportable Procedures list. This list is consistent with the Australian Institute of Health and Welfare (AIHW) excluded procedures list. It also includes additional procedure codes that are intended to better reflect the procedures identified in the AIHW excluded procedures list.

Target
The 2016-17 target for patients waiting over boundary for all urgency categories is 0 per cent. A result equal to target is desired.

Results
Figure 4a demonstrates that EMHS did not meet the target across all elective surgery categories. Please note that this data represents an average result for the whole financial year.

The EMHS was unable to meet this performance target due primarily to the need to address an ongoing high demand for emergency theatre services. While this directly affected EMHS’ ability to address the elective surgery wait list, significant reductions in over boundary wait list patients (for reportable procedures) were achieved, with the initial average of 11 per cent on the establishment of the health service in July 2016, reducing to 8 per cent at the close of the financial year. Per urgency category this equates to:

<table>
<thead>
<tr>
<th>Urgency Category</th>
<th>Boundary (days)</th>
<th>July 2016 (per cent)</th>
<th>June 2017 (per cent)</th>
<th>Variance (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>30</td>
<td>32</td>
<td>23</td>
<td>9</td>
</tr>
<tr>
<td>2</td>
<td>90</td>
<td>24</td>
<td>17</td>
<td>7</td>
</tr>
<tr>
<td>3</td>
<td>365</td>
<td>3</td>
<td>4</td>
<td>-1</td>
</tr>
</tbody>
</table>

The data period is 2016-17 financial year.

Data source: Elective Surgery Wait List Data Collection (ESWLDC), Inpatient Data Collections
Unplanned hospital readmissions within 28 days for selected surgical procedures (per 1000)

Rationale

Readmission rate is considered a global performance measure, as it potentially points to deficiencies in the functioning of the overall healthcare system. Good intervention, appropriate treatment together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. A low unplanned readmission rate suggests that good clinical practice is in operation. These readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

By measuring and monitoring this indicator, the level of potentially avoidable hospital readmissions can be assessed in order to identify key areas for improvement. This in turn can facilitate the development and delivery of targeted care pathways and interventions which can help to ensure effective restoration to health and improve the quality of life of Western Australians.

Target

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

Table: Unplanned hospital readmissions within 28 days

<table>
<thead>
<tr>
<th>Surgical procedure</th>
<th>Unplanned hospital readmissions within 28 days (rate per 1000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knee replacement</td>
<td>22</td>
</tr>
<tr>
<td>Hip replacement</td>
<td>21</td>
</tr>
<tr>
<td>Tonsillectomy and adenoidectomy</td>
<td>71</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>47</td>
</tr>
<tr>
<td>Prostatectomy</td>
<td>34</td>
</tr>
<tr>
<td>Cataract surgery</td>
<td>1</td>
</tr>
<tr>
<td>Appendicectomy</td>
<td>39</td>
</tr>
</tbody>
</table>

Results

The performance of EMHS met or exceeded target for four of the seven selected surgical procedures. EMHS strives to provide safe, high quality care to its patients at all times.

This practice is reflected in the performance (relative to the target) for knee replacement and tonsillectomy and adenoidectomy procedures in particular.

EMHS performance to target for hip replacement was attributable to six cases across two sites and on review, represented post-operative complications.

EMHS performance to target for hysterectomy was attributable to very low numbers, both in terms of the number of procedures being carried out and the number of readmissions. Performance is representative of three cases in total across the health service and no system issues have been identified.

Figure 5a demonstrates performance against the target for the selected surgical procedures.

Figure 5b - Unplanned hospital readmissions within 28 days for selected surgical procedures (per 1000)

- Knee replacement: Target 22, Actual 8.3
- Hip replacement: Target 21, Actual 30.6
- Tonsillectomy and adenoidectomy: Target 71, Actual 28.1
- Hysterectomy: Target 47, Actual 66.7
- Prostatectomy: Target 34, Actual 34.5
- Cataract surgery: Target 1, Actual 0.5
- Appendicectomy: Target 39, Actual 34.4

Data period: July – December 2016.

Data source: Hospital Morbidity Data System, Inpatient Data Collections.
Rate of unplanned readmissions within 28 days to the same hospital for a mental health condition (per 1000)

**Outcome one** Effectiveness KPI

**Rationale**
Readmission rate is considered a global performance measure because it potentially points to deficiencies in the functioning of the overall healthcare system. Admissions to a psychiatric facility following a recent discharge may indicate that inpatient treatment was incomplete or ineffective, or that follow-up care was inadequate to maintain the person out of hospital. These readmissions necessitate patients spending additional time in hospital and utilise additional hospital resources.

Good intervention and appropriate treatment together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. A low unplanned readmission rate suggests that good clinical practice is in operation. By measuring and monitoring this indicator, the level of potentially avoidable hospital readmissions for mental health patients can be assessed to identify key areas for improvement. This in turn can facilitate the development and delivery of targeted care pathways and interventions, which can aim to improve mental health and the quality of life of Western Australians.

For this indicator a sample period of three months is used and relevant data is subjected to clinical review to ensure the accuracy of the readmission status – unplanned or otherwise.

**Target**
The 2016 target rate is 66 unplanned readmissions per 1000.

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

**Results**
The EMHS did not meet the target rate for this indicator due primarily to the significant number of patients with complex mental health conditions amongst its patient cohort. However, strategies to ensure the effective transition of care for mental health patients into the community continue to be identified and adopted to reduce the rate of unplanned readmissions into the future.

Figure 6 - Rate of unplanned readmissions within 28 days to the same hospital for a mental health condition (per 1000).

<table>
<thead>
<tr>
<th>Target</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>66</td>
<td>81.9</td>
</tr>
</tbody>
</table>

Data period: This indicator is based on a three month period each year. For 2016, data is reported from 1 September – 30 November 2016.

Data source: Hospital Morbidity Data System, Inpatient Data Collections, clinical review

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

**Outcome one** Effectiveness KPI

**Rationale**
This indicator of the condition of the baby 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 possibly ten minutes after delivery to determine how well the infant is adapting outside the mother's womb. 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.

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

**Target**
The 2016 target is 1.8 per cent.

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

**Results**
The outcome of 0.82 per cent against a target of 1.8 per cent represents a good result for patients attending EMHS maternity units. The result is attributed to the low risk nature of EMHS maternity units and sound clinical practice.

Figure 7 - Percentage of liveborn term infants with an Apgar score of less than seven at five minutes post-delivery.

<table>
<thead>
<tr>
<th>Target</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.8%</td>
<td>0.82%</td>
</tr>
</tbody>
</table>

Data period: July – December 2016.

Data source: Midwives Notification System and Birth Notification Database.
Average cost per casemix adjusted separation for tertiary hospitals

Rationale
Tertiary hospitals provide critical health care for Western Australians and generally treat patients with complex health needs. While the role of tertiary hospitals is constantly evolving to meet the changing needs and characteristics of the population, they still provide core healthcare services such as acute medical care, emergency and intensive care services, complex specialty procedures, clinical research and training.

Target
The target for 2016–17 is $6789 per casemix adjusted separation for tertiary hospitals. A result below the target is desirable.

Results
EMHS average cost per casemix adjusted separation for tertiary hospitals was $6415, which is below the target of $6789. This refers only to RPH in EMHS as the single tertiary site across the health service. This has been achieved through improved cost capture and realignment of investigative costs associated with emergency presentations subsequently admitted to the average cost per ED attendance indicator and the increase in patient activity with minimal increase in staffing to deliver these services.

Average cost per casemix adjusted separation for non–tertiary hospitals

Rationale
WA Health aims to provide safe, high-quality health care to ensure healthier, longer and better quality lives for all Western Australians. Non-tertiary hospitals provide crucial health care for Western Australians. As with tertiary hospitals, the role of non-tertiary hospitals is constantly evolving to meet the changing needs and characteristics of the population, yet still provide comprehensive specialist healthcare services. Through measuring the cost of a hospital stay by the range and type of patients (the casemix) treated in non-tertiary hospitals, this indicator can facilitate improved efficiency in these hospitals by providing a transparent understanding of the cost of care.

Target
The target for 2016-17 is $6451 per casemix adjusted separation for non-tertiary hospitals. A result below the target is desirable.

Results
EMHS average cost per casemix adjusted separation for non-tertiary hospitals was $6172, which is below the target of $6451. This result has been driven by improved cost capture and realignment of investigative costs associated with emergency presentations subsequently admitted and changes in service delivery and models of care at those sites included in this measure, which enhance efficiency and productivity in patient care whilst maintaining a focus on patient safety.

Data period: 2016-17 financial year.
Data source: Hospital Morbidity Data System, health service financial systems.
Average cost per emergency department attendance

Rationale
WA Health aims to provide safe, high-quality health care to ensure healthier, longer and better quality lives for all Western Australians.

Emergency departments are specialist multidisciplinary units with expertise in managing acutely unwell patients for the first few hours in hospital. With the ever increasing demand on emergency departments and health services, it is imperative that health service provision is continually monitored to ensure the effective and efficient delivery of safe and high quality care.

Target
The target for 2016-17 is $714 per emergency department attendance.
A result below the target is desirable.

Results
For 2016-2017 the average cost per emergency department attendance was $858, above the target of $714. The increased cost was primarily due to improved cost capture and inclusion of investigative costs for patients presenting at EDs and subsequently admitted as an inpatient.

Figure 10 - Average cost per emergency department attendance

Average cost per public patient non-admitted activity

Rationale
WA Health aims to provide safe, high quality health care to ensure healthier, longer and better quality lives for all Western Australians.

Non-admitted care encompasses services provided to patients who do not undergo a formal admission process and do not occupy a hospital bed. These services provide consultations with a clinician or specialist to determine the most appropriate treatment of a patient’s condition.

Target
The target for 2016-17 is $277 per non-admitted activity.
A result below the target is desirable.

Results
EMHS average cost per public patient non-admitted activity was $382 against a target of $277, which was largely driven by the increased drug costs associated with the hepatitis C program.

Figure 11 - Average cost per public patient non-admitted activity
Percentage of contacts with community-based public mental health non-admitted services within seven days prior to admission to a public mental health inpatient unit

Outcome two Effectiveness KPI

Rationale
The impact of mental illness within the Australian population has become increasingly apparent, with mental illness being one of the leading causes of non-fatal burden of disease in Australia. In 2014-15 there were four million Australians (17.5 per cent of total population*) who reported having a mental or behavioural condition. That is why it is crucial to ensure effective and appropriate care is provided not only in a hospital setting, but also in the community care setting. A large proportion of treatment of mental illness is carried out in community care setting through ambulatory mental health services. The aim is to provide the best health outcomes for the individual through the provision of accessible and appropriate community mental healthcare. Thus, alleviating the need for, or assisting with improving the management of, admissions to hospital-based inpatient care for mental illness.

Monitoring the level of accessibility to community mental health services pre-admission to hospital can be gauged in terms of their practices. 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.

Results
Performance below target is attributed to the complex nature of mental health issues and situational crises that occur. Navigation through the mental health system can be challenging and EMHS is committed to improving this result to ensure mental health consumers have access to the most appropriate care and interventions at the most appropriate time and are provided with information on available services.

Caveat: Mental health community contacts and acute inpatient separations are sourced from two different data collection systems. Each system has a different unique patient identifier and requires the use of data linkage to allow unique tracking of consumers across all public mental health services in WA. This could result in an under estimate in the proportion of contacts identified.

Figure 12 - Percentage of contacts with community-based public mental health non-admitted services within seven days prior to admission

<table>
<thead>
<tr>
<th>Outcome two</th>
<th>Effectiveness KPI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target</strong></td>
<td>70%</td>
</tr>
<tr>
<td><strong>Actual</strong></td>
<td>57.1%</td>
</tr>
</tbody>
</table>

Data period: July – December 2016.
Data source: Mental Health Information System, Hospital Morbidity Data System.

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

Outcome two Effectiveness KPI

Rationale
In 2014-15 there were four million Australians (17.5 per cent of total population*) 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.

Results
In 2016, 72.4 per cent of patients who were admitted to an EMHS public mental health inpatient unit were contacted by a community-based public mental health services.

Caveat: Mental health community contacts and acute inpatient separations are sourced from two different data collection systems. Each system has a different unique patient identifier and requires the use of data linkage to allow unique tracking of consumers across all public mental health services in WA. This could result in an under estimate in the proportion of contacts identified.

Figure 13 - Percentage of contacts with community-based public mental health non-admitted services within seven days post-discharge

<table>
<thead>
<tr>
<th>Outcome two</th>
<th>Effectiveness KPI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target</strong></td>
<td>75%</td>
</tr>
<tr>
<td><strong>Actual</strong></td>
<td>72.4%</td>
</tr>
</tbody>
</table>

Data period: July – December 2016.
Data source: Mental Health Information System, Hospital Morbidity Data System.
Average cost per capita of population health units

**Outcome two Efficiency KPI**
Service seven: prevention, promotion and protection

**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 2012–2016 (the latest version is due for publication at the end of this year). This is based on the growing understanding of the social, cultural and economic factors that contribute to a person’s health status.

**Target**
The target for 2016-17 is $39 per capita of population health units. A result below the target is desirable.

**Results**
EMHS average cost per capita of population health units was $22 which is below the target of $39. This was due to reduction in expenditure associated with the phased establishment of EMHS population health units in our first year of operation.

Figure 14 - Average cost per capita of population health units

Notes: The total population used in the calculation of this KPI is based on the WA Health Epidemiology Branch from 2011–2015 estimates using the FORECAST function of Microsoft Excel 2010.
Data period: 2016-17 financial year.
Data source: Australian Bureau of Statistics, health service financial systems.

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

**Outcome two Efficiency KPI**
Service ten: contracted mental health

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

**Target**
The target for 2016-17 is $1379 per bed-day in specialised mental health inpatient units. A result below the target is desirable.

**Results**
EMHS average cost per bed-day in specialised mental health inpatient units was $1586 against a target of $1379, which is driven largely by the requirement to ensure a safe environment for staff and patients in this highly complex environment, with appropriate staffing and supports in place.

Figure 15 - Average cost per bed-day in specialised mental health inpatient units

Notes: The average unit cost for the delivery of mental health services includes statewide corporate overheads that incorporate costs borne by WA Health that are not included in the target methodology and Mental Health Commission service provision agreement.
Data period: 2016-17 financial year.
Data source: Mental Health Information System, BedState, health service financial systems.
Average cost per three month period of care for community mental health

**Rationale**
Mental health is having an increasing impact on the Australian population and is one of the leading causes of disability burden in Australia. In 2014-15 there were four million Australians (17.5 per cent of total population*) who reported having a mental or behavioural condition. Therefore, it is important to ensure effective and appropriate care is provided to mental health clients not only in a hospital setting, but also in the community through the provision of community mental health services.

Community mental health services consist of a range of community-based services such as emergency assessment and treatment, case management, day programs, rehabilitation, psychosocial and residential services. The aim is to provide the best health outcomes for the individual through the provision of accessible and appropriate community mental health care.


**Target**
The target for 2016-17 is $977 per three month period of care for a person receiving community mental health services.
A result below the target is desirable.

**Results**
The average cost per three month period for community mental health was $1752 against a target of $977. The result was primarily due an increase in services, including Midland/Swan mental health programs and inner city mental health programs that transitioned from NMHS to EMHS.

Figure 16 - Average cost per three month period of care for community mental health

Notes: The average unit cost for the delivery of mental health services includes statewide corporate overheads that incorporate costs borne by WA Health that are not included in the target methodology and Mental Health Commission service provision agreement.

Data period: 2016-17 financial year.
Data source: Non Admitted Patient Activity and Wait List Data Collection, Interim Collection of Aggregate Data (ICAD), health service financial systems.
Important note
All information within the disclosure and legal compliance section pertaining to staff is inclusive of staff working within EMHS corporate areas, AKG and RPBG. This data does not include staff employed at SJGMPH (with the exception of clinical staff who work on a rotational basis, such as medical interns) as they are employed privately by SJGMPH and will be included in the SJGMPH Annual Report for 2016-17.

Ministerial directives
Treasurer’s Instructions 903 (12) requires disclosing information on any Ministerial directives relevant to the setting of desired outcomes or operational objectives, the achievement of desired outcomes or operational objectives, investment activities and financing activities.
Although no ministerial directives were issued for EMHS in 2016-17, the Minister for Health provided a Statement of Expectation, which set out the Minister’s expectations for the roles and responsibilities of the EMHS Board, as well as its accountabilities and priorities. This was responded to by the EMHS Board with a Statement of Intent.
Click here to view these documents (external site).

Summary of board and committee remuneration
The total annual remuneration for each board or committee is listed in the following table. For full details of individual board or committees, please see appendix.

<table>
<thead>
<tr>
<th>Board/committee</th>
<th>Total remuneration ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Metropolitan Health Service Board</td>
<td>344,708</td>
</tr>
<tr>
<td>Armadale Kalamunda Group Consumer Advisory Committee</td>
<td>2190</td>
</tr>
<tr>
<td>Bentley Hospital Community Advisory Council</td>
<td>3240</td>
</tr>
<tr>
<td>Royal Perth Hospital Community Advisory Council</td>
<td>1320</td>
</tr>
<tr>
<td>Royal Perth Bentley Group Mental Health Consumer and Carer Advisory Group</td>
<td>3380</td>
</tr>
<tr>
<td>Midland Consumer Advisory Group (Mental Health)</td>
<td>1740</td>
</tr>
<tr>
<td>Armadale Aboriginal Health Community Advisory Group</td>
<td>3450</td>
</tr>
<tr>
<td>Bentley Aboriginal Health Community Advisory Group</td>
<td>2870</td>
</tr>
<tr>
<td>Swan Hills/Midland Aboriginal Health Community Advisory Group</td>
<td>1335</td>
</tr>
<tr>
<td>Royal Perth Inner City Aboriginal Health Community Advisory Group</td>
<td>2130</td>
</tr>
<tr>
<td>Aboriginal Health Advisory Council</td>
<td>1230</td>
</tr>
<tr>
<td>Royal Perth Hospital Animal Ethics Group</td>
<td>28,540</td>
</tr>
</tbody>
</table>

Pricing policy
EMHS complies with the National Health Reform Agreement 2016 and the Department of Health Fees and Charges Manual regarding prices set for public hospital fees and charges. As outlined in the National Health Reform Agreement 2016, an eligible person who receives services as a public patient in a public hospital or a publicly contracted bed in a private hospital is treated free of charge. The Fees and Charges Manual sets out the rules and pricing in relation to fees and charges that EMHS may apply for health services, goods and other services. EMHS updates the fees they charge to patients on an annual basis to ensure they comply with the manual. As stated in the manual, EMHS is able to charge fees for the following patient categories:
- Privately insured patients: fees for private inpatients admitted to an EMHS hospital are charged as outlined in the Fees and Charges Manual. The same day and shared room fee is set according to the Commonwealth Minimum Benefit Table.
- Privately uninsured patients: fees for privately uninsured patients are set as above however the fees are charged directly to the patient.
- Ineligible overseas visitor: overseas visitors who are not Medicare-eligible or have a Reciprocal Health Care Agreement with Australia are charged fees as outlined in the Fees and Charges Manual. These fees are charged either directly to the patient or to their travel insurance.
- Overseas student: overseas students are required to have health insurance cover as part of their visa requirements to enter Australia. Fees are charged as outlined in the Fees and Charges Manual. Where students do not have appropriate insurance, they are treated as ineligible overseas visitors.
- Motor vehicle: there is a memorandum of understanding between the Department of Health and the Insurance Commission of WA (ICWA) which involves ICWA accepting upfront liability for medical expenses associated with legitimate motor vehicle accident (MVA) claims. Fees are charged directly to ICWA.
- Eastern States motor vehicle: in the event of a MVA involving only vehicles registered in other States, then the relevant interstate third party insurance authority is charged the applicable compensable patient rate.
- Australian Defence Force: patients who are members of the Australian Defence Force are classified as compensable and fees charged as outlined in the Fees and Charges Manual. Fees are charged directly to the Department of Defence as the liable insurer.
- Foreign Defence Force: patients who are members of a Foreign Defence Force are classified as compensable and fees charged as outlined in the Fees and Charges Manual. Invoices are issued in partnership with the Australian Defence Force.
- Department of Veterans’ Affairs (DVA): hospital charges of eligible war service veterans are determined under a separate Commonwealth-State agreement with DVA. Under this agreement, EMHS 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 merchant.

Further information on the classification and charging of the patient categories listed above can be found in the Fees and Charges Manual 2017-18.
Capital works

EMHS has made substantial investment in improvement and development of its infrastructure during the 2016-17 financial year.

Table 8 shows the capital work projects (CWP) undertaken during this financial year.

Table 8 - Capital works projects undertaken during 2016-17

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Estimated Total Cost ($'000)</th>
<th>Original budget 2016-17 ($'000)</th>
<th>Revised Budget 2016-17 ($'000)</th>
<th>Actual 2016-17 ($'000)</th>
<th>Variance ($'000)</th>
<th>Expected Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armadale Health Service - Development (CWP)</td>
<td>11,146</td>
<td>-</td>
<td>190</td>
<td>0</td>
<td>190</td>
<td>30/06/18</td>
</tr>
<tr>
<td>Bentley Hospital - Development (CWP)</td>
<td>9,962</td>
<td>475</td>
<td>475</td>
<td>0</td>
<td>475</td>
<td>30/06/20</td>
</tr>
<tr>
<td>Kalamunda Hospital Infrastructure Upgrade (CWP)</td>
<td>1,939</td>
<td>-</td>
<td>1,374</td>
<td>0</td>
<td>1,374</td>
<td>30/06/18</td>
</tr>
<tr>
<td>Royal Perth Hospital - Redevelopment Stage 1 (CWP)</td>
<td>16,880</td>
<td>9,029</td>
<td>16,731</td>
<td>10,884</td>
<td>5,847</td>
<td>30/06/17</td>
</tr>
<tr>
<td>St John of God Midland Public Hospital (CWP)</td>
<td>348,603</td>
<td>498</td>
<td>1,476</td>
<td>295</td>
<td>1,181</td>
<td>31/12/17</td>
</tr>
<tr>
<td>RPH Helipad (CWP)</td>
<td>6,800</td>
<td>0</td>
<td>520</td>
<td>0</td>
<td>520</td>
<td>30/06/19</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>395,330</strong></td>
<td><strong>10,002</strong></td>
<td><strong>20,766</strong></td>
<td><strong>11,179</strong></td>
<td><strong>9,587</strong></td>
<td></td>
</tr>
</tbody>
</table>

Notes:
1. The expected completion date was not met due to the complexities in the manufacturing process for major equipment
2. Completion of works related to minor defects in ICT interoperability extended the life of the project beyond the expected completion date.

