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

Annual Report

2021-2022

Contents

Executive Summary

Statement of compliance

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 2022.

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

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. We acknowledge the majority of our business is conducted on Whadjuk Noongar Boodjar, and a number of services are conducted statewide. We recognise, respect, and value 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.

Our staff celebrating NAIDOC week

Foreword

Board Chair's overview

It is our privilege to have the opportunity to report on our performance for the financial year ending 30 June 2022.

In this report we provide you with information about:

- who we are, what we do, how we do it, and how we are governed
- the challenges and significant issues we faced throughout the year
- how we cared for our patients, staff, and community in the face of those challenges
- our plan for setting up for success, identifying early priorities, and building momentum for the future
- our financial and business performance over the past financial year

While there is no doubt that this has been another challenging year as we faced the ongoing impacts of the COVID-19 pandemic and demand for services, we maintained focus on our role as part of the wider health service in delivering the priorities of the **WA Recovery Plan**[1] and managing the surge of COVID-19 cases in WA. Our achievements highlighted in this report are a tribute to the outstanding commitment of our staff and our partners as we strive to deliver the highest quality person-centred care to our patients and community. As we navigated the COVID-19 surge in Western Australia, we were met with workforce shortages, critical levels of ambulance ramping, delays to emergency access and elective surgery, and increased wait times for outpatient appointments that could not be undertaken via Telehealth. Our sites and services responded readily, flexibly, and safely to the increased demand for our hospital services whilst providing critical care to our COVID-19 positive patients. I wish to acknowledge the persistent efforts of our staff, who rapidly implemented strategies to keep themselves, their colleagues, our patients, and our community safe as we've adapted to the changing clinical environment and the directions issued within the **COVID-19 Framework for System Alert and Response (SAR)**[2].

It is an honour to serve alongside our trusted and capable people as the NMHS Board Chair and I am pleased to endorse the 2021/22 Annual Report.

Clinical Professor David Forbes AM
Board Chair
North Metropolitan Health Service

Chief Executive's report

As the new Chief Executive for NMHS, I sincerely thank Tony Dolan who was the Acting Chief Executive for most of 2021/22 prior to my arrival in April 2022. I have joined NMHS at a time of unprecedented disruption to our service as a result of the COVID-19 pandemic. I would like to acknowledge our staff for their understanding and patience under such unprecedented circumstances. Our staff have continued to provide an exceptional level of care to our patients and each other and it is a privilege to lead such a dedicated workforce.

Our performance this year against our Key Performance Indicators (KPIs), is reflective of the challenges we've faced related to managing the impact of COVID-19 and associated staff furlough. In particular, there was an increase in some clinical incidents. However, there has also been a positive shift in reporting of these clinical incidents and the importance of establishing root causes and attendant actions.

As we look to the future, we consider the reality of living with COVID-19 and the on-going impact of this pandemic on our patients, our staff, and our community. We are focussed on delivering strategies and support mechanisms with both patient and staff well-being at the forefront of our minds.

As we transition, we make a renewed commitment to eliminate ambulance ramping, improve the flow of patients through our hospitals, and address major access block to ensure our patients receive the right care, in the right place, at the right time.

In the year ahead we aim to set up a new and innovative approach to our core business of providing excellent care and access for our patients. This will be a whole of NMHS focus, accounting for the learnings from past programs, but with a renewed focus on investing in and supporting our workforce to achieve the required outcomes. The aim of the program is to map patient flow from the hospital to home, examine processes through the Emergency Department (ED), on the ward, and at discharge. The program will involve new models of care and link to our home programs.

Improving access to excellent care is at the heart of our work. As we work to improve patient flow and address access block, I am confident we will also improve the way we work and the care we provide.

Comments and feedback

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

Dr Shirley Bowen
Chief Executive
North Metropolitan Health Service

Summary of our performance

Healthcare delivery

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 (HSP), we are 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

- **Service 1** – Public hospital admitted services
- **Service 2** – Public hospital emergency services
- **Service 3** – Public hospital non-admitted services
- **Service 4** – Mental health services

Outcome 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
- **Service 8** – Community dental health services

Our performance against these activities and outcomes is summarised in the following section **'summary of key performance indicators'** and subsequently described in the latter section **'detailed information in support of key performance indicators'.**

Changes to the OBM Framework

The OBM framework was implemented for annual reporting from 2017/18. There were no material changes to the framework in 2021/22.

Shared responsibilities with other agencies

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

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

WA Department of 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 healthcare for Western Australians

Effectiveness KPIs

- Unplanned hospital readmissions for patients within 28 days for selected surgical procedures
- Percentage of elective wait list 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
  - Average admitted cost per weighted activity unit
- **Service 2** Public hospital emergency services
  - Average emergency department cost per weighted activity unit
- **Service 3** Public hospital non-admitted services
  - Average non-admitted cost per weighted activity unit
- **Service 4** Mental health services
  - 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

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 retreated within six 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
  - Average cost per person of delivering population health programs by population health units
  - Average cost per breast screening
- **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

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

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

Summary of key performance indicators

KPIs help us to assess and monitor the extent to which government outcomes are being achieved.

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

Actual results versus KPI targets

Outcome 1: Public hospital-based services that enable effective treatment and restorative health care for Western Australians	2021 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	23.4	0.4	×
Hip replacement	≤ 17.1	14.2	2.9	✓
Tonsillectomy and adenoidectomy	≤ 81.8	150.0	68.2	×
Hysterectomy	≤ 42.3	54.6	12.3	×
Prostatectomy	≤ 36.1	42.8	6.7	×
Cataract surgery	≤ 1.1	2.1	1.0	×
Appendicectomy	≤ 25.7	27.3	1.6	×
Note: Expressed as a rate per 1,000 separations				
Healthcare-associated Staphylococcus aureus bloodstream infections (HA-SABSI) per 10,000 occupied bed-days	≤ 1.0	0.5	0.5	✓

Outcome 1: Public hospital-based services that enable effective treatment and restorative health care for Western Australians	2021 calendar year			
Effectiveness KPI (continued)	**Target**	**Actual**	**Variation**	**Target met**
Survival rates for sentinel conditions				
Stroke				
0 to 49 years	≥ 95.2%	93.7%	1.5%	×
50 to 59 years	≥ 94.9%	91.3%	3.6%	×
60 to 69 years	≥ 94.1%	91.6%	2.5%	×
70 to 79 years	≥ 92.3%	89.2%	3.1%	×
80+ years	≥ 86.0%	85.3%	0.7%	×
Acute myocardial infarction				
0 to 49 years	≥ 99.1%	100.0%	0.9%	✓
50 to 59 years	≥ 98.8%	98.8%	0.0%	✓
60 to 69 years	≥ 98.1%	98.6%	0.5%	✓
70 to 79 years	≥ 96.8%	94.0%	2.8%	×
80+ years	≥ 92.1%	90.9%	1.2%	×
Fractured neck of femur				
70 to 79 years	≥ 98.9%	96.9%	2.0%	×
80+ years	≥ 96.9%	95.5%	1.4%	×
Percentage of admitted patients who discharged against medical advice				
Aboriginal patients	≤ 2.78%	3.46%	0.68%	×
Non-Aboriginal patients	≤ 0.99%	0.74%	0.25%	✓
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%	×

Outcome 1: Public hospital-based services that enable effective treatment and restorative health care for Western Australians	2021 calendar year			
Effectiveness KPI (continued)	**Target**	**Actual**	**Variation**	**Target met**
Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services	≥ 75%	86%	11%	✓
	2021/2022 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%	15%	15%	×
Category 2 over 90 days	0%	26%	26%	×
Category 3 over 365 days	0%	10%	10%	×
	2021/2022 financial year			
Efficiency KPI	**Target**	**Actual**	**Variation**	**Target met**
Average admitted cost per weighted activity unit	≤ $6,907	$7,715	$808	×
Average emergency department cost per weighted activity unit	≤ $6,847	$7,129	$282	×
Average non-admitted cost per weighted activity unit	≤ $6,864	$7,258	$394	×
Average cost per bed-day in specialised mental health inpatient services	≤ $1,484	$1,595	$111	×
Average cost per treatment day of non-admitted care provided by mental health services	≤ $435	$412	$23	✓

Outcome 2: Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives	2020-2021 calendar years			
Effectiveness KPI	**Target**	**Actual**	**Variation**	**Target met**
Rate of women aged 50–69 years who participate in breast screening	≥ 70%	50%	20%	×
	2021/2022 financial year			
Effectiveness KPI	**Target**	**Actual**	**Variation**	**Target met**
Percentage of people who have a tooth retreated within 6 months of receiving initial restorative dental treatment				
adults	< 7.7%	5.9%	1.8%	✓
children	< 2.6%	1.9%	0.7%	✓
Percentage of eligible school children who are enrolled in the School Dental Service program	≥ 78%	75%	3%	×
Percentage of eligible people who accessed Dental Health Services	≥ 15%	13%	2%	×
	2021/2022 financial year			
Efficiency KPI	**Target**	**Actual**	**Variation**	**Target met**
Average cost per person of delivering population health programs by population health units	≤ $57	$97	$40	×
Average cost per breast screening	≤ $144	$153	$11	×
Average cost per patient visit of WA Health-provided dental health programs for				
school children	≤ $235	$302	$67	×
socio-economically disadvantaged adults	≤ $321	$365	$44	×

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

Summary of our performance

Safety and quality

At a glance

We strive across all sites and services to deliver safe, trusted, and valued care in alignment with our values and the Australian Commission on Safety and Quality in Health Care. We have worked tirelessly to embed evidence-based best practice National Safety, Quality Health and Safety Standards and this year have successfully completed Australian Council on Healthcare Standards accreditation at both Osborne Park Hospital (OPH) and the Women and Newborn Health Service (WNHS). We have started the new reporting year by commencing the accreditation journey with Mental Health and are preparing for assessment for Sir Charles Gairdner Hospital (SCGH) in early 2023.

Throughout the past year, in response to significant workforce and health system challenges, we have increased focus on ensuring ongoing surveillance and quality assurance of safe patient care during a period of elevated workforce pressures, pandemic responses, and limited resources. Attentive scrutiny allows us to celebrate the excellent holistic clinical care provided by our staff to our patients across our sites and services, and identify areas requiring ongoing attention based on clinical incident reporting. Strategies to address identified concerns are in development and change applications are continuously monitored.

Patient safety and health outcome indicators are critical in monitoring performance of health care delivery to Western Australians. The following data offers insight into how we have maintained focus on the delivery of safe, quality health care to our consumers whilst managing the impact of the COVID-19 pandemic. Further detail on how we have focussed on the experience of our consumers can be found in the **'How we listened'** section of this report.

