



Government of **Western Australia**
WA Country Health Service



Annual Report
2016-17



WA Country Health Service

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The WA Country Health Service
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Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.

ABOUT THIS REPORT

This annual report describes the performance and operation of the WA Country Health Service during 2016–17. The report has been prepared according to parliamentary reporting and legislative requirements and is arranged in the following sections:

Overview of agency

An introduction to the WA Country Health Service vision, values, purpose, strategic directions, guiding principles, reports by our Chair and Chief Executive and information about our Board and Executive members.

Agency performance

Summarises our performance against agreed financial and service delivery outcomes. This section includes the financial statements and the key performance indicators.

Significant issues

Key issues for the WA Country Health Service, including demand and activity, workforce challenges, achievements and initiatives, managing funding reform and cost efficiencies and health inequalities.

Disclosure and compliance

Reports on governance, public accountability, financial management, information management, people management and equity and diversity.

Appendices

Additional information and data to supplement the report.

Statement of compliance

**Hon Mr Roger Cook BA GradDipBus (PR) MBA MLA
Minister for Health**

In accordance with section 63 of the *Financial Management Act 2006*, we hereby submit for your information and presentation to Parliament, the Annual Report of the WA Country Health Service for the financial year ended 30 June 2017.

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



PROFESSOR NEALE FONG
CHAIR
WA COUNTRY HEALTH SERVICE BOARD

20 September 2017



MR ALAN FERRIS
BOARD MEMBER
WA COUNTRY HEALTH SERVICE BOARD

20 September 2017



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*Healthier country
communities through
partnerships and innovation*



Government of Western Australia
WA Country Health Service



1 | Overview
of the agency

About us

VISION

Healthier country communities through partnerships and innovation.



The WA Country Health Service values

VALUES

WA Country Health Service values are:

Community — making a difference through teamwork, cooperation, a ‘can do’ attitude, and country hospitality.

Compassion — listening and caring with empathy, respect, courtesy and kindness.

Quality — creating a quality healthcare experience for every consumer, continual improvement, innovation and learning.

Integrity — accountability, honesty and professional, ethical conduct in all that we do.

Justice — valuing diversity, achieving health equality, cultural respect and a fair share for all.

PURPOSE

The WA Country Health Service improves country people’s health and wellbeing through access to quality services and by supporting people to look after their own health.

STRATEGIC DIRECTIONS

- Improving health and the experience of care.
- Valuing consumers, staff and partnerships.
- Governance, performance and sustainable services.

GUIDING PRINCIPLES

- Consumers first in all we do.
- Safe, high quality services and information at all times.
- Care closer to home where safe and viable.
- Evidence-based services.
- Partnerships and collaboration.

MINISTER

The WA Country Health Service is responsible to the Minister for Health, the Honourable Roger Cook MLA.

ACCOUNTABLE AUTHORITY

The WA Country Health Service Board Chair Professor Neale Fong is the reporting officer for the WA Country Health Service in 2016–17.

ENABLING LEGISLATION

The WA Country Health Service was established as a Board-governed health service provider in the Health Services (Health Service Provider) Order 2016 made by the Minister under section 32 of the *Health Services Act 2016*. The WA Country Health Service is responsible to the Minister for Health and the Department CEO of the Department of Health (System Manager) for the efficient and effective management of the organisation.

OUR RELEVANT LEGISLATION

Acts 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 & Part 5, 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 June 2017

- There were no bills in Parliament as at 30 June 2017

Amalgamation and establishment of Boards

- Child and Adolescent Health Service Board
- East Metropolitan Health Service Board
- North Metropolitan Health Service Board
- South Metropolitan Health Service Board
- WA Country Health Service Board
- Western Australian Health Promotion Foundation Board

Executive summary

CHAIR'S REPORT

The release of the WA Country Health Service Annual Report 2016–17 marks the end of the first year since the establishment of the WA Country Health Service (WACHS) Board.

It has been a challenging and rewarding year, and the Board has embraced these challenges and seen the rewards that come with guiding one of the most complex and geographically dispersed country health services in the world.

In the first year of Board operations, we have seen the progress of significant change within the WA health system. The Board, as the accountable authority, has led the organisation through this change, and I am proud of the way in which the organisation has responded, adapting to the changing environment, while maintaining a clear focus on ensuring our patients continue to receive the quality services they need.

I am fortunate to be joined on the inaugural WACHS Board by a group of well-respected and forward-thinking members who bring a diverse range of skills and experience in a variety of key areas, including financial management, legal, clinical and the regional experience.

Throughout the year the Board and I have made it a priority to meet with staff and country communities in order to ensure that decision making at the Board level is well informed by service need on the ground. As a country health service Board, we have convened meetings within many of our regional centres and seen first-hand the extremes and contrasts that characterise life in regional and remote Western Australia.



We have visited world-class health campuses in urbanised towns and driven hours from the nearest airport to visit hospitals with fewer than 10 beds. We have witnessed the benefits of some of the most advanced health technology in the world and seen remote communities that live with the burden of diseases that are rarely found in developed nations such as trachoma, tuberculosis, leprosy and rheumatic heart disease. The overwhelming impression the Board has gained is of a highly skilled workforce absolutely committed to providing their communities with the best possible healthcare.

The Board's focus to date has been on formalising governance arrangements and guiding WACHS's first year of operation as a Health Service Provider under the *Health Services Act 2016*. We have spent time putting the right governance measures in place including establishing Board Committees for Finance; Safety, Quality and Performance; and Audit and Risk.

Critical to these governance arrangements is a strong audit and risk framework. The Board has endorsed the WACHS Five Year Strategic Audit Plan (2017–18 to 2021–22). This plan will inform a comprehensive audit program which will provide assurance to the Board in key areas.

The Board has also recently agreed key Service Agreements with the Department of Health and the Mental Health Commission that formalise the services WACHS is funded to deliver. The Service Agreements outline the funding arrangements for delivering services to communities and are underpinned by the performance framework under which WACHS operates.

During this year, the Board has continued to observe the use of technological innovation through the use of telehealth, which is helping to create virtual emergency departments as well as nurse practitioner home visits, specialist consultations, mental health counselling, antenatal classes and chronic disease education sessions to be delivered to patients in their communities, reducing the burden of travel for many people. This is only the beginning.

Innovation can also be seen in our capital works program that is replacing the architectural legacy of an outdated health system with contemporary technology-enabled healthcare hubs. We have had the opportunity to view many of the health service infrastructure developments and see how healthcare design can deliver contemporary and culturally secure healthcare environments that are reflective of the country landscapes.

I am confident as we move into our second year that we have laid strong foundations that will serve us well as we commence the planning process for setting our strategic direction for 2018 and beyond.

We will continue our focus on supporting our organisation's leaders to pursue excellence and to transition from a high-performing health service to becoming a leader in the delivery of rural and remote health care in Australia and the world.



PROFESSOR NEALE FONG
CHAIR
WA COUNTRY HEALTH SERVICE BOARD

The use of technological innovation is helping to deliver services that reduce the burden of travel for many patients.



CHIEF EXECUTIVE'S REPORT

It has been a momentous 12 months for the WA Country Health Service (WACHS). The beginning of the financial year was also the start of an exciting new era for WACHS with the implementation of the *Health Services Act 2016*. The new Act replaced legislation that was almost 90 years old and allows us to better respond to the scale and complexity of contemporary health system requirements.

The Act establishes the WACHS as a health service provider and the Department of Health as the System Manager under revised governance arrangements. It also resulted in the establishment of the Board to guide the organisation's direction and priorities and to bring decision-making closer to service delivery and patient care.

The new Act allows us to better respond to the scale and complexity of the contemporary health system.



Working with the Board

Our first year working with the Board has been very productive. The Board membership includes nine diverse and experienced professionals who are highly respected in their particular fields and across the community. Board Chair Professor Neale Fong, Ms Wendy Newman (Deputy Chair), Mr Michael Hardy, Dr Daniel Heredia, Dr Kim Isaacs, Mr Joshua Nisbet, Mrs Mary Anne Stephens, Mr Alan Ferris and Mrs Meredith Waters have enthusiastically embraced their new roles. The executive team and our regional staff have enjoyed getting to know the Board members and demonstrating the services, facilities, rewards and challenges of country health.

The Board members have worked hard to ensure they are fully informed across all areas of our business and in a relatively short time we have built a strong working relationship. The Board has been impressed with the dedication of our staff and our demonstrated willingness to improve and the passion our staff show every day in the work they do.

Quality and standards

Robust systems and standards are essential for high quality health care. Independent assessment and testing of these systems and standards is important for assurance and improvement. With this in mind, I was delighted that WACHS received a positive report following a rigorous four-day assessment of our corporate offices against the 10 National Safety and Quality Health (NSQHS) Standards and five Evaluation and Quality Improvement Program (EQUIP) content standards of the Australian Council on Healthcare Standards (ACHS) Evaluation and Quality Management EQUIP National Corporate Program.



Pictured (back left to right) are Chief Executive Jeff Moffet, Chief Operating Officer – Strategy and Reform Melissa Vernon, Director Safety and Quality Wendy McIntosh, Chief Operating Officer – Operations Shane Matthews, Program Officer Sarah Beneke-Nielsen and the ACHS surveyors (front left to right) Adrienne Copley, June Graham, Mavis Smith, Kaye Hogan.

Staff in our corporate offices are to be congratulated on their contribution to this important achievement. Feedback from the assessors indicated that WACHS satisfactorily met all the mandatory criteria and would receive two recommendations for developmental criteria assessed as ‘not met’. WACHS has now met the stringent requirements of the NSQHS Standards and ACHS EQulPNational Corporate accreditation, processes that are required to be repeated every three years.

This means that regional residents can be assured that WACHS has subjected itself voluntarily to independent testing of our systems of safety and quality.

Patient Opinion

The one-year pilot of Patient Opinion, an independent, non-profit online consumer feedback platform where consumers can provide comment on health services, concluded in December 2016. In February 2017 it was implemented across all seven WACHS regions. Our District Health Advisory Councils (DHACs) have partnered with WACHS to promote the feedback platform in the community and encourage people to share their stories.

As at 30 June 2017, WACHS had received 222 stories on Patient Opinion which had been viewed a total of 82,695 times. The overwhelming majority (79 per cent) of these stories have been positive comments on the quality of care provided by WACHS staff. Of those that drew attention to needed changes, 18 stories have resulted in improvements made or planned to enhance our services.

The DHACs’ commitment to Patient Opinion, and foresight in understanding the strengths of using social media platforms in this innovative way, was instrumental in the success of the pilot and implementation.

Infrastructure program

WACHS is currently overseeing the biggest transformation of country hospitals and health facilities in more than a generation. The building program is the most ambitious ever undertaken in regional Western Australia and includes more than 80 projects.