Staff profile

Government agencies are required to report a summary of the number of employees for the financial year. As at the pay period ending 25 June 2017, EMHS employed a total of 7154 staff (individual staff head count), or 5776 full time equivalent (FTE).

Table 9 shows the year to date (as at June 2017) number of EMHS FTE employees for 2016-17 by employment category.

Table 9 - Full-time equivalent (FTE) employees for 2016-17 financial year by category

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
<th>2016-17 FTE equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>Includes all clerical-based occupations together with patient-facing (ward) clerical support staff.</td>
<td>904</td>
</tr>
<tr>
<td>Hotel services</td>
<td>Includes:</td>
<td>806</td>
</tr>
<tr>
<td>- Catering</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Cleaning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Stores/supply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Laundry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Transport occupations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>Includes all salary-based medical occupations including:</td>
<td>845</td>
</tr>
<tr>
<td>- Interns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Registrars</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Specialist medical practitioners.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Specialist medical practitioners engaged on a sessional basis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical support</td>
<td>Includes all allied health and scientific / technical related occupations.</td>
<td>789</td>
</tr>
<tr>
<td>Nursing</td>
<td>Includes all nursing occupations and agency nursing</td>
<td>2269</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Includes:</td>
<td>138</td>
</tr>
<tr>
<td>- Engineering</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Grounds and garden</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Security</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Maintenance (infrastructure)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other services</td>
<td>Includes Aboriginal and ethnic health worker related occupations.</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>5776</strong></td>
</tr>
</tbody>
</table>
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 now 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 application and interpretation of industrial agreements
- represents EMHS in IR matters before industrial tribunals.

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.

Staff development
The provision of ongoing staff development is an essential contributing factor to quality service delivery, employee engagement, performance and retention within EMHS.

EMHS has a dedicated team of education staff who provide high quality training to all staff. 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:

- opportunities to participate in information and education sessions, skills training, formal and informal upskilling programs
- clinical scenario training and innovative scenario unit based specialty simulations aimed at developing technical and non-technical skills

Additionally, a team development approach has been taken for training on topical issues, using principles such as evidence based practice, clinical audit, accreditation standards, organisational development and redesign.

Workers’ compensation
The Western Australian Workers’ Compensation system was established by the State Government and exists under that statute of the Workers’ Compensation and Industry Management Act 1981.

EMHS is committed to providing staff with a safe and health work environment in order to deliver effective and efficient health care services. In 2016-17 a total of 299 workers compensation claims were made.

<table>
<thead>
<tr>
<th>Employee category</th>
<th>Total claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration and clerical</td>
<td>35</td>
</tr>
<tr>
<td>Assistants in nursing</td>
<td>6</td>
</tr>
<tr>
<td>Hotel services</td>
<td>80</td>
</tr>
<tr>
<td>Medical salaried</td>
<td>12</td>
</tr>
<tr>
<td>Medical support</td>
<td>28</td>
</tr>
<tr>
<td>Nursing</td>
<td>113</td>
</tr>
<tr>
<td>Site services</td>
<td>27</td>
</tr>
<tr>
<td>Other categories</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>299</strong></td>
</tr>
</tbody>
</table>
Unauthorised use of Western Australian Government purchasing cards ("credit cards")

Western Australian Government purchasing cards can be issued by EMHS to employees where their functions warrant usage of this facility. These credit cards are not to be used for personal (unauthorised) purposes (i.e. a purpose that is not directly related to performing functions for the agency).

All credit card purchases are reviewed by someone other than the cardholder to monitor compliance. If during a review it is determined that the credit card was used for unauthorised purchases, written notice must be given to the cardholder and the EMHS board.

EMHS did not have any instances where a purchasing card was used for personal purposes in 2016-17.

Contracts with 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 2016–17 all EMHS board members and Executives submitted annual declarations and there were none that held interests in an existing or proposed contract that has, or could result in, the member receiving financial benefits.

Expenditure on advertising

In 2016–17 in accordance with section 175Z of the Electoral Act 1907 EMHS incurred a total advertising expenditure of $380,036.05.

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

<table>
<thead>
<tr>
<th>Summary of advertising</th>
<th>Amount ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advertising agencies</td>
<td>0.00</td>
</tr>
<tr>
<td>Market research organisations</td>
<td></td>
</tr>
<tr>
<td>Press Ganey (patient survey)</td>
<td>285,145.38</td>
</tr>
<tr>
<td>Press Ganey (staff survey)</td>
<td>82,427.71</td>
</tr>
<tr>
<td>Total</td>
<td>367,573.09</td>
</tr>
<tr>
<td>Polling organisations</td>
<td>0.00</td>
</tr>
<tr>
<td>Media advertising organisations</td>
<td></td>
</tr>
<tr>
<td>Adcorp</td>
<td>10,391.23</td>
</tr>
<tr>
<td>Fairfax Media</td>
<td>400.06</td>
</tr>
<tr>
<td>Curtin FM</td>
<td>80.00</td>
</tr>
<tr>
<td>Minnis Journals</td>
<td>765.00</td>
</tr>
<tr>
<td>The Royal Australian and New Zealand College of Psychiatrists</td>
<td>160.00</td>
</tr>
<tr>
<td>Australian and New Zealand Intensive Care Society</td>
<td>666.67</td>
</tr>
<tr>
<td>Total</td>
<td>12,462.96</td>
</tr>
<tr>
<td>Total advertising expenditure</td>
<td>380,036.05</td>
</tr>
</tbody>
</table>

Table 11 - Advertising (by class of expenditure) in 2016-17
Government building training policy

The Works Procurement Policy stipulates that for all capital and maintenance works above $2 million, 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.

Disability access and inclusion plan outcomes

EMHS is committed to ensuring that people with disabilities, their families and carers are provided with the same opportunity, rights and responsibilities as other people in the community. EMHS has developed a Disability Access and Inclusion Plan (DAIP) in accordance with the statutory responsibilities of the Disability Services Act’s Regulations 2004 and other related legislation (such as Equal Opportunity Act of 1984) and is based on seven desired disability outcomes. This plan acknowledges the Department of Health’s 2016-2020 DAIP and the requirement for all staff to actively work towards progressing better access and inclusion in our workplaces.

Opportunity to provide feedback

Staff and consumers are provided with a range of ways to provide feedback to the organisation. Staff are made aware of the need to identify alternate communication mediums as required to enable people with a disability to provide feedback on our services.

Participation in public consultation

Opportunities for public consultation are advertised externally giving consideration to the requirements of people with a disability. The health service also seeks to ensure that venues used for public participation and consultation events are accessible and that information provided during consultation processes is made available in alternative formats as required.

Opportunities to obtain and maintain employment

EMHS is committed to assisting people with disability to obtain and maintain employment with the health service. This is supported through a number of initiatives as detailed below:

- The requirement to adhere to the Equal Opportunity Act of 1984 is standard duty in all EMHS positions. This is formalised in the EMHS job description form (JDF) template. Additionally managers are required to identify their knowledge in relation to this legislation when addressing essential selection criteria within the recruitment process.

- The accessibility of the EMHS JDF is taken into consideration including formatting and the use of plain English and inclusive and non-discriminatory language.

- All recruitment processes include a statement to encourage applications from people with disabilities. Where positions are advertised on the WA Government jobs board, the WA Health diversity statement highlights our requirement to adhere to the Equal Opportunity Act of 1984 is standard duty in all EMHS positions. This is formalised in the EMHS job description form (JDF) template. Additionally managers are required to identify their knowledge in relation to this legislation when addressing essential selection criteria within the recruitment process.

- The accessibility of the EMHS JDF is taken into consideration including formatting and the use of plain English and inclusive and non-discriminatory language.

- All recruitment processes include a statement to encourage applications from people with disabilities. Where positions are advertised on the WA Government jobs board, the WA Health diversity statement highlights our commitment to eliminating discrimination in the provision of our service and encourages applications from a number of diversity groups including people with disabilities.

- Where an employee discloses that they have a disability, EMHS human resource services are available for support and advice in relation to application of reasonable adjustments/modifications to the assessment process, as well as in the workplace where this may be required to support appointment of a person with a disability as outlined in the WA Health Recruitment, Selection and Appointment policy.

- During induction, education on employee responsibilities in relation to equal opportunity as well as information to improve awareness of the objectives of the WA Health Equity and Diversity Strategy 2015–2020 is provided.
Compliance with public sector standards and ethical codes

EMHS is committed to the Public Sector Standards in Human Resource Management. The following policies and guidelines cover EMHS and are consistent with the public sector standards and available to all employees on the EMHS and/or WA Health intranet sites.

- WA Health Employee Grievance Resolution Policy
- EMHS Employee Grievance Resolution Guidelines
- WA Health Recruitment Selection and Appointment Policy and Procedure
- WA Health Discipline Policy, Explanatory Notes and Template letters
- EMHS Performance Development Policy and generic template
- EMHS Employee Separation Policy
- EMHS Expression of Interest Guidelines and template

Information relating to the Public Sector Standards and 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 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
- Health Support Services Termination/Cessation Forms and checklists
- EMHS Employee Support Officer Network – trained employees available to provide information about processes/resources to employees with workplace concerns/queries.

HR Managers/Consultants are also available at each EMHS site to provide information and support to managers in the implementation of the public sector standards.

EMHS Human Resource (HR) Services and site based Training and Development Departments make training available to managers on a number of HR topics. Stand-alone training is available for recruitment, selection and appointment and EMHS Industrial Relations has also commenced roll out during 2016-17 of new information/training sessions aimed more specifically at supporting management of disciplinary issues.

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 required to review and investigate all complaints alleging non-compliance with the Code of Ethics or Code of Conduct. During the 2016-17 financial year, EMHS had 110 reported cases of potential breaches of discipline (some of which involve misconduct) including 33 as a potential breach of the WA Health Code of Conduct, with 15 cases that contained substantiated breaches of the Code.

Freedom of information

The Western Australian 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 Western Australian Freedom of Information Act 1992.

Note: please see the appendix for site contact details.

In the 2016-17 financial year, EMHS received 2758 new applications under FOI legislation. This included:

- Armadale Health Service: 422 personal access applications and 53 non-personal access applications
- Kalamunda Hospital: 3 personal access applications
- Royal Perth Hospital: 1710 personal access applications and 296 non-personal access applications
- Bentley Hospital: 260 personal access applications and 13 non-personal access applications
- EMHS: 1 non-personal access application.

For additional information about FOI, including application forms and information brochures please see:
- Armadale Kalamunda Group (external site)
- Royal Perth Hospital (external site)
- Bentley Hospital (external site)
- Office of the Information Commissioner of Western Australia (external site)
Recordkeeping plans
The EMHS Recordkeeping Plan was developed to progress compliance against the State Records Act 2000 and was approved by the State Records Commission (SRC) in April 2017. As part of this approval, the SRC acknowledged EMHS's commitment to improve recordkeeping practices within the timeframes contained in the plan. The EMHS Recordkeeping Plan provides an accurate reflection of the current recordkeeping systems/programs within the organisation, including information regarding the organisations recordkeeping system(s), disposal arrangements, policies, practices and processes. EMHS has committed to reviewing existing guidelines and corporate recordkeeping policies and procedures, with a longer term plan to implement an electronic document records management system. All EMHS staff are required to complete Records Awareness Training. With the implementation of an electronic recordkeeping system, further training will be conducted through online modules and education sessions. Resources, advice and guidance regarding corporate recordkeeping are made available to all staff through the intranet, recordkeeping system, further training will be conducted through online modules and education sessions.

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:

- Establishing strategic partnerships with Aboriginal people through the creation of four Aboriginal Health Community Advisory Groups and an Aboriginal Health Advisory Council.
- Using the Aboriginal Impact Statement and Declaration process which aims to ensure that the needs, interests and circumstances of Aboriginal clients and employees are incorporated into the development of new and revised policies, programs, strategies and practices.
- Delivering community and population health programs specifically for Aboriginal people across the metropolitan region by appropriately trained Aboriginal staff, with the aim of education, prevention and management of chronic disease and illnesses.
- Engaging with Aboriginal patients and families to improve access and pathways for Aboriginal people in hospital through Aboriginal Health Liaison Officers located throughout EMHS sites.
- Delivery of 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.
- Cultural Respect strategies currently being undertaken include engagement in activities and events of cultural significance, such as the Aboriginal community calendar and cultural protocols that respect and acknowledge Aboriginal ways of communicating and engaging in all aspects of health service delivery. This includes formal practice of Welcome to Country and Acknowledgement of Traditional Owners, flag raising ceremonies and smoking ceremonies.
- Engaging with the Aboriginal workforce in EMHS is occurring through the establishment of an Aboriginal Workforce Engagement Group. The aim of the group is to engage with Aboriginal staff, share information and seek their feedback to support development of strategies and initiatives that support attraction, retention and recruitment of Aboriginal people which will ultimately contribute to culturally appropriate service delivery.
- Developing targeted employment strategies for Aboriginal people who are currently under-represented in the health workforce.

Occupational safety, health and injury management
EMHS is committed to ensuring the safety, health and welfare of its staff, volunteers, students, contractors, patients and visitors through the following principles:

- compliance with all relevant Occupational Safety and Health (OSH) legislation, regulations and EMHS OSH policies, procedures and safe work practices
- enhancing the effectiveness of the OSH management system by consulting with employees and contractors on issues of health and safety
- improving our OSH performance by establishing measurable objectives and targets through OSH planning activities
- undertaking OSH risk management activities to adequately control risks to people in the work environment
- providing adequate facilities to protect the health, safety and welfare of all employees
- adequately communicating with all staff to enable safe work practices that minimise the risk to health
- promoting, training and supporting safety and health representatives to be a key safety resource and provide sufficient time to undertake their legislative responsibilities and duties.

Furthermore, the OSH Commitment Statement, which is made on behalf of the Chief Executive, is currently under review given the recency of EMHS being established as a statutory authority. This statement will include information related to the EMHS Executive OSH Steering Group being responsible for the ongoing monitoring and review of OSH management requirements and Area Strategic Occupational Health and Safety Plan initiatives and action plans.

Employee consultation
Consultation with employees is undertaken by site OSH committee members at departmental meetings through standing agenda items. All EMHS sites have OSH management committees, as well as Workplace Safety and Health Committees. These relate to work areas where the size of the health service requires its own organisational structure.

Workplace Safety and Health Committees are responsible for:

- facilitating consultation and cooperation between the employer and employees in initiating, developing and implementing measures designed to ensure the safety and health of employees in the workplace
- ensuring its members are kept informed about current safety and health standards in comparable workplaces
- reviewing and providing recommendations to the employer about workplace rules and procedures in relation to the safety and health of its employees
- providing recommendations to the employer and employees about the establishment, maintenance and monitoring of programs, measures and procedures in the workplace that are related to the safety and health of the employees
- retaining any records and statistics supplied by the employer regarding the hazards to persons that arise or may arise at the workplace
- considering and making recommendations to the employer about any changes or intended changes in the workplace that could possibly affect the safety or health of employees at the workplace
- considering any matters referred to the Committee by an elected or otherwise recognised Occupational, Safety and Health representative
- perform any other functions that may be prescribed in the Regulations or given to the Committee, with its consent, by the employer.

Workplace Safety and Health Committees are evaluated at least bi-annually to ensure they meet their functional requirement and objectives. Each site has an active base of safety representatives in place which is 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 System 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. This includes:

- Employee rehabilitation
- Review of return to work programs and injury management programs at EMHS. The organisation has been evaluated by RiskCover as fully compliant with the WA Workers Compensation and Injury Management code of practice.
- Employee Assistance Programs and injury management programs at EMHS. The organisation has been evaluated by RiskCover as fully compliant with the WA Workers Compensation and Injury Management code of practice.

Best practice injury management strategies implemented in EMHS include:

- Provision of return to work without delay to assist with recovery and consideration of alternative work areas where appropriate
- Provision of exercise and treatment programs while on workers’ compensation to facilitate recovery and return to work
- Provision of counselling through employee assistance program provider 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 an injury management programs at EMHS. The organisation has been evaluated by RiskCover as fully compliant under the WA Workers Compensation and Injury Management code of practice.

Employee rehabilitation

EMHS has established a systematic approach to workplace-based injury management services for all employees following work-related injury, illness or disability. This includes:

- Active IMS and injury management policies and guidelines
- Fitness for work policy and program including occupational physician assessments
- Employee Assistance Program
- Exercise, fitness and wellness programs whilst on Workers’ Compensation
- Graduated return to work plans in place for all workers with medical restrictions
- Detailed claim pack containing information on claim process and Injury management
- Manager education regarding injury management and an easy to follow guide
- IMC to provide support and guidance throughout the claim process, ensuring that we remain in constant contact with the workers.

Assessment of the occupational safety and health management system and performance indicators

OSH management system audits have been completed at AHS and Kalamunda Hospital (2013), BHS (2014) and RPH (2016) against AS/NZS 4801:2001 and the WorkSafe Plan as an assessment tool. AHS and BHS 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, BHS in 2019 and RPH in 2021. A chemical substances and compliance audit is undertaken every three years in order to maintain an up-to-date database of all chemicals and dangerous goods used in the organisation by site. This audit was conducted in March 2015 and action plans are now completed or ongoing actions monitored through each of the hospitals’ Workplace Health and Safety Committees. A further audit across EMHS is planned for 2018.

EMHS monitors and manages any WorkSafe improvement notices through their site OSH Committees and centrally to ensure they are completed by the due date set by WorkSafe. Any WorkSafe notices received by any EMHS site are also reviewed by all other EMHS sites to ensure compliance.

Performance reported for EMHS for occupational safety, health an injury indicators for 2016-17 is summarised in Table 12.

### Occupational safety, health and injury performance 2016-17

<table>
<thead>
<tr>
<th>Target</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.71¹</td>
<td>3.42</td>
</tr>
</tbody>
</table>

**Notes:**

Data excludes declined or cancelled claims where no compensation was paid, but includes withdrawn and pending claims (where lost time was estimated). Other exclusions as outlined in the Code of Practice: Occupational Safety and Health in the Western Australian Public Sector apply.

1 Target is a 10% reduction of LTI as at 01/07/13 to 30/06/14 = 3.01
2 Target is a 10% reduction of LTBI as at 01/07/13 to 30/06/14 = 43.8%

This is an aspirational target determined internally as no formal target is stipulated.

1 and 2: Target outlined in the Occupational safety, health and injury management annual reporting guidelines for 2014 to 2016 (as attached to Premier’s Circular 2007/12, Public Sector Commissioner’s Circular 2009-11 Code of Practice: Occupational Safety and Health in the Western Australian Public Sector).

LTI/D - Total incidents (injury/disease) where a day/shift or more was lost from work. Calculation is [total claims divided by total employees (FTE - excluding leave)]

LTI/D severity rate (per 100) - Lost time injury severity rate (percentage of all LT/D) - Percentage of injured workers returned to work within 13 weeks

LTI/D incident rate (per 100) - Lost time injury diseases (LTI/D) - Percentage of injured workers returned to work within 26 weeks

Percentage of managers trained in occupational safety, health and injury management responsibilities

### Table 12 - Annual performance for 2016-17

<table>
<thead>
<tr>
<th></th>
<th>Fatalities</th>
<th>Lost time injury diseases (LTI/D) incident rate (per 100)</th>
<th>Lost time injury severity rate (percentage of all LT/D)</th>
<th>Percentage of injured workers returned to work within 13 weeks</th>
<th>Percentage of injured workers returned to work within 26 weeks</th>
<th>Percentage of managers trained in occupational safety, health and injury management responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>0</td>
<td>2.71¹</td>
<td>39.4²</td>
<td>70⁰</td>
<td>80’ or above</td>
<td>80° or above</td>
</tr>
<tr>
<td>Actual</td>
<td>0</td>
<td>3.42</td>
<td>50.30</td>
<td>56.3</td>
<td>69.8</td>
<td>81</td>
</tr>
</tbody>
</table>

### Notes:

Data excludes declined or cancelled claims where no compensation was paid, but includes withdrawn and pending claims (where lost time was estimated). Other exclusions as outlined in the Code of Practice: Occupational Safety and Health in the Western Australian Public Sector apply.

1 Target is a 10% reduction of LTI as at 01/07/13 to 30/06/14 = 3.01
2 Target is a 10% reduction of LTBI as at 01/07/13 to 30/06/14 = 43.8%

3 This is an aspirational target determined internally as no formal target is stipulated.

4 and 5: Target outlined in the Occupational safety, health and injury management annual reporting guidelines for 2014 to 2016 (as attached to Premier’s Circular 2007/12, Public Sector Commissioner’s Circular 2009-11 Code of Practice: Occupational Safety and Health in the Western Australian Public Sector).

LTI/D - Total incidents (injury/disease) where a day/shift or more was lost from work. Calculation is [total claims divided by total employees (FTE - excluding leave)].