324

Quality improvement projects completed focussing on improving patient care and quality of healthcare delivery

387

New quality improvement projects commenced

15,305

Completed MySay inpatient surveys providing us with patient experience feedback

28,944

Completed MySay outpatient surveys since 15 October 2021

+77

Average Net Promoter Score inpatients providing patient satisfaction rating of those admitted to our hospitals

+76

Average Net Promoter Score outpatients giving us information on the satisfaction rating of our outpatient clinics

186

Stories about our health service shared on CareOpinion Australia

78%

Recommendation rate on CareOpinion Australia

88% Hand Hygiene compliance rate, reducing risk of potential infections

7,082 non SAC 1 clinical incidents
650 SAC 2 incidents
5,998 SAC 3 incidents

434 Incidents are yet to have a Severity Assessment Code

Top 5

Hospitals nationally in staff listening and responding to consumer stories on CareOpinion Australia

SAC = Severity Assessment Code | SAC figures do not include Joondalup Health Campus

Learning from critical incidents

We are committed to driving safety, quality, and value through transparent reporting that supports continuous improvement.

Given two thirds of our resources are used to deliver public hospital-based services, it is critical that we learn from events that don't quite go to plan to ensure we can improve on our delivery of the most efficient, high value clinical care to our patients.

Definitions[3]

Clinical incident – *an event or circumstance resulting from health care provision (or lack thereof) which could have, or did, lead to unintended or unnecessary physical or psychological harm to a patient*

Near miss – *an incident that may have, but did not, cause harm – either by chance or through timely intervention*

Sentinel Event (SE) – *refers to a subset of serious clinical incidents that have caused or could have caused serious harm or death of a patient. It refers to preventable occurrences involving physical or psychological injury, or risk thereof*

The 10 nationally endorsed SE categories are reflected in the **WA Health policy**[4] , however, this list is broadened in WA to mandate reporting of near miss SEs, which is not the case nationally.

Severity Assessment Codes (SACs) – Before an investigation of the clinical incident can take place, a SAC rating must be confirmed and allocated which will determine the prioritisation of the clinical incident investigation.

SAC 1 – A clinical incident that has or could have (near miss), caused serious harm or death; and which is attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.

SAC 2 – A clinical incident that has or could have (near miss), caused moderate harm; and which is attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.

SAC 3 – A clinical incident that has or could have (near miss) caused minor or no harm; and which is attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.

Safety culture and improved governance

We support a just culture and have continued the work outlined in last year's Annual Report, providing education and training, strengthening our governance processes, and increasing the strength and visibility of recommendations resulting from investigations. This has been achieved through lowering the threshold to classify an incident as a SAC 1, increasing our focus on near miss incidents (including sentinel events) and reducing requests for declassification when health care factors are identified that may not have directly contributed to the outcome. Combined, these factors are reflected in the increased number of reported SAC 1 incidents and the decreased proportion of declassifications (currently 21% compared to 34% in 2020-21). It is not possible to estimate how many of the 24 incidents currently undergoing the investigation process will result in declassification, so ultimately the figures may be closer to those of previous years.

Summary of SAC 1 incidents and level of harm

(excluding Joondalup Health Campus (JHC)):

Of the remaining 123 incidents, 24 were under investigation at the time of reporting and 99 had been completed. 23 (19%) of SAC 1s resulted in the death of the patient, 78 (63%) resulted in serious harm, 11 (9%) resulted in moderate harm, and 11 (9%) resulted in minor or no harm to the patient.

Summary of Sentinel Events

(excluding JHC):

Included in the 123 incidents were 15 SEs. This represents a significant increase from previous years. The factors contributing to this increase include changes to the definitions of SEs during 2018 to broaden the definitions to include serious harm; lowering of the threshold to meet the criteria for SE based on serious harm definition; and the inclusion of 'near miss' incidents within the SEs category.

Of the 15 SEs, 10 related to medication errors, four related to surgical procedures and one was the result of a blood transfusion error. Two of the medication errors and the sole blood transfusion error were near miss incidents, with no harm caused to the patient. None of the SEs resulted in the death of a patient.

The investigations into these SEs resulted in 35 recommendations being made, with 22 already completed.

- 21 recommendations related to development, review, or updating of processes/procedures/guidelines
- 9 recommendations involved education of staff (where this is the primary focus of the recommendation)
- 1 recommendation resulted in change of medical devices
- 1 involved correspondence to an external agency to consider technology changes
- 2 involved development of a business case/review of service capacity
- 1 resulted in medication patient safety alerts

NMHS SAC 1 Clinical incidents	NMHS combined 2019/2020		NMHS combined 2020/2021		NMHS combined 2021/2022	
Total reported	150	–	145	–	176	–
Declassified	56	37%	47	32%	33	19%
Investigation completed (excl declass)	94	63%	98	68%	118	67%
Investigation in progress	N/A	–	N/A	–	25	14%
Total completed and in progress SAC 1 Investigations	**94**	**–**	**98**	**–**	**143**	**–**
Outcome of completed + SAC 1 in progress						
Death	24	26%	29	30%	27	19%
Serious harm	49	52%	50	51%	93	65%
Moderate harm	10	11%	6	6%	11	8%
Minor harm	3	3%	5	5%	1	1%
No harm	8	9%	8	8%	11	8%
	94	**–**	**98**	**–**	**143**	**–**

NMHS SAC 1 Clinical incidents type (excl declass)	NMHS combined 2019/2020			NMHS combined 2020/2021			NMHS combined 2021/2022		
	Other	Sentinel Event	Total	Other	Sentinel Event	Total	Other	Sentinel Event	Total
Investigation completed	92	2	**94**	92	6	**98**	105	13	**118**
Investigation in progress	–	–	–	–	–	–	23	2	**25**
	–	–	–	–	–	–	**128**	**15**	**143**

Note: the figures in the table are inclusive of JHC

Finance

Financial summary

Our annual budget is contained within the approved Minister for Health; Mental Health *Financial Management Act 2006* section 40 Annual Financial Estimates, which were developed based on the initial Service Agreement (2022).

This agreement outlines the health services to be provided by the HSP 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 2021/22, the total cost of providing state services and health services to the NMHS community was $2.4 billion. Results for 2021/22 against agreed financial targets (based on the Budget Statements) are presented on the next page. Full details of our financial performance during 2021/22 are provided in the **financial statements** section of this Report.

Actual results versus budget targets

Financial targets	2022 Target [1] $000	2022 Actual $000	Variation [2] $000	Explanation of variance - key factors
Total cost of services (expense limit) (sourced from Statement of comprehensive income)	2,187,989	2,435,785	(247,796)	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 repairs and maintenance works funded mostly by COVID-19 economic stimulus spending.
Net cost of services (sourced from Statement of comprehensive income)	2,031,422	2,259,098	(227,676)	Total cost of services negative variance of $248 million offset by higher recoveries from the Pharmaceutical Benefits Scheme (PBS) under Other Fees for Services.
Total equity (sourced from Statement of financial position)	2,055,126	2,116,759	61,633	$111 million increment in revaluation reserve, arising largely from Landgate's valuation of NMHS's land and buildings as at 30 June 2022; offset by lower Capital Appropriation received due to impact of COVID-19 pandemic on the progression of capital projects;
Net increase / (decrease) in cash held (sourced from Statement of cash flows)	4,913	5,379	466	Additional $178 million cash provided by State Government; and $12 million less spending on purchases of fixed assets; offset by additional $188 million cash used in operating activities.
Approved salary expense level	1,130,442	1,276,488	(146,046)	The increase in expenditure as a result of additional funding received to manage the COVID-19 pandemic as well as increase in Full-time Equivalent (FTE) to support provision of increasing health services.

Data source: Budget strategy and reporting:

1. As per 2021/22 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 targets	2022 Agreed limit $000	2022 Target / Actual $000	Variation $000
Agreed working cash limit (at budget)	101,763	101,763	–
Agreed working cash limit (at actuals)	111,918	105,919[(a)]	(5,999)

Data source: Funding plan from the NMHS and DHS Service Agreements 2021/22.

(a) The Actual working cash held totals $105,918,898 which includes an amount of $18,021,429 held for Capital Project works and $58,743,625 held for restricted or contractual obligations. NMHS therefore has $29,035,378 discretionary cash of which $4,674,679 is quarantined by DHS related to an upgrade to their Electronic Dental Records system and $2,507,279 is quarantined by NMHS primarily for research.

Expenses by services

Public hospital admitted services	**55%**
Public hospital non-admitted services	**13%**
Mental health services	**11%**
Public hospital emergency services	**8%**
Public and community health services	**7%**
Community dental health services	**4%**
Aged and continuing care services	**1%**
Health system management – policy and corporate services	**1%**
Small rural hospital services	**0%**

Operating expenses

Employee benefits expense	**52%**
Contracts for services	**20%**
Patient support costs	**15%**
Other supplies and services	**4%**
Other expenses	**3%**
Depreciation and amortisation expenses	**3%**
Repairs, maintenance and consumable equipment	**3%**

Income other than income from State Government

Other fees for services	**50%**
Patient charges	**37%**
Other revenue	**12%**
Other grants and contributions	**1%**
Donation revenue	**0%**

About us

Who we are

Overview of our people

We are 12,808[5] people dedicated to delivering sustainable, quality health services to our patients, promoting and improving health outcomes in our community, and taking care of each other. The majority of us are permanently employed and have served for five years or more, highlighting our commitment to one another and our work:

1,673
Casuals

7,707
Permanent

3,428
Fixed term

50 of us report living with disability

We perform in a range of **different occupations:**

Nursing	**4,592**
Midwifery	**625**
Hotel & Site Services	**1,436**
Medical Services	**1,850**
Medical Support Services	**2,173**
Administration & Clerical	**2,132**

We are proud to say we have an appropriate number of **women in leadership (7) aligned to our ratio of women overall (73%)**

