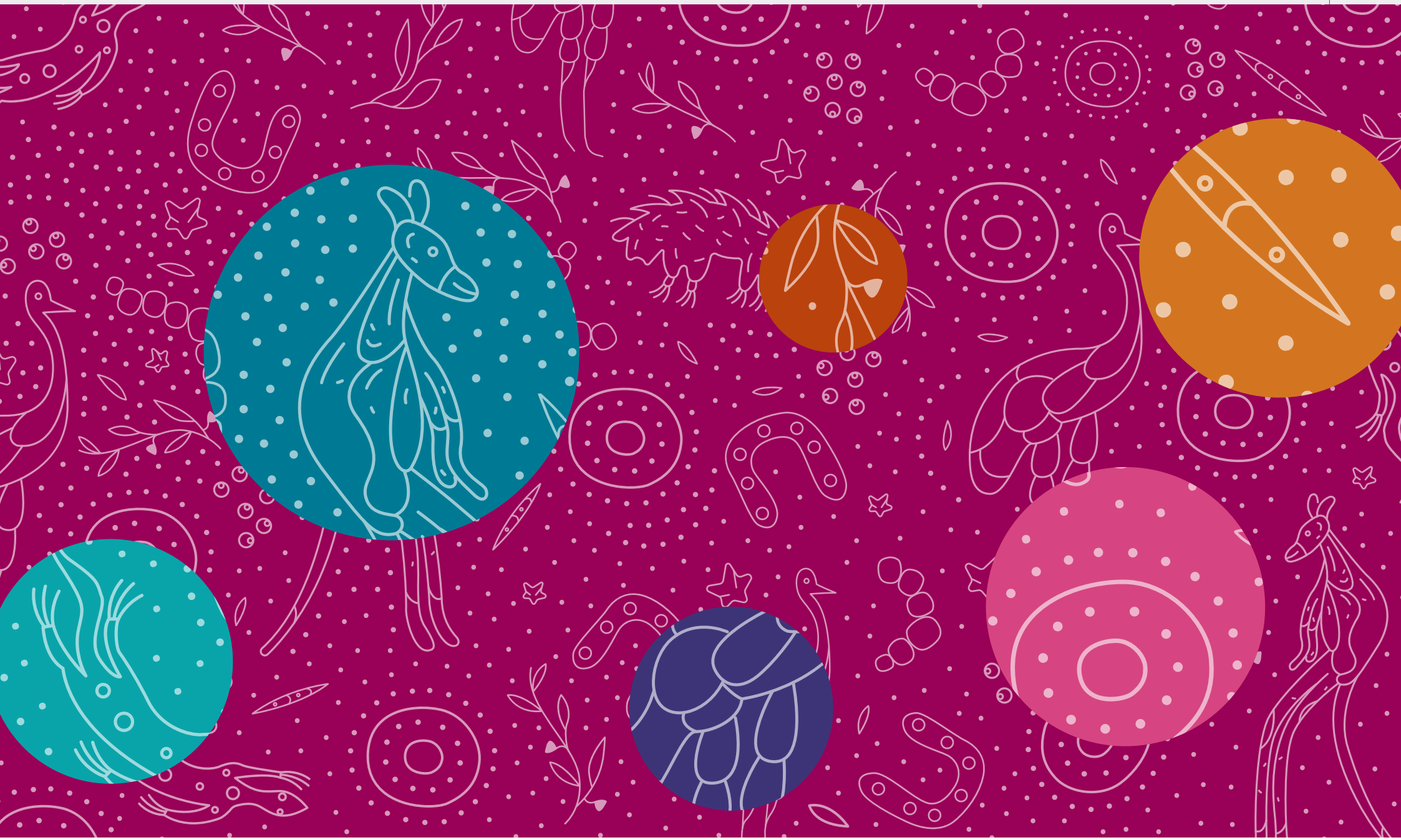
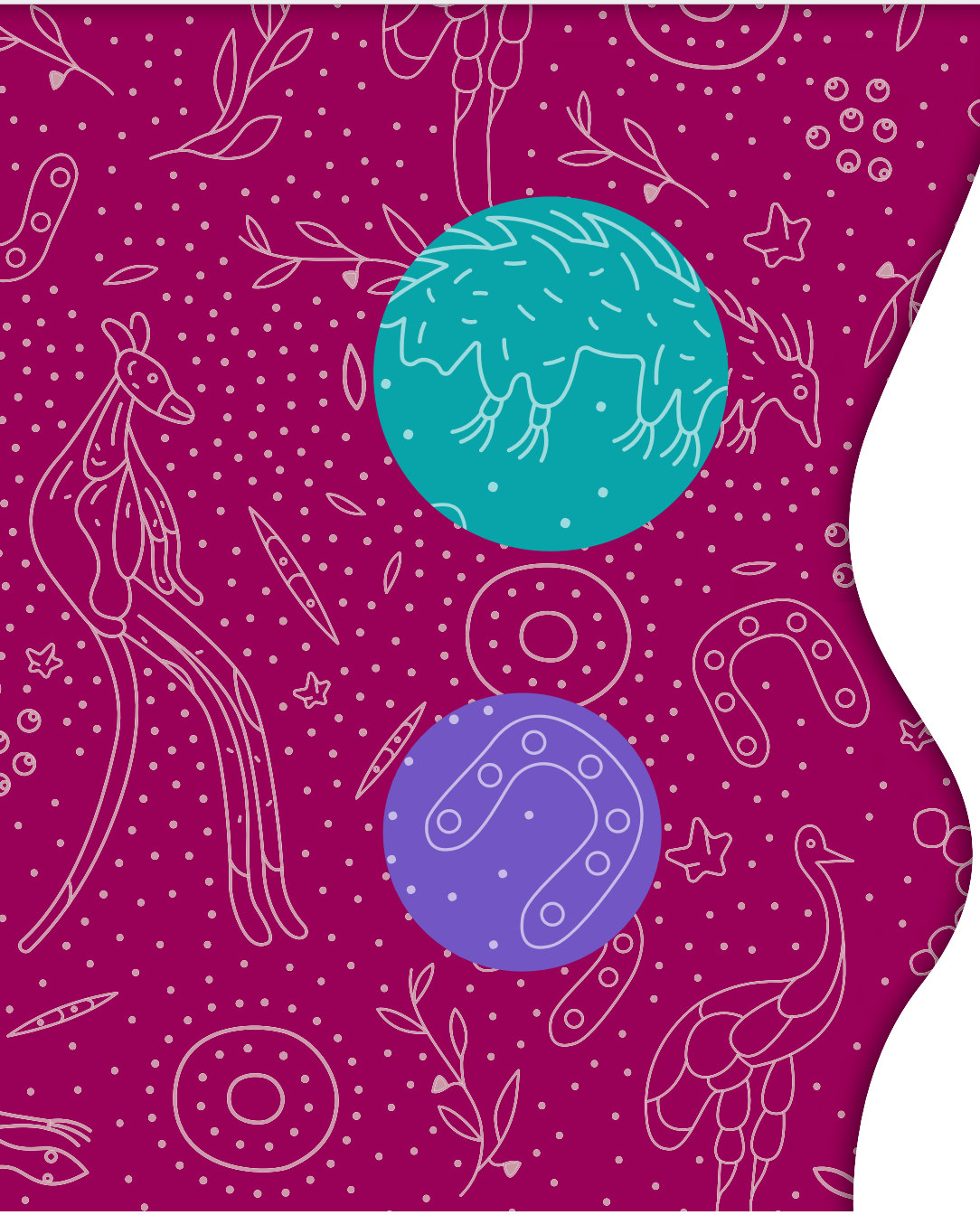
Government of **Western Australia**
North Metropolitan Health Service

Annual Report 2021





Acknowledgement of Country and People

We acknowledge the Noongar people as the traditional owners and custodians of the land on which we work, and pay respect to their elders both past and present.

North Metropolitan Health Service (NMHS) recognises, respects and values Aboriginal cultures as we walk a new path together.

Using the term – Aboriginal

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. Aboriginal and Torres Strait Islander may be referred to in the national context and Indigenous may be referred to in the international context. No disrespect is intended to our Torres Strait Islander colleagues and community.

Written permission has been obtained for all staff and patient images used in this report. Aboriginal readers are warned photographs within this publication may contain images of deceased persons that may cause sadness or distress.

This document may be made available in alternative formats on request for a person with a disability.

Note: Some photographs were taken before the need to socially distance.

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Statement of compliance

Hon. Roger Cook MLA

Deputy Premier and
Minister For Health

For year ended 30 June 2021

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 North Metropolitan Health Service (NMHS) for the financial year ended 30 June 2021.

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

Tony Dolan
Acting Chief Executive
North Metropolitan Health Service

Clinical Professor David Forbes AM
Board Chair
North Metropolitan Health Service

Foreword

It is our privilege to report on our performance for 2020/21. Beyond the impact of the COVID-19 pandemic, the year has presented unexpected challenges but has also allowed us to demonstrate the vital work we do in serving the people of Western Australia. We delivered on a multitude of commitments, but our real success lies in our clear focus on making NMHS a leader in person-centred care, known for our community health outcomes, innovation and excellence.

This report will provide you with information about:

- our service network – who we are and the services we provide
- our governance – our Board, Executive and key performance indicators
- how we made a difference – our performance highlights aligned to our strategic priorities
- our financial and business performance
- significant issues impacting NMHS.

We pay tribute to our people, who have worked tirelessly in new and resourceful ways to meet the challenges of COVID-19, and who have done so with enthusiasm, dedication and compassion. Our staff have adapted, learned new skills and broadened their use of technology and digital solutions to stay connected with patients, their carers, colleagues and consumers. They have become well accustomed to using personal protective equipment, from full suits through to masks and gloves, when caring for patients with confirmed or suspected COVID-19, adapted to new work policies and practices, and delivered care in a safe manner, thus helping to prevent the spread of the coronavirus disease. Our sincere thanks to each and every one of you for the important role you have played.

We launched our new strategic plan – One team, many dreams: One integrated NMHS. Developed by the Board and the Executive with extensive input from staff, stakeholders and the community, it describes our vision, intent and focus for the next 5 years. In particular, our aspirations to 2025 are:

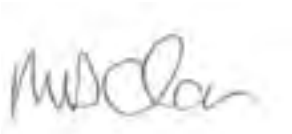
- to be a trusted partner, delivering excellent health care for our people and our communities
- to promote and improve the health of our people and communities.

The strategic plan will guide an integrated service in our journey towards improved community health outcomes, innovation and excellence as we continue our critical role in progressing the overall WA health system goals of the Sustainable Health Review.

The Board and the Executive are proud of our people and the services we offer Western Australians. We have been able to achieve positive results and progress together in 2020/21 and we look forward to 2021/22 and beyond.

Comments and feedback

We welcome your comments, feedback or thoughts on our approach or any aspect of this annual report.



Tony Dolan
Acting Chief Executive
North Metropolitan Health Service

Clinical Professor David Forbes AM
Board Chair
North Metropolitan Health Service


30 maximum

Executive summary

Overview

North Metropolitan Health Service

Since our establishment in 2016, NMHS has embraced best practice to deliver improved clinical outcomes in the face of rising challenges for all healthcare providers. With a budget of $2.16 billion and 8,917 full-time equivalent (FTE) staff, we serve a population of 736,907 people (about 28% of Western Australia's total population) within a catchment area of almost 1,000 square kilometres.

The population we serve is projected to increase by 17% between 2021 and 2031, and the number aged 65 years and older will increase by 41% over the same period.

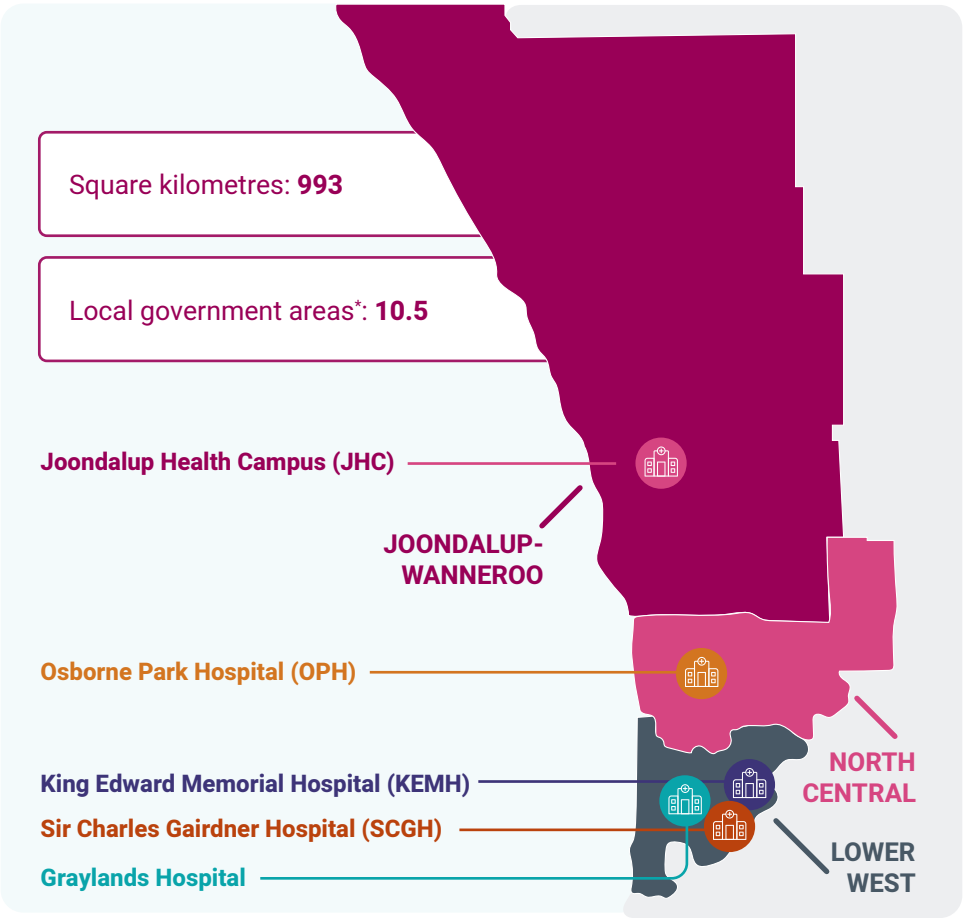
NMHS provides a comprehensive range of adult specialist medical, surgical, mental health and obstetric services in WA, delivered across 3 tertiary hospitals and 2 secondary hospitals, all fully accredited.

NMHS oversees the provision of contracted public health care from Joondalup Health Campus operated under a public–private partnership. A range of statewide, highly specialised multidisciplinary services is offered from several NMHS hospital and clinic sites.

- Sir Charles Gairdner Osborne Park Health Care Group (SCGOPHCG)
- Women and Newborn Health Service (WNHS)
- Mental Health, Public Health and Dental Services (MHPHDS)
- Joondalup Health Campus (JHC)

$2.16
billion budget

8,917
Full-time equivalent (FTE)



* Cambridge, Claremont, Cottesloe, Joondalup, Mosman Park, Nedlands, Peppermint Grove, Subiaco, Wanneroo, Stirling (94%), and Vincent. Also Swan (15%), Perth (9.8%) and Bayswater (9%).

Our goals

Vision

A trusted partner, delivering excellent health care for our people and our communities

Mission

To promote and improve the health of our people and our communities

Strategic plan

One team, many dreams: One integrated NMHS.

- Enabling healthy communities
- People-centred care
- Integration and connection
- Innovation and adaptive models of care
- Trusted, engaged and capable people
- Sustainable and reliable

Values

 Care  Respect  Innovation  Teamwork  Integrity

At a glance

How we made a difference in 2020/21

183,636
People presented to emergency department

200,270
People were admitted

91,666
Patients underwent elective surgery

840,318
Outpatient appointments provided

NMHS
10,694
births

39,566
WA Poisons Information Centre calls

17,546
Mental health patients cared for

163,667
School Dental Service patients

99.1%
peak bed capacity at Sir Charles Gairdner Hospital (SCGH)

78
Transplant patients

40 kidney

21 bone marrow

17 liver

27,458
Cancer patients received treatment

At a glance

Safety and quality

83.2%
hand hygiene compliance rate

79%
recommendation rate on Care Opinion Australia

Top 5
nationally in staff listening to consumer stories on Care Opinion Australia

+77
average Net Promoter Score

559
quality improvement projects completed

461
new quality improvement projects commenced

240
stories about NMHS shared on Care Opinion Australia

17,890
completed MySay Healthcare Surveys since 8 July 2020

8,105
incidents notified

84 (SAC 1)
722 (SAC 2)
6,883 (SAC 3)

395 awaiting SAC confirmation

2,974
registered compliments

vs **524** complaints (Datix CFM)

Launched our inaugural INSPIRE* conference with:

- **130 in-person and virtual attendees**
- **16 poster presentations**
- **25 presenters**
- **8 workshops**

* Ideas and Networks for the Safety of Patients and the Improvement of Real Experiences

SAC= Severity Assessment Code | SAC figures do not include JHC

At a glance

Research

Our research focuses on some major diseases that affect our community, changing and even saving lives. Current research projects include cystic fibrosis, stroke, dementia, liver disease and nursing practices. Our Strategic Plan 2020–2025 promotes the use of research, innovation and technology to improve health care. Guided by the plan, we aim to build research capacity and culture, and to translate findings into clinical practice, delivering better patient outcomes faster.

We achieve this through a focus on our four pillars:

- grow research capacity
- raise the profile of research
- build cohesive inter-professional research teams
- build infrastructure to support research sustainability.

Our plan for an NMHS-wide research structure to be formed is also currently underway.

COVID-19 posed a challenge to research activities this year. A number of research projects were delayed and recruitment for studies was also impacted. However, many NMHS researchers have also been successful in obtaining funding for COVID-19 directed research.

Health and medical research is supported by contributions from our partners that include the State Government, non-government organisations, not-for-profit groups and the private sector.

Published peer-reviewed journal articles, books or book chapters by our staff

39	MHPHDS	Mental Health, Public Health and Dental Services
153	WNHS	Women and Newborn Health Service
1,132	SCGOPHCG	

Current NMHS research projects*

21	COVID-related studies
129	new projects
887	continuing projects

*** Data source:** Research Governance Service (RGS). Sources of funding may include commercial, university, and state or federal government grants. All figures are estimations and were based on information that was available at the time of data entry. The actual funding that is received by NMHS may differ. Does not include monies received for projects underway that obtained approval prior to 30 June 2020.

The Sir Charles Gairdner Osborne Park Health Care Group (SCGOPHCG) Research Advisory Committee – in collaboration with the Charlies Foundation for Research – offers up to $30,000 to SCGOPHCG grant applicants to complete short-term research projects within the financial year.

Applications are reviewed by independent assessors, who score the applications against a range of criteria.

Dr Ivan Ling received the highest score in this year's round of applicants for his research proposal titled 'The effect of long-term Continuous Positive Airway Pressure therapy on sub-clinical cardiovascular disease in patients with obstructive sleep apnoea' and received the 2020 Peter Thompson Award to acknowledge this achievement.

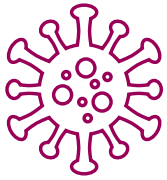
Charlies Foundation for Research generously provided $500,000 of funding for the 2020/21 projects.

At a glance

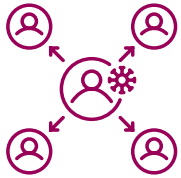
COVID-19 snapshot

All data as of 30 June 2021

80,444
COVID-19 tests performed



5,714
episodes of contact tracing



7
dedicated testing clinics

26%
increase in telehealth activity

6
positive COVID-19 cases

21
COVID-related clinical trials or research studies

2
COVID-19 hospital admissions

0
critical care admissions to ICU

Staff COVID-19 vaccinations

69.4%
of staff have received at least one dose of the AstraZeneca or Pfizer vaccine

60.9%
have received both doses

78%
have consented to receive a COVID-19 vaccine

Financial summary

Our annual budget is contained within the approved Minister for Health *Financial Management Act 2006* section 40 Annual Financial Estimates, which were developed based on the initial Service Agreement (2021).

This agreement outlines the health services to be provided by the health service provider during the term of the agreement that are within the overall expense limit set by the Department CEO, as System Manager, in accordance with the State Government's purchasing intentions.

In 2020/21, the total cost of providing state services and health services to the NMHS community was $2.3 billion. Results for 2020/21 against agreed financial targets (based on the Budget Statements) are presented on the next page.

Full details of our financial performance during 2020/21 are provided in the financial statements.

Our operations

Actual results versus budget targets

Total cost of services

(expense limit) (sourced from Statement of Comprehensive Income)

2021 Target[1] ($000) = 2,183,323
2021 Actual[1] ($000) = 2,279,398
Variation ($000) = 96,075 ⊗

Explanation of variance - key factors

- Costs incurred to manage the COVID-19 pandemic;
- Additional expenditure incurred on continuing and other services for which funding had not been included in the initial target but was recovered through budget adjustments throughout the year and at mid-year review in the form of appropriation from State Government; and
- Higher dispensing of drugs under the Pharmaceutical Benefits Scheme; offset by
- Lower spending on maintenance works (carried over to 2021/22).

Net cost of services

(expense limit) (sourced from Statement of Comprehensive Income)

2021 Target[1] ($000) = 2,019,196
2021 Actual[1] ($000) = 2,107,031
Variation ($000) = 87,835 ⊗

Explanation of variance - key factors

- Total cost of services negative variance of $96 million offset by higher recoveries from the Pharmaceutical Benefits Scheme (PBS) under Other Fees for Services.

Total equity

(sourced from Statement of Financial Position)

2021 Target[1] ($000) = 2,004,648
2021 Actual[1] ($000) = 1,916,715
Variation ($000) = 87,933 ✓

Explanation of variance - key factors

- Lower than anticipated contributed equity. This was the result of
- Lower Capital Appropriation for capital projects impacted by COVID-19 pandemic;
- $31.3 million decrease in accumulated surplus for the year; offset by
- $13.3 million increment in revaluation reserve, arising largely from Landgate's valuation of NMHS's land and buildings as at 30 June 2021.

Data source: Budget strategy and reporting: [1] As per 2020/21 section 40 Annual Financial Estimates. [2] Further explanations of variances are contained in Note 9.12 'Explanatory statement' to the financial statements.

Actual results versus budget targets (continued)

Net increase / (decrease) in cash held

(sourced from Statement of Cash Flows)

2021 Target[1] ($000) = 9,259
2021 Actual[1] ($000) = 6,748
Variation ($000) = 2,511 ⊗

Explanation of variance - key factors

- $42.4 million less Capital Appropriations received;
- $33.7 million more cash used in operating activities; offset by
- $37.8 million more Service Appropriations received; and
- $37.0 million less spending on purchases of fixed assets.

Approved salary expense level

2021 Target[1] ($000) = 1,138,738
2021 Actual[1] ($000) = 1,195,020
Variation ($000) = 56,282 ⊗

Explanation of variance - key factors

- Expenditure on services funded through budget adjustments received during the year, including costs incurred to manage the COVID-19 pandemic, not included in the initial target; offset by
- Favourable end of year accounting adjustments not included in the target.

Data source: Budget strategy and reporting: [1] As per 2020/21 section 40 Annual Financial Estimates. [2] Further explanations of variances are contained in Note 9.12 'Explanatory statement' to the financial statements.

Working cash targets

The Health Service is required to operate within an agreed working cash limit, defined as 5% of budgeted cash payments. This is detailed in the Department of Treasury's Cash Management Policy.

Financial target

Agreed working cash limit
(at budget)

2021 Agreed limit ($000) = 102,687
2021 Target / Actual ($000) = 102,867
Variation ($000) = -

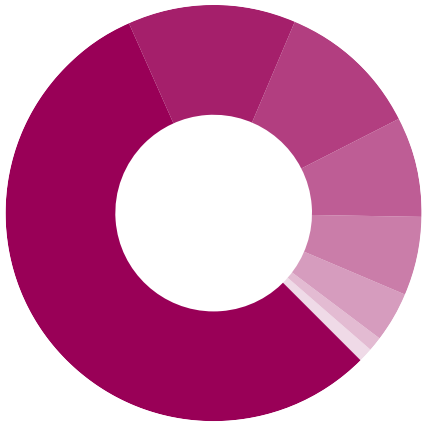
Financial target

Agreed working cash limit
(at actuals)

2021 Agreed limit ($000) = 105,132
2021 Target / Actual ($000) = 106,399[a]
Variation ($000) = 1,268

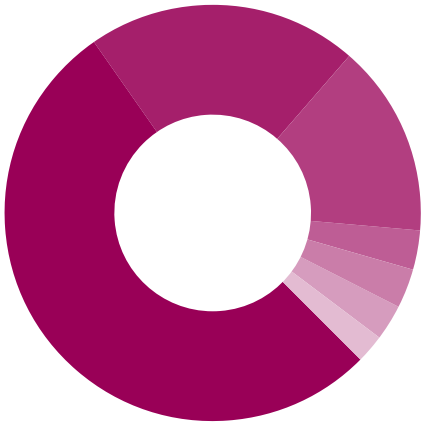
Data source: Funding plan from the NMHS Service Agreement 2020/21. [a]The Actual working cash held totals $106,399,313 which includes an amount of $8,982,090 held for Capital Project works and $44,945,324 held for restricted or contractual obligations. NMHS therefore has $52,471,899 discretionary cash of which $3,302,636 is quarantined by NMHS, primarily for research.

Our operations



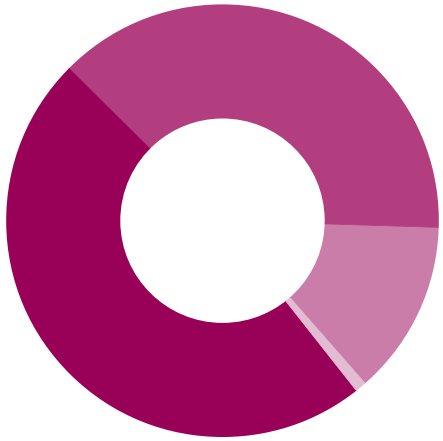
Expenses by services

- 56% | Public hospital admitted services
- 13% | Public hospital non-admitted services
- 11% | Mental health services
- 8% | Public hospital emergency services
- 6% | Public and community health services
- 4% | Community dental health services
- 1% | Aged and continuing care services
- 1% | Health system management – policy and corporate services
- 0% | Small rural hospital services



Operating expenses

- 53% | Employee benefits expense
- 21% | Contracts for services
- 15% | Patient support costs
- 3% | Other expenses
- 3% | Other supplies and services
- 3% | Depreciation and amortisation expenses
- 2% | Repairs, maintenance and consumable equipment



Income

Other than income from State Government

- 48% | Other fees for services
- 38% | Patient charges
- 13% | Other revenue
- 1% | Other grants and contributions

Summary of key performance indicators

Key performance indicators (KPIs) help us to assess and monitor the extent to which government outcomes are being achieved.

Table 1 provides a summary of our KPIs and variation from the 2020/21 targets.

Effectiveness indicators measure how well the outputs of a service achieve the stated objectives of that service. The dimensions of effectiveness include access, appropriateness and/or quality.

Efficiency indicators describe overall economic efficiency - the level of resource input required to deliver it.

Table key ✓ Desired result ✗ Undesired result

Table 1: Outcome 1 - Public hospital-based services that enable effective treatment and restorative health care for Western Australians	**2020 calendar year**			
Effectiveness KPI	**Target**	**Actual**	**Variation**	**Target met**
Unplanned hospital readmissions for patients within 28 days for selected surgical procedures				
Knee replacement	≤ 23.0	34.9	11.9	✗
Hip replacement	≤ 17.1	7.2	9.9	✓
Tonsillectomy and adenoidectomy	≤ 81.8	157.2	75.4	✗
Hysterectomy	≤ 42.3	38.3	4.0	✓
Prostatectomy	≤ 36.1	25.4	10.7	✓
Cataract surgery	≤ 1.1	1.6	0.5	✗
Appendicectomy	≤ 25.7	33.6	7.9	✗
Note: Expressed as a rate per 1000 separations				
Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days	≤ 1.0	0.6	0.4	✓
Survival rates for sentinel conditions				
Stroke				
0 to 49 years	≥ 95.2%	94.4%	0.8%	✗
50 to 59 years	≥ 94.9%	92.6%	2.3%	✗
60 to 69 years	≥ 94.1%	89.9%	4.2%	✗
70 to 79 years	≥ 92.3%	87.6%	4.7%	✗
80+ years	≥ 86.0%	85.8%	0.2%	✗

Summary of key performance indicators

Table 2: Outcome 1 - Public hospital-based services that enable effective treatment and restorative health care for Western Australians	2020 calendar year			
Effectiveness KPI (continued)	**Target**	**Actual**	**Variation**	**Target met**
Acute myocardial infarction				
0 to 49 years	≥ 99.1%	98.6%	0.5%	⊗
50 to 59 years	≥ 98.8%	99.4%	0.6%	✓
60 to 69 years	≥ 98.1%	99.1%	1.0%	✓
70 to 79 years	≥ 96.8%	97.1%	0.3%	✓
80+ years	≥ 92.1%	90.5%	1.6%	⊗
Fractured neck of femur				
70 to 79 years	≥ 98.9%	98.0%	0.9%	⊗
80+ years	≥ 96.9%	97.1%	0.2%	✓
Percentage of admitted patients who discharged against medical advice				
Aboriginal patients	≤ 2.78%	3.92%	1.14%	⊗
Non-Aboriginal patients	≤ 0.99%	0.76%	0.23%	✓
Percentage of liveborn term infants with an Apgar score of less than 7 at five minutes post delivery	≤ 1.8%	1.7%	0.1%	✓
Readmissions to acute specialised mental health inpatient services within 28 days of discharge	≤ 12%	15%	3%	⊗
Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services	≥ 75%	84%	9%	✓

Summary of key performance indicators

Table 3: Outcome 1 - Public hospital-based services that enable effective treatment and restorative health care for Western Australians	2020/21 financial year			
Effectiveness KPI	**Target**	**Actual**	**Variation**	**Target met**
Percentage of elective waitlist patients waiting over boundary for reportable procedures:				
Category 1 over 30 days	0%	11%	11%	⊗
Category 2 over 90 days	0%	14%	14%	⊗
Category 3 over 365 days	0%	5%	5%	⊗
	2020/21 financial year			
Efficiency KPI	**Target**	**Actual**	**Variation**	**Target met**
Average admitted cost per weighted activity unit	≤ $7,073	$7,330	$257	⊗
Average emergency department cost per weighted activity unit	≤ $6,853	$6,798	$55	✓
Average non-admitted cost per weighted activity unit	≤ $7,025	$7,020	$5	✓
Average cost per bed-day in specialised mental health inpatient services	≤ $1,471	$1,490	$19	⊗
Average cost per treatment day of non-admitted care provided by mental health services	≤ $421	$384	$37	✓

Summary of key performance indicators

Table 4: Outcome 2 - Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives	2019-2020 calendar years			
Effectiveness KPI	**Target**	**Actual**	**Variation**	**Target met**
Rate of women aged 50–69 years who participate in breast screening	≥ 70%	50%	20%	⊗
	2020/21 financial year			
Percentage of people who have a tooth re-treated within 6 months of receiving initial restorative dental treatment				
adults	< 7.7%	5.6%	2.1%	✓
children	< 2.6%	1.9%	0.7%	✓
Percentage of eligible school-children who are enrolled in the School Dental Service program	≥ 69%	77%	8%	✓
Percentage of eligible people who accessed Dental Health Services	≥ 15%	14%	1%	⊗
	2020/21 financial year			
Efficiency KPI	**Target**	**Actual**	**Variation**	**Target met**
Average cost per person of delivering population health programs by population health units	≤ $43	$66	$23	⊗
Average cost per breast screening	≤ $177	$168	$9	✓
Average cost per patient visit of WA Health-provided dental health programs for				
school-children	≤ $230	$225	$5	✓
socio-economically disadvantaged adults	≤ $329	$294	$35	✓

Note: For detailed information on each KPI refer to the 'Detailed information in support of key performance indicators' section of this report.

Governance

Enabling legislation

NMHS was established as a health service provider on 1 July 2016 under section 32 of the *Health Services Act 2016* (WA).

NMHS Executive Group as at June 2021

Accountable authority

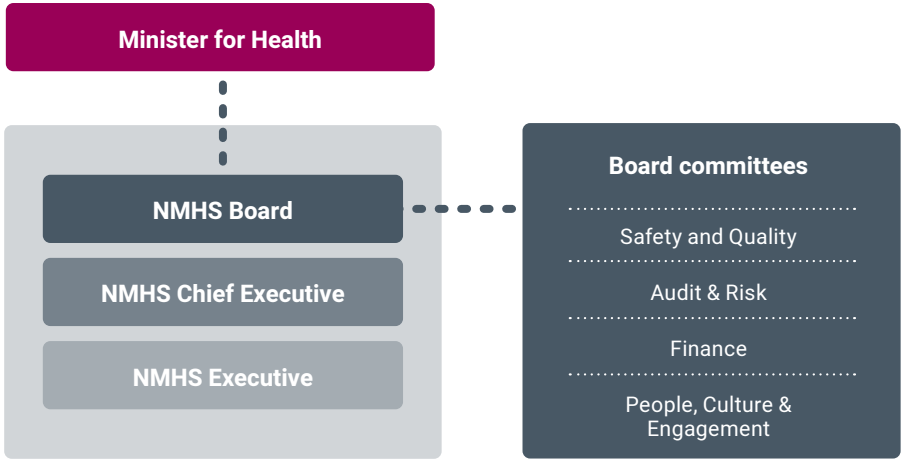
NMHS is a board-governed health service provider under section 70 of the Act.

The NMHS Board is the accountable authority for NMHS and Clinical Professor David Forbes AM is the Board Chair, with the Honorable Jim McGinty AM serving as Board Chair from July 2020 to January 2021.

Responsible Minister

NMHS is responsible to the Hon. Roger Cook MLA, Deputy Premier and Minister for Health.

Our governance structure



Board of Authority

Our Board of Authority

Under section 34 of the *Health Services Act*, the Board is responsible for the stewardship of the health service, including the governance of all aspects of service delivery and financial performance. It is also responsible for setting the direction within the scope of policy frameworks set by the Department of Health.

The Board is supported by an established structure of committees. These committees monitor various aspects of our performance, make decisions and recommendations, and help us to be responsive to emerging change.

The Minister for Health appoints Board members for terms of up to 3 years. A member is eligible for reappointment but cannot hold office for more than 9 consecutive years. Members are appointed according to their expertise and experience in areas relevant to our activities.

NMHS Board as at May 2021

Our organisational structure

Tony Dolan
A/Chief Executive

Dr Jodi Graham

Executive Director Women and Newborn Health Service

FUNCTIONS

- BreastScreen WA
- Community Midwifery Program
- Genetic Services and Familial Cancer Program of WA
- King Edward Memorial Hospital
- Perinatal Mental Health
- Sexual Assault Resource Centre
- Statewide Obstetric Support Unit
- WA Cervical Cancer Prevention Program
- WA Register of Developmental Anomalies
- Women's Health Clinical Support Programs

Stuart Windsor

Executive Director Procurement, Infrastructure and Contract Management

FUNCTIONS

- Facilities management
- Fleet management
- Infrastructure Development and Asset Investment Program
- Mail
- Metropolitan parking
- Procurement, contract management and leasing
- Property Management
- Public–Private Partnership JHC
- Security
- Strategic asset planning and delivery
- Telecommunications

Dr Theresa Marshall

Executive Director Safety, Quality, Governance and Consumer Engagement

FUNCTIONS

- Community and Stakeholder Engagement
- Corporate Governance
- Intellectual Property
- Medicolegal Services
- Safety and Quality

Jordan Kelly

Executive Director Business and Performance

FUNCTIONS

- Audit and risk
- Business information and performance Clinical planning (and Telehealth service)
- Corporate Governance
- Finance
- Integrity and ethics
- Workforce

Ros Elmes

Executive Director Mental Health, Public Health and Dental Services

FUNCTIONS

- Aboriginal Health Strategy
- Area Mental Health Services
- Dental Health Services
- DonateLife WA
- Public Health
- State Head Injury Unit

Janet Zagari

Executive Director Sir Charles Gairdner Osborne Park Health Care Group

FUNCTIONS

- Osborne Park Hospital
- Sir Charles Gairdner Hospital

Dr Ajitha Nair

Area Executive Director Clinical Services

FUNCTIONS

- Medical Education and Research
- Medical Governance
- Medical Workforce

Amanda McKnight

A/Area Executive Director Nursing and Midwifery Services

FUNCTIONS

- Medical Equipment Replacement Program
- Nursing and Midwifery Education and Research
- Nursing and Midwifery Governance
- Nursing and Midwifery Workforce

Nicole Bennett

Director Office of the Chief Executive

FUNCTIONS

- General Counsel
- Board Support
- Ministerial and Parliamentary Liaison
- Staff Travel
- Office of Chief Executive Support
- Corporate Communications
- Innovative Future Program
- Specific Organisational Projects

Board profiles

Clinical Professor David Forbes AM

Board Chair
Chair, Safety and Quality Committee
Member, NMHS Board Finance Committee

David has had a career in academic paediatrics, working primarily as a paediatric gastroenterologist. He has worked in paediatric emergency medicine, general and rural paediatrics and child and adolescent mental health. He led undergraduate teaching in paediatrics vocational training at Princess Margaret Hospital for Children (PMH) at different times. David was a member and then Chair of the Royal Australasian College of Physicians' Paediatric Physician Training Committee, and the Division of Paediatrics and Child Health Policy for The University of Western Australia, and Advocacy Committee. He has also held roles in health service management as the Chair of Paediatric Medicine at PMH, and as a Clinical Advisor and Acting Chief Medical Officer in the Department of Health.