LTI/D severity rate (per 100) - Lost time injury severity rate (percentage of all LT/D) - Percentage of injured workers returned to work within 13 weeks

LTI/D incident rate (per 100) - Lost time injury diseases (LTI/D) - Percentage of injured workers returned to work within 26 weeks

Percentage of managers trained in occupational safety, health and injury management responsibilities

A proportion of LTI/D incidents used in this calculation were lodged pre-July 2016 (given the periods used to calculate RTW rates) and therefore these staff were employed by another health service provider when the claim was lodged.
### Annual estimates for 2017-18

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 2017–18 as approved by the Minister for Health are:

Table 13 - Statement of comprehensive income

<table>
<thead>
<tr>
<th>Description</th>
<th>2017-18 estimate ($’000)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INCOME</strong></td>
<td></td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
</tr>
<tr>
<td>Patient charges</td>
<td>65,506</td>
</tr>
<tr>
<td>Other fees for services</td>
<td>51,237</td>
</tr>
<tr>
<td>Commonwealth grants and contributions</td>
<td>386,489</td>
</tr>
<tr>
<td>Other grants and contributions</td>
<td>167,964</td>
</tr>
<tr>
<td><strong>Total revenue</strong></td>
<td><strong>671,195</strong></td>
</tr>
<tr>
<td><strong>Total income other than income from State Government</strong></td>
<td><strong>671,195</strong></td>
</tr>
<tr>
<td><strong>NET COST OF SERVICES</strong></td>
<td><strong>736,489</strong></td>
</tr>
<tr>
<td><strong>Income from State Government</strong></td>
<td></td>
</tr>
<tr>
<td>Service appropriation</td>
<td>694,762</td>
</tr>
<tr>
<td>Services received free of charge</td>
<td>41,727</td>
</tr>
<tr>
<td><strong>Total income from State Government</strong></td>
<td><strong>736,489</strong></td>
</tr>
<tr>
<td><strong>SURPLUS FOR THE PERIOD</strong></td>
<td>-</td>
</tr>
<tr>
<td><strong>OTHER COMPREHENSIVE PROFIT/(LOSS)</strong></td>
<td></td>
</tr>
<tr>
<td>Items not reclassified subsequently to profit or loss</td>
<td>-</td>
</tr>
<tr>
<td><strong>TOTAL COMPREHENSIVE LOSS FOR THE PERIOD</strong></td>
<td>-</td>
</tr>
</tbody>
</table>

Note: Section 40 estimates were approved by the Minister for Health prior to the finalisation of the State budget and the figures are based on the Service Agreement with the Department of Health as at 30 June 2017.
### Table 14 - Statement of financial position

**Statement of financial position**

<table>
<thead>
<tr>
<th>ASSETS</th>
<th>2017-18 estimate ($'000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current assets</td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>83,848</td>
</tr>
<tr>
<td>Restricted cash and cash equivalents</td>
<td>26,395</td>
</tr>
<tr>
<td>Receivables</td>
<td>32,200</td>
</tr>
<tr>
<td>Inventories</td>
<td>5,585</td>
</tr>
<tr>
<td>Other current assets</td>
<td>1,028</td>
</tr>
<tr>
<td>Total current assets</td>
<td>149,056</td>
</tr>
<tr>
<td>Non-current assets</td>
<td></td>
</tr>
<tr>
<td>Amounts receivable for services</td>
<td>430,654</td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>915,322</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>2,885</td>
</tr>
<tr>
<td>Other non-current assets</td>
<td>2,977</td>
</tr>
<tr>
<td>Total non-current assets</td>
<td>1,351,838</td>
</tr>
<tr>
<td>Total assets</td>
<td>1,500,894</td>
</tr>
</tbody>
</table>

**LIABILITIES**

<table>
<thead>
<tr>
<th>Current liabilities</th>
<th>2017-18 estimate ($'000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payables</td>
<td>70,186</td>
</tr>
<tr>
<td>Borrowings</td>
<td>30</td>
</tr>
<tr>
<td>Provisions</td>
<td>142,319</td>
</tr>
<tr>
<td>Other current liabilities</td>
<td>220</td>
</tr>
<tr>
<td>Total current liabilities</td>
<td>212,755</td>
</tr>
<tr>
<td>Non-current liabilities</td>
<td></td>
</tr>
<tr>
<td>Borrowings</td>
<td>1,658</td>
</tr>
<tr>
<td>Provisions</td>
<td>33,674</td>
</tr>
<tr>
<td>Total non-current liabilities</td>
<td>35,332</td>
</tr>
<tr>
<td>Total liabilities</td>
<td>248,087</td>
</tr>
<tr>
<td>NET ASSETS</td>
<td>1,252,807</td>
</tr>
</tbody>
</table>

**EQUITY**

<table>
<thead>
<tr>
<th></th>
<th>2017-18 estimate ($'000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributed equity</td>
<td>1,127,610</td>
</tr>
<tr>
<td>Reserves</td>
<td>74,893</td>
</tr>
<tr>
<td>Accumulated surplus</td>
<td>50,304</td>
</tr>
<tr>
<td>TOTAL EQUITY</td>
<td>1,252,807</td>
</tr>
</tbody>
</table>

Note: Section 40 estimates were approved by the Minister for Health prior to the finalisation of the State budget and the figures are based on the Service Agreement with the Department of Health as at 30 June 2017.
Table 15 - Statement of cash flows

<table>
<thead>
<tr>
<th>CASH FLOWS FROM STATE GOVERNMENT</th>
<th>2017-18 estimate ($'000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service appropriation</td>
<td>655,133</td>
</tr>
<tr>
<td>Capital appropriations</td>
<td>15,572</td>
</tr>
<tr>
<td><strong>Net cash provided by State Government</strong></td>
<td><strong>670,705</strong></td>
</tr>
</tbody>
</table>

**Utilised as follows:**

<table>
<thead>
<tr>
<th>CASH FLOWS FROM OPERATING ACTIVITIES</th>
<th>2017-18 estimate ($'000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments</td>
<td></td>
</tr>
<tr>
<td>Employee benefits</td>
<td>(786,274)</td>
</tr>
<tr>
<td>Supplies and services</td>
<td>(540,055)</td>
</tr>
<tr>
<td><strong>Receipts</strong></td>
<td></td>
</tr>
<tr>
<td>Receipts from customers</td>
<td>65,505</td>
</tr>
<tr>
<td>Commonwealth grants and contributions</td>
<td>386,489</td>
</tr>
<tr>
<td>Other grants and contributions</td>
<td>167,965</td>
</tr>
<tr>
<td>Other receipts</td>
<td>51,237</td>
</tr>
<tr>
<td><strong>Net cash used in operating activities</strong></td>
<td><strong>(655,133)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CASH FLOWS FROM INVESTING ACTIVITIES</th>
<th>2017-18 estimate ($'000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments</td>
<td></td>
</tr>
<tr>
<td>Payment for purchase of non-current assets</td>
<td>(15,572)</td>
</tr>
<tr>
<td><strong>Receipts</strong></td>
<td></td>
</tr>
<tr>
<td>Proceeds from sale of non-current assets</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net cash used in investing activities</strong></td>
<td><strong>(15,572)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CASH FLOWS FROM FINANCING ACTIVITIES</th>
<th>2017-18 estimate ($'000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments</td>
<td></td>
</tr>
<tr>
<td>Repayment of finance lease liabilities</td>
<td>-</td>
</tr>
<tr>
<td>Repayment of borrowings</td>
<td>-</td>
</tr>
<tr>
<td>Repayment of other liabilities</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net cash used in financing activities</strong></td>
<td><strong>-</strong></td>
</tr>
<tr>
<td>Net increase/(decrease) in cash and cash equivalents</td>
<td>-</td>
</tr>
<tr>
<td>Cash and cash equivalent at the beginning of the period</td>
<td>83,848</td>
</tr>
<tr>
<td>Restricted cash at the beginning of period</td>
<td>26,395</td>
</tr>
<tr>
<td>Cash transferred from Department of Health</td>
<td>-</td>
</tr>
<tr>
<td>Cash and cash equivalents transferred to other agencies</td>
<td>-</td>
</tr>
<tr>
<td><strong>CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD</strong></td>
<td><strong>110,243</strong></td>
</tr>
</tbody>
</table>

Note: Section 40 estimates were approved by the Minister for Health prior to the finalisation of the State budget and the figures are based on the Service Agreement with the Department of Health as at 30 June 2017.
Table 16 - Statement of changes in equity

<table>
<thead>
<tr>
<th>Statement of changes in equity</th>
<th>2017-18 estimate ($'000)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CONTRIBUTED EQUITY</strong></td>
<td></td>
</tr>
<tr>
<td>Balance at start of period</td>
<td>1,111,276</td>
</tr>
<tr>
<td>Transactions with owners in their capacity as owners</td>
<td>-</td>
</tr>
<tr>
<td>Contributions by owners</td>
<td>16,334</td>
</tr>
<tr>
<td>Other contributions by owners</td>
<td>-</td>
</tr>
<tr>
<td>Distributions to owners</td>
<td>-</td>
</tr>
<tr>
<td><strong>Balance at end of period</strong></td>
<td>1,127,610</td>
</tr>
<tr>
<td><strong>RESERVES</strong></td>
<td></td>
</tr>
<tr>
<td>Asset revaluation reserve</td>
<td></td>
</tr>
<tr>
<td>Balance at start of period</td>
<td>74,893</td>
</tr>
<tr>
<td>Other comprehensive income for the period</td>
<td>-</td>
</tr>
<tr>
<td><strong>Balance at end of period</strong></td>
<td>74,893</td>
</tr>
<tr>
<td><strong>ACCUMULATED SURPLUS</strong></td>
<td></td>
</tr>
<tr>
<td>Balance at start of period</td>
<td>50,304</td>
</tr>
<tr>
<td>Correction of prior period errors</td>
<td>-</td>
</tr>
<tr>
<td>Changes in accounting policy</td>
<td>-</td>
</tr>
<tr>
<td>Restated balance at start of period</td>
<td>-</td>
</tr>
<tr>
<td>Surplus for the period</td>
<td>-</td>
</tr>
<tr>
<td><strong>Balance at end of period</strong></td>
<td>50,304</td>
</tr>
<tr>
<td><strong>TOTAL EQUITY</strong></td>
<td></td>
</tr>
<tr>
<td>Balance at start of period</td>
<td>1,236,473</td>
</tr>
<tr>
<td>Total comprehensive loss for the year</td>
<td>-</td>
</tr>
<tr>
<td>Transactions with owners in their capacity as owners</td>
<td>16,334</td>
</tr>
<tr>
<td><strong>Balance at end of period</strong></td>
<td>1,252,807</td>
</tr>
</tbody>
</table>

Note: Section 40 estimates were approved by the Minister for Health prior to the finalisation of the State budget and the figures are based on the Service Agreement with the Department of Health as at 30 June 2017.
East Metropolitan Health Service

Financial statements
Certification of financial statements

EAST METROPOLITAN HEALTH SERVICE

CERTIFICATION OF FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

The accompanying financial statements of the East Metropolitan Health Service have been prepared in compliance with the provisions of the Financial Management Act 2006 from proper accounts and records to represent fairly the financial transactions for the financial year ending 30 June 2017 and financial position as at 30 June 2017.

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

Ian Smith PSM
Board Chair
East Metropolitan Health Service
27 September 2017

Peter Forbes
Chair, EMHS Board Finance Committee
East Metropolitan Health Service
27 September 2017

Graeme Jones
Chief Finance Officer
East Metropolitan Health Service
27 September 2017
Audit opinion

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 2017, 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 2017 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 it 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.


3/Floor Albert Facey House 448 Wellington Street Perth | Mail: To Perth BC PO Box 6489 Perth WA 6001 | Tel: 08 6557 7950 Fax: 08 6557 7000
- 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 2017.

**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 A150 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 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 2017. 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 2017.

Matter of Significance
Emergency Department Waiting Times
The Under Treasurer approved the removal of the following indicator as an audited key performance indicator (KPI):
- Percentage of Emergency Department patients seen within recommended times (by triage category)

The approval was conditional on its inclusion as an unaudited performance indicator in the Annual Report and that it be reinstated as an audited KPI following the implementation of a new Emergency Department data collection system. A new system had not been developed at 30 June 2017. Consequently, the KPI has not been included in the audited KPIs for the year ended 30 June 2017. My opinion is not modified in respect to this matter.

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 presentation 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 judgment, 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 2017 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 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.

Colin Murphy
AUDITOR GENERAL
FOR WESTERN AUSTRALIA
Perth, Western Australia
27 September 2017
East Metropolitan Health Service

Statement of Comprehensive Income
For the year ended 30 June 2017

<table>
<thead>
<tr>
<th>Note</th>
<th>2017</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COST OF SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits</td>
<td>7</td>
<td>744,622</td>
</tr>
<tr>
<td>Fees for visiting medical practitioners</td>
<td>8</td>
<td>24,596</td>
</tr>
<tr>
<td>Contracts for services</td>
<td>10</td>
<td>242,257</td>
</tr>
<tr>
<td>Patient support costs</td>
<td>11</td>
<td>222,502</td>
</tr>
<tr>
<td>Finance costs</td>
<td>12</td>
<td>95</td>
</tr>
<tr>
<td>Depreciation and amortisation expense</td>
<td>13</td>
<td>39,165</td>
</tr>
<tr>
<td>Asset revaluation decrement</td>
<td>43</td>
<td>3,831</td>
</tr>
<tr>
<td>Repairs, maintenance and consumable equipment</td>
<td>15</td>
<td>27,553</td>
</tr>
<tr>
<td>Other supplies and services</td>
<td>16</td>
<td>11,250</td>
</tr>
<tr>
<td>Other expenses</td>
<td>17</td>
<td>85,024</td>
</tr>
<tr>
<td><strong>Total cost of services</strong></td>
<td></td>
<td>1,401,209</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient charges</td>
<td>18</td>
<td>63,698</td>
</tr>
<tr>
<td>Other fees for services</td>
<td>19</td>
<td>63,797</td>
</tr>
<tr>
<td>Commonwealth grants and contributions</td>
<td>20(i)</td>
<td>410,855</td>
</tr>
<tr>
<td>Other grants and contributions</td>
<td>20(ii)</td>
<td>128,334</td>
</tr>
<tr>
<td>Donations revenue</td>
<td>22</td>
<td>399</td>
</tr>
<tr>
<td>Commercial activities</td>
<td>23</td>
<td>2,537</td>
</tr>
<tr>
<td>Other revenue</td>
<td>24</td>
<td>11,072</td>
</tr>
<tr>
<td><strong>Total revenue</strong></td>
<td></td>
<td>680,692</td>
</tr>
<tr>
<td><strong>Total cost of services</strong></td>
<td></td>
<td>1,401,209</td>
</tr>
<tr>
<td><strong>NET COST OF SERVICES</strong></td>
<td></td>
<td>720,517</td>
</tr>
<tr>
<td><strong>INCOME FROM STATE GOVERNMENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service appropriations</td>
<td>25</td>
<td>705,935</td>
</tr>
<tr>
<td>Assets assumed</td>
<td>26</td>
<td>228</td>
</tr>
<tr>
<td>Services received free of charge</td>
<td>27</td>
<td>64,658</td>
</tr>
<tr>
<td><strong>Total income from State Government</strong></td>
<td></td>
<td>795,831</td>
</tr>
<tr>
<td><strong>SURPLUS FOR THE PERIOD</strong></td>
<td></td>
<td>50,304</td>
</tr>
<tr>
<td><strong>OTHER COMPREHENSIVE INCOME/(LOSS)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Items not reclassified subsequently to profit or loss</td>
<td>43</td>
<td>74,893</td>
</tr>
<tr>
<td>Changes in asset revaluation reserve</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total other comprehensive income / (loss)</strong></td>
<td></td>
<td>74,893</td>
</tr>
<tr>
<td><strong>TOTAL COMPREHENSIVE INCOME FOR THE PERIOD</strong></td>
<td></td>
<td>125,197</td>
</tr>
</tbody>
</table>

Refer also to note 57 ‘Schedule of Income and Expenses by Service’.

The Statement of Comprehensive Income should be read in conjunction with the accompanying notes.

---

East Metropolitan Health Service

Statement of Financial Position
As at 30 June 2017

<table>
<thead>
<tr>
<th>Note</th>
<th>2017</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>28</td>
<td>83,848</td>
</tr>
<tr>
<td>Restricted cash and cash equivalents</td>
<td>29</td>
<td>26,395</td>
</tr>
<tr>
<td>Receivables</td>
<td>30</td>
<td>32,288</td>
</tr>
<tr>
<td>Inventories</td>
<td>32</td>
<td>5,585</td>
</tr>
<tr>
<td>Other current assets</td>
<td>33</td>
<td>765</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td></td>
<td>148,381</td>
</tr>
<tr>
<td>Non-Current Assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restricted cash and cash equivalents</td>
<td>29</td>
<td>2,976</td>
</tr>
<tr>
<td>Amounts receivable for services</td>
<td>31</td>
<td>391,092</td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>34</td>
<td>939,313</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>36</td>
<td>2,885</td>
</tr>
<tr>
<td>Other non-current assets</td>
<td>33</td>
<td>263</td>
</tr>
<tr>
<td><strong>Total Non-Current Assets</strong></td>
<td></td>
<td>1,336,529</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td></td>
<td>1,485,410</td>
</tr>
<tr>
<td><strong>LIABILITIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payables</td>
<td>38</td>
<td>70,186</td>
</tr>
<tr>
<td>Borrowings</td>
<td>39</td>
<td>792</td>
</tr>
<tr>
<td>Provisions</td>
<td>40</td>
<td>142,319</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td></td>
<td>213,517</td>
</tr>
<tr>
<td>Non-Current Liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions</td>
<td>40</td>
<td>33,674</td>
</tr>
<tr>
<td>Borrowings</td>
<td>39</td>
<td>1,658</td>
</tr>
<tr>
<td><strong>Total Non-Current Liabilities</strong></td>
<td></td>
<td>35,332</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td></td>
<td>248,849</td>
</tr>
<tr>
<td><strong>NET ASSETS</strong></td>
<td></td>
<td>1,236,561</td>
</tr>
<tr>
<td><strong>EQUITY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributed equity</td>
<td>42</td>
<td>1,111,364</td>
</tr>
<tr>
<td>Reserves</td>
<td>43</td>
<td>74,893</td>
</tr>
<tr>
<td>Accumulated surplus</td>
<td>44</td>
<td>50,304</td>
</tr>
<tr>
<td><strong>TOTAL EQUITY</strong></td>
<td></td>
<td>1,236,561</td>
</tr>
</tbody>
</table>

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 2017

<table>
<thead>
<tr>
<th>Note</th>
<th>2017</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTRIBUTED EQUITY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance at 1 July 2016</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Transactions with owners in their capacity as owners:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital appropriations</td>
<td>18,048</td>
<td></td>
</tr>
<tr>
<td>Other contributions by owners</td>
<td>1,096,199</td>
<td></td>
</tr>
<tr>
<td>Distributions to owners</td>
<td>(2,883)</td>
<td></td>
</tr>
<tr>
<td>Balance at 30 June 2017</td>
<td>1,111,364</td>
<td></td>
</tr>
<tr>
<td>RESERVES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asset Revaluation Reserve</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>Balance at start of period</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Other comprehensive income for the period</td>
<td>74,893</td>
<td></td>
</tr>
<tr>
<td>Balance at 30 June 2017</td>
<td>74,893</td>
<td></td>
</tr>
<tr>
<td>ACCUMULATED SURPLUS</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Balance at 1 July 2016</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Surplus for the period</td>
<td>50,304</td>
<td></td>
</tr>
<tr>
<td>Balance at 30 June 2017</td>
<td>50,304</td>
<td></td>
</tr>
<tr>
<td>TOTAL EQUITY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance at 1 July 2016</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Total comprehensive income for the period</td>
<td>125,197</td>
<td></td>
</tr>
<tr>
<td>Transactions with owners in their capacity as owners</td>
<td>1,111,364</td>
<td></td>
</tr>
<tr>
<td>Balance at 30 June 2017</td>
<td>1,236,561</td>
<td></td>
</tr>
</tbody>
</table>

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 2017

<table>
<thead>
<tr>
<th>Note</th>
<th>2017</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inflows</td>
<td>Outflows</td>
</tr>
<tr>
<td>CASH FLOWS FROM STATE GOVERNMENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service appropriations</td>
<td>661,508</td>
<td></td>
</tr>
<tr>
<td>Capital appropriations</td>
<td>17,321</td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents transferred from Metropolitan Health Service (abolished)</td>
<td>27,254</td>
<td></td>
</tr>
<tr>
<td>Net cash provided by State Government</td>
<td>706,083</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilised as follows:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CASH FLOWS FROM OPERATING ACTIVITIES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits</td>
<td>(724,222)</td>
<td></td>
</tr>
<tr>
<td>Supplies and services</td>
<td>(539,877)</td>
<td></td>
</tr>
<tr>
<td>Finance costs</td>
<td>(6)</td>
<td></td>
</tr>
<tr>
<td>Receipts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receipts from customers</td>
<td>59,597</td>
<td></td>
</tr>
<tr>
<td>Commonwealth grants and contributions</td>
<td>410,855</td>
<td></td>
</tr>
<tr>
<td>Other grants and contributions</td>
<td>128,333</td>
<td></td>
</tr>
<tr>
<td>Donations received</td>
<td>292</td>
<td></td>
</tr>
<tr>
<td>Other receipts</td>
<td>87,380</td>
<td></td>
</tr>
<tr>
<td>Net cash used in operating activities</td>
<td>(577,648)</td>
<td></td>
</tr>
<tr>
<td>CASH FLOWS FROM INVESTING ACTIVITIES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchase of non-current assets</td>
<td>(15,195)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net cash used in investing activities</td>
<td>(15,195)</td>
<td></td>
</tr>
<tr>
<td>CASH FLOWS FROM FINANCING ACTIVITIES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repayment of finance lease liabilities</td>
<td>(31)</td>
<td></td>
</tr>
<tr>
<td>Net cash used in financing activities</td>
<td>(31)</td>
<td></td>
</tr>
<tr>
<td>Net increase in cash and cash equivalents</td>
<td>113,219</td>
<td></td>
</tr>
<tr>
<td>CASH AND CASH EQUIVALENTS AT THE END OF PERIOD</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| The Statement of Cash Flows should be read in conjunction with the accompanying notes.
East Metropolitan Health Service

Notes to the Financial Statements
For the year ended 30 June 2017

Note 1 Australian Accounting Standards

General
The financial statements of East Metropolitan Health Service (the Health Service) for the year ended 30 June 2017 have been prepared in accordance with Australian Accounting Standards. The term 'Australian Accounting Standards' includes Standards and Interpretations issued by the Australian Accounting Standards Board (AASB).

The Health Service has adopted any applicable new and revised Australian Accounting Standards from their operative dates.

Early adoption of standards
The Health Service cannot early adopt an Australian Accounting Standard unless specifically permitted by TI 1101 ‘Application of Australian Accounting Standards and Other Pronouncements’. There has been no early adoption of any other Australian Accounting Standards that have been issued or amended (but not operative) by the Health Service for the annual reporting period ended 30 June 2017.

Note 2 Summary of significant accounting policies

(a) General statement
The Health Service is a not-for-profit reporting entity that prepares general purpose financial statements in accordance with Australian Accounting Standards, the Framework, Statements of Accounting Concepts and other authoritative pronouncements of the AASB as applied by the Treasurer’s instructions. Several of these are modified by the Treasurer’s instructions to vary application, disclosure, format and wording.

The Financial Management Act 2006 and the Treasurer’s instructions impose legislative provisions that govern the preparation of financial statements and take precedence over the Australian Accounting Standards, the Framework, Statements of Accounting Concepts and other authoritative pronouncements of the AASB.

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.

(b) Basis of preparation
The financial statements have been prepared on the accrual basis of accounting using the historical cost convention, except for land and buildings which have been measured at fair value.

The accounting policies adopted in the preparation of the financial statements have been consistently applied throughout all periods presented unless otherwise stated.

The financial statements are presented in Australian dollars and all values are rounded to the nearest thousand dollars ($'000). Note 3 ‘Judgements made by management in applying accounting policies’ discloses judgements that have been made in the process of applying the Health Service’s accounting policies resulting in the most significant effect on amounts recognised in the financial statements.

Note 4 ‘Key sources of estimation uncertainty’ discloses key assumptions made concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next reporting period.