A \$1.5 billion-plus construction program is replacing or upgrading ageing buildings with modern campuses that incorporate the best contemporary thinking about how good design can contribute to an improved patient experience.

Along with new bricks and mortar comes the installation of state-of-the-art information and communications technology (ICT), including telehealth links and videoconferencing to facilitate services such as emergency telehealth and more options for access to specialists.



In line with contemporary international approaches to planning, the program focuses on bringing services together into healthcare hubs – community mental health, child health and allied health, prevention and education, and emergency care.

A major milestone was achieved in the Pilbara during the financial year with the commencement of construction on the \$207.15 million Karratha Health Campus. This flagship health campus will be the biggest investment in a public hospital ever undertaken in regional WA. Planning has ensured that it will have an expanded emergency department, a brand new surgical centre, new delivery suites and maternity wing, new and expanded outpatient facilities and essential services such as child health and medical imaging, all located together in a single healthcare hub.

The \$13 million redevelopment of Harvey Health Service was completed this year. Eighteen months in the making, the refurbishment included a brand new emergency department, outpatient facilities, refurbished ward areas, improved areas for community-based services and a new administration, main entry and reception.

In the Goldfields, a new generation is being welcomed into the world with the opening of the Esperance Health Campus maternity unit. The two new birthing suites, four private rooms and level-one neonatal nursery are located next to the new surgical centre.

WACHS is leading the construction of six new renal facilities across the Kimberley as part of the Australian Government's \$45.8 million Bringing Renal Dialysis and Support Services Closer to Home project. It will expand the number of renal chairs in the Kimberley to 30 with 68 dedicated renal hostel beds in the Kimberley region. Facilities in Derby and Fitzroy Crossing are all due to be completed by the end of 2017.

Karratha Health Campus takes shape. Pictured are WACHS Pilbara Regional Director Ron Wynn and WACHS Infrastructure Director Rob Pulsford.



New dialysis units have opened in Kalgoorlie and Carnarvon, enabling long-term patients to return home from Perth and receive treatment close to loved ones and support networks.

Cancer patients are benefiting from the state-of-the-art Midwest Cancer Centre which opened in November 2016. It means that more cancer patients from the region can be treated closer to where they live. The new facility includes six chemotherapy chairs, one chemotherapy bed and expanded treatment facilities.

The Southern Inland Health Initiative's \$300 million capital works program is in full swing in 37 towns across the Wheatbelt, Great Southern, South West and Midwest regions, with several projects completed or expected to be completed by the end of 2017. The redevelopments of Narrogin Health Service, Katanning Health Service, Merredin Health Service and Northam Health Service are well underway. The Collie Health Service upgrade was completed in June 2017 and the Warren Health Service build which began in September 2016 is progressing well.

Construction of the innovative Pingelly Health Centre is underway and includes facilities for chronic disease prevention and management, as well as an improved emergency department. Boddington Health Service achieved practical completion in June 2017 and Lake Grace Health Service was completed in August 2016. The Dalwallinu Health Service refurbishment started in January 2017 and improvements to Bruce Rock, Corrigin, Kellerberrin, Kondinin and Narembeen Health Services have also commenced.

Small hospitals and health centre refurbishments are also progressing well in Goomalling, Kununoppin, Wyalkatchem-Koorda, Quairading, Jurien Bay, Beverley, Southern Cross, York, Moora, Mukinbudin, Williams and Wongan Hills.

Expansion of innovative telehealth services

Telehealth continues to expand, providing innovative solutions that are improving health outcomes for country people and bringing specialist care closer to home. These service advances are also benefiting city residents.

TeleStroke is one of a number of new stroke services incorporating telehealth being trialled by WACHS. TeleStroke is proving to be a critical element in life-saving treatment for acute stroke patients in regional centres. Videoconferencing technology links regional clinicians treating patients in the emergency department with metropolitan stroke specialists, helping them to quickly identify a stroke and implement the appropriate treatment protocols, significantly improving patient outcomes and recovery time.

WACHS is also trialling the use of telehealth to deliver cancer care closer to home for country patients and their families. TeleOncology has grown significantly across the major specialties (medical oncology, radiation oncology and haematology) in the past 12 months, with the emphasis now on expanding services while increasing the ability for people to receive care directly into their homes.

The Emergency Telehealth Service (ETS) continues to provide regional clinicians with emergency specialist support when treating critically ill and injured country patients. There are currently 76 ETS locations across WACHS, averaging a total of around 1300 consultations each month. On average, 75 per cent of ETS patients

are assessed, diagnosed, treated and discharged in their home towns. ETS is now operating a 24-hour service Friday to Monday, with operating hours of 8am to 11pm Tuesday to Thursday.

Outpatient services continue to grow, reducing the need for country people to travel and improving timely access to care.

WACHS is driving innovation and effective use of contemporary technology to extend services into the country and in the future into people's homes, while embedding telehealth into everyday clinical care.

Aboriginal health

WACHS aims to achieve improved health outcomes for Aboriginal people by providing culturally respectful and competent services throughout regional WA, and ensuring 'Aboriginal health is everybody's business'.

The Statewide Aboriginal Health Network (SAHN) has been established to optimise expertise, potential solutions and partnerships at the highest level. The Director General of the Department of Health is the SAHN Chair and membership includes the chief executives and chairs of the Aboriginal Health Council of WA, Mental Health Commission, Health Service Providers, Rural Health West, WA Primary Health Network, Commonwealth Department of Health, and the Aboriginal Health Planning Forums.

I take a strong interest in Aboriginal health and for that reason I am pleased to have been appointed Chair of the Aboriginal Health Executive Group, which provides oversight and leadership across WA Health.

Four Regional Aboriginal Health Consultant positions in the Pilbara, Kimberley, Midwest and Great Southern have been approved. These newly created positions form part of the regional executive teams and report to the regional director, to enable senior staff with expertise in Aboriginal health to play a greater role in key decision-making across all aspects of regional business.

We have facilitated an independent evaluation of the Footprints to Better Health Strategy and participated in the WA Health Strategic Aboriginal Health Group, comprising the Aboriginal Directors of each health service provider.

WACHS continues to support traineeships, apprenticeships, cadetships, on-the-job training and the Aboriginal Mentorship Program. Importantly, as at the end of the 2016–17 year, Aboriginal employees comprise four per cent of the WACHS workforce.

WACHS aims to achieve improved health outcomes for Aboriginal people by providing culturally respectful and competent services throughout regional WA.



Central to providing effective and culturally secure health care for Aboriginal patients is attracting and retaining Aboriginal staff. The Aboriginal Employment Strategy 2014–18 and the WACHS Aboriginal Mentorship Program, which align with the WA Health Aboriginal Health and Wellbeing Framework, are helping us to achieve this. In April 2017, we introduced the Aboriginal Entry Level Employment Framework, under which managers can apply for funding to support Aboriginal employees. During 2016–17, this framework has supported 16 Aboriginal staff members through a variety of training.

Mental health

WACHS Mental Health Service has strengthened its partnership with the Mental Health Commission (MHC), the WA Primary Health Alliance (WAPHA), and other government and non-government agencies to expand services to country people experiencing mental health issues.

The \$1.8 million Youth Mental Health Program has established targeted community youth mental health programs in the Pilbara and South West along with more psychiatric positions and support in the Kimberley. The initiative has also made it easier for clinicians to access education and training in youth mental health.

A partnership with WAPHA has resulted in additional psychiatric liaison nursing services in Port Hedland and Karratha to provide mental health assessment and treatment to people presenting at emergency departments.

The Statewide Specialist Aboriginal Mental Health Program continues to provide culturally secure services to Aboriginal people.

WACHS has established two Suicide Prevention Coordinator positions, one each in the Kimberley and Midwest. Other regions, particularly the Goldfields, have worked hard to improve interagency collaboration to deal more effectively with suicide prevention.

To reflect the growing importance of mental health in country health, WACHS has strengthened its structure and governance with the establishment of an Executive Director of Mental Health who is a member of the WACHS Executive. Mental health functions have been restructured and strengthened across the organisation with an increased focus on clinical governance, quality improvement, financial performance, education, training, research and innovation.

Nursing and midwifery

One of the most innovative improvements in patient care has come from our own staff. 'Releasing Time to Care' is a project to improve the admission and discharge of patients. It was developed by a project advisory group of WACHS nurses in collaboration with consumers and carers with the aim of giving nurses more time caring for patients. In 2016, a new and simplified suite of admission and discharge forms was successfully trialled across 15 medical wards and two day-surgery units. Three of the forms have now been implemented across WACHS. A trial of short-stay admission forms was completed in June 2017 and this will mean that patients who stay in hospital for less than 24 hours will also benefit from the new process.

The Nursing and Midwifery Practice Framework and Guidelines that provide a contemporary approach to clinical accountability for nurses and midwives across WACHS was presented at the International Conference of Innovations in Nursing in November 2016. The presentation was very well received by the international audience and garnered a lot of interest.

This new performance approach where each nurse must demonstrate their safe, high quality, evidence-based practice in their specific rural and remote setting, began as a pilot in the Great Southern. It was then launched across all acute care areas and has been extremely successful and resulted in ACHS assessors in 2016–17 commenting positively on our contemporary approach to clinical accountability. It continues to be rolled out throughout our regional services.

Leading the way

The Statewide WA Trachoma Program won the top award at the 2016 WA Health Excellence Awards presented in November 2016. Since the program began in 2006, the incidence of trachoma in rural and remote Aboriginal communities in WA has dropped from 24 per cent to 2.6 per cent, with the program on track to help eliminate the potentially blinding eye infection by 2020.

The WA Trachoma Program team at the awards ceremony.



WACHS initiatives were in the spotlight during the 14th National Rural Health Conference held in Cairns, Queensland in April 2017. A total of 10 WACHS papers were accepted from more than 500 abstracts, giving our staff the valuable opportunity to share their work with more than 1200 key influencers and leaders in rural and remote health.

I would like to congratulate Dr Monica Gope, a Director of the WACHS Medical Education Unit, who was named National Clinical Educator of the Year after previously being announced Clinical Educator of the Year in WA for her extensive contribution to pre-vocational education and training for junior doctors.

And finally, congratulations to Medical Director Statewide Obstetrics Unit and WACHS Director and Clinical Lead for Obstetrics and Gynaecology, Dr Diane Mohen, who was awarded a Public Service Medal in the Queen's Birthday Honours List 2016. Also honoured with a Public Service Medal in the 2017 Queen's Birthday Honours List was former WACHS Clinical Director for Child and Adolescent Mental Health Service Dr Prue Stone. Dr Stone, who retired from WACHS on 30 June 2016, pioneered video conferencing for the delivery of clinical services.