We range in **age:**

2,419
Baby Boomers
1946 – 1964

4,240
Gen X
1965 – 1980

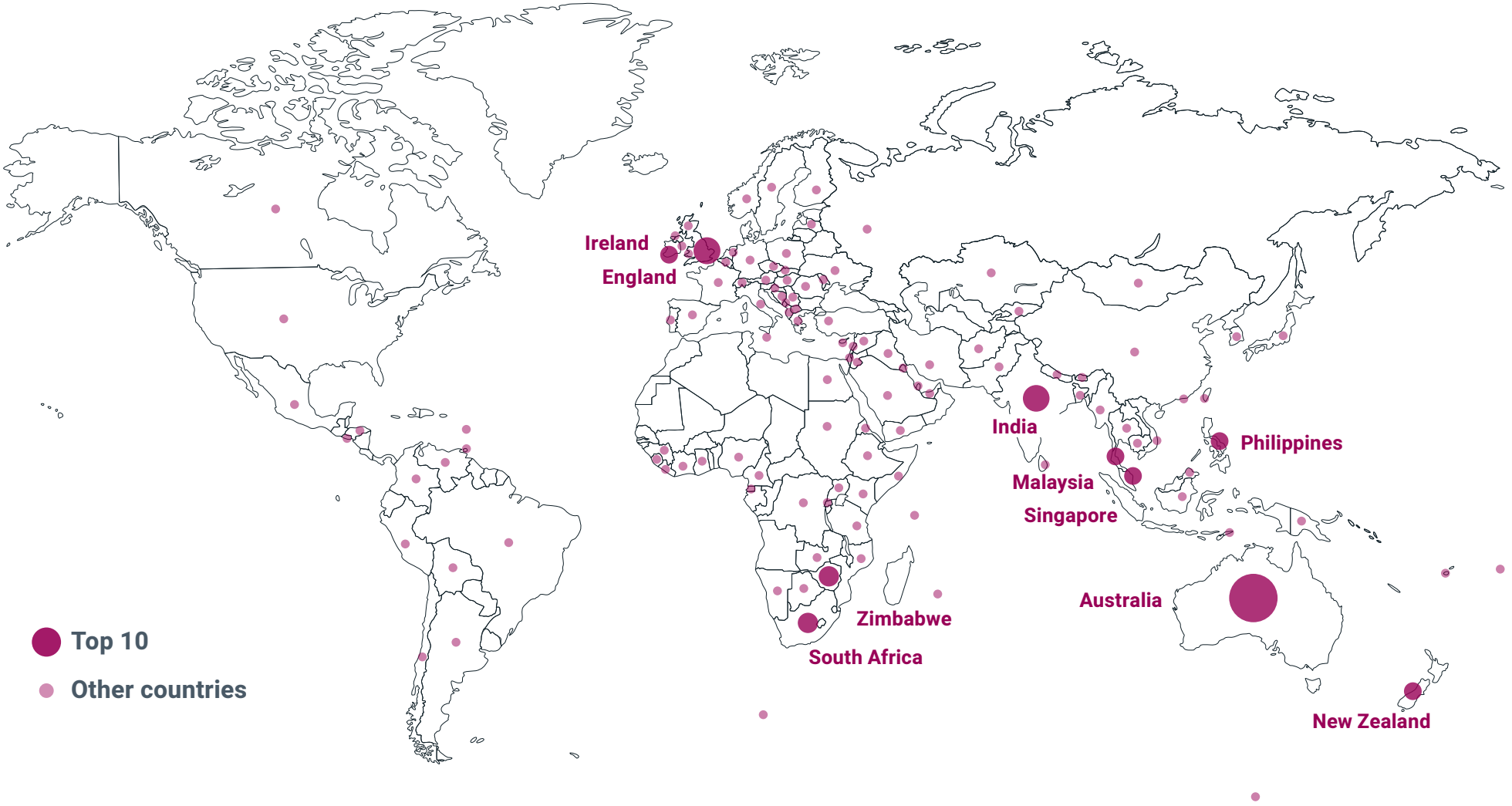
5,128
Gen Y
1981 – 1996

1,021
Gen Z
1996 – 2015

We are increasingly shifting to **flexible working arrangements:**	July 2021	May 2022	YTD Change	YTD Change %
Fixed term part-time	1,856	1,927	71	3.8%
Permanent part-time	4,128	4,450	322	7.8%

Culturally and Linguistically Diverse

We come from many cultures, with 1,743 of us identifying as Culturally and Linguistically Diverse (CaLD)



Note: CaLD reporting relies on staff self-reporting therefore is prone to under-reporting. 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.

Aboriginal employment

We aim to ensure Aboriginal people have access to health services that are culturally safe and welcoming.

We are committed to closing the gap and improving health outcomes for Aboriginal people. One way we do this, as part of our broader **NMHS Aboriginal Health and Wellbeing Strategy 2022-2025**[6], is to strengthen our Aboriginal workforce. This year we marginally increased our Aboriginal workforce to 0.8% (up by 0.1% from last year). As a health service we must do better, we only employed 11 additional Aboriginal staff. Our Public Health division created seven new permanent 50D positions and our Sir Charles Gairdner Osborne Park Health Care Group (SCGOPHCG) Aboriginal Health Liaison Officer (AHLO) team were converted to permanency. The AHLOs had been on fixed-term contracts for the last nine years due to annual funding arrangements.

Training opportunities and partnerships

Our Dental Health Services (DHS) division offered six Aboriginal applicants full-time employment working as Dental Assistants four days per week at various metropolitan adult clinics while they were sponsored to attend TAFE one day per week to gain a qualification.

Four of our Aboriginal staff attended the 2022 First Step Aboriginal Leaders Program and two participated in the Aboriginal LEAD program.

We hosted four university students on an Aboriginal cadetship program with placements in both corporate and clinical disciplines, providing them the opportunity to develop work readiness and employment while studying full-time.

This year we hosted one trainee under the Public Sector Commission's Aboriginal Traineeship Program. They received on the job training while completing a nationally recognised Certificate III in Government. Many areas across our health service nominated to host a trainee, with demand for trainees exceeding supply.

Our Learning and Development team developed a nationally accredited qualification (Certificate II in Health Support Services) as part of an Aboriginal Traineeship Program for Patient Support Services.

Artwork created by our AHLO team

LGBTQIA+

We are committed to ensuring all people, no matter their sexual orientation or gender identity, have access to safe health services and an inclusive workplace. Sir Charles Gairdner Hospital (SCGH) is a registered '**Welcome Here**'[7] organisation, meaning we aim to create and promote environments that are visibly welcoming and inclusive of LGBTQIA+ people. Other sites and services will soon follow.

This year our LGBTQIA+ working group transformed into the NMHS Pride Network, welcoming all LGBTQIA+ employees and allies to connect socially and professionally with others across our organisation. The Network now has 88 proud members who meet monthly to discuss what is happening across sites and services for LGBTQIA+ employees, patients, and consumers, to advance innovative strategies for improving inclusion, to share resources, and to plan events to educate and celebrate all things LGBTQIA+.

Our key activities this year included:

The development of a new logo and signature block that our people can download, and opt to include their pronouns, to demonstrate their support.

Screening Saves Lives – we collaborated with the National Bowel Cancer Screening Program, BreastScreen WA, and the WA Cervical Cancer Prevention Program to develop a new suite of resources reflecting diversity, equity, and inclusion. The program was launched at the Pride WA Fairday on 14 November 2021. We welcomed over 100 people to our stall, with many taking the opportunity to book a free mammogram with BreastScreen WA.

Attendance at Perth's 30th Pride Parade was a first for us and involved over 50 of our people marching and riding our Pride Parade Float in celebration of, and encouragement for, all LGBTQIA+ communities and allies loving and respecting themselves and each other.

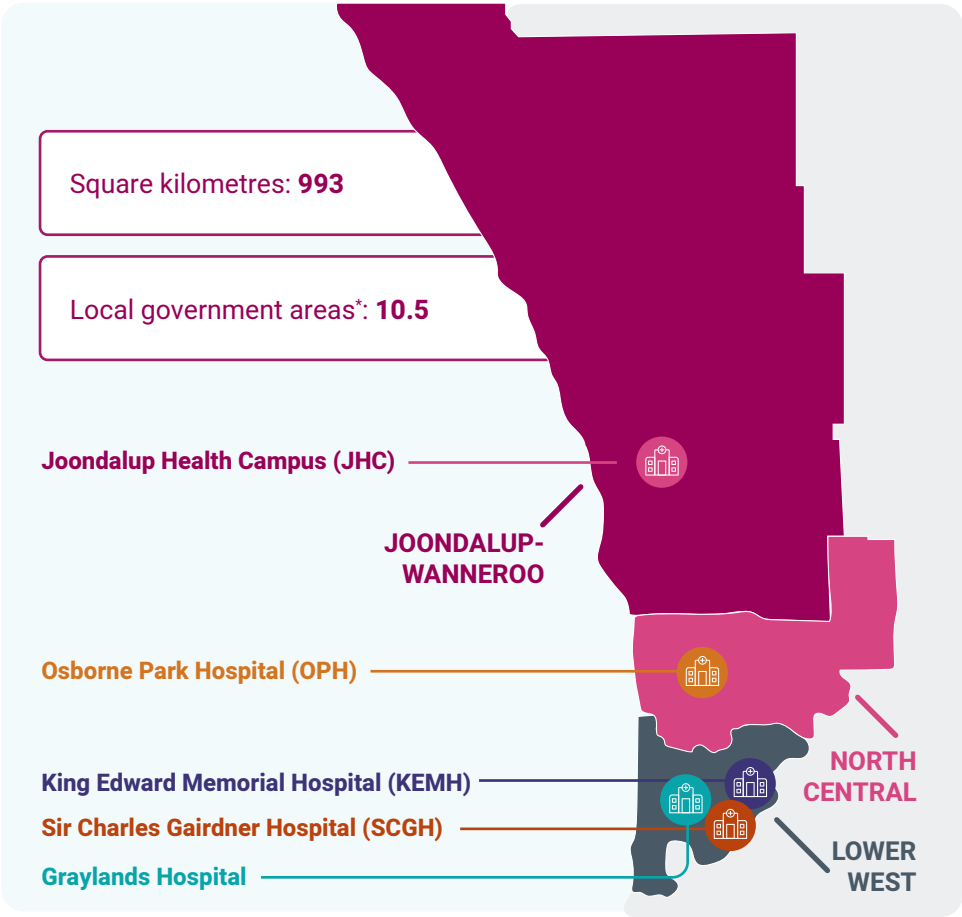
On 17 May 2022, in celebration of International Day Against Homophobia, Biphobia, and Transphobia (IDAHOBIT), over 100 of our people, including our Chief Executive Dr Shirley Bowen, made a public pledge to stand with LGBTQIA+ people, never stay silent about discrimination, and learn and share knowledge to improve equity. This was a multi-site celebration and education day which included multiple information stalls and a live transgender education session hosted by the Chair of TransFolk WA, Hunter Gurevich (he/him).

Our staff representing NMHS at Perth's 30th Pride Parade

What we do

Overview of us

Since our establishment in 2016, we have embraced best practice to deliver improved clinical outcomes in the face of rising challenges for all health care providers. With a budget of $2.4 billion and 8,837 full-time equivalent (FTE) staff, we care for a population of 740,602 people (about 28% of WA's total population) within a catchment area of almost 1,000 square kilometres on Whadjuk Noongar Boodjar. The population we serve is projected to increase by 17% between 2022 and 2031, and the number of persons aged 65 years and older is projected to increase by 36% over the same period8. We are one of the six Health Service Providers (HSPs) who deliver health care to Western Australians as part of WA health system. We provide a comprehensive range of adult specialist medical, surgical, mental health, and obstetric services in WA, delivered across three tertiary hospitals and two secondary hospitals, all fully accredited. We also oversee the provision of contracted public health care from Joondalup Health Campus (JHC), operated under a public-private partnership. A range of state-wide, highly specialised services are offered from several of our hospital and clinic sites, including BreastScreen WA, WA Cancer and Palliative Care Network Clinical Implementation Unit, Donate Life, Humanitarian Entrant Health Service (HEHS), DHS, Infection Prevention and Control (IPC), Metropolitan Communicable Disease Control (MCDC), the State Head Injury Unit (SHIU), and the WA Tuberculosis Control Program.