East Metropolitan Health Service

Notes to the Financial Statements
For the year ended 30 June 2017

Note 2 Summary of significant accounting policies (continued)

(c) 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. See also note 42 ‘Contributed equity’.

(d) Income

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.

Interest
Revenue is recognised as the interest accrues.

Service appropriations
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 to the bank account or credited to the ‘Amounts receivable for services’ (holding account) held at Treasury.

See also note 25 ‘Service appropriations’ for further information.

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.

(e) Borrowing costs
Borrowing costs are expensed in the period in which they are incurred.
Notes to the Financial Statements

For the year ended 30 June 2017

Note 2  Summary of significant accounting policies (continued)

(f) Property, plant and equipment

Property, plant and equipment include site infrastructure.

Capitalisation/expensing of assets

Items of property, plant and equipment costing $5,000 or more are recognised as assets and the cost of utilising assets is expensed (depreciated) over their useful lives. Items of property, plant and equipment costing less than $5,000 are immediately expensed direct to the Statement of Comprehensive Income (other than where they form part of a group of similar items which are significant in total).

Initial recognition and measurement

Property, plant and equipment are initially recognised at cost.

For items of property, plant and equipment acquired at no cost or for nominal cost, the cost is the fair value at the date of acquisition.

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 stated 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 determined 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 depreciated 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.

Land and buildings are independently valued annually by the Western Australian Land Information Authority (Valuation Services) 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.

The most significant assumptions and judgements in estimating fair value are made in assessing whether to apply the existing use model or the replacement cost model. Where market-based evidence is available, the most appropriate method is used.

Depreciation

Estimates of useful lives are reviewed annually. Depreciation is calculated for the period of the expected benefit (estimated useful life less accumulated depreciation and accumulated impairment losses).

The cost model is applied for subsequent measurement requiring the asset to be carried at cost less any accumulated amortisation and accumulated impairment losses.

Amortisation for intangible assets with finite useful lives is calculated for the period of the expected benefit (estimated useful life less accumulated amortisation and accumulated impairment losses).

Intangible assets

Intangible assets are initially recognised at cost. For assets acquired at no cost or for nominal cost, the cost is their fair value at the date of acquisition.

The cost model is applied for subsequent measurement requiring the asset to be carried at cost less any accumulated amortisation and accumulated impairment losses.

Amortisation for intangible assets with finite useful lives is calculated for the period of the expected benefit (estimated useful life less accumulated amortisation and accumulated impairment losses).

Intangible assets are classified as property, plant and equipment. These are anticipated to have indefinite useful lives. Their service potential has not, in any material sense, been consumed during the reporting period and consequently no depreciation has been recognised.

The assets’ useful lives are reviewed annually. Estimated useful lives for each class of depreciable asset 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

(g) Intangible assets

Capitalisation/expensing of assets

Acquisitions of intangible assets costing $5,000 or more and internally generated intangible assets costing $5,000 or more are capitalised. The cost of utilising the assets is expensed (amortised) over their useful lives. Costs incurred below these thresholds are immediately expensed directly to the Statement of Comprehensive Income.

Intangible assets are initially recognised at cost. For assets acquired at no cost or for nominal cost, the cost is their fair value at the date of acquisition.

The cost model is applied for subsequent measurement requiring the asset to be carried at cost less any accumulated amortisation and accumulated impairment losses.

Amortisation for intangible assets with finite useful lives is calculated for the period of the expected benefit (estimated useful life which is reviewed annually) on the straight line basis. All intangible assets controlled by the Health Service have a finite useful life and zero residual value.

- Estimated useful life of intangible asset is:
  - Computer software
    - 5 - 10 years

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.
East Metropolitan Health Service

Notes to the Financial Statements
For the year ended 30 June 2017

Note 2 Summary of significant accounting policies (continued)

(h) 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.

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 falling replacement costs.

Intangible assets not yet available for use are tested for impairment at the end of each reporting period irrespective of whether there is any indication of impairment.

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.

See also note 37 ‘Impairment of assets’ for the outcome of impairment reviews and testing.

(i) 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.

(j) Leases

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.

Operating leases are expensed on a straight line basis over the lease term as this represents the pattern of benefits derived from the leased properties.

East Metropolitan Health Service

Notes to the Financial Statements
For the year ended 30 June 2017

Note 2 Summary of significant accounting policies (continued)

(k) Financial instruments

In addition to cash, the Health Service has two categories of financial instrument:
- Loans and receivables; and
- Financial liabilities measured at amortised cost.

Financial instruments have been disaggregated into the following classes:

Financial assets:
* Cash and cash equivalents
* Restricted cash and cash equivalents
* Receivables
* Amounts receivable for services

Financial liabilities:
* Payables
* Department of Treasury loans
* Finance lease liabilities

Initial recognition and measurement of financial instruments is at fair value which normally equates to the transaction cost or the face value. Subsequent measurement is at amortised cost using the effective interest method.

The fair value of short-term receivables and payables is the transaction cost or the face value because there is no interest rate applicable and subsequent measurement is not required as the effect of discounting is not material.

(l) Cash and cash equivalents

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.

(m) Accrued salaries

Accrued salaries (see note 38 ‘Payables’) represent the amount due to employees 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.

(n) Amounts receivable for services (holding account)

The Health Service receives services appropriation funding from the State Government partly in cash and partly as an asset (holding account receivable). The holding account receivable balance is accessible on the emergence of the cash funding requirement to cover leave entitlements and asset replacement.

See also note 25 ‘Service appropriations’ and note 31 ‘Amounts receivable for services’.

(o) Inventories

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 (See note 32 ‘Inventories’).
Notes to the Financial Statements

For the year ended 30 June 2017

Note 2  Summary of significant accounting policies (continued)

(p) Receivables

Receivables are recognised at original invoice amount less an allowance for any uncollectible amounts (i.e. impairment). The collectability of receivables is reviewed on an ongoing basis and any receivables identified as uncollectible are written-off against the allowance account. The allowance for uncollectible amounts (doubtful debts) is raised when there is objective evidence that the Health Service will not be able to collect the debts. The carrying amount is equivalent to fair value as it is due for settlement within 30 days.

See also note 3(b) ‘Financial Instruments’ and note 30 ‘Receivables’.

Accounting procedure for Goods and Services Tax

Rights to collect amounts receivable from the Australian Taxation Office (ATO) and responsibilities to make payments for 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 NGR for the GST Group as from 1 July 2012. The ‘Minister for Health in his Capacity of the Co-mandate 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, QEII 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.

(q) Payables

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.

See also note 3(b) ‘Financial Instruments’ and note 38 ‘Payables’.

(r) Borrowings

All loans payable are initially recognised at fair value, being the net proceeds received. Subsequent measurement is at amortised cost using the effective interest rate method.

See also note 3(b) ‘Financial Instruments’ and note 39 ‘Borrowings’.

(s) Provisions

Provisions are liabilities of uncertain timing or amount and are recognised where there is a present legal or constructive obligation as a result of a past event and when the outflow of resources embodying economic benefits is probable and a reliable estimate can be made of the amount of the obligation. Provisions are reviewed at the end of each reporting period.

See also note 40 ‘Provisions’.

Provisions - employee benefits

All annual leave, time off in lieu leave and long service leave provisions are in respect of employees’ services up to the end of the reporting period.

Annual Leave and Time Off in Lieu Leave

Annual leave and time off in lieu leave are not expected to be settled wholly within 12 months after the end of the reporting period and are therefore considered to be ‘other long-term employee benefits’. The annual leave liability and time off in lieu leave liability are 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.
Notes to the Financial Statements
For the year ended 30 June 2017

Note 2 Summary of significant accounting policies (continued)

(a) Provisions (continued)

Provisions - employee benefits (continued)

Superannuation

The Government Employees Superannuation Board (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.

Eligible employees contribute to the Pension Scheme, a defined benefit pension scheme closed to new members since 1987, or the Gold State Superannuation Scheme (GSS), a defined benefit lump sum scheme closed to new members since 1995.

Employees commencing employment prior to 16 April 2007 who were not members of either the Pension Scheme or the GSS became non-contributory members of the West State Superannuation Scheme (WSS). Employees commencing employment on or after 16 April 2007 became members of the GESB Super Scheme (GESBS). From 30 March 2012, existing members of the WSS or GESBS and new employees have been able to choose their preferred superannuation fund provider. The Health Service makes contributions to GESB or other fund providers on behalf of employees in compliance with the Commonwealth Government’s Superannuation Guarantee (Administration) Act 1992. Contributions to these accumulation schemes extinguish the Health Service’s liability for superannuation charges in respect of employees who are not members of the Pension Scheme or GSS.

The GSS is a defined benefit scheme for the purposes of employees and whole-of-government reporting. However, it is a defined contribution plan for agency purposes because the concurrent contributions (defined contributions) made by the Health Service to GSS extinguishes the Health Service’s obligations to the related superannuation liability.

The Health Service has no liabilities under the Pension Scheme or the GSS. 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 GSSB.

The GESB makes all benefit payments in respect of the Pension Scheme and GSS, and is recouped from the Treasurer for the employer's share. See also note 2(f) ‘Superannuation expense’.

Employment on-costs

Employment on-costs (workers’ compensation insurance) are not employee benefits and are recognised separately as liabilities and expenses when the employment to which they relate has occurred. Employment on-costs are included as part of ‘Other expenses’ and are not included as part of the Health Service’s ‘Employee benefits expense’. The related liability is included in ‘Employment on-costs provision’.

See also note 17 ‘Other expenses’ and note 40 ‘Provisions’.

(f) Superannuation expense

Superannuation expense is recognised in the profit or loss of the Statement of Comprehensive Income and comprises employer contributions paid to the GSS (concurrent contributions), WSS, the GESBS, and other superannuation funds.

The judgements that have been made in the process of applying accounting policies that have the most significant effect on the amounts recognised in the financial statements are presented in note 3.

Details of Trust Accounts are reported in ‘Administered trust accounts’ (refer to note 53).

Trust Accounts do not form part of the resources available to the Health Service, and are not reported as assets in the financial statements.

Details of Trust Accounts are reported in ‘Administered trust accounts’ (refer to note 53).

Note 3 Judgements made by management in applying accounting policies

The preparation of financial statements requires management to make judgements about the application of accounting policies that have a significant effect on the amounts recognised in the financial statements. The Health Service evaluates these judgements regularly.

The judgements that have been made in the process of applying accounting policies that have the most significant effect on the amounts recognised in the financial statements include:

Operating lease commitments

The Health Service has entered into a number of leases for buildings for branch office accommodation. 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.
Notes to the Financial Statements

For the year ended 30 June 2017

Note 4 Key sources of estimation uncertainty

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 reporting period:

Buildings
In order to estimate fair value on the basis of existing use, the depreciated 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.

Employee benefits provision
In estimating the non-current long service leave liabilities, employees are assumed to leave the Health Service each year on account of resignation or retirement at 7.5%. This assumption was based on an analysis of the turnover rates exhibited by employees over a five year period. Employees with leave benefits to which they are fully entitled are assumed to take all available leave uniformly over the following five years or to age 65 if earlier.

Other estimations and assumptions used in calculating the Health Service’s long service leave provision include expected future salary rates, discount rates, employee retention rates and expected future payments. Changes in these estimations and assumptions may impact on the carrying amount of the long service leave provision.

Provision for doubtful debts
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.

Note 5 Disclosure of changes in accounting policy and estimates

Initial application of an Australian Accounting Standard

The Health Service has applied the following Australian Accounting Standards effective for annual reporting periods beginning on or after 1 July 2016 that impacted on the Health Service.

Title
AASB 1057 Application of Australian Accounting Standards
This Standard lists the application paragraphs for each other Standard (and Interpretation), grouped where they are the same. There is no financial impact.

AASB 2014-4 Amendments to Australian Accounting Standards - Clarification of Acceptable Methods of Depreciation and Amortisation [AASB 116 & 138]
The adoption of this Standard has no financial impact for the Health Service as depreciation and amortisation is not determined by reference to revenue generation, but by reference to consumption of future economic benefits.

AASB 2015-1 Amendments to Australian Accounting Standards - Annual Improvements to Australian Accounting Standards 2012-2014 Cycle [AASB 1, 2, 3, 5, 7, 11, 100, 110, 119, 121, 133, 134, 137 & 140]
These amendments arise from the issuance of International Financial Reporting Standard Annual Improvements to IFRSs 2012-2014 Cycle in September 2014, and editorial corrections. The Health Service has determined that the application of the Standard has no financial impact.

East Metropolitan Health Service

Notes to the Financial Statements

For the year ended 30 June 2017

Note 5 Disclosure of changes in accounting policy and estimates (continued)

Initial application of an Australian Accounting Standard (continued)

Title
AASB 2015-2 Amendments to Australian Accounting Standards - Disclosure Initiative: Amendments to AASB 101 [AASB 7, 101, 134 & 1049]
This Standard amends AASB 101 to provide clarification regarding the disclosure requirements in AASB 101. Specifically, the Standard proposes narrow-focus amendments to address some of the concerns expressed about existing presentation and disclosure requirements and to ensure entities are able to use judgement when applying a Standard in determining what information to disclose in their financial statements. There is no financial impact.

AASB 2015-6 Amendments to Australian Accounting Standards - Extending Related Party Disclosures to Not-for-profit Public Sector Entities [AASB 10, 124 & 1049]
The amendments extend the scope of AASB 124 to include application by not-for-profit public sector entities. Implementation guidance is included to assist application of the Standard by not-for-profit public sector entities. There is no financial impact.

AASB 2015-10 Amendments to Australian Accounting Standards - Effective Date of Amendments to AASB 10 & 128
This Standard defers the mandatory effective date (application date) of amendments to AASB 10 & AASB 128 that were originally made in AASB 2014-10 so that the amendments are required to be applied for annual reporting periods beginning on or after 1 January 2018 instead of 1 January 2016. There is no financial impact.

Future impact of Australian Accounting Standards 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. By virtue of a limited exemption, the Health Service has early adopted AASB 2015-2 Amendments to Australian Accounting Standards - Fair Value Disclosures of Not-for-Profit Public Sector Entities. Where applicable, the Health Service plans to apply the following Australian Accounting Standards from their application date.

Title
AASB 9 Financial Instruments
Operative for reporting periods beginning on/after
1 Jan 2018
This Standard supersedes AASB 139 Financial Instruments: Recognition and Measurement, introducing a number of changes to accounting treatments. The mandatory application date of this Standard is currently 1 January 2018 after being amended by AASB 2012-6, AASB 2013-9 and AASB 2014-1 Amendments to Australian Accounting Standards. The Health Service has not yet determined the application or the potential impact of the Standard.
### East Metropolitan Health Service Notes to the Financial Statements
#### For the year ended 30 June 2017

**Note 5 Disclosure of changes in accounting policy and estimates (continued)**

<table>
<thead>
<tr>
<th>Title</th>
<th>Operative for reporting periods beginning</th>
</tr>
</thead>
<tbody>
<tr>
<td>AASB 15 Revenue from Contracts with Customers</td>
<td>1 Jan 2019</td>
</tr>
<tr>
<td>AASB 16 Leases</td>
<td>1 Jan 2019</td>
</tr>
<tr>
<td>AASB 1058 Income of Not-for-Profit Entities</td>
<td>1 Jan 2019</td>
</tr>
<tr>
<td>AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010)</td>
<td>1 Jan 2018</td>
</tr>
</tbody>
</table>

This Standard establishes the principles that the Health Service shall apply to report useful information to users of financial statements about the nature, amount, timing and uncertainty of revenue and cash flows arising from a contract with a customer. The Health Service’s income is principally derived from contracts with patients and suppliers which will be measured under AASB 1058 Income of Not-for-Profit Entities. This change will not affect the amount of revenue to be recognised in the statement of financial position, excepting amounts pertinent to short term or low value leases. Interest and amortisation expense will increase and rental expense will decrease.

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. Leases which the Health Service anticipates most of this amount will be brought onto the statement of financial position, excepting amounts pertinent to short term or low value leases. Interest and amortisation expense will increase and rental expense will decrease.

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 a performance obligation (a promise to transfer a good or service), or an obligation to acquire an asset. The Health Service has not yet determined the application or the potential impact of the Standard.

This Standard makes consequential amendments to other Australian Accounting Standards (including Interpretations) arising from the issuance of AASB 9 (December 2010). The mandatory application date of this Standard has been amended by AASB 2014-5 to 1 January 2018 instead of 1 January 2017. For not-for-profit entities, the mandatory effective date has subsequently been amended to 1 January 2019 by AASB 2016-7. The Health Service has not yet determined the application or the potential impact of the Standard.
Notes to the Financial Statements
For the year ended 30 June 2017

Note 6 Services of the Health Service

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

<table>
<thead>
<tr>
<th>Title</th>
<th>Operative for reporting periods beginning</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>AASB 2016-4 Amendments to Australian Accounting Standards - Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities</td>
<td>1 Jan 2017</td>
<td>This Standard clarifies that the recoverable amount of primarily non-cash-generating assets of not-for-profit entities, which are typically specialised in nature and held for continuing use of their service capacity, is expected to be materially the same as fair value determined under AASB 13 Fair Value Measurement. The Health Service has not yet determined the application or the potential impact.</td>
</tr>
<tr>
<td>AASB 2016-7 Amendments to Australian Accounting Standards - Deferral of AASB 15 for Not-for-Profit Entities</td>
<td>1 Jan 2017</td>
<td>This Standard amends the mandatory effective date (application date) of AASB 15 and defers the consequential amendments that were originally set out in AASB 2014-5 Amendments to Australian Accounting Standards arising from AASB 15 for not-for-profit entities to annual reporting periods beginning on or after 1 January 2019, instead of 1 January 2018. There is no financial impact.</td>
</tr>
<tr>
<td>AASB 2016-8 Amendments to Australian Accounting Standards - Australian Implementation Guidance for Not-for-Profit Entities</td>
<td>1 Jan 2019</td>
<td>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.</td>
</tr>
<tr>
<td>AASB 2017-2 Amendments to Australian Accounting Standards - Further Annual Improvements 2014-2016 Cycle</td>
<td>1 Jan 2017</td>
<td>This Standard clarifies the scope of AASB 12 by specifying that the disclosure requirements apply to an entity’s interests in other entities that are classified as held for sale, held for distribution to owners in their capacity as owners or discontinued operations in accordance with AASB 5. There is no financial impact.</td>
</tr>
</tbody>
</table>

Note 7 Employee benefits expense

<table>
<thead>
<tr>
<th>Description</th>
<th>Amounts ($000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and wages (a)</td>
<td>681,331</td>
</tr>
<tr>
<td>Superannuation - defined contribution plans (b)</td>
<td>63,291</td>
</tr>
<tr>
<td>(a) Includes the value of the fringe benefits to the employees plus the fringe benefits tax component, leave entitlements including superannuation contribution components and redundancy expenses of $2.8 million.</td>
<td></td>
</tr>
<tr>
<td>(b) Defined contribution plans include West State, Gold State and GESB Super and other eligible funds.</td>
<td></td>
</tr>
</tbody>
</table>

Note 6 Services of the Health Service

Information about the Health Service’s services and the expenses and revenues which are reliably attributable to those services are set out in note 57. The key services of the Health Service are:

Public Hospital Admitted Patient
Public hospital admitted patient services describe the care services provided to inpatients in public hospitals (excluding specialised mental health wards) and to public patients treated in private facilities under contract to the Department of Health. An admission to hospital can be for a period of one or more days and includes medical and surgical treatment, renal dialysis, oncology services and obstetric care.

Prevention, Promotion and Protection
Prevention, promotion and protection services describe programs implemented to increase optimal health and wellbeing, encourage healthy lifestyles, reduce the onset of disease and disability, reduce the risk of long-term illness and disability with early detection and developmental interventions, or monitor the incidence of disease in the population to determine the effectiveness of health measures and provide direction for new policies and programs. Specific areas of service include genomic, the management and development of health information, Aboriginal health, breast screening services, child and community health, health promotion, communicable disease control, environmental health, disaster planning and management and statutory medical notifications.

Mental Health
Contracted mental health services describe inpatient care in an authorised ward and community mental health services provided by Health Services under agreement with the Mental Health Commission for specialised admitted and community mental health.

Note 6 Services of the Health Service (continued)

Emergency Department
Emergency department services describe the treatment provided in metropolitan hospitals to those people with sudden onset of illness or injury of such severity and urgency that they need immediate medical help which is either not available from their general practitioner, or for which their general practitioner has referred them for treatment. An emergency department can provide a range of services and may result in admission to hospital in treatment without admission. Not all public hospitals provide emergency care services. Privately provided contracted emergency services are included.

Public Hospital Non-admitted Patients
Medical officers, nurses and allied health staff provide non-admitted (out-patient) care services and include clinics for pre and post-surgical care, allied health care and medical care.

Employee benefits expense

<table>
<thead>
<tr>
<th>Description</th>
<th>Amounts ($000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and wages (a)</td>
<td>681,331</td>
</tr>
<tr>
<td>Superannuation - defined contribution plans (b)</td>
<td>63,291</td>
</tr>
<tr>
<td>(a) Includes the value of the fringe benefits to the employees plus the fringe benefits tax component, leave entitlements including superannuation contribution components and redundancy expenses of $2.8 million.</td>
<td></td>
</tr>
<tr>
<td>(b) Defined contribution plans include West State, Gold State and GESB Super and other eligible funds.</td>
<td></td>
</tr>
</tbody>
</table>

Note 5 Disclosure of changes in accounting policy and estimates (continued)

For the year ended 30 June 2017

Notes to the Financial Statements
East Metropolitan Health Service
East Metropolitan Health Service

Notes to the Financial Statements
For the year ended 30 June 2017

Note 9 Compensation of Key Management Personnel
The Health Service has determined that key management personnel include the Minister, board members and senior officers of the Health Service. However, the Health Service is not obligated to compensate the Minister and therefore disclosures in relation to the Minister’s 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 Authority for the period are presented within the following bands:

Compensation of members of the accountable authority

<table>
<thead>
<tr>
<th>Compensation Band ($)</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 0 - $ 10,000 (a)</td>
<td>2</td>
</tr>
<tr>
<td>$ 10,001 - $ 20,000</td>
<td>7</td>
</tr>
<tr>
<td>$ 20,001 - $ 30,000</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
</tr>
</tbody>
</table>

Compensation of senior officers

<table>
<thead>
<tr>
<th>Compensation Band ($)</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 30,001 - $ 60,000</td>
<td>1</td>
</tr>
<tr>
<td>$50,001 - $ 100,000</td>
<td>1</td>
</tr>
<tr>
<td>$100,001 - $ 150,000</td>
<td>2</td>
</tr>
<tr>
<td>$150,001 - $ 200,000</td>
<td>2</td>
</tr>
<tr>
<td>$200,001 - $ 250,000</td>
<td>1</td>
</tr>
<tr>
<td>$250,001 - $ 300,000</td>
<td>1</td>
</tr>
<tr>
<td>$300,001 - $ 400,000</td>
<td>1</td>
</tr>
<tr>
<td>$400,001 - $ 500,000</td>
<td>1</td>
</tr>
<tr>
<td>$500,001 - $ 600,000</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
</tr>
</tbody>
</table>

Total compensation of key management personnel

<table>
<thead>
<tr>
<th>Compensation Band ($)</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>$000</td>
<td>3,397</td>
</tr>
</tbody>
</table>

(a) Includes two members of the accountable authority with compensation of zero.