MR JEFFREY MOFFET
CHIEF EXECUTIVE
WA COUNTRY HEALTH SERVICE



WA Country Health Service at a glance

WA COUNTRY HEALTH SERVICE

The WA Country Health Service provides comprehensive health services to people living in country areas of the State, from the most remote towns in the Kimberley, Pilbara and the Goldfields to coastal cities in the Great Southern, Midwest and the Southwest, and to numerous small towns in the Wheatbelt. The geographical area covered by WACHS spans approximately 2.55 million square kilometres. WACHS is the largest country health system in Australia covering the whole of the State outside the Perth metropolitan area.

According to the latest available Australian Bureau of Statistics Estimated Resident Population (ERP) data (2016), the population of WACHS's catchment area is 531,934 people. Just over 10 per cent of these people (52,588) identify as Aboriginal. The population we service is diverse and expansive and as a result has widely varying health needs.

People living in rural and remote areas tend to experience poorer general health than those in metropolitan areas and Aboriginal health and life expectancy, in particular, is significantly less than that of non-Aboriginal people.

Despite the challenges of vast distances and health inequalities, WACHS offers comprehensive health services to country residents and visitors that encompass emergency and hospital services, population, public and primary health care, mental health, drug and alcohol services, Aboriginal health, child and community health and

residential and community aged care services. We do this in our 68 gazetted hospitals and health centres – six larger regional hospitals, 15 medium sized district hospitals, 47 small hospitals – 42 health centres (nursing posts) [WA Government Gazette 2016], 24 community-based mental health services, four dedicated inpatient mental health services, and 175 population health facilities.

WACHS provides comprehensive health services to people living in country areas of the State.

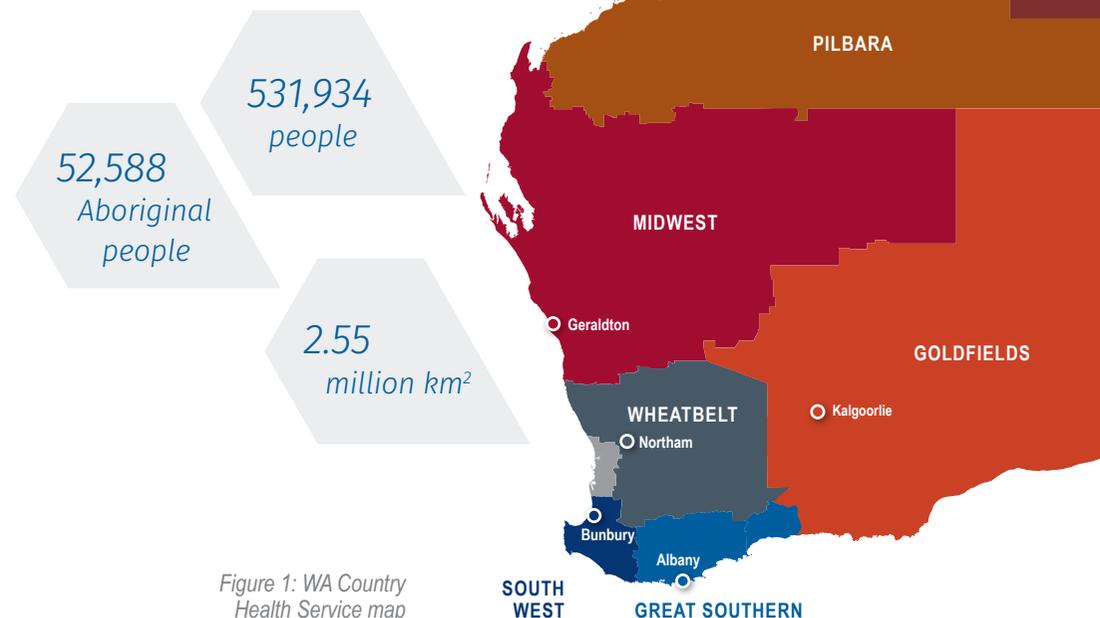


Figure 1: WA Country Health Service map

Government funding and industry investment over recent years have brought about a transformation of country health care through major and minor capital works. More towns now have contemporary health campuses, expanded hospitals, greater emergency service capacity and modern facilities and equipment. Coupled with technological and service innovations such as Telehealth, WACHS is now delivering health care closer to home for more country Western Australians than ever before.

WACHS is committed to improving the health and wellbeing of country people through access to quality services and by supporting people to look after their own health. The key to this focus is the partnerships formed with communities, consumers, staff and service providers dedicated to delivering outstanding services to country people.

WACHS is committed to improving the health and wellbeing of country people through access to quality services and by supporting people to look after their own health.



STRATEGIC DIRECTIONS AND PRIORITIES

WACHS continued to be guided by the *WA Country Health Service Strategic Directions 2015–18* which focuses on strategic directions to be achieved consistent with our vision, purpose, values, and guiding principles.

Key strategies have focused on improving health and the experience of care, valuing consumers, staff and partnerships, as well as governance, performance and sustainable services.

The Board has focused clearly on its role setting the strategic directions for WACHS and commenced the development of a new strategic plan to begin in 2019. The plan will allow us to set a clear vision for the organisation into the future, while building on our many successes and achievements over time.

OUR VALUES IN ACTION

Research ethics Chair recognised for voluntary service

Human Research Ethics Committee Chair Professor Samar Aoun stepped down after more than 20 years of voluntary service.

WACHS Chief Executive Jeff Moffet said Professor Aoun had taken the committee from a small, Bunbury-based group to an influential WACHS-wide committee overseeing one of the most critical areas of our business with an exceptionally high standard of stewardship.

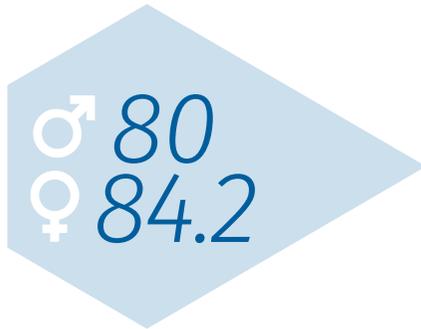
“My sincere thanks and appreciation go to Professor Aoun,” Jeff said.

The new Chair is Judy Allen, Honorary Fellow at UWA, who has a long-standing interest in health research and advocacy. Ms Allen is currently a consultant for the national Population Health Research Network and was Chair of the Department of Health Human Research Ethics Committee for two terms (six years).

*Professor Aoun
with WACHS
Chief Executive
Jeff Moffet.*



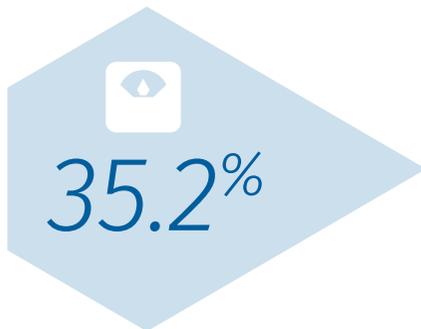
WA COUNTRY HEALTH SERVICE SNAPSHOT



In country WA a male is expected to live to 80 years of age and a female to 84.2 years of age



There were 13,081 new cases of cancer recorded in West Australians living in rural locations in 2016



35.2% of adults living in country WA are obese

119,779

119,779 admissions to a country public hospital in 2016



14,393 people in country WA were treated by a specialised public mental health service in 2016



91.5% of adults living in country WA do not eat 2 serves of fruit and 5 serves of vegetables daily



1,058 people on any day will present to a major country emergency department

42.5%

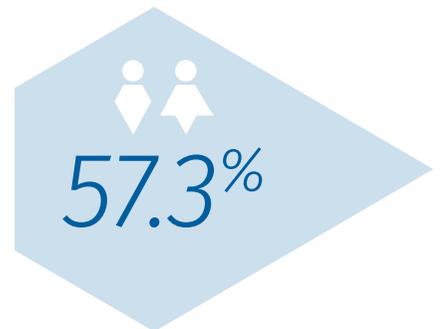
42.5% of all potentially preventable hospitalisations in country WA were due to chronic conditions



6,464 patients accessed the Royal Flying Doctor Service in 2016



508 deaths in country WA are caused by coronary heart disease



57.3% of children living in country WA do not undertake sufficient physical activity



37,009 Telehealth occasions of service were accessed by patients in 2016

SHARED RESPONSIBILITIES

In delivering health care, WACHS works closely with numerous human service agencies, including but not limited to: other Health Service Providers, the Mental Health Commission, WA Police, the Department of Corrective Services, the Department of Child Protection and Family Services and the Department of Communities and its Disability Services section.

OUTCOME BASED PERFORMANCE MANAGEMENT FRAMEWORK

To comply with its legislative obligation as a State Government agency, and as part of the WA health system, WACHS operates under the Outcome Based Management Performance Management Framework. This framework describes how outcomes, services and key performance indicators (KPIs) are used to measure agency performance towards achieving the relevant overarching whole-of-government goal. For the WA health system, this goal is for greater focus on achieving results in key service delivery areas for the benefit of all Western Australians.

The Department of Health, in supporting the System Manager role, determines how the WA health system will achieve this State Government goal through the establishment of desired outcomes. The department also establishes the suite of KPIs used to measure the WA health system's effectiveness in achieving these outcomes, as well as the efficiency of service delivery. In 2016–17, the Outcome Based Management Framework was updated to reflect the implementation of the *Health Services Act 2016* and the nine legal entities that now comprise the WA health system. In order to comply with this change, a new outcome, as well as new services and KPIs were introduced to align the department, as the System Manager, and Health Support Services to the State Government goal.

The desired outcomes for 2016–17 are:

Outcome 1: Restoration of patients' health, provision of maternity care to women and newborns, and support for patients and families during terminal illness.

Outcome 2: Enhanced health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care.

Outcome 3: Strategic leadership, planning and support services that enable a safe, high quality and sustainable WA health system.

As a Health Service Provider, WACHS reports KPIs against Outcomes 1 and 2, and the services that aim to achieve these outcomes. Activities that support Outcomes 1 and 2 include:





Outcome 1

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 2

1. Increase the likelihood of optimal health and wellbeing by:
 - providing programs that support the optimal physical, social and emotional development of infants and children
 - encouraging healthy lifestyles (for example, 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 (for example, breast and cervical cancer screening, and screening of newborns)
 - programs that support self-management by people with diagnosed conditions and disease (for example, diabetes 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 is summarised in the Summary of KPIs section on page 39 and described in detail in the KPI section starting on page 89.

Table 1: The WA Health System outcomes and services as they align to the overarching State Government goal.