Who we care for in our catchment area

28%
of WA's total population

38%
were born overseas

20%
Culturally and Linguistically Diverse

40%
aged 45 and above

41%
aged 15 to 44

Better utilisation of community services

63% of adults used a dental care service in the past 12 months, compared to the total WA figure of 57%

11% of adults used a mental health care service in the past 12 months, compared to the total WA figure of 9%

56% of adults used an allied health care service in the past 12 months, compared to the total WA figure of 54%

Lower utilisation of hospitals

26% of adults used a hospital in the past 12 months, compared to the total WA figure of 28%

Preventative health

93% of children (aged 24-27 months) were fully immunised, compared to the total WA figure of 92%

95% of children (aged 60-63 months) were fully immunised, compared to the total WA figure of 94%

55% of female adults participated in cervical cancer screening, compared to the total WA figure of 52%

Lower youth suicide

The rate of youth suicide for males (aged 15-24 years) was 13.7 per 100,000 persons, compared to the total WA figure of 20.4 per 100,000 persons

The rate of youth suicide for females (aged 15-24 years) was 6.6 per 100,000 persons, compared to the total WA figure of 8.2 per 100,000 persons

Lower rate of death for specific conditions

Compared to the total WA rate, residents in our catchment area had a significantly lower rate of death caused by ischaemic heart disease (males), lung cancer (males and females), chronic obstructive pulmonary disease (males and females), intentional self-harm (males), dementia (females), and diabetes and impaired glucose regulation (females).

Reference: Summary of population characteristics and the health and wellbeing of residents of the North Metro Health Region. Epidemiology Branch, Public and Aboriginal Health Division, Department of Health WA in collaboration with the Cooperative Research Centre for Spatial Information (CRC-SI). Accessed 22 July 2022.

Our activities at a glance

184,650

People presented to one of our emergency departments

391

New admissions to the State Head Injury Unit

181,305

People were admitted

790

Patients receiving services at the State Head Injury Unit

124,123

Patients accessed elective services

27,334

Cancer patients received treatment

832,222

Outpatient appointments provided

101

Transplant patients

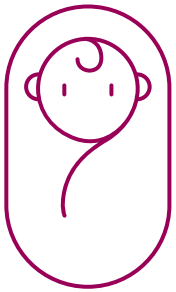
42 Kidney

39 Bone marrow

20 Liver

NMHS

10,031 births



19,830

Patients with mental health illness were cared for

35,833

Calls were received at the WA Poisons Information Centre

126

Active, and 491 latent, cases of tuberculosis were managed

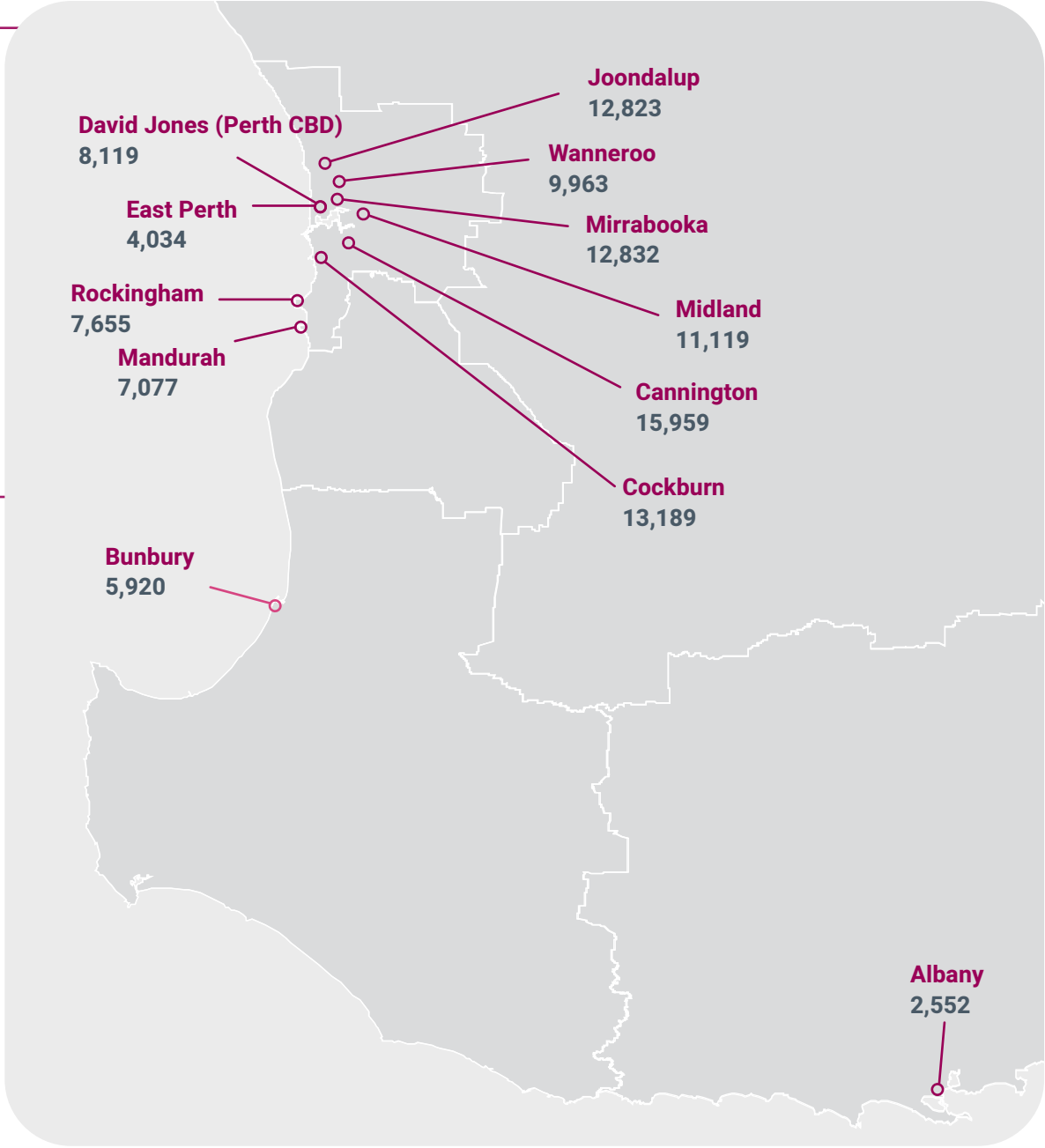
Our WA Tuberculosis Control Program Team

BreastScreens

Number of screens
this financial year

132,106

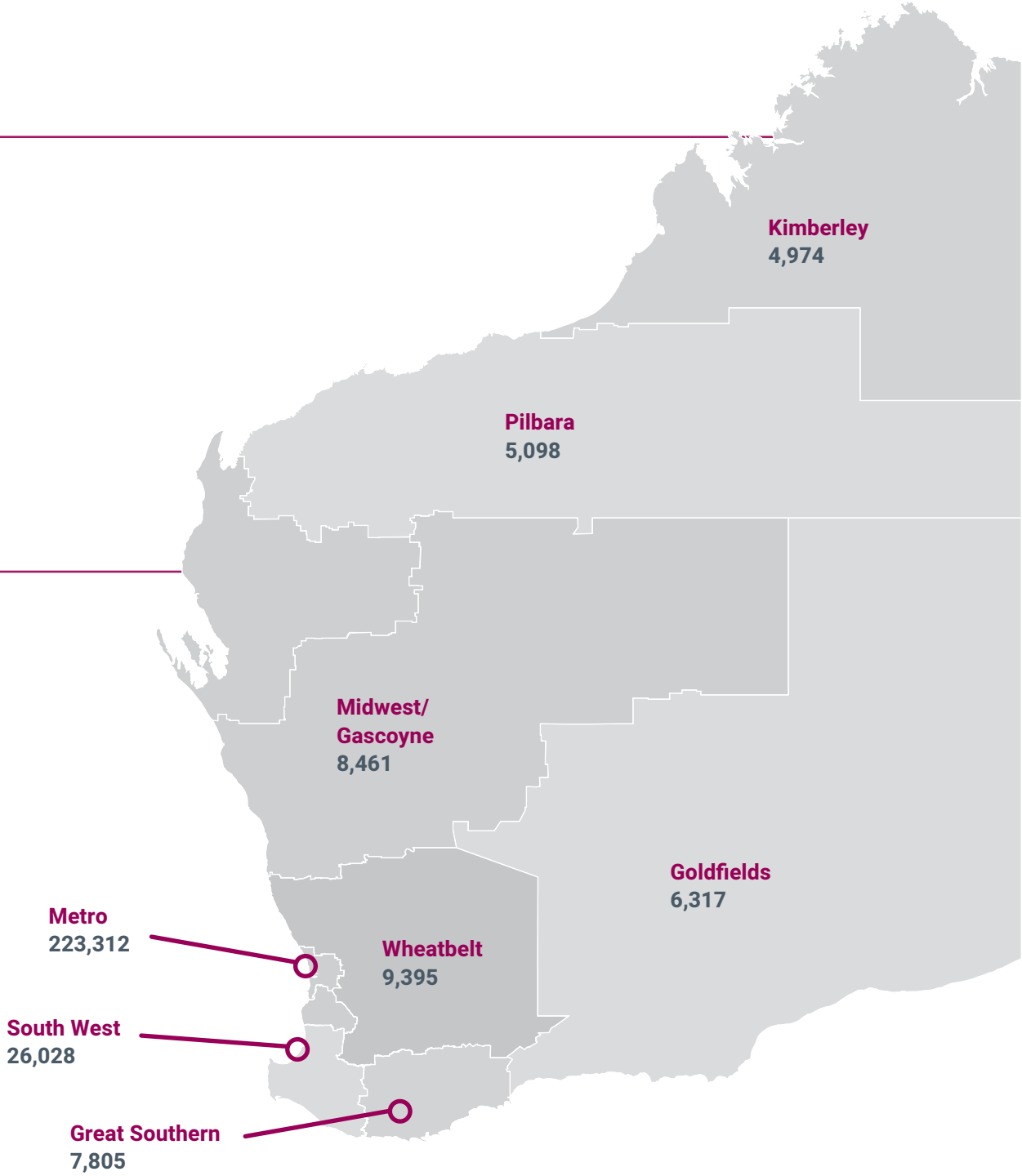
Mobile visits	Screens
Great Southern	5,720
North West	6,035
Outer Metro	4,985
South West	3,836
Islands (Indian Ocean Territory)	288



Dental services

Number of visits
this financial year

291,390



Our diverse services

Sir Charles Gairdner Osborne Park Health Care Group

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

The group configuration allows the flexibility to provide our patients with the right care at the right site, balancing demand and service provision. As one service across two sites, we operate as a single team to provide care seamlessly from the front door of the emergency and outpatient areas, through to the inpatient and specialty same-day units, rehabilitation, and back into the community. SCGOPHCG currently employs 4,977 full-time equivalent (FTE) staff.

Sir Charles Gairdner Hospital

The tertiary campus for the group, SCGH provides a comprehensive range of adult clinical services including the State Stroke Service, neuro-intervention, neurosurgery and epilepsy services, kidney and liver transplantation, vascular surgery, rehabilitation and aged care and more.