Note 10 Contracts for services

<table>
<thead>
<tr>
<th>Public patients services (a)</th>
<th>211,559</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health services (a)</td>
<td>26,635</td>
</tr>
<tr>
<td>Other contracts</td>
<td>63</td>
</tr>
<tr>
<td>Total</td>
<td>242,257</td>
</tr>
</tbody>
</table>

(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 2017

Note 11 Patient support costs
Medical supplies and services 194,414
Domestic charges 12,584
Fuel, light and power 7,265
Food supplies 5,674
Patient transport costs 3,916
Research, development and other grants 245
Total 222,502

Note 12 Finance costs
Interest expense 89
Finance lease charges 6
Total 95

Note 13 Depreciation and amortisation expense
Depreciation
Buildings 23,987
Medical equipment 8,766
Site infrastructure 2,302
Other plant and equipment 1,734
Computer equipment 706
Furniture and fittings 560
Leasehold improvements 259
Motor vehicles 5
Total 38,367
Amortisation
Computer software 864
Total depreciation and amortisation 39,231

Note 14 Loss/(Gain) on disposal of non-current assets
Carrying amount of non-current assets disposed:
Property, plant and equipment 314
Net loss/(gain) 314
See note 34 ‘Property, plant and equipment’.

Note 15 Repairs, maintenance and consumable equipment
Repairs and maintenance 19,608
Consumable equipment 7,946
Total 27,554
Notes to the Financial Statements
For the year ended 30 June 2017

Note 16 Other supplies and services
Sanitisation and waste removal services 1,429
Administration and management services 1,030
Interpreter services 934
Security services 166
Rehabilitation and complex needs services 4,993
Library subscription 4,858
Contract management 930
Other 483
11,250

Note 17 Other expenses
Services provided by Health Support Services: (a)
ICT services 22,748
Supply chain services 7,776
Financial services 4,734
Human resources services 7,344
Workers compensation insurance (b) 17,124
Doubtful debts expense 7,467
Other insurances 5,254
Write-down of assets (c) 3,513
Printing and stationery 2,336
Communications 1,612
Operating lease expenses 1,530
Consultancy fees 1,264
Other employee related expenses 1,064
Computer services 433
Other 483
85,024

Note 18 Patient charges
Inpatient bed charges 52,437
Inpatient other charges 6,768
Outpatient charges 4,495
63,698

Note 19 Other fees for services
Recoveries from the Pharmaceutical Benefits Scheme (PBS) 51,209
Health Technology Management Services 5,106
Business Intelligence Services 4,243
Non clinical services to other health organisations 3,190
Other 49
63,797

Note 20 Grants and contributions
i) Commonwealth grants and contributions
Capital Grants:
Bentley Rehabilitation Beds (National Partnership Agreement) 28
Recurrent Grants:
National Health Reform Agreement (funding via the Department of Health) (a) (b) 367,999
National Health Reform Agreement (funding via the Mental Health Commission) (a) 39,550
Other - Commonwealth Specific Grants (Recurrent) 3,278
410,856

ii) Other grants and contributions
Mental Health Commission – service delivery agreement 120,013
Mental Health Commission – other 3,532
Disability Services Commission - community aids and equipment program 2,001
Lotteries Commission 18
Other 2,770
128,334

(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.

(b) See also Note 49 ‘Contingent liabilities and contingent assets’.
East Metropolitan Health Service

Notes to the Financial Statements
For the year ended 30 June 2017

Note 21 Related Party Transactions
The Health Service is a wholly owned and controlled entity of the State of Western Australia. In conducting its activities, the Health Service is required to pay various taxes and levies based on the standard terms and conditions that apply to all tax and levy payers to the State and entities related to the State.

Related parties of the Health Service include:
- the Minister of Health and his/her close family members, and his/her controlled or jointly controlled entities;
- all members of the accountable authority, and their close family members, and their controlled or jointly controlled entities;
- all senior officers and their close family members, and their controlled or jointly controlled entities;
- the Government Employees Superannuation Board (GESB); and
- other departments and public sector entities, including related bodies included in the whole of government consolidated financial statements.

Material transactions with related parties
The Health Service had no material related party transactions with related parties. Transactions with related parties that are considered ‘Ordinary Citizen Transactions (OCT)’ such as paying taxes or rates are not disclosed as they have immaterial implication to the financial position and performance of the Health Service.

Significant transactions with government related entities
Significant transactions include:
- service appropriations (Note 25);
- capital appropriations (Note 42);
- services received free of charge (Note 27);
- superannuation payments to GESB (Note 7); and
- motor vehicle fleet management payments to State Fleet (Note 17).

2017
$000

Note 22 Donation revenue
General public contributions 399

Note 23 Commercial activities
Sales:
- Cafeteria sales revenue 3,277
- Car parking fees revenue 2,268

5,545

Cost of sales (a) (3,009)

Gross profit 2,537

(a) The cost of sales does not include salaries or other costs.

Note 24 Other revenue
Royalty revenues 1,043
Rent from commercial properties 766
Car parking fees revenue 424
Commissions 282
Sponsorship 213
Other 1,009

11,072

Note 25 Service appropriations
Appropriation revenue received during the period:
Service appropriations (funding via the Department of Health) 705,935

RiskCover insurance premium rebate 5,813
Abatements 1,522
Royalty revenues 1,043
Parking 766
Commissions 282
Sponsorship 213

Note 26 Assets (transferred)/assumed
- Transfer of furniture and fittings to South Metropolitan Health Service 168
- Transfer of medical equipment from South Metropolitan Health Service 49
- Transfer of medical equipment from North Metropolitan Health Service 25
- Transfer of equipment from the Department of Health 7
- Transfer of artwork from South Metropolitan Health Service 5
- Transfer of medical equipment to WA Country Health Service (10)
- Transfer of furniture and fittings to South Metropolitan Health Service (16)

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East Metropolitan Health Service

Notes to the Financial Statements
For the year ended 30 June 2017

2017
$000

Note 24 Other revenue
RiskCover insurance premium rebate 5,813
Abatements 1,522
Royalty revenues 1,043
Parking 766
Commissions 282
Sponsorship 213
Other 1,009

11,072

Note 25 Service appropriations
Appropriation revenue received during the period:
Service appropriations (funding via the Department of Health) 705,935

RiskCover insurance premium rebate 5,813
Abatements 1,522
Royalty revenues 1,043
Parking 766
Commissions 282
Sponsorship 213
Other 1,009

11,072

Note 26 Assets (transferred)/assumed
- Transfer of software from South Metropolitan Health Service 168
- Transfer of medical equipment from South Metropolitan Health Service 49
- Transfer of medical equipment from North Metropolitan Health Service 25
- Transfer of equipment from the Department of Health 7
- Transfer of artwork from South Metropolitan Health Service 5
- Transfer of medical equipment to WA Country Health Service (10)
- Transfer of furniture and fittings to South Metropolitan Health Service (16)

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Discretionary transfers of net assets (assets and liabilities) between State Government agencies free of charge, 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 ‘Contributions’ in respect of net assets transferred. Other non-disclosure transfers of assets and liabilities designated as contributions by owners under TI 955 are also recognised directly to equity.

BACK CONTENTS NEXT
East Metropolitan Health Service

Notes to the Financial Statements
For the year ended 30 June 2017

2017
$000

Note 27 Services received free of charge

Services received free of charge from other State government agencies during the period:
PathWest indirect costs 22,056
Health Support Services - shared services 42,602
Services received free of charge 64,658

Services received free of charge or for nominal cost, are recognised as revenues at the fair value of those services that can be reliably determined and which would have been purchased if they were not donated.

Note 28 Cash and cash equivalents

Current
Includes cash assigned to meet ongoing internal obligations arising from allocated donations, research program commitments, education and training grants, funds directed and quarantined under medical industrial agreement and funds directed and quarantined under previous Ministerial Directive.

Note 29 Restricted cash and cash equivalents

Current
Restricted cash assets held for other specific purposes (a) 26,395

(a) These include medical research grants, donations for the benefits of patients, medical education, scholarships, capital projects, employee contributions and staff benevolent funds.

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

Note 30 Receivables

Current
Patient fee debtors (a) 42,196
Other receivables 6,004
Less: Allowance for impairment of receivables (28,553)
Accrued revenue 9,942
GST Receivables 2,699
Total current 32,288

(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 $2.7 million in ex-gratia payments for 2016-17.

See also note 2(p) 'Receivables' and note 56 'Financial instruments'.

Note 31 Amounts receivable for services (Holding Account)

Non-current 391,092

Note 32 Inventories

Current
Pharmaceutical stores - at cost 4,686
Engineering stores - at cost 5,585

Note 33 Other assets

Current
Prepayments 765
Total current 765
Non-current
Prepayments 263
Total non-current 263

Reconciliation of changes in the allowance for impairment of receivables:

Transfers from the Metropolitan Health Service (abolished) 25,547
Doubtful debts expense (note 17) 7,467
Amounts written off during the period (4,380)
Adjustment to opening balance (81)
Balance at end of period 28,553

The Health Service does not hold any collateral or other credit enhancements as security for receivables.

See also note 2(o) 'Inventories'.

Note 34 Special purpose accounts

Represents 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. See note 2(n) 'Amounts receivable for services'.
### Notes to the Financial Statements
For the year ended 30 June 2017

#### Note 34 Property, plant and equipment

<table>
<thead>
<tr>
<th>Description</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note 34 Property, plant and equipment</td>
<td>9,000</td>
</tr>
<tr>
<td>Land</td>
<td></td>
</tr>
<tr>
<td>At fair value (a)</td>
<td>98,638</td>
</tr>
<tr>
<td>Buildings</td>
<td></td>
</tr>
<tr>
<td>At fair value (a)</td>
<td>697,889</td>
</tr>
<tr>
<td>Total land and buildings</td>
<td>796,527</td>
</tr>
<tr>
<td>Site infrastructure</td>
<td></td>
</tr>
<tr>
<td>At cost</td>
<td>64,971</td>
</tr>
<tr>
<td>Accumulated depreciation</td>
<td>(2,302)</td>
</tr>
<tr>
<td>Leasehold improvements</td>
<td></td>
</tr>
<tr>
<td>At cost</td>
<td>2,709</td>
</tr>
<tr>
<td>Accumulated depreciation</td>
<td>(259)</td>
</tr>
<tr>
<td>Computer equipment</td>
<td></td>
</tr>
<tr>
<td>At cost</td>
<td>2,360</td>
</tr>
<tr>
<td>Accumulated depreciation</td>
<td>(706)</td>
</tr>
<tr>
<td>Furniture and fittings</td>
<td></td>
</tr>
<tr>
<td>At cost</td>
<td>4,651</td>
</tr>
<tr>
<td>Accumulated depreciation</td>
<td>(658)</td>
</tr>
<tr>
<td>Motor vehicles</td>
<td></td>
</tr>
<tr>
<td>At cost</td>
<td>13</td>
</tr>
<tr>
<td>Accumulated depreciation</td>
<td>(5)</td>
</tr>
<tr>
<td>Medical equipment</td>
<td></td>
</tr>
<tr>
<td>At cost</td>
<td>51,207</td>
</tr>
<tr>
<td>Accumulated depreciation</td>
<td>(8,746)</td>
</tr>
<tr>
<td>Other plant and equipment</td>
<td></td>
</tr>
<tr>
<td>At cost</td>
<td>24,812</td>
</tr>
<tr>
<td>Accumulated depreciation</td>
<td>(1,736)</td>
</tr>
<tr>
<td>Works in progress</td>
<td></td>
</tr>
<tr>
<td>Buildings under construction (at cost)</td>
<td>4,344</td>
</tr>
<tr>
<td>Artworks</td>
<td></td>
</tr>
<tr>
<td>At cost</td>
<td>2,031</td>
</tr>
<tr>
<td>Total property, plant and equipment</td>
<td>939,313</td>
</tr>
</tbody>
</table>

#### Reconciliations

<table>
<thead>
<tr>
<th>Description</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land</td>
<td></td>
</tr>
<tr>
<td>Transfers from the Metropolitan Health Service (abolished)</td>
<td>81,109</td>
</tr>
<tr>
<td>Other reporting entities</td>
<td></td>
</tr>
<tr>
<td>Revaluation increments/(decrements)</td>
<td>(3,831)</td>
</tr>
<tr>
<td>Carrying amount at end of period</td>
<td>98,638</td>
</tr>
<tr>
<td>Buildings</td>
<td></td>
</tr>
<tr>
<td>Transfers from the Metropolitan Health Service (abolished)</td>
<td>639,517</td>
</tr>
<tr>
<td>Additions</td>
<td></td>
</tr>
<tr>
<td>Revaluation increments/(decrements)</td>
<td>74,893</td>
</tr>
<tr>
<td>Depreciation</td>
<td></td>
</tr>
<tr>
<td>Carrying amount at end of period</td>
<td>697,889</td>
</tr>
<tr>
<td>Site infrastructure</td>
<td></td>
</tr>
<tr>
<td>Transfers from the Metropolitan Health Service (abolished)</td>
<td>63,664</td>
</tr>
<tr>
<td>Additions</td>
<td></td>
</tr>
<tr>
<td>Depreciation</td>
<td></td>
</tr>
<tr>
<td>Carrying amount at end of period</td>
<td>62,060</td>
</tr>
<tr>
<td>Leasehold improvements</td>
<td></td>
</tr>
<tr>
<td>Transfers from the Metropolitan Health Service (abolished)</td>
<td>2,253</td>
</tr>
<tr>
<td>Additions</td>
<td></td>
</tr>
<tr>
<td>Depreciation</td>
<td></td>
</tr>
<tr>
<td>Carrying amount at end of period</td>
<td>2,450</td>
</tr>
<tr>
<td>Computer equipment</td>
<td></td>
</tr>
<tr>
<td>Transfers from the Metropolitan Health Service (abolished)</td>
<td>2,390</td>
</tr>
<tr>
<td>Additions</td>
<td></td>
</tr>
<tr>
<td>Depreciation</td>
<td></td>
</tr>
<tr>
<td>Carrying amount at end of period</td>
<td>1,854</td>
</tr>
</tbody>
</table>

---

(a) Land and buildings were revalued as at 1 July 2016 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2017 and recognised at 30 June 2017. In undertaking the revaluation, fair value was determined by reference to market values for land $25.5 million and buildings $2.9 million. For the remaining balance, fair value of buildings was determined on the basis of depreciated 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).

See also notes 35 ‘Fair Value Measurement’ and note 2(f) ‘Property, plant and equipment’.
East Metropolitan Health Service
Notes to the Financial Statements
For the year ended 30 June 2017

Note 34 Property, plant and equipment (continued)
Reconciliations (continued)

Furniture and fittings
Transfers from the Metropolitan Health Service (abolished) 4,370
Additions 770
Transfers from/(to) other reporting entities (24)
Disposals 48
Depreciation 560
Write-down of assets (a) 415
Carrying amount at end of period 4,093

Motor vehicles
Transfers from the Metropolitan Health Service (abolished) 13
Depreciation (5)
Carrying amount at end of period 8

Medical equipment
Transfers from the Metropolitan Health Service (abolished) 48,000
Additions 5,610
Transfers from/(to) other reporting entities 495
Disposals (8,766)
Depreciation 2,624
Write-off of assets (47)
Carrying amount at end of period 42,461

Other plant and equipment
Transfers from the Metropolitan Health Service (abolished) 19,034
Additions 6,154
Transfers from/(to) other reporting entities 43
Depreciation (421)
Carrying amount at end of period 23,076

Works in progress
Transfers from the Metropolitan Health Service (abolished) 258
Additions 4,115
Write-off of assets (29)
Carrying amount at end of period 4,344

Artworks
Transfers from the Metropolitan Health Service (abolished) 2,026
Transfers from/(to) other reporting entities 5
Carrying amount at end of period 2,031

Total property, plant and equipment
Transfers from the Metropolitan Health Service (abolished) 862,634
Additions 18,992
Disposals (253)
Transfers from/(to) other reporting entities 28,752
Revaluation increments/(decrements) 71,062
Depreciation (38,302)
Write-down of assets (a) (b) 3,513
Write-off of assets (47)
Carrying amount at end of period 939,313

(a) Expensing of assets less than $5,000 transferred to the Health Service as a result of establishment of the Health Service under the Health Service Act 2016, effective 1 July 2016. Refer to note 17 'Other expenses'.
(b) Work in progress capitalised in prior years, expensed in the current financial year. Refer to note 17 'Other expenses'.

Note 35 Fair value measurements

(a) Fair value hierarchy
AASB 13 requires disclosure of fair value measurements by level of the following fair value measurement hierarchy:
1) quoted prices (unadjusted) in active markets for identical assets (level 1);
2) input other than quoted prices included within level 1 that are observable for the asset either directly or indirectly (level 2); and
3) inputs for the asset that are not based on observable market data (unobservable input) (level 3).

The following table represents the Health Service's assets measured and recognised at fair value at 30 June 2017.

<table>
<thead>
<tr>
<th>Category</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
</tr>
<tr>
<td>Land</td>
<td>-</td>
<td>5,780</td>
<td>-</td>
<td>5,780</td>
</tr>
<tr>
<td>Vacant land</td>
<td>-</td>
<td>73,108</td>
<td>-</td>
<td>73,108</td>
</tr>
<tr>
<td>Specialised</td>
<td>-</td>
<td>2,860</td>
<td>-</td>
<td>2,860</td>
</tr>
<tr>
<td>Residential and commercial car park</td>
<td>-</td>
<td>695,029</td>
<td>-</td>
<td>695,029</td>
</tr>
<tr>
<td>Specialised</td>
<td>-</td>
<td>-</td>
<td>695,029</td>
<td>695,029</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>28,390</td>
<td>28,390</td>
</tr>
</tbody>
</table>

There were no transfers between Levels 1, 2 or 3 for the current period.
East Metropolitan Health Service

Notes to the Financial Statements
For the year ended 30 June 2017

Note 35 Fair value measurements (continued)

(b) Valuation techniques used 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 (Valuation Services) 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 (Valuation Services) 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.

In some instances the legal, physical, economic and socio political restrictions on a 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 valued under the cost approach. This approach uses the depreciated replacement cost method which estimates the current cost of reproduction or replacement of the buildings, on its current site, less deduction for physical deterioration and relevant forms of obsolescence. Depreciated replacement cost is the current replacement cost of an asset less, where applicable, accumulated depreciation calculated on the basis of such cost to reflect the already consumed or expired future economic benefits of the asset.

East Metropolitan Health Service

Notes to the Financial Statements
For the year ended 30 June 2017

Note 35 Fair value measurements (continued)

(b) Valuation techniques used to derive level 2 and level 3 fair values (continued)

The techniques involved in the determination of the current replacement costs include:

a) Review and updating of the ‘as-constructed’ drawing documentation;

b) Categorisation of the drawings using the Building Utilisation Categories (BUC) 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 Centre
• Metropolitan Secondary, Specialist and General Hospitals

c) Measurement of the general floor areas;

d) Application of the BUC cost rates per square meter of general floor areas;

e) Application of the applicable regional cost indices, which are used throughout the construction industry to estimate the additional costs associated with building construction in locations of the Perth area.

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 to derive the depreciated replacement cost, assuming a uniform pattern of consumption over the initial 37 years of asset life (up to 75% of current replacement costs). All specialised buildings are assumed to have a residual value of 25% of their current replacement costs.

The valuations are prepared on a going concern basis until the year in which the current use is discontinued. Grouped buildings with definite demolition plans are not subject to annual revaluation. The depreciated 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.

(c) Fair value measurements using significant unobservable inputs (Level 3)

The following table represents the changes in level 3 items for the year ended 30 June 2017:

<table>
<thead>
<tr>
<th>Year</th>
<th>Land</th>
<th>Buildings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>$500</td>
<td>$000</td>
</tr>
<tr>
<td>Fair value of balances transferred from the Metropolitan Health Service (abolished)</td>
<td>54,889</td>
<td>636,657</td>
</tr>
<tr>
<td>Additions</td>
<td>21,360</td>
<td>7,447</td>
</tr>
<tr>
<td>Revaluation increments/(decrements) recognised in Profit or Loss</td>
<td>(5,241)</td>
<td>74,835</td>
</tr>
<tr>
<td>Revaluation increments/(decrements) recognised in Other</td>
<td></td>
<td>(25,910)</td>
</tr>
<tr>
<td>Depreciation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fair value at end of period</td>
<td>73,108</td>
<td>695,059</td>
</tr>
</tbody>
</table>

(d) Valuation processes

The Department of Health manages the valuation processes for the Health Service. These include the provision of property information to quantity surveyors and Western Australian Land Information Authority (Valuation Services) and the review of the valuation reports. Valuation processes and results are discussed with the Chief Financial Officer at least once every year.
East Metropolitan Health Service

Notes to the Financial Statements
For the year ended 30 June 2017

Note 35 Fair value measurements (continued)
(d) Valuation processes (continued)
Western Australian Land Information Authority (Valuation Services) determines the fair values of the Health Service’s land and buildings. A quantity surveyor is engaged by the Department of Health to provide an update of the current replacement costs for specialised buildings. Western Australian Land Information Authority (Valuation Services) endorses the current replacement costs calculated by the quantity surveyor for specialised buildings and calculates the depreciated replacement costs.

2017
$000

Note 36 Intangible assets
Computer software
At cost
3,761
Accumulated amortisation
(876)
Total intangible assets
2,885

Reconciliations:
Reconciliations of the carrying amount of intangible assets at the beginning and end of the reporting period are set out below:
Computer software
Additions
(864)
Carrying amount at end of period
2,885

Note 37 Impairment of assets
There were no indications of impairment to property, plant and equipment and intangible assets at 30 June 2017. The Health Service held no goodwill or intangible assets with an indefinite useful life during the reporting period. At the end of the reporting period there were no intangible assets not yet available for use.

Note 38 Payables
Current
Accrued expenses
41,158
Trade creditors
13,326
Accrued salaries
10,088
Other creditors
5,607
Accrued interest
7
70,186

See also note 2(j) ‘Payables’ and note 56 ‘Financial instruments’. 