Greater focus on achieving results in key service delivery areas for the benefit of all Western Australians		
Outcomes		
Outcome 1	Outcome 2	Outcome 3
Restoration of patients' health, provision of maternity care to women and newborns, and support for patients and families during terminal illness.	Enhanced health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care.	Strategic leadership, planning and support services that enable a safe, high quality and sustainable WA health system.
Services		
<p>Service 1: Public hospital admitted services</p> <p>Service 2: Home-based hospital programs</p> <p>Service 3: Palliative care</p> <p>Service 4: Emergency department</p> <p>Service 5: Public hospital non-admitted patients</p> <p>Service 6: Patient transport</p>	<p>Service 7: Prevention, promotion and protection</p> <p>Service 8: Dental health</p> <p>Service 9: Continuing care</p> <p>Service 10: Contracted mental health</p>	<p>Service 11: Health System management – policy and corporate services</p> <p>Service 12: Health support services</p>

Table 2: Effectiveness and efficiency indicators reported by WACHS.

Key Performance Indicators Reported by WACHS			
	Effectiveness KPIs	Services	Efficiency KPIs
Outcome 1	Percentage of patients discharged to home after admitted hospital treatment	Service 1: Public hospital admitted services	Average cost per casemix adjusted separation for non-tertiary hospitals
	Survival rates for sentinel conditions (%)	Service 2: Home-based hospital programs	Average cost per bed-day for admitted patients (small hospitals)
	Proportion of elective wait list patients waiting over boundary for reportable procedures	Service 3: Palliative care	Not reported by WACHS
	Unplanned hospital readmissions within 28 days for selected surgical procedures (per 1,000)	Service 4: Emergency department	Not reported by WACHS
	Rate of unplanned readmissions within 28 days to the same hospital for a mental health condition (per 1,000)	Service 5: Public hospital non-admitted patients	Average cost per emergency department/service attendance
	Percentage of live born term infants with an Apgar score of seven or less, five minutes post delivery	Service 6: Patient transport	Average cost per public patient non-admitted activity
Outcome 2	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	Service 7: Prevention, promotion and protection	Average cost per non-admitted occasion of service provided in a nursing post
	Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from a public mental health inpatient unit	Service 8: Dental health	Average cost per trip of Patient Assisted Travel Scheme
		Service 9: Continuing care	Average cost per capita of Population Health Units
		Service 10: Contracted mental health	Not reported by WACHS
		Service 11: Health System management - policy and corporate services	Average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing home type residents
		Service 12: Health support services	Average cost per bed-day in specialised mental health inpatient units
			Average cost per three-month period of care for community mental health
			Not reported by WACHS
			Not reported by WACHS

OUR VALUES IN ACTION

Art leads the way with welcoming patients and visitors

Four Goldfields artists took the opportunity to be involved with providing art for welcome and wayfinding as part of the \$3.66 million Goldfields Renal Service built at Kalgoorlie Health Campus.

Paintings were commissioned to reflect the Goldfields area with the themes of welcome, wellness, healing and safety and are displayed in the Goldfields Renal Service.

Elements of the paintings were then used to create designs in the vinyl flooring and for backlit ceiling panels, to act as unique wayfinding for patients and visitors and create an uplifting and healing environment.

The healing power of art has been successfully used in the Goldfields for a number of years.

Reference groups held with local Aboriginal stakeholders and community members spoke of using art and alternative wayfinding to improve accessibility and create culturally effective health facilities early in the Kalgoorlie Health Campus redevelopment project.

It was so successful that the concept was carried through all of the redeveloped areas in Kalgoorlie and is also being undertaken at Esperance Health Campus.

Goldfields Regional Director Geraldine Ennis said getting sick was also about getting well again and the artwork was a useful tool to remind people of that.

“Hospitals have the potential to be large and scary spaces. But by filling them with these beautiful artworks we can provide a focal point for patients and families and they also act as a unique wayfinding guide,” Geraldine said.

Artist Buodoon Edie Ulrich with the floor art. Her artwork was also used for the ceiling panels.



Governance structure

WA COUNTRY HEALTH SERVICE BOARD

The WA Country Health Service (WACHS) is a State Government statutory authority under the *Health Services Act 2016*. The legislation, which came into effect on 1 July 2016, replaced the *Hospitals and Health Services Act 1927* and involved the establishment of Boards that are responsible and accountable for delivering safe, high-quality, efficient and economical health services to their local communities.

From 1 July 2016, the WACHS Board commenced as the governing body for WACHS. It comprises highly capable and committed professionals with a diverse range of experience across the fields of medicine and health care, finance, law and community and consumer engagement. The Board works closely with the Chief Executive, who manages the day-to-day organisational operations to deliver safe, high-quality and efficient health services to local communities.

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The WACHS Board and CE Jeff Moffet visit Kalgoorlie as part of a regional Board meeting.



BOARD MEMBERS



Professor Neale Fong

Neale Fong is a registered medical practitioner with more than 30 years' experience in medical and health care delivery and leadership roles. His strengths lie in reform and change management, developing strategic direction for healthcare organisations and leading over the entire spectrum of health policy and service delivery.

In addition to his role as Chair of the WA Country Health Service Board, Neale is also Chairman of Bethesda Health Care, and Chairman of the Ministerial Council for Suicide Prevention. He consults to Curtin University on the establishment of WA's third medical school and is a Professor in Healthcare Leadership. He runs his own management consulting firm and has engagements with a number of government and health-related companies.

Neale is a former Director General of the Department of Health (WA) and CEO of St John of God Hospital Subiaco. He holds Masters degrees in Business Administration and Theological Studies, and Bachelor degrees in Medicine and Surgery. He is the National and WA President of the Australasian College of Health Service Management.

Neale was the Chairman of the WA Football Commission for 10 years, responsible for managing and growing Australian Rules Football in WA.



Ms Wendy Newman

Wendy Newman has most recently been CEO of the Wheatbelt Development Commission. She has extensive experience in individual, organisational and regional development and in addition to her role as Deputy Chair of the WACHS Board, is on the Board of Regional Development Australia, Wheatbelt and Deputy Chair of Directions Workforce Solutions.

Wendy has extensive experience in working at all levels of government to develop strategy and drive reform. More recently, this effort has been applied to driving collaboration across local government boundaries on priority development issues, assisting in the development of sustainable child care services and developing and delivering innovative models for aged care in regional settings.

Wendy has a Masters in Commerce (Management), a Bachelor of Education and is a graduate of the Australian Institute of Company Directors' program.

**Mr Alan Ferris**

Alan Ferris currently leads the consulting team at BDO, a large accounting firm. He has significant experience in government and not-for-profit sectors. He has worked in the Senior Executive Service of the State Government in positions including General Manager of the Perth Theatre Trust and Acting Director General of the Department of Culture and the Arts. He also held the position of Chief Financial Officer in Culture and the Arts for seven years.

Alan sits on the Board of the Palmerston Association and is also a member of the WA Planning Commission's Executive Finance and Property Committee. Alan also has significant local government experience having been Mayor of the Town of East Fremantle for six years and a Councillor for eight years. Alan holds a Bachelor of Commerce (Accounting and Information Systems), is a Certified Practising Accountant and also a Fellow of Leadership WA.

Outside the finance industry, Alan enjoys all sports, especially soccer and golf, and spending time with his wife and two daughters.

**Mr Michael Hardy**

Michael Hardy is a lawyer who practised for some 40 years in a large national firm, a boutique firm and as a sole practitioner. Michael's principal areas of practice were administrative, contract, planning, environmental and property law.

In addition to his position on the Board of WACHS, he is a member of the Contaminated Sites Committee and a member of the Metropolitan Central Joint Development Assessment Panel. Michael is a former chairman and non-executive director of Fleetwood Limited and Senior Vice President of the Law Society of Western Australia.

In addition to the roles above, Michael enjoys music, film and cycling.

**Dr Daniel Heredia**

Daniel Heredia is the Deputy CEO at Hollywood Private Hospital, the largest private hospital in WA. He has previously worked as a Medical Advisor to Medicare Australia and prior to this, worked in clinical medicine at various hospitals in WA. Daniel sits on the WA Board of the Medical Board of Australia and was a Director of the Australian Medical Association (WA) for six years.

Daniel has completed a Bachelor of Medicine and Bachelor of Surgery with Honours, an MBA with Distinction, and a Diploma of Public Health. He is a Graduate of the Australian Institute of Company Directors, Fellow of the Royal Australasian College of Medical Administrators and Fellow of the Australasian College of Health Service Management.

Daniel is passionate about developing the next generation of leaders in the healthcare system. Outside work, Daniel enjoys traveling and spending time with his young family.



Dr Kim Isaacs

Kim Isaacs is a GP practising at the Broome Regional Aboriginal Medical Service and previously has held medical roles at Sir Charles Gairdner Hospital, Royal Perth Hospital, Princess Margaret Hospital, Broome Regional Hospital and Alice Springs Hospital.

A Yaruwu, Karajarri and Noongar woman, Kim has a strong background in rural and remote medicine and Aboriginal primary health care since completing her medical degree at the University of Western Australia. She has previously been a Board member of Derbarl Yerrigan Health Service. She is also a lecturer in Aboriginal Health at Notre Dame University, a Fellow of the Royal Australian College of General Practitioners and a Fellow of the Australian Rural Leadership Foundation. Prior to entering medical school, Kim completed a Bachelor of Commerce degree at UWA with a major in Accounting and Finance.

Kim is passionate about developing young people and has a particularly strong interest in child and maternal health, and mental health and wellbeing. She brings to the Board a particular understanding of the issues and challenges around rural and remote health service delivery.



Mr Joshua Nisbet

Joshua Nisbet is the Manager of Aboriginal Economic Participation with Rio Tinto, responsible for the employment and contracting obligations Rio Tinto Iron Ore has with the Traditional Owners of the Pilbara, arising from the commercial agreements and Indigenous Land Use Agreements. Joshua's previous roles with Rio Tinto included Expansions Studies Manager where he was responsible for Order of Magnitude through to Bankable Feasibility Studies for expansions of mines and ports, with capital budgets in excess of US\$1 billion. He was also Manager of Next Generation Operations Centre where he co-led a review of Iron Ore's Operating Model which identified ways to extract greater value through improved integration.

Joshua has post-graduate qualifications in Psychology and Commerce from UWA, Murdoch and the University of NSW and commenced his career working for WA's specialist psychiatric disability employment agency, Workright (WA). During this time he championed evidence-based practices on a national level and helped establish a national consortium of mental health employment agencies, for which he was the inaugural Vice-Chair. Following the successful merger of Workright with Ruah Community Service, Joshua worked in Strategy and Operations consulting and Oil and Gas construction before joining Rio Tinto.

Joshua is married to a health promotion and health policy specialist from Busselton and together they are raising two boys.



Mrs Mary Anne Stephens

Mary Anne Stephens is a senior executive and non-executive director with more than 25 years' experience leading teams within the financial services, IT and not-for-profit sectors in Australia and the United States. She has extensive experience in strategy, finance, risk management, audit and governance. Mary Anne is currently the Chief Financial Officer for Amana Living.