Mr Grant Robinson

(1 July 2018 to 14 May 2021)
Chair, Finance Committee
Member, Audit and Risk Committee

Grant is a former partner of KPMG in the Audit, Assurance and Risk Consulting Division, a Fellow Chartered Accountant (FCA) and has many years of experience as a board and committee member of various not-for-profit organisations. His expertise includes governance, risk management, financial analysis, audit, accounting and compliance. His current and recent board roles include Bethesda Health Care, Juniper, Zoological Parks Authority (Chair), Netball WA (President), Botanic Gardens and Parks Authority (Deputy Chair) and the Perth Festival.

Ms Rebecca Strom

Deputy Board Chair
Chair Audit and Risk Committee
Member, Finance Committee

Rebecca is a partner at Thomson Geer Lawyers and has extensive national experience as a commercial property lawyer. She was previously a partner at Corrs Chambers Westgarth and is currently a non-executive director of Access Housing Australia and Chair of the Governance Committee. Rebecca is also a member of the Executive Finance and Property Committee of the Western Australian Planning Commission.

Board profiles

Professor Selma Alliex

Member, Safety and Quality Committee
Member, People, Culture and Engagement Committee

Selma is the Pro-Vice Chancellor, Head of Fremantle Campus University of Notre Dame. Previously, Selma was Dean of the School of Nursing and Midwifery at the university, responsible for nursing programs in Fremantle and Broome. Selma has been on the boards of several nursing and non-nursing organisations, including research committees. She is the immediate past chair of the Human Research Ethics Committee at the University of Notre Dame Australia and has worked at the university for 18 years in roles ranging from lecturing and research supervision to administration. Selma currently oversees the university's Department of Rural Health based in the Kimberley.

Ms Angela Edwards

Member, Audit and Risk Committee
Member, People, Culture and Engagement Committee

Angela has an extensive background in human resources, industrial relations, change management, organisational development and stakeholder management. She formerly held the role of Human Resources Director Asia Pacific at CHC Helicopter Australia and was General Manager of Human Resources at Crown Perth. Angela is also a board member of the not-for-profit cancer support group, Blue Dot Army.

Dr Hilary Fine

Chair, People, Culture and Engagement Committee
Member, Safety and Quality Committee

Hilary has been a GP in urban and rural general practice for over 30 years. She is Principal GP and Medical Director at East Fremantle Medical Centre and Adjunct Associate Professor at Notre Dame University. Hilary has held director and chair positions on the boards of local, state and national not-for-profit primary care organisations together with the Royal Australian College of General Practitioners and the External Advisory Board, Notre Dame.

Ms Kim Farmer

Member, Finance Committee
Member, People, Engagement and Culture Committee

Kim is a criminal defence lawyer, working for many years at the Aboriginal Legal Service WA and as a sole practitioner. She is currently Principal Lawyer of her own criminal defence legal firm, Farmer Legal. Kim has also worked in other areas of the law, including supporting people affected by family violence and child sexual abuse. She is a board member of the Graham (Polly) Farmer Foundation, supporting Aboriginal children in aspirational education programs; community membership with the Prisoner Review Board WA and board representation on a WAFL football team and the Indigenous Players Alliance.

Board profiles

Professor Paul Norman

Chair, Safety, Quality and Consumer Engagement Committee
Member, Audit and Risk Committee

Paul is a Consultant Vascular Surgeon at the Fiona Stanley Hospital Group, and Emeritus Professor of Surgery and Senior Honorary Research Fellow at The University of Western Australia. He is an active clinical researcher with interests in abdominal aortic aneurysm, and peripheral and diabetic arterial disease. Doctor of Surgery; Fellow of the Royal Australasian College of Surgeons; Fellow of the Royal College of Surgeons; Bachelor of Medicine and Surgery; Bachelor of Science (Hons).

Ms Paula Rogers

(commenced 18/01/2021)
Member, People, Culture and Engagement Committee

Paula has significant experience in stakeholder management, communications, marketing and business development. She directs her own consulting firm, providing thought leadership, stakeholder engagement, communication strategy, marketing and event advice. She is also a Board Member of the Barking Gecko Theatre Company and an independent director on the Edith Cowan College Board. Paula has worked in a variety of senior roles in WA, including most recently as the State Director of the Committee for Economic Development of Australia (CEDA). Before this, Paula was employed in roles including managing director and event management CEO and publisher. Paula holds a Bachelor of Social Science, University College Dublin; and is a Member of the Australian Institute of Company Directors.

Mr Steve Toutountzis

Member, Finance Committee
Member, Audit and Risk Committee

Steve is a certified practising accountant and has an extensive background in finance, procurement, public sector service delivery and policy at an executive and strategic level. In his former role as Director, Performance and Evaluation – Group 1, Department of Treasury, his responsibilities included analysis and strategic advice to the government on budgetary and financial management issues impacting a range of portfolios, including Health. He is currently a member of the Board of Commissioners, Legal Aid Western Australia.

Outcome-based management framework

The outcome-based management (OBM) framework is a Department of Treasury mandatory requirement for State Government agencies.

The OBM framework describes how outcomes, services and key performance indicators (KPIs) are used to measure the performance of the WA health system towards the State Government goal of 'Strong communities, safe communities and supported families' and the WA Health agency goal of 'Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians'. The KPIs measure the effectiveness and efficiency of the services delivered against agreed government priorities and desired outcomes.

As a health service provider, NMHS is responsible for delivering and reporting against the following outcomes and services:

Outcome 1 - Public hospital-based services that enable effective treatment and restorative health care for Western Australians	**Outcome 2** - Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives
Service 1 - Public hospital admitted services	Service 5 - Aged and continuing care services
Service 2 - Public hospital emergency services	Service 6 - Public and community health services
Service 3 - Public hospital non-admitted services	Service 8 - Community dental health services
Service 4 - Mental health services	Service 9 - Small rural hospital services

Performance against these activities and outcomes is summarised in Tables 1–4 and subsequently described in detail in the section Detailed information in support of KPIs.

Changes to OBM framework

The OBM framework was implemented for annual reporting from 2017/18. There were no material changes to the framework in 2020/21.

Shared responsibilities with other agencies

NMHS works closely with the Department of Health, as the System Manager, and partners with other agencies, both government and non-government, in delivering health services to achieve the stated desired outcomes of the OBM framework.

Notes: NMHS provides some aged and continuing care services (Service 5); however, most are provided by the Department of Health on our behalf.

The Find Cancer Early program is an election commitment-funded program (Service 9). It aims to educate people throughout regional Western Australia about the signs and symptoms of cancer, which will lead them to seek help from a doctor. The program is being administered by the NMHS via the Cancer Council Western Australia and the messages are being delivered through partnerships with community organisations, local media, radio and newspaper advertisements, presentations and campaign resources across 7 regions (Goldfields, Wheatbelt, Great Southern, Pilbara, Kimberley, Midwest and Southwest). Resources are also focused on hard-to-reach audiences, specifically remote and Aboriginal and Torres Strait Islander people.

No performance measures are reportable for services 5, 7, 9, 10 and 11 as per the OBM framework.

Performance management framework

WA Government goal: Strong communities, safe communities and supported families

WA Health goal: Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians

Outcome 1 - Public hospital-based services that enable effective treatment and restorative health care for Western Australians

Effectiveness KPIs

- Unplanned hospital readmissions for patients within 28 days for selected surgical procedures
- Percentage of elective waitlist patients waiting over boundary for reportable procedures
- Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days
- Survival rates for sentinel conditions
- Percentage of admitted patients who discharged against medical advice
- Percentage of liveborn term infants with an Apgar score of less than 7 at five minutes post delivery
- Readmissions to acute specialised mental health inpatient services within 28 days of discharge
- Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services

Efficiency KPIs

Service 1 Public hospital admitted services	Service 2 Public hospital emergency services	Service 3 Public hospital non-admitted services	Service 4 Mental health services
Average admitted cost per weighted activity unit	Average emergency department cost per weighted activity unit	Average non-admitted cost per weighted activity unit	• Average cost per bed-day in specialised mental health inpatient services • Average cost per treatment day of non-admitted care provided by mental health services

Performance management framework

WA Government goal: Strong communities, safe communities and supported families

WA Health goal: Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians

Outcome 2 - Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives

Effectiveness KPIs

- Rate of women aged 50–69 years who participate in breast screening
- Percentage of adults and children who have a tooth re-treated within 6 months of receiving initial restorative dental treatment
- Percentage of eligible school-children who are enrolled in the School Dental Service program
- Percentage of eligible people who accessed Dental Health Services

Efficiency KPIs

Service 6 - Public and community health services	Service 8 - Community dental health services
• Average cost per person of delivering population health programs by population health units • Average cost per breast screening	Average cost per patient visit of WA Health provided dental health programs for school-children and socio-economically disadvantaged adults


MIDWIFE

Our service network

Our hospital network

NMHS hospitals

Sir Charles Gairdner Hospital (SCGH)

Osborne Park Hospital (OPH)

King Edward Memorial Hospital (KEMH)

Graylands Hospital

Joondalup Health Campus (JHC)

Our hospital network

Sir Charles Gairdner Osborne Park Health Care Group

Formed in 2012, the Sir Charles Gairdner Osborne Park Health Care Group (SCGOPHCG) consists of Sir Charles Gairdner Hospital and Osborne Park Hospital. The group provides services in the inpatient, outpatient and community settings to a diverse population across a broad range of specialty areas.

The group configuration provides the flexibility to provide the right care at the right site for each of our patients, balancing demand and service provision between the 2 sites. Since 2019/20, the leadership teams have been working under the umbrella of the 'one service, two sites' philosophy. This ensures we operate as a single team providing seamless care from the doors of the emergency and outpatient areas through to inpatient, specialty same day and rehabilitation units, and back into the community. SCGOPHCG currently employs 4,864 full time equivalent staff.

Sir Charles Gairdner Hospital
630 beds

Osborne Park Hospital
187 beds

Specialist
154 beds

+

Maternity (WNHS)
33 beds

Sir Charles Gairdner Hospital

The tertiary-quaternary campus for the group, SCGH provides clinical services to adults, including trauma, emergency and critical care, orthopaedics, general medicine, general surgery and cardiac care. Tertiary and quaternary care require highly specialised equipment and expertise. A single provider is the best model for some services such as liver transplantation.

SCGH opened in 1958 and treated 177,436 patients and provided 443,454 outpatient appointments this year.

Located at the QEII Medical Centre, the co-location of SCGH with significant research facilities and university facilities provides opportunities for collaboration. The thriving research community has many active research projects underway this year.

This number will only grow, and SCGH is able to offer students from all health disciplines exposure to a wide range of clinical experiences and a strong ethos of pursuit of research, education and clinical excellence.

Osborne Park Hospital

Established in 1962, OPH is the other integral part of the group. As a specialist hospital, OPH staff focus on the provision of aged care and rehabilitation services; elective surgery; gastroenterology and urology same-day surgical activity; obstetrics and gynaecology. With a busy medical imaging (radiology) department, OPH serves as the lower acuity site for the group.

OPH treated 15,753 patients, and provided 87,842 outpatient appointments this year.

The $24.9 million redevelopment of OPH completed this year includes a purpose-built rehabilitation unit with additional bed capacity, and a specialised 'therapy hub' that supports the delivery of multidisciplinary therapy.

The OPH Women and Newborn Health Services delivered 1,436 babies in 2020/21, bringing a new generation into the world and allowing women to deliver closer to home. A new Neonatal Nursery and Maternal Assessment Unit was completed as part of the redevelopment and will allow babies to receive care closer to their families when they need the support of a special care nursery.

Women and Newborn Health Service

The Women and Newborn Health Service provides clinical care to women and families. It comprises King Edward Memorial Hospital, the Maternity Unit at Osborne Park Hospital and other specialist health services.

The Women and Newborn Services at Osborne Park Hospital merged with WNHS in 2020. The new service became part of the overall Women and Newborn Health Service. The merging of the two services created a synergy for women's healthcare options, encouraging greater opportunity for cross-site communication and collaboration. The new service is an additional pregnancy care option for women, all governed by WNHS.

Established in 1916, KEMH is the State's largest maternity hospital and the only referral centre for complex, high acuity pregnancies in WA.

WNHS employs 1,277 FTE who provide care for more than 45,005 gynaecological occasions of service with conditions including general gynaecology, gynae-oncology, endometriosis, IVF and urogynaecology.

Our holistic range of services includes specialist reproductive medicine and fertility clinics, Genetic Services of Western Australia, Sexual Assault Resource Centre, statewide Perinatal and Infant Mental Health Program, WA Register of Developmental Anomalies, WA Cervical Cancer Prevention Program, BreastScreen WA, Mother and Baby Unit, statewide Obstetric Support Unit and Women's Health Strategy and Programs.

There were **6,551 births at King Edward Memorial Hospital** last year, with 60% of women needing high acuity care. The Maternity Unit at **Osborne Park Hospital delivered 1,437 babies** in 2020/21.

Women in the northern corridor are offered an array of continuity of care birthing options across our sites, including in the hospitals, in the home and in the family birth centre.

General obstetrics and maternal fetal medicine specialist services are available for women with high-risk pregnancies, and specialist clinics are provided in the areas of diabetes, dietetics, the Women and Newborn Drug and Alcohol Service (WANDAS), Childbirth and Mental Illness (CAMI) and Adolescent Pregnancies.

6,551 births at King Edward Memorial Hospital

147 home births by Community Midwifery Practice

160 beds at KEMH (obstetric and gynaecology)

92 beds at KEMH NICU

Extensive postnatal care is provided, including breastfeeding, psychological medicine, social work, occupational therapy, physiotherapy, dietetics and pastoral care.

The Child and Adolescent Health Service Neonatal Intensive Care Unit (NICU) onsite at KEMH comprises **92 beds** for prematurely born or sick babies.

Our hospital network

Mental Health, Public Health and Dental Services

Mental Health

Our Mental Health directorate provides youth, adult, older adult, forensic and statewide mental health services in a variety of settings that include inpatient services, community mental health centres, day therapy, outreach and in people's homes.

These services are delivered by multidisciplinary teams comprising medical, nursing and allied health professionals who provide high-quality programs that are evidence-based, person-centred and recovery-focused.

Facilities include:

- **Graylands Hospital (121 beds)** provides acute, extended care and rehabilitation services
- **Sir Charles Gairdner Hospital Mental Health Service (38 beds)** services an authorised unit and an Observation Area adjacent to the Emergency Department
- **Selby Lodge and Osborne Lodge (58 beds)** provide older adult mental health services
- **State Forensic Mental Health Service – Frankland Centre (30 beds)** is a medium secure inpatient facility for mentally ill offenders on the Graylands Hospital Campus
- **Hospital in the Home (HITH) (48 virtual beds)** provides acute care to youth, adult and older adults in their own home as an alternative to admitted hospital care.

Our Mental Health Service also provides consultation liaison service to SCGH, a psychiatric liaison within the SCGH emergency department, a specialist statewide eating disorders outreach and consultant service and a day therapy service providing electroconvulsive therapy (ECT) and transcranial magnetic stimulation (TMS). TMS is a noninvasive procedure that uses magnetic fields to stimulate nerve cells in the brain to improve symptoms of depression.

Our Community Mental Health Service delivers a range of services in community clinics and home settings for people in partnership with consumers, their families, carers, GPs, professional groups and community-managed organisations. Adult and youth mental health clinics are located in Joondalup, Butler, Mirrabooka, Osborne Park, Subiaco, Wembley and many other locations close to public transport.

Admitted and Community Mental Health Services are supported by several dedicated teams based on the Graylands Hospital Campus, including;

- Centre for Clinical Interventions
- Clinical Research Centre
- Creative Expression Centre for Arts Therapy
- Mental Health Pharmacy Service
- MHPHDS Safety Quality and Performance Unit
- Patient Support Services
- Professional Education and Training
- Psychiatric Services Library.

Infection Prevention and Control, also based Graylands, provides a flexible and responsive program to meet the needs of MHPHDS. The team support our staff by advising on standards, practices, clinical care and interventional programs, including staff vaccination programs and specialist COVID-19 related initiatives.

Mental Health inpatient services
247 beds

Hospital in the Home
48 virtual beds

Our hospital network

Mental Health, Public Health and Dental Services (continued)

Public Health

Our Public Health team provides a range of services to protect, promote and improve the health of whole populations, with a focus on the prevention of disease and the promotion of good health.

Services include Metropolitan Communicable Disease Control, Health Promotion, the WA Tuberculosis Control Program, DonateLife (organ and tissue donation), the State Head Injury Unit and the Humanitarian Entrant Health Service.

Dental Health

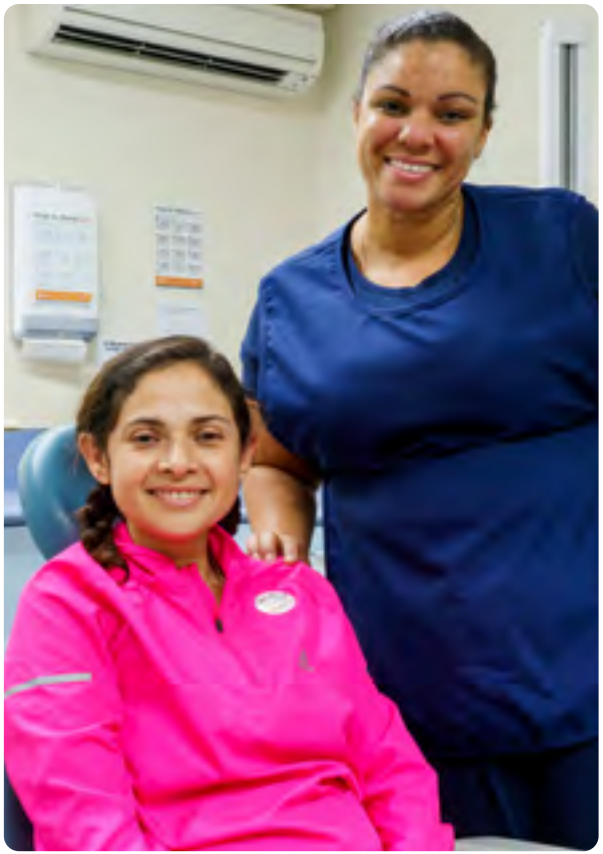
Dental Health Services is the largest public dental service in WA. It consists of **730 FTE** who provide oral health services to children aged 5 to 16 through the statewide School Dental Service, general and emergency dental care for eligible people through metropolitan and country general dental clinics, dental services to eligible clients of the Department of Communities and treatment to residents in metropolitan aged-care and corrective services facilities. Dental Health Services also provides dental care for mental health patients at Graylands Hospital.

Aboriginal Health Division

The Aboriginal Health Division team implements our Aboriginal Health Strategy. The team are responsible for the development and delivery of Aboriginal strategic programs throughout the North Metropolitan region.

Their goal is to improve health outcomes for Aboriginal people through improving access to culturally secure services and by promoting engagement with the Aboriginal communities and consumers. The strategy also aims to increase representation within the NMHS workforce of staff who identify as Aboriginal.

The team has a strong focus in community-based mental health, public health and dental promotional services. Aboriginal Health Liaison Officers provide a range of culturally appropriate care and support services based on the needs of inpatients, including patients on long-term oncology and dialysis therapies.



DHS developed a social storybook titled Maggie Goes to the Dentist as an anxiety management tool for patients with autism spectrum disorder

Joondalup Health Campus

Joondalup Health Campus 572 beds (public)

We provide comprehensive services to public patients at the Joondalup Health Campus (JHC) through a public–private partnership with Ramsay Health Care.

JHC is one of WA's largest hospitals, serving more than **73,000 inpatients annually**. It offers a range of medical and surgical services including critical care, interventional cardiology, maternity, neonatal and paediatric services, aged care and rehabilitation.

In 2020/21, the JHC emergency department responded to over **107,000 presentations** with a dedicated paediatric area and a 10-bed mental health observation area within the ED. The JHC also contains a purpose-built Mental Health Unit that includes secure accommodation.

JHC is expanding with the construction of a new 77-bed inpatient mental health building with 30 additional inpatient beds; 90 inpatient beds in a design to meet future demand, a 12-bed ED expansion; a Behavioural Assessment Urgent Care Clinic, 6 critical care beds, an operating theatre and a cardiac catheter laboratory.

2,560
births at JHC (public)

73,000
inpatients annually

572 beds
(beds, bays and birth suites)
Joondalup Health Campus

Our community

NMHS population: 727,059

28% of WA's population

38% born overseas

20% culturally and linguistically diverse

- **40%** of NMHS population aged 45 years and above, 41% are 15–44 years
- **64%** of adults are considered to be overweight or obese
- **53%** of adults do not eat 2 serves of fruit a day as per recommended guidelines
- **90%** of adults do not eat 5 serves of vegetables as per recommended guidelines
- **36%** of adults reported doing less than 150 minutes of physical activity per week
- **15%** of adults reported consuming alcohol at levels deemed short-term high risk
- **15%** of adults reported mental health problems diagnosed by a doctor last year
- **7%** of adults currently smoke

* Based on sample of adults aged 16 years and over in North Metropolitan Health Service.

Hospitals: 5

Employees: 8,917 (FTE)

Main reasons for hospitalisation between 2015 and 2019:

- dialysis (10.1%)
- chemotherapy (7.3%)
- diseases of the eye and adnexa (5.7%)

Main reasons for deaths between 2014 and 2018:

- ischaemic heart diseases (12.7%)
- dementia (7.7%)
- cerebrovascular diseases (5.8%)

Most commonly diagnosed cancers between 2014 and 2018:

- prostate gland (15.6%)
- breast (14.8%)
- melanoma (11.3%)

Most common outpatient appointments:

- midwifery and maternity (13.8%)
- radiation therapy treatment (4.3%)
- orthopaedics (4.1%)

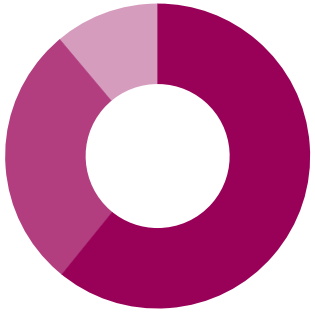
Our people

Overview of employment profile

All data as of 30 June 2021

In these charts, the total employee number is 12,032.

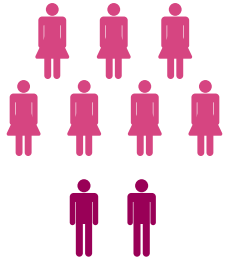
Headcount by job type



- Permanent: 7,343 | 61%
- Fixed term: 3,354 | 28%
- Casual: 1,335 | 11%

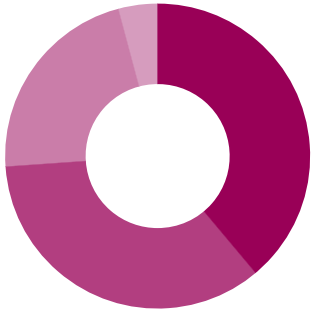
Women in leadership

(Tier 2 positions)



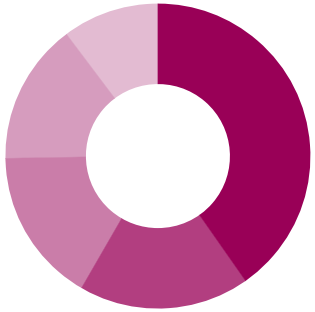
- 7 | 77.8%
- **Men: 2 | 22.2%**

Employees by generation



- Baby boomers 1946–1964 | 2,689 | 22%
- Gen X 1965–1980 | 4,160 | 35%
- Gen Y 1981–1996 | 4,668 | 39%
- Gen Z 1997–2015 | 515 | 4%

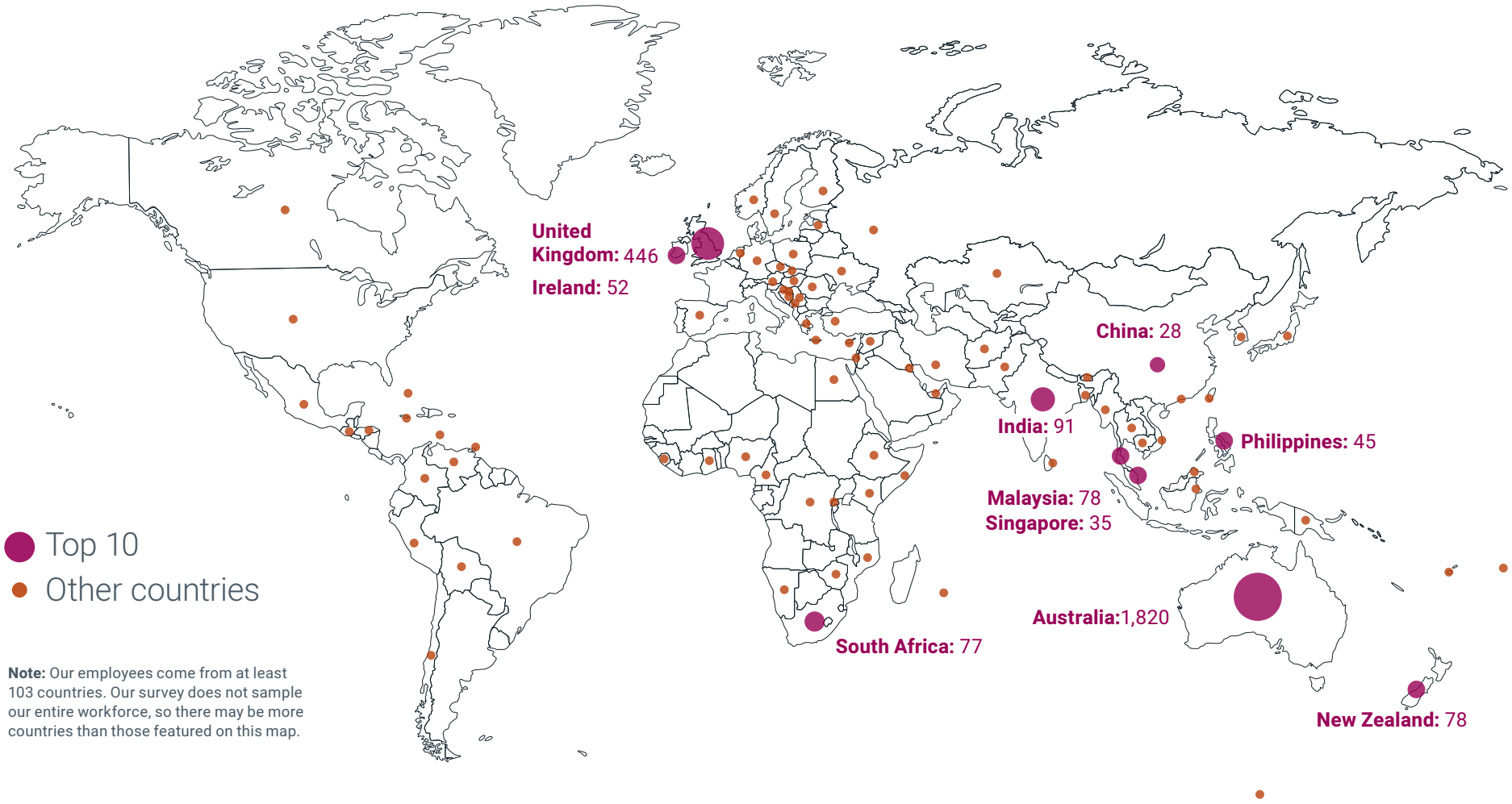
Headcount by occupational group



- Nursing & Midwifery: 4,864 | 40%
- Hotel & Site Services: 1,260 | 10%
- Medical Services: 1,807 | 15%
- Medical Support Services: 2,118 | 18%
- Administration & Clerical: 1,983 | 16%

Our people

Employees by country of birth



Note: Our employees come from at least 103 countries. Our survey does not sample our entire workforce, so there may be more countries than those featured on this map.

Encouraging diversity and multiculturalism

Diversity

A diverse and inclusive workforce has a positive effect on our productivity in shaping effective and evidence-based policy, embedding our position as an employer of choice and building the confidence and capabilities of our people.

For our community, a diverse and inclusive workplace means:

- a greater appreciation of different ways of thinking and working
- a broader understanding of the needs of our community
- an enhanced ability to serve the needs of our community
- innovation and solutions driving greater productivity
- improved connections.

For our employees, a diverse and inclusive workplace means:

- flexibility to balance work, family and personal responsibilities
- an equitable, respectful, open and supportive work environment
- access to a broad range of skills, experiences and perspectives.

We acknowledge the need to remove conscious and unconscious biases and stereotyping from recruitment processes and the workplace.

We also seek to reap the benefits of having a workforce that reflects our patient base. This will strengthen engagement and partnership with patients, carers and our community and deliver better patient health outcomes.

This year, work continued on our new Diversity and Inclusion Strategy with action plans developed for each of the following:

- women
- youth (24 years and under)
- Aboriginal and Torres Strait Islander people
- culturally and linguistically diverse people
- people with disability
- people of diverse sexualities and genders.

Our milestones and achievements included:

Partnering with National Disability Services to improve employment outcomes for people with disability. Together, we developed or made available resources and training materials to promote disability awareness and promote inclusive and accessible recruitment practices for people with disability. These materials will be released on a webpage and incorporated into a new training package.

Establishing an LGBTQIA+ working group to help create a safe environment for staff and patients of diverse sexualities and genders. The LGBTQIA+ acronym is intended to extend to all those who are part of the wider diversity of bodies, genders, sexualities, relationships and identities. Key achievements in 2020/21 include the development of a webpage for staff and multi-site celebrations of IDAHOBIT (International Day Against Homophobia, Biphobia, Interphobia & Transphobia). IDAHOBIT celebrates LGBTQIA+ people globally, and raises awareness for the work still needed to combat discrimination. It is celebrated each year on May 17.

Encouraging diversity and multiculturalism

Multicultural plan

Western Australia is the most culturally diverse state in Australia, with Aboriginal people, migrants and refugees accounting for nearly 30% of the population.

Our workforce reflects the wider population and we are committed to creating an inclusive work environment that recognises individual and cultural differences.

Our Strategic Plan 2020–2025 will help us build strong connections and partnerships with culturally and linguistically diverse (CaLD) communities, resulting in improved health and workforce outcomes. It will be complemented by our Multicultural Plan 2021–24. This plan demonstrates how we will implement the WA Multicultural Policy Framework (WAMPF), which was endorsed by Cabinet in February 2020. Our plan identifies strategies we can undertake to reflect the 3 priority areas outlined in the framework.

Priority areas of the WAMPF	NMHS strategic priorities
Priority 1 – Harmonious and inclusive communities	• Enabling healthy communities • People-centred care • Integration and connection • Innovation and adaptive models of care • Trusted, engaged and capable people • Sustainable and reliable
Priority 2 – Culturally responsive policies, programs and services	
Priority 3 – Economic, social, cultural, civic and political participation	

Actioning these priorities will help people from CaLD backgrounds to reach their highest potential in our workplace and ensure our services are inclusive and accessible for everyone, irrespective of first language or cultural heritage.

The Multicultural Plan also embraces the principle of substantive equality. This principle is a fundamental aspect of human rights law that is concerned with equitable outcomes and equal opportunities for disadvantaged and marginalised people and groups in society.

Key elements of the plan include:

- developing a communications strategy to promote diversity and inclusion, training and cultural inclusion events
- building cultural awareness
- educating people to prevent conscious and unconscious bias, discrimination and harassment
- partnering with CaLD clients and employees to review, co-design and develop strategies, services and employment practices to improve outcomes for CaLD populations.

Aboriginal health and employment

As at June 2021, the proportion of our staff identifying as Aboriginal and Torres Strait Islander was 0.7%, increasing from 0.6% the previous year.

We are committed to engaging, developing and retaining Aboriginal people in our workforce and supporting inclusion within and outside of NMHS.

During the year, we developed our Aboriginal Health and Wellbeing Strategy. It outlines the key issues that affect Aboriginal people in our health community and workforce. It explains how we will address those needs and measure our progress. Three main priorities as identified by Aboriginal communities are:

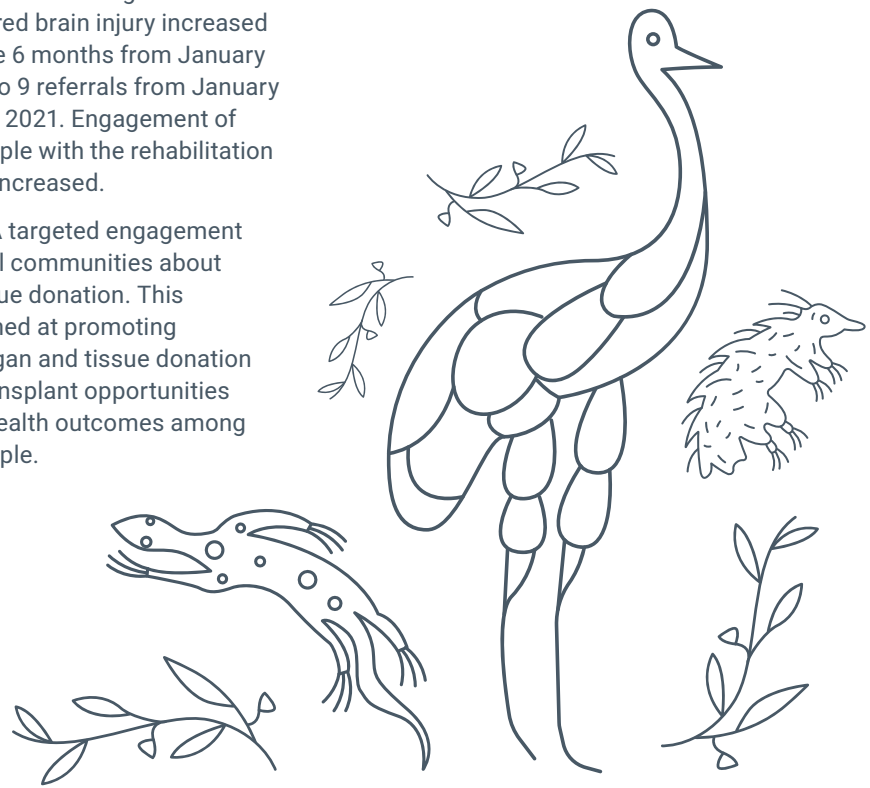
- **Cultural security** – improving our services so that Aboriginal people feel culturally secure using them
- **Consumer engagement** – listening to, and acting on, what Aboriginal people are telling us
- **Aboriginal workforce** – prioritising employment and career development of Aboriginal people in our workforce.

In addition, we provided a range of healthy lifestyle and health promotion programs that meet the specific needs of Aboriginal people.

Dental Health Services (DHS) continued to partner with 10 Aboriginal Medical Services in regional locations to provide oral health care in a culturally safe environment for Aboriginal people. DHS contracts the Royal Flying Doctor Service to provide oral health care to Ngangganawili Aboriginal Health Service and Ngaanyatjarra Health. It also reviews and updates oral health promotion material to ensure it is appropriate for both Aboriginal and CaLD communities.

The State Head Injury Unit (SHIU) and NMHS Aboriginal Health worked together to streamline referral processes and improve access to rehabilitation services and community linkages for Aboriginal clients with an acquired brain injury. As a result, referrals to SHIU for Aboriginal clients following aquired brain injury increased from one in the 6 months from January to June 2020 to 9 referrals from January 2020 to March 2021. Engagement of Aboriginal people with the rehabilitation program also increased.

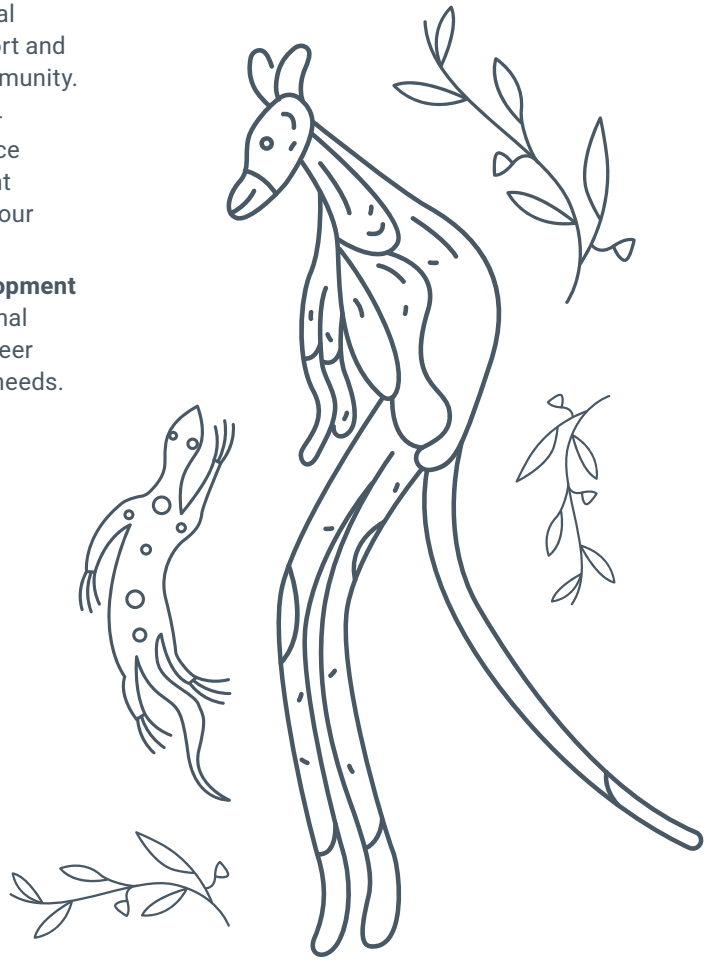
DonateLife WA targeted engagement with Aboriginal communities about organ and tissue donation. This initiative is aimed at promoting support for organ and tissue donation to increase transplant opportunities and improve health outcomes among Aboriginal people.