East Metropolitan Health Service

Notes to the Financial Statements
For the year ended 30 June 2017

Note 36 Intangible assets
Computer software
At cost
3,761
Accumulated amortisation
(876)
Total intangible assets
2,885

Reconciliations:
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Note 38 Payables
Current
Accrued expenses
41,158
Trade creditors
13,326
Accrued salaries
10,088
Other creditors
5,607
Accrued interest
7
70,186

See also note 2(j) ‘Payables’ and note 56 ‘Financial instruments’.

2017
$000

Note 39 Borrowings
Current
Department of Treasury loans (a)
762
Finance lease liabilities - Other (b)
30
792

Non-current
Department of Treasury loans (a)
1,636
Finance lease liabilities - Other (b)
22
1,658

Total borrowings
2,450

(a) This debt was taken up by the Health Service on 1 July 2017 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.

Note 40 Provisions
Current
Employee benefits provision
Annual leave (a)
62,538
Long service leave (b)
50,253
Time off in lieu leave (a)
28,718
Deferred salary scheme (c)
810
142,319

Non-current
Employee benefits provision
Long service leave (b)
33,674
33,674

Total provisions
176,063
East Metropolitan Health Service

Notes to the Financial Statements
For the year ended 30 June 2017

Note 40   Provisions (continued)

Total provisions (continued)

(b) Long service leave liabilities have been classified as current where there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

Within 12 months of the end of the reporting period

11,648

More than 12 months after the end of the reporting period

72,279

83,927

(2017)

$000

Note 41   Other liabilities

Current

Refundable deposits 134

Paid parental leave scheme 86

220

(2017)

$000

Note 42   Contributed equity

(a) The Health Services Act 2016 has been enacted to replace the Hospitals and Health Services Act 1927 as from 1 July 2016. The old Metropolitan Health Service as a statutory authority was abolished and their assets and liabilities were transferred to five health service providers (Child and Adolescent Health Service, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service and Health Support Services) that are separate statutory authorities. The assets and liabilities transferred to East Metropolitan Health Service are outlined below.

ASSETS

Cash and cash equivalents 27,264

Receivables 381,438

Inventories 5,368

Property, plant and equipment 862,635

Intangible assets 5,546

Other current assets 1,147

1,281,398

LIABILITIES

Payables 56,945

Borrowings 3,147

Provisions 163,979

Other liabilities 151

224,222

Net Contribution 1,057,176

(b) Treasurer’s Instruction (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’. (c) 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 transferor 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.

Note 43   Reserves

(a) The Health Services Act 2016 has been enacted to replace the Hospitals and Health Services Act 1927 as from 1 July 2016. The old Metropolitan Health Service as a statutory authority was abolished and their assets and liabilities were transferred to five health service providers (Child and Adolescent Health Service, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service and Health Support Services) that are separate statutory authorities. The assets and liabilities transferred to East Metropolitan Health Service are outlined below.

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Provisions 163,979

Other liabilities 151

224,222

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Note 42 Contributed equity (continued)

(a) The Health Services Act 2016 has been enacted to replace the Hospitals and Health Services Act 1927 as from 1 July 2016. The old Metropolitan Health Service as a statutory authority was abolished and their assets and liabilities were transferred to five health service providers (Child and Adolescent Health Service, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service and Health Support Services) that are separate statutory authorities. The assets and liabilities transferred to East Metropolitan Health Service are outlined below.

Balance at start of period

Contributions by owners (c)

Transfer of assets from the Department of Health 15,033

Transfer of assets and liabilities from South Metropolitan Health Service 23,140

Total contributions by owners 1,114,247

Distributions to owners (c)

Transfer of assets and liabilities to South Metropolitan Health Service (2,012)

Transfer of assets and liabilities to North Metropolitan Health Service (871)

Total distributions to owners (2,883)

Balance at end of period 1,111,364
Note 43 Reserves (continued)
(a) The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets.
(b) 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.
(c) Land revaluation decrement recognised as expense on Statement of Comprehensive Income.

Note 44 Accumulated surplus

Balance at start of period
- 
Result for the period
50,304 
Balance at end of period
50,304 

Note 45 Notes to the Statement of Cash Flows
Reconciliation of cash
Cash assets at the end of the reporting period as shown in the Statement of Cash Flows are reconciled to the related items in the Statement of Financial Position as follows:
Cash and cash equivalents
83,848 
Restricted cash and cash equivalents
29,371 
113,219 

Reconciliation of net cost of services to net cash flows used in operating activities
Net cash used in operating activities (Statement of Cash Flows) (577,648)
Increase/(decrease) in assets:
Change in GST receivable
(54) 
Other current receivables
(8,254) 
Inventories
218 
Prepayments and other current assets
(381) 
Other non-current assets
263 
Decrease/(increase) in liabilities:
Payables
(9,927) 
Current provisions
(9,588) 
Non-current provisions
(2,426) 
Other current liabilities
(69) 

Note 46 Revenue, public and other property written off
a) Revenue and debts written off under the authority of the Accountable Authority
3,808 
b) Public and other property written off under the authority of the Accountable Authority
59 
c) Revenue and debts written off under the authority of the Minister
572 
4,439 

Note 47 Remuneration of auditor
Remuneration payable to the Auditor General in respect of the audit for the current reporting period is as follows:
Auditing the accounts, financial statements and key performance indicators
155
East Metropolitan Health Service

Notes to the Financial Statements
For the year ended 30 June 2017

2017 $000

Capital expenditure commitments:
Within 1 year 8,894
Later than 1 year, and not later than 5 years 263
9,157

Operating lease commitments:
Within 1 year 585
Later than 1 year, and not later than 5 years 1,827
Later than 5 years 1,671
4,083

Finance lease commitments:
Minimum lease payment commitments in relation to finance leases are payable as follows:
Within 1 year 33
Later than 1 year, and not later than 5 years 23
Minimum finance lease payments 56
Less future finance charges (4) (4)
Present value of finance lease liabilities (note 39) 52

Other expenditure commitments:
Within 1 year 19,895
Later than 1 year, and not later than 5 years 651
Later than 5 years 163
20,709

Contingent liabilities and contingent assets:
Contingent liabilities
Contingent liabilities in addition to the liabilities included in the financial statements, the Health Service has the following contingent liabilities:
The Health Service received $21.2 million additional Commonwealth NHRA revenue in 2016-17 which was higher than budgeted. The Commonwealth has yet to reconcile this amount. It is anticipated that this may result in a refund back to the Commonwealth via the NHRA funding adjustment processes during 2017-18. The exact impact of this adjustment is yet to be determined.

Contingent liabilities

Litigation in progress
Pending litigation that are not recoverable from RiskCover insurance and may affect the financial position of the Health Service.

Number of claims 232
Contaminated sites
Under the Contaminated Sites Act 2003, the Health Service is required to report known and suspected contaminated sites to the Department of Environment and Conservation (DEC). In accordance with the Act, DEC 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.

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

Events occurring after the end of the reporting period
The Health Service is unaware of any event occurring after the reporting date that would materially affect the financial statements.
East Metropolitan Health Service

Notes to the Financial Statements
For the year ended 30 June 2017

Note 51 Related bodies
A related body is a body which receives more than half its funding and resources from the Health Service and is subject to operational control by the Health Service.
The Health Service had no related bodies during the reporting period.

Note 52 Affiliated bodies
An affiliated body is a body which receives more than half its funding and resources from the Health Service but is not subject to operational control by the Health Service.
The Health Service had no affiliated bodies during the reporting period.

Note 53 Administered trust accounts
Funds held in these trust accounts are not controlled by the Health Service and are therefore not recognised in the financial statements.

a) The Health Service administers a trust account for the purpose of holding patients’ private moneys.
A summary of the transactions for this trust account is as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at the start of period</td>
<td>$5</td>
</tr>
<tr>
<td>Add Receipts</td>
<td></td>
</tr>
<tr>
<td>Less Payments</td>
<td></td>
</tr>
<tr>
<td>Balance at the end of period</td>
<td>$5</td>
</tr>
</tbody>
</table>

b) Other trust accounts not controlled by the Health Service.
RPH Private Trust Account
Balance at the start of period 292
Add Receipts 1
Less Payments 293
Balance at the end of period 293

Funds held in these trust accounts are not controlled by the Health Service and are therefore not recognised in the financial statements.
The Health Service had no affiliated bodies during the reporting period.
The Health Service had no related bodies during the reporting period.

Other trust accounts not controlled by the Health Service.

East Metropolitan Health Service

Notes to the Financial Statements
For the year ended 30 June 2017

Note 54 Special purpose accounts

<table>
<thead>
<tr>
<th>Description</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at the start of period</td>
<td></td>
</tr>
<tr>
<td>Add Receipts</td>
<td></td>
</tr>
<tr>
<td>Service delivery agreement</td>
<td></td>
</tr>
<tr>
<td>Commonwealth contributions (note 20 (i))</td>
<td>39,550</td>
</tr>
<tr>
<td>State contributions (note 20 (ii))</td>
<td>120,013</td>
</tr>
<tr>
<td>Other (note 20 (ii))</td>
<td>3,532</td>
</tr>
<tr>
<td>Total Mental Health Commission special purpose accounts</td>
<td>163,105</td>
</tr>
<tr>
<td>Payments</td>
<td>(162,931)</td>
</tr>
<tr>
<td>Balance at the end of period</td>
<td>124</td>
</tr>
</tbody>
</table>

The special purpose accounts are established under section 161(1)(c) of the Financial Management Act 2006.
East Metropolitan Health Service

Notes to the Financial Statements
For the year ended 30 June 2017

Note 55  Explanatory statement

All variances between estimates (original budget) and actual results for 2017 are shown below. Narratives are provided for selected significant variances, which is generally greater than 5% and $25 million.

### Statement of Comprehensive Income

#### Note 2017 2017 estimate Actual and actual

<table>
<thead>
<tr>
<th>COST OF SERVICES</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee benefits expense</td>
<td>732,353</td>
<td>744,622</td>
<td>12,269</td>
</tr>
<tr>
<td>Fees for visiting medical practitioners</td>
<td>23,802</td>
<td>24,596</td>
<td>794</td>
</tr>
<tr>
<td>Contracts for services</td>
<td>240,150</td>
<td>242,257</td>
<td>2,107</td>
</tr>
<tr>
<td>Patient support costs</td>
<td>161,320</td>
<td>222,502</td>
<td>61,182</td>
</tr>
<tr>
<td>Finance costs</td>
<td>253</td>
<td>95</td>
<td>(158)</td>
</tr>
<tr>
<td>Depreciation and amortisation expense</td>
<td>29,692</td>
<td>39,165</td>
<td>9,473</td>
</tr>
<tr>
<td>Loss on disposal of non-current assets</td>
<td>-</td>
<td>314</td>
<td>314</td>
</tr>
<tr>
<td>Repairs, maintenance and consumable equipment</td>
<td>23,882</td>
<td>27,553</td>
<td>3,671</td>
</tr>
<tr>
<td>Other supplies and services</td>
<td>4,596</td>
<td>11,250</td>
<td>6,654</td>
</tr>
<tr>
<td>Other expenses</td>
<td>35,269</td>
<td>85,024</td>
<td>49,755</td>
</tr>
<tr>
<td><strong>Total cost of services</strong></td>
<td>1,251,317</td>
<td>1,401,209</td>
<td>149,892</td>
</tr>
</tbody>
</table>

#### INCOME

<table>
<thead>
<tr>
<th>Revenue</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient charges</td>
<td>53,653</td>
<td>63,698</td>
<td>10,045</td>
</tr>
<tr>
<td>Other fees for services</td>
<td>35,646</td>
<td>63,797</td>
<td>28,151</td>
</tr>
<tr>
<td>Commonwealth grants and contributions</td>
<td>493,313</td>
<td>410,855</td>
<td>(82,458)</td>
</tr>
<tr>
<td>Other grants and contributions</td>
<td>6,244</td>
<td>128,334</td>
<td>122,090</td>
</tr>
<tr>
<td>Donation revenue</td>
<td>-</td>
<td>399</td>
<td>399</td>
</tr>
<tr>
<td>Commercial activities</td>
<td>-</td>
<td>2,537</td>
<td>2,537</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>589,109</td>
<td>680,692</td>
<td>91,583</td>
</tr>
</tbody>
</table>

#### NET COST OF SERVICES

662,208 736,517 74,309

#### INCOME FROM STATE GOVERNMENT

Service appropriations (a) 660,836 705,935 45,099

Assets assumed - 228 228

Services received free of charge (f) - 64,658 64,658

**Total income from State Government** 660,836 770,821 109,985

#### SURPLUS/(DEFICIT) FOR THE PERIOD (1,372) 50,304 51,676

#### OTHER COMPREHENSIVE INCOME/(LOSS)

<table>
<thead>
<tr>
<th>Items not reclassified subsequently to profit or loss</th>
<th>$000</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes in asset revaluation reserve (g)</td>
<td>-</td>
<td>74,893</td>
</tr>
</tbody>
</table>

**Total other comprehensive income (loss)** 74,893 74,893

**TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE PERIOD** (1,372) 125,197 126,569

---

#### Significant variances between estimated and actuals for 2017 - Statement of Comprehensive Income

(a) **Patient support costs**

Patient support costs increased by $61M due to an overall increase in patient activity ($19M) and an increase in expenditure on the new Hepatitis C treatment program using high cost drugs ($23M). In addition there were indirect pathology costs not in original estimates ($22M), included as Resources Received Free of Charge from PathWest.

(b) **Other expenses**

Health Support Service costs of $43M for shared services not included in original estimates provided by the Department of Health, have been included as Resources Received Free of Charge (expenditure). Improved analysis of collection rates for patient debtors were used in 2017 to ascertain the health service’s doubtful debts expense which resulted in a $6M increase from original estimates.

(c) **Other fees for services**

This variance is represented by unbudgeted revenue for health technology management unit and business intelligence services provided ($9M) and internal and external service recoup revenue that has been offset to expenditure, additional pharmacy fees raised through the Pharmaceutical Benefits Scheme for the new Hepatitis C drug treatment and other general drugs due to additional patient activity ($23M) and one-off patient revenues ($3M).

(d) **Commonwealth grants and contributions and other grants and contributions**

A total of $35M in additional NHRA funding was received above the original budget. Of this, $21M was as a result of the Commonwealth Treasurer deferring the determination of the 2015-16 revenue adjustments from 2016-17 to 2017-18 and $13M was for additional activity in 2016-17 (offset by decreased service appropriation). Commonwealth grants for Aged Care Assessment Program (ACAP) of $3M were not included in the original estimates.

(e) **Service appropriations**

Additional service appropriation was received over and above the original estimate. This included $39M in funding for increased activity, $15M for increased depreciation expenditure relating to the transfer of assets for the St. John of God Midland Public Hospital from the Metropolitan Health Service, $9M increase in funding for specific purpose programs and $2M for staff severance expenditure. This was offset by a decrease of $13M that the Health Service received as NHRA revenue for additional activity performed during the year.

(f) **Services received free of charge**

Health Support Service costs of $43M for shared services and PathWest indirect pathology costs of $22M not included in initial budget from the Department of Health, have been included as Resources Received Free of Charge.
### East Metropolitan Health Service

#### Notes to the Financial Statements

For the year ended 30 June 2017

---

#### Note 55 Explanatory statement (continued)

Variance between Estimated and Actual

### Statement of Financial Position

<table>
<thead>
<tr>
<th>Note</th>
<th>Assets</th>
<th>2017 Estimates</th>
<th>2017 Actual</th>
<th>Variance between estimate and actual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CURRENT ASSETS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cash and cash equivalents</td>
<td>1,583</td>
<td>83,848</td>
<td>82,265</td>
</tr>
<tr>
<td></td>
<td>Restricted cash and cash equivalents</td>
<td>25,680</td>
<td>26,395</td>
<td>715</td>
</tr>
<tr>
<td></td>
<td>Receivables</td>
<td>25,588</td>
<td>32,288</td>
<td>6,700</td>
</tr>
<tr>
<td></td>
<td>Inventories</td>
<td>4,735</td>
<td>5,585</td>
<td>850</td>
</tr>
<tr>
<td></td>
<td>Other current assets</td>
<td>5</td>
<td>760</td>
<td>560</td>
</tr>
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<td></td>
<td>Total Current Assets</td>
<td>57,591</td>
<td>148,881</td>
<td>91,290</td>
</tr>
<tr>
<td></td>
<td>NON-CURRENT ASSETS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Restricted cash and cash equivalents</td>
<td>2,976</td>
<td>2,976</td>
<td>0</td>
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<tr>
<td></td>
<td>Amounts receivable for services</td>
<td>372,876</td>
<td>391,092</td>
<td>18,216</td>
</tr>
<tr>
<td></td>
<td>Property, plant and equipment</td>
<td>847,195</td>
<td>939,313</td>
<td>92,118</td>
</tr>
<tr>
<td></td>
<td>Intangible assets</td>
<td>3,546</td>
<td>2,885</td>
<td>(661)</td>
</tr>
<tr>
<td></td>
<td>Other non-current assets</td>
<td>263</td>
<td>263</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Total Non-Current Assets</td>
<td>1,223,517</td>
<td>1,336,529</td>
<td>112,912</td>
</tr>
<tr>
<td></td>
<td>Total Assets</td>
<td>1,281,208</td>
<td>1,485,410</td>
<td>204,202</td>
</tr>
</tbody>
</table>

#### LIABILITIES

<table>
<thead>
<tr>
<th>Note</th>
<th>Liabilities</th>
<th>2017</th>
<th>2017</th>
<th>Variance between estimate and actual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$000</td>
<td>$000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CURRENT LIABILITIES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Payables</td>
<td>58,317</td>
<td>70,186</td>
<td>11,869</td>
</tr>
<tr>
<td></td>
<td>Borrowings</td>
<td>737</td>
<td>792</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>Provisions</td>
<td>140,528</td>
<td>142,319</td>
<td>1,791</td>
</tr>
<tr>
<td></td>
<td>Other current liabilities</td>
<td>5</td>
<td>220</td>
<td>195</td>
</tr>
<tr>
<td></td>
<td>Total Current Liabilities</td>
<td>109,063</td>
<td>213,517</td>
<td>13,454</td>
</tr>
<tr>
<td></td>
<td>NON-CURRENT LIABILITIES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Borrowings</td>
<td>2,410</td>
<td>1,658</td>
<td>(752)</td>
</tr>
<tr>
<td></td>
<td>Provisions</td>
<td>31,248</td>
<td>33,674</td>
<td>2,426</td>
</tr>
<tr>
<td></td>
<td>Total Non-Current Liabilities</td>
<td>33,658</td>
<td>35,332</td>
<td>1,674</td>
</tr>
<tr>
<td></td>
<td>Total Liabilities</td>
<td>233,391</td>
<td>248,849</td>
<td>15,458</td>
</tr>
</tbody>
</table>

#### NET ASSETS

<table>
<thead>
<tr>
<th>Note</th>
<th>Net assets</th>
<th>2017</th>
<th>2017</th>
<th>Variance between estimate and actual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$000</td>
<td>$000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TOTAL NET ASSETS</td>
<td>1,047,817</td>
<td>1,236,561</td>
<td>188,744</td>
</tr>
</tbody>
</table>

#### EQUITY

<table>
<thead>
<tr>
<th>Note</th>
<th>Equity</th>
<th>2017</th>
<th>2017</th>
<th>Variance between estimate and actual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$000</td>
<td>$000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contributed equity</td>
<td>1,049,189</td>
<td>1,111,364</td>
<td>62,175</td>
</tr>
<tr>
<td></td>
<td>Reserves</td>
<td>74,893</td>
<td>74,893</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Accumulated surplus</td>
<td>51,676</td>
<td>51,676</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>TOTAL EQUITY</td>
<td>1,047,817</td>
<td>1,236,561</td>
<td>188,744</td>
</tr>
</tbody>
</table>

---

**Significant variances between estimated and actuals for 2017 - Statement of Financial Position**

- **(g) Cash and cash equivalents**
  - The actual final cash balance position was greater than estimated due to the phased establishment of the Health Service, which resulted in some savings, additional patient revenue, one-off abnormal revenue items and additional NHRA Commonwealth revenue of $21M.

- **(h) Property plant and equipment**
  - The revaluation of land and buildings increased the net carrying value of this class of asset by $71M. In addition, there was a $29M net transfer of assets from other health service entities, partially offset by an increased depreciation budget of $10M.

- **(i) Contributed equity**
  - Contributed equity was greater than estimated due to a revision of $22M of net assets transferred primarily because the St. John of God Midland Private Hospital June 2016 activity was incorrectly transferred to the Health Service. In addition, during the course of the year, an additional $39M of assets and liabilities were transferred to the Health Service as a result of the disaggregation of the Metropolitan Health Service. Capital appropriation funding was $4M higher than originally estimated.