SCGH catered for 70,801 emergency presentations, treated 100,592 inpatients and provided 444,712 outpatient appointments this year.

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

Sir Charles Gairdner Hospital

Osborne Park Hospital

Established in 1962, OPH is the other integral part of SCGOPHCG. Being a specialist hospital, OPH staff focus on the provision of specialist 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 15,665 patients and provided 81,768 outpatient appointments this year.

A 30-bed modular hospital ward opened at OPH this year, caring for patients who required rehabilitation following an amputation. Taking six months to construct, the new facility includes a gymnasium, therapy pod, dining room, 10 single-bed rooms, 10 double-bed rooms, staff offices and reception facilities, all seamlessly connected to the existing hospital.

The Women and Newborn Health Service (WNHS) at OPH provides gynaecological, obstetric, and newborn care. The service sits within the governance of the Obstetrics & Gynaecology Directorate located at King Edward Memorial Hospital (KEMH), alongside the Family Birth Centre and Community Midwifery Program. WNHS at OPH delivered 1,600 babies this year.

Osborne Park Hospital

Women and Newborn Health Service

Our Women and Newborn Health Service (WNHS) provides clinical care to women and families. It comprises King Edward Memorial Hospital (KEMH), WNHS at OPH, and other specialist women's health services.

Established in 1916, KEMH is the state's largest women's health hospital and the main referral centre for complex, high acuity obstetric and gynaecological care in WA. There were 5,475 births at KEMH this year, with 69% of mothers needing high acuity care.

WNHS employs 1,294 full-time equivalent staff who catered for 11,995 emergency presentations, treated 16,071 inpatients, and provided 165,088 outpatient appointments at KEMH this year.

Our holistic range of community health services includes Genetic Services of Western Australia, the Sexual Assault Resource Centre, the state-wide Perinatal and Infant Mental Health Program, the WA Register of Developmental Anomalies, the WA Cervical Cancer Prevention Program, BreastScreen WA, and the Women's Health Strategy and Programs.

General gynaecological and specialist services such as specialist reproductive medicine and fertility clinics, urogynaecology, endo-gynaecology and gynae-oncology services (Western Australian Gynaecological Cancer Service) are all provided at KEMH.

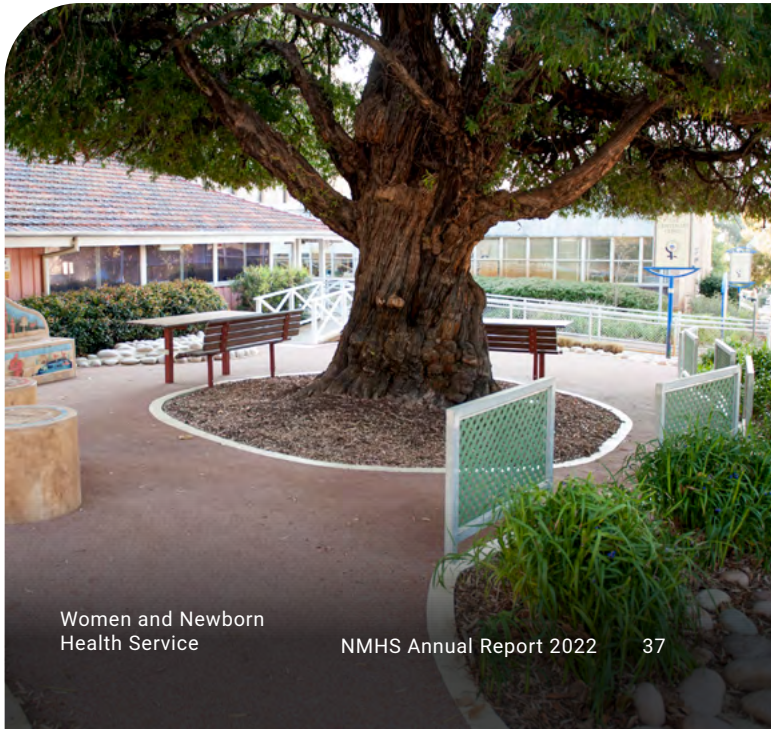
General obstetrics and maternal fetal medicine specialist services are available to women with high-risk pregnancies and specialist clinics are provided in the areas of diabetes, dietetics, the Women and Newborn Drug and Alcohol Service (WANDAS), Childbirth and Mental Illness (CAMI), and Adolescent Pregnancies. The Family Birth Centre is semi-detached at KEMH, offering low-risk women continuity of care with a primary midwife. Midwives work within teams known as Midwifery Group Practice to facilitate holistic care throughout the antenatal, labour/birth, and postpartum periods. The Breastfeeding Centre of WA (BFC) provides breastfeeding information and support for families in WA. The team of lactation consultants provide breastfeeding information and support for families and health professionals via a telephone counselling service and an outpatient service for mothers and babies who attend WNHS for their pregnancy and birth.

Women who birth at KEMH are offered extensive postnatal care and social support options including breastfeeding, physiotherapy, psychological medicine, social work, occupational therapy, physiotherapy, dietetics, and pastoral care.

The Mother and Baby Unit is an authorised in-patient treatment centre for acute psychiatric conditions in the perinatal period. The stand-alone unit is situated in Subiaco within the campus of WNHS.

The onsite Child and Adolescent Health Service (CAHS) Neonatal Intensive Care Unit (NICU) works collaboratively with WNHS and includes 92 beds for prematurely born or sick babies.

This year witnessed ongoing commitment from our consumers, carers, and workforce across WNHS, SCGOPHCG, and CAHS to contribute to assessing our service delivery and associated models of care as we collaborate together for a shared vision in relation to the Women and Newborn Service Relocation Project (WNSRP) (see section **Women and Newborn Service Relocation Project**).



Women and Newborn Health Service

Mental Health, Public Health and Dental Services

Our Mental Health, Public Health and Dental Service (MHPHDS) is comprised of three distinct services – North Metropolitan and Specialty Mental Health, Metropolitan-wide Public Health, and State-wide Dental Health Services.

Mental Health

We are home to the State's largest mental health service providing youth, adult, older adult, forensic and State-wide services in a variety of settings that include inpatient units within our hospitals, community mental health centres, day therapy, and outreach programs to a catchment area of almost one million people.

Inpatient Adult Mental Health provides acute authorised care and rehabilitation services across Graylands Hospital and SCGH. Graylands Hospital also provides Hospital Extended Care, caring for consumers who are not experiencing an acute mental health episode but require specialist rehabilitation and recovery support. Our SCGH-based service oversees the Emergency Department Psychiatric Liaison Service and provides a Psychiatric Consultation Liaison Service as well as the Mental Health Observation Area for admissions of less than 72 hours. Inpatient Adult Services also provide a Hospital in the Home (HITH) service delivering acute mental health care to adults in their own home as an alternative to admitted hospital care, while a day therapy service offers electroconvulsive therapy and transcranial magnetic stimulation.

Our Mental Health Specialties teams provide specialised mental health services across six distinct service areas: youth, older adult, forensics, eating disorders, neurosciences, and a dedicated clinical psychology service (the Centre for Clinical Interventions). These services are located throughout the Perth metropolitan area and are delivered across admitted, community, HITH, courts, prison and residential aged care settings. This includes two Older Adult Inpatient Mental Health Units: Selby Lodge and Osborne Lodge as well as the State Forensics Mental Health Service, the Frankland Centre, and a medium secure inpatient facility for mentally ill offenders, situated at Graylands Hospital.

Our Community Adult Mental Health Services work in partnership with service providers and consumer and carer stakeholders to deliver mental health treatment in a community clinic or home-based setting. The clinics are staffed by various multidisciplinary teams including Community Treatment, Assessment and Treatment, Intensive Clinical Outreach, NMHS MH Dialectical Behaviour Therapy, Obstetric Liaison Consultation Service, and Post-natal teams. Community Adult Mental Health also includes the Neuromodulation Service and the Creative Expression Centre for Arts Therapy (CECAT), a therapeutic creative arts service that utilises a range of creative mediums and processes to assist in mental illness recovery. Community clinics are situated at Wanneroo, Butler, Mirrabooka, Osborne Park and Subiaco.

Our Mental Health Services are supported by several dedicated teams, including:

- Clinical Research Centre
- Creative Expression Centre for Arts Therapy
- Infection Prevention and Control
- Mental Health Pharmacy Service
- MHPHDS Safety Quality and Performance Unit
- Nursing Workforce
- Patient Support Services
- Professional Education and Training
- Psychiatric Services Library
- State-wide Postgraduate Training in Psychiatry

Graylands Hospital

Public Health

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

Services include Metropolitan Communicable Disease Control (MCDC), Health Promotion, the WA Tuberculosis Control Program, DonateLife (organ and tissue donation), the State Head Injury Unit (SHIU), and the Humanitarian Entrant Health Service (HEHS). The NMHS COVID Vaccination Program, under the governance of Public Health, delivers COVID-19 and Influenza vaccinations to at-risk and hard to reach populations across the Perth metropolitan community including Aboriginal people, those experiencing homelessness, people in custody, and Culturally and Linguistically Diverse people, in addition to our patients and consumers.

Our AHLOs (part of the SHIU team) received the Mindlink Brightwater Award for their research.

State Head Injury Unit

As a dedicated, motivated, and committed state-wide service, the SHIU has continued to work through the challenges of the pandemic to promote and improve our service delivery to ensure that clients have access to high quality education and rehabilitation following a life changing event such as an Acquired Brain Injury (ABI).

The SHIU continues to provide relevant, evidence-based rehabilitation programs, in addition to developing and progressing quality improvement and project opportunities. This included the finalisation of the SHIU restructure, finalisation of the WA Primary Health Alliance (WAPHA) Concussion Pathway as subject matter experts, and development of the WA Acquired Brain Injury Advisory Group. This year Aboriginal Health Liaison Officers joined the team to progress improvement of engagement of Aboriginal patients in rehabilitation services following an ABI.

This year the SHIU received 685 referrals. The primary diagnoses were stroke (32%), traumatic brain injury (28%), and concussion (28%), with case management being the primary reason for referral (62%). The SHIU embraced virtual care as a community rehabilitation service with 5,767 occasions of service (OOS) provided virtually (31% of OOS).

DonateLife WA

DonateLife WA works in collaboration with the Australian Organ and Tissue Authority delivering a national program to improve organ and tissue donation so more Western Australians have access to a transplant. Key elements of the DonateLife WA service include ensuring donation is always considered at end-of-life-care and families are provided with accurate information including knowledge of registered donation decisions and are supported by skilled donation specialist staff.

As a state-wide service operated by us, DonateLife WA is firmly embedded across all public and private health services in the metropolitan area. Critical to increasing consent and donation opportunities is having optimal donation services and staff in hospitals and a high level of community awareness and support for donation.