Aboriginal health and employment

Our future workforce needs to reflect our patient base. To better attract and recruit Aboriginal employees to NMHS, we implemented the following initiatives:

- **Targeted Aboriginal recruitment** – applying sections 50d and 51 of the *Equal Opportunity Act 1984* in our recruitment processes.
- **Developing Aboriginal leaders** – 3 nominees from NMHS attended the 2021 First Step Aboriginal Leaders Program and 4 are participating in the Aboriginal LEAD program.
- **Establishing partnerships with TAFE** – across the north and south metropolitan areas to attract students to a career in health and to enhance our reputation as an employer of choice. We are also seeking to establish partnerships with other educational institutions and community organisations to create pipelines to recruit Aboriginal people.
- **Aboriginal cadetship program** – designed to provide Aboriginal university students with an opportunity to gain an income while studying full-time for an undergraduate degree and to develop work readiness for future employment in WA Health. In 2021, NMHS hosted 5 Aboriginal cadets on placements across the service in both corporate and clinical disciplines.
- **Aboriginal traineeship program** – we participated in the Public Sector Commission Aboriginal traineeship program. It provides an entry pathway for Aboriginal people aged 24 or under to a career in the public sector. Trainees receive on-the-job training while completing a nationally recognised Certificate III in Government. Many areas of NMHS nominated to host a trainee, with demand for trainees always exceeding supply.
- **Certificate II in Health Support Services** – NMHS is developing a nationally accredited qualification as part of an Aboriginal traineeship program in Patient Support Services.
- **Aboriginal employee network** – building a network of Aboriginal employees to offer peer support and connect to the Aboriginal community.
- **Aboriginal health dashboard** – analysis of Aboriginal workforce data to inform the development of targeted strategies to grow our Aboriginal workforce.
- **'Our Time' professional development workshops** – to assist Aboriginal employees to identify their career aspirations and development needs.




STAFF
STAFF

How we made a difference

One team, many dreams

Our Strategic Plan 2020–2025

Over the next 5 years, we are focusing on 6 strategic priorities:

Our Strategic Plan guides NMHS in our journey towards innovation and excellence. It was developed in collaboration between the Board and Executive, staff and consumers to understand how we can deliver services differently and improve the experience for our community.

Enabling healthy communities – we will build healthy and engaged communities

- We will empower people in our communities to live healthy lives
- We will co-design and collaborate to improve services and deliver community centred care
- We will partner to improve the health of people in the first and last 1000 days of life

Integration and connection – we will build strong connections and partnerships

- We will integrate service, business and finance delivery
- We will remove barriers to integrated service delivery
- We will lead the way in collaborating with other health services

Trusted, engaged and capable people – we will invest in our people and our culture

- We will prioritise the wellbeing of our people
- We will demonstrate our values in everything we do
- We will encourage our people to have a go
- We will inspire our people to be their best selves

People-centred care – we will place our consumers' and their carers' best interests and experience at the core of all we do

- We will provide services that recognise individuals, their abilities and cultures
- We will listen to our consumers and carers about what matters to them
- We will respect the consumer and carer as essential members of the healthcare team
- We will ensure our health services deliver the best care, all the time

Innovation and adaptive models of care – we will use research, innovation and technology to improve outcomes

- We will utilise advances in technology
- We will design and deliver care in the most appropriate setting
- We will be creative and innovative in how we deliver care
- We will collaborate with other communities to develop care pathways

Sustainable and reliable – we will reduce harm, waste and unwarranted variation

- We will seek to have the resources we need to deliver the best care
- We will provide quality services in a sustainable manner

Our performance highlights

NMHS aims to provide the community with confidence in the delivery of health care through excellence, new ways of working and positive cultural change. Here, we highlight some of our achievements in 2020/21 according to the 6 strategic priorities from Our Strategic Plan 2020–2025.

Strategic priorities

Enabling healthy communities

Dental Health Services (DHS) joins with volunteer and non-government organisations to provide dental care to people in rural and remote communities. Our partners include the Royal Flying Doctor Service, which provides oral health care for up to 600 Aboriginal patients each year, and the Kimberley Aboriginal Medical Services Council. Because of these partnerships, Aboriginal communities in Port Hedland, Roebourne, Geraldton, Carnarvon, Kalgoorlie, Broome, Derby, Kununurra, Halls Creek, Wiluna and Warburton can access dental care either through dental clinics within an Aboriginal Medical Service facility or through visiting dental services.

DHS also partnered with Clontarf Aboriginal College, which provides learning opportunities for students from Year 7 to Year 12. Students painted vibrant artwork, representing acceptance, unity and the Noongar 6 seasons, on a dental van used to deliver mobile services. DHS General Manager Sam Carrello said the collaboration was a great success, helping to raise awareness of Aboriginal culture and contributing to the students' sense of pride.

The SCGH Speech Therapy Department developed a video to help Aboriginal patients through the life-changing process of laryngectomy (removal of the voice box usually because of cancer). Therapy after laryngectomy teaches people to breathe in a new way and is vital for learning to speak and swallow. Speech pathologist Melanie Sonsee worked with Aboriginal patient Rosie to produce an educational video where Rosie shares her experience – from diagnosis to treatment and beyond.

> We will build healthy and engaged communities

Two new breast-screening clinics were opened in 2020/21. BreastScreen WA opened Mardalup Clinic in East Perth in November 2020 and Yakamia Clinic in Albany in June 2021. The East Perth clinic is co-named with a traditional Aboriginal designation, with Mardalup meaning 'place of small marsupial'. The Yakamia Clinic will operate all year-round 3 days a week, which equates to about 3,000 screens each year. It is close to public transport and easily accessible for women with disabilities. Screening services help to detect breast cancer early. BreastScreen WA provides over 120,000 screening mammograms each year.

BreastScreen WA provides

120,000

screening mammograms each year

BreastScreen WA mobile screening clinic

Strategic priorities

People-centred care

WNHS won a 2021 Care Opinion Award, reflecting their incredible work in supporting pregnant women, newborn babies and their families. The Community Midwifery Practice (CMP), Midwifery Group Practice (MGP) and Breastfeeding Centre WA were the 3 services included in the annual award. Patients recognised support from the CMP, whose philosophy is to protect and support natural birth and to provide clients with evidence-based, holistic care from a known midwife throughout the pregnancy, labour, birth and the post-natal period. The MGP model of care enables women to develop a trusting relationship with a primary midwife, with backup from other midwives if the primary midwife is unavailable. At the breastfeeding centre, over 1,300 new mums take part in the education and support program each year. These important services were recognised by patients who gave their feedback via 98 feedback stories with the Care Opinion Hero tag.

> We will place our consumers' and their carers' best interests and experience at the core of all we do

Voluntary Assisted Dying (VAD) came into effect in WA on 1 July 2021. This allows eligible Western Australians to legally choose the manner and timing of their death. During the year, an Implementation Leadership team prepared resources and taught staff, enabling VAD to be implemented on schedule across NMHS.

In February 2021, **Dr Carol Kaplanian launched an educational flipchart** to help clinicians diagnose and classify female genital cutting/mutilation (FGC/M) so they can provide appropriate treatment. FGC/M, which is illegal in WA, is a procedure where female genitals are deliberately cut, injured or changed without medical reason. Women's Health Coordinator, Dr Kaplanian of the WNHS, supported by the Women & Infants Research Foundation, drove development of the flipchart, which is the first resource of its kind in WA.

Changing Places are secure, private facilities for people with disability who need extra space and help to use the bathroom. SCGH's Changing Place and parenting room opened in 2020, improving services for staff and visitors, including those who are living with a disability. Upgrades to E Block included a universally accessible toilet (UAT) as well as the construction of a staff UAT, parenting room and Changing Place facility, which provides an inclusive environment for all. SCGH Changing Place is nationally accredited.

Patients and visitors at SCGH now have greater reassurance that their mobile devices won't run out of charge. In June 2021, under our Innovative Future Program, USB charging ports were installed in the ED waiting room and observation ward, intensive care unit waiting room and the E block outpatient clinic. We also provided charger packs on wards for patients to use. Having access to chargers helps family and friends stay informed and connected while visiting or attending appointments. The Innovative Future Program aims to bring out the best creative ideas and inspire staff to experiment, generate new ideas or solve long-standing problems that will make positive change at NMHS.

In February 2021, **SCGH installed photographic artwork** on the ceiling of Ward 73 to provide a calming distraction for patients who would otherwise stare at bland ceiling tiles. Photographs for the 'healing ceiling' feature scenery from around the State. They have created talking points and a calming ambiance for patients, their families and friends. The Innovative Future Program supported this art installation by local photographers.

Strategic priorities

Integration and connection

Leadership is an influential factor in shaping organisations and developing culture. **In 2021, we introduced the NMHS Visibility with Purpose program.** Under this program, NMHS Executive members visit a different hospital or service each month. Frontline staff welcomed the visits, which allowed them to engage with the Area Executive Group and to provide insights into their daily activities, roles and responsibilities. Executives said they were impressed by the teamwork and genuine commitment to care that staff showed. They also gathered ideas for further discussion among local Executive teams.

WNHS introduced a new schedule of Executive Committee meetings, increasing visibility across the organisation. The new schedule includes connectivity, operational, leadership and visibility, and strategic meetings. The committee invited a wider range of staff to the connectivity meeting, invited more internal and external leaders to present at the leadership meeting and developed more structured, regular reporting as a feature of the operational and strategic meetings.

The **SCGH Frailty Rapid Access Clinic (FRAC)** started accepting referrals in October 2020 to keep older patients out of hospital during the pandemic. The FRAC pilot operated as a new outpatient service offered by the Department of Rehabilitation and Aged Care, with support from the Innovative Future Program. FRAC provides rapid outpatient review by a geriatrician or multidisciplinary team member for older patients living in the SCGH catchment area, reducing their time waiting for care. During the first 7 months of the pilot, FRAC reduced the average length of stay by 1.1 days, reduced hospital acquired complications (HACs), and reduced costs by an average of more than $30,000 per patient.

We will build strong connections and partnerships

FRAC reduced the average length of stay by

1.1 days

WNHS Executive Committee increasing their visibility among staff

Strategic priorities

Innovation and adaptive models of care

On 26 March 2021, NMHS hosted the inaugural **INSPIRE Conference** at the Harry Perkins Institute of Medical Research. The aim was to create time and space for Ideas and Networks for the Safety of Patients and the Improvement of Real Experiences. The conference featured presentations, workshops and scientific posters with external and NMHS staff as presenters. For many people, this was their first opportunity to present publicly – an important skill for healthcare professionals to learn. Sessions on safety and quality were open to WA healthcare sector staff and members of the public, both in-person and virtually. Over 500 hours of professional development time was accrued and feedback was positive, with many people reporting they had applied improvements in other parts of the service.

Television's entertaining 'Shark Tank' concept became the backdrop for new ideas, projects and events across NMHS during the year. On **5 May 2021, the Innovative Future team held the inaugural NMHS Shark Tank** where intrepid staff pitched their ideas to the 'shiver of sharks'. An expert panel led by the Chief Executive and comprising professionals from the NMHS Board and other health service providers assessed 10 pitches that aimed to improve NMHS as a safe, efficient and patient-focused health service. Six ideas won immediate support and the remaining 4 will be explored further. The Innovative Future team continue to boost innovation across NMHS through the Innovation Strategic Intent Statement and a suite of principles that will create value.

The **Innovative Future Program** supported many staff-initiated projects in 2020/21 including (i) Shift Match, an electronic rostering system for nursing staff; (ii) an electronic auditing system for hospital cleaning; (iii) AI (artificial intelligence) methodology for predicting ED pathways; (iv) QR codes for out-of-hours access to patient medication lockers; (v) next-of-kin SMS messaging from the theatre management system; (vi) SHOEBOX Audiometry, tablet-based hearing testing; (vii) proof of concept for an electronic application for targeted enteral nutrition (tube feeding) in critical care; (viii) trials of early supported discharge for delirium patients; and (ix) web-based self-management and co-care resources for the State Head Injury Unit.

> We will use research, innovation and technology to improve outcomes

NMHS INSPIRE Conference

130 in-person and virtual attendees

Jill Kemp presenting the 'Opioid Wisely' initiative at the INSPIRE Conference

Strategic priorities

Trusted, engaged and capable people

The NMHS People Strategy (2019–2024) is aimed at developing and supporting our workforce. Success will be measured by increased talent selection and retention rates, improved workplace health and safety standards, and increased participation in professional development activities.

Two examples of NMHS People Strategy events held during the year are Shark Tank and the recruitment 'hackathon'.

In March 2021, **Workforce and the Innovative Future Program conducted a recruitment 'hackathon'** (sprint-like event) to review our recruitment practices, aimed at making them more culturally appealing and accessible to people of diversity. Over 40 staff from across NMHS submitted and explored a range of ideas on 5 themes: attraction and advertising; the application process; screening and selection; values-based recruitment; and diversity and accessibility.

> We will invest in our people and our culture

WA Health's Aboriginal Cadetship Program is aimed at attracting Aboriginal university students to careers in health. Under the program, students from both corporate and clinical disciplines can earn an income while studying full-time for an undergraduate degree.

This year, **Jiah Reidy became a graduate officer within the Health Promotion team at MHPHDS** at the completion of his 12-month cadetship working in the Physiotherapy Department at OPH. In 2020/21, the 5 Aboriginal cadets hosted across NMHS were Rhiannon Potiphar (Allied Health, KEMH); Latoya Lewis (WA Cancer Palliative Care Network); Jessica Jackson-Reid (BreastScreen WA); Amelia Woods (Office of the Chief Executive); and Shakayla Walley (Statewide Perinatal and Infant Mental Health, KEMH).

Jiah Reidy with a patient at OPH

Strategic priorities

Trusted, engaged and capable people (continued)

Learning from critical incidents

In health care, patient safety incidents can, and do, occur. Clinical incidents that have caused, or could have caused, serious harm or death are categorised as Severity Assessment Code (SAC) 1. This year, at NMHS, there has been an increased focus on improving how we investigate these incidents and providing strong recommendations that create positive and sustainable change to improve the care of our patients.

When a SAC 1 incident occurs, a team of experts are assembled to investigate and analyse information relating to the incident. This team (the panel) is made up of clinical or subject matter experts who have been selected by the site Executive team. Between 1 July 2020 and 30 June 2021, the NMHS Safety, Quality, Governance and Consumer Engagement directorate has delivered 12 training sessions to 172 existing or potential panel members from across the sites and services. The purpose of this training has been to provide information, methods and tools to potential panel members. This will assist them in taking a systems approach to identifying contributing factors and exploring actions to prevent or reduce the likelihood of a similar incident from occurring. All NMHS sites have processes in place that require review and endorsement of the investigation report by members of the executive team prior to submission to the Patient Safety Surveillance Unit. This ensures the findings and recommendations are appropriate and supported by the organisation.

We have encouraged sites to broaden their definition of 'root cause', understanding that contemporary health care is complex and it is often difficult to attribute a single cause to an incident. Often there are multiple contributing factors that interact and contribute to the adverse outcome. Using this approach, we have started to reduce the number of requested declassifications* of SAC 1 incidents and this gives us greater visibility of system-wide issues and the degree of success of the recommendations implemented.

Over the next 12 months, we will continue to increase the capability of our teams to investigate and analyse factors that contribute to SAC 1 clinical incidents and develop a sustainable training program to ensure the quality of the investigation process continues to grow.

Almost everyone in our health system at some time considers how things could have been avoided, overcome or improved. We recognise the value of learning from when things go wrong and understand that, when an incident occurs, this can be a source of great distress to staff, patients and their families. These events might be labelled 'critical incidents' because they encourage us to reflect on what has happened, to challenge our practices and to resolve to do better next time. The path, however, from critical incident to learning experience is not always an easy one, as the example on the next page shows.

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

Strategic priorities

Trusted, engaged and capable people (continued)

Table 5: NMHS SAC 1 clinical incidents reported

SAC 1 clinical incident	NMHS 2018/19	JHC 2018/19	NMHS 2019/20	JHC 2019/20	NMHS 2020/21	JHC 2020/21
Total reported	129	39	119	31	119	25
Declassified*	57 (29%)	5 (13%)	43 (36%)	6 (26%)	35 (29%)	4 (16%)
Investigation completed (excluding declassification)	78	30	60	21	74	19
Investigation in progress	14	4	16	2	10	2
Completed and SAC 1 investigations in progress	92	34	76	23	84	21
Outcome of completed and SAC 1 in progress						
Death	17 (19%)	6 (18%)	18 (24%)	10 (43%)	29 (35%)	5 (24%)
Serious harm	48 (52%)	18 (53%)	39 (51%)	11 (48%)	38 (45%)	13 (62%)
Moderate harm	9 (10%)	8 (23%)	9 (12%)	1 (4%)	5 (6%)	1 (5%)
Minor harm	4 (4%)	2 (6%)	2 (3%)	1 (4%)	5 (6%)	0 (0%)
No harm	14 (15%)	0 (0%)	8 (11%)	0 (0%)	7 (8%)	2 (10%)

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

Strategic priorities

Trusted, engaged and capable people (continued)

Situation

The patient concerned was a man in his forties with suspected tuberculosis (TB). Over the phone, he said he was feeling unwell and was advised to attend the TB clinic that same day. At the clinic, he described symptoms of nausea, fatigue and lethargy. Blood samples were collected for a full blood count, renal function test and liver function test (LFT) and he was taken off pain relief. At home over the next 3 days, the patient received daily phone calls and continued to describe worsening symptoms. On day 4, he was admitted to hospital with hepatotoxicity (liver damage) and required a liver transplant. The treating team were unaware that the results of the patient's LFT were abnormal. A severity assessment code (SAC) 1 clinical incident was notified to the Patient Safety Surveillance Unit. SAC 1 is a clinical incident that has or could have (near miss) caused serious harm or death and which is attributed to the quality of health care. An Open Disclosure discussion was initiated with the patient and his family.

Investigation

The team of experts that reviewed the case included the Director of Humanitarian Entrant Health Service, the Director of Nursing and representatives from PathWest. The panel reviewed the patient's medical records, considered the policies and guidelines relevant to the case and interviewed staff.

Findings

The panel noted that the patient described symptoms that were consistent with hepatitis and was appropriately referred for a blood test to check liver function.

Through interviews with staff, it emerged that software used to manage blood results at PathWest had been replaced recently. The new software did not have the ability to trigger an alert for pre-programmed liver enzyme (ALT) limits, as had been the case with the previous software. These limits had been set significantly lower than the normal limits specifically for this group of patients to be more sensitive to subtle changes in liver function.

Under the old system, programmed alerts would prompt a phone call to the Clinical Nurse Manager of the clinic, who would advise the treating team of the LFT result. As neither the laboratory staff nor the treating team were aware of the absence of this feature in the new software, the patient's blood results were not followed up.

In addition, the panel identified that there was no system in place to ensure that blood results were regularly reviewed, and the clinical deterioration was not recognised.

Recommended actions

- The iSOFT/Medtech link be updated so results will automatically transfer.
- A procedure to be developed and implemented that requires all medical staff to check their Medtech inbox at the start of their shift and file results (as normal or abnormal).
- Random audits implemented to monitor compliance.

The panel also recommended that an essential skill requirements document be developed for existing Case Managers and distributed to new staff as part of their orientation. This would ensure Case Managers would be alerted to the blood test skills required. An action plan would be developed to address any additional training and education requirements.

Summary

The investigation identified the nature and source of the critical incident and showed how systems and processes can create an environment where mistakes can occur. In this case, the clinicians had become reliant on abnormal results being supplied to them and, when this system failed, there was no process that ensured blood results were checked and followed up. As a result of the investigation and actions taken, the risk of recurrence is low and our care has been made safer.

Strategic priorities

Sustainable and reliable

The $24 million Osborne Park Hospital expansion was completed early due to dedicated work by the project team and hospital staff. In November 2020, we **completed works on the Maternity Assessment Unit at OPH's Women's and Newborn Services**. In May 2021, the Rehabilitation Ward (Ward 2) opened to patients. Next to the ward is the new therapy garden, a purpose-built outdoor space for inpatients and outpatients. It features modern, functional rehabilitation services for people who have had a stroke, amputation or those living with a neurological condition.

We established a **Climate and Sustainability Program (CSP) across NMHS in 2020**. This was in response to the WA Climate Health Inquiry and growing expectations by staff to reduce the organisation's environmental footprint while delivering sustainable, high-quality care. Supported by the Innovative Future team, the CSP will deliver on initiatives under each of its identified pillars: leadership, waste, energy and purchasing. In a staff survey conducted in August 2020, employees identified ways the hospital could improve. Common themes included education, more accessible recycling and reduction of single-use items.

Within the hospital community, the 'Green Team' from the SCGH Operating Theatre Suites is known as the 'go to' team when it comes to all things recycling. **This year, the team won the Waste Team of the Year category in the 2021 WasteSorted Awards.** The awards recognise projects that avoid waste, recover value from waste streams and protect the environment. The Green Team's doctors, nurses, anaesthetic technicians and patient support staff are leading the charge in hospital waste management – and inspiring others to do the same.

> We will reduce harm, waste and unwarranted variation

$24 million

Osborne Park Hospital expansion

OPH therapy garden: an attractive alternative to indoor activity

Significant issues impacting NMHS

COVID-19 response

COVID-19 significantly impacted the NMHS hospital and health service network in 2020/21, requiring us to operate in new or different ways. As the viral respiratory infection spread across the world, we tried to ensure our staff, patients and community were as safe as possible. In March 2020, we established an Emergency Operations Committee (EOC) to guide our actions. The 14-person committee consists of executive leaders structured into 6 workstreams, covering planning, operations, clinical, workforce, equipment supplies and facilities, and information management and technology. The committee directed, managed and coordinated all workstream functions and associated issues, risks and actions, helping to keep our staff and patients safe and maintaining continuity of service across NMHS.

Vaccination program

Our role in the State's historic immunisation program began in February 2021. By 30 June, we had established fixed-site hospital clinics and delivered more than 26,500 COVID-19 vaccines to staff and people in the community. The take-up rate fluctuated from day to day but peaked at just under 400 vaccinations on our busiest day. Each site will continue to provide COVID-19 vaccines to staff and ensure pathways for patient access to the vaccines.

This significant contribution to the program was made possible only because our staff worked tirelessly to provide reassurance and maintain the highest possible standards of care over a prolonged period. The resource-intensive effort was waged throughout the year and will continue until everybody who must be, or who wants to be, vaccinated has received their second dose. This work included setting up the physical clinics to comply with Commonwealth requirements, providing appropriate signage to the clinics to enable mandatory physical distancing, educating over 60 staff to use the multidose vials and inputting and extracting data from the newly created database VaccinateWA.

Staff vaccinations

At the end of the financial year, almost 8,000 NMHS staff (around 69.4% of the total) had been vaccinated with at least one dose of the AstraZeneca or Pfizer vaccine, with 60.9% (7000) receiving both doses. NMHS continues to encourage the remainder of staff to 'Roll up for WA' and get vaccinated.

About 86% of priority 1a staff received at least one dose of a COVID-19 vaccine, and more than 78% of NMHS staff have now consented to receiving a COVID-19 vaccine (equating to more than 10,000 NMHS staff).

Registered nurse taking part in staff vaccination program

COVID-19 response (continued)

Table 6: Number of staff vaccinated

Clinic	AstraZeneca vaccines given as of 5 July* 2021	Pfizer vaccines given as of 5 July* 2021	Total vaccines given as of 5 July* 2021
Sir Charles Gairdner Hospital	10,760	–	10,760
Joondalup Health Campus	4,097	2,604	6,701
Osborne Park Hospital	1,279	5,533	6,812
King Edward Memorial Hospital	1,546	–	1,546
Graylands Hospital	762	–	762
Total	**18,444**	**8,137**	**26,581**

Intensivist, Paul Woods awaits COVID-19 vaccination

* Reports are generated weekly from the Department of Health, therefore to include the end of the financial year, reporting was required until 5 July.

Addressing demand for services

Increasing demand for our services remains a challenge for NMHS, specifically in specialties such as emergency departments (EDs) and theatres/elective surgery, as well as admissions and bed occupancy.

Emergency department presentations

Public hospital EDs are accessible 24 hours a day, 7 days a week to provide acute and emergency care to patients arriving either by ambulance or by other means. While some people require immediate attention for life-threatening conditions or trauma, most require less urgent care.

This year, the number of people arriving at EDs across NMHS increased by 9.6% over the previous year. 183,636 patients presented to hospital EDs between July 2020 and June 2021, with an average of 503 presentations per day.

Timely access to care is a high priority for patients, healthcare providers and the public at large. 62.7% of ED presentations were completed within 4 hours and 99.6% of patients completed their ED stay within 24 hours, while 36.9% were subsequently admitted to the hospital.

In general, our hospitals had delayed transit times for patients requiring emergency care. During 2020/21, Western Australia's Emergency Access (WEAT) compliance rate was 64%, below the target of 90%. Compliance was impacted by demand pressures associated with patient flow and inpatient bed capacity.

As a large and complex organisation, we seek to constantly improve. To increase our accountability, we implemented the following strategies to accommodate demand and to mitigate access issues to EDs:

- introduced waiting room staff in EDs to assist with triage and assessment
- employed Aboriginal Liaison Officers to provide cultural support for admitted Aboriginal patients
- introduced the Geriatric Assessment Team
- implemented criteria-led discharge
- implemented an Advanced Scope Physiotherapist roster to support patients presenting in Fast Track and ED areas
- opened rapid access clinics for specific patient cohorts.

Addressing demand for services (continued)

Elective surgery

Surgery that is medically necessary and can be scheduled in advance is called elective surgery. Our elective surgery activity declined by between 21% and 45% because of restrictions imposed during COVID-19 lockdowns but overall demand increased by 8.6% in 2019/20 compared to the previous year.

To help clear the elective surgery waitlist, the State Government invested $36 million towards an elective surgery blitz from July 2020. The NMHS blitz ran until December 2020, successfully reducing key specialty demand for a range of elective patients, particularly in gastroenterology. We reduced the number of patients on the waitlist for gastroenterology surgery by 35% between July and December. Other specialties with high volumes were ear nose and throat, urology, ophthalmology, general surgery, orthopaedic surgery and plastic surgery.

The blitz also successfully reduced cancellations of elective surgery due to COVID-19 from 925 to one, and SCGH remains ahead of the demand curve.

Obstetric demand

Unprecedented levels of obstetric demand (pregnancy and birth) were recorded across KEMH in 2020/21. This demand, coupled with international border restrictions, saw both demand and activity pushed to new heights.

A WNHS Activity and Demand Action plan was implemented to mitigate ongoing demand and activity concerns and staff fatigue.

Strategies included:

- Proposal to purchase private obstetric beds and to realign activity across the NMHS service to ensure a balanced load between OPH and KEMH.
- Initiation of statewide discussion around the clinical services framework and the distribution of obstetric activity.
- A strategic recruitment campaign to attract new employees.
- Planning for a statewide patient flow and demand management system and diversion policy.

Addressing demand for services (continued)

Efficiency of operating theatres

The efficiency of our public hospital operating theatres is just one of many important and complex issues that the health system must manage. Efficient theatres save money, enable hospitals to manage their waitlist and help minimise the time patients have to wait for surgery. Theatre utilisation (the proportion of time patients are in theatre within a scheduled session) measures the efficiency of our operating theatres.

Despite the continuing impact of COVID-19, SCGH theatre utilisation remained high at 84.2%, consistent with the previous year's figure. KEMH theatre utilisation was 83.9%, an improvement of 2.9% on the previous year. By way of comparison, New South Wales has a target of 80% utilisation.

Admissions and bed occupancy

Throughout the year, SCGH was operating at full capacity, with bed occupancy averaging 97.2%, peaking at 99.1% capacity in August 2020. Admissions via the SCGH emergency department increased by 8.6% and elective surgery admissions increased by 4.8%.

NMHS implemented a number of key strategies to increase bed and patient flow capacity across the system as follows:

- secured an extra 10 inpatient beds through a fast-tracked agreement with South Perth Hospital
- increased aged care bed capacity at OPH by opening an additional 6 stroke and general rehabilitation beds at OPH
- expanded Young Adult Rehabilitation bed capacity at OPH
- negotiated with country hospitals to return patients to their local catchment areas
- negotiated for an increase in inter-hospital transfers
- negotiated with other departments and agencies for placement of long-stay patients
- improved utilisation of the residential care line service for early supported aged care discharges
- improved utilisation of Home Link, Hospital in the Home, and Rehabilitation in the Home services to support early discharge.

Palliative care beds

Palliative and end of life care is an NMHS priority. In November 2020, the Final Report of the Joint Select Committee (JSC) on End of Life Choices in WA was released. The key recommendations for implementation addressed palliative and end of life care. Recommendation 15 requires NMHS and the Department of Health to provide information on the progress of implementing Recommendation 7, which states that the Minister for Health should facilitate the establishment of an inpatient specialist palliative care hospice providing publicly funded beds in the northern suburbs of Perth.

An open tender process was conducted via TendersWA, in which 2 offers were received. Both offers were deemed unsuitable to meet the requirements of the tender. As such, an alternative arrangement was settled to provide the required services. Through this arrangement, NMHS was able to deliver a specialist palliative care unit service, in line with the JSC recommendation of a 'hospice' service delivery model.

Outpatient reform

Sometimes, patients may not receive surgery within the clinically recommended time frames. These cases are known as 'over boundary'. Our Outpatient Reform Program succeeded in reducing capacity and demand issues throughout the hospital and health service network during the year. Extensive data cleansing resulted in a 13.9% reduction of over-boundary referrals in our outpatient system (from 55.3% in 2019/20 to 41.4% in 2020/21). Virtual Care (telehealth) utilisation and monitoring has increased by 9.2% since 2018/19.

Investing in our infrastructure

Ageing infrastructure (buildings, equipment and technology) is an ongoing problem for older health services.

Women and Newborn Service Relocation Project

We therefore welcomed the Minister for Health's approval of our concept for the long-awaited new women's and babies' hospital for the State in November. Concept approval for the Women and Newborn Service Relocation Project was quickly followed by the State Government's confirmation of a $1.8 billion funding commitment to the project.

The next step in the move from the ageing King Edward Memorial Hospital on its century-old site to new premises at the QEII Medical Centre will be the development of a business case.

Many people will play a role in establishing the new hospital. Stakeholder consultation commenced in June with the establishment of over 45 potential user groups made up of clinicians, staff and consumer representatives. Building work on the multistorey hospital is expected to start in 2023.

Joondalup Health Campus

Building started on an expanded emergency department (ED) at Joondalup Health Campus in April 2021 and construction commenced on the staff car park in June 2021. The new facilities are part of a $256.7 million hospital expansion project due for completion in 2025.

When complete, the hospital will include:

- a new mental health building, with 102 beds in total (47 existing beds, 30 new beds and 25 shelled beds*)
- 12 ED bays
- additional beds for the medical/surgical specialty with 90 beds in total (an additional 60 shelled beds* to meet future demand)
- 6 critical care beds
- an operating theatre
- a cardiac catheter laboratory
- a new Behavioural Assessment Urgent Care Clinic to treat alcohol-affected patients
- additional upgrades to support infrastructure.

Cyclotron

A cyclotron is a machine used to make relatively short-lived radioisotopes (radioactive atoms) that can be used for medical imaging techniques such as PET scans. Over the past decade, demand has steadily increased for the State's only cyclotron at SCGH, which is very efficient at detecting various cancers. Work on the design phase of expansion plans for the $23.31 million Radiopharmaceutical Laboratories at SCGH, including a new cyclotron, continued during the year. The new cyclotron will increase the hospital's abilities in providing radiopharmaceuticals for cancer, neurological conditions and other diseases. The existing cyclotron will remain operational during construction, which is due for completion in early 2023.

* Shell space refers to space within a building that has not yet been fully fitted out for use. The shelled bed numbers listed are the number of beds that could occupy the shelled space if full fit out was carried out.

Workforce

Our future workforce needs to be able to respond to a rapidly changing internal and external environment with a strategic approach to workforce planning. Our planning must support delivery now and into the future. A Workforce and Capability working group has been formed to investigate and propose strategies to address workforce supply issues for NMHS.

Leave liability is a major challenge for health service providers across the State. Additional demands on the health service relating to COVID-19 and staff shortages in certain areas has made it difficult for some staff to clear excess leave. Due to staffing shortages in some areas, many longer-term vacancies, such as parental leave, were covered by fixed-term contracts and we had to rely heavily on relief pools as well as casual and agency staff to supplement current FTEs. COVID-related lockdowns and border closures also exacerbated our leave liability as many staff opted to defer planned leave arrangements.

In response to COVID-19, we diverted significant nursing and administrative resources to the establishment of an emergency response team as well as to testing and vaccination clinics.

Initiatives

The workforce mix of NMHS is constantly changing, as the make-up of the community we service continues to grow and diversify. We are also moving into a time of global shortages of healthcare practitioners, changing healthcare practices/models of care and looming retirements for a significant portion of our workforce. This raises concern regarding the availability of key skills as we prepare for increased service demand and look to improve the experiences of our staff, patients and consumers.

NMHS has developed a succession planning framework to be implemented in 2021/22 to identify critical positions within our organisation and create a talent pipeline to ensure service continuity. We are also conducting analysis and developing strategies to plan for, build and maintain a diverse and agile workforce that has the capacity and capability to meet the needs of our community.

We explored different recruitment practices to help promote NMHS and attract mission critical staff. Several initiatives are being implemented to streamline and improve our recruitment practices and ensure they are inclusive, culturally appealing and accessible.

As the demand for healthcare services continues to increase, staff are using our Innovative Future program to find new ways to maximise efficiency. For example, the inaugural Shark Tank initiative helped support and develop the clever Shift Match web-based system to automatically match available clinical staff with available shifts; ward ultrasound machines are aiding difficult cannulation; interpreter translation apps are improving patient communication; and discharging delirium patients earlier with education and support is reducing length of stay and improving outcomes.

NMHS developed action plans for key diversity groups (Aboriginal people, culturally and linguistically diverse people, people with disability, people of diverse sexualities and genders, youth and women) to increase staff attraction, recruitment, development and retention.

Achieving our vision of excellence in health care for our community requires employees to be enabled, empowered and engaged. This is a key focus of our People Strategy.

Workforce (continued)

Workplace violence

Protecting our staff from workplace violence and aggression (WVA) remains a high priority across all NMHS sites, with 5,190 aggressive incidents reported this year.

To provide support for our staff, we launched the Stop the Violence Strategy 2020–2025 in October, which aims to identify, eliminate and reduce the exposure of staff to aggressive incidents.

During this period:

- we created the position of a WVA coordinator and filled that position
- we developed an implementation plan under the Stop the Violence Strategy
- with government funding, we purchased 206 personal duress alarms for healthcare staff who make home and community visits
- we reviewed use of duress systems and lone worker solutions
- we reviewed aggression management training materials and notified high-risk staff of the requirement to complete training
- we trained staff in workplace design to help reduce aggressive incidents.

By June 2021, 35% of the Stop the Violence Strategy implementation plan was completed and a start was made on 89% of all actions in the plan.

In particular, working groups were established across NMHS to carry out site-based and service-based actions, improving safety in the workplace.

Active engagement from all levels of our health service will help ensure that aggression should never be seen as 'part of the job' for any healthcare worker.

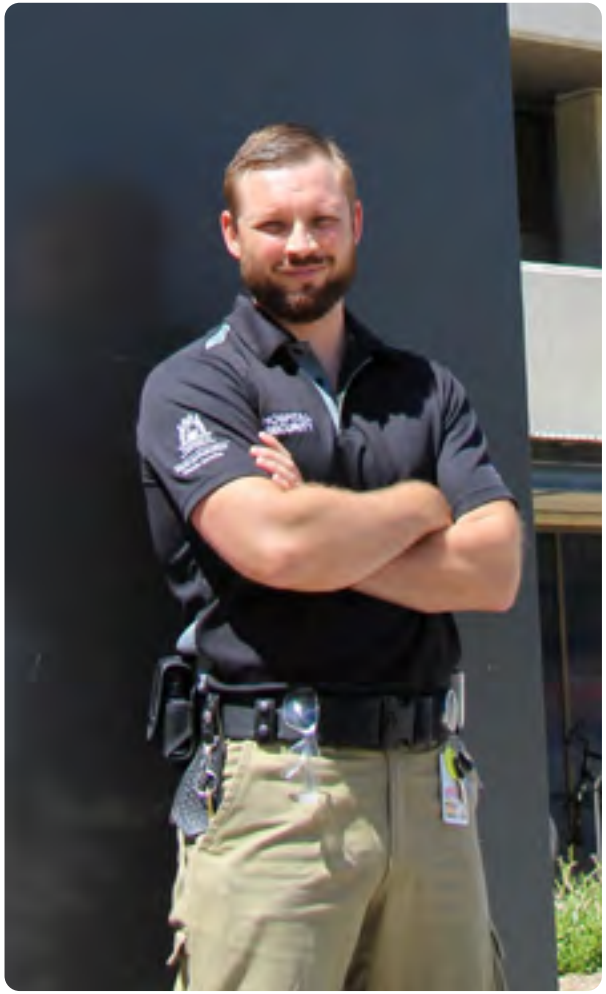
Staff wellbeing

We take staff wellbeing seriously, particularly under the impact of COVID-19, as the health and wellbeing of our workforce is critical to supporting engagement, productivity and serving the community.