Mary Anne is a Non-Executive Director of Diabetes WA, a Board Member of VenuesWest, and an external member of the Football West Finance and Audit Sub-committee.

She holds a Master of Accounting degree, is a Fellow of CPA Australia, a Fellow of the Institute of Public Accountants, a Fellow of the Australian Institute of Management and a graduate of the Australian Institute of Company Directors' program.

Mary Anne is passionate about the need to continually improve health outcomes within the WA community. Her goal is to leverage her skills and experience to contribute in a positive way to WACHS.



Mrs Meredith Waters

Meredith Waters arrived in the Esperance area 18 years ago from Melbourne, and quickly grew to love life in the regional community. With a background in the justice system as a Clerk of Courts in Victoria, Meredith commenced with the Esperance Court House in 2000.

Loving a new challenge and still with the Department of Justice, Meredith later took up work as an adult corrections officer. Following a gap in paid work to spend time caring for her three sons, Meredith held the role of coordinator with the adult literacy program Read Write Now.

Since 2010, Meredith has held a variety of roles in the community and volunteer sector, including Service Manager of Bay of Isles Community Outreach (BOICO), a local not-for-profit organisation supporting people with mental illness and their carers, Project Officer with the Esperance Volunteer Resource Centre writing policies and procedures, and Area Chaplain with YouthCARE in the Kalgoorlie-Esperance region.

Meredith is currently a member of Esperance Local Drug Action Group, Board member for 103.9HopeFM community radio and Esperance Community Arts, and the Chairperson of the South East District Health Advisory Council with WACHS.

Meredith has a strong interest in social justice, community advocacy and creating change through providing information, training and education to people living in remote and regional Western Australia.

BOARD COMMITTEES

Finance Committee

The role of the Finance Committee is to assist the WACHS Board to perform its functions and to ensure the implementation of, and adherence to, the Financial Management Policy Framework, and the Board's external obligations, as prescribed in the *Financial Management Act 2006*, Treasurer's Instructions and other relevant legislation.

The committee supports and advises the Board in exercising its authority in financial matters and makes recommendations to the Board regarding the annual WACHS budget.

Its role is to monitor and report on the health service's financial performance against WACHS priorities, key performance indicators and approved budgets. It also supports management in the formulation of strategies for improving WACHS's financial position, including the approval and monitoring of the departmental budget processes.

Audit and Risk Committee

The role of the Audit and Risk Committee is to provide advice, independent assurance and assistance to the Board on maintaining effective and efficient audit functions, risk, control and compliance frameworks, and the Board's external obligations as prescribed in the *Financial Management Act 2006*, the *Auditor General Act 2006*, Treasurer's Instructions and other relevant legislation.

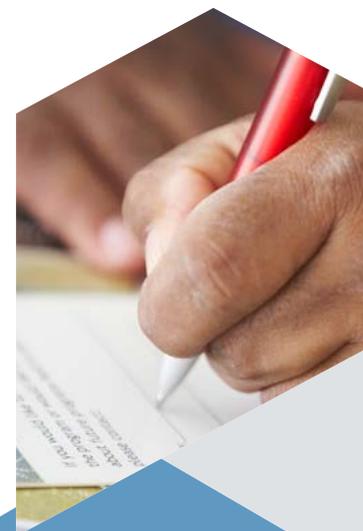
The committee also ensures the implementation of, and adherence to, the Risk, Compliance and Audit Policy Framework and is directly responsible and accountable to the Board for the exercise of its duties and responsibilities.

Safety, Quality and Performance Committee

The role of the Safety, Quality and Performance Committee is to assist the Board in fostering safety and quality in patient care across WACHS by monitoring and advising on matters relating to safety and quality. It also provides assurance to the Board that the Clinical Governance, Safety and Quality Policy Framework is implemented and adhered to and that clinical systems, processes and outcomes are effective.

The committee is directly responsible and accountable to the WACHS Board for the exercise of its duties and responsibilities.

Note: Committees comprise Board members only and are not formally registered.



BOARD MEETING AND COMMITTEE ATTENDANCE
Table 3: Board meeting attendance 2016–17.

Name	Number of meetings	Meetings attended
Full Board meeting		
Professor Neale Fong (Chair)	12	11
Ms Wendy Newman (Deputy Chair)	12	10
Mr Alan Ferris	12	10
Mr Michael Hardy	12	10
Dr Daniel Heredia	12	8
Dr Kim Isaacs	12	12
Mr Joshua Nisbet	12	11
Mrs Mary Anne Stephens	12	10
Mrs Meredith Waters	12	12
Finance Committee		
Alan Ferris (Chair)	10	10
Wendy Newman	10	9
Mary Anne Stephens	10	10
Audit and Risk Committee		
Michael Hardy (Chair)	6	6
Alan Ferris	6	5
Mary Anne Stephens	6	6
Safety, Quality and Performance Committee		
Daniel Heredia (Chair)	5	4
Kim Isaacs	5	5
Joshua Nisbet	5	4
Meredith Waters	5	5



WA COUNTRY HEALTH SERVICE ORGANISATIONAL STRUCTURE

Figure 2: WACHS organisational structure.



Our place in the wider health system

The WA health system consists of the Department of Health, five Health Service Providers, Quadriplegic Centre and Health Support Services. The Department of Health, led by the Director General, provides leadership and management of the health system as a whole, ensuring the delivery of high quality, safe and timely health services.

Each Health Service Provider is governed by a Board appointed by the Minister for Health. Board members bring a wealth of experience in a range of fields such as health care, finance, law, and community and consumer engagement.

Health Service Providers are responsible and accountable for the delivery of safe, high quality, efficient and economical health services to their local areas and communities. They include the Child and Adolescent Health Service, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service, and the WA Country Health Service. While WACHS is the State Government health care provider for country patients, it works together with the Department of Health and other Health Service Providers to ensure country patients have coordinated care when needed.

System-wide support to Health Service Providers, including some technology, supply, workforce and financial services, are provided through a shared services arrangement by Health Support Services, which is a Chief Executive-governed Health Service Provider.

SENIOR OFFICERS

Senior officers and their area of responsibility for the WA Country Health Service as at 30 June 2017 are listed in Table 4.

Table 4: WA Country Health Service senior officers

Area of responsibility	Title	Name	Basis of appointment
WA Country Health Service	Chief Executive	Mr Jeffrey Moffet	Term contract
Operations	Chief Operating Officer	Mr Shane Matthews	Term contract
Strategy and Reform	Chief Operating Officer	Ms Melissa Vernon	Acting
Nursing and Midwifery	Executive Director	Ms Marie Baxter	Term contract
Medical Services	Executive Director	Dr Anthony Robins	Term contract
Workforce	Executive Director	Mr Marshall Warner	Secondment
Business Services	Executive Director	Mr Jordan Kelly	Term contract
Mental Health	Executive Director ***	Ms Paula Chatfield	Term contract
Public Health and Ambulatory Care	Executive Director	Ms Margaret Denton	Acting
Regional Operations	Regional Director Goldfields	Ms Geraldine Ennis	Substantive
Regional Operations	Regional Director Great Southern **	Mr David Naughton	Term contract
Regional Operations	Regional Director Kimberley	Ms Rebecca Smith	Term contract
Regional Operations	Regional Director Midwest *	Mr Jeffrey Calver	Term contract
Regional Operations	Regional Director Pilbara	Mr Ronald Wynn	Term contract
Regional Operations	Regional Director Southwest	Ms Kerry Winsor	Substantive
Regional Operations	Regional Director Wheatbelt	Mr Sean Conlan	Term contract
Office of the Chief Executive	Director	Ms Tracy Rainford	Substantive
Finance	Director	Mr John Arkell	Substantive
Infrastructure	Director	Mr Robert Pulsford	Substantive

Note:

*The position of A/Regional Director Midwest was held by Ms Margaret Denton up until April 2017. Jeff Calver was appointed to the role on 21 June 2017.

**Ms Susan Kay was Regional Director Great Southern until 31 December 2016

***Mr David Naughton was Acting Executive Director Mental Health until 17 February 2017

OUR VALUES IN ACTION

Benefits of telehealth in the spotlight

A week to increase awareness of the use and value of telehealth to patients and clinicians ran for the first time in 2017.

Telehealth Awareness Week (12–16 June), launched by Professor Fiona Wood, included a range of initiatives, such as updating telehealth's web presence and uploading educational videos to online media, coordinating information displays across metropolitan and regional hospitals, and preparing local patient-based stories for local media and metropolitan and regional hospital newsletters.

As well, informative posters, brochures and pull-up banners were created for displays and will be used as patient information resources over coming years.

Chief Operating Officer Strategy and Reform Melissa Vernon said she was very excited at the positive community and staff reaction to the week.

“Our telehealth coordinators always go above and beyond to promote telehealth but it was exciting to see other staff get behind it this week,” Melissa said.

“There’s obviously a lot of support for telehealth from consumers and clinicians, and our telehealth coordinators are integral to increasing this uptake by supporting the clinicians and promoting services to consumers.”

Melissa Vernon with Professor Fiona Wood at the launch of Telehealth Awareness Week.





Healthier country
communities through
partnerships and innovation



Government of Western Australia
WA Country Health Service



2 | Agency
performance

Financial summary

The total cost of providing health services to rural and regional areas in Western Australia in 2016–17 was \$1.78 billion. Results for 2016–17 against agreed financial targets (based on Budget statements) are presented in Table 5.

Full details of the WACHS's financial performance during 2016–17 are provided in the financial statements section of this report.

Table 5: Actual results versus budget targets for WACHS.

	2016–17 Target (\$ '000)	2016–17 Actual (\$ '000)	Variation (+/-) (\$ '000)	Explanation of variance
Total cost of services	1,566,208	1,783,070	216,862	Continuing and new services for which funding was not included in the initial target but were the subject of budget adjustments throughout the year and at Mid-year Review.
Net cost of services	920,302	1,119,281	198,979	Continuing and new services for which funding was not included in the initial target but were the subject of budget adjustments throughout the year and at Mid-year Review.
Total Equity	2,512,241	2,277,450	(234,791)	Delays in the Capital Works program and asset revaluation decrements.
Approved full time equivalent staff level (salary associated with FTE)	7,664.9	7,606	(58.9)	Reduced staffing levels in the first half of the year following the 2015–16 recruitment freeze.

Summary of key performance indicators

Key Performance Indicators (KPIs) assist the WA Country Health Service to assess and monitor the extent to which Government outcomes are being achieved. Effectiveness indicators provide information that aids in the assessment of the extent to which outcomes have been achieved through the resourcing and delivery of services to the community. Efficiency indicators monitor the relationship between the service delivered and the resources used to provide the service. Key performance indicators also provide a means to communicate to the community how the WA Country Health Service is performing.