DonateLife WA works with multicultural, faith, and Aboriginal and Torres Strait Islander leaders, organisations and communities. The role of the community is pivotal to increasing organ and tissue donation in WA because consent is dependent on individuals and their families agreeing to donation. DonateLife also provides support for families of organ and tissue donors before, during and after donation through the National DonateLife Family Support Service program.

Metropolitan Communicable Disease Control

Metropolitan Communicable Disease Control (MCDC) is responsible for the public health management of notifiable infectious diseases across the Perth metropolitan area. This includes public health management of cases (e.g., advice and isolation), contact tracing (including prophylaxis and vaccination) and outbreak control. The service also provides immunisation advice and assists practices with immunisation catch up plans and management of cold chain breaches.

This year our MCDC Immunisation and Aboriginal Health teams worked together to continue our Moorditj Kids program, which supports families to access vaccination for overdue Aboriginal children to be vaccinated, including a unique home visiting service. This year, the teams collaborated with King Edward Memorial Hospital to introduce two pilot programs (Moorditj Start and Koorlongka Baskets), which are culturally safe engagement services supporting families of Aboriginal infants to receive their first vaccines on time. Timely immunisation is a key element in closing the gap in immunisation coverage.

MCDC also continues to support other high-risk groups to improve immunisation coverage.

Humanitarian Entrant Health Service

The Humanitarian Entrant Health Service (HEHS) provides a holistic health assessment service for all refugees and humanitarian entrants who are resettled in WA under the Commonwealth Government's Humanitarian Program and Special Humanitarian Program. Health issues not identified, or addressed by pre-migration health checks, may not be adequately addressed by Australian mainstream health services due to linguistic, cultural, and financial barriers.

Due to the world-wide impacts of the pandemic and the closure of international borders, client numbers this year were markedly reduced, however HEHS provided services to refugees from both Afghanistan and Ukraine following civil unrest in these countries.

WA Tuberculosis Control Program

The WA Tuberculosis Control Program (WATBCP) offers a State-wide public health service that operates as a resource centre and clinic to accommodate the needs of both adult and paediatric clientele with tuberculosis (TB). The service operates Monday to Friday and includes both medical and nurse led outpatient clinics. A management plan is developed that includes regular home visits by nursing case managers.

Although the target clientele for the program is the entire community of WA, emphasis is invariably on high-risk groups, people from high TB prevalence countries, people who have had contact with infectious TB, socially disadvantaged groups, those with medical conditions known to predispose to TB, as well as special occupational groups (e.g. health care workers).

Health Promotion

The Health Promotion team works across our catchment area to keep the population healthy by helping to prevent chronic disease and injury. In 2022, our Health Promotion team expanded to provide population-wide activities focused on reducing tobacco smoking, obesity, poor diet, physical inactivity, and harmful alcohol use, as these cause the greatest burden of disease in our community. The team's three programs are:

- **Healthy Service** – leading NMHS action on health service policies on smoking and healthy food options
- **Healthy Population** – partnering with local organisations, including local governments, to develop interventions that support healthy lifestyles for the community at large
- **Priority Communities** – collaborating with local service providers and communities at high risk of poor health to develop tailored interventions

Dental Health

Dental Health Services is the largest public dental service in WA, which provides oral health services to children aged five to 16 years through the State-wide School Dental Service as well as via general and emergency dental care for eligible people. Our public dental clinics operate throughout metropolitan and country areas to eligible clients of the Department of Communities, residents in metropolitan aged-care, and those in Corrective Services facilities. Dental Health Services also provide dental care for mental health patients at Graylands Hospital.

Aboriginal Health Division

Our Aboriginal Health team are core to implementing our **Aboriginal Health Strategy**[10]. The team are responsible for the development and delivery of Aboriginal strategic programs across our sites and services. The goal is to improve health outcomes for Aboriginal people through improving access to culturally secure services and promoting engagement of the Aboriginal community and consumers. The Strategy also aims to increase representation of Aboriginal staff within our workforce.

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

A dental health patient at our mobile van in Tom Price

Joondalup Health Campus

Joondalup Health Campus (JHC) has 572 public beds. We provide comprehensive services to public patients at JHC through public–private partnership with Ramsay Health Care.

JHC is one of WA's largest hospitals, serving more than 45,116 public inpatients annually, and offering a range of medical and surgical services including critical care, interventional cardiology, maternity, neonatal and paediatric services, aged care, and rehabilitation.

This year, the JHC Emergency Department catered for over 101,854 presentations with a dedicated paediatric area and a 10-bed Mental Health Observation Area. JHC also contains a purpose-built Mental Health Unit that includes secure accommodation.

JHC is expanding, with the construction of:

- a new 102-bed Mental Health Unit (comprising 30 additional beds, 47 replacement beds and 25 shelled beds to meet future demand)
- a 112-bed public ward block (including a 16-bed Cardiac Care Unit comprised of six additional and 10 relocated beds as well as a 30-bed medical/surgical ward and 66 shelled beds to meet future demand)
- a 12-bed ED expansion
- a Behavioural Assessment Urgent Care Clinic
- an operating theatre
- a cardiac catheter laboratory
- engineering plant upgrades
- other improved amenities including more parking for staff, patients and visitors

It is anticipated that the entire build for the JHC Development Stage 2 project will be completed in early 2025.

Joondalup Health Campus

Research

Throughout the year, the Sir Charles Gairdner Osborne Park Health Care Group (SCGOPHCG) Department of Research continued to make headway on its goal of implementing the four key pillars of the **Research Strategic Plan**[11] that were developed following the consultation process last year.

These include:

- grow research capacity
- raise the profile of research
- develop cohesive teams
- improve organisation processes to support research and researchers

Grant Funding

Each year, in collaboration with the Charlies Foundation for Research, the SCGOPHCG Research Advisory Committee offer funding programs for staff with research projects that can be completed within 12-24 months and conducted at the SCGOPHCG sites. Charlies Foundation for Research generously provided support for the following grant funding programs in 2021/22:

- Major Grant Funding Program: $198,969
- Mid-Range Grant Funding Program: $605, 925
- Small Grant Funding Program: $54,564

Applications were reviewed by independent assessors, who scored them against a range of criteria. Dr Laurence Morandeau received the highest score in this year's round of applicants for her research proposal titled *'Pilot study of fibroblast activation factor expression in recurrent/progressive pancreatic cancer and mesothelioma using [68Ga]Ga-FAPI PET imaging, a first step towards personalised molecular radiotherapy?'* and received the 2021 Peter Thompson Award to acknowledge this achievement.

Dr Laurence Morandeau in action

What we did

Number of published peer-reviewed journal articles, books, or book chapters by our staff:

- **865** SCGOPHCG
- **111** Women and Newborn Health Service (WNHS)
- **27** Mental Health, Public Health, Dental Services (MHPHDS)

Number of approved research projects (site authorisation):

- **75** SCGOPHCG
- **14** WNHS
- **10** MHPHDS

Number of research projects approved by the Human Research Ethics Committee (HREC):

- **52** SCGOPHCG
- **11** WNHS
- **9** MHPHDS

Current NMHS research projects:

- **537** continuing projects
- **34** COVID-19 related studies

Our Clinical Research Centre team presented their new Statoolio App project at Science on the Swan 2022 Conference

How we do it

Values

- Care
- Respect
- Innovation
- Team work
- Integrity

Mission

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

Our innovation and development hub team

Vision

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

Horizon 1

Connected services and engaged people

Our immediate focus is to lay the foundations for future success by connecting services across all of NMHS and engaging our people. We will authentically engage our workforce and nurture relationships with our community and our partners to create quality connections and greater accountability. This will foster an environment ready for change and innovation to come.

This Horizon was our key focus in 2021/22 as it was critical to the resilience of our health service in responding to the impact of COVID-19.

Horizon 2

Consistently excellent health care service

In order to deliver consistently excellent health care, we will anticipate and respond to the needs of those we serve, focusing more in public health and community health services; and develop our collective capabilities. We will build foundations for excellence in teaching, training, research, infrastructure and innovation, and continuously improve our environmental and financial performance.

Horizon 3

A trusted partner within health care

Our longer-term vision is to solidify our position as a trusted partner within health care, in WA, across Australia and globally. This will be achieved by being agile, by adapting our services to continually deliver exceptional outcomes and lead the way in operational excellence; attracting and retaining the very best talent.

Sustainable Health Review

Our Strategic Plan 2020-2025 was developed in consideration of the 30 Recommendations across eight Enduring Strategies of the **Sustainable Health Review Final Report**[12] published in April 2019, with the aim to prioritise the delivery of patient-centred, high quality, and financially sustainable healthcare across the state.

Our Strategic Plan 2020-2025

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

Over the coming years, we are focusing on six strategic priorities aligned with the Enduring Strategies of the Sustainable Health Review:

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

Physiotherapists delivering group treatment via Telehealth

How we are governed

Legislation

We were established as a Health Service Provider (HSP) on 1 July 2016 under section 32 of the *Health Services Act 2016* (WA).

Responsible Minister

We are responsible to the Hon. Amber-Jade Sanderson MLA Minister for Health; Mental Health.

Accountable Authority

We are a Board governed HSP pursuant to section 70 of the *Health Services Act 2016* (WA).

Our Board is the accountable authority for NMHS and Clinical Professor David Forbes AM is the Board Chair.

Our governance structure

Our board of authority

Under section 34 of the *Health Services Act 2016* (WA), 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 mandatory 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; Mental Health appoints Board members for terms of up to three years. A member is eligible for reappointment, but may not hold office, for more than nine consecutive years. Members are appointed according to their expertise and experience in areas relevant to our activities.

Board profiles

David Forbes

Board Chair

David has had a career in academic paediatrics, working primarily as a paediatric gastroenterologist. He has also worked in general practice, in paediatric emergency medicine, general and rural paediatrics and child and adolescent mental health. With the University of Western Australia he led undergraduate teaching in paediatrics and child health, and was Head of the School of Paediatrics and Child Health. He led vocational training at the Princess Margaret Hospital for Children (PMH) at different points in his career. For the Royal Australasian College of Physicians David was a member and then Chair of the Paediatric Physician Training Committee, and the Division of Paediatrics and Child Health Policy and Advocacy Committee. He 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. He joined the NMHS Board in 2018.

Rebecca Strom

Deputy Board Chair and Chair of Audit and Risk Committee

Rebecca is a solicitor and experienced Non-Executive Director. She has recently stepped away from her role as a national law firm Partner, where for nearly 20 years she practiced in commercial real estate across Australia. Rebecca is also currently a Non-Executive Director of not-for-profit housing provider, Housing Choices WA (formerly Access Housing Australia), and a member of the WA Netball League Tribunal Panel. She has held roles on the Executive, Finance and Property Committee of the Western Australian Planning Commission and the Department of Planning Audit and Risk Committee. Rebecca holds a Bachelor of Science and Bachelor of Laws (Hons) from Sydney University, and is a member and graduate of the Australian Institute of Company Directors. Rebecca took on the NMHS Deputy Chair role in May 2021 and has been the Audit and Risk Committee Chair since joining the Board in July 2018.

Steve Toutountzis

Board Member and Chair of Finance 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 Western Australian 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.