We have a range of initiatives to support us in achieving this outcome and to eliminate or minimise work health and safety risks. Examples include:

- setting up Wellbeing Committees at all NMHS sites and services
- supporting People and Culture ambassadors
- committing to the creation of an NMHS-wide Wellbeing Manager role
- coordinating an evidence-based approach to wellbeing services for staff.

The next stage is to develop increased wellbeing initiatives, support and information with input from NMHS staff. The results will be disseminated in a variety of formats over the next 12 months.



Security officer, Matthew Marsh stands outside Sir Charles Gairdner Hospital

Disclosures and legal compliance

Audit opinion

Auditor General

INDEPENDENT AUDITOR'S OPINION
2021
North Metropolitan Health Service

To the Parliament of Western Australia

Report on the audit of the financial statements

Opinion

I have audited the financial statements of the North Metropolitan Health Service (Health Service) which comprise:

- the Statement of Financial Position at 30 June 2021, and the Statement of Comprehensive Income, Statement of Changes in Equity and Statement of Cash Flows for the year then ended
- Notes comprising a summary of significant accounting policies and other explanatory information.

In my opinion, the financial statements are:

- based on proper accounts and present fairly, in all material respects, the operating results and cash flows of the North Metropolitan Health Service for the year ended 30 June 2021 and the financial position at the end of that period
- in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions.

Basis for opinion

I conducted my audit in accordance with the Australian Auditing Standards. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my report.

I am independent of the Health Service in accordance with the *Auditor General Act 2006* and the relevant ethical requirements of the Accounting Professional & Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants (including Independence Standards)* (the Code) that are relevant to my audit of the financial statements. I have also fulfilled my other ethical responsibilities in accordance with the Code.

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

Responsibilities of the Board for the financial statements

The Board is responsible for:

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

In preparing the financial statements, the Board is responsible for:

- assessing the entity's ability to continue as a going concern
- disclosing, as applicable, matters related to going concern
- using the going concern basis of accounting unless the Western Australian Government has made policy or funding decisions affecting the continued existence of the Health Service.

Auditor's responsibilities for the audit of the financial statements

As required by the *Auditor General Act 2006*, my responsibility is to express an opinion on the financial statements. The objectives of my audit are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Australian Auditing Standards will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal control.

A further description of my responsibilities for the audit of the financial statements is located on the Auditing and Assurance Standards Board website. This description forms part of my auditor's report and can be found at https://www.auasb.gov.au/auditors_responsibilities/ar4.pdf.

Report on the audit of controls

Basis for qualified opinion

I identified significant weaknesses in network security and remote access controls at North Metropolitan Health Service. These weaknesses could result in a potential security exposure such as unauthorised access to sensitive information and an increased risk of information loss. The weaknesses exposed the network to increased vulnerabilities which could undermine the integrity of data across all systems, including the financial system.

Audit opinion

Qualified opinion

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

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

In my opinion, except for the possible effects of the matters described in the Basis for Qualified Opinion paragraph, in all material respects, the controls exercised by the North Metropolitan Health Service are sufficiently adequate to provide reasonable assurance that the receipt, expenditure and investment of money, the acquisition and disposal of property and the incurring of liabilities have been in accordance with legislative provisions during the year ended 30 June 2021.

The Board's responsibilities

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

Auditor General's responsibilities

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

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

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

Limitations of controls

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

Report on the audit of the key performance indicators

Opinion

I have undertaken a reasonable assurance engagement on the key performance indicators of the North Metropolitan Health Service for the year ended 30 June 2021. The key performance indicators are the Under Treasurer-approved key effectiveness indicators and key efficiency indicators that provide performance information about achieving outcomes and delivering services.

In my opinion, in all material respects, the key performance indicators of the North Metropolitan Health Service are relevant and appropriate to assist users to assess the Health Service's performance and fairly represent indicated performance for the year ended 30 June 2021.

The Board's responsibilities for the key performance indicators

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

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

Auditor General's responsibilities

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

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

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

Audit opinion

My independence and quality control relating to the reports on controls and key performance indicators

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

Other information

Those charged with governance are responsible for the other information. The other information is the information in the entity's annual report for the year ended 30 June 2021, but not the financial statements, key performance indicators and my auditor's report.

My opinions do not cover the other information and, accordingly, I do not express any form of assurance conclusion thereon.

Matters relating to the electronic publication of the audited financial statements and key performance indicators

This auditor's report relates to the financial statements, controls and key performance indicators of the North Metropolitan Health Service for the year ended 30 June 2021 included on the Health Service's website. The Health Service's management is responsible for the integrity of the Health Service's website. This audit does not provide assurance on the integrity of the Health Service's website. The auditor's report refers only to the financial statements, controls and key performance indicators described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these financial statements, controls or key performance indicators. If users of the financial statements, controls and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to contact the entity to confirm the information contained in the website version of the financial statements, controls and key performance indicators.

Caroline Spencer
Auditor General for Western Australia
Perth, Western Australia
24 September 2021

Certification of financial statements

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

Disclosures and Legal Compliance

Financial Statements

Certification of Financial Statements

For the reporting period ended 30 June 2021

The accompanying financial statements of the North Metropolitan Health Service have been prepared in compliance with the provisions of the *Financial Management Act 2006* from proper accounts and records to present fairly the financial transactions for the reporting period ended 30 June 2021 and financial position as at 30 June 2021.

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

Date 23/09/21

Name: Michael Hutchings
North Metropolitan Health Service
Chief Finance Officer

Date 23 Sept 21

Name: Clinical Professor David Forbes AM
North Metropolitan Health Service
Board Chair, NMHS Board

Date 23/09/2021

Name: Mr Steve Toutountzis
North Metropolitan Health Service
Board Member and Finance Committee Chair, NMHS Board

Financial statements

Statement of Comprehensive Income

For the year ended 30 June 2021

	Notes	2021 $'000	2020 $'000
COST OF SERVICES			
Expenses			
Employee benefits expense	3.1	1,195,020	1,144,530
Contracts for services	3.2	486,219	457,407
Patient support costs	3.3	342,814	322,379
Finance costs	7.2	689	603
Depreciation and amortisation expense	5.1, 5.2, 5.3, 5.4	71,528	69,675
Loss on disposal of non-current assets		373	180
Repairs, maintenance and consumable equipment	3.4	44,503	39,017
Other supplies and services	3.5	79,118	71,989
Other expenses	3.6	59,134	55,096
Total cost of services		**2,279,398**	**2,160,876**
INCOME			
Revenue			
Patient charges	4.2	66,197	71,895
Other fees for services	4.3	81,345	78,406
Other grants and contributions	4.4	2,501	3,288
Donation revenue		629	654
Interest revenue		-	67
Other revenue	4.5	21,695	24,781
Total revenue		**172,367**	**179,091**
Gains			
Other gains	4.6	-	210
Total gains		**-**	**210**
Total income other than income from State Government		**172,367**	**179,301**
NET COST OF SERVICES		**2,107,031**	**1,981,575**
Income from State Government			
Department of Health - Service Agreement - State Component	4.1	1,177,916	1,068,551
Department of Health - Service Agreement - Commonwealth Component	4.1	538,389	590,727
Grants and subsidies from Mental Health Commission	4.1	252,074	243,678
Grants from other state government agencies	4.1	1,078	1,676
Assets (transferred)/assumed	4.1	788	14
Services received free of charge	4.1	105,490	97,038
Royalties for Regions Fund	4.1	-	400
Total income from State Government		**2,075,735**	**2,002,084**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(31,296)**	**20,509**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.10	13,306	9,794
Total other comprehensive income		**13,306**	**9,794**
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**(17,990)**	**30,303**

See also the 'Schedule of income and expenses by service'.

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

Statement of Financial Position

As at 30 June 2021

	Notes	2021 $'000	2020 $'000
ASSETS			
Current Assets			
Cash and cash equivalents	7.3	52,472	45,000
Restricted cash and cash equivalents	7.3	53,927	59,181
Receivables	6.1	48,054	68,417
Inventories	6.3	7,465	7,067
Other current assets	6.4	2,907	2,084
Total Current Assets		**164,825**	**181,749**
Non-Current Assets			
Restricted cash and cash equivalents	7.3	22,486	17,956
Amounts receivable for services	6.2	904,003	831,718
Infrastructure, property, plant and equipment	5.1	1,079,871	1,088,295
Right-of-use assets	5.2	20,724	22,822
Service concession assets	5.3	254,708	235,613
Intangible assets	5.4	922	500
Total Non-Current Assets		**2,282,714**	**2,196,904**
TOTAL ASSETS		**2,447,539**	**2,378,653**
LIABILITIES			
Current Liabilities			
Payables	6.5	177,282	169,703
Contract liabilities	6.6	7,757	2,903
Employee related provisions	3.1	264,527	243,067
Lease liabilities	7.1	2,629	2,671
Other current liabilities	6.7	1,889	1,989
Total Current Liabilities		**454,084**	**420,333**
Non-Current Liabilities			
Employee related provisions	3.1	56,492	61,326
Lease liabilities	7.1	20,248	21,101
Total Non-Current Liabilities		**76,740**	**82,427**
TOTAL LIABILITIES		**530,824**	**502,760**
NET ASSETS		**1,916,715**	**1,875,893**
EQUITY			
Contributed equity	9.10	1,708,987	1,650,175
Reserves	9.10	186,909	173,603
Accumulated surplus/(deficit)		20,819	52,115
TOTAL EQUITY		**1,916,715**	**1,875,893**

The Statement of Financial Position should be read in conjunction with the accompanying notes.

Statement of Changes in Equity

For the year ended 30 June 2021

	Notes	Contributed equity $'000	Reserves $'000	Accumulated deficit $'000	Total equity $'000
Balance at 1 July 2019		1,643,491	163,809	52,706	1,860,006
Initial application of accounting standards		-	-	(21,100)	(21,100)
Restated balance at 1 July 2019		**1,643,491**	**163,809**	**31,606**	**1,838,906**
Surplus/(deficit)		-	-	20,509	20,509
Other comprehensive income		-	9,794	-	9,794
Total comprehensive income for the year		**-**	**9,794**	**20,509**	**30,303**
Transactions with owners in their capacity as owners:	9.10				
Capital appropriations administered by Department of Health		24,381	-	-	24,381
Distribution to owners		(17,697)	-	-	(17,697)
Total		6,684	**-**	**-**	6,684
Balance at 30 June 2020		**1,650,175**	**173,603**	**52,115**	**1,875,893**
Balance at 1 July 2020		1,650,175	173,603	52,115	1,875,893
Surplus/(deficit)		-	-	(31,296)	(31,296)
Other comprehensive income		-	13,306	-	13,306
Total comprehensive income for the year		**-**	**13,306**	**(31,296)**	**(17,990)**
Transactions with owners in their capacity as owners:	9.10				
Capital appropriations administered by Department of Health		58,812	-	-	58,812
Total		58,812	**-**	**-**	58,812
Balance at 30 June 2021		**1,708,987**	**186,909**	**20,819**	**1,916,715**

The Statement of Changes in Equity should be read in conjunction with the accompanying notes.

Statement of Cash Flows

For the year ended 30 June 2021

	Notes	2021 $'000	2020 $'000
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriation		1,897,170	1,831,941
Capital appropriations administered by Department of Health		58,812	23,566
Royalties for Regions fund		-	400
Net cash provided by State Government		**1,955,982**	**1,855,907**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(1,173,415)	(1,131,322)
Supplies and services		(903,957)	(850,174)
Finance costs		(689)	(590)
Receipts			
Receipts from customers		61,662	75,474
Other grants and contributions		2,502	3,289
Donations received		546	432
Interest received		-	67
Other receipts		131,732	92,701
Net cash used in operating activities	7.3.2	**(1,881,619)**	**(1,810,123)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Payment for purchase of non-current physical and intangible assets		(64,296)	(21,599)
Receipts			
Proceeds from sale of non-current physical assets		67	5
Net cash used in investing activities		**(64,229)**	**(21,594)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Payments for principal element of lease		(3,386)	(2,989)
Net cash used in financing activities		**(3,386)**	**(2,989)**
Net increase/(decrease) in cash and cash equivalents		6,748	21,201
Cash and cash equivalents at the beginning of the year		122,137	117,144
Cash transferred to other health agencies as part of demergers		-	(16,208)
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.3.1	**128,885**	**122,137**

The Statement of Cash Flows should be read in conjunction with the accompanying notes.

Notes to the Financial Statements

For the year ended 30 June 2021

1 Basis of Preparation

The Health Service is a WA Government entity and is controlled by the State of Western Australia, which is the ultimate parent. The entity is a not- for-profit entity (as profit is not its principal objective).

A description of the nature of its operations and its principle activities have been included in the **Overview** which does not form part of these financial statements.

Statement of compliance

These general purpose financial statements are prepared in accordance with:

1 The *Financial Management Act 2006* **(FMA)**

2 The Treasurer's Instructions **(the Instructions or TI)**

3 Australian Accounting Standards **(AAS)** including applicable interpretations

4 Where appropriate, those **AAS** paragraphs applicable for not-for-profit entities have been applied.

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

Basis of preparation

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

Judgements and estimates

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

Contributed equity

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

Comparative figures

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

Notes to the Financial Statements
For the year ended 30 June 2021

2 Health Service outputs

How the Health Service operates

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

2.1 Health Service objectives

Mission

The Health Service's mission is to improve, promote and protect the health and wellbeing of our patients, population and community. The Health Service is predominantly funded by Parliamentary appropriations.

Services

The Health Service provides the following services:

1. Public Hospital Admitted Services

The provision of healthcare services to patients in metropolitan and major rural hospitals that meet the criteria for admission and receive treatment and/or care for a period of time, including public patients treated in private facilities under contract to the WA health system.

Admission to hospital and the treatment provided may include access to acute and/or subacute inpatient services, as well as hospital in the home services. Public Hospital Admitted Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to admitted services. This Service does not include any component of the Mental Health Services reported under Service Four, 'Mental Health Services'.

2. Public Hospital Emergency Services

The provision of services for the treatment of patients in emergency departments of metropolitan and major rural hospitals, inclusive of public patients treated in private facilities under contract to the WA health system.

The services provided to patients are specifically designed to provide emergency care, including a range of pre-admission, post-acute and other specialist medical, allied health, nursing and ancillary services. Public Hospital Emergency Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to emergency services. This Service does not include any component of the Mental Health Services reported under Service Four, 'Mental Health Services'.

3. Public Hospital Non-Admitted Services

The provision of metropolitan and major rural hospital services to patients who do not undergo a formal admission process, inclusive of public patients treated by private facilities under contract to the WA health system.

This Service includes services provided to patients in outpatient clinics, community based clinics or in the home, procedures, medical consultation, allied health or treatment provided by clinical nurse specialists. Public Hospital Non-Admitted Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to non-admitted services. This Service does not include any component of the Mental Health Services reported under Service Four, 'Mental Health Services'.

Notes to the Financial Statements
For the year ended 30 June 2021

2.1 Health Service objectives (continued)

4. Mental Health Services

The provision of inpatient services where an admitted patient occupies a bed in a designated mental health facility or a designated mental health unit in a hospital setting; and the provision of non-admitted services inclusive of community and ambulatory specialised mental health programs such as prevention and promotion, community support services, community treatment services, community bed based services and forensic services.

This Service includes the provision of statewide mental health services such as perinatal mental health and eating disorder outreach programs as well as the provision of assessment, treatment, management, care or rehabilitation of persons experiencing alcohol or other drug use problems or co-occurring health issues. Mental Health Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to mental health or alcohol and drug services. This service includes public patients treated in private facilities under contract to the WA health system.

5. Aged and Continuing Care Services

The provision of aged and continuing care services and community-based palliative care services.

Aged and continuing care services include programs that assess the care needs of older people, provide functional interim care or support for older, frail, aged and younger people with disabilities to continue living independently in the community and maintain independence, inclusive of the services provided by the WA Quadriplegic Centre. Aged and Continuing Care Services is inclusive of community-based palliative care services that are delivered by private facilities under contract to the WA health system, which focus on the prevention and relief of suffering, quality of life and the choice of care close to home for patients.

6. Public and Community Health Services

The provision of healthcare services and programs delivered to increase optimal health and wellbeing, encourage healthy lifestyles, reduce the onset of disease and disability, reduce the risk of long-term illness as well as detect, protect and monitor the incidence of disease in the population.

Public and Community Health Services includes public health programs, Aboriginal health programs, disaster management, environmental health, the provision of grants to non-government organisations for public and community health purposes, emergency road and air ambulance services, services to assist rural-based patient travel to receive care, and statewide pathology services provided to external WA Agencies.

7. Community Dental Health Services

Dental health services include the school dental service (providing dental health assessment and treatment for school children); the adult dental service for financially, socially and/or geographically disadvantaged people and Aboriginal people; additional and specialist dental, and oral health care provided by the Oral Health Centre of Western Australia to holders of a Health Care Card.

Services are provided through government-funded dental clinics, itinerant services and private dental practitioners participating in the metropolitan, country and orthodontic patient dental subsidy schemes.

8. Small Rural Hospital Services

Provides emergency care and limited acute medical/minor surgical services in locations 'close to home' for country residents/visitors, by small and rural hospitals classified as block funded. Includes community care services aligning to local community needs.

9. Health System Management – Policy and Corporate Services

The provision of strategic leadership, policy and planning services, system performance management and purchasing linked to the statewide planning, budgeting and regulation processes.

Health System Policy and Corporate Services includes corporate services, inclusive of statutory financial reporting requirements, overseeing, monitoring and promoting improvements in the safety and quality of health services and system-wide infrastructure and asset management services

Notes to the Financial Statements
For the year ended 30 June 2021

2.2 Schedule of Income and Expenses by Service

	Public Hospital Admitted Patient		Public Hospital Emergency Services		Public Hospital Non-Admitted Services		Mental Health Services		Aged Continuing Care Services	
	2021 $'000	2020 $'000	2021 $'000	2020 $'000	2021 $'000	2020 $'000	2021 $'000	2020 $'000	2021 $'000	2020 $'000
COST OF SERVICES										
Expenses										
Employee benefits expense	617,698	596,224	65,058	56,884	160,725	149,229	202,661	199,863	13,322	11,039
Contracts for services	320,218	302,820	93,852	90,850	27,780	22,677	23,385	22,410	2,998	2,067
Patient support costs	206,393	194,124	12,385	11,722	83,086	73,516	9,735	10,269	1,876	2,434
Finance costs	12	18	1	1	9	6	502	444	3	3
Depreciation and amortisation expense	42,230	41,260	4,006	3,644	9,870	9,847	7,853	7,306	92	81
Loss on disposal of non-current assets	233	68	13	-	53	8	4	-	-	-
Repairs, maintenance and consumable equipment	17,104	15,820	1,289	1,185	6,338	5,856	4,127	4,068	171	249
Other supplies and services	49,504	39,841	4,980	3,500	13,679	10,559	813	7,293	45	500
Other expenses	17,590	19,738	1,793	1,387	4,110	4,930	9,402	9,688	231	312
Total cost of services	**1,270,982**	**1,209,913**	**183,377**	**169,173**	**305,650**	**276,628**	**258,482**	**261,341**	**18,738**	**16,685**
INCOME										
Revenue										
Patient charges	48,398	54,189	1,308	1,513	10,365	10,002	917	461	-	-
Other fees and services	23,583	24,541	20	18	47,411	44,418	196	252	-	-
Other grants and contributions	138	317	15	28	166	132	6	11	-	-
Donation revenue	49	12	2	1	20	12	8	-	-	-
Interest revenue	-	-	-	-	-	-	-	-	-	-
Other revenue	1,917	4,815	111	345	5,656	5,622	861	333	-	1
Total revenue	**74,085**	**83,874**	**1,456**	**1,905**	**63,618**	**60,186**	**1,988**	**1,057**	**-**	**1**
Gains										
Other gains	-	162	-	-	-	32	-	-	-	-
Total gains	**-**	**162**	**-**	**-**	**-**	**32**	**-**	**-**	**-**	**-**
Total income other than income from State Government	**74,085**	**84,036**	**1,456**	**1,905**	**63,618**	**60,218**	**1,988**	**1,057**	**-**	**1**
NET COST OF SERVICES	**1,196,897**	**1,125,877**	**181,921**	**167,268**	**242,032**	**216,410**	**256,494**	**260,284**	**18,738**	**16,684**
INCOME FROM STATE GOVERNMENT										
Department of Health - Service Agreement - State Component	719,172	667,424	109,309	99,374	145,429	100,818	4,419	11,230	17,635	15,542
Department of Health - Service Agreement - Commonwealth Component	359,198	402,021	63,067	59,507	87,999	107,028	-	-	4,708	4,435
Grants and subsidies from Mental Health Commission	-	-	-	-	-	-	252,074	243,678	-	-
Grants from other state government agencies	285	192	11	13	109	70	-	-	598	1,133
Assets (transferred)/assumed	442	-	33	-	185	-	-	-	-	-
Services received free of charge	70,818	60,879	7,050	5,953	18,279	15,438	-	5,377	-	439
Royalties for regions fund	-	-	-	-	-	-	-	-	-	-
Total income from State Government	**1,149,915**	**1,130,516**	**179,470**	**164,847**	**252,001**	**223,354**	**256,493**	**260,285**	**22,941**	**21,549**
SURPLUS/(DEFICIT) FOR THE PERIOD	**(46,982)**	**4,639**	**(2,451)**	**(2,421)**	**9,969**	**6,944**	**(1)**	**1**	**4,203**	**4,865**

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

Notes to the Financial Statements
For the year ended 30 June 2021

2.2 Schedule of Income and Expenses by Service (continued)

	Public and Community Health Services		Community Dental Services		Small Rural Hospital Services		Health System Management - Policy and Corporate Services		Total	
	2021 $'000	2020 $'000	2021 $'000	2020 $'000	2021 $'000	2020 $'000	2021 $'000	2020 $'000	2021 $'000	2020 $'000
COST OF SERVICES										
Expenses										
Employee benefits expense	53,824	49,860	70,390	74,684	-	-	11,342	6,747	1,195,020	1,144,530
Contracts for services	16,747	15,499	843	688	396	396	-	-	486,219	457,407
Patient support costs	15,012	16,639	14,293	13,673	-	-	34	2	342,814	322,379
Finance costs	140	115	22	16	-	-	-	-	689	603
Depreciation and amortisation expense	4,895	5,228	2,582	2,308	-	-	-	1	71,528	69,675
Loss on disposal of non-current assets	28	109	42	(5)	-	-	-	-	373	180
Repairs, maintenance and consumable equipment	12,999	9,132	2,449	2,689	-	-	26	18	44,503	39,017
Other supplies and services	5,186	5,871	4,849	4,403	-	10	62	12	79,118	71,989
Other expenses	19,524	12,914	5,995	5,794	-	-	489	333	59,134	55,096
Total cost of services	**128,355**	**115,367**	**101,465**	**104,250**	**396**	**406**	**11,953**	**7,113**	**2,279,398**	**2,160,876**
INCOME										
Revenue										
Patient charges	-	-	5,209	5,730	-	-	-	-	66,197	71,895
Other fees and services	4,712	4,424	5,423	4,753	-	-	-	-	81,345	78,406
Other grants and contributions	2,083	2,071	93	729	-	-	-	-	2,501	3,288
Donation revenue	550	629	-	-	-	-	-	-	629	654
Interest revenue	-	67	-	-	-	-	-	-	-	67
Other revenue	12,705	13,338	445	327	-	-	-	-	21,695	24,781
Total revenue	**20,050**	**20,529**	**11,170**	**11,539**	**-**	**-**	**-**	**-**	**172,367**	**179,091**
Gains										
Other gains	-	16	-	-	-	-	-	-	-	210
Total gains	**-**	**16**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**210**
Total income other than income from State Government	**20,050**	**20,545**	**11,170**	**11,539**	**-**	**-**	**-**	**-**	**172,367**	**179,301**
NET COST OF SERVICES	**108,305**	**94,822**	**90,295**	**92,711**	**396**	**406**	**11,953**	**7,113**	**2,107,031**	**1,981,575**
INCOME FROM STATE GOVERNMENT										
Department of Health - Service Agreement - State Component	94,009	90,008	78,178	77,629	396	-	9,369	6,526	1,177,916	1,068,551
Department of Health - Service Agreement - Commonwealth Component	11,996	8,050	11,421	9,686	-	-	-	-	538,389	590,727
Grants and subsidies from Mental Health Commission	-	-	-	-	-	-	-	-	252,074	243,678
Grants from other state government agencies	25	232	50	36	-	-	-	-	1,078	1,676
Assets (transferred)/assumed	131	-	-	14	-	-	(3)	-	788	14
Services received free of charge	4,874	4,797	4,469	4,149	-	6	-	-	105,490	97,038
Royalties for regions fund	-	-	-	-	-	400	-	-	-	400
Total income from State Government	**111,035**	**103,087**	**94,118**	**91,514**	**396**	**406**	**9,366**	**6,526**	**2,075,735**	**2,002,084**
SURPLUS/(DEFICIT) FOR THE PERIOD	**2,730**	**8,265**	**3,823**	**(1,197)**	**-**	**-**	**(2,587)**	**(587)**	**(31,296)**	**20,509**

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

Notes to the Financial Statements
For the year ended 30 June 2021

3 Use of our funding

Expenses incurred in the delivery of services

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

	Notes	2021 $'000	2020 $'000
Employee benefits expenses	3.1(a)	1,195,020	1,144,530
Employee related provisions	3.1(b)	321,019	304,393
Contracts for services	3.2	486,219	457,407
Patient support costs	3.3	342,814	322,379
Repairs, maintenance and consumable equipment	3.4	44,503	39,017
Other supplies and services	3.5	79,118	71,989
Other expenses	3.6	59,134	55,096

3.1(a) Employee benefits expenses

	2021 $'000	2020 $'000
Wages and salaries	1,094,944	1,046,514
Superannuation - defined contributions plans	100,076	98,016
Total employee benefits expenses	**1,195,020**	**1,144,530**
Add: AASB 16 Non-monetary benefits	1,760	1,190
Less: Employee Contribution	(36)	(44)
Net employee benefits	**1,196,744**	**1,145,676**

Wages and salaries: Employee expenses include all costs related to employment including wages and salaries, fringe benefit tax, and leave entitlements.

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

The amount recognised in profit or loss of the Statement of Comprehensive Income comprises employer contributions paid to the GSS (concurrent contributions), the WSS, the GESBs, or other superannuation funds.

AASB 16 Non-monetary benefits: Non-monetary employee benefits, that are employee benefits expenses, predominantly relate to the provision of vehicle and housing benefits are measured at the cost incurred by the Agency.

Employee Contributions: Contributions made to the Agency by employees towards employee benefits that have been provided by the Agency. This includes both AASB 16 and non-AASB 16 employee contributions.

Notes to the Financial Statements
For the year ended 30 June 2021

3.1(b) Employee related provisions

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

	2021 $'000	2020 $'000
Current		
Annual leave [a]	129,347	119,439
Time off in lieu [a]	30,185	28,677
Long service leave [b]	103,270	93,577
Deferred salary scheme [c]	1,725	1,374
	264,527	**243,067**
Non-Current		
Long service leave [b]	56,492	61,326
	56,492	**61,326**
Total employee related provisions	**321,019**	**304,393**

a) **Annual leave and time off in lieu liabilities:** Classified as current as there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

	2021 $'000	2020 $'000
Within 12 months of the end of the reporting period	105,291	97,757
More than 12 months after the end of the reporting period	54,241	50,359
	159,532	**148,116**

The provision for annual leave and time off in lieu is calculated at the present value of expected payments to be made in relation to services provided by employees up to the reporting date.

b) **Long service leave liabilities:** Unconditional long service leave provisions are classified as current liabilities as the Health Service does not have an unconditional right to defer settlement of the liability for at least 12 months after the end of the reporting period.

Pre-conditional and conditional long service leave provisions are classified as non-current liabilities because the Health Service has an unconditional right to defer the settlement of the liability until the employee has completed the requisite years of service.

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

	2021 $'000	2020 $'000
Within 12 months of the end of the reporting period	17,556	15,908
More than 12 months after the end of the reporting period	142,206	138,995
	159,762	**154,903**

Notes to the Financial Statements
For the year ended 30 June 2021

3.1(b) Employee related provisions (continued)

The provisions for long service leave is calculated at present value as the Health Service does not expect to wholly settle the amounts within 12 months. The present value is measured taking into account the present value of expected future payments to be made in relation to services provided by employees up to the reporting date. These payments are estimated using the remuneration rate expected to apply at the time of settlement, and discounted using market yields at the end of the reporting period on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

c) **Deferred salary scheme liabilities:** Classified as current where there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Actual settlement of the liabilities is expected to occur as follows:

	2021 $'000	2020 $'000
Within 12 months of the end of the reporting period	1,035	824
More than 12 months after the end of the reporting period	690	550
Carrying amount at end of period	**1,725**	**1,374**

Key sources of estimation uncertainty – long service leave

Key estimates and assumptions concerning the future are based on historical experience and various other factors that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year.

Several estimates and assumptions are used in calculating the Health Service's long service leave provision. These include:

- Expected future salary rates
- Discount rates
- Employee retention rates
- Expected future payments

Changes in these estimations and assumptions may impact on the carrying amount of the long service leave provision.

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

3.2 Contracts for services

	2021 $'000	2020 $'000
Public patients services [(a)]	426,976	425,205
Mental Health	32,687	23,016
Other aged-care services	12,451	1,256
Other contracts	14,105	7,930
Total contracts for services	**486,219**	**457,407**

Contracts for services are recognised as an expense in the reporting period in which they are incurred.

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

Notes to the Financial Statements
For the year ended 30 June 2021

3.3 Patient support costs

	2021 $'000	2020 $'000
Medical supplies and services	240,706	227,093
Pathology services received free of charge	34,941	33,644
Domestic charges	23,032	18,077
Fees for visiting medical practitioners	14,376	13,563
Fuel, light and power	11,348	11,475
Food supplies	8,628	8,943
Patient transport costs	2,286	1,741
Research, development and other grants	7,497	7,843
Total patient support costs	**342,814**	**322,379**

Patient support costs are recognised as an expense in the reporting period in which they are incurred.

3.4 Repairs, maintenance and consumable equipment

	2021 $'000	2020 $'000
Repairs and maintenance	30,862	28,983
Consumable equipment	13,641	10,034
Total repairs, maintenance and consumable equipment	**44,503**	**39,017**

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

3.5 Other supplies and services

	2021 $'000	2020 $'000
Sanitisation and waste removal services	2,777	2,762
Administration and management services	2,353	2,879
Interpreter services	1,882	2,613
Security services	746	331
Services provided by Health Support Services: [(a)]		
ICT services	51,460	43,565
Supply chain services	6,824	6,499
Financial services	2,786	2,994
Human resource services	9,461	10,329
Other	829	17
Total other supplies and services	**79,118**	**71,989**

Other supplies and services are recognised as an expense in the reporting period in which they are incurred.

(a) Services received free of charge, see note 4.1 Income from State Government.

Notes to the Financial Statements
For the year ended 30 June 2021

3.6 Other expenses

	2021 $'000	2020 $'000
Communications	4,357	4,123
Computer services	2,249	2,644
Workers' compensation insurance	13,192	13,003
Other insurances	12,636	11,647
Consultancy fees	4,262	2,623
Other employee related expenses	4,541	4,869
Printing and stationery	3,818	3,754
Expected credit losses expense	662	179
Freight and cartage	1,722	916
Periodical subscriptions	772	1,032
Motor vehicle expenses	1,361	1,419
General administration	6,574	5,749
Legal expenses	105	202
Rental	1,339	1,031
Other	1,544	1,905
Total other expenses	**59,134**	**55,096**

Other expenses generally represent the day-to-day running costs incurred in normal operations.

Expected credit losses expense is recognised as the movement in the allowance for expected credit losses. The allowance for expected credit losses of trade receivables is measured at the lifetime expected credit losses at each reporting date. The Health Service has established a provision matrix that is based on its historical credit losses experience, adjusted for forward-looking factors specific to the debtors and the economic environment. Please refer to note 6.1.1 Movement in the allowance for impairment of receivables.

Rental expenses include variable lease payments, short-term leases with a lease term of 12 months of less and low value leases with an underlying value of $5,000 or less, except where the leases are with another wholly owned public sector entity lessor agency.

Notes to the Financial Statements
For the year ended 30 June 2021

4 Our funding sources

How we obtain our funding

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

	Notes	2021 $'000	2020 $'000
Income from State Government	4.1	2,075,735	2,002,084
Patient charges	4.2	66,197	71,895
Other fees for services	4.3	81,345	78,406
Other grants and contributions	4.4	2,501	3,288
Donation revenue		629	654
Interest revenue		-	67
Other revenue	4.5	21,695	24,781
Other gains	4.6	-	210

4.1 Income from State Government

	2021 $'000	2020 $'000
Appropriation received for the period:		
Department of Health - Service Agreement - State Component	1,177,916	1,068,551
Department of Health - Service Agreement - Commonwealth Component		
- Capital grants	2,308	820
- Recurrent grants	536,081	589,907
Grants and subsidies from Mental Health Commission	252,074	243,678
Total appropriation received	**1,968,379**	**1,902,956**
Grants and income from other state government agencies:		
Disability Services Commission	598	1,133
Recoveries for Insurance Claims from State Government Insurers	206	62
Pathology services to other Health Services	31	147
Other specific grants	243	334
Total grants and subsidies	**1,078**	**1,676**
Assets from/(to) WA Country Health Service (WACHS)	788	14
Total assets assumed	788	14
Resources received from other public sector entities during the period:		
Department of Finance - government leased accommodation	18	6
PathWest - pathology services	34,941	33,644
Services received from Health Support Services (HSS)		
ICT Services	51,460	43,566
Supply chain services	6,824	6,499
Financial services	2,786	2,994
Human resources services	9,461	10,329
Total received	**105,490**	**97,038**
Regional Community Services Account	-	400
Total Royalties for Regions Fund	**-**	**400**
Total income from State Government	**2,075,735**	**2,002,084**

Following the update in Treasury Instruction 1102, revenue is recognised based on the immediate funding source. As a result, service appropriation, Commonwealth grants and contributions received via the service agreements with Department of Health, and other grants and contributions that are received from other public sector entities in the prior year have been reclassified accordingly.

Notes to the Financial Statements
For the year ended 30 June 2021

4.1 Income from State Government (continued)

Service Appropriation is recognised at fair value in the period in which the Health Service gains control of the appropriated funds. The Health Service gains control of appropriated funds at the time those funds are deposited to the bank account or credited to the holding account held at Treasury.

The Health Service has determined that all grant income is to be recognised as income of not-for-profit entities in accordance with AASB 1058, except for grants that are enforceable and with sufficiently specific performance obligations and accounted for as revenue from contracts with customers in accordance with AASB 15. The grants are recognised as revenue on receipt of cash, except for capital grants.

Key judgements include determining the timing of revenue from contracts with customers in terms of timing of satisfaction of performance obligations and determining the transaction price and the amounts allocated to performance obligations.

Capital grants are recognised as income in accordance with the progress of the capital project.

Assets transferred from other parties are recognised as income at fair value when the assets are transferred.

Services received free of charge (SRFOC) that the Health Service would otherwise purchase if not donated, are recognised as income at the fair value of the services where they can be reliably measured.

The Regional Community Services Account is a sub-fund within the overarching 'Royalties for Regions Fund'. The recurrent funds are committed to projects and programs in WA regional areas and are recognised as revenue when the Health Service receives the funds. The Health Service has assessed Royalties for Regions agreements and concludes that they are not within the scope of AASB 15 as they do not meet the 'sufficiently specific' criterion.

4.2 Patient charges

	2021 $'000	2020 $'000
Inpatient bed charges	44,507	47,508
Inpatient other charges	4,822	7,149
Outpatient charges	16,868	17,238
Total patient charges	**66,197**	**71,895**

The WA Health Fees and Charges Manual sets out the standard fees and charges that may be applied by the Health Service when providing specific health services to patients. The fees and charges are recognised at the point in time that the services are provided.

4.3 Other fees for services

	2021 $'000	2020 $'000
Recoveries from Commonwealth Government	76,408	73,632
Clinical services to other health organisations	3,531	3,165
Non-clinical services to other health organisations	1,406	1,609
Total other fees for services	**81,345**	**78,406**

Other fees for services are recognised when the services are performed.

For example, the recoveries from the Pharmaceutical Benefits Scheme (PBS) represents the reimbursement for subsidised pharmaceuticals items under Highly Specialised Drugs program. The recoveries are typically received in arrears and are recognised as recoveries from Commonwealth Government.

Notes to the Financial Statements
For the year ended 30 June 2021

4.4 Other grants and contributions

	2021 $'000	2020 $'000
Research grants	2,501	3,288
	2,501	**3,288**

The accounting policy for other grants and contributions are similar to that of Commonwealth grants and contributions. Please refer to Note 4.1.

4.5 Other revenue

	2021 $'000	2020 $'000
Use of hospital facilities	7,284	6,252
Rent from commercial properties	335	288
Rent from residential properties	258	293
Boarders' accommodation	2,100	1,904
RiskCover insurance premium rebate	1,945	5,739
Sale of radiopharmacies	3,513	2,613
Parking	4,787	4,583
Other	1,473	3,109
Total other revenue	**21,695**	**24,781**

Other revenue items, other than RiskCover insurance premium rebate, have been assessed as revenue under AASB 15 and have been recognised at either a point-in-time or over-time when the performance obligations have been fulfilled.