- **(j) Accumulated surplus**
  - Actual surplus was greater than estimated, primarily due to additional unbudgeted NHRA funding ($21M). There was increased patient fee revenue compared to what was originally estimated ($10M) and one off revenues received that were not included in the original estimates.
East Metropolitan Health Service

Notes to the Financial Statements
For the year ended 30 June 2017

Note 55 Explanatory statement (continued)

<table>
<thead>
<tr>
<th>Statement of Cash Flows</th>
<th>Note</th>
<th>2017 Estimates</th>
<th>2017 Actual</th>
<th>Variance between estimate and actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>CASH FLOWS FROM STATE GOVERNMENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service appropriations</td>
<td>(k)</td>
<td>625,796</td>
<td>661,508</td>
<td>35,712</td>
</tr>
<tr>
<td>Capital appropriations</td>
<td></td>
<td>14,252</td>
<td>17,321</td>
<td>3,069</td>
</tr>
<tr>
<td>Cash and cash equivalents transferred from the Metropolitan Health Service (abolished)</td>
<td>(l)</td>
<td>-</td>
<td>27,264</td>
<td>27,264</td>
</tr>
<tr>
<td>Net cash provided by State Government</td>
<td></td>
<td>640,048</td>
<td>708,093</td>
<td>68,045</td>
</tr>
</tbody>
</table>

Utilised as follows:

<table>
<thead>
<tr>
<th>CASH FLOWS FROM OPERATING ACTIVITIES</th>
<th>Payments</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee benefits</td>
<td>(725,792)</td>
<td>(724,222)</td>
<td>1,570</td>
</tr>
<tr>
<td>Supplies and services</td>
<td>(489,018)</td>
<td>(539,877)</td>
<td>(50,859)</td>
</tr>
<tr>
<td>Finance costs</td>
<td>(94)</td>
<td>(6)</td>
<td>88</td>
</tr>
<tr>
<td>Receipts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receipts from customers</td>
<td>53,653</td>
<td>59,597</td>
<td>5,944</td>
</tr>
<tr>
<td>Commonwealth grants and contributions</td>
<td>403,313</td>
<td>410,855</td>
<td>7,542</td>
</tr>
<tr>
<td>Other grants and contributions</td>
<td>6,244</td>
<td>128,333</td>
<td>122,089</td>
</tr>
<tr>
<td>Donations received</td>
<td>-</td>
<td>292</td>
<td>292</td>
</tr>
<tr>
<td>Other receipts</td>
<td>35,898</td>
<td>87,380</td>
<td>51,482</td>
</tr>
<tr>
<td>Net cash used in operating activities</td>
<td>(625,796)</td>
<td>(577,648)</td>
<td>48,148</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CASH FLOWS FROM INVESTING ACTIVITIES</th>
<th>Payments</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment for purchase of non-current physical and intangible assets</td>
<td>(14,252)</td>
<td>(15,195)</td>
<td>(943)</td>
</tr>
<tr>
<td>Net cash used in investing activities</td>
<td>(14,252)</td>
<td>(15,195)</td>
<td>(943)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CASH FLOWS FROM FINANCING ACTIVITIES</th>
<th>Payments</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Repayment of finance lease liabilities</td>
<td>-</td>
<td>-</td>
<td>(31)</td>
</tr>
<tr>
<td>Net cash used in financing activities</td>
<td>-</td>
<td>(31)</td>
<td>(31)</td>
</tr>
</tbody>
</table>

| Net increase / (decrease) in cash and cash equivalents | (l) | 27,263 | 113,219 | 85,956 |

| CASH AND CASH EQUIVALENTS AT THE END OF PERIOD | | 27,263 | 113,219 | 85,956 |

Significant variances between estimated and actuals for 2017 - Statement of Cash Flows

(k) Service appropriations
Additional service appropriation received over and above the original estimate included $39M in funding for increased activity, $5M increase in funding for specific purpose programs and $2M for staff severance payments. This was offset by a decrease of $13M received as NHRA funding.

(l) Cash and cash equivalents transferred on 1 July 2016
$27M in cash and cash equivalents was transferred from the Metropolitan Health Service with the establishment of East Metropolitan Health Service on 1 July 2016.

(m) Supplies and services
The variance relates primarily to actual cash outflows from the purchase of supplies and services that were $51M greater than estimated. This is primarily due to increases in patient activity during 2016-17 and increased expenditure resulting from the use of new high cost Hepatitis C drugs.

(n) Commonwealth grants and contributions and other grants and contributions
Combined inflows were $49M greater than estimated, partially due to $21M in additional NHRA funding received above original estimates and $13M increased NHRA funding for increased patient activity. In addition, $3M for Commonwealth grants for Aged Care Assessment Program (ACAP) was not included in original estimates.

(iii) Other receipts
This is primarily related to increased recoup revenue from the Pharmaceutical Benefits Scheme (PBS) for the Hepatitis C drugs ($20M) and other general drugs due to increased patient activity ($3M). Original estimates did not include additional revenues associated with the receipt of insurance rebates from prior periods ($8M), one-off patient revenues ($3M), commercial revenues ($3M) and other miscellaneous revenues ($6M). The decrease in net accruals (accounts receivable and accrued revenues) resulted in a net inflow of $10M which was not included in the original estimates.
East Metropolitan Health Service

Notes to the Financial Statements
For the year ended 30 June 2017

Note 55   Explanatory statement (continued)

Statement of Changes in Equity

Note  Variance between
          2017    2017 estimate          2017 estimate
          Estimates  Actual and actual
          $000     $000                       $000

CONTRIBUTED EQUITY
Balance at 1 July 2016 (p) 1,034,778 - (1,034,778)
Transactions with owners in their capacity as owners:
  Capital appropriations 14,411 18,048 3,637
  Other contributions by owners - 1,096,199 1,096,199
  Distributions to owners - (2,883) (2,883)
Balance at 30 June 2017 1,049,189 1,111,364 62,175

RESERVES
Asset Revaluation Reserve
Balance at start of period - - -
    Other comprehensive income for the period (f) - 74,893 74,893
    Balance at 30 June 2017 - 74,893 74,893

ACCUMULATED SURPLUS
Balance at 1 July 2016 (q) (1,372) 50,304 51,676
Surplus for the period - - -
Balance at 30 June 2017 (1,372) 50,304 51,676

TOTAL EQUITY
Balance at 1 July 2016 (p) 1,034,778 - (1,034,778)
Total comprehensive income for the period (f) (1,372) 125,197 126,569
Transactions with owners in their capacity as owners (s) 14,411 1,111,364 1,096,953
Balance at 30 June 2017 1,047,817 1,236,561 188,744

The Health Services Act 2016 has been enacted to replace the Hospitals and Health Services Act 1927 as from 1 July 2016. The old Metropolitan Health Service as a statutory authority was abolished and their assets and liabilities were transferred to five health service providers, of which $1.1B net assets and liabilities were transferred to East Metropolitan Health Service during the 2016-17 financial year. In addition, Capital Appropriation was $4M above the initial budget.

Significant variances between estimated and actuals for 2017 - Statement of Changes in Equity

(a) Contributed equity opening balance
The Health Service was established on 1 July 2016 and all equity was acquired after that date.

(b) Surplus for the period
Actual surplus was greater than estimated, primarily due to additional unbudgeted NHRA funding ($21M). There was increased patient fee revenue compared to what was originally estimated ($10M) and one-off revenues received that were not included in the original estimates.

(c) Total comprehensive income for the period
The total variance comprises a $52M surplus for the period, together with an increase in building values of $75M arising from the revaluation of land and buildings during the year. This also resulted in an increase in the asset revaluation reserve for the Health Service.

(d) Transactions with owners in their capacity as owners
The Health Services Act 2016 has been enacted to replace the Hospitals and Health Services Act 1927 as from 1 July 2016. The old Metropolitan Health Service as a statutory authority was abolished and their assets and liabilities were transferred to five health service providers, of which $1.1B net assets and liabilities were transferred to East Metropolitan Health Service during the 2016-17 financial year. In addition, Capital Appropriation was $4M above the initial budget.
East Metropolitan Health Service

Notes to the Financial Statements
For the year ended 30 June 2017

Note 56  Financial instruments

a)  Financial risk management objectives and policies

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.

Credit risk
Credit risk arises when there is the possibility of the Health Service’s receivables defaulting on their contractual obligations resulting in financial loss to the Health Service. The maximum exposure to credit risk at the end of the reporting period in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any allowance for impairment as shown in the table at Note 56(c) ‘Financial instrument disclosures’ and note 30 ‘Receivables’.

Credit risk associated with the Health Service’s financial assets is generally confined to patient fee debtors (see note 30). The main receivable of the Health Service is the amounts receivable for services (holding account). For receivables other than government agencies and patient fee debtors, the Health Service trades only with recognised, creditworthy third parties. The Health Service has policies in place to ensure that sales of products and services are made to customers with an appropriate credit history. In addition, receivable balances are monitored on an ongoing basis with the result that the Health Service’s exposure to bad debts is minimal. At the end of the reporting period, there were no significant concentrations of credit risk.

In circumstances where a third party is responsible for payment, or there are legal considerations, payment of accounts can be delayed considerably. Unpaid debts are referred to an external debt collection service on a case by case basis, considering financial election and reasons for non-payment.

Allowance for impairment of financial assets is calculated based on objective evidence such as observable data and historical trends. For financial assets that are either past due or impaired, refer to Note 56 (c) ‘Financial instrument disclosures’.

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 include the Department of Treasury (DT) loans and finance leases (fixed rates with varying maturities). The interest rate risk for the loans is managed by DT through portfolio diversification and variation in maturity dates.

The carrying amounts of each of the following categories of financial assets and financial liabilities at the end of the reporting period are:

<table>
<thead>
<tr>
<th>Category</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$000</td>
</tr>
<tr>
<td><strong>Financial Assets</strong></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>83,848</td>
</tr>
<tr>
<td>Restricted cash and cash equivalents</td>
<td>29,731</td>
</tr>
<tr>
<td>Loans and receivables (a)</td>
<td>29,589</td>
</tr>
<tr>
<td><strong>Financial Liabilities</strong></td>
<td></td>
</tr>
<tr>
<td>Financial liabilities measured at amortised cost</td>
<td>72,636</td>
</tr>
</tbody>
</table>

(a) The amount of loans and receivables excludes GST recoverable from ATO (statutory receivable).
## Aged analysis of financial assets

<table>
<thead>
<tr>
<th>Carrying amount</th>
<th>Not past due and not impaired</th>
<th>Past due but not impaired</th>
<th>Impaired Financial assets</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>83,848</td>
<td>83,848</td>
<td>-</td>
</tr>
<tr>
<td>Restricted cash and cash equivalents</td>
<td>29,371</td>
<td>29,371</td>
<td>-</td>
</tr>
<tr>
<td>Receivables (a)</td>
<td>391,092</td>
<td>391,092</td>
<td>5,209</td>
</tr>
<tr>
<td>Amounts receivable for services</td>
<td>391,092</td>
<td>391,092</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>533,900</strong></td>
<td><strong>522,314</strong></td>
<td><strong>5,209</strong></td>
</tr>
</tbody>
</table>

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

Interest rate exposure and maturity analysis of financial assets and financial liabilities

<table>
<thead>
<tr>
<th>Interest rate exposure</th>
<th>Maturity dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weighted average</td>
<td>Nominal Amount</td>
</tr>
<tr>
<td>effective interest rate</td>
<td>$000</td>
</tr>
</tbody>
</table>

**2017**

**Financial Assets**

<table>
<thead>
<tr>
<th>Description</th>
<th>Weighted average interest rate</th>
<th>Nominal Amount</th>
<th>Up to 3 months</th>
<th>3 months to 1 year</th>
<th>1-5 years</th>
<th>5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and cash equivalents</td>
<td>3.17%</td>
<td>70,186</td>
<td>70,186</td>
<td>70,186</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Restricted cash and cash equivalents</td>
<td>3.17%</td>
<td>3,398</td>
<td>3,398</td>
<td>3,398</td>
<td>946</td>
<td>30</td>
</tr>
<tr>
<td>Receivables - non interest bearing (a)</td>
<td>-</td>
<td>-</td>
<td>70,186</td>
<td>70,186</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Receivables - interest bearing</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Amounts receivable for services</td>
<td>-</td>
<td>3,398</td>
<td>3,398</td>
<td>3,398</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**Financial Liabilities**

<table>
<thead>
<tr>
<th>Description</th>
<th>Weighted average interest rate</th>
<th>Nominal Amount</th>
<th>Up to 3 months</th>
<th>3 months to 1 year</th>
<th>1-5 years</th>
<th>5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payables</td>
<td>3.17%</td>
<td>2,398</td>
<td>2,398</td>
<td>2,513</td>
<td>137</td>
<td>15</td>
</tr>
<tr>
<td>Department of Treasury Loans</td>
<td>3.17%</td>
<td>2,063</td>
<td>2,063</td>
<td>2,063</td>
<td>120</td>
<td>12</td>
</tr>
<tr>
<td>Finance lease liabilities - Royal Perth</td>
<td>7.58%</td>
<td>2,063</td>
<td>2,063</td>
<td>2,063</td>
<td>120</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>72,636</td>
<td>72,636</td>
<td>72,636</td>
<td>72,636</td>
<td>72,636</td>
</tr>
</tbody>
</table>

(a) The amount of receivables excludes the GST recoverable from ATO (statutory receivable)
East Metropolitan Health Service

Notes to the Financial Statements

For the year ended 30 June 2017

Note 56 Financial instruments (continued)

c) Financial instrument disclosures (continued)

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.

<table>
<thead>
<tr>
<th>Amount Exposed to Interest Rate Risk</th>
<th>-100 basis points</th>
<th>+100 basis points</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Surplus $000</td>
<td>Equity $000</td>
</tr>
<tr>
<td>Financial Assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receivables</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Financial Liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department of Treasury Loans</td>
<td>2,398</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td></td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>(24)</td>
<td>(24)</td>
</tr>
<tr>
<td>Total Increase/(Decrease)</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>(24)</td>
<td>(24)</td>
</tr>
</tbody>
</table>

Fair values

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.
### Notes to the Financial Statements

For the year ended 30 June 2017

**Note 57** Schedule of income and expenses by service

<table>
<thead>
<tr>
<th>Public Hospital Admitted Patient</th>
<th>Emergency Department</th>
<th>Public Hospital Non-Admitted Patients</th>
<th>Prevention, Promotion &amp; Protection</th>
<th>Mental Health</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017 $000</td>
<td>2017 $000</td>
<td>2017 $000</td>
<td>2017 $000</td>
<td>2017 $000</td>
<td>2017 $000</td>
</tr>
<tr>
<td>COST OF SERVICES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits expense</td>
<td>450,827</td>
<td>89,489</td>
<td>104,646</td>
<td>6,522</td>
<td>93,138</td>
</tr>
<tr>
<td>Fees for visiting medical practitioners</td>
<td>14,891</td>
<td>2,956</td>
<td>3,457</td>
<td>215</td>
<td>3,077</td>
</tr>
<tr>
<td>Contracts for services</td>
<td>146,673</td>
<td>29,114</td>
<td>34,046</td>
<td>2,122</td>
<td>30,302</td>
</tr>
<tr>
<td>Patient support costs</td>
<td>136,382</td>
<td>28,817</td>
<td>32,113</td>
<td>1,754</td>
<td>25,436</td>
</tr>
<tr>
<td>Finance costs</td>
<td>58</td>
<td>11</td>
<td>13</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Depreciation and amortisation expense</td>
<td>23,712</td>
<td>7,007</td>
<td>5,504</td>
<td>343</td>
<td>4,898</td>
</tr>
<tr>
<td>Asset revaluation decrement</td>
<td>2,319</td>
<td>461</td>
<td>538</td>
<td>34</td>
<td>479</td>
</tr>
<tr>
<td>Loss on disposal of non-current assets</td>
<td>190</td>
<td>38</td>
<td>44</td>
<td>3</td>
<td>39</td>
</tr>
<tr>
<td>Repairs, maintenance and consumable equipment</td>
<td>16,682</td>
<td>3,111</td>
<td>3,872</td>
<td>242</td>
<td>3,446</td>
</tr>
<tr>
<td>Other supplies and services</td>
<td>6,811</td>
<td>1,362</td>
<td>1,581</td>
<td>99</td>
<td>1,407</td>
</tr>
<tr>
<td>Other expenses</td>
<td>50,784</td>
<td>10,218</td>
<td>11,949</td>
<td>745</td>
<td>11,328</td>
</tr>
<tr>
<td>Total cost of services</td>
<td>849,329</td>
<td>168,474</td>
<td>197,763</td>
<td>12,080</td>
<td>173,563</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient charges</td>
<td>56,243</td>
<td>3,185</td>
<td>4,270</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other fees for services</td>
<td>44,147</td>
<td>8,763</td>
<td>10,248</td>
<td>639</td>
<td>-</td>
</tr>
<tr>
<td>Commonwealth grants and contributions</td>
<td>256,943</td>
<td>51,003</td>
<td>59,642</td>
<td>3,717</td>
<td>39,550</td>
</tr>
<tr>
<td>Other grants and contributions</td>
<td>3,313</td>
<td>658</td>
<td>769</td>
<td>48</td>
<td>123,546</td>
</tr>
<tr>
<td>Donation revenue</td>
<td>276</td>
<td>55</td>
<td>64</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Commercial activities</td>
<td>1,774</td>
<td>352</td>
<td>411</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other revenue</td>
<td>7,662</td>
<td>1,521</td>
<td>1,779</td>
<td>110</td>
<td>-</td>
</tr>
<tr>
<td>Total income other than income from State Government</td>
<td>370,358</td>
<td>65,537</td>
<td>77,183</td>
<td>4,518</td>
<td>163,056</td>
</tr>
<tr>
<td>NET COST OF SERVICES</td>
<td>478,971</td>
<td>102,937</td>
<td>120,580</td>
<td>7,562</td>
<td>10,467</td>
</tr>
<tr>
<td>INCOME FROM STATE GOVERNMENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service appropriations</td>
<td>472,880</td>
<td>101,631</td>
<td>119,049</td>
<td>7,466</td>
<td>4,899</td>
</tr>
<tr>
<td>Assets assumed</td>
<td>158</td>
<td>31</td>
<td>37</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Services received free of charge</td>
<td>40,816</td>
<td>7,847</td>
<td>9,930</td>
<td>373</td>
<td>5,692</td>
</tr>
<tr>
<td>Total income from State Government</td>
<td>533,554</td>
<td>109,509</td>
<td>129,016</td>
<td>7,841</td>
<td>16,591</td>
</tr>
<tr>
<td>SURPLUS FOR THE PERIOD</td>
<td>34,893</td>
<td>6,572</td>
<td>8,436</td>
<td>279</td>
<td>124</td>
</tr>
</tbody>
</table>

The Schedule of Income and Expenses by Service should be read in conjunction with the accompanying notes.
Locations and contact information

East Metropolitan Health Service (area office)

Address:
10 Murray Street
PERTH WA 6000

Postal address:
GPO box X2213
PERTH WA 6847

Telephone:  (08) 9224 2244
Fax:  (08) 9224 3511
Email:  EMHS.GeneraEnquiries@health.wa.gov.au
Website:  www.eastmetropolitan.health.wa.gov.au
Royal Perth Bentley Group (RPBG)

Royal Perth Hospital
Address: 197 Wellington Street
PERTH WA 6000
Postal address: GPO box X2213
PERTH WA 6847
Telephone: (08) 9224 2244
Fax: (08) 9224 3511
Email: EMHS.GeneralEnquiries@health.wa.gov.au
Website: www.rph.health.wa.gov.au

Bentley Hospital
Address: 18 – 56 Mills Street
BENTLEY WA 6102
Postal address: PO box 158
BENTLEY WA 6982
Telephone: (08) 9416 3666
Fax: (08) 9416 3711
Email: EMHS.GeneralEnquiries@health.wa.gov.au
Website: www.bhs.health.wa.gov.au
Armadale Kalamunda Group (AKG)

Armadale Health Service

Address:
3056 Albany Highway
MOUNT NASURA WA 6112

Postal address:
PO box 460
ARMADALE WA 6992

Telephone: (08) 9391 2000
Fax: (08) 9391 2149
Email: EMHS.GeneralEnquiries@health.wa.gov.au
Website: www.ahs.health.wa.gov.au

Kalamunda Hospital

Address:
Elizabeth Street
KALAMUNDA WA 6076

Postal address:
PO box 243
KALAMUNDA WA 6926

Telephone: (08) 9257 8100
Fax: (08) 9293 2488
Email: EMHS.GeneralEnquiries@health.wa.gov.au
Website: www.eastmetropolitan.health.wa.gov.au
St John of God Midland Public Hospital

Address:
1 Clayton Street
MIDLAND WA 6056

Postal address:
PO box 1254
MIDLAND WA 6936

Telephone:  (08) 9462 4000
Fax:  (08) 9462 4050
Email: info.midland@sjog.org.au
Website: www.midlandhospitals.org.au
Board and committee remuneration

Please see the following remuneration for EMHS boards and committees for the 2016-17 financial year:

East Metropolitan Health Service board

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Type of remuneration</th>
<th>Period of membership (within the financial year)</th>
<th>Gross/actual remuneration for 2016-17 financial year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Chair</td>
<td>Ian Smith</td>
<td>Annual</td>
<td>1 year</td>
<td>$66,290</td>
</tr>
<tr>
<td>Board member (Deputy chair)</td>
<td>Suzie May</td>
<td>Annual</td>
<td>1 year</td>
<td>$39,774</td>
</tr>
<tr>
<td>Board member</td>
<td>Debra Zanella</td>
<td>Annual</td>
<td>1 year</td>
<td>$39,774</td>
</tr>
<tr>
<td>Board member</td>
<td>Hannah Seymour</td>
<td>n/a</td>
<td>1 year</td>
<td>$0.00</td>
</tr>
<tr>
<td>Board member</td>
<td>Peter Forbes</td>
<td>Annual</td>
<td>1 year</td>
<td>$39,774</td>
</tr>
<tr>
<td>Board member</td>
<td>Richard Guit</td>
<td>Annual</td>
<td>1 year</td>
<td>$39,774</td>
</tr>
<tr>
<td>Board member</td>
<td>Ross Keesing</td>
<td>Annual</td>
<td>1 year</td>
<td>$39,774</td>
</tr>
<tr>
<td>Board member</td>
<td>Stephanie Trust</td>
<td>Annual</td>
<td>1 year</td>
<td>$39,774</td>
</tr>
<tr>
<td>Board member</td>
<td>Kingsley Faulkner</td>
<td>Annual</td>
<td>1 year</td>
<td>$39,774</td>
</tr>
<tr>
<td>Board member</td>
<td>Geraldine Ennis</td>
<td>n/a</td>
<td>1 year</td>
<td>$0.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>$344,708</strong></td>
</tr>
</tbody>
</table>
### Consumer advisory committees (general)

#### Armadale Kalamunda Group Consumer Advisory Committee
(formerly Armadale Health Service Community Advisory Council)

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Type of remuneration</th>
<th>Period of membership (within the financial year)</th>
<th>Gross/actual remuneration for 2016-17 financial year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair</td>
<td>Dorothy Harrison</td>
<td>Per meeting</td>
<td>8 months</td>
<td>300.00</td>
</tr>
<tr>
<td>Deputy chair</td>
<td>Julie Hoey</td>
<td>Per meeting</td>
<td>8 months</td>
<td>360.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Diane Pierce</td>
<td>Per meeting</td>
<td>5 months</td>
<td>360.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Sandra Hawkins</td>
<td>Per meeting</td>
<td>5 months</td>
<td>150.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Julie Brown</td>
<td>Per meeting</td>
<td>5 months</td>
<td>180.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Sheryl Little</td>
<td>Per meeting</td>
<td>8 months</td>
<td>300.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Sherrin Roberts</td>
<td>Per meeting</td>
<td>5 months</td>
<td>210.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Jan Stone</td>
<td>Per meeting</td>
<td>5 months</td>
<td>210.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Eric Wynne</td>
<td>Per meeting</td>
<td>5 months</td>
<td>120.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Kerry Buby</td>
<td>Per meeting</td>
<td>8 months</td>
<td>0.00</td>
</tr>
<tr>
<td>Council member</td>
<td>John Hancock</td>
<td>Per meeting</td>
<td>8 months</td>
<td>0.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Sarah Ladwig</td>
<td>Per meeting</td>
<td>4 months</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>$2190.00</strong></td>
</tr>
</tbody>
</table>

Note: this committee did not meet during the period of December 2016 to April 2017. During this period, expressions of interest for membership to the committee were sought and Kalamunda Hospital was incorporated.