Paula Rogers

Board Member and Chair of People and Culture Committee

Paula has significant experience in stakeholder management, communications, events facilitation, marketing and business development. She is currently the Director of her own consulting firm, providing thought leadership, stakeholder engagement, communication strategy, marketing and event advice. She is also currently an Independent Director on the Edith Cowan College Board and a member of the AWARE WA (previously First State Super) Advisory Council and of the Art Gallery of WA Foundation Council. Paula has worked in a variety of senior roles in Western Australia including most recently as the State Director of the Committee for Economic Development of Australia. Prior to 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 (Ireland); and has completed the Australian Institute of Company Directors (AICD) Company Directors Course and continues to be a Member of the AICD.

Hilary Fine

Board Member

Hilary has been a General Practitioner (GP) in urban and rural General Practice for nearly 40 years. She is currently Principal GP at East Fremantle Medical Centre which she started in 1993 and grew the business from a solo GP to employ over 30 people. She is also 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 External Advisory Board, Notre Dame. She was also, until recently, a senior sessional member on the State Administration Tribunal and a Clinical Advisor at the Australian Health Practitioner Regulation Agency.

Anthony (Tony) Evans (commenced 17 Feb 2022)

Board Member

Tony is a Certified Practising Accountant with extensive commercial, financial, and corporate governance experience in the health, aged care, education, insurance, property, resources, government and not-for-profit sectors. He is an experienced non-executive director and has been a member of a number of boards and committees, including the RAC, Australian Health Practitioner Regulation Agency Finance, Audit and Risk Management Committee, Optometry Board of Australia, Therapeutic Guidelines, Australasian College for Emergency Medicine, Local Government Insurance Scheme, and Central Regional TAFE. Tony has a Bachelor of Business, a Postgraduate Diploma in Education, and is a Fellow of CPA Australia, the Governance Institute of Australia, and the Australian Institute of Company Directors.

Professor Paul Norman

Board Member and Chair of Safety and Quality Committee

Paul is a current 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, peripheral and diabetic arterial disease.

Paul has a Bachelor of Science (Hons), Bachelor of Medicine and Surgery, Doctor of Surgery and is a Fellow of the Royal Australasian College of Surgeons and the Royal College of Surgeons.

Angela Edwards

Board Member

Angela is an HR professional and has an extensive career as a Senior Executive in People and Culture, Industrial Relations, Change Management, Organisational Structures, Cultural Impact and Stakeholder Management. Angela has worked within ASX listed Companies and international/global services providers in a variety of industries including Aviation and Emergency Services, Hospitality and Integrated Resorts as well as a number of not for profits in support services. She is currently the Senior People and Culture professional at Crown Perth.

Angela holds a Bachelor of Business, Trinity College Dublin, a Post Graduate Diploma in Adult Learning and Development from Melbourne University and is a Certified professional member of the Australian Human Resources Institute.

Kim Farmer

Board Member

Kim is an experienced criminal defense lawyer, working many years at the Aboriginal Legal Service WA and as a sole practitioner, and is currently Principle Lawyer of her own criminal defense legal firm, Farmer Legal. She also worked in other areas of the law, including supporting people impacted 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; has community membership with the Prisoner Review Board WA and board representation on WAFL football team and the Indigenous Players Alliance.

Our organisational structure

North Executive Team

Until June 30 2022

BOARD
North Metropolitan Health Service (NMHS)

Dr Shirley Bowen
Chief Executive

- General Counsel
- Project Director QEIIMC Trust
- Director Innovation and Development

Diane Barr

A/Executive Director Women and Newborn Health Service

- 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

Scott Goder

A/Executive Director Procurement, Infrastructure and Contract Management

- 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

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

Jordan Kelly

Executive Director Business and Performance

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

Karen Kyriakou

A/Executive Director Mental Health, Public Health and Dental Services

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

Dr Jodi Graham

A/Executive Director Sir Charles Gairdner Osborne Park Health Care Group

- Osborne Park Hospital
- Sir Charles Gairdner Hospital

Tanya Adair

Executive Director Major Infrastructure Projects

- Joondalup Health Campus Development Stage 2 (JHCD2)
- Women and Newborn Service Relocation Project (WNSRP)
- Graylands and Forensics
- Spinal Cord Injury Service Reconfiguration (SCISR)

Dr Ajitha Nair

Area Director Clinical Services

- Medical Education and Research
- Medical Governance
- Medical Workforce

Tony Dolan

Area Executive Director Nursing Services

- 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

- Board Support
- Ministerial and Parliamentary Liaison
- Staff Travel
- Office of Chief Executive Support
- Corporate Communications
- Specific Organisational Projects

There were numerous position changes across the North Executive Team throughout the financial year 2021/22.

Our year

Challenges we faced

COVID-19 – our preparedness and response

The State Government's WA Recovery Plan 2020 continued to be the foundation for the health system this year. Delivering services that supported the WA Government Goal of 'strong communities, safe communities and supported families' was a challenge, our public hospital-based services were disrupted and therefore our prevention and promotion services were also impacted. Our focus on putting patients first continued, as we also tried to address the unprecedented demand on the health and mental health system and respond to COVID-19.

Over the past 12 months, the COVID-19 pandemic remained an ongoing threat to the WA community. The surge in cases placed a significant burden on our hospital and health services as we responded to unprecedented patient need with innovative ways to deliver care. This flexibility was key to not only withstanding the pandemic, but also maintaining sight of our vision to deliver excellent healthcare to our patients and our community.

To allow us to continue to deliver effective treatment and restorative health care to our patients, we developed the NMHS COVID-19 Response Team to bring together key COVID-19 leads from our sites and services. This team focussed on meeting the **COVID-19 Framework for System Alert and Response** (SAR) and multiple other new directions, including Personal Protective Equipment (PPE) mandates, hospital visitor restrictions, screening, transition to Telehealth, and staff, patient and visitor testing guidelines. Our NMHS COVID-19 Command Centre was established to help us ensure we had the right bed for the right patient. We ensured our staff were protecting themselves, our patients, and our community by complying with mandatory PPE training, including correct donning and doffing procedures, N95 mask fit testing and use, and COVID-19 vaccination directions for staff.

2 dedicated testing clinics

118,653 COVID-19 PCR tests performed

PCR testing at SCGH

Increased demand on hospitals and disruption to the patient journey

Across the WA health system this year there was a significant increase in case numbers of COVID-19 in the community, both patients and staff, impacting the ability for Emergency Departments (EDs) to deliver care within designated access Key Performance Indicators.

At NMHS, we are extremely proud of the ability of our staff to deliver safe, patient-focused care under such challenging circumstances. Increasing complexity and high acuity patients were cared for, alongside increasing numbers of people in the community who acquired the Omicron variant of COVID-19. This year saw 1,369 hospital admissions and 59 Intensive Care Unit admissions with COVID-19. At our peak we cared for over 100 COVID-19 positive patients across our hospitals. We worked collaboratively with ambulance colleagues to provide clinical care for patients. Increasing numbers of people with COVID-19 were admitted to hospital, this influenced the cancellation of elective surgery as guided by the Department of Health, freeing up valued resources (human and physical) across the health sector to be redirected into managing the pandemic.

The ED entrance at Sir Charles Gairdner Hospital

Nurse in a box

To keep our patients and staff safe, all patients and visitors attending hospital sites were required to be screened for COVID-19 and directed to the appropriate area for PCR testing and further triage/treatment.

Front entrance screening procedures were put in place at all hospital sites. To streamline this process for the large volume of people attending Sir Charles Gairdner Hospital, our Facilities Management team arranged for a sea container to be set up outside of the existing infrastructure to provide a safe, climate-controlled environment for our nursing staff to process patients. However, following record rainfall and flooding in South Australia, trains carrying freight from the eastern states to WA were halted and our sea container was delayed in transit. Thankfully, a generous mining company agreed to an exchange, allowing us to have their container which had already arrived. As a result, the 'Nurse in a Box' was equipped and installed alongside a climate-controlled marquee in front of the ED to allow for overflow of patients who were undergoing testing.

'Nurse in a Box' at SCGH

Infrastructure and equipment needs

Delivering the necessary services to accommodate COVID-19 requirements, while aiming to minimise disruption to our delivery of hospital-based services to our patients by addressing capacity pressure points, required extensive and rapid action in obtaining, establishing, and repurposing infrastructure and equipment, collaborating with other providers, and greater use of digital technology. The pressure of this was felt across all sites and services on top of the pre-existing challenges related to ageing infrastructure. Additionally, planned projects such as the SCGH-RAPID Laboratories Upgrade and 2nd Cyclotron project and the SCGH Emergency Department and Urgent Care Clinic Toxicology project were delayed due to COVID-19 related construction cost and supply issues.

Our priority actions were as follows:

- we altered wards to ensure they were safe to become cohort wards for COVID-19
- we secured an extra 24 beds at Hollywood Private Hospital for preparedness
- we set up marquees at site entrances to enable COVID-19 screening
- we created a modular ward at Osborne Park Hospital
- we established electronic dashboards to monitor compliance with staff vaccination, fit testing, and PPE training
- we rapidly transitioned to Telehealth to deliver a significant number of outpatient appointments throughout the year
- we delivered additional computers and a big screen to facilitate Telehealth at King Edward Memorial Hospital
- we constructed additional storage areas and cupboards to facilitate more efficient re-stocking of linen and equipment
- we partnered with South Perth Hospital to increase our bed capacity

Construction of the Osborne Park Hospital modular ward

Our workforce

As COVID-19 spread rapidly throughout our community, 4,669 of our staff required leave to isolate as a result of contracting the virus. A further 4,159 staff required leave to isolate as a result of being deemed a COVID-19 close contact.

Alongside the physical and psychological impact of this on our people and their families, the workforce shortfall resulted in increased pressure on remaining staff to go above and beyond their usual duties.

Our staff responded to the unprecedented patient need and resource constraints by innovatively delivering care. Across all employee types and occupational groups, our staff picked up additional shifts to ensure all additional tasks were completed. This flexibility demonstrated the capability of our people to not only withstand the pandemic, but also deliver a world class health care system in the process.

We implemented numerous strategies to mitigate ongoing workforce shortages and staff furloughing including utilisation of alternative staffing models and employment of COVID-19 Support Officers. We diverted significant staff resources (343 in total) to COVID-19 specific activities including vaccinations (63), surge workforce (220), fit testing (31), and PCR testing (29).