RiskCover insurance premium rebate represents an adjustment received from RiskCover relating to prior year expenditure. This performance adjustment is received in arrears from RiskCover and is recognised as revenue upon receiving the adjustment. The Health Service recognises the revenue when the rebate is received.

4.6 Other gains

	2021 $'000	2020 $'000
Reversal of impairment losses in prior year	-	210
	-	**210**

5 Key Assets

Assets the Health Service utilises for economic benefit or service potential

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

	Notes	2021 $'000	2020 $'000
Property, plant and equipment	5.1	1,079,871	1,088,295
Depreciation	5.1.1	58,172	59,378
Right-of-use assets	5.2	20,724	22,822
Depreciation	5.2	4,589	3,931
Service concession assets	5.3	254,708	235,613
Depreciation	5.3	8,637	6,209
Intangible assets	5.4	922	500
Amortisation	5.4.1	130	157

Notes to the Financial Statements
For the year ended 30 June 2021

5.1 Infrastructure, property, plant and equipment

	Land $'000	Buildings $'000	Buildings under construction $'000	Site infrastructure $'000	Leasehold improvements $'000	Computer equipment $'000	Furniture and fittings $'000	Motor vehicles $'000	Medical equipment $'000	Other plant and equipment $'000	Work in progress $'000	Artworks $'000	Total $'000
1 July 2019													
Opening carrying amount	229,788	894,764	5,217	124,265	3,082	380	5,158	97	63,075	63,022	5	310	1,389,163
Net adjustment on initial application of AASB 1059	(28,500)	(190,305)	(83)	(42,306)	-	(128)	(1,952)	-	(4,663)	(55)	-	-	(267,992)
Restated opening carrying amount 1 July 2019	**201,288**	**704,459**	**5,134**	**81,959**	**3,082**	**252**	**3,206**	**97**	**58,412**	**62,967**	**5**	**310**	**1,121,171**
Gross carrying amount	201,288	704,459	5,434	93,688	4,598	759	4,713	210	104,557	74,600	51	345	1,194,702
Accumulated depreciation	-	-	-	(11,729)	(1,516)	(507)	(1,392)	(113)	(44,531)	(11,550)	-	-	(71,338)
Accumulated impairment loss	-	-	(300)	-	-	-	(115)	-	(1,615)	(83)	(46)	(35)	(2,194)
Carrying amount at start of year	**201,288**	**704,459**	**5,134**	**81,959**	**3,082**	**252**	**3,206**	**97**	**58,411**	**62,967**	**5**	**310**	**1,121,170**
Additions	-	294	2,760	-	-	2,312	870	-	12,154	723	-	-	19,113
Disposal	-	-	-	-	-	-	(4)	-	(173)	(7)	-	-	(184)
Transfers to other reporting entities	-	-	-	-	-	-	(31)	-	(2,810)	(56)	-	-	(2,897)
Transfers from /(to) other asset classes	-	(493)	493	-	-	-	5	-	(5)	-	-	-	-
Revaluation increments/(decrements)	(172)	10,433	-	-	-	-	-	-	-	-	-	-	10,261
Impairment losses reversed	-	-	-	-	-	-	-	-	210	-	-	-	210
Depreciation	-	(38,084)	-	(3,817)	(639)	(350)	(463)	(27)	(12,307)	(3,691)	-	-	(59,378)
Carrying amount at 30 June 2020	**201,116**	**676,609**	**8,387**	**78,142**	**2,443**	**2,214**	**3,583**	**70**	**55,480**	**59,936**	**5**	**310**	**1,088,295**
Gross carrying amount	201,116	676,609	8,687	93,688	4,598	3,071	5,553	210	113,723	75,260	51	345	1,182,911
Accumulated depreciation	-	-	-	(15,546)	(2,155)	(857)	(1,855)	(140)	(56,838)	(15,241)	-	-	(92,632)
Accumulated impairment loss	-	-	(300)	-	-	-	(115)	-	(1,405)	(83)	(46)	(35)	(1,984)

The infrastructure, property, plant and equipment should be read in conjunction with the accompanying notes.

Notes to the Financial Statements
For the year ended 30 June 2021

5.1 Infrastructure, property, plant and equipment (continued)

	Land $'000	Buildings $'000	Buildings under construction $'000	Site infrastructure $'000	Leasehold improvements $'000	Computer equipment $'000	Furniture and fittings $'000	Motor vehicles $'000	Medical equipment $'000	Other plant and equipment $'000	Work in progress $'000	Artworks $'000	Total $'000
1 July 2020													
Gross carrying amount	201,116	676,609	8,687	93,688	4,598	3,071	5,553	210	113,723	75,260	51	345	1,182,911
Accumulated depreciation	-	-	-	(15,546)	(2,155)	(857)	(1,855)	(140)	(56,838)	(15,241)	-	-	(92,632)
Accumulated impairment loss	-	-	(300)	-	-	-	(115)	-	(1,405)	(83)	(46)	(35)	(1,984)
Carrying amount at start of period	**201,116**	**676,609**	**8,387**	**78,142**	**2,443**	**2,214**	**3,583**	**70**	**55,480**	**59,936**	**5**	**310**	**1,088,295**
Additions	-	-	24,193	-	-	174	393	30	9,276	115	2,338	-	36,519
Disposals	-	-	-	-	-	(7)	(197)	-	(457)	(584)	-	-	(1,245)
Transfers from/(to) other reporting entities	-	-	-	-	-	-	-	-	778	11	-	-	789
Transfers from /(to) other asset classes	-	-	-	-	-	(340)	(61)	-	401	-	-	-	-
Revaluation increments/(decrements)	155	13,530	-	-	-	-	-	-	-	-	-	-	13,685
Depreciation	-	(37,148)	-	(3,817)	(483)	(342)	(519)	(24)	(12,219)	(3,620)	-	-	(58,172)
Carrying amount at 30 June 2021	**201,271**	**652,991**	**32,580**	**74,325**	**1,960**	**1,699**	**3,199**	**76**	**53,259**	**55,858**	**2,343**	**310**	**1,079,871**
Gross carrying amount	201,271	652,991	32,580	93,251	4,599	2,705	5,437	246	106,620	74,125	2,343	310	1,176,478
Accumulated depreciation	-	-	-	(18,926)	(2,639)	(1,006)	(2,165)	(170)	(53,182)	(18,216)	-	-	(96,304)
Accumulated impairment loss	-	-	-	-	-	-	(73)	-	(179)	(51)	-	-	(303)

The infrastructure, property, plant and equipment should be read in conjunction with the accompanying notes.

5.1 Infrastructure, property, plant and equipment (continued)

Initial recognition

Items of property, plant and equipment and infrastructure costing, $5,000 or more are measured initially at cost. Where an asset is acquired for no or nominal cost, the cost is valued at its fair value at the date of acquisition. Items of property, plant and equipment and infrastructure costing less than $5,000 are immediately expensed direct to the Statement of Comprehensive Income (other than where they form part of a group of similar items which are significant in total).

Assets transferred as part of a machinery of government change are transferred at their fair value.

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

Subsequent measurement

Subsequent to initial recognition of an asset, the revaluation model is used for the measurement of:

- land
- buildings

Land is carried at fair value.

Buildings are carried at fair value less accumulated depreciation and accumulated impairment losses.

All other property, plant and equipment are stated at historical cost less accumulated depreciation and accumulated impairment losses.

Revaluation model:

(a) Fair value where market-based evidence is available

The fair value of land and buildings is on the basis of current market values determined by reference to recent market transactions.

(b) Fair value in the absence of market-based evidence

Buildings are specialised or where land is restricted: Fair value of land and buildings is determined on the basis of existing use.

Existing use buildings: Fair value is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset, i.e. the current replacement cost.

Restricted use land: Fair value is determined by comparison with market evidence for land with similar approximate utility (high restricted use land) or market value of comparable unrestricted land (low restricted use land).

Significant assumptions and judgements: The most significant assumptions and judgements in estimating fair value are made in assessing whether to apply the existing use basis to assets and in determining estimated economic life. Professional judgement by the valuer is required where the evidence does not provide a clear distinction between market type assets and existing use assets.

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

Land and buildings were revalued as at 1 July 2020 by the Western Australian Land Information Authority (Valuations and Property Analytics). The valuations were performed during the year ended 30 June 2021 and recognised at 30 June 2021. In undertaking the revaluation, fair value was determined by reference to market values for land: $4.215 million (2020: $4.07 million) and buildings: $0.34 million (2020: $0.32 million). For the remaining balance, fair value of buildings was determined on the basis of current replacement cost and fair value of land was determined on the basis of comparison with market evidence for land with low level utility (high restricted use land).

Notes to the Financial Statements
For the year ended 30 June 2021

5.1.1 Depreciation and impairment

	2021 $'000	2020 $'000
Depreciation		
Buildings	37,149	38,084
Site infrastructure	3,817	3,817
Leasehold improvement	483	639
Computer equipment	342	350
Furniture and fittings	519	463
Motor vehicles	24	27
Medical equipment	12,219	12,307
Other plant and equipment	3,619	3,691
Total depreciation for the period	**58,172**	**59,378**

All surplus assets at 30 June 2021 have either been classified as assets held for sale or have been written-off.

Please refer to note 5.4 for guidance in relation to the impairment assessment that has been performed for intangible assets.

Finite useful lives

All infrastructure, property, plant and equipment having a limited useful life are systematically depreciated over their estimated useful lives in a manner that reflects the consumption of their future economic benefits. The exceptions to this rule include assets held for sale, land and investment properties.

Depreciation is generally calculated on a straight line basis at rates that allocate the asset's value, less any estimated residual value, over its estimated useful life. Typical estimated useful lives for the different asset classes for current and prior years are included in the table below:

Asset	Useful life:
Buildings	50 years
Site infrastructure	50 years
Leasehold Improvements	Life of lease
Computer equipment	4 to 10 years
Furniture and fittings	5 to 20 years
Motor vehicles	4 to 7 years
Medical equipment	3 to 25 years
Other plant and equipment	3 to 50 years

The estimated useful lives, residual values and depreciation method are reviewed at the end of each annual reporting period, and adjustments made where appropriate.

Land and works of art, which are considered to have an indefinite life, are not depreciated. Depreciation is not recognised in respect of these assets because their service potential has not, in any material sense, been consumed during the reporting period.

Impairment

Non-financial assets, including items of plant and equipment, are tested for impairment whenever there is an indication that the asset may be impaired. Where there is an indication of impairment, the recoverable amount is estimated. Where the recoverable amount is less than the carrying amount, the asset is considered impaired and is written down to the recoverable amount and an impairment loss is recognised.

Where an asset measured at cost is written down to its recoverable amount, an impairment loss is recognised through profit or loss.

Where a previously revalued asset is written down to its recoverable amount, the loss is recognised as a revaluation decrement through other comprehensive income.

Notes to the Financial Statements
For the year ended 30 June 2021

5.1.1 Depreciation and impairment (continued)

As the Health Service is a not-for-profit Health Service, the recoverable amount of regularly revalued specialised assets is anticipated to be materially the same as fair value.

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

The risk of impairment is generally limited to circumstances where an asset's depreciation is materially understated, where the replacement cost is falling or where there is a significant change in useful life. Each relevant class of assets is reviewed annually to verify that the accumulated depreciation/amortisation reflects the level of consumption or expiration of the asset's future economic benefits and to evaluate any impairment risk from declining replacement costs.

5.2 Right-of-use assets

	Land $'000	Buildings $'000	Plant equipment and vehicles $'000	Total $'000
1 July 2019				
Gross carrying amount	-	-	-	-
Accumulated amortisation	-	-	-	-
Carrying amount at start of period	-	-	-	-
Recognition of right-of-use asset on initial application of AASB 16	677	15,916	3,082	19,675
Adjusted balance at 1 July 2019	**677**	**15,916**	**3,082**	**19,675**
Additions	-	8,309	-	8,309
Transfers from/(to) other reporting entities	-	-	(20)	(20)
Derecognition	-	(1,211)	-	(1,211)
Depreciation	(115)	(2,683)	(1,133)	(3,931)
Carrying amount at 30 June 2020	**562**	**20,331**	**1,929**	**22,822**
Gross carrying amount	677	23,014	3,062	26,753
Accumulated amortisation	(115)	(2,683)	(1,133)	(3,931)
1 July 2020				
Gross carrying amount	677	23,014	3,062	26,753
Accumulated amortisation	(115)	(2,683)	(1,133)	(3,931)
Carrying amount at start of period	**562**	**20,331**	**1,929**	**22,822**
Additions		1,581	167	1,748
Cost Adjustment	30	5	864	899
Disposals	-	(103)	(53)	(156)
Depreciation	(115)	(2,772)	(1,702)	(4,589)
Carrying amount at 30 June 2021	**477**	**19,042**	**1,205**	**20,724**
Gross carrying amount	706	23,597	3,886	28,189
Accumulated amortisation	(229)	(4,555)	(2,681)	(7,465)

Notes to the Financial Statements
For the year ended 30 June 2021

5.2 Right-of-use assets (continued)

Initial recognition

At inception of a contract, the Health Service assesses whether a contract is, or contains, a lease. A contract is, or contains, a lease if the contract conveys a right to control the use of an identified asset for a period of time in exchange for consideration.

The Health Service assesses whether:

i. The contract involves the use of an identified asset. The asset may be explicitly or implicitly specified in the contract.

ii. The customer has the right to obtain substantially all of the economic benefits from the use of the asset throughout the period of use.

iii. The customer has the right to direct the use of the asset throughout the period of use. The customer is considered to have the right to direct the use of the asset only if either:

1. The customer has the right to direct how and for what purpose the identified asset is used throughout the period of use; or

2. The relevant decisions about how and for what purposes the asset is used is predetermined and the customer has the right to operate the asset, or the customer designed the asset in a way that predetermines how and for what purpose the asset will be used throughout the period of use.

Right-of-use assets are measured at cost including the following:

- the amount of the initial measurement of lease liability
- any lease payments made at or before the commencement date less any lease incentives received
- any initial direct costs, and
- restoration costs, including dismantling and removing the underlying asset

This includes all leased assets other than investment property ROU assets, which are measured in accordance with AASB 140 'Investment Property'.

The Health Service has elected not to recognise right-of-use assets and lease liabilities for short-term leases (with a lease term of 12 months or less) and low value leases (with an underlying value of $5,000 or less) except where the lease is with another wholly-owned public sector entity lessor agency. Lease payments associated with these leases are expensed over a straight-line basis over the lease term and are recognised as an expense in the statement of comprehensive income.

Subsequent Measurement

The cost model is applied for subsequent measurement of right-of-use assets, requiring the asset to be carried at cost less any accumulated depreciation and accumulated impairment losses and adjusted for any re-measurement of lease liability.

Depreciation and impairment of right-of-use assets

Right-of-use assets are depreciated on a straight-line basis over the shorter of the lease term and the estimated useful lives of the underlying assets.

If ownership of the leased asset transfers to the Health Service at the end of the lease term or the cost reflects the exercise of a purchase option, depreciation is calculated using the estimated useful life of the asset.

Right-of-use assets are tested for impairment when an indication of impairment is identified. The policy in connection with testing for impairment is outlined in note 5.1.1.

Notes to the Financial Statements
For the year ended 30 June 2021

5.2 Right-of-use assets (continued)

The following amounts relating to leases have been recognised in the statement of comprehensive income:

	2021 $'000	2020 $'000
Depreciation expense of right-of-use assets	4,589	3,931
Lease interest expense	689	586
Expenses relating to variable lease payments not included in lease liabilities	48	17
Short-term leases	59	78
Low-value leases	-	1
		-
Total amount recognised in the statement of comprehensive income	**5,385**	**4,613**

The total cash outflow for leases in 2021 was $4,182,000.

The Health Service has leases for vehicles, office and residential accommodations.

The Health Service has also entered into a Memorandum of Understanding Agreements (MOU) with the Department of Finance for the leasing of office accommodation. These are not recognised under AASB 16 because of substitution rights held by the Department of Finance and are accounted for as an expense as incurred.

The Health Service recognises leases as right-of-use assets and associated lease liabilities in the Statement of Financial Position.

The corresponding lease liabilities in relation to these right-of-use assets have been disclosed in note 7.1.

Notes to the Financial Statements
For the year ended 30 June 2021

5.3 Service concession assets

	Land $'000	Buildings $'000	Buildings under construction $'000	Site infrastructure $'000	Computer equipment $'000	Furniture & fittings $'000	Medical equipment $'000	Other plant & equipment $'000	Total $'000
1 July 2019									
Opening carrying amount									-
Net adjustment on initial application of AASB 1059	28,500	190,305	83	14,120	128	1,952	4,663	55	239,806
Restated opening carrying amount	**28,500**	**190,305**	**83**	**14,120**	**128**	**1,952**	**4,663**	**55**	**239,806**
1 July 2019									
Gross carrying amount	28,500	190,305	83	14,120	128	1,952	4,663	55	239,806
Accumulated depreciation	-	-	-	-	-	-	-	-	
Carrying amount at start of period	**28,500**	**190,305**	**83**	**14,120**	**128**	**1,952**	**4,663**	**55**	**239,806**
Additions	-	-	2,483	-	-	-	-	-	2,483
Transfer from Work in Progress	-	747	(747)	-	-	-	-	-	-
Revaluation increments/(decrements)	-	(467)							(467)
Depreciation	-	(4,628)	-	(336)	(32)	(205)	(1,000)	(8)	(6,209)
Carrying amount at 30 June 2020	**28,500**	**185,957**	**1,819**	**13,784**	**96**	**1,747**	**3,663**	**47**	**235,613**
Gross carrying amount	28,500	185,957	1,819	14,120	128	1,952	4,663	55	237,194
Accumulated depreciation	-	-	-	(336)	(32)	(205)	(1,000)	(8)	(1,581)
1 July 2020									
Gross carrying amount	28,500	185,957	1,819	14,120	128	1,952	4,663	55	237,194
Accumulated amortisation	-	-	-	(336)	(32)	(205)	(1,000)	(8)	(1,581)
Carrying amount at start of period	**28,500**	**185,957**	**1,819**	**13,784**	**96**	**1,747**	**3,663**	**47**	**235,613**
Additions			28,111						28,111
Revaluation increments/(decrements)		(379)							(379)
Depreciation		(3,969)	-	(337)	(32)	(720)	(3,549)	(30)	(8,637)
Carrying amount at 30 June 2021	**28,500**	**181,609**	**29,930**	**13,447**	**64**	**1,027**	**114**	**17**	**254,708**
Gross carrying amount	28,500	181,609	29,930	14,120	128	1,952	4,663	55	260,957
Accumulated depreciation	-	-	-	(673)	(64)	(925)	(4,549)	(38)	(6,249)

The Service concession assets should be read in conjunction with the accompanying notes.

Notes to the Financial Statements
For the year ended 30 June 2021

5.3 Service concession assets (continued)

Initial recognition

A service concession arrangement is an arrangement which involves an operator:

- that is contractually obliged to provide public services related to a service concession asset on behalf of the grantor; and
- managing at least some of those services under its own discretion, rather than at the direction of the grantor.

The health service as the grantor has identified one service concession arrangement in operation at the time of initial recognition on 1 July 2019.

Ramsay Health Care (Ramsay) holds a 20-year contract to provide a range of services to public patients at Joondalup Health Campus. The contract, which is managed by the North Metropolitan Health Service (NMHS), specifies an annual maximum operating budget for required levels of activity and the services to be provided to public patients.

Where the health service has existing assets which meet the conditions specified in the policy, these assets have been reclassified as service concession assets and have been measured based on the current replacement cost in accordance with the cost approach to fair value in AASB 13 as at the date of reclassification.

Subsequent to initial recognition or reclassification, a service concession asset is depreciated or amortised in accordance with AASB 116 Property, Plant and Equipment with any impairment recognised in accordance with AASB 136.

Subsequent measurement

Subsequent to initial recognition of an asset, the revaluation model is used for the measurement of:

- land
- buildings

The policy in connection with the revaluation model is outlined in note 5.1

Depreciation and impairment of service concession assets

	2021 $'000	2020 $'000
Charge for the period		
Buildings	3,969	4,628
Site infrastructure	337	336
Plant and equipment	31	8
Information, computer and telecommunications equipment	32	32
Furniture and fittings	719	205
Medical equipment	3,549	1,000
Total depreciation for the period	**8,637**	**6,209**

Notes to the Financial Statements
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5.3 Service concession assets (continued)

Finite useful lives

Service concession assets are systematically depreciated over their estimated useful lives in a manner that reflects the consumption of their future economic benefits.

Depreciation is calculated on a straight-line basis, at rates that allocate the asset's value, less any estimated residual value, over its estimated useful life.

Estimated useful lives for the different asset classes for current and prior years are included in the table below:

Asset	Useful life:
Buildings	50 years
Site infrastructure	50 years
Medical equipment	2 to 25 years
Other plant and equipment	3 to 25 years

The estimated useful lives, residual values and depreciation method are reviewed at the end of each annual reporting year, and any adjustments are made where appropriate.

Land and artworks, which are considered to have an indefinite life, are not depreciated. Depreciation is not recognised in respect of these assets because their service potential had not, in any material sense, been consumed during the reporting period.

Impairment

Service concession assets with finite useful lives are tested for impairment annually or when an indication of impairment is identified.

As at 30 June 2021 there were no indications of impairment to service concession assets.

The policy in connection with testing for impairment is outlined in Depreciation and impairment note 5.1.1.

5.4 Intangible assets

	Computer software $'000	Works in progress $'000	Total $'000
Year ended 30 June 2020			
1 July 2019			
Gross carrying amount	785	-	785
Accumulated amortisation	(331)	-	(331)
Carrying amount at start of year	**454**	**-**	**454**
Additions	203	-	203
Amortisation expense	(157)	-	(157)
Carrying amount at 30 June 2020	**500**	**-**	**500**
Gross carrying amount	988	-	988
Accumulated amortisation	(488)	-	(488)
Year ended 30 June 2021			
1 July 2020			
Gross carrying amount	988	-	988
Accumulated amortisation	(488)	-	(488)
Carrying amount at start of year	**500**	**-**	**500**
Additions	559	-	559
Disposals	(7)	-	(7)
Amortisation expense	(130)	-	(130)
Carrying amount at 30 June 2021	**922**	**-**	**922**
Gross carrying amount	1,462	-	1,462
Accumulated amortisation	(540)	-	(540)

Notes to the Financial Statements
For the year ended 30 June 2021

5.4 Intangible assets (continued)

Initial recognition

Acquisitions of intangible assets costing $5,000 or more and internally generated intangible assets costing $50,000 or more that comply with the recognition criteria as per AASB 138.57 (as noted below), are capitalised.

Costs incurred below these thresholds are immediately expensed directly to the Statement of Comprehensive Income.

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

An internally generated intangible asset arising from development (or from the development phase of an internal project) is recognised if, and only if, all of the following are demonstrated:

(a) the technical feasibility of completing the intangible asset so that it will be available for use or sale;

(b) an intention to complete the intangible asset and use or sell it;

(c) the ability to use or sell the intangible asset;

(d) the intangible asset will generate probable future economic benefit;

(e) the availability of adequate technical, financial and other resources to complete the development and to use or sell the intangible asset; and

(f) the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Cost incurred in the research phase of a project are immediately expensed.

Subsequent measurement

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

5.4.1 Amortisation and impairment

	2021 $'000	2020 $'000
Computer software	130	157
Total amortisation for the period	**130**	**157**

The Health Service held no goodwill or intangible assets with an indefinite useful life during the reporting period. At the end of the reporting period there were no intangible assets not yet available for use.

Amortisation of finite life intangible assets is calculated on a straight line basis at rates that allocate the asset's value over its estimated useful life. All intangible assets controlled by the Health Service have a finite useful life and zero residual value. Estimated useful lives are reviewed annually.

The estimated useful life for the following intangible asset class is:

Computer software [a]	5 years

(a) Software that is an integral part of the related hardware is recognised as property, plant and equipment. Software that is not an integral part of the related hardware is recognised as an intangible asset. Software costing less than $5,000 is expensed in the year of acquisition.

Impairment of intangible assets

Intangible assets with finite useful lives are tested for impairment annually or when an indication of impairment is identified.

The policy in connection with testing for impairment is outlined in note 5.1.1.

Notes to the Financial Statements
For the year ended 30 June 2021

6 Other assets and liabilities

This section sets out those assets and liabilities that arose from the Health Service's controlled operations and includes other assets utilised for economic benefits and liabilities incurred during normal operations:

	Notes	2021 $'000	2020 $'000
Receivables	6.1	48,054	68,417
Amounts receivable for services	6.2	904,003	831,718
Inventories	6.3	7,465	7,067
Other current assets	6.4	2,907	2,084
Payables	6.5	177,282	169,703
Contract liabilities	6.6	7,757	2,903
Other liabilities	6.7	1,889	1,989

6.1 Receivables

	2021 $'000	2020 $'000
Current		
Trade receivables	34,326	56,591
Other receivables	472	516
Allowance for impairment of trade receivables	(13,349)	(29,944)
Accrued revenue	18,291	32,649
GST receivable	8,314	8,605
Total current receivables	**48,054**	**68,417**

Trade receivables are recognised at original invoice amount less any allowances for uncollectible amounts (i.e. impairment). The carrying amount of net trade receivables is equivalent to fair value as it is due for settlement within 30 days.

6.1.1 Movement in the allowance for impairment of trade receivables

	2021 $'000	2020 $'000
Reconciliation of changes in the allowance for impairment of trade receivables		
Balance at start of period	29,944	37,200
Transfer to another Health Service	-	(255)
Expected credit losses expense	804	179
Amounts written off during the period	(17,399)	(7,180)
Balance at end of period	**13,349**	**29,944**

The maximum exposure to credit risk at the end of the reporting period for receivables is the carrying amount of the asset inclusive of any allowance for impairment as shown in the table at Note 8.1'(c) 'Credit risk exposure'.

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

6.2 Amounts receivable for services

	2021 $'000	2020 $'000
Current	-	-
Non-current	904,003	831,718
Balance at end of period	**904,003**	**831,718**

Amounts receivable for services represent the non-cash component of service appropriations. It is restricted in that it can only be used for asset replacement or payment of leave liability.

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

Notes to the Financial Statements
For the year ended 30 June 2021

6.3 Inventories

	2021 $'000	2020 $'000
Current		
Pharmaceutical stores - at cost	6,954	6,557
Engineering stores - at cost	511	510
Total inventories	**7,465**	**7,067**

Inventories are measured at the lower of cost and net realisable value. Costs are assigned on a weighted average cost basis.

Inventories not held for resale are measured at cost unless they are no longer required, in which case they are measured at net realisable value.

6.4 Other current assets

	2021 $'000	2020 $'000
Current		
Prepayments	2,907	2,084
Total other current assets	**2,907**	**2,084**

Other non-financial assets include prepayments which represent payments in advance of receipt of goods or services or that part of expenditure made in one accounting period covering a term extending beyond that period.

6.5 Payables

	2021 $'000	2020 $'000
Current		
Trade payables	10,036	20,251
Other payables	17,145	16,490
Accrued expenses	120,443	107,301
Accrued salaries	29,658	25,661
Total current payables	**177,282**	**169,703**

Payables are recognised at the amounts payable when the Health Service becomes obliged to make future payments as a result of a purchase of assets or services. The carrying amount is equivalent to fair value as settlement is generally within 30 days.

Accrued salaries represent the amount due to staff but unpaid at the end of the reporting period. Accrued salaries are settled within a fortnight after the reporting period. The Health Service considers the carrying amount of accrued salaries to be equivalent to its fair value.

6.6 Contract liabilities

	2021 $'000	2020 $'000
Current	7,757	2,903
Non-current	-	-
Total contract liabilities	**7,757**	**2,903**

The Health Service's contract liabilities relate to capital grants received for critical infrastructure upgrade. Refer to Note 4.1 for more information.

6.7 Other current liabilities

	2021 $'000	2020 $'000
Refundable deposits	1,188	1,113
Paid parental leave scheme	203	244
Other	498	632
Total other current liabilities	**1,889**	**1,989**

Notes to the Financial Statements
For the year ended 30 June 2021

7 Financing

This section sets out the material balances and disclosures associated with the financing and cash flows of the Health Service.

	Notes	2021 $'000	2020 $'000
Lease liabilities	7.1	22,877	23,772
Finance costs	7.2	689	603
Cash and cash equivalents	7.3		
Cash and cash equivalents	7.3.1	52,472	45,000
Restricted cash and cash equivalents	7.3.1	76,413	77,137
Reconciliation of net cost of services to net cash used in operating activities	7.3.2	(1,881,619)	(1,810,123)
Capital commitments	7.4	282,194	19,860

7.1 Lease liabilities

The statement of financial position shows the following amounts relating to lease liabilities:

	2021 $'000	2020 $'000
Lease liabilities		
Current	2,629	2,671
Non-current	20,248	21,101
Total lease liabilities	**22,877**	**23,772**

The Health Service measures a lease liability, at the commencement date, at the present value of the lease payments that are not paid at that date. The lease payments are discounted using the interest rate implicit in the lease. If that rate cannot be readily determined, the Health Service uses the incremental borrowing rate provided by Western Australia Treasury Corporation.

Lease payments included by the Health Service as part of the present value calculation of lease liability include:

- Fixed payments (including in-substance fixed payments), less any lease incentives receivable;
- Variable lease payments that depend on an index or a rate initially measured using the index or rate as at the commencement date;
- Amounts expected to be payable by the lessee under residual value guarantees;
- The exercise price of purchase options (where these are reasonably certain to be exercised);
- Payments for penalties for terminating a lease, where the lease term reflects the Health Service exercising an option to terminate the lease.

The interest on the lease liability is recognised in profit or loss over the lease term so as to produce a constant periodic rate of interest on the remaining balance of the liability for each period. Lease liabilities do not include any future changes in variable lease payments (that depend on an index or rate) until they take effect, in which case the lease liability is reassessed and adjusted against the right-of-use asset.

Periods covered by extension or termination options are only included in the lease term by the Health Service if the lease is reasonably certain to be extended (or not terminated).

Variable lease payments, not included in the measurement of lease liability, that are dependent on sales are recognised by the Health Service in profit or loss in the period in which the condition that triggers those payments occurs.

This section should be read in conjunction with Note 5.2.

Notes to the Financial Statements
For the year ended 30 June 2021

7.1 Lease liabilities (continued)

Subsequent measurement

Lease liabilities are measured by increasing the carrying amount to reflect interest on the lease liabilities; reducing the carrying amount to reflect the lease payments made; and remeasuring the carrying amount at amortised cost, subject to adjustments to reflect any reassessment or lease modifications.

Key judgements to be made for AASB 16 include identifying leases within contracts, determination whether there is reasonable certainty around exercising extension and termination options, identifying whether payments are variable or fixed in substance and determining the stand-alone selling prices for lease and non-lease components.

Estimation uncertainty that may arise is the estimation of the lease term, determination of the appropriate discount rate to discount the lease payments and assessing whether the right-of-use asset needs to be impaired.

7.2 Finance costs

	2021 $'000	2020 $'000
Lease interest expense	689	586
Other interest expense	-	17
Finance costs expensed	**689**	**603**

7.3 Cash and cash equivalents

7.3.1 Reconciliation of cash

	2021 $'000	2020 $'000
Cash and cash equivalents	52,472	45,000
Restricted cash and cash equivalents	76,413	77,137
Balance at end of period	**128,885**	**122,137**
Restricted cash and cash equivalents		
Current		
Grants from State and Commonwealth Governments	8,982	11,391
Other specific purposes [a]	43,667	47,423
Mental Health Commission funding [b]	1,278	367
Total current	**53,927**	**59,181**
Non-current		
Accrued salaries suspense account [c]	22,486	17,956
Total non-current	**22,486**	**17,956**
Balance at end of period	**76,413**	**77,137**

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

(a) These include medical research grants, donations for the benefits of patients, medical education, medical equipment, scholarships, recurrent grants from the Commonwealth Government, employee contributions and employee benevolent funds.

(b) See note 9.8 Special purpose accounts.

(c) Funds held in the suspense account for the purpose of meeting the 27th pay which next occurs in the 2028 financial period. This account is classified as non-current for 10 out of 11 years.

For the purpose of the statement of cash flows, cash and cash equivalent (and restricted cash and cash equivalent) assets comprise cash on hand and short-term deposits with original maturities of three months or less that are readily convertible to a known amount of cash and which are subject to insignificant risk of changes in value.

Notes to the Financial Statements
For the year ended 30 June 2021

7.3.2 Reconciliation of net cost of services to net cash flows used in operating activities

	Notes	2021 $'000	2020 $'000
Net cost of services		(2,107,028)	(1,981,575)
Non-cash items:			
Expected credit losses expense		804	179
Depreciation and amortisation expense		71,526	69,677
Asset impairment losses/(reversal)		-	(210)
Net loss from disposal of non-current assets		374	180
Net donation of non-current assets		(83)	(222)
Adjustment for expenses related to transfer to PathWest		-	788
Services received free of charge		105,490	97,038
(Increase)/decrease in assets:			
GST receivable		291	(226)
Receivables		19,268	(8,820)
Inventories		(398)	(1,728)
Other current assets		(823)	57
Increase/(decrease) in liabilities:			
Payables		7,578	4,289
Contract liabilities		4,853	2,903
Current employee related provisions		21,462	8,683
Non-current employee related provisions		(4,834)	(1,375)
Other current liabilities		(99)	239
Net cash used in operating activities		**(1,881,619)**	**(1,810,123)**

7.4 Capital commitments

The commitments below are inclusive of GST where relevant.

	2021 $'000	2020 $'000
Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows:		
Within 1 year	95,280	10,504
Later than 1 year and not later than 5 years	186,914	9,356
Later than 5 years	-	-
	282,194	**19,860**

Notes to the Financial Statements
For the year ended 30 June 2021

8 Risks and Contingencies

This section sets out the key risk management policies and measurement techniques of the Health Service.

8.1 Financial risk management

Financial instruments held by the Health Service are cash and cash equivalents, restricted cash and cash equivalents, receivables, payables, leases and borrowings. The Health Service has limited exposure to financial risks. The Health Service's overall risk management program focuses on managing the risks identified below.

(a) Summary of risks and risk management

Credit risk

Credit risk arises when there is the possibility of the Health Service's receivables defaulting on their contractual obligations resulting in financial loss to the Health Service.

Credit risk associated with the Health Service's financial assets is minimal because the main receivable is the amounts receivable for services (Holding Account). For receivables other than Government, the Health Service trades only with recognised, creditworthy third parties. The Health Service has policies in place to ensure that sales of products and services are made to customers with an appropriate credit history. In addition, receivable balances are monitored on an ongoing basis with the result that the Health Service's exposure to bad debts is minimal. Debt will be written-off against the allowance account when it is improbable or uneconomical to recover the debt. At the end of the reporting period there were no significant concentrations of credit risk.

Liquidity risk

Liquidity risk arises when the Health Service is unable to meet its financial obligations as they fall due.

The Health Service is exposed to liquidity risk through its trading in the normal course of business.

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

Market risk

Market risk is the risk that changes in market prices such as foreign exchange rates and interest rates will affect the Health Service's income or the value of its holdings of financial instruments. The Health Service does not trade in foreign currency and is not materially exposed to other price risks (for example, equity securities or commodity prices changes). The Health Service's exposure to market risk for changes in interest rates relate primarily to the long-term debt obligations.

The Health Service is not exposed to interest rate risk because the majority of cash and cash equivalents and restricted cash are non-interest bearing and it has no other borrowings other than lease liabilities.

Notes to the Financial Statements
For the year ended 30 June 2021

8.1 Financial risk management (continued)

(b) Categories of financial instruments

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

	2021 $'000	2020 $'000
Financial assets		
Cash and cash equivalents	128,885	122,137
Financial assets at amortised cost	943,743	891,530
Total financial assets	**1,072,628**	**1,013,667**
Financial liabilities		
Financial liabilities measured at amortised cost	200,159	193,475
Total financial liabilities	**200,159**	**193,475**

(c) Credit risk exposure

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

		Days past due				
	Total $'000	Current $'000	<30 days $'000	31-60 days $'000	61-90 days $'000	>91 days $'000
30 June 2021						
Expected credit loss rate		2.73%	4.40%	15.97%	11.20%	64.56%
Estimated total gross carrying amount at default	34,326	8,204	3,927	1,369	1,333	19,493
Expected credit losses	(13,350)	(224)	(173)	(219)	(149)	(12,585)
30 June 2020						
Expected credit loss rate		4.28%	10.60%	15.44%	13.27%	83.46%
Estimated total gross carrying amount at default	57,346	19,114	2,098	863	949	34,322
Expected credit losses	(29,944)	(818)	(222)	(133)	(126)	(28,645)

Notes to the Financial Statements
For the year ended 30 June 2021

8.1 Financial risk management (continued)

(d) Liquidity risk and Interest rate exposure

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

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

		Interest rate exposure				Maturity dates				
	Weighted average effective interest rate %	Carrying amount $'000	Fixed interest rate $'000	Variable interest rate $'000	Non-interest bearing $'000	Nominal amount $'000	Up to 1 month $'000	1 to 3 months $'000	3 months to 1 year $'000	1 to 5 years $'000	More than 5 years $'000
2021											
Financial Assets											
Cash and cash equivalents	-	128,885	-	-	128,885	128,885	128,885	-	-	-	-
Receivables [(a)]	-	39,740	-	-	39,740	39,740	39,740	-	-	-	-
Amounts receivable for services	-	904,003	-	-	904,003	904,003		-	-	-	904,003
		1,072,628	**-**	**-**	**1,072,628**	**1,072,628**	**168,625**	**-**	**-**	**-**	**904,003**
Financial Liabilities											
Payables	-	177,282	-	-	177,282	177,282	177,282	-	-	-	-
Finance lease liabilities	2.33	22,877	22,877	-	-	22,877	233	473	1,922	6,602	13,647
		200,159	**22,877**	**-**	**177,282**	**200,159**	**177,515**	**473**	**1,922**	**6,602**	**13,647**
2020											
Financial Assets											
Cash and cash equivalents	-	122,137	-	-	122,137	122,137	122,137	-	-	-	-
Receivables [(a)]	-	59,812	-	-	59,812	59,812	59,812	-	-	-	-
Amounts receivable for services	-	831,718	-	-	831,718	831,718	-	-	-	-	831,718
		1,013,667	**-**	**-**	**1,013,667**	**1,013,667**	**181,949**	**-**	**-**	**-**	**831,718**
Financial Liabilities											
Payables	-	169,703	-	-	169,703	169,703	169,703	-	-	-	-
Lease liabilities	2.79	23,772	23,772	-	-	24,542	233	459	1,979	7,404	14,467
		193,475	**23,772**	**-**	**169,703**	**194,245**	**169,936**	**459**	**1,979**	**7,404**	**14,467**

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

Notes to the Financial Statements
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8.2 Contingent assets and liabilities

Contingent assets and contingent liabilities are not recognised in the Statement of Financial Position but are disclosed and, if quantifiable, measured at the best estimate.