A summary of the WA Country Health Service key performance indicators and variations from targets is given in Table 6.

Note: Table 6 should be read in conjunction with detailed information on each key performance indicator found in the disclosure and compliance section of this report.

Table 6: Actual results versus KPI targets.

Key performance indicator	2016-17 Target	2016-17 Actual	Variance
OUTCOME 1: Restoration of patients' health, provision of maternity care to women and newborns, and support for patients and families during terminal illness.			
Percentage of patients discharged to home after admitted hospital treatment	97.6%	97.5%	0.1%
Survival rates for sentinel conditions			
Stroke by age group			
0-49	98.5%	95.8%	-2.7%
50-59	98.2%	100.0%	1.8%
60-69	98.7%	92.3%	-6.4%
70-79	96.1%	92.9%	-3.2%
80+	81.9%	84.1%	2.2%
Acute myocardial infarction by age group			
0-49	99.1%	100.0%	0.9%
50-59	99.2%	100.0%	0.8%
60-69	99.2%	94.7%	-4.5%
70-79	98.4%	94.7%	-3.7%
80+	96.0%	90.7%	-5.3%
Fractured neck of femur by age group			
70-79	98.7%	100.0%	1.3%
80+	97.8%	95.8%	-2.0%
Proportion of elective wait list patients waiting over boundary for reportable procedures	0%	removed*	removed*

* WACHS has identified errors in the data used to calculate this KPI in 2016/17 and as such this section has been removed. WA Country Health Service places the highest priority on transparent and rigorous reporting of its performance in providing healthcare for WA country communities. The organisation is putting stringent measures in place to ensure accurate reporting of this KPI in the future.

Key performance indicator	2016-17 Target	2016-17 Actual	Variance
Unplanned hospital readmissions within 28 days for selected surgical procedures (per 1,000)			
Knee replacement	29	22.6	-6.4
Hip replacement	22	36.7	14.7
Tonsillectomy and adenoidectomy	64	46.2	17.8
Hysterectomy	28	33.8	5.8
Prostatectomy	27	89.3	62.3
Cataract surgery	1	3.9	2.9
Appendectomy	37	41.2	4.2
Rate of unplanned readmissions within 28 days to the same hospital for a mental health condition (per 1,000)	61.0	82.0	21.0
Percentage of live born term infants with an Apgar score of seven or less, five minutes post delivery	1.8%	1.5%	-0.3%
Average cost per casemix adjusted separation for non-tertiary hospitals	\$6,877	\$6,408	-\$469
Average cost per bed-day for admitted patients (small hospitals)	\$2,125	\$3,806	\$1,681
Average cost per emergency department/service attendance	\$840	\$951	\$111
Average cost per public patient non-admitted activity	\$442	\$491	\$49
Average cost per non-admitted occasion of service provided in a nursing post	\$374	\$418	\$44
Average cost per trip of Patient Assisted Travel Scheme	\$448	\$438	-\$10

Key performance indicator	2016-17 Target	2016-17 Actual	Variance
OUTCOME 2: Enhanced health and well-being of Western Australians through health promotion, illness and injury prevention and appropriate continuing care.			
Percentage of contacts with community-based public mental health non-admitted services within seven days prior to admissions to a public mental health inpatient unit	70.0%	47.3%	-22.7%
Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units	75.0%	67.5%	-7.5%
Average cost per capita of Population Health Units	\$352	\$294	-\$58
Average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing home type residents	\$420	\$526	\$106
Average cost per bed-day in specialised mental health inpatient units	\$2,092	\$2,186	\$94
Average cost per three month period of care for community mental health	\$2,649	\$2,434	-\$215

Improvements towards emergency department access

Emergency departments are specialist multidisciplinary units with expertise in managing acutely unwell patients for their 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 high-quality care.

PERCENTAGE OF EMERGENCY DEPARTMENT PATIENTS SEEN WITHIN RECOMMENDED TIMES (MAJOR RURAL HOSPITALS)

When patients first enter an emergency department they are assessed by specially trained nursing staff on how urgently treatment should be provided. The aim of this process, known as triage, is to ensure treatment is given in the appropriate time and should prevent adverse conditions arising from deterioration in the patient's condition.

The triage process and scores are recognised by the Australasian College for Emergency Medicine and are recommended for prioritising those who present to an emergency department. A patient is allocated a triage score between 1 (immediate) and 5 (least urgent) that indicates their treatment acuity. Treatment should commence within the recommended time of the triage category allocated (see Table 7).

Table 7: Triage category, treatment acuity and WA performance targets.

Triage Category	Description	Treatment Acuity	Target
1	Immediate life-threatening	Immediate (< 2 minutes)	100%
2	Imminently life-threatening	< 10 minutes	> 80%
3	Potentially life-threatening or important time-critical treatment or severe pain	< 30 minutes	> 75%
4	Potentially life-serious or situational urgency or significant complexity	< 60 minutes	> 75%
5	Less urgent	< 120 minutes	> 70%

By measuring this indicator, changes over time can be monitored that assist in managing the demand on emergency department services and the effectiveness of service provision. This in turn can enable the development of improvement strategies that ensure optimal restoration to health for patients.

In 2016–17, the proportion of WA patients in major rural hospital emergency departments who were seen within recommended time was above the minimum benchmarks for all triage categories (see Table 8).

Table 8: Percentage of major rural hospital emergency department patients seen within recommended times by triage category 2016–17.

Triage Category	2016-17 Performance	Target
1	100%	100%
2	90.3%	> 80%
3	85.7%	> 75%
4	85.7%	> 70%
5	96.0%	> 70%

PERCENTAGE OF EMERGENCY ATTENDANCES WITH A TRIAGE SCORE OF 4 AND 5 NOT ADMITTED

Typically, patients who are clinically assessed as Australasian Triage Score (ATS) 4 and 5 at presentation to an emergency department are attending as lower acuity and are subsequently treated within the emergency department but may not require formal admission to the inpatient ward.

For a large number of country hospitals, information regarding triage 4 and 5 attendances may indicate the level of availability of primary care services and out-of-hours general practice options in that community. Where these services are unavailable or restrictive, community members may need to attend a rural hospital emergency department or service for treatment.

The outcome of a patient attending a rural emergency department or service is based on clinical need and therefore a target for this measure has not been determined.

In 2016–17, the percentage of emergency department attendances triaged as category 4 and 5 and not admitted can be seen in Table 9.

Table 9: Percentage of major rural hospital emergency attendances with a triage score of 4 and 5 not admitted.

Triage Category	2016–17
4	91.3%
5	97.7%

Learning from clinical incidents

Health care, particularly in acute hospital settings can at times be complex and involve a degree of risk. Nationally, all hospital systems experience unintended harm to a very small proportion of patients who are cared for in the health system. This is why national safety and quality standards, including incident monitoring and investigation processes, are in place to support quality improvement in health care.

WACHS continually strives to provide the very best, high quality consumer-centred care to all our patients. We achieved this for the vast majority of the 120,000 annual admissions and nearly 400,000 patients who present to our emergency departments each year. However, similar to other health services, despite the very best intentions of our dedicated staff, a small proportion of patients unfortunately experience poor outcomes which is contributed to by the care they receive.

In support of recommendations related to the transparency of public reporting made in the recent WA Health Safety and Quality Review led by Professor Hugo Mascie-Taylor, we are sharing the number of serious clinical incidents that occurred at our hospitals and services in 2016–17.

WACHS is committed to full and open communication, including open disclosure with patients and families, where a serious clinical incident has occurred. We fully investigate these incidents to prevent or reduce possible future harm to consumers by learning from what has happened and taking corrective actions.

Clinical incidents are assigned a Severity Assessment Code (SAC) rating that guides the type of investigation method that is to take place.

SAC 1 clinical incidents are the most serious category resulting in serious harm or death that is, or could be, specifically caused by health care rather than the patient's underlying condition or illness.

In 2016–17, a total of 95 SAC 1 clinical incidents were reported internally.

None of the SAC 1 clinical incidents met the criteria for reporting as a national sentinel event. National sentinel events are a discrete set of SAC 1 events that are considered wholly preventable and caused serious harm or death to a patient. Sentinel events occur relatively infrequently and are independent of a patient's condition.

The most common types of SAC 1 events reported in 2016–17 are similar to those reported across WA Health including:

- complications of a fall involving patients in a hospital or residential aged care facility
- healthcare acquired infections
- misdiagnosis
- delays in recognising and/or responding to deterioration in a patient's condition.

WACHS encourages staff to report clinical incidents and values the opportunity to learn and act on factors that contribute to poor outcomes for consumers. The lessons learned from clinical incidents inform priorities for improvement. In 2016–17, the WACHS Safety and Quality Priorities were:

Priority 1: Recognition and response to clinical deterioration, with a focus on sepsis.

Priority 2: Patients awaiting transfer.

Priority 3: Supporting patients, family members or carers to seek assistance when worried about a change in condition.

Of the 95 SAC 1 clinical incidents in WACHS over the past year:

- 91 SAC 1 investigations have been completed
- four investigations are still being finalised
- five incidents have been declassified – health care provided was determined not to have contributed to the poor patient outcome and only factors related to the patient's clinical condition were identified
- 86 cases were confirmed as SAC 1 clinical incidents, where health care did or could have contributed to a poor clinical outcome. Of these cases:
 - 13 patients did not sustain serious harm or death, but the events were considered 'near misses' to have had the potential for serious harm or death, and were therefore notified and investigated as a SAC 1 event
 - 45 patients sustained serious harm where health care was deemed to be a contributory factor
 - 28 patients died where health care was deemed to be a contributory factor.

Some of the SAC 1 events resulting in death occurred in the community, including unexpected deaths of mental health patients, and babies where co-sleeping was found to be a contributing factor.

WACHS has a well-developed approach to the review of SAC 1 clinical incidents internally and through the Board Safety, Quality and Performance Committee.

OUR VALUES IN ACTION

Trachoma Program wins top award at WA's annual Health Excellence Awards

The State Trachoma Program, managed by WACHS Goldfields, won the Director General's Award in the 2016 WA Health Excellence Awards.

The Trachoma Program is on track to eliminate the potentially blinding eye infection by 2020 and has successfully reduced the rates of trachoma infection in rural and remote Aboriginal communities from 24 per cent in 2006 to 2.6 per cent in 2015.

The program won Category 4 – Achieving better outcomes for Aboriginal people and was chosen out of the eight category winners on the night as the overall winner. WACHS also won *Category 8: Promoting healthy habits and preventing illness and injury – Great Southern Easy Movers program.*

The WA Health Excellence Awards are held annually and culminate in a gala dinner in November.



Community Health Nurse Jane Bell tests a child's eyes while Public Health Physician Dr Clare Huppertz looks on.