#### Bentley Hospital Community Advisory Council
(formerly Bentley Health Service Community Advisory Council)

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Type of remuneration</th>
<th>Period of membership (within the financial year)</th>
<th>Gross/actual remuneration for 2016-17 financial year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair</td>
<td>Marie-Louise Matthews</td>
<td>Per meeting</td>
<td>12 months</td>
<td>600.00</td>
</tr>
<tr>
<td>Deputy chair</td>
<td>Colin Stevenson</td>
<td>Per meeting</td>
<td>12 months</td>
<td>540.00</td>
</tr>
<tr>
<td>Deputy chair</td>
<td>Alma Digweed</td>
<td>Per meeting</td>
<td>12 months</td>
<td>600.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Felicity Graham</td>
<td>Per meeting</td>
<td>12 months</td>
<td>360.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Linda Beresford</td>
<td>Per meeting</td>
<td>12 months</td>
<td>600.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Philip Lim</td>
<td>Per meeting</td>
<td>12 months</td>
<td>480.00</td>
</tr>
<tr>
<td>Council member</td>
<td>David Brown</td>
<td>n/a</td>
<td>11 months</td>
<td>0.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Member 8</td>
<td>Per meeting</td>
<td>2 months</td>
<td>60.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>$3240.00</strong></td>
</tr>
</tbody>
</table>
Royal Perth Hospital Community Advisory Council

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Type of remuneration</th>
<th>Period of membership (within the financial year)</th>
<th>Gross/actual remuneration for 2016-17 financial year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair</td>
<td>Petrina Lawrence</td>
<td>Per meeting</td>
<td>12 months</td>
<td>60.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Edward Biggs</td>
<td>Per meeting</td>
<td>7 months</td>
<td>0.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Jill Bond</td>
<td>Per meeting</td>
<td>7 months</td>
<td>60.00</td>
</tr>
<tr>
<td>Council member</td>
<td>David Booth</td>
<td>Per meeting</td>
<td>12 months</td>
<td>60.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Suzanne Bourke</td>
<td>Per meeting</td>
<td>12 months</td>
<td>120.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Kerri Colegate</td>
<td>Per meeting</td>
<td>7 months</td>
<td>0.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Leah Cooper</td>
<td>Per meeting</td>
<td>7 months</td>
<td>0.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Lyn Dimer</td>
<td>Per meeting</td>
<td>7 months</td>
<td>0.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Laura Elkin</td>
<td>Per meeting</td>
<td>7 months</td>
<td>0.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Peter Farmer</td>
<td>Per meeting</td>
<td>12 months</td>
<td>60.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Miranda Farmer</td>
<td>Per meeting</td>
<td>12 months</td>
<td>60.00</td>
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<tr>
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<td>Adrian Gallo</td>
<td>Per meeting</td>
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<td>60.00</td>
</tr>
<tr>
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<td>Suzanne Jensen</td>
<td>Per meeting</td>
<td>7 months</td>
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<tr>
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<td>Colette Kingsbury</td>
<td>Per meeting</td>
<td>7 months</td>
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<tr>
<td>Council member</td>
<td>Mary-Louise Allen</td>
<td>Per meeting</td>
<td>12 months</td>
<td>60.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Carmel Lissaman</td>
<td>Per meeting</td>
<td>7 months</td>
<td>0.00</td>
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<tr>
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<td>Bruce Loo</td>
<td>n/a</td>
<td>7 months</td>
<td>0.00</td>
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<td>Robert McCormack</td>
<td>Per meeting</td>
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<td>Dayle McNamara</td>
<td>Per meeting</td>
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<td>Bill Middleton</td>
<td>Per meeting</td>
<td>7 months</td>
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<tr>
<td>Council member</td>
<td>Ambreen Munir</td>
<td>Per meeting</td>
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<tr>
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<td>John Powdrill</td>
<td>Per meeting</td>
<td>12 months</td>
<td>120.00</td>
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Position | Name              | Type of remuneration | Period of membership (within the financial year) | Gross/actual remuneration for 2016-17 financial year |
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Council member</td>
<td>Richard Schwenke</td>
<td>Per meeting</td>
<td>7 months</td>
<td>60.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Gwenda Smith</td>
<td>Per meeting</td>
<td>9 months</td>
<td>60.00</td>
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<td>Markene Sykes</td>
<td>n/a</td>
<td>7 months</td>
<td>0.00</td>
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<tr>
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<td>Joe Wallam</td>
<td>n/a</td>
<td>7 months</td>
<td>0.00</td>
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<td>Robin Watts</td>
<td>Per meeting</td>
<td>12 months</td>
<td>0.00</td>
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<tr>
<td>Council member</td>
<td>Eric Wynne</td>
<td>Per meeting</td>
<td>12 months</td>
<td>120.00</td>
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<tr>
<td>Council member</td>
<td>Darianne Zambotti</td>
<td>Per meeting</td>
<td>12 months</td>
<td>120.00</td>
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<td>Council member</td>
<td>Peter Evans</td>
<td>Per meeting</td>
<td>12 months</td>
<td>180.00</td>
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<tr>
<td>Council member</td>
<td>Angela Dominish</td>
<td>Per meeting</td>
<td>12 months</td>
<td>120.00</td>
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<td>Member 35</td>
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### Consumer advisory committees (Mental health)

**Royal Perth Bentley Group Mental Health Consumer and Carer Advisory Group**  
(formerly Bentley Health Service Mental Health Consumer Advisory Group and Psychiatry CAG: Royal Perth Hospital Psychiatry Department Consumer Advisory Group)

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Type of remuneration</th>
<th>Period of membership (within the financial year)</th>
<th>Gross/actual remuneration for 2016-17 financial year</th>
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<tbody>
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<td>Chair</td>
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<td>Per meeting</td>
<td>12 months</td>
<td>560.00</td>
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<tr>
<td>Council member</td>
<td>Member 2</td>
<td>Per meeting</td>
<td>12 months</td>
<td>240.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Member 3</td>
<td>Per meeting</td>
<td>12 months</td>
<td>180.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Member 4</td>
<td>Per meeting</td>
<td>12 months</td>
<td>480.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Member 5</td>
<td>Per meeting</td>
<td>12 months</td>
<td>480.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Member 6</td>
<td>Per meeting</td>
<td>12 months</td>
<td>240.00</td>
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<td>Council member</td>
<td>Member 7</td>
<td>Per meeting</td>
<td>12 months</td>
<td>300.00</td>
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<td>Council member</td>
<td>Member 8</td>
<td>Per meeting</td>
<td>12 months</td>
<td>60.00</td>
</tr>
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<td>Council member</td>
<td>Member 9</td>
<td>Per meeting</td>
<td>12 months</td>
<td>240.00</td>
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<td>Council member</td>
<td>Member 10</td>
<td>Per meeting</td>
<td>12 months</td>
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</tr>
<tr>
<td>Council member</td>
<td>Member 11</td>
<td>Per meeting</td>
<td>12 months</td>
<td>300.00</td>
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<td>Council member</td>
<td>Member 12</td>
<td>Per meeting</td>
<td>12 months</td>
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<td>Council member</td>
<td>Member 13</td>
<td>Per meeting</td>
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**Midland Consumer Advisory Group (Mental health)**  
(formerly Consumer Advisory Group Swan Mental Health Service)

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<tr>
<th>Position</th>
<th>Name</th>
<th>Type of remuneration</th>
<th>Period of membership (within the financial year)</th>
<th>Gross/actual remuneration for 2016-17 financial year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair</td>
<td>Member 1</td>
<td>Per meeting</td>
<td>12 months</td>
<td>480.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Member 2</td>
<td>Per meeting</td>
<td>10 months</td>
<td>360.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Member 3</td>
<td>Per meeting</td>
<td>10 months</td>
<td>180.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Member 4</td>
<td>Per meeting</td>
<td>10 months</td>
<td>180.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Member 5</td>
<td>Per meeting</td>
<td>10 months</td>
<td>360.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Member 6</td>
<td>Per meeting</td>
<td>10 months</td>
<td>180.00</td>
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<td><strong>Total</strong></td>
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### Aboriginal health

**Armadale Aboriginal Health Community Advisory Group**  
(formerly Armadale District Aboriginal Health Action Group)

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Type of remuneration</th>
<th>Period of membership (within the financial year)</th>
<th>Gross/actual remuneration for 2016-17 financial year</th>
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</thead>
<tbody>
<tr>
<td>Chair</td>
<td>Eric Wynne</td>
<td>Per meeting</td>
<td>8 months</td>
<td>480.00</td>
</tr>
<tr>
<td>Vice chair</td>
<td>Leon Hayward</td>
<td>Per meeting</td>
<td>8 months</td>
<td>480.00</td>
</tr>
<tr>
<td>Community rep.</td>
<td>Madge Hill</td>
<td>Per meeting</td>
<td>7 months</td>
<td>240.00</td>
</tr>
<tr>
<td>Community rep.</td>
<td>Mason Nicholson</td>
<td>Per meeting</td>
<td>7 months</td>
<td>360.00</td>
</tr>
<tr>
<td>Community rep.</td>
<td>Teresa Miller</td>
<td>Per meeting</td>
<td>7 months</td>
<td>120.00</td>
</tr>
<tr>
<td>Community rep.</td>
<td>Raealene Hayward</td>
<td>Per meeting</td>
<td>8 months</td>
<td>480.00</td>
</tr>
<tr>
<td>Community rep.</td>
<td>Norma Garlett</td>
<td>Per meeting</td>
<td>7 months</td>
<td>180.00</td>
</tr>
<tr>
<td>Community rep.</td>
<td>Aiken Garlett</td>
<td>Per meeting</td>
<td>7 months</td>
<td>180.00</td>
</tr>
<tr>
<td>Community rep.</td>
<td>Eunice Bynder</td>
<td>Per meeting</td>
<td>8 months</td>
<td>450.00</td>
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<tr>
<td>Community rep.</td>
<td>Daniel Taylor</td>
<td>Per meeting</td>
<td>7 months</td>
<td>120.00</td>
</tr>
<tr>
<td>Community rep.</td>
<td>Elizabeth Evans</td>
<td>Per meeting</td>
<td>7 months</td>
<td>120.00</td>
</tr>
<tr>
<td>Community rep.</td>
<td>Marlon Johns</td>
<td>Per meeting</td>
<td>2 months</td>
<td>120.00</td>
</tr>
<tr>
<td>Community rep.</td>
<td>Brenda Greenfield</td>
<td>Per meeting</td>
<td>8 months</td>
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<td><strong>Total</strong></td>
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<th>Position</th>
<th>Name</th>
<th>Type of remuneration</th>
<th>Period of membership (within the financial year)</th>
<th>Gross/actual remuneration for 2016-17 financial year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair</td>
<td>Brenda Greenfield</td>
<td>Per meeting</td>
<td>8 months</td>
<td>385.00</td>
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<td>Vice chair</td>
<td>Charmaine Bartlett</td>
<td>Per meeting</td>
<td>4 months</td>
<td>265.00</td>
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<tr>
<td>Community rep.</td>
<td>Albert Knapp</td>
<td>Per meeting</td>
<td>8 months</td>
<td>375.00</td>
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<tr>
<td>Community rep.</td>
<td>Shirley Voss</td>
<td>Per meeting</td>
<td>8 months</td>
<td>255.00</td>
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<td>Kerry Thorne</td>
<td>Per meeting</td>
<td>8 months</td>
<td>210.00</td>
</tr>
<tr>
<td>Community rep.</td>
<td>Joanne Hayward</td>
<td>Per meeting</td>
<td>8 months</td>
<td>375.00</td>
</tr>
<tr>
<td>Community rep.</td>
<td>Dorothy Winnar</td>
<td>Per meeting</td>
<td>8 months</td>
<td>360.00</td>
</tr>
<tr>
<td>Community rep.</td>
<td>Herman Eades</td>
<td>Per meeting</td>
<td>8 months</td>
<td>240.00</td>
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<tr>
<td>Community rep.</td>
<td>Penina Chadd</td>
<td>Per meeting</td>
<td>8 months</td>
<td>435.00</td>
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<tr>
<td>Community rep.</td>
<td>Eric Wynne</td>
<td>Per meeting</td>
<td>8 months</td>
<td>30.00</td>
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<tr>
<td>Community rep.</td>
<td>(non member) Janice McEwan</td>
<td>Per meeting</td>
<td>n/a</td>
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### Swan Hills/Midland Aboriginal Health Community Advisory Group (new)

<table>
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<th>Position</th>
<th>Name</th>
<th>Type of remuneration</th>
<th>Period of membership (within the financial year)</th>
<th>Gross/actual remuneration for 2016-17 financial year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair</td>
<td>Annette Dennis</td>
<td>Per meeting</td>
<td>4 months</td>
<td>120.00</td>
</tr>
<tr>
<td>Vice chair</td>
<td>Denis Hayward</td>
<td>Per meeting</td>
<td>4 months</td>
<td>120.00</td>
</tr>
<tr>
<td>Community representative</td>
<td>Shirley Harris-Kickett</td>
<td>Per meeting</td>
<td>4 months</td>
<td>120.00</td>
</tr>
<tr>
<td>Community representative</td>
<td>Marisa Daniels</td>
<td>Per meeting</td>
<td>4 months</td>
<td>120.00</td>
</tr>
<tr>
<td>Community representative</td>
<td>Clayton Prosser</td>
<td>Per meeting</td>
<td>4 months</td>
<td>120.00</td>
</tr>
<tr>
<td>Community representative</td>
<td>Bradley Bolton</td>
<td>Per meeting</td>
<td>4 months</td>
<td>120.00</td>
</tr>
<tr>
<td>Community representative</td>
<td>Ceciley Phillips</td>
<td>Per meeting</td>
<td>4 months</td>
<td>120.00</td>
</tr>
<tr>
<td>Community representative</td>
<td>Jasmine Page</td>
<td>Per meeting</td>
<td>4 months</td>
<td>120.00</td>
</tr>
<tr>
<td>Community representative</td>
<td>Dianne Ryder</td>
<td>Per meeting</td>
<td>4 months</td>
<td>60.00</td>
</tr>
<tr>
<td>Community representative</td>
<td>Tracey Woods</td>
<td>Per meeting</td>
<td>4 months</td>
<td>105.00</td>
</tr>
<tr>
<td>Community representative</td>
<td>Glenys Woods</td>
<td>Per meeting</td>
<td>4 months</td>
<td>105.00</td>
</tr>
<tr>
<td>Community representative</td>
<td>Peter Terranova</td>
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### Royal Perth Inner City Aboriginal Health Community Advisory Group (new)

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<th>Position</th>
<th>Name</th>
<th>Type of remuneration</th>
<th>Period of membership (within the financial year)</th>
<th>Gross/actual remuneration for 2016-17 financial year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair</td>
<td>Allira Clinch</td>
<td>Per meeting</td>
<td>2 months</td>
<td>240.00</td>
</tr>
<tr>
<td>Vice chair</td>
<td>Anton Van De Berg</td>
<td>Per meeting</td>
<td>3 months</td>
<td>240.00</td>
</tr>
<tr>
<td>Community representative</td>
<td>Benedict Taylor</td>
<td>Per meeting</td>
<td>4 months</td>
<td>240.00</td>
</tr>
<tr>
<td>Community representative</td>
<td>Dianne Ryder</td>
<td>Per meeting</td>
<td>4 months</td>
<td>240.00</td>
</tr>
<tr>
<td>Community representative</td>
<td>Veronica Wallam</td>
<td>Per meeting</td>
<td>3 months</td>
<td>240.00</td>
</tr>
<tr>
<td>Community representative</td>
<td>Vicki Blurton</td>
<td>Per meeting</td>
<td>3 months</td>
<td>240.00</td>
</tr>
<tr>
<td>Community representative</td>
<td>Victor Ronan</td>
<td>Per meeting</td>
<td>7 months</td>
<td>60.00</td>
</tr>
<tr>
<td>Community representative</td>
<td>Kerry Thorne</td>
<td>Per meeting</td>
<td>2 months</td>
<td>90.00</td>
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<tr>
<td>Community representative</td>
<td>Gilbert Hansen</td>
<td>Per meeting</td>
<td>7 months</td>
<td>120.00</td>
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<tr>
<td>Community representative</td>
<td>Eric Wynne</td>
<td>Per meeting</td>
<td>7 months</td>
<td>300.00</td>
</tr>
<tr>
<td>Community representative</td>
<td>(non member) Diana Cox</td>
<td>Per meeting</td>
<td>n/a</td>
<td>60.00</td>
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<td>Community representative</td>
<td>(non member) Lynette Cox</td>
<td>Per meeting</td>
<td>n/a</td>
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### Aboriginal Health Advisory Council (new)

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<th>Type of remuneration</th>
<th>Period of membership (within the financial year)</th>
<th>Gross/actual remuneration for 2016-17 financial year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Council member</td>
<td>Annette Dennis</td>
<td>Per meeting</td>
<td>3 months</td>
<td>150.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Denis Hayward</td>
<td>Per meeting</td>
<td>3 months</td>
<td>180.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Anton Van De Berg</td>
<td>Per meeting</td>
<td>3 months</td>
<td>180.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Allira Clinch</td>
<td>Per meeting</td>
<td>2 months</td>
<td>0.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Eric Wynne</td>
<td>Per meeting</td>
<td>3 months</td>
<td>180.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Leon Hayward</td>
<td>Per meeting</td>
<td>3 months</td>
<td>180.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Brenda Greenfield</td>
<td>Per meeting</td>
<td>3 months</td>
<td>180.00</td>
</tr>
<tr>
<td>Council member</td>
<td>Charmaine Bartlett</td>
<td>Per meeting</td>
<td>3 months</td>
<td>180.00</td>
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### Royal Perth Hospital Animal Ethics Group

<table>
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<tr>
<th>Position</th>
<th>Name</th>
<th>Type of remuneration</th>
<th>Period of membership (within the financial year)</th>
<th>Gross/actual remuneration for 2016-17 financial year</th>
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<tbody>
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<td>Prof Kevin Croft</td>
<td>Sessional</td>
<td>12 months</td>
<td>20,940.00</td>
</tr>
<tr>
<td>Executive Officer</td>
<td>Dr Linda Manning</td>
<td>N/A</td>
<td>12 months</td>
<td>0.00</td>
</tr>
<tr>
<td>Category A</td>
<td>A/Prof Len Cullen</td>
<td>Per meeting</td>
<td>12 months</td>
<td>1000.00</td>
</tr>
<tr>
<td>Category A</td>
<td>Dr Fiona Anderson</td>
<td>Per meeting</td>
<td>12 months</td>
<td>1000.00</td>
</tr>
<tr>
<td>Category B</td>
<td>Dr Ann Barden</td>
<td>Per meeting</td>
<td>12 months</td>
<td>1200.00</td>
</tr>
<tr>
<td>Category B</td>
<td>Dr Jacky Bentel</td>
<td>N/A</td>
<td>12 months</td>
<td>0.00</td>
</tr>
<tr>
<td>Category C</td>
<td>Mr Noel Smith</td>
<td>Per meeting</td>
<td>12 months</td>
<td>1200.00</td>
</tr>
<tr>
<td>Category C</td>
<td>Mr Steve Vanstan</td>
<td>Per meeting</td>
<td>12 months</td>
<td>1200.00</td>
</tr>
<tr>
<td>Category D</td>
<td>Mr Mike Field</td>
<td>Per meeting</td>
<td>12 months</td>
<td>1200.00</td>
</tr>
<tr>
<td>Category D</td>
<td>Dr Pam Barnett</td>
<td>Per meeting</td>
<td>12 months</td>
<td>800.00</td>
</tr>
<tr>
<td>Category E</td>
<td>Mr Nicholas Grainger</td>
<td>N/A</td>
<td>12 months</td>
<td>0.00</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td>$28,540</td>
</tr>
</tbody>
</table>

Note: both the NHMRC Code of Practice and the State regulator (WA Animal Welfare Act 2002) require that the Animal Ethics group has representatives from the following:
- Category A: Vet
- Category B: Animal-based research
- Category C: Animal welfare
- Category D: Community
- Category E: Animal care
### Data from ‘year in review’ section

Please see the following inclusions and exclusions for the data found in the ‘year in review’ section:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Inclusions and exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency presentations</td>
<td>Total of all patients who presented to an Emergency Department. Includes Royal Perth Hospital, Armadale Health Service and St John of God Midland Public Hospital.</td>
</tr>
<tr>
<td>Patients admitted</td>
<td>Total of all patients admitted to hospital. Excludes boarders, unqualified newborns, contracted services and organ procurements. Includes Royal Perth Hospital, Bentley Hospital, Armadale Health Service, Kalamunda Hospital and St John of God Midland Public Hospital.</td>
</tr>
<tr>
<td>Operations performed</td>
<td>Total of all operations performed in any theatre. Includes status suggesting that an operation occurred (i.e. operation was not cancelled). Includes Royal Perth Hospital, Bentley Hospital, Armadale Health Service, Kalamunda Hospital and St John of God Midland Public Hospital.</td>
</tr>
<tr>
<td>Duration of admission</td>
<td>Average length of stay (days) for multi-day patients (i.e. not day cases). Calculation = (discharge date – admission date) – days on leave. Excludes boarders, unqualified newborns, contracted services and organ procurements. Includes Royal Perth Hospital, Bentley Hospital, Armadale Health Service, Kalamunda Hospital and St John of God Midland Public Hospital.</td>
</tr>
<tr>
<td>Outpatient appointments</td>
<td>Total of all outpatient appointments attended. Does not include patients that ‘did not arrive’ (DNA) or ‘chart only’. Includes Royal Perth Hospital, Bentley Hospital, Armadale Health Service, Kalamunda Hospital and St John of God Midland Public Hospital.</td>
</tr>
<tr>
<td>Aboriginal staff</td>
<td>Total count of all staff who identify as Aboriginal or Torres Strait Islander. Includes Royal Perth Hospital, Bentley Hospital, Armadale Health Service and Kalamunda Hospital. Does not include staff at St John of God Midland (as they are employed privately by St John of God Health Care).</td>
</tr>
<tr>
<td>Aboriginal inpatients</td>
<td>Total count of all discharges where the patient has an indigenous status of Aboriginal, Aboriginal/Torres Strait Islander or Torres Strait Islander. Includes Royal Perth Hospital, Bentley Hospital, Armadale Health Service, Kalamunda Hospital and St John of God Midland Public Hospital.</td>
</tr>
</tbody>
</table>
In 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.