Contingent assets and contingent liabilities are presented inclusive of GST receivable or payable respectively.

8.2.1 Contingent assets

The following contingent assets are excluded from the assets included in the financial statements:

	2021 $'000	2020 $'000
Litigation in progress		
Pending litigation that may be recoverable on settlement of claims from former employee	1,000	1,000
Number of claims	1	1

8.2.2 Contingent liabilities

The following contingent liabilities are excluded from the liabilities included in the financial statements:

	2021 $'000	2020 $'000
Litigation in progress		
Pending litigation that is not recoverable from RiskCover insurance and may affect the financial position of the Health Service	800	385
Number of claims	2	2

Long Service Leave for Casual Employee

Under the Long Service Leave Act 1958 (LSL Act) casual employees who have been employed for more than 10 years and meet continuous service requirements may be entitled to long service leave. Whilst a provision for casual employees who are currently still employed by WA Health and who meet the criteria has been recognised in the financial statements, the amount of the obligation for those casual employees who are no longer employed by WA Health cannot be measured with sufficient reliability at reporting date. The Health Service are currently assessing the impact of the LSL Act for those casual employees.

Sites with external flammable cladding

The Department of Health (DoH) has undertaken a review across all Health Service Providers to establish whether any building contains aluminium composite cladding that may present a fire risk under the National Construction Code 2016 and Australian Standard AS5113:2016 Fire propagation testing and classification of external walls of buildings.

The undernoted NMHS buildings have been identified as having an element of Aluminium Composite Panelling (ACP) façade:

- RR Block – Sarich Building, QEII MC
- DD Block – Cancer Centre, QEII MC
- UU Block – Adult Mental Health, QEII MC
- WW Block – Engineering Workshops, QEII MC
- YY Block – Engineering Workshops, QEII MC
- HH Block – Central Energy Plant, QEII MC

Full risk assessments have been undertaken for each building and, while not considered a high risk, all ACP's will be removed.

BMW have been engaged via the Health Infrastructure Unit DoH to manage the works.

Notes to the Financial Statements
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8.3 Fair value measurements

Fair value hierarchy

AASB 13 requires disclosure of fair value measurements by level of the following fair value measurement hierarchy:

1) quoted prices (unadjusted) in active markets for identical assets (level 1)
2) input other than quoted prices included within level 1 that are observable for the asset either directly or indirectly (level 2); and
3) inputs for the asset that are not based on observable market data (unobservable input) (level 3).

	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
2021				
Assets measured and recognised at fair value:				
Land				
Residential	-	35	-	35
Specialised	-	4,180	225,556	229,736
Buildings				
Residential and commercial car park	-	150	8,768	8,918
Specialised	-	190	825,492	825,682
	-	**4,555**	**1,059,816**	**1,064,371**

	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
2020				
Assets measured and recognised at fair value:				
Land				
Residential	-	30	-	30
Specialised	-	4,040	225,547	229,587
Buildings				
Residential and commercial car park	-	130	8,963	9,093
Specialised	-	190	853,283	853,473
	-	**4,390**	**1,087,793**	**1,092,183**

Valuation techniques to derive Level 2 fair values

The level 2 fair values of residential properties, commercial car park and land are derived using the market approach. Market evidence of sales prices of comparable land and buildings (office accommodation) in close proximity is used to determine price per square metre.

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8.3 Fair value measurements (continued)

Fair value measurements using significant unobservable inputs (Level 3)

	Land $'000	Buildings $'000	Total $'000
2021			
Fair value at start of period	225,547	862,246	1,087,793
Additions and transfers from work in progress	-	-	-
Revaluation increments/(decrements)	9	13,126	13,135
Depreciation	-	(41,112)	(41,112)
Fair value at end of period	**225,556**	**834,260**	**1,059,816**
2020			
Fair value at start of period	225,276	894,234	1,119,510
Additions and transfers from work in progress	-	548	548
Revaluation increments/(decrements)	271	10,165	10,436
Depreciation	-	(42,701)	(42,701)
Fair value at end of period	**225,547**	**862,246**	**1,087,793**

Valuation processes

There were no changes in valuation techniques during the period.

Land (Level 3 fair values)

Fair value for restricted use land is based on comparison with market evidence for land with low level utility (high restricted use land). The relevant comparators of land with low level utility is selected by the Western Australian Land Information Authority (Valuations and Property Analytics) and represents the application of a significant Level 3 input in this validation methodology. The fair value measurement is sensitive to values of comparator land, with higher values of comparator land correlating with higher estimated fair values of land.

Buildings and Infrastructure (Level 3 fair values)

Fair value for existing use specialised buildings and infrastructure assets is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset, i.e. the current replacement cost. Current replacement cost is generally determined by reference to the market observable replacement cost of a substitute asset of comparable utility and the gross project size specifications, adjusted for obsolescence. Obsolescence encompasses physical deterioration, functional (technological) obsolescence and economic (external) obsolescence.

Valuation using current replacement cost utilises the significant Level 3 input, consumed economic benefit/obsolescence of asset which is estimated by the Western Australian Land Information Authority (Valuations and Property Analytics). The fair value measurement is sensitive to the estimate of consumption/obsolescence, with higher values of the estimate correlating with lower estimated fair values of buildings and infrastructure.

Basis of valuation

In the absence of market-based evidence, due to the specialised nature of some non-financial assets, these assets are valued at Level 3 of the fair value hierarchy on an existing use basis. The existing use basis recognises that restrictions or limitations have been placed on their use and disposal when they are not determined to be surplus to requirements. These restrictions are imposed by virtue of the assets being held to deliver a specific community service.

Notes to the Financial Statements
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9 Other disclosures

This section includes additional material disclosures required by accounting standards or other pronouncements, for the understanding of this financial report.

9.1 Events occurring after the end of the reporting period

There were no events occurring after the reporting period which had significant financial effects on these financial statements.

9.2 Initial application of Australian Accounting Standards

(a) AASB 1059 Service Concession Arrangements: Grantors

AASB 1059 applies to arrangements that involve an operator providing public services related to a service concession asset on behalf of a public sector grantor for a specified period of time and managing at least some of those services.

AASB 1059 requires a grantor to assess all arrangements with an operator where the:

- Operator:
  - provides public services relating to a service concession asset on behalf of the grantor
  - manages at least some of those public services under its own discretion, rather than at the direction of the grantor
- Grantor:
  - controls or regulates what services the operator must provide with the asset, to whom it must provide them, and at what price
  - grantor controls (through ownership, beneficial entitlement or otherwise) any significant residual interest in the asset at the end of the term of the arrangement.

Where an arrangement falls under the scope of AASB 1059, the grantor will be required to:

- recognise or reclassify a service concession asset; and
- assess if a financial liability is required to be recognised.

Notes to the Financial Statements

For the year ended 30 June 2021

9.2 Initial application of Australian Accounting Standards (continued)

Joondalup Health Campus

Joondalup Health Campus (JHC) is managed by Ramsay Health Care – Australia's largest private hospital operator.

It has been determined that:

- NMHS controls or regulates the services provided by JHC through the provision to Ramsay of an Annual Notice that sets out the type and volume of services to be provided.
- NMHS controls the assets used to deliver services to public patients, as the contract stipulates that, at the end of the arrangement, NMHS is entitled to the residual interest of those assets.
- On the basis that the facilities and medical equipment used in JHC to deliver services to public patients fall within the scope of AASB 1059 and that NMHS has control of these assets, NMHS should recognise the facilities and equipment as Service Concession Arrangement assets.

NMHS has applied AASB1059 retrospectively by recognising and measuring service concession assets at the date of initial application.

The comparatives have been adjusted this year to apply the requirements of the standard.

	Notes	2020 $'000	Increase/ (decrease) $'000	2020 Restated $'000
Asset				
Infrastructure, property, plant and equipment		1,351,423	(263,128)	1,088,295
Service concession asset		-	235,613	235,613
Expense				
Depreciation and amortisation expense		70,346	(671)	69,675
Equity				
Accumulated surplus		79,630	(27,515)	52,115

Notes to the Financial Statements
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9.3 Future impact of Australian Accounting Standards not yet operative

The Agency cannot early adopt an Australian Accounting Standard unless specifically permitted by TI 1101 Application of Australian Accounting Standards and Other Pronouncements or by an exemption from TI 1101. Where applicable, the Agency plans to apply the following Australian Accounting Standards from their application date.

		Operative for reporting periods beginning on/after
AASB 17	*Insurance Contracts* This Standard establishes principles for the recognition, measurement, presentation and disclosure of insurance contracts. The Agency has not assessed the impact of the Standard.	**1 Jan 2023**
AASB 1060	*General Purpose Financial Statements – Simplified Disclosures for For-Profit and Not-for-Profit Tier 2 Entities* This Standard sets out a new, separate disclosure standard to be applied by all entities that are reporting under Tier 2 of the Differential Reporting Framework in AASB 1053. These is no financial impact.	**1 Jul 2021**
AASB 2020-1	*Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-current* This Standard amends AASB 101 to clarify requirements for the presentation of liabilities in the statement of financial position as current or non-current. These is no financial impact.	**1 Jan 2023**
AASB 2020-3	*Amendments to Australian Accounting Standards – Annual Improvements 2018–2020 and Other Amendments* This Standard amends: (a) AASB 1 to simplify the application of AASB 1; (b) AASB 3 to update a reference to the Conceptual Framework for Financial Reporting; (c) AASB 9 to clarify the fees an entity includes when assessing whether the terms of a new or modified financial liability are substantially different from the terms of the original financial liability; (d) AASB 116 to require an entity to recognise the sales proceeds from selling items produced while preparing property, plant and equipment for its intended use and the related cost in profit or loss, instead of deducting the amounts received from the cost of the asset; (e) AASB 137 to specify the costs that an entity includes when assessing whether a contract will be loss-making; and (f) AASB 141 to remove the requirement to exclude cash flows from taxation when measuring fair value. There is no financial impact.	**1 Jan 2022**

Notes to the Financial Statements
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9.3 Future impact of Australian Accounting Standards not yet operative (continued)

		Operative for reporting periods beginning on/after
AASB 2020-5	*Amendments to Australian Accounting Standards – Insurance Contracts* This Standard amends AASB 17 to reduce the costs of applying AASB 17 by simplifying some of its requirements. The Agency has not assessed the impact of the Standard.	**1 Jan 2021**
AASB 2020-6	*Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-current – Deferral of Effective Date* This Standard amends AASB 101 to defer requirements for the presentation of liabilities in the statement of financial position as current or non-current that were added to AASB 101 in AASB 2020-1. There is no financial impact.	**1 Jan 2022**
AASB 2020-7	*Amendments to Australian Accounting Standards – Covid-19-Related Rent Concessions: Tier 2 Disclosures* This Standard adds new disclosure requirements to AASB 1060. There is no financial impact.	**1 Jul 2021**
AASB 2021-1	*Amendments to Australian Accounting Standards – Transition to Tier 2: Simplified Disclosures for Not-for-Profit Entities* This Standard amends AASB 1060 to provide not-for-profit entities with optional relief from presenting comparative information in the notes to the financial statements where the entity did not disclose the comparable information in its most recent previous general purpose financial statements. There is no financial impact.	**1 Jul 2021**
AASB 2021-2	*Amendments to Australian Accounting Standards – Disclosure of Accounting Policies and Definition of Accounting Estimates* This Standard amends: (a) AASB 7, to clarify that information about measurement bases for financial instruments is expected to be material to an entity's financial statements; (b) AASB 101, to require entities to disclose their material accounting policy information rather than their significant accounting policies; (c) AASB 108, to clarify how entities should distinguish changes in accounting policies and changes in accounting estimates; (d) AASB 134, to identify material accounting policy information as a component of a complete set of financial statements; and (e) AASB Practice Statement 2, to provide guidance on how to apply the concept of materiality to accounting policy disclosures. There is no financial impact.	**1 Jan 2023**
AASB 2021-3	*Amendments to Australian Accounting Standards – Covid-19-Related Rent Concessions beyond 30 June 2021* This Standard amends AASB 16 to extend by one year the application period of the practical expedient added to AASB 16 by AASB 2020-4. There is no financial impact.	**1 Apr 2021**

Notes to the Financial Statements
For the year ended 30 June 2021

9.4 Key management personnel

The Health Service has determined key management personnel to include Ministers, Board members (accountable authority) and senior officers of the Health Service. The Health Service does not incur expenditures to compensate Ministers and these disclosures may be found in the *Annual Report on State Finances*.

The total fees, salaries and superannuation for members of the accountable authority of the Health Service for the reporting period are presented within the following bands:

Compensation band of members of the accountable authority

	2021	2020
Compensation band ($)		
$0 – $10,000	-	1
$10,001 – $20,000	1	-
$40,001 – $50,000	9	7
$60,001 – $70,000	1	-
$80,001 – $90,000	-	1
	11	**9**

	2021 $'000	2020 $'000
Short-term employee benefits	446	368
Post-employment benefits	42	35
	488	**403**

Compensation band of senior officers

A senior officer is any officer who has responsibility and accountability for the functioning of a section or division that is significant in the operation of the reporting entity or who has equivalent responsibility. For the purposes of this report, senior officers comprise the CEO and the heads of services reporting to the CEO.

The total fees, salaries, superannuation, non-monetary benefits and other benefits for senior officers of the Health Service for the reporting period are presented within the following bands:

	2021	2020
Compensation band ($)		
$50,001 – $60,000	1	-
$130,001 – $140,000	-	1
$190,001 – $200,000	1	-
$200,001 – $210,000	-	1
$210,001 – $220,000	1	1
$220,001 – $230,000	-	2
$230,001 – $240,000	1	-
$240,001 – $250,000	2	-
$250,001 – $260,000	-	1
$260,001 – $270,000	1	-
$270,001 – $280,000	-	1
$320,001 – $330,000	1	-
$390,001 – $400,000	-	1
$420,001 – $430,000	-	1
$490,001 – $500,000	1	-
$500,001 – $510,000	1	-
$570,001 – $580,000	-	2
$580,001 – $590,000	1	-
	11	**11**

Notes to the Financial Statements
For the year ended 30 June 2021

9.4 Key management personnel (continued)

	2021 $'000	2020 $'000
Short-term employee benefits	2,803	2,824
Post-employment benefits	249	313
Other long-term benefits	323	363
Termination benefits	-	-
Total compensation of senior officers	**3,375**	**3,500**

9.5 Related party transactions

The Health Service is a wholly owned public sector entity that is controlled by the State of Western Australia.

Related parties of the Health Service include:

- all cabinet ministers and their close family members, and their controlled or jointly controlled entities;
- all senior officers and their close family members, and their controlled or jointly controlled entities;
- other departments and statutory authorities, including related bodies, that are included in the whole-of-government consolidated financial statements (i.e. wholly-owned public sector entities);
- associates and joint ventures, of a wholly-owned public sector entity; and
- the Government Employees Superannuation Board (GESB).

All related party transactions have been entered into on an arm's length basis.

Significant Transactions with Government-related entities

In conducting its activities, the Health Service is required to transact with the State and entities related to the State. These transactions are generally based on the standard terms and conditions that apply to all agencies. Such transactions include:

- income from State Government;
- equity contributions;
- services received free of charge from Health Support Services, PathWest and Department of Finance;
- lease rentals payments to Department of Finance (Government Office Accommodation and State Fleet);
- insurance payments to the Insurance Commission and RiskCover fund;
- lease rentals payments to Department of Housing (Government Regional Officer Housing);
- remuneration for services provided by the Auditor General.

Material transactions with other related parties

Outside of normal citizen type transactions with the Health Service, there were no related party transactions that involved key management personnel and/or their close family members and/or their controlled (or jointly controlled) entities.

Significant transactions with other related parties

The Health Service makes superannuation payments to GESB as nominated by employees.

9.6 Related bodies

A related body is a body which receives more than half its funding and resources from the Health Service, and is subject to operational control by the Health Service.

The Health Service had no related bodies during the financial year.

Notes to the Financial Statements
For the year ended 30 June 2021

9.7 Affiliated bodies

An affiliated body is a body that receives more than half its funding and resources from the Health Service, but is not subject to operational control by the Health Service.

The Health Service had no affiliated bodies during the financial year.

9.8 Special purpose accounts

Mental Health Commission Fund Account

The purpose of the account is to receive funds from the Mental Health Commission, to fund the provision of mental health services as jointly endorsed by the Department of Health and the Mental Health Commission, in accordance with the annual Service Agreement and subsequent agreements.

	2021 $'000	2020 $'000
Balance at start of period	367	367
Add receipts		
Service delivery arrangement:		
Commonwealth contributions	87,631	74,488
State contributions	162,032	167,354
Other	2,411	1,836
	252,074	243,678
Less Payments	(251,163)	(243,678)
Balance at end of period	**1,278**	**367**

The special purpose accounts are established under section 16(1)(d) of the FMA.

9.9 Remuneration of auditors

Remuneration paid or payable to the Auditor General in respect of the audit is as follows:

	2021 $'000	2020 $'000
Auditing the accounts, controls, financial statements and key performance indicators	330	292
	330	**292**

9.10 Equity

The Western Australian Government holds the equity interest in the Health Service on behalf of the community. Equity represents the residual interest in the net assets of the Health Service.

	2021 $'000	2020 $'000
Balance at start of period	1,650,175	1,643,491
Contribution by owners		
Capital Appropriations administered by Department of Health	58,812	24,381
	1,708,987	**1,667,872**
Distributions to owners		
Transfer of Neonatal Services to Child and Adolescent Health Service	-	(18,485)
Demerger of PathWest	-	788
Total contribution by owners	**-**	**(17,697)**
Balance at end of period	**1,708,987**	**1,650,175**

	2021 $'000	2020 $'000
Asset revaluation reserve		
Balance at the start of period	173,603	163,809
Net revaluation increments/(decrements):		
Land	155	(172)
Buildings	13,151	9,966
Balance at end of period	**186,909**	**173,603**

Notes to the Financial Statements
For the year ended 30 June 2021

9.11 Supplementary financial information

(a) Write-offs

	2021 $'000	2020 $'000
Revenue and debts written off under the authority of the Accountable Authority	17,399	7,180
Public and other property written off under the authority of the Accountable Authority	-	509
	17,399	**7,689**

(b) Losses through theft, defaults and other causes

	2021 $'000	2020 $'000
Losses of public monies and public or other property through theft or default	96	170
Less amount recovered	(57)	(5)
Net losses	**39**	**165**

(c) Services provided free of charge

During the reporting period, the following services were provided to other agencies free of charge for functions outside the normal operations of the Health Service:

	2021 $'000	2020 $'000
Department of Corrective Services - dental treatment	1,410	1,552
Disability Services Commission - dental treatment	1,643	1,469
	3,053	**3,021**

Notes to the Financial Statements
For the year ended 30 June 2021

9.12 Explanatory statement (Controlled operations)

All variances between annual estimates (original budget) and actual results for 2021, and between the actual results for 2021 and 2020 are shown below. Narratives are provided for key major variances, which are greater than 10% and 1% of Total Cost of Services for the Statements of Comprehensive Income and Statement of Cash Flows, and are greater than 10% and 1% of Total Assets for the Statement of Financial Position.

9.12.1 Statement of Comprehensive Income Variances

	Variance Notes	Estimate 2021 $'000	Actual 2021 $'000	Actual 2020 $'000	Variance between actual and estimate $'000	Variance between actual results for 2021 and 2020 $'000
COST OF SERVICES						
Expenses						
Employee benefits expense		1,138,738	1,195,020	1,144,530	56,282	50,490
Contracts for services		473,685	486,219	457,407	12,534	28,812
Patient support costs		320,952	342,814	322,379	21,862	20,435
Finance costs		622	689	603	67	86
Depreciation and amortisation expense		73,751	71,528	69,675	(2,223)	1,853
Loss on disposal of non-current assets		-	373	180	373	193
Repairs, maintenance and consumable equipment		57,745	44,503	39,017	(13,242)	5,486
Other supplies and services		64,918	79,118	71,989	14,200	7,129
Other expenses		52,912	59,134	55,096	6,222	4,038
Total cost of services		**2,183,323**	**2,279,398**	**2,160,876**	**96,075**	**118,522**
INCOME						
Revenue						
Patient charges		69,987	66,197	71,895	(3,790)	(5,698)
Other fees for services		71,811	81,345	78,406	9,534	2,939
Other grants and contributions		-	2,501	3,288	2,501	(787)
Donation revenue		13	629	654	616	(25)
Interest revenue		-	-	67	-	(67)
Other revenue		22,316	21,695	24,781	(621)	(3,086)
Total revenue		**164,127**	**172,367**	**179,091**	**8,240**	**(6,724)**
Gains						
Other gains			-	210	-	(210)
Total gains		**-**	**-**	**210**	**-**	**(210)**
Total income other than income from State Government		**164,127**	**172,367**	**179,301**	**8,240**	**(6,934)**
NET COST OF SERVICES		**2,019,196**	**2,107,031**	**1,981,575**	**87,835**	**125,456**
INCOME FROM STATE GOVERNMENT						
Department of Health - Service Agreement - State Component	a	1,082,012	1,177,916	1,068,551	95,904	109,365
Department of Health - Service Agreement - Commonwealth Component		599,739	538,389	590,727	(61,350)	(52,338)
Grants and subsidies from Mental Health Commission		249,200	252,074	243,678	2,874	8,396
Grants from other state government agencies		2,199	1,078	1,676	(1,121)	(598)
Assets (transferred)/assumed		-	788	14	788	774
Services received free of charge		85,636	105,490	97,038	19,854	8,452
Royalties for Regions Fund		410	-	400	(410)	(400)
Total income from State Government		**2,019,196**	**2,075,735**	**2,002,084**	**56,539**	**73,651**
Surplus/(deficit) for the period		**-**	**(31,296)**	**20,509**	**(31,296)**	**(51,805)**
Other comprehensive income						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve		-	13,306	9,794	13,306	3,512
Total other comprehensive income		**-**	**13,306**	**9,794**	**13,306**	**3,512**
Total comprehensive income for the period		**-**	**(17,990)**	**30,303**	**(17,990)**	**(48,293)**

Notes to the Financial Statements
For the year ended 30 June 2021

9.12 Explanatory statement (Controlled operations)

9.12.2 Statement of Financial Position Variances

	Variance Notes	Estimate 2021 $'000	Actual 2021 $'000	Actual 2020 $'000	Variance between actual and estimate $'000	Variance between actual results for 2021 and 2020 $'000
ASSETS						
Current assets						
Cash and cash equivalents		56,620	52,472	45,000	(4,148)	7,472
Restricted cash and cash equivalents		47,700	53,927	59,181	6,227	(5,254)
Receivables		61,047	48,054	68,417	(12,993)	(20,363)
Inventories		7,067	7,465	7,067	398	398
Other current assets		2,084	2,907	2,084	823	823
Total Current Assets		**174,518**	**164,825**	**181,749**	**(9,693)**	**(16,924)**
Non-current assets						
Restricted cash and cash equivalents		22,516	22,486	17,956	(30)	4,530
Amounts receivable for services		905,470	904,003	831,718	(1,467)	72,285
Infrastructure, property, plant and equipment	1	1,384,181	1,079,871	1,088,295	(304,310)	(8,424)
Right-of-use assets		17,553	20,724	22,822	3,171	(2,098)
Service concession assets	1	-	254,708	235,613	254,708	19,095
Intangible assets		500	922	500	422	422
Total non-current assets		**2,330,220**	**2,282,714**	**2,196,904**	**(47,506)**	**85,810**
Total assets		**2,504,738**	**2,447,539**	**2,378,653**	**(57,199)**	**68,886**
LIABILITIES						
Current liabilities						
Payables		169,703	177,282	169,703	7,579	7,579
Contract liabilities		2,903	7,757	2,903	4,854	4,854
Employee related provisions		243,067	264,527	243,067	21,460	21,460
Lease liabilities		2,437	2,629	2,671	192	(42)
Other current liabilities		1,989	1,889	1,989	(100)	(100)
Total current liabilities		**420,099**	**454,084**	**420,333**	**33,985**	**33,751**
Non-current liabilities						
Employee related provisions		61,326	56,492	61,326	(4,834)	(4,834)
Lease liabilities		18,664	20,248	21,101	1,584	(853)
Total non-current liabilities		**79,990**	**76,740**	**82,427**	**(3,250)**	**(5,687)**
Total liabilities		**500,089**	**530,824**	**502,760**	**30,735**	**28,064**
NET ASSETS		**2,004,648**	**1,916,715**	**1,875,893**	**(87,933)**	**40,822**
EQUITY						
Contributed equity		1,831,045	1,708,987	1,650,175	(122,058)	58,812
Reserves		173,603	186,909	173,603	13,306	13,306
Accumulated surplus/(deficit)		-	20,819	52,115	20,819	(31,296)
Total equity		**2,004,648**	**1,916,715**	**1,875,893**	**(87,933)**	**40,822**

Notes to the Financial Statements
For the year ended 30 June 2021

9.12 Explanatory statement (Controlled operations)

9.12.3 Statement of Cash Flows Variances

	Variance Notes	Estimate 2021 $'000	Actual 2021 $'000	Actual 2020 $'000	Variance between estimate and actual $'000	Variance between actual results for 2021 and 2020 $'000
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriation		1,859,399	1,897,170	1,831,941	37,771	65,229
Capital appropriations administered by Department of Health	2,b	101,240	58,812	23,566	(42,428)	35,246
Royalties for Regions Fund		410	-	400	(410)	(400)
Net cash provided by State Government		**1,961,049**	**1,955,982**	**1,855,907**	**(5,067)**	**100,075**
Utilised as follows:						
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits		(1,134,178)	(1,173,415)	(1,131,322)	(39,237)	(42,093)
Supplies and services		(884,575)	(903,957)	(850,174)	(19,382)	(53,783)
Finance costs		(622)	(689)	(590)	(67)	(99)
Receipts						
Receipts from customers		77,357	61,662	75,474	(15,695)	(13,812)
Other grants and contributions		-	2,502	3,289	2,502	(787)
Donations received		13	546	432	533	114
Interest received		-	-	67	-	(67)
Other receipts	3,c	94,127	131,732	92,701	37,605	39,031
Net cash used in operating activities		**(1,847,878)**	**(1,881,619)**	**(1,810,123)**	**(33,741)**	**(71,496)**
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Payment for purchase of non-current physical and intangible assets	2,b	(101,240)	(64,296)	(21,599)	36,944	(42,697)
Receipts						
Proceeds from sale of non-current physical assets		-	67	5	67	62
Net cash used in investing activities		**(101,240)**	**(64,229)**	**(21,594)**	**37,011**	**(42,635)**
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Payments for principal element of lease		(2,671)	(3,386)	(2,989)	(715)	(397)
Net cash used in financing activities		**(2,671)**	**(3,386)**	**(2,989)**	**(715)**	**(397)**
Net increase/(decrease) in cash and cash equivalents		9,259	6,748	21,201	(2,511)	(14,453)
Cash and cash equivalents at the beginning of the year		122,137	122,137	117,144	(0)	4,993
Cash transferred to other health agencies as part of demergers		(4,560)	-	(16,208)	4,560	16,208
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**126,836**	**128,885**	**122,137**	**2,049**	**6,748**

Notes to the Financial Statements
For the year ended 30 June 2021

9.12 Explanatory statement (Controlled operations) (continued)

Major Estimate and Actual (2021) Variance Narratives

1. Infrastructure, property, plant and equipment and Service concession assets

The Actuals for service concession assets is due to the application of AASB 1059 which was not budgeted in the Estimates. These assets were formerly reflected in property, plant and equipment and relate to assets located at Joondalup Health Campus (JHC).

2. Capital appropriations administered by Department of Health and payments for purchase of non-current physical and intangible assets

Actual capital appropriations administered by Department of Health are lower than Estimate due to lower spending on capital projects that were impacted by COVID-19 such as JHC Stage 2 development, Osborne Park Hospital and King Edward Memorial Hospital Critical Infrastructure.

3. Other receipts

Actual is higher than Estimate mostly due to balance sheet movement of receivables as a result of ongoing improvements to collection practices.

Major Actual (2021) and Comparative (2020) Variance Narratives

a. Department of Health - Service Agreement - Commonwealth Component

Increased funding received via budget transfers from the Department of Health in respect of Transitional Funding Assistance, as well as various programs including COVID-19, Waitlist, ABF Activity and Adult Public Dental Services.

b. Capital appropriations administered by Department of Health and payments for purchase of non-current physical and intangible assets

The increase in capital appropriations administered by Department of Health compared with last year is due to higher spending for the acquisition of property, plant and equipment related to a number of new capital projects which commenced in 2020-21 such as the JHC Stage 2 development.

c. Other receipts

Receipts from non-patients has increased as a result of ongoing improvements to collection practices and record keeping.

Notes to the Financial Statements

For the year ended 30 June 2021

10 Trust Accounts

10.1 Disclosure of Trust Accounts

Funds held in these trust accounts are not controlled by the Health Service and are therefore not recognised in the financial statements:

(a) The Health Service administers a trust account for the purpose of holding patients' private monies.

A summary of the transactions for this trust account is as follows:

	2021 $'000	2020 $'000
Balance at the start of period	195	180
Add Receipts	850	936
Less Payments	(872)	(921)
Balance at the end of period	**173**	**195**

(b) Other trust accounts not controlled by the Health Service:

	2021 $'000	2020 $'000
RF Shaw Foundation	1,106	1,166
King Edward Memorial Clinical Staff Association	-	59
Balance at the end of period	**1,106**	**1,225**
Balance at start of period	1,225	1,211
Add Receipts	-	80
Less Payments	(119)	(66)
Balance at the end of period	**1,106**	**1,225**

Trust Accounts are used by the Health Service to account for funds that they may be holding on behalf of another party, such as patients' cash. The Health Service does not have control of the use of these funds, and cannot deploy them to meet its objectives. Trust accounts do not form part of the resources available to the Health Service, and are not reported as assets in the financial statements.

Certification of key performance indicators

Government of Western Australia
North Metropolitan Health Service

Disclosures and Legal Compliance

Financial Statements

Certification of Key Performance Indicators

For the reporting period ended 30 June 2021

We hereby certify the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the North Metropolitan Health Service's (NMHS) performance, and fairly represent the performance of the NMHS for the financial year ended 30 June 2021.

Name: Clinical Professor David Forbes AM
North Metropolitan Health Service
Board Chair, NMHS Board

Date

Name: Mr Steve Toutountzis
North Metropolitan Health Service
Board Member and Finance Committee Chair, NMHS Board

Date

Detailed information in support of key performance indicators

Material changes in KPI definitions and cost allocation methodologies in accordance with the outcome-based management framework are noted where applicable.

The latest available data has been used to report performance, which in some instances means results are for the 2020 calendar year.

Detailed information in support of key performance indicators

Outcome 1 - Public hospital-based services that enable effective treatment and restorative health care for Western Australians

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

Rationale

Unplanned hospital readmissions may reflect less than optimal patient management and ineffective care pre-discharge, post discharge and/or during the transition between acute and community-based care[1]. These readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

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

The 7 surgeries selected for this indicator are based on those in the current National Health Agreement Unplanned Readmission performance indicator (NHA PI 23).

Target

Please see the 2020 targets for each surgical procedure in Table 7. Performance is achieved by a result below, or equal to, the target.

[1]Australian Institute of Health and Welfare (2009). Towards national indicators of safety and quality in health care. Cat. no. HSE 75. Canberra: AIHW. Available at: https://www.aihw.gov.au/reports/health-care-quality-performance/towards-national-indicators-of-safety-and-quality/contents/table-of-contents

Results on the next page →

Detailed information in support of key performance indicators

Results

In 2020, the rate of unplanned readmissions within 28 days achieved target for hip replacement, hysterectomy and prostatectomy (Table 7). All other surgical procedure indicators did not meet target. The number of readmission cases for most procedures were small and results should be interpreted with caution.

Clinical reviews and investigations have been completed for all readmissions and no trends or systemic issues have been identified.

Of the 14 knee replacement patients that readmitted, some were admitted due to inflammation or for pain or wound management. Further investigation will be carried out to determine if patients returning to country areas post-procedure have enough nursing or allied health support. Strategies to assist include offering joint replacement education sessions before the surgery at hospitals not already offering this service and working with the Australian Orthopaedic Association Joint Registry to monitor patient outcome measures.

Compared to 2019, performance for hip replacement has improved following a review of processes and feedback mechanisms and the provision of patient education of the hospital journey and post-operative care before the procedure.

Of the 36 tonsillectomy and adenoidectomy patients that readmitted, most had post-operative bleeding and were admitted for monitoring and were discharged. Collaboration between the Ear, Nose and Throat Ward and Short Stay Unit has led to standardised and updated pre- and post-operative patient information, including outlining the expected and acceptable blood loss post operation in the post-operative material.

There were 7 readmissions for prostatectomy procedures across sites, some readmissions did not require further surgical treatment.

Of the 3 cataract readmissions, no trends or systemic issues have been identified.

Appendicectomy had 29 readmissions of which some were for pain management, some of which were admitted for conservative management for pain management. Processes such as antibiotic prescription for complex appendicitis cases and feedback mechanisms are being reviewed.

Table on the next page →

Detailed information in support of key performance indicators

Table 7: Unplanned hospital readmissions for patients within 28 days for selected surgical procedures (per 1,000 separations), 2016–20

	Calendar year						
Surgical procedure	**2016 (per 1,000)**	**2017 (per 1,000)**	**2018 (per 1,000)**	**2019 (per 1,000)**	**2020 (per 1,000)**	**Target (per 1,000)**	**Target met**
Knee replacement	21.9	36.1	27.0	13.1	34.9	≤ 23.0	⊗
Hip replacement	16.5	21.3	14.4	14.7	7.2	≤ 17.1	✓
Tonsillectomy and adenoidectomy	142.9	112.4	102.7	149.2	157.2	≤ 81.8	⊗
Hysterectomy	34.9	45.5	51.9	40.2	38.3	≤ 42.3	✓
Prostatectomy	48.1	45.5	48.9	46.5	25.4	≤ 36.1	✓
Cataract surgery	3.6	2.0	1.1	1.2	1.6	≤ 1.1	⊗
Appendicectomy	28.0	18.4	33.5	46.9	33.6	≤ 25.7	⊗

Data sources: WA Data Linkage System; Hospital Morbidity Data Collection.

Detailed information in support of key performance indicators

Outcome 1 - Public hospital-based services that enable effective treatment and restorative health care for Western Australians

Percentage of elective waitlist patients waiting over boundary for reportable procedures

Rationale

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

Elective surgical services delivered in the WA health system are those deemed to be clinically necessary. Excessive waiting times for these services can lead to deterioration of the patient's condition and/or quality of life, or even death[2]. Waiting lists must be actively managed by hospitals to ensure fair and equitable access to limited services, and that all patients are treated within clinically appropriate timeframes.

Patients are prioritised based on their assigned clinical urgency category:

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

On 1 April 2016, the WA health system introduced a new state-wide performance target for the provision of elective services. For reportable procedures, the target requires that no patients (0%) on the elective waiting lists wait longer than the clinically recommended time for their procedure, according to their urgency category.

Reportable cases are defined as:

All waiting list cases that are not listed on the Elective Services Wait List Data Collection (ESWLDC) Commonwealth Non-Reportable Procedures list. This list is consistent with the Australian Institute of Health and Welfare (AIHW) list of Code 2 (other) procedures that do not meet the definition of elective surgery. It also includes additional procedure codes that are intended to better reflect the procedures identified in the AIHW Code 2 list.

Target

The 2020/21 target is 0%. Performance is achieved by a result equal to the target.

Table on the next page →

[2]Derrett, S., Paul, C., Morris, J.M. (1999). Waiting for Elective Surgery: Effects on Health-Related Quality of Life, International Journal of Quality in Health Care, Vol 11 No. 1, 47-57.

Detailed information in support of key performance indicators

Results

In 2020/21, all urgency categories for elective surgery wait list patients waiting over boundary did not meet target (Table 8). During the year, NMHS experienced challenges associated with demand, capacity and health system restrictions.

In 2021, elective surgery was scaled back across the public health system to prepare hospital capacity for COVID-19 from 31 January to 5 February, 27 April to 30 April and 29 June to 9 July. WA Health hospitals were permitted to continue Category 1 elective procedures while reviewing Category 2 elective surgeries and proceeding with cases deemed urgent. All Category 3 elective surgeries were postponed during these periods.