*Healthier country
communities through
partnerships and innovation*



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WA Country Health Service



3 | Significant
issues

Demand and activity

The WA Country Health Service aims to provide excellent health care that assists country Western Australians to lead healthy and fulfilling lives. WACHS is building links with primary care (for example, general practitioners), and child health and development services as well as building capacity in critical care and rehabilitation services.

A \$1.5 billion capital works program, and the reform of country health services is bringing high quality health care closer to home for more people living in regional and remote WA. Significant factors driving demand in regional WA include changes in population size and population demographics, increased availability in the scope of local services and a higher than average burden of disease in Aboriginal and rural populations.

Within WACHS there was a **3.3 per cent** increase in weighted activity (measure of health service activity) in **2016–17**, driven by increased activity across all modalities of hospital service delivery.

Systemic demographic factors also continue to be a driver, with the ageing regional population affecting residential and community aged care places. Limitations to service capability and capacity leads to some consumers not being able to stay in their home towns, especially as their care needs increase or become more specialised.

Country populations carry a high burden of disease in areas where access to general practitioners and other primary health care is limited. Initiatives aimed at improving access to these services have been implemented and are expected to improve detection of chronic and other health conditions. Long term, this will increase the requirement for hospital and specialist intervention and health expenditure.

WACHS is working towards reducing hospitalisation and length of stay through better care coordination and links with primary care. The health service is undergoing considerable reforms and service expansion, particularly in areas of child health and development, chronic disease prevention, coordination and management, and acute mental health. There is direct emphasis on expanding chronic disease programs and delivering cancer and renal services closer to home.

Ongoing capital investment is aimed at facilitating higher levels of self-sufficiency within the regions, namely improved access and quality of emergency and primary care, improved inpatient services and enabling more patients to access care closer to home. In 2016–17, capital investment projects that directly met these objectives included Southern Inland Health Initiative infrastructure upgrades, the Esperance Health Campus redevelopment, the planning, design and part construction of Karratha Health Campus and investment in renal dialysis.

The health service is undergoing considerable reforms and service expansion, particularly in areas of child health and development, chronic disease prevention, coordination and management, and acute mental health.

Several factors affecting progress towards addressing demand and activity issues include:

- The Activity Based Funding model. This is based on the Independent Hospital Pricing Authority (IHPA) model and does not adequately recognise costs specific to providing care in regional WA such as:
 - **location-based costs** – staff accommodation, allowances, travel, turnover and utilities
 - **costs of scale** – many WACHS hospitals have patient activity volumes that do not generate sufficient revenue to offset the minimum cost of providing the service.
- The WA Country Health Service has provided supporting evidence for these types of cost variations not adequately recognised in the National Pricing model for assessment through the IHPA Legitimate and Unavoidable Cost Variations Framework.
- Longer-term patient retention in acute settings rather than in alternative accommodation such as aged care placements, sub-acute services, or mental health step-down facilities that can place capacity pressures on acute hospitals.

Progress towards meeting activity and demand requirements in 2016–17 included:

- Continued construction of the Karratha Health Campus.
- Commencement of construction of the Onslow Health Campus redevelopment.
- Redevelopment of Emergency Departments at Esperance Health Campus and Harvey Health Campus.
- Opening of the Esperance Health Campus maternity unit.
- Expansion of renal facilities in areas of need.
- Completion of the Harvey Health Service redevelopment.
- Progression of the Remote Aboriginal Health Clinics project – redevelopment of primary health facilities at various remote communities across the Kimberley and Pilbara regions.
- Increased access to the Emergency Telehealth Service, providing patients and staff with state-of-the-art access to high quality emergency medical care.
- Increased access to outpatient and clinical services via telehealth (stroke, cancer, respiratory diseases and diabetes).

Workforce challenges, achievements and initiatives

Key workforce challenges that affect WACHS's ability to provide safe, accessible and quality health services centre on our ability to attract and retain clinical staff and the uninterrupted provision of safe medical, nursing and allied health care within regional areas. The WACHS service area covers approximately 2.5 million square kilometres and some of our hospitals and many of our health services and nursing posts are in remote locations. Attracting permanent clinical staff to these locations is often difficult.

During 2016–17, WACHS developed innovative staffing models to address regional staff requirements across nursing and midwifery, medical, allied health, mental health and Aboriginal health.



Some of the challenges specific to developing a highly skilled and experienced clinical workforce include:

- Recruitment and retention of medical practitioners that meet regional clinical requirements.
- Increased numbers of Australian medical school graduates requiring intern places and the subsequent need for investment in post-graduate medical education and regional support to ensure high quality care.
- The demand for flexible contracting arrangements to ensure ongoing service provision while maintaining high standards of governance and high standards of safety and quality care for patients.
- Determination of minimum skills and experience required by health practitioners to provide high quality and safe clinical care.
- Increased use of agency nursing and midwifery staff to fill roster shortages makes it difficult to maintain consistency in standards.
- Recruitment and retention of Aboriginal mental health workers due to the short-term nature of funding for specialised Aboriginal mental health services.
- Recruitment of senior clinical allied health professionals.

During 2016–17, WACHS developed innovative staffing models to address regional staff requirements across nursing and midwifery, medical, allied health, mental health and Aboriginal health.

These included:

- The continued recruitment of nurse practitioners throughout WACHS, now totalling 31.
- Development of a WACHS casual nursing pool for enrolled nurses, registered nurses, registered midwives and nurse practitioners.
- Increasing the number of graduate nurses employed in 2017 from 72 to 150 with all the graduates remaining in the program throughout the year.
- Continuing to recruit to the 12-month rotational travel program for more experienced metropolitan nurses.
- The use of LinkedIn for nurse recruitment (also used for recruitment of other staff).
- Development of innovative models of care as an attraction to specific specialised nursing and midwifery groups, for example, the employment of direct entry midwives.
- Development of the novice nurse program for two-year appointments of newly graduated nurses in the Wheatbelt Region. The success of the program will see the expected rollout of the program to other regions.
- Development of Medical Workforce Framework to identify standards for medical practitioners being employed by WACHS.
- Development of the Better Medical Care Initiative to support the development and upskilling of medical practitioners in regional areas.
- Development of Clinical Lead Surgical Services role, a Surgical Advisory and Leadership Group and the role of Chief Pharmacist to provide clinical and corporate governance for WACHS.
- Development of three Director Leads for Psychiatry – Child and Adolescent, Youth, Adult (and Older Adult) to provide clinical leadership and governance for WACHS Mental Health services.
- Confirmation of 'Area of Need' status for psychiatry to support recruitment.
- Achievement of Primary Employed Health Service status allowing WACHS to directly employ interns and development of the Community Residency Program to provide junior doctors with exposure to community-based positions.
- Review of WACHS Research, Ethics and Governance function to determine requirements for WACHS to meet legislative and organisational requirements.
- Continued commitment to the employment and development of Aboriginal employees through the Aboriginal Entry Level Employment Program. This program enables regions to employ trainees, cadets, apprentices and/or provide on-the-job training for employees in entry level positions.
- Encouraging managers to apply section 51 of the *Equal Opportunity Act 1984* to recruitment processes to encourage more Aboriginal candidates to apply for jobs and assist WACHS to increase employment opportunities for Aboriginal people.
- Creation of the Allied Health Practice Framework to guide skills requirements and development of clinical staff.
- Implementation of WACHS-wide recruitment pools for occupational therapy, physiotherapy, speech pathology and dietetics with 128 applicants to the pools, 69 appointments and 28 employment contracts.
- Increasing the number of staff participating in the Allied Health Senior Leadership program from 25 to 42, supporting a 'grow your own' approach to senior staff recruitment.
- Attracting and supporting new graduate allied health professionals to work in WACHS through the Allied Health Graduate program.

OUR VALUES IN ACTION

WACHS interns embark on rural medical careers

An inaugural group of 10 junior doctors commenced a year-long internship with WACHS in 2017, with Albany Hospital and Bunbury Hospital employing five interns each.

Medical Education Unit Senior Project Officer Nicole Barbarich said the unit was delighted to welcome the health service's inaugural cohort of interns, as they embarked on their rural careers.

"After receiving accreditation as a Primary Employing Health Service, WACHS was successful in recruiting the interns, who will complete their entire 12-month placement in regional WA," Nicole said.

"During a year of intense learning, the interns can expect to receive quality education and a high level of supervision."

The interns were officially welcomed to WACHS by CEO Jeff Moffet and Executive Director of Medical Services Dr Tony Robins during Orientation Week at the East Point Plaza office, prior to travelling to their respective rural hospital sites.

Bunbury Hospital Intern Kate Nuthall said one of her primary motivations for studying medicine was a passion for rural health.

"My family is from rural NSW and I've seen the challenges many rural communities face," Dr Nuthall said. "Working in the country, we have the opportunity to operate in smaller teams and have much closer contact with our consultants."

"We have been so warmly welcomed into the community. Everyone at the hospital has been so supportive and the teaching we receive from our clinical mentors is wonderful."

Interns based in Perth hospitals are also offered the opportunity to do rotations in country hospitals, including Broome, Geraldton, Kalgoorlie, and Port Headland, as well as Bunbury and Albany.

The 2017 WACHS interns with CE Jeff Moffet (centre back), Executive Director Medical Services Dr Tony Robins (back fourth from left), PMEU Director Dr Monica Gope (back far right) and Dr Paul Myhill (first back right).



Managing funding reform and cost efficiencies

A key challenge for WACHS is delivering financially sustainable services. Implementing reforms and cost efficiencies across country WA is challenging and is affected by the higher costs of providing services in rural and remote areas. The higher cost associated with the location of services is also significantly affected by other markets such as the mining sector, and the small scale of operation in some sites. Workforce and recruitment costs add to the overall cost of service delivery.

WACHS is undertaking considerable work to fully understand and effectively communicate the costs of delivering services in a rural and remote environment, and the key cost drivers to support negotiations and discussions with funding authorities to inform future budget requirements.

WACHS continues to present analysis and supporting evidence to illustrate the additional costs associated with running hospitals in the more remote areas of WA. These additional costs relate to factors such as unavoidable higher input costs associated with attracting and retaining staff, the employer-provided accommodation location-based allowances, and other factors such as higher utility costs.

In 2016–17, WACHS provided supporting evidence for these types of cost variations not adequately recognised in the National Pricing model for assessment through the Independent Hospital Pricing Authority (IHPA) Legitimate and Unavoidable Cost Variations Framework.

WACHS accepts the challenge of being able to deliver services more efficiently and, where possible, identifies areas to reduce future budget pressures.

The health service has developed strategies to improve the revenue and cost profile of its services including:

- business process strategies to increase efficiency through improved business management
- revenue enhancement strategies
- cost savings and procurement/contract strategies to reduce expenditure.

Revenue enhancement strategies can be limited by the operating and medical workforce model in WACHS. The opportunities to increase revenue in the country are limited in comparison with the metropolitan environment.