Compared to 2018/19, demand for Category 1 and 2 elective surgery has increased by 13%. Category 1 was impacted by demand pressures and the reduction in available lists due to reduced capacity related to bed pressures, ageing infrastructure, maintenance works and resource availability.

Backlog in Category 1 has led to a delay in Category 2 and 3 patients being undertaken. NMHS sites and services implemented an elective surgery 'blitz' until December 2020 to accommodate demand, mitigate elective surgery access issues and reduce elective surgery cancellations due to COVID-19.

Further plans have been developed to clear the backlog of elective surgeries, support increased demand for medical beds during winter periods, improve patient flow, have additional theatre sessions scheduled where appropriate and engagement with contracted health entities to address over boundary cases. Performance and strategies continue to be monitored.

Table 8: Percentage of elective waitlist patients waiting over boundary for reportable procedures, 2016/17–2020/21

	Financial year						
	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)	2020/21 (%)	Target (%)	Target met
Category 1 over 30 days	5	6	8	8	11	0	⊗
Category 2 over 90 days	7	7	8	13	14	0	⊗
Category 3 over 365 days	2	3	5	8	5	0	⊗

Data source: Elective Services Waitlist Data Collection.

Detailed information in support of key performance indicators

Outcome 1 - Public hospital-based services that enable effective treatment and restorative health care for Western Australians

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

Rationale

Staphylococcus aureus bloodstream infection is a serious infection that may be associated with the provision of healthcare. *Staphylococcus aureus* is a highly pathogenic organism and even with advanced medical care, infection is associated with prolonged hospital stays, increased healthcare costs and a marked increase in morbidity and mortality (SABSI mortality rates are estimated at 20-25%[3]).

HA-SABSI is generally considered to be a preventable adverse event associated with the provision of healthcare, therefore this KPI is a robust measure of the safety and quality of care provided by WA public hospitals.

Target

The 2020 target is ≤1.0 per 10,000 occupied bed-days. Performance is achieved by a result below, or equal to, the target.

A low or decreasing HA-SABSI rate is desirable and the WA target reflects the nationally agreed benchmark.

Results

In 2020, HA-SABSI per 10,000 occupied bed-days in public hospitals achieved target (Table 9). Implementation of strategies to enhance patient outcomes such as minor changes to practice and introduction of after hours cannulation nursing services to assist in the management of peripheral intravenous catheter have assisted in achieving target.

These strategies have helped to enhance outcomes and performance continues to be monitored.

Table 9: Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days, 2017–20

	Calendar year					
	2017 (per 10,000)	2018 (per 10,000)	2019 (per 10,000)	2020 (per 10,000)	Target (per 10,000)	Target met
HA-SABSI	0.7	1.0	0.8	0.6	≤ 1.0	✓

Data source: Healthcare Infection Surveillance WA Data Collection.

[3]van Hal, S. J., Jensen, S. O., Vaska, V. L., Espedido, B. A., Paterson, D. L., & Gosbell, I. B. (2012). Predictors of mortality in *Staphylococcus aureus* Bacteremia. Clinical microbiology reviews, 25(2), 362–386. doi:10.1128/CMR.05022-11

Detailed information in support of key performance indicators

Outcome 1 - Public hospital-based services that enable effective treatment and restorative health care for Western Australians

Survival rates for sentinel conditions

Rationale

This indicator measures performance in relation to the survival of people who have suffered a sentinel condition - specifically a stroke, acute myocardial infarction (AMI), or fractured neck of femur (FNOF).

These 3 conditions have been chosen as they are leading causes of hospitalisation and death in Australia for which there are accepted clinical management practices and guidelines. Patient survival after being admitted for one of these sentinel conditions can be affected by many factors including the diagnosis, the treatment given or procedure performed, age, co-morbidities at the time of the admission and complications which may have developed while in hospital. However, survival is more likely when there is early intervention and appropriate care on presentation to an emergency department and on admission to hospital.

By reviewing survival rates and conducting case-level analysis, targeted strategies can be developed that aim to increase patient survival after being admitted for a sentinel condition.

Target

Please see the targets for each condition in Table 10, Table 11 and Table 12. Performance is achieved by a result above, or equal to, the target.

Results

In 2020, the survival rates for stroke for all patient age groups cohorts did not meet target (Table 10). Survival rates are impacted by severity of disease on admission and patients with multiple comorbidities. Strategies to improve patient outcomes include the Stroke Rehabilitation Liaison Service and an integrated approach between inpatient care, rehabilitation at home and outpatient care.

Table 10: Survival rate for stroke, 2016–20

Data source: Hospital Morbidity Data Collection.	Calendar year						
Age group (years)	**2016 (%)**	**2017 (%)**	**2018 (%)**	**2019 (%)**	**2020 (%)**	**Target (%)**	**Target met**
0 to 49	87.7	93.5	92.8	94.6	94.4	≥ 95.2	⊗
50 to 59	87.5	91.8	92.2	91.5	92.6	≥ 94.9	⊗
60 to 69	92.4	92.0	93.1	88.4	89.9	≥ 94.1	⊗
70 to 79	90.6	91.2	88.7	91.3	87.6	≥ 92.3	⊗
80+	84.4	86.1	84.6	86.7	85.8	≥ 86.0	⊗

Detailed information in support of key performance indicators

The survival rates for patients with acute myocardial infarction achieved target for age groups 50 to 59, 60 to 69 and 70 to 79 (Table 11). Survival rates for all other age groups did not meet target and are impacted by severity of disease on admission and patients with multiple comorbidities.

Table 11: Survival rate for acute myocardial infarction, 2016–20

	Calendar year						
Age group (years)	**2016 (%)**	**2017 (%)**	**2018 (%)**	**2019 (%)**	**2020 (%)**	**Target (%)**	**Target met**
0 to 49	100.0	99.1	96.9	98.9	98.6	≥ 99.1	⊗
50 to 59	99.2	98.9	97.9	99.0	99.4	≥ 98.8	✓
60 to 69	97.9	96.9	97.7	97.8	99.1	≥ 98.1	✓
70 to 79	93.3	96.6	96.3	97.7	97.1	≥ 96.8	✓
80+	90.1	91.6	91.2	88.4	90.5	≥ 92.1	⊗

Data source: Hospital Morbidity Data Collection.

Survival rates for patients with fractured neck of femur achieved target for age group 80+ while age group 70 to 79 did not meet target (Table 12). Review of cases have been completed and no specific issues were identified. Compliance with Clinical Care Standards were reviewed and identified an area for improvement that has now been updated.

Table 12: Survival rate for fractured neck of femur, 2016–20

	Calendar year						
Age group (years)	**2016 (%)**	**2017 (%)**	**2018 (%)**	**2019 (%)**	**2020 (%)**	**Target (%)**	**Target met**
70 to 79	93.8	100.0	95.9	97.7	98.0	≥ 98.9	⊗
80+	97.4	96.6	95.2	96.2	97.1	≥ 96.9	✓

Data source: Hospital Morbidity Data Collection.

Detailed information in support of key performance indicators

Outcome 1 - Public hospital-based services that enable effective treatment and restorative health care for Western Australians

Percentage of admitted patients who discharged against medical advice

Rationale

Discharge against medical advice (DAMA) refers to patients leaving hospital against the advice of their treating medical team or without advising hospital staff (e.g. absconding or missing and not found). Patients who do so have a higher risk of readmission and mortality[4] and have been found to cost the health system 50% more than patients who are discharged by their physician.[5]

Between July 2013 and June 2015, Aboriginal patients in WA were almost 12.7 times more likely than non-Aboriginal patients to discharge against medical advice, compared with 7 times nationally[6]. This statistic indicates a need for improved responses by the health system to the needs of Aboriginal patients.

This indicator provides a measure of the safety and quality of inpatient care. Reporting the results by Aboriginal status measures the effectiveness of initiatives within the WA health system to deliver culturally secure services to Aboriginal people. While the aim is to achieve equitable treatment outcomes, the targets reflect the need for a long-term approach to progressively closing the gap between Aboriginal and non-Aboriginal patient cohorts.

Target

Please see the 2020 targets for Aboriginal and non-Aboriginal patients in Table 13. Performance is achieved by a result below, or equal to, the target.

Results

In 2020, the percentage of admitted patients who DAMA achieved target for non-Aboriginal patients while Aboriginal patients did not meet target (Table 13). Case reviews indicate that Aboriginal patients commonly DAMA due to family/community responsibilities, social issues or discharge following an improvement in their condition despite not completing prescribed treatment.

Aboriginal Health Liaison Officers are available, however not all patients choose to use the service or DAMA overnight or out of hours when the service is unavailable. Strategies to improve performance include sites aiming to receive advice from expert clinicians on potential management of high risk patients, developing solutions in consultation with key Aboriginal stakeholders and developing educational packages for staff to manage discharge process.

Non-Aboriginal performance was due to the implementation of strategies to manage efficient discharge process.

[4]Yong et al. Characteristics and outcomes of discharges against medical advice among hospitalised patients. Internal medicine journal 2013:43(7):798-802.
[5]Aliyu ZY. Discharge against medical advice: sociodemographic, clinical and financial perspectives. International journal of clinical practice 2002;56(5):325-27.
[6]Commonwealth of Australia. (2017). Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report, Commonwealth of Australia, Canberra.

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Detailed information in support of key performance indicators

Table 13: Percentage of admitted patients who discharged against medical advice, 2017–20

	Calendar year					
	2017 (%)	2018 (%)	2019 (%)	2020 (%)	Target (%)	Target met
Aboriginal	3.36	3.81	3.73	3.92	≤ 2.78	⊗
Non-Aboriginal	0.76	0.75	0.80	0.76	≤ 0.99	✓

Data source: Hospital Morbidity Data Collection.

Detailed information in support of key performance indicators

Outcome 1 - Public hospital-based services that enable effective treatment and restorative health care for Western Australians

Percentage of live-born term infants with an Apgar score of less than 7 at five minutes post-delivery

Rationale

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

The Apgar score is an assessment of an infant's health at birth based on breathing, heart rate, colour, muscle tone and reflex irritability. An Apgar score is applied at one, 5 and (if required by the protocol) 10 minutes after delivery to determine how well the infant is adapting outside the mother's womb. Apgar scores range from zero to 2 for each condition with a maximum final total score of 10. The higher the Apgar score the better the health of the newborn infant.

This outcome measure can lead to the development and delivery of improved care pathways and interventions to improve the health outcomes of Western Australian infants and aligns to the National Core Maternity Indicators (2019) Health, Standard 19/06/2019.

Target

The 2020 target for liveborn term infants with an Apgar score of less than 7 at five minutes post-delivery is ≤ 1.8%. Performance is achieved by a result below, or equal to, the target.

Results

In 2020, the percentage of live-born infants with an Apgar score of less than 7 at five minutes post-delivery achieved target (Table 14). Audits are conducted throughout the year and case studies are used for continued learning and education in addition to regular staff education.

Table 14: Percentage of liveborn term infants with an Apgar score of less than 7 at five minutes post-delivery, 2016–20

	Calendar year						
Live births	**2016 (%)**	**2017 (%)**	**2018 (%)**	**2019 (%)**	**2020 (%)**	**Target (%)**	**Target met**
Apgar Score <7	1.6	1.6	2.0	1.5	1.7	≤ 1.8	✓

Data source: Midwives Notification System.

Detailed information in support of key performance indicators

Outcome 1 - Public hospital-based services that enable effective treatment and restorative health care for Western Australians

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

Rationale

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

While multiple hospital admissions over a lifetime may be necessary for someone with ongoing illness, a high proportion of readmissions shortly after discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was not adequate to maintain the patient's recovery out of hospital[7]. These readmissions mean that patients spend additional time in hospital and utilise additional resources. A low readmission rate suggests that good clinical practice is in operation. Readmissions are attributed to the facility at which the initial separation (discharge) occurred rather than the facility to which the patient was readmitted.

By monitoring this indicator, key areas for improvement can be identified. This can facilitate the development and delivery of targeted care pathways and interventions aimed at improving the mental health and quality of life of Western Australians.

Target

The 2020 target is ≤12% readmissions within 28 days to an acute specialised mental health inpatient service. Performance is achieved by a result below, or equal to, the target.

Results

In 2020, the rate of readmissions to acute specialised mental health inpatient service within 28 days of discharge did not meet target (Table 15). This indicator looks at total readmissions and it should be noted that some readmission cases are warranted as part of accepted best practice protocols.

Patients are given appropriate discharge planning, including community follow-up and often readmit due to relapse or worsened condition. Readmissions were often attributable to non-compliance with prescribed medications and drug use. Education resources have been developed and implemented for clinical and clerical staff and clinical review of all readmissions continues.

Table 15: Readmissions to acute specialised mental health inpatient services within 28 days of discharge, 2017–20

Data source: Hospital Morbidity Data Collection.	Calendar year					
	2017 (%)	2018 (%)	2019 (%)	2020 (%)	Target (%)	Target met
Readmission rate	18	16	15	15	≤ 12	⊗

[7]Australian Health Ministers Advisory Council Mental Health Standing Committee (2011). Fourth National Mental Health Plan Measurement Strategy. Available at: https://www.aihw.gov.au/getmedia/d8e52c84-a53f-4eef-a7e6-f81a5af94764/Fourth-national-mental-health-plan-measurement-strategy-2011.pdf.aspx

Detailed information in support of key performance indicators

Outcome 1 - Public hospital-based services that enable effective treatment and restorative health care for Western Australians

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

Rationale

In 2017-18, one in 5 (4.8 million) Australians reported having a mental or behavioural condition[8]. Therefore, it is crucial to ensure effective and appropriate care is provided not only in a hospital setting but also in the community.

Discharge from hospital is a critical transition point in the delivery of mental health care. People leaving hospital after an admission for an episode of mental illness have increased vulnerability and, without adequate follow up, may relapse or be readmitted.

The standard underlying this measure is that continuity of care requires prompt community follow-up in the period following discharge from hospital. A responsive community support system for persons who have experienced a psychiatric episode requiring hospitalisation is essential to maintain their clinical and functional stability and to minimise the need for hospital readmissions. Patients leaving hospital after a psychiatric admission with a formal discharge plan that includes links with public community-based services and support are less likely to need avoidable hospital readmissions.

Target

The 2020 target is ≥ 75%. Performance is achieved by a result above, or equal to, the target.

Results

In 2020, the percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services achieved target (Table 16).

Compared to 2019, there has been a 12% increase in performance. Performance has improved due to strategies such as updated staff education and training on processes, monthly review of cases and monthly action plans by co-directors for areas of non-compliance.

Table 16: Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services, 2016–20

Data sources: Mental Health Information Data Collection; Hospital Morbidity Data Collection.	Calendar year						
Live births	**2016 (%)**	**2017 (%)**	**2018 (%)**	**2019 (%)**	**2020 (%)**	**Target (%)**	**Target met**
Post-discharge community care	53	66	71	72	84	≥ 75	✓

Note: Comparison to prior years should be approached with caution due to a methodology update. The 2019 definition is aligned to the national definition and is inclusive of community contacts with patients' carers/next of kin.

[8] National Health Survey 2017-18

Detailed information in support of key performance indicators

Outcome 1 - Public hospital-based services that enable effective treatment and restorative health care for Western Australians

Service 1 - Public hospital admitted services

Average admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per weighted activity unit (WAU) compared with the State target, as approved by the Department of Treasury and published in the 2020-21 Budget Paper No. 2, Volume 1.

The measure ensures a consistent methodology is applied to calculating and reporting the cost of delivering inpatient activity against the State's funding allocation. As admitted services received nearly half of the overall 2020-21 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

Target

The 2020/21 target is $7,073 per WAU. Performance is achieved by a result below, or equal to, the target.

Results

In 2020/21, the average cost per WAU did not meet target (Table 17).

Table 17: Average admitted cost per weighted activity unit, 2017/18–2020/21

	Financial year					
	2017/18 ($)	2018/19 ($)	2019/20 ($)	2020/21 ($)	Target ($)	Target met
Average cost	7,087	7,137	7,475	7,330	≤ 7,073	⊗

Data sources: OBM Allocation application; Oracle 11i financial system; Hospital Morbidity Data Collection; The Open Patient Administration System (TOPAS); Web-Based Patient Administration System (webPAS); Contracted Health Entities (CHEs) discharge extracts.

Detailed information in support of key performance indicators

Outcome 1 - Public hospital-based services that enable effective treatment and restorative health care for Western Australians

Service 2 - Public hospital emergency services

Average emergency department (ED) cost per weighted activity unit

Rationale

This indicator is a measure of the cost per WAU compared with the State target as approved by the Department of Treasury, which is published in the 2020-21 Budget Paper No. 2, Volume 1.

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

Target

The 2020/21 target is $6,853 per WAU. Performance is achieved by a result below, or equal to, the target.

Results

In 2020/21, the average emergency department cost per WAU achieved target (Table 18).

Table 18: Average emergency department cost per weighted activity unit, 2017/18–2020/21

	Financial year					
	2017/18 ($)	2018/19 ($)	2019/20 ($)	2020/21 ($)	Target ($)	Target met
Average cost	6,095	6,212	6,893	6,798	≤ 6,853	✓

Data sources: OBM Allocation application; Oracle 11i financial system; Emergency Department Data Collection.

Detailed information in support of key performance indicators

Outcome 1 - Public hospital-based services that enable effective treatment and restorative health care for Western Australians

Service 3 - Public hospital non-admitted services

Average non-admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per WAU compared with the State (aggregated) target, as approved by the Department of Treasury, which is published in the 2020-21 Budget Paper No. 2, Volume 1.

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

Target

The 2020/21 target is $7,025 per WAU. Performance is achieved by a result below, or equal to, the target.

Results

In 2020/21, the average non-admitted cost per WAU achieved target (Table 19).

Table 19: Average non-admitted cost per weighted activity unit, 2017/18–2020/21

	Financial year					
	2017/18 ($)	2018/19 ($)	2019/20 ($)	2020/21 ($)	Target ($)	Target met
Average cost	7,224	7,018	7,347	7,020	≤ 7,025	✓

Data sources: OBM Allocation application; Oracle 11i financial system; Non-Admitted Patient Activity and Waitlist (NAPAAWL) Data Collection; Interim Collection of Aggregate Data (ICAD).

Detailed information in support of key performance indicators

Outcome 1 - Public hospital-based services that enable effective treatment and restorative health care for Western Australians

Service 4 - Mental health services

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

Rationale

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

Target

The 2020/21 target is $1,471 per bed-day in specialised mental health inpatient services. Performance is achieved by a result below, or equal to, the target.

Results

In 2020/21, the average cost per bed-day in specialised mental health inpatient services did not meet target (Table 20).

Table 20: Average cost per bed-day in specialised mental health inpatient services, 2016/17–2020/21

	Financial year						
	2016/17 ($)	2017/18 ($)	2018/19 ($)	2019/20 ($)	2020/21 ($)	Target ($)	Target met
Average cost	1,501	1,482	1,500	1,538	1,490	≤ 1,471	⊗

Data sources: OBM Allocation application; Oracle 11i financial system; BedState.

Detailed information in support of key performance indicators

Outcome 1 - Public hospital-based services that enable effective treatment and restorative health care for Western Australians

Service 4 - Mental health services

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

Rationale

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

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

Target

The 2020/21 target is $421 per treatment day of non-admitted care provided by mental health services. Performance is achieved by a result below, or equal to, the target.

Results

In 2020/21, the average cost per treatment day of non-admitted care provided by mental health services achieved target (Table 21).

Table 21: Average cost per treatment day of non-admitted care provided by mental health services, 2017/18–2020/21

	Financial year					
	2017/18 ($)	2018/19 ($)	2019/20 ($)	2020/21 ($)	Target ($)	Target met
Average cost	465	432	403	384	≤ 421	✓

Data sources: OBM Allocation application; Oracle 11i financial system; Mental Health Information Data Collection.

Detailed information in support of key performance indicators

Outcome 2 - Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives

Rate of women aged 50–69 years who participate in breast screening

Rationale

BreastScreen Australia aims to reduce illness and death resulting from breast cancer through organised screening to detect cases of unsuspected breast cancer in women, thus enabling early intervention which leads to increased treatment options and improved survival. It has been estimated that breast cancer detected early is considerably less expensive to treat than when the tumour is discovered at a later stage. Mass screening using mammography can improve early detection by as much as 15-35%.[9]

High rates reported against this KPI will reflect the efficient use of the physical infrastructure and specialist staff resources required for the population-based breast cancer screening program. High rates will also be an indication of a sustainable health system as early detection reduces the cost to hospital services at the later stages of a patient's journey.

Target

The 2019–20 target is ≥ 70% of women aged 50–69 years who participate in breast screening. Performance is achieved by a result above, or equal to, the target.

Results

From 2019 to 2020, the rate of women aged 50–69 years who participated in breast screening did not meet target (Table 22). Population growth increased the demand on resources and participation has been limited due to screening and assessment capacity shortfalls caused by COVID-19.

Funding from COVID-19 recovery strategies is expected to assist BreastScreen WA in increasing activity in 2021/22 and in establishing a new breast assessment centre in December 2021 to enable full utilisation of screening capacity.

Table 22: Rate of women aged 50–69 years who participate in breast screening, 2016–17–2019–20

	Calendar years					
	2016–17 (%)	2017–18 (%)	2018–19 (%)	2019–20 (%)	Target (%)	Target met
Participation rate	56	56	55	50	≥ 70	⊗

[9]Elixhauser A, Costs of breast cancer and the cost-effectiveness of breast cancer screening, Int J Technol Assess Health Care. 1991; 7(4):604-15. Review

Note: This measure counts the women screened within a 24-month period (1 January 2019 to 31 December 2020) as it is recommended that women in the cohort attend the free screening every two years.

Data sources: BreastScreen WA Register; Australian Bureau of Statistics.

Detailed information in support of key performance indicators

Outcome 2 - Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives

Percentage of adults and children who have a tooth re-treated within 6 months of receiving initial restorative dental treatment

Rationale

This KPI is used to assess, compare and determine the potential to improve dental care for WA clients. This KPI represents the growing recognition that a capacity to evaluate and report on quality is a critical building block for system-wide improvement of healthcare delivery and patient outcomes.

A low unplanned retreatment rate suggests that good clinical practice is in operation. Conversely, unplanned returns may reflect:

- less than optimal initial management
- development of unforeseen complications
- treatment outcomes that have a direct bearing on cost, resource utilisation, future treatment options and patient satisfaction.

By measuring and monitoring this KPI, the level of potentially avoidable unplanned returns can be assessed in order to identify key areas for improvement (i.e. cost effectiveness and efficiency, initial treatment and patient satisfaction). This KPI is nationally reported in the Australian Council on Healthcare Standards Oral Health Indicators. Its inclusion provides opportunity for benchmarking across jurisdictions.

Target

Please see the targets for adults and children in Table 23. Performance is achieved by a result below the target.

Results

In 2020/21, the percentage of adults and children who have a tooth re-treated within 6 months of receiving initial restorative dental treatment achieved target (Table 23).

Performance was attributable to training provided to clinicians, regular monitoring of clinic/clinician re-treatment rates via the Dental Health Service Clinical Oral Health Advisory Committee, using feedback to improve clinical techniques and procedures where issues are identified and quality assurance of the standard filling materials used state-wide.

Table 23: Percentage of adults and children who have a tooth re-treated within 6 months of receiving initial restorative dental treatment, 2017/18–2020/21

Note: Prior year data is used to ensure results are aligned to the reports provided to the Australian Council on Healthcare Standards. **Data source:** Dental Information Management Patient Management System (DenIM PMS).	Financial year					
	2017/18 (%)	2018/19 (%)	2019/20 (%)	2020/21 (%)	Target (%)	Target met
Adults	6.0	6.1	5.8	5.6	< 7.7	✓
Children	2.2	2.1	2.0	1.9	< 2.6	✓

Detailed information in support of key performance indicators

Outcome 2 - Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives

Percentage of eligible school-children who are enrolled in the School Dental Service program

Rationale

Early detection and prevention of dental health problems in children can ensure better health outcomes and improved quality of life throughout the crucial childhood development years and into adult life. While dental disease is common in children, it is largely preventable through population-based interventions and individual practices such as personal oral hygiene, better diet and regular preventive dental care.

The School Dental Service program ensures early identification of dental problems and, where appropriate, provides treatment. By measuring the percentage of school-children enrolled, the number of children proactively involved in publicly funded dental care can be determined in order to gauge the effectiveness of the program. This in turn can help identify areas that require more focused intervention and prevention and health promotion strategies to help improve the dental health and well-being of Western Australian children.

Target

The 2020/21 target is ≥ 69%. Performance is achieved by a result above, or equal to, the target.

Results

In 2020/21, the percentage of eligible children who are enrolled in the School Dental Service program achieved target (Table 24). Performance for this indicator continues to be above target as the Dental Health Service actively promotes the benefit of the 'free' School Dental Service and engages with parents to enrol their children into the program.

Table 24: Percentage of eligible school-children who are enrolled in the School Dental Service program, 2016/17–2020/21

	Financial year						
	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)	2020/21 (%)	Target (%)	Target met
Eligible school-children who are enrolled in the School Dental program	80	79	79	77	77	≥ 69	✓

Note: Eligible school-children are all school-children aged 5 to 16 or until the end of year 11 (whichever comes first) who attend a Western Australian Department of Education recognised school. A parent/guardian is required to consent to dental examination and screening of their child in the School Dental Service program.

Data sources: Dental Information Management Patient Management System (DenIM PMS); Department of Education WA

Detailed information in support of key performance indicators

Outcome 2 - Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives

Percentage of eligible people who accessed Dental Health Services

Rationale

Oral health, including dental health, is fundamental to overall health, wellbeing and quality of life, with poor oral health likely to exist when general health is poor and vice versa. This makes access to timely dental treatment services critical in reducing the burden of dental disease on individuals and communities, as it can enable early detection, diagnosis and the use of preventative interventions rather than extensive restorative or emergency treatments.

To facilitate equity of access to dental health care for all Western Australians, dental treatment services (including both emergency care and non-emergency care) are provided through subsidised dental programs to eligible Western Australians in need. This indicator measures the level of access to these subsidised dental health services by monitoring the proportion of all eligible people receiving the services.

Measuring the use of dental health services provided to eligible people can help identify areas that require more focused intervention and prevention and health promotion strategies to help ensure the improved dental health and well-being of Western Australians with the greatest need.

Target

The 2020/21 target is ≥ 15%. Performance is achieved by a result above, or equal to, the target.

Results

In 2020/21, the percentage of eligible people who accessed Dental Health Services did not meet target (Table 25).

Despite 5,780 more eligible people accessing Dental Health Services compared to 2019/20, the number of eligible people also increased by 65,578 due to the economic impact of COVID-19 on the WA population.

Table 25: Percentage of eligible people who accessed Dental Health Services, 2017/18–2020/21

	Financial year					
	2017/18 (%)	2018/19 (%)	2019/20 (%)	2020/21 (%)	Target (%)	Target met
Eligible people who accessed Dental Health Services	15	14	14	14	≥ 15	⊗

Note: Eligible people are defined as those who hold a current Pension Concession Card (Centrelink) or Health Care Card.

Data sources: Dental Information Management (DenIM) database; Commonwealth Department of Social Services (DSS) Payment Demographic data.

Detailed information in support of key performance indicators

Outcome 2 - Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives

Service 6 - Public and community health services

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

Rationale

Population health units support individuals, families and communities to increase control over and improve their health.

Population health aims to improve health by integrating all activities of the health sector and linking them with broader social and economic services and resources as described in the WA Health Promotion Strategic Framework 2017–2021. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

The 2020/21 target is $43. Performance is achieved by a result below, or equal to, the target.

Results

In 2020/21, the average cost per person of delivering population health programs by population health units did not meet target (Table 26). The target setting has not been aligned to the cost of service provision and the higher costs in 2020/21 and 2019/20 were due to COVID-19 costs relating to State payments, vaccine costs and costs not relating to activity.

Table 26: Average cost per person of delivering population health programs by population health units, 2017/18–2020/21

	Financial year					
	2017/18 ($)	2018/19 ($)	2019/20 ($)	2020/21 ($)	Target ($)	Target met
Average cost	50	50	69	66	≤ 43	⊗

Data sources: OBM Allocation application; Oracle 11i financial system; WA Department of Health Epidemiology Branch.

Detailed information in support of key performance indicators

Outcome 2 - Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives

Service 6 - Public and community health services

Average cost per breast screening

Rationale

Breast cancer remains the most common cause of cancer death in women under 65 years. Early detection through screening and early diagnosis can increase the survival rate of women significantly. Breast screening mammograms are offered through BreastScreen WA to women aged 40 years and over as a preventative initiative.

Target

The 2020/21 target is $177 per breast screening. Performance is achieved by a result below, or equal to, the target.

Results

In 2020/21, the average cost per breast screening achieved target (Table 27).

Table 27: Average cost per breast screening, 2017/18–2020/21

	Financial year					
	2017/18 ($)	2018/19 ($)	2019/20 ($)	2020/21 ($)	Target ($)	Target met
Average cost	165	158	174	168	≤ 177	✓

Data sources: OBM Allocation application; Oracle 11i financial system; Mammography Screening Register; BreastScreen WA.

Detailed information in support of key performance indicators

Outcome 2 - Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives

Service 8 - Community dental health services

Average cost per patient visit of WA Health-provided dental health programs for school-children and socio-economically disadvantaged adults

Rationale

Early detection and prevention of dental health problems in children can ensure better health outcomes and improved quality of life throughout the crucial childhood development years and into adult life. The School Dental Service program ensures early identification of dental problems and, where appropriate, provides treatment.

Dental disease places a considerable burden on individuals and communities. While dental disease is common, it is largely preventable through population-based interventions, and individual practices such as personal oral hygiene and regular preventive dental care. Costly treatment and high demand on public dental health services emphasises the need for a focus on prevention and health promotion.

Target

Please see the targets for patient groups in Table 28. Performance is achieved by a result below, or equal to, the target.

Results

In 2020/21, the average cost per patient visit of WA Health-provided dental health programs achieved target for school-children and socio-economically disadvantaged adults (Table 28).

Access to dental health programs improved due to reduced COVID-19 restrictions compared to 2019/20. The socio-economically disadvantaged adults result was influenced by the increase in patients who received treatment against the available budget, which remained similar to 2019/20.

Table 28: Average cost per patient visit of WA Health-provided dental health programs for school-children and socio-economically disadvantaged adults, 2017/18–2020/21

Data sources: OBM Allocation application; Oracle 11i financial system; Dental Information Management (DenIM) database.	Financial year					
	2017/18 ($)	2018/19 ($)	2019/20 ($)	2020/21 ($)	Target ($)	Target met
School-children	198	193	237	225	≤ 230	✓
Socio-economically disadvantaged adults	272	281	303	294	≤ 329	✓

Detailed information in support of key performance indicators

Outcome 1 - Public hospital-based services that enable effective treatment and restorative health care for Western Australians

Percentage of emergency department patients seen within recommended times (unaudited performance indicator)

Under Treasurer approval remains in place for the 'Percentage of emergency department patients seen within recommended time (by triage category)' indicator to remain as an unaudited KPI, due to system-wide data capture and validation limitations.

Rationale

The Australasian College for Emergency Medicine developed the Australasian Triage Scale (ATS) to ensure that patients presenting to emergency departments are medically assessed, prioritised according to their clinical urgency and treated in a timely manner[10].

This performance indicator measures the percentage of patients being assessed and treated within the required ATS timeframes. This provides an overall indication of the effectiveness of WA's emergency departments which can assist in driving improvements in patient access to emergency care.

Target

The 2020/21 targets for ED patients seen within recommended times by triage category as per the Australasian College for Emergency Medicine are as follows:

Triage category	Description	Treatment acuity (minutes)	Target (%)
1	Immediate life-threatening	Immediate (≤ 2)	100
2	Imminently life-threatening or important time-critical treatment or very severe pain	≤ 10	≥ 80
3	Potentially life-threatening or situational urgency or humane practice mandates the relief of severe discomfort or distress	≤ 30	≥ 75
4	Potentially serious or situational urgency or significant complexity or severity or humane practice mandates the relief of discomfort or distress	≤ 60	≥ 70
5	Less urgent or clinico-administrative problems	≤ 120	≥ 70

Performance is achieved by a result above, or equal to, the target.

[10]Australasian College for Emergency Medicine. (2013) Policy on the Australasian Triage Scale, Australasian College for Emergency Medicine, Melbourne. Available from: https://acem.org.au/getmedia/484b39f1-7c99-427b-b46e-005b0cd6ac64/P06-Policy-on-the-ATS-Jul-13-v04.aspx

Detailed information in support of key performance indicators

Results

In 2020/21, the percentage of ED patients seen within recommended times for triage category 1 was equal to target; triage category 5 was above target and all other triage categories were below target (Table 29).

Compared to 2019/20, ED presentations have increased by 9.6%. The results were impacted by demand pressures, particularly around issues with patient flow and inpatient bed capacity.

All cases have been reviewed and strategies such as introducing ED waiting room staff to assist with triage and assessment, rapid access clinics for specific patient cohorts, improvements to models of care and discharge planning have been implemented to accommodate demand and to mitigate access issues. Strategies and performance continue to be monitored.

Table 29: Percentage of emergency department patients seen within recommended times, by triage category, 2016/17–2020/21

	Financial year						
Triage category	**2016/17 (%)**	**2017/18 (%)**	**2018/19 (%)**	**2019/20 (%)**	**2020/21 (%)**	**Target (%)**	**Target met**
1	100	100	100	100	100	100	✓
2	77	80	76	80	78	≥ 80	✗
3	40	43	45	51	40	≥ 75	✗
4	57	59	57	64	54	≥ 70	✗
5	93	92	85	87	82	≥ 70	✓

Data sources: Emergency Department Data Collection.

Ministerial Directives

Treasurer's Instruction 903 (12) requires the disclosure of information about Ministerial Directives relevant to the setting of desired outcomes or operational objectives, the achievement of desired outcomes or operational objectives, investment activities and financing activities.

NMHS did not receive any Ministerial Directives during the 2020/21 financial year.

Financial disclosures

Pricing policy

The National Health Reform Agreement sets the policy framework for public hospital fees and charges. Under the agreement, an eligible person who receives public hospital services as a public patient in a public hospital or a publicly contracted bed in a private hospital is treated at no charge to the patient.

The majority of hospital fees and charges for public hospitals are set under Schedule 1 of the Health Services (Fees and Charges) Order 2016 and are reviewed annually. The following informs fees and charges at WA public hospitals for a range of patients.

Nursing home type patients

The State charges public patients who require nursing care and/or accommodation after the 35th day of their stay in hospital, providing they no longer need acute care and they are deemed to be Nursing Home Type Patients. The total daily amount charged is no greater than 87.5% of the current daily rate of the single aged pension and the maximum daily rate of rental assistance.

Compensable or Medicare ineligible patients

Patients who are 'compensable' or Medicare ineligible (overseas residents) may be charged an amount for public hospital services as determined by the State. The setting of compensable and Medicare ineligible hospital accommodation fees is set close to, or at, full cost recovery.

Private patients

(Medicare eligible Australian residents)

The Commonwealth Department of Health regulates the minimum benefit payable by health funds to privately insured patients for private shared ward and same-day accommodation. The Commonwealth also regulates the Nursing Home Type Patient 'contribution' based on March and September pension increases. To achieve consistency with the *Commonwealth Private Health Insurance Act 2007*, the State sets these fees at a level equivalent to the Commonwealth minimum benefit.

Veterans

Hospital charges of eligible war service veterans are determined under a separate Commonwealth–State agreement with the Department of Veterans' Affairs. Under this agreement, the Department of Health does not charge medical treatment to eligible war service veteran patients; instead, medical charges are fully recouped from the Department of Veterans' Affairs.

Further fees and charges

The Pharmaceutical Benefits Scheme regulates and sets the price of pharmaceuticals supplied to eligible outpatients, eligible patients on discharge and eligible day-admitted chemotherapy patients. Inpatient medications are supplied free to all eligible patients. Medicare ineligible patients are charged at the rates set by the WA Department of Health within the Fees and Charges Manual.

Other categories of fees are specified under health regulations through 'determinations', such as the supply of surgically implanted prostheses, magnetic resonance imaging services and pathology services. The pricing for these hospital services is determined according to their cost of service.

The Dental Health Services' charges to eligible patients for dental treatment are based on the Department of Veterans' Affairs fee schedule of dental services for dentists and dental specialists.

Eligible patients are charged the following co-payment rates:

- 50% of the treatment fee if the patient holds a current Healthcare Card or Pensioner Concession Card
- 25% of the treatment fee if the patient is the current holder of one of the above cards and receives a near full pension or an allowance from Centrelink or the Department of Veterans' Affairs.

Financial disclosures

Capital works

We have a substantial Asset Investment Program that facilitates remodelling and development of health infrastructure. Program initiatives include the continuation of major projects to reconfigure infrastructure and investment in metropolitan general and tertiary hospitals (Table 30).