The Royalties for Regions (RfR) program has been a major vehicle for injecting capital and recurrent funding into the improvement of infrastructure and services in country areas.

In 2016–17, approximately \$267.3 million was committed under RfR for programs including the Patient Assisted Travel Scheme, the Royal Flying Doctor Service, ambulance services, Southern Inland Health Initiative (SIHI) and infrastructure projects.

Health inequalities

The health of country people is significantly poorer than the health of people who live in the metropolitan area. The life expectancy of people living in country WA is less than that of their metropolitan counterparts – 2.1 years less for men and 1.6 years less for women. This disparity means that greater effort and investment in innovative models, telehealth and other technology, and partnerships with other health providers is required to achieve health equity. Environment, housing, transport, education, employment, workforce challenges and access to healthy lifestyles and services contribute to health outcomes and health inequity.

Approximately 60 per cent (estimated 52,588 people) of the State's Aboriginal population live in country WA. Health inequity is even greater between Aboriginal and non-Aboriginal people and more pronounced in areas where primary care services are limited and communities experience socio-economic disadvantage. Aboriginal people in WA have a significantly lower life expectancy compared with non-Aboriginal people. In 2013, the gap was estimated by the Australian Bureau of Statistics (ABS) to be 15.1 years for males and 13.5 years for females. Aboriginal male life expectancy is 65 years and Aboriginal female life expectancy is 70.2 years (for babies born in 2010–12 in WA).

The burden of disease is higher in people living in socio-economically disadvantaged areas. In Australia, geographic areas are classed into five levels of disadvantage with level one being the most disadvantaged and level five being the least disadvantaged (see Figure 3). Fourteen per cent of WACHS residents live in the least disadvantaged localities (those classed as level five), whereas 35 per cent of metropolitan residents live in this type of locality. Approximately 41 per

cent (217,491) of country residents live in the highest areas of disadvantage (those areas classed as levels one and two). In contrast, no metropolitan residents live in localities classed as level one and only seven per cent live in localities classed as level two.

All Kimberley residents (38,801) live in areas classed level one (the most disadvantaged type of area), and 86 per cent of Midwest residents and 37 per cent of Wheatbelt residents live in areas classed as levels one and two. The standard of housing plays a role in poorer health standards. In country WA, 21 per cent of Aboriginal families live in housing below acceptable standards.

Country residents are more likely than metropolitan residents to have potentially preventable hospitalisations. The rates of hospitalisation for diabetes, some cancers, respiratory diseases, circulatory diseases, cellulitis and ear, nose and throat conditions are significantly higher in country WA than in the metropolitan area. Country people are 1.4 times more likely to be hospitalised for respiratory diseases, cellulitis, epilepsy and ear, nose and throat infections, 1.3 times for diabetes and impaired glucose regulation and 1.2 times for dialysis, injury and poisoning compared to statewide rates. In contrast, metropolitan residents are hospitalised at less than the State rates for all these conditions (0.9 times the State rates).

Hospitalisations for many of these types of potentially preventable conditions are greater in the Kimberley and other northern WA areas. For example, hospitalisation for respiratory disease is 4.2 times higher, cardiac failure is four times higher and cellulitis is 5.4 times higher in the Kimberley than the State rates.

Aboriginal people living in country WA are 34.8 times more likely to require hospitalisation for dialysis than non-Aboriginal people living in country WA. The rate of diabetes-related hospitalisations is greatest in the northern regions of WACHS (7.6 times higher in the Kimberley, 2.6 in the Pilbara and 1.7 in Goldfields) than the State rates.

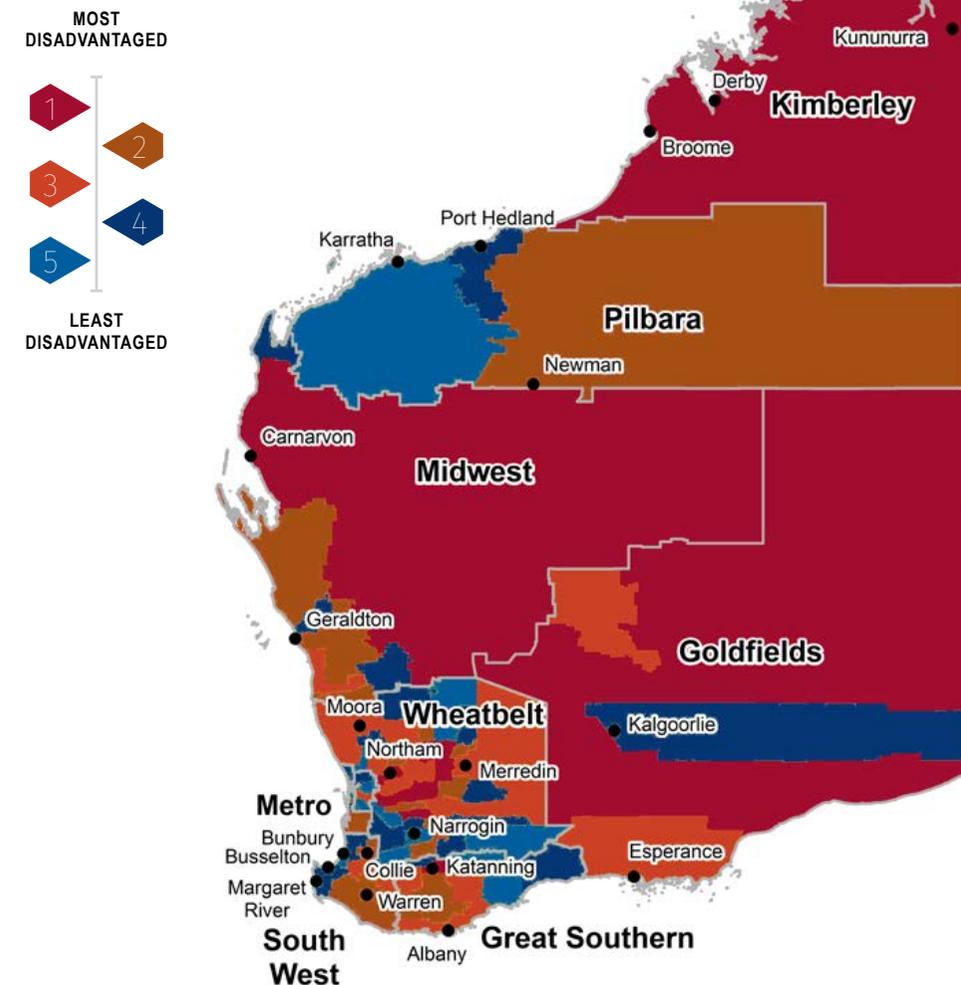
Motor vehicle accidents lead to significantly more hospitalisations and deaths for country residents compared with metropolitan areas. The country motor vehicle accident death rate is 2.2 times the State rate.

Aboriginal children in country WA are two to three times more likely to die before 12 months of age, be born prematurely and have a low birth weight, compared with non-Aboriginal children. Aboriginal children are nearly 30 times more likely to suffer from anaemia and malnutrition in the first four years of life and suffer infectious and parasitic diseases, compared with non-Aboriginal children.

Country people experience higher rates of chronic conditions than people living in the city and many of these conditions are lifestyle related. In 2015, 35 per cent of country residents were obese compared with 25 per cent of metropolitan residents. As well, more country people drink and smoke at high-risk levels compared with people living in the city. Rates of trachoma, diarrhoeal disease and skin infections are higher in remote communities.

The rates of death from intentional self-harm are high in country WA compared with metropolitan rates (1.9 times for Aboriginal and 1.1 times for non-Aboriginal people).

Fig 3: Index of relative socio-economic disadvantage quintiles



Source: Australian Bureau of Statistics: Index of Relative Socio-economic Disadvantage, 2011

WACHS seeks to improve service access and health outcomes through a focus on innovation and sustained service availability, including:

- Emergency services enhancement – securing medical and nursing cover for country emergency departments supported by the expansion of Emergency Telehealth Service to seven days each week.
- The development of WACHS Link to assist with the transfer and care coordination between WACHS and metropolitan hospitals for unplanned and planned hospital admissions.
- Primary care services investment to improve access to general practitioner services.
- Expansion of early years services with a focus on Aboriginal children, their families and other vulnerable groups through the implementation of the Healthy Country Kids Strategy.
- The Child Development Service Framework providing a consistent and family-centred approach to these services and guiding service planning, delivery and performance.
- Development of the Community Health Information System that supports significant improvement in child and community health services, ensuring that data capture informs service improvement and coordination.
- Continuation of key initiatives and programs, including the Improving Ear, Eye and Oral Health Initiative, the WA Trachoma Program, the Footprints to Better Health and Aboriginal Comprehensive Primary Care programs.
- The Chronic Conditions and Hospital Avoidance programs expansion with the introduction of asthma and diabetes tele-education services with key non-government partners.
- Continued development and expansion of renal services, including the establishment of multidisciplinary regional renal teams, increased dialysis services and renal hostel accommodation under construction.
- Cancer services development of tele-oncology and new infrastructure, including patient accommodation.
- The continued development of the Tele-Mental Health Program, Aboriginal and Youth Mental Health programs.
- Implementation of a Stroke Model of Care and introduction of tele-stroke services.
- Establishment of a Clinical Lead Geriatric Medicine to support acute and sub-acute aged care services, continued provision of residential and community aged care and investment in age-appropriate accommodation.
- Country Health Connect, a Perth-based service, continues to support Aboriginal people who need to travel to Perth for specialist medical assessment and intervention.
- The Patient Assisted Travel Scheme (supporting access to specialist services not available locally), launched a new information video for consumers to raise awareness and simplify the application process.
- An extensive hospital and health service infrastructure program aligned to the refined Clinical Services Framework is well progressed.
- Joint service planning with the WA Primary Health Alliance and Regional Aboriginal Health Forums that supports partnership opportunities in service provision and improved resource targeting to address identified needs.

OUR VALUES IN ACTION

Squeaky Clean Kids Program to benefit health of children in remote areas

An innovative program designed to help reduce the incidence of trachoma and other diseases in regional WA was launched in Kalgoorlie in June 2017.

The Squeaky Clean Kids program provides free soap to communities in the Kimberley, Pilbara, Midwest and Goldfields regions that are at risk of trachoma or trachoma resurgence. It also promotes hygiene messages in local schools and the wider community.

Australia is the only developed country with trachoma – a bacterial infection which causes inflammation of the inside of the eyelid, that if left untreated, can cause scarring and blindness.

Trachoma is spread through contact with eye discharge of an infected person, especially by flies, fingers and shared towels. There are no obvious symptoms of trachoma in its early stages, which is why prevention methods are so important.



Zakota Alone with some of the soap provided by Soap Aid.



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communities through
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