Table 30: Major Asset Investment Program works in progress, 2020/21

Initiatives	Estimated total cost (A)	Actual expenditure to 30/06/2021 (B)	Estimated cost to complete (A) – (B)	Estimated completion date
	$'000	$'000	$'000	
Joondalup Health Campus Development stage 2[1,2,4]	255,215	1,826	253,389	Ongoing
Osborne Park Hospital[1,2,4]	24,538	2,294	22,244	Completed
Osborne Park Hospital reconfiguration stage 1[1]	273	261	12	Ongoing
Reconfiguring the Western Australian Spinal Cord Injury Service[1,2]	6,520	170	6,320	Ongoing
Sarich Neuroscience[1,2,3]	35,265	34,382	883	Completed
Infection prevention and control system[1,2]	2,381	1,443	2,237	Ongoing
Fremantle Dental Clinic[1,2,3]	2,539	2,370	169	Completed
Automated Controlled Substance Storage[4]	800	18	782	Ongoing
KEMH Critical Infrastructure[4]	15,200	271	14,929	Ongoing
NMHS Adult Mental Health Unit	450	2	448	Ongoing
NMHS Critical Infrastructure	1,731	418	1,313	Ongoing
SCGH Cardiac Catheter Laboratory and Interventional Radiology Rooms Upgrade	9,065	41	9,024	Ongoing
SCGH Emergency Department Upgrade and Behavioural Assessment Urgent[4]	19,000	415	18,585	Ongoing
KEMH Façade Cladding Remediation Works[4]	892	-	892	Ongoing
Emergency Capital Works (COVID-19 Response)[4]	921	-	921	New works
COVID-19 Medical Equipment[4]	392	-	392	New works
SCGH GMP Laboratories and Cyclotron[4]	23,311	10	23,301	New works
Stop the Violence[4]	361	-	361	New works
SCGH – Redevelopment of the Watling Walk Retail Precinct[4]	1,480	-	1,480	New works

[1] The information above is based upon the: i) 2020/21 published budget papers. ii) 2019/20 published budget papers. [2] Completion timeframes are based upon a combination of known dates at the time of reporting.

[3] Projects listed above as 'completed' may still be in the defects period. [4] Includes new works project published in 2020/21 budget papers.

Employee disclosures

Industrial relations

The Industrial Relations team provide expert advice and support to enable us to deliver our strategic priorities and strive to foster productive relationships between NMHS and our employees, unions and internal and external stakeholders.

During the year, major activities included:

- providing representation and advocacy on workplace issues before the WA Industrial Relations Commission, Public Service Arbitrator, Public Service Appeal Board, Australian Human Rights Commission, Equal Opportunity Commission and the Industrial Magistrates Court
- contributing to the development, review and implementation of workforce-related policies, strategies, systems and processes
- providing industrial advice on workplace change
- providing advice on workforce issues in response to COVID-19
- interpreting and applying industrial agreements and awards
- participating in internal and external committees including union joint consultative committees
- conducting information and education sessions for executives and managers for newly registered WA Health System United Workers Union (WA) Hospital Support Workers Industrial Agreement 2020 and the WA Health System – HSUWA – PACTS Industrial Agreement 2020
- providing continued support and feedback to the System Manager in negotiations for the replacement of the WA Health System – Medical Practitioners – AMA Industrial Agreement 2016.

Assurance that we are meeting our obligation is provided by the team's advice in the following areas:

- large-scale workforce initiatives and change management programs
- management of claims and disputes related to investigations, disciplinary matters and contractual/agreement claims (e.g. pay, rosters and conditions)
- implementation of new conversion to permanency provisions for fixed-term contract and casual employees in replacement industrial agreements.

Employee disclosures

Employment profile

Government agencies are required to report the number of employees, by category. Table 31 shows the year-to-date (June 2021) number of NMHS full-time equivalent (FTE) employees for 2020/21.

Table 31: NMHS total full-time equivalent employees by category

Category	Definition	Number	%
Nursing and midwifery	All nursing and midwifery occupations, excluding agency nurses and midwives	3,226	36.3
Administration & clerical	All clerical-based occupations including patient-facing (ward) clerical support employees (83 FTE from Department of Health Health Services Union in specific cost centres)	1,529	17.2
Medical support	All allied health and scientific/technical related occupations	1,399	15.7
Medical salaried and sessional	All medical occupations including interns, registrars and specialist medical practitioners	1,286	14.5
Hotel services	Includes catering, cleaning, stores/supply laundry and transport occupations	758	8.5
Dental clinic assistants	Dental clinic assistants	316	3.6
Site services	Engineering, garden and security-based occupations	192	2.2
Agency	Includes the following occupational categories: administration and clerical, medical support, hotel services, site services, medical salaried (excludes visiting medical practitioners) and medical sessional	70	0.8
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care	88	1.0
Agency nursing and midwifery	Workers engaged on a ‘contract for service’ basis. Does not include workers employed by NurseWest	25	0.3
Other occupations	Including, but not limited to, Aboriginal and ethnic health employees	7	0.1
Total FTE employees		**8,898**	**100**

Recognition and awards

Staff Recognition Program

Our Staff Recognition Program (SRP) allows high performing employees to receive the recognition they deserve from management and their peers. NMHS has an SRP to recognise and reward dedicated individuals, teams and volunteers who help make our service one to be proud of. The SRP forms one of the initiatives designed to engage and enable employees and enhance productivity and organisational performance. They are part of the Organisational Development Strategy endorsed by the Area Executive Group.

The SRP is sponsored by our Platinum sponsors Paywise, Smartsalary and HESTA and Gold sponsor Aware Super.

The SRP is delivered through three streams:

- **NMHS GEM Awards**
- **Employee of the Month, Season and Quarter Awards**
- **Long Service Awards.**

NMHS GEM Awards

The NMHS Going the Extra Mile (GEM) Awards provide an opportunity to celebrate and reward high achieving staff (individuals and teams) who exemplify our values of Care, Respect, Innovation, Teamwork and Integrity in their daily service. The 10 GEM Award categories align with our strategic priorities and recognise our ongoing commitment to delivering the best outcomes and highest levels of care for our patients and community. This includes a focus on improving clinical excellence, improving the patient experience, establishing strong partnerships and engagement, and driving innovation. A new category of Outstanding commitment to improving the culture of NMHS was introduced this year.

The GEM Awards provide a valuable opportunity to showcase the great work being done throughout our service and celebrate our exceptional staff. The 2021 GEM finalists were announced on 18 June 2021 and were celebrated at an event on 30 July, with a total of 45 finalists from 63 nominations.

GEM award winners in the category of Driving Innovation: Department of Rehabilitation and Age Care Consultants; Kien Chan, Dr Sarah Bernard, Dr Sook Lee

Recognition and awards

NMHS Employee of the Month, Season and Quarter Awards

The Employee of the Month, Season and Quarter Awards aim to showcase and celebrate employees who have shown exceptional effort, gone beyond the scope of their usual duties, and whose contributions have led to improved outcomes for patients, staff or the community. We recognise that all employees play an important role in achieving the NMHS vision of excellence in health care for our community and in demonstrating our values in everything we do. These awards give our people the opportunity to be recognised and acknowledged by their peers at local site-based celebrations.

- NMHS Corporate and OPH – 4 awards (quarterly)
- MHPHDS – 6 awards (Aboriginal seasons – two monthly)
- SCGH and WNHS – 12 awards (monthly)

NMHS Long Service Awards

The Long Service Awards recognise staff members who have completed continuous service at any of the NMHS sites or services in 10, 20, 30 and 40-year increments. We recognised 538 employees in 2020.

- 10 years – 350
- 20 years – 115
- 30 years – 56
- 40 years – 17

Long service award recipient Judy Gan with Executive Director of WNHS, Dr Jodi Graham

Employee development

Organisational learning practices in healthcare organisations can help to improve existing skills and knowledge, and to discover better ways of working together. We are committed to promoting organisational learning and development with a strong focus on support services and employee career development.

All employees undertake mandatory training to address modifiable risks to both patients and staff, to better provide safe and sustainable health care. Mandatory training includes modules in accountable and ethical decision-making, Aboriginal cultural awareness, emergency procedures, manual tasks, clinical deterioration and basic life support, My Health Record and management of aggression.

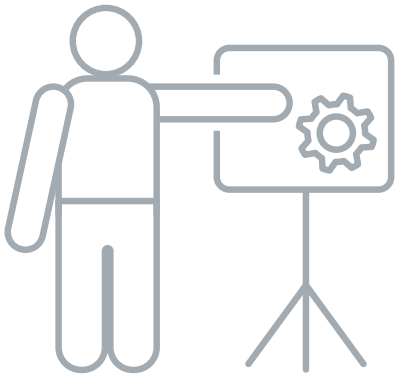
Each NMHS site provides in-house training and education to ensure staff have the appropriate skills and knowledge to fulfil their clinical and non-clinical roles. Training can be conducted either internally or externally at sites and through online eLearning resources.

Additional programs support our 2,000 managerial and supervisory staff as well as frontline managers. This training focuses on equipping managers with the leadership skills required to recruit, manage and develop their staff, including communication, coaching, feedback, conflict management and motivation.

NMHS provides a wide range of undergraduate and graduate training and leadership development programs to employees. As a Registered Training Organisation, we offer nationally recognised qualifications such as the Diploma of Leadership and Management. As at 30 June, NMHS had 130 staff enrolled. Hundreds of NMHS staff completed the 12-hour Mental Health First Aid training, a course focused on recognising and supporting colleagues inside (and outside) the workplace.

Mandatory training continued through the COVID-19 response to ensure the ongoing provision of safe, high-quality care. Wherever practicable, training was converted to eLearning programs; other modified training respected social distancing rules. There was also significant focus on refreshing COVID-19 related training, to ensure our people were well-prepared to deal with any subsequent outbreaks.

In total, more than **10,000 NMHS staff** and volunteers accessed the online learning platform in 2020/21, which now includes a catalogue of **over 300 courses**.



Employee disclosures

Workers compensation

NMHS has a dedicated injury management system in place which governs the standardised management of workers compensation claims, and the provision of injury management services. These are administered in accordance with the *Workers Compensation and Injury Management Act 1981* and Workers Compensation Code of Practice (Injury Management) 2005.

Injury management consultants in collaboration with occupational health physicians are accessible to all staff and managers to ensure high levels of specialist support are provided for staff with work-related injuries or illnesses. These consultants provide expert advice and services to ensure best practice case management strategies, including timely opportunities for staff to return to productive duties when it is medically appropriate.

NMHS adopts a multidisciplinary case management approach to facilitate timely and safe return to work of injured workers which involves the injury management consultant, line managers, injured workers and their treating physicians. This approach ensures the programs are appropriate to the employees' capacity and the workplace. NMHS has also enhanced an early intervention model to provide funding for early treatment for staff with work-related injuries.

Employee rehabilitation programs extend to non-compensable injuries where there is a risk of exacerbating factors or a requirement to provide expert advice to facilitate the employee's safe return to work. This is facilitated by the NMHS occupational health physician.

Table 32:
Number of NMHS workers compensation claims 2020/21

Employee category	Claims
Nursing and midwifery services/dental clinic assistants	153
Administration and clerical	24
Medical (support)	45
Hotel services	57
Maintenance	23
Medical (salaried)	9
Total	**311**

Table 33:
Claims by body location

Bodily location group	Claims
Head	17
Lower limbs	47
Multiple locations	43
Neck	4
Non-physical locations (psychological)	26
System locations (eg. nervous, digestive)	3
Trunk (including back)	67
Unspecified locations	3
Upper limbs	101
Total	**311**

Note: The workers compensation total claims made and employee categories were obtained from RiskCover all claims monthly spreadsheet as at 30 June 2021 and filtered by FY 2020/21.

Board and committee remuneration

Table 34: Board and committee remuneration

Board/Committee	Total remuneration ($)
NMHS Board	488,200
WNHS Community Advisory Council	6,720
SCGH Community Advisory Council	5,250
OPH Community Advisory Council	1,645
Mental Health Community Advisory Council	21,799

Other legal requirements

Act of Grace payments

No Act of Grace payments pursuant to authorisations given under Section 80(1) of the Financial Management Act were made in the 2020/21 financial year.

Unauthorised use of credit cards

NMHS officers are issued with corporate credit cards (Purchasing Cards) when their functions require this facility. The credit cards provide a clear audit trail for the purchase of goods and services and are not to be used for personal (unauthorised) purposes. If a cardholder makes a personal purchase, they must give written notice to NMHS within 5 working days and refund the total amount of expenditure.

Five NMHS cardholders recorded personal purchases on their Purchasing Card. All of these cardholders declared a personal expenditure and all monies were refunded in full (Table 35). No referrals for disciplinary action were instigated during the reporting period.

Table 35: Personal use credit card expenditure by NMHS cardholders 2020/21

Credit card personal use expenditure	Aggregate amount ($)
Reporting period	263.10
Settled by the due date (within 5 working days)	213.10
Settled after the period (after 5 working days)	50.00
Outstanding at balance date	0

Advertising and sponsorship

In accordance with section 175Z of the *Electoral Act 1907*, Health Service Providers are required to report total advertising expenditure. In 2020/21, the total expenditure was $80,453, compared with $92,936 in 2019/20. The organisations from which advertising services were procured and the amount paid to each organisation are shown in Table 36.

Table 36: 2020/21 NMHS advertising expenditure by provider

Category	Provider	$
Advertising agencies	ASMIRT Website – MIT	400
	Australian Diabetes Educators' Association Limited	150
	Birdhouse Media Pty Ltd	6,915
	BMJ Publishing Group Limited	3,864
	Gatecrasher Advertising Pty Ltd	22,304
	Government Education and Business Directories Pty Ltd	908
	Mahlab Media Pty Ltd	500
	Sensis Pty Ltd	683
	Telstra Corporation Limited	9,943
	Yellow Pages	3,119
	Other	466
	Artref Pty Ltd	2,127
	Delta Print	1,170
	Graphic Source Pty Ltd	2,027
	Subtotal	**54,576**
Market research organisations	Nil	
	Subtotal	**-**
Media advertising organisations	Carat Australia Media Services	25,877
	Subtotal	**25,877**
	Total	**80,453**

Other legal requirements

Freedom of information

The broad objective of the *Freedom of Information Act 1992* (FOI Act) is to give the community access to information held by the WA Government.

Members of the public can request access to documents held by NMHS via an FOI application. Applications for patient records are received and managed at individual hospital sites and forms can be accessed via each hospital's website.

Statistics about FOI applications are provided to the Information Commissioner's Office as required by section 111(3)(a) of the *FOI Act* and are published in its annual report available on the Information Commissioner's website.

Compliance with public sector standards and ethical codes

All NMHS employees are required to comply with the Western Australian Public Sector Standards in Human Resource Management and Commissioner's Instructions. To assist employees to understand and comply with the principles of workplace behaviour and conduct, a comprehensive set of WA Health and NMHS policies and guidelines are made available to all employees. NMHS employees may access these via the NMHS intranet, which includes external links to the Department of Health and Public Sector Commission websites. Onsite human resource and Integrity Directorate staff are available to provide information and support to line managers in the implementation of the Public Sector Standards.

To ensure adherence with the Discipline Standard, the WA health system Discipline Policy specifies the principles and minimum requirements with which NMHS must comply to ensure a fair, reasonable and consistent approach to the management of matters that may concern a breach of discipline. The Integrity Directorate ensures that decisions made regarding potential breaches of discipline are made by decision-makers independent of the discipline process and investigated by experienced staff. This ensures matters are appropriately assessed and investigated and decisions are consistent and transparent.

Recruitment and selection

In 2020/21, 7 breach of standard claims were lodged regarding the recruitment, selection and appointment process, or the resolution of a grievance process. Of these, no claims were able to be finalised internally and 7 were sent to the Public Sector Commission for review. Of these, all have subsequently been dismissed. NMHS uses a central recruitment and selection process through Health Support Services to assist with a consistent approach and capacity for monitoring the compliance of the Standards in respect to human resource management. As part of the recruitment, selection and appointment process, applicants are notified of the breach claim process through a standardised letter.

Grievance resolution

The WA Health Grievance Resolution Policy complies with the Public Sector Standards in Human Resource Management – Grievance Resolution Standard, the Public Sector Code of Ethics and the WA Health Code of Conduct. All NMHS employees involved in grievances receive the WA Health Grievance Resolution Policy and the NMHS Guidelines for Resolving Employee Grievances. The guidelines have been further advanced to explain the role of a support person when attending a meeting related to grievances. The option of having a support person during meetings ensures procedural fairness, as well as assisting with the welfare of employees, and fulfilling our commitment to the principles of natural justice.

Other legal requirements

Code of Conduct

The WA Health Code of Conduct Policy (the Code), which was updated in October 2019, defines the standards for ethical and professional conduct and outlines the behaviours expected of all staff throughout the WA health system. All NMHS staff are responsible for ensuring their behaviour reflects the standards of conduct embodied in the Code. The requirements of the Code are further emphasised in online training modules which include Accountable and Ethical Decision Making, Code of Conduct and Workplace Bullying eLearning package (NMHS), Aboriginal Cultural eLearning and Recordkeeping Awareness.

The Code requires staff to report a suspected breach of the Code and contributes to building an ethical workplace culture. The Integrity Directorate has a mandate to assess potential breaches of the Code and undertake disciplinary investigations, when appropriate, in adherence with the WA Health Discipline Policy.

Corruption prevention and integrity education is a new function of the NMHS Integrity Directorate which provides tailored integrity education to all staff across NMHS. In summary, these sessions focus on providing staff with information on relevant policies and procedures to support them in making ethical workplace decisions, knowing where they can seek advice in managing an ethical workplace dilemma or report potential unethical behaviour. The Code is central to all integrity education sessions.

In 2020/21, a total of 153 matters were received for assessment for potential misconduct by the Integrity Directorate.

Recordkeeping plan

Good records management is a necessary element of good governance and integrity. Records are assets which allow the government to function effectively. They provide evidence of actions taken and decisions made by government organisations and allow the government to account for its actions.

The *State Records Act 2000* governs the recordkeeping for all State organisations in WA. Our recordkeeping plan captures key information about processes and systems used by NMHS to manage records of information.

During the year, we continued to action our recordkeeping plan, which details recordkeeping programs and systems, disposal arrangements, policies and procedures. Our plan was endorsed by the State Records Commission in 2015 with a review completed in August 2020. A full review of the plan is due for submission by August 2021.

Record management training sessions continued to be offered to all staff. Feedback from these sessions is used to gauge the effectiveness of delivery and enhance future development of training. Training is supported by our intranet site where resources are available for all staff.

Disability Access and Inclusion Plan

The *Disability Services Act 1993* (WA) requires selected agencies to develop a Disability Access and Inclusion Plan (DAIP). These plans benefit people with disability, the elderly, young parents and people from culturally and linguistically diverse backgrounds. We are committed to ensuring that people with disability, their families and carers can fully access NMHS services, facilities and information. In 2020/21, NMHS progressed several initiatives within the **7 outcome areas of our plan**.

General services and events

Outcome 1: People with disability have the same opportunities as other people to access the services of, and any events organised by, a public authority

To raise awareness of the needs of people with disability, NMHS celebrated International Day of People with Disability on 3 December 2020. On this day, the updated DAIP eLearning package and disability awareness poster were launched and activities were held at each site. At SCGH, planning started for the trial of a portable device to test hearing without the need for a hearing booth or audiologist. Also at SCGH, a new online app has provided access to on-demand interpreting services to facilitate effective communication between staff and non-English speaking patients, including those with disability.

Buildings and facilities

Outcome 2: People with disability have the same opportunities as other people to access the buildings and other facilities of a public authority

New facilities at E Block SCGH include universally accessible toilets (UATs) and an accredited Changing Places bathroom. A purpose-built therapy hub and therapy garden at OPH provide an ideal space for people undertaking rehabilitation. A functional training unit incorporates a universally accessible kitchen, laundry, bathroom and bedroom, enhancing the patient's rehabilitation experience and outcomes.

Information and communications

Outcome 3: People with disability receive information from a public authority in a format that will enable them to access the information as readily as other people.

At SCGH, a new staff training package and video has been developed for Aboriginal patients that require a laryngectomy. Patients who undergo this procedure have a long-term disability and require a lot of support and equipment to engage in daily activities. Also at SCGH, a Delirium Action Plan has been developed to help people with cognitive impairment or intellectual difficulties to better recall important information following an operation.

Disability Access and Inclusion Plan

Quality of service

Outcome 4: People with disability receive the same level and quality of service from the staff of a public authority as other people receive from the staff of that public authority

A team within SCGH provides education to staff about National Disability Insurance Scheme (NDIS) pathways and resources and works closely with an on-site Health Liaison Officer to ensure the best outcomes for patients with disability. At WNHS, a new Cognitive Impairment Guideline has been developed to establish the minimum standards for screening, assessment and management of patients with, or at risk of, cognitive impairment while receiving care. The patient health questionnaire at WNHS, completed by people before admission, has been redeveloped to improve the identification of patients' needs and subsequent care planning, including any vision, mobility, hearing or cognitive impairments.

Complaints and safeguarding

Outcome 5: People with disability have the same opportunities as other people to make complaints to a public authority

A range of feedback mechanisms, including the new MySay survey, is available to enable patients to submit a complaint, compliment or feedback. People with disability are provided with the same access to this process and can lodge a complaint in person, in writing or over the phone. We also subscribe to Care Opinion, an independent site where people can anonymously share their stories about their experience of care. Care Opinion has an accessible website and people have the option to tell their story with visual aids or verbally to a Care Opinion staff member.

Consultation and engagement

Outcome 6: People with disability have the same opportunities as other people to participate in any public consultation by a public authority

The Joondalup Health Campus redevelopment includes relocation of the Occupational Therapy Department, which will provide better access for patients attending outpatient appointments. People with lived experienced of disability were consulted about the design of these treatment spaces.

Employment, people and culture

Outcome 7: People with disability have the same opportunities as other people to obtain and maintain employment with a public authority

An action plan for people with disability has been developed as part of our response to the Workforce Diversification and Inclusion Strategy for WA Sector Employment 2020–2025. NMHS has partnered with National Disability Services (NDS) to improve employment outcomes for people with disability, including employment practice review, resource development and staff training. A recruitment hackathon was conducted to review our recruitment and selection practices and generate ideas to make them more accessible and appealing for diversity groups, including people with disability.

Government policy

Substantive equality

Substantive equality seeks to address inequalities that stem from an individual's particular circumstances. It aims to ensure the same opportunities and access to services are available to everyone equally. We know that policies and practices that appear neutral can unintentionally disadvantage minority groups by not catering for their needs. It is important then that our services are reviewed continuously to ensure that they are fair and suitable for all.

NMHS has made significant progress in ensuring that our services are not only accessible but also responsive to the needs of different people and groups of people. Our initiatives in substantive equality align with WA Government policy.

They include:

- the use of the Aboriginal Health Impact Statement and Declarations (ISDs) when developing new and revised policies within NMHS
- implementing policies, processes and pathways to reduce complexities involved in navigating the health system for Aboriginal patients, their carers and families
- consulting with our Aboriginal Community Advisory Group to co-design facilities and projects on-site at SCGH
- establishing and supporting Aboriginal leadership groups and network opportunities at a local level
- improving identification of Aboriginal patients on admission by delivering information sessions for clinicians and providing resources to support clinicians in identifying Aboriginal patients.

As at May 2021, **NMHS employed 3 Aboriginal Mental Health Liaison Officers** as part of a 6-month pilot program with the aim of supporting the patient's journey in mental health services as well as to assist clinicians and staff with cross-cultural education.

We intend to install **Noongar names on signage at SCGH** to promote a culturally secure workplace. A substantive equality video was produced by NMHS Aboriginal Health to raise awareness of the importance of accessible and equitable services for all.

This year's International Women's Day theme encouraged us to #ChooseToChallenge and work together to help create an inclusive world. To support this theme, a video was created where staff across NMHS raised their hands to show they were choosing to challenge and call out inequality, and to open up discussions about how we might challenge gender stereotypes and celebrate women in our workforce and lives.

New diversity clothing (scrubs and polos) for staff were made in collaboration with the 'Welcome Here' project to promote environments that are visibly welcoming and inclusive of LGBTQIA+ communities. Staff were encouraged to wear rainbow scrubs and polos on IDAHOBIT (17 May) to raise awareness for the work still needed to combat discrimination towards LGBTQIA+ people around the world.

MHPHDS and WNHS promoted education and adopted the Rainbow Tick accreditation, which is awarded to organisations that achieve the highest standard of LGBTQIA+ inclusive practice. The tick conveys a message to LGBTQIA+ clients that we are committed to providing a welcoming, culturally safe and supportive workplace.

DHS developed a social storybook titled Maggie Goes to the Dentist as an anxiety management tool for patients with autism spectrum disorder. The storybook helps prepare these special patients and their carers for the sights, sounds and experience of going to the dentist.

Our policies are reviewed and updated to consider the differentiated needs of our diverse community and workforce as required.

Government policy

Priority start policy

We are committed to complying with the Government Priority Start Policy (formerly the Government Building Training Policy). In particular, we include appropriate clauses in our tender documentation and monitor compliance of in-scope building, construction and maintenance contractors for projects with a total contract value of greater than $5 million inclusive of GST.

As at 30 June 2021, NMHS has one Capital works contract for $5,588,269.64 including GST. The contract with contractor Built Ltd requires the Contractor to submit its Head Contractor Priority Start Report directly to the Department of Training and Workforce Development.

Occupational safety and health, and injury management

NMHS is committed to providing a safe workplace and achieving high standards in safety and health for our employees, contractors, volunteers and visitors. To achieve this, an integrated risk management approach to occupational safety and health (OSH) is in place, underpinned by policies and procedures in accordance with the *Occupational Safety and Health Act 1984*, the Occupational Safety and Health Regulations 1996 and the Code of Practice on Occupational Safety and Health in the Western Australian Public Sector.

The establishment of clear OSH policies, goals and strategies, the articulation of employee responsibilities and the development of preventive programs enables a proactive approach to OSH and forms components of the Occupational Safety and Health Management Framework. The framework also reinforces executive and management commitment to occupational safety and health through:

- executives and managers showing leadership in safety
- prioritising OSH tasks
- implementing safety improvements and
- measuring safety performance.

A consultative approach to the resolution of safety risks is adopted to ensure hazards are addressed, and incidents are investigated, thereby promoting a positive safety culture. NMHS regularly provides information about safety and health and promotes activities to ensure that all staff have access to current information, particularly when it applies to their roles and the healthcare environment. Safety and health policies, procedures, guidelines and other related information are available to all staff through HealthPoint and intranet pages.

All NMHS sites facilitate OSH management and consultation through:

- the election of OSH representatives
- the establishment of OSH committees and working groups
- hazard/incident reporting and investigation
- routine workplace inspections
- resolution of issues process and
- implementation of regular audits, risk assessments and control measures to prevent incidents occurring.

OSH committees meet regularly to discuss and resolve occupational safety and health issues. Committee members are available to management and employees to support discussion and resolution of OSH issues. This ensures issues are formally recognised and actions are communicated back to the employee and OSH representative.

Because of COVID-19, training for managers and supervisors was cancelled. COVID-19 clinical activities and training in personal protective equipment (PPE) was given priority. This resulted in a reduction in manager training percentage from the base year. Training has recommenced targeting non-compliant managers and supervisors to increase compliance.

Table on the next page →

Government policy

Table 37: Occupational safety and health assessment and performance indicators

Measures	Results 2018/19[1] Base year	Results 2019/20 Prior year	Results 2020/21 Current reporting year	Targets[1]	Comments towards targets
Number of fatalities	0	0	0	0	Target met
Lost time injury and disease incidence rate[2]	2.3[3]	2.3	2.9	0 or 10% reduction (2.07)	Target not met
Lost time injury and severity rate[2]	35.41	41.95	37.93	0 or 10% reduction (31.9)	Further information regarding impacts on claim severity is detailed below[4]
Percentage of injured workers returned to work (i) within 13 weeks[5]	61%[3]	59%	56%	N/A	N/A
Percentage of injured workers returned to work (ii) within 26 weeks[5]	69%[3]	70%	63%	Greater than or equal to 80%	KPI not met
Percentage of managers trained in occupational safety, health and injury management responsibilities, including refresher training within 3 years[6]	69%	51%	55%	Greater than or equal to 80%	KPI not met. Ability to conduct training has been impacted by COVID-19

Notes:

[1] Target is 10% improvement on base year 2018/19. The performance reporting examines a 3-year trend and, as such, the comparison base year is 2 years prior to the current reporting year.

[2] LTIs and Severe Claims lodged during the financial year as provided by RiskCover (excludes declined and withdrawn claims). Severity Rate for prior financial years is as extracted at the relevant reporting period.

[3] 2018/19 and 2019/20 data may be different to previous annual report data. The data reported above has been recalculated in line with current methodologies by using RiskCover data only, in alignment with other HSPs.

[4] Claim severity. It is important to note that there may be numerous factors impacting on injured staff and their ability to return to productive work. Return to work can be complicated by real or perceived workplace stress and conflict, personal issues, underlying health concerns, performance issues, mental health disorders and other factors.

[5] Calculated from RiskCover All Claims Report. Includes lost time claims with an accident date within the last calendar year. Return to Work is calculated by using days lost/days normally worked where the worker has a level of fitness of 'Fit for Pre-injury duties on Pre-injury Hours'.

[6] Managers and supervisors requiring training are determined from our HR records by flagging management position numbers.

Appendices

Contact details

North Metropolitan Health Service

QEII Medical Centre, 2 Verdun Street,
Nedlands WA 6009
Locked Bag 2012, Nedlands WA 6009
(08) 6457 3333
nmhs.corporatecommunications@health.wa.gov.au
www.nmhs.health.wa.gov.au

Joondalup Health Campus (public)*

Street and postal address: Shenton Avenue,
Joondalup WA 6027
(08) 9400 9400
www.joondaluphealthcampus.com.au

* Operated on behalf of the State Government by Joondalup Hospital Pty Ltd, a subsidiary of Ramsay Health Care

Women and Newborn Health Service

374 Bagot Road, Subiaco WA 6008
PO Box 134, Subiaco WA 6904
(08) 6458 2222
www.kemh.health.wa.gov.au

Sir Charles Gairdner Osborne Park Health Care Group

Sir Charles Gairdner Hospital

Hospital Avenue, Nedlands WA 6009
Locked Bag 2012, Nedlands WA 6009
(08) 6457 3333
www.scgh.health.wa.gov.au

Osborne Park Hospital

36 Osborne Park Place, Stirling WA 6021
(08) 6457 8000
www.oph.health.wa.gov.au

Mental Health, Public Health and Dental Services

Mental Health

54 Salvado Road, Wembley WA 6014
(08) 9380 7700
www.nmhs.health.wa.gov.au/Hospitals-and-Services/Mental-Health

Graylands Hospital Campus

Brockway Road, Mount Claremont WA 6010
PO Private Bag No.1, Claremont WA 6910
(08) 6159 6600
www.nmhs.health.wa.gov.au/Hospitals-and-Services/Hospitals/Graylands

Public Health

Anita Clayton Centre
Suite 1, 311 Wellington Street, Perth WA 6000
(08) 9222 8500
https://nmhs.health.wa.gov.au/Hospitals-and-Services/Public-Health

Dental Health Services

43 Mount Henry Road, Como WA
6152 Locked Bag 15, Bentley Delivery Centre, WA 6983
(08) 9313 0555
www.dental.wa.gov.au

Board and committee remuneration 2020/21

Table 38: NMHS Board

Position title	Member name	Type of remuneration	Period of membership (months)	Term of appointment / tenure	Base salary / Sitting fees ($)	Gross / actual remuneration ($)
Chair	David Forbes	Per annum	6	3 years	37,993	41,603
Chair	Hon. Jim McGinty AM	Per annum	7	3 years	40,550	44,403
Deputy Chair	David Forbes	Per annum	6	3 years	19,946	21,841
Deputy Chair	Grant Robinson	Per annum	5	3 years	18,485	20,241
Member	Steve Toutountzis	Per annum	12	3 years	41,792	45,762
Member	Hilary Fine	Per annum	12	3 years	41,792	45,762
Member	Rebecca Strom	Per annum	12	3 years	41,792	45,762
Member	Selma Alliex	Per annum	12	3 years	41,792	45,762
Member	Angela Edwards	Per annum	12	3 years	41,792	45,762
Member	Paul Norman	Per annum	12	3 years	40,667	44,530
Member	Kim Farmer	Per annum	12	3 years	40,667	44,530
Member	Paula Rogers	Per annum	5	3 years	17,681	19,361
Member	Grant Robinson	Per annum	6	3 years	20,896	22,881
					Total	**488,200**

Board and committee remuneration 2020/21

Table 39: WNHS Community Advisory Council

Position title	Member name	Type of remuneration	Period of membership (months)	Term of appointment / tenure	Base salary / Sitting fees ($)	Gross / actual remuneration ($)
Chair	Jody Blake	Per hour	12	Sessional	35	805
Deputy Chair	Sonja Whimp	Per hour	12	Sessional	35	910
Member	Nicole Woods	Per hour	12	Sessional	35	350
Member	Amanda Hocking	Per hour	12	Sessional	35	805
Member	Ann McRae	Per hour	12	Sessional	35	840
Member	Caitlin Kameron	Per hour	12	Sessional	35	665
Member	Gail Yarran	Per hour	12	Sessional	35	420
Member	Gemma Cadby	Per hour	12	Sessional	35	700
Member	Jane Jones	Per hour	12	Sessional	35	455
Member	Joanne Beedie	Per hour	12	Sessional	35	665
Member	Maryam Aghamohammadi	Per hour	5	Sessional	35	105
Member (Carer)	Jenny Bedford	Per hour	12	Sessional	35	-
Member	Sirad Elmi	Per hour	1	Sessional	35	-
					Total	**6,720**

Board and committee remuneration 2020/21

Table 40: SCGH Community Advisory Council

Position title	Member name	Type of remuneration	Period of membership (months)	Term of appointment / tenure	Base salary / Sitting fees ($)	Gross / actual remuneration ($)
Chair	Carolyn Boyd	Per hour	12	Sessional	35	525
Deputy Chair	Elizabeth Mills	Per hour	12	Sessional	35	805
Member	Tanya Basile	Per hour	12	Sessional	-	-
Member	Anne-Marie Fanning	Per hour	12	Sessional	-	-
Member	Chris Cullen	Per hour	12	Sessional	-	-
Member	Jay Jay Jegathesan	Per hour	12	Sessional	35	735
Member	Howard Lance	Per hour	12	Sessional	35	665
Member	Judy Russell	Per hour	12	Sessional	35	805
Member	Karen Tambree	Per hour	12	Sessional	35	805
Member	Bakare Oluaseun	Per hour	12	Sessional	35	210
Member	Carol Kagi	Per Hour	12	Sessional	35	700
					Total	**5,250**

Board and committee remuneration 2020/21

Table 41: OPH Community Advisory Council

Position title	Member name	Type of remuneration	Period of membership (months)	Term of appointment / tenure	Base salary / Sitting fees ($)	Gross / actual remuneration ($)
Chair	Joan Varian	Per hour	2	Sessional	35	-
Chair	Dianne Glenister	Per hour	7	Sessional	35	210
Deputy Chair	Merrianne Soloway	Per hour	7	Sessional	35	665
Member	Dianne Glenister	Per hour	2	Sessional	35	105
Member	Merrianne Soloway	Per hour	2	Sessional	35	315
Member	Sue Haydon	Per hour	9	Sessional	35	210
Member	Bakare Oluwaseun	Per hour	9	Sessional	35	140
Member	Beverley Port Louis	Per hour	2	Sessional	35	-
Member	Diane Yappo	Per hour	2	Sessional	35	-
Member	Margaret Erneste	Per hour	2	Sessional	35	140
Member	Peter Wilson	Per hour	2	Sessional	35	-
					Total	**1,645**

Board and committee remuneration 2020/21

Table 42: Mental Health Community Advisory Council

Position title	Member name	Type of remuneration	Period of membership (months)	Term of appointment / tenure (years)	Base salary / Sitting fees ($)	Gross / actual remuneration ($)
Chair	Alan Alford	Per hour	12	Sessional	35	1,470
Deputy Chair	Phoebe Kingston	Per hour	12	Sessional	35	350
Member	Seamus Murphy	Per hour	12	Sessional	35	140
Member	Virginia Catterall	Per hour	12	Sessional	35	245
Member	Sonja Whimp	Per hour	12	Sessional	35	1,120
Member	Ron Deng	Per hour	12	Sessional	35	420
Member	Lynette Murphy	Per hour	12	Sessional	35	490
Member	Nathan Issel	Per hour	12	Sessional	35	1,015
Member	Shauna Gaebler	Per hour	12	Sessional	35	-
Member	Mei Huang	Per hour	12	Sessional	35	-
Member	Marisha Gerovich	Per hour	12	Sessional	35	350
Member	Lachlan Rodenburg	Per hour	12	Sessional	35	-
					Total	**5,600**

Board and committee remuneration 2020/21

Table 43: Board and committee attendance and eligibility 2020/21

	Board		Audit and Risk		Safety and Quality		Finance		People, Culture and Engagement	
No. of meetings held	**12**		**6**		**11**		**11**		**11**	
	Attended	Eligible to attend	Attended	Eligible to attend	Attended	Eligible to attend	Attended	Eligible to attend	Attended	Eligible to attend
Hon. Jim McGinty AM (Chair – 1 July 2020 to 17 January 2021)	6	6								
David Forbes (Chair – 17 January 2021)	11	12			6	6	6	6		
Grant Robinson (Deputy Chair 17 Jan to 13 May 2021)	10	10	5	5			9	9		
Hilary Fine	12	12			11	11			11	11
Selma Alliex	8	12			8	11			7	11
Rebecca Strom (Deputy Chair from 13 May 2021)	11	12	6	6			11	11		
Paul Norman	12	12			10	10				
Steve Toutountzis	11	12	6	6	10	10	11	11		
Angela Edwards	12	12	5	6					11	11
Kim Farmer	12	12					4	6	9	10
Paula Rogers	6	6							4	4
Pip Brennan* (ceased 19 March 2021)									7	8

* Executive Director, Health Consumers' Council, Specialist advisor to the NMHS Board

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