Our Patient Flow team at SCGH

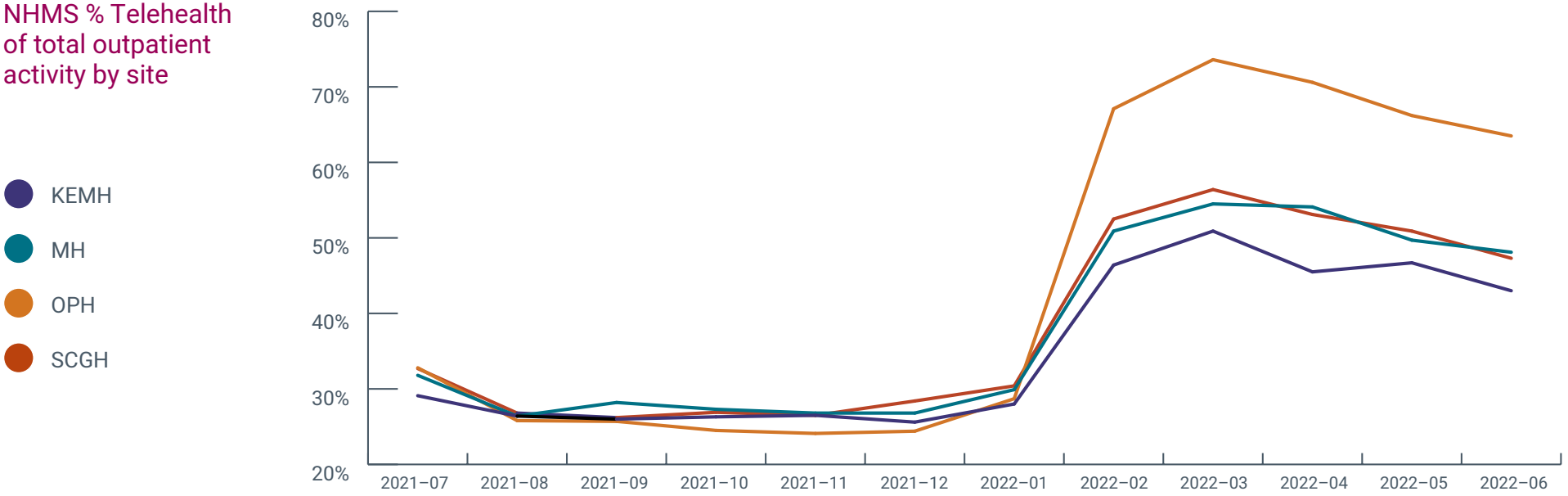
How we cared for our patients

The challenges we faced this year were felt across the spectrum of staff, patients, and their families in numerous ways. Our committed staff worked tirelessly to ensure the provision of quality health care across all sites, partnering with consumers throughout their health journey during times of anxiety, primarily related to living through a pandemic and experiencing longer stays in hospital, visitor restrictions, delays in discharge, and increased wait times for elective surgeries and other services. During the course of the pandemic we were unable to meet some of our key targets in delivering against the Government Goals, however our primary focus is, and always will be, providing an exceptional level of care, communication, and access to our patients.

The following pages highlight some of our key achievements in delivering excellent care for our patients throughout the year.

One achievement of which we are particularly proud, was our ability to rapidly implement the delivery of Telehealth appointments to ensure our patients retained access to the outpatient care and support they needed. This year we delivered 274,157 appointments via Telehealth which equates to 37.5% of all appointments that were delivered by our sites and services[13]. From January 2022 onwards, more than 50% of our outpatient appointments were being delivered by Telehealth to help minimise the risk of COVID-19.

NHMS % Telehealth of total outpatient activity by site



A positive experience

We are dedicated to focusing forward by celebrating positive outcomes for our patients through the current pandemic. Warren Yorkshire was one of the first patients we cared for in our dedicated COVID-19 Ward at Sir Charles Gairdner Hospital. On presentation, he was suffering from serious COVID-19 symptoms along with underlying conditions including diabetes and heart problems and was cared for by a range of our staff including the Respiratory and Sleep Medicine and nursing teams.

We were delighted that Warren recovered from the virus and were honoured when, following discharge, he visited our team to offer his gratitude for the life-saving treatment he received on the ward. Warren also sought to publicly acknowledge our staff for their exceptional care and spread the word to the Aboriginal people of WA, and the broader community, about the importance of vaccination and getting checked if you feel unwell.

Channel 9 spoke with Warren about his experience – the heart-warming interview can be viewed by scanning the QR code.

Warren Yorkshire speaking to Channel 9 about his experience with COVID-19 and SCGH

How we listened

Engagement is the process of involving people in decisions that will affect their lives and/or work.

It is a way of giving people a say in how services are planned, delivered, and evaluated by:

- developing effective channels of communication
- providing information to make informed choices about their care
- working in partnership to make decisions about service improvement

Engagement in healthcare contributes to:

- better patient outcomes
- improved take up of preventative services
- services that are more responsive to needs
- staff feeling more valued and involved
- decrease in admission rates and hospital stays
- a more flexible, motivated, and skilled workforce

Over the coming years, the NMHS Strategic Plan 2020-2025 is focused on six strategic priorities, two of which directly relate to strengthening engagement with consumers and providing people-centred care:

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

We are committed to improving the health or our people and our communities, and working together with consumers, carers, clinicians, and the community to listen to what matters to them and ensure our health services deliver the best care, all the time.

One of our registered nurses caring for one of our patients

MySay Healthcare Survey

Implemented in July 2020, the MySay Healthcare Survey is a voluntary and confidential tool used throughout the WA health system which allows patients the opportunity to provide us with their perspective on how we cared for them. Measuring the experience of our patients in this way allows us to identify what we are doing well and where we may need to focus our attention to improve their experience of our care. It also enables us to monitor and benchmark the experience of our patients compared to those cared for by other Health Service Provider (HSPs).

With around 300 inpatient and day procedure patients surveyed each week, the MySay Survey has, so far, yielded over 30,000 responses with a pleasing 90% of patients feeling 'cared for, listened to, informed, and involved in treatment and care'.

To ensure all patients across our sites and services have the opportunity to provide feedback on their care, in 2021 the NMHS Safety, Quality, Governance and Consumer Engagement team worked in collaboration with staff and consumers across various services including Cancer Services, Dental Health, Emergency Medicine, Nursing, Public Health, Clinical Planning and Consumer Liaison Services to develop a version of the survey for Outpatient and Emergency Departments (ED). The team engaged with consumers to ensure the questions captured the core aspects of patient experience and were easy to understand and interpret. Like the inpatient version, the MySay Visit survey is sent via SMS, two days after a patient has attended an outpatient appointment or visited the ED.

Since the launch of the MySay Visit survey in October 2021, we have received feedback from over 28,000 outpatient and ED visitors, with over 90% feeling 'respected, listened to, informed, involved and safe' in their treatment and care.

Following the success of this initiative in our health service, the survey was adopted by all HSPs across WA. This will provide all WA public health patients with equal access to the continuous survey and enable HSPs to monitor and benchmark patient experience between sites.

A Net Promoter Score (NPS) is used in the surveys to track overall patient experience over time. This score can be used to benchmark the quality of our services with other hospitals in WA, interstate and internationally. In healthcare, a score over 70 is considered excellent and we received a high combined NPS of 77+ for inpatients, and 76+ for outpatient and EDs. This is a fabulous result, confirming that our services are delivering high quality person-centred care to our patients.

CareOpinion Australia

CareOpinion[14] is an independent website where anyone can share their stories about their experience of care. The site covers health care, aged care, and community services in Australia, giving service users, their families, and carers the opportunity to publish their personal experiences, good or bad, of the care system. Here is some feedback we received on our care across our sites and services this year:

"As I experienced challenges early on in my breastfeeding journey I was referred to the Centre and from my very first appointment I began to feel mentally and emotionally encouraged and supported and experienced more success in the efficiency and ease of our feeds. The lactation consultants and midwives have all been open, friendly, professional, knowledgeable and experienced, and above all else - extremely helpful. I was determined to breastfeed my daughter and have only been able to succeed in this desire with the support, encouragement and coaching from these amazing women."

New mum at Breastfeeding Centre of WA

"On the day of appointment, the nurses we dealt with were really nice, so patient, and so caring. My daughter is needle-phobic due to other experiences, but they kept trying and got the job done. I really do appreciate it. Thank you very much for your kindness and understanding."

Parent of a child attending Adam Road Dental Therapy Clinic

"They've helped me a lot to understand about my mental health issue. I appreciate them a lot for helping me on my journey, if it wasn't for these guys and even some of the patients, I don't know where I would be. Since I've been here I have had all the help I needed, I was given medication, I feel healthy, I feel comfortable, I feel like myself."

A patient at Graylands Hospital

"My partner and I were very happy with the care we received from the midwifery program at KEMH. All the interactions I had with the midwives from MGP5 and the staff at KEMH were extremely positive. I felt so well supported through the whole journey, from the first appointment to the last home visit after the birth. My main midwife was so calm and professional throughout my pregnancy and birth, and it was so great to have a consistent person involved in my care."

New mum at King Edward Memorial Hospital

Our mental health consumers

One program – two campus model

Mental health is one of the most critical issues to be addressed to meet sustainability objectives and improve health and wellbeing outcomes for Western Australians[15]. There is immense pressure on mental health services in WA, with capacity issues across all sectors, and we recognise that a consumer's journey in the mental health system can often be disconnected. To improve the experience of our inpatients with acute mental health presentations, we have implemented the 'one program-two campus' model whereby we have integrated our 52 acute beds at Graylands Hospital and 30 acute beds at Sir Charles Gairdner Hospital Mental Health Unit (SCGH MHU). The realignment has allowed us to manage admission of our patients based primarily on their needs as opposed to being limited to their residential area. We have seen an improvement in the flow of our patients, meaning they are spending less time in Emergency Departments (EDs), commencing treatment quicker, spending less time in the more restrictive high-dependency wards, and being discharged back into the community faster where the environment is more conducive to their recovery.

Moving out of EDs and accessing the right care as quickly as possible in the most appropriate setting is key to improving mental health outcomes. Additionally, with the increased flexibility in placement, we have seen increased bed utilisation and a more evenly spread workload for our staff, with high-risk and complex needs patients being spread more evenly across our service. There has been a marked improvement in culture and collaboration between the sites, resulting in more timely and robust decisions on complex case issues. By the end of this financial year the average length of stay at Graylands Hospital was 20 days, and 19 days at SCGH MHU, indicating the improved approach to care and more even spread of the patient population. We anticipate the positive impact on workload will help to reduce risk of burnout in our staff and ensure breadth of clinical expertise is retained across sites, ultimately improving our ability to provide excellent care to our consumers with acute mental health needs.

Wanneroo Adult Community Mental Health Service

As part of the Government's commitment to develop a new inpatient Mental Health Unit on the Joondalup Hospital Campus, and the broader plan to develop more community-based services for mental health treatment and prevention, on 14 December 2021 we officially opened the Wanneroo Adult Community Mental Health Service (WACMHS). This is a world-class facility which replaces the Joondalup Community Mental Health Service (JCMHS) site that was located at Regents Park Road and the Joondalup Older Adult Community Mental Health Campus site that was in Grace House, Shenton Avenue. It also brings together several other Adult Mental Health teams.

The building was custom designed in consultation with consumers, staff, and stakeholders for the purpose of providing mental health services. Occupying 1700m2 of space, it includes fit-for-purpose facilities including interview, family meeting, and treatment rooms with beautiful features such as serene native flora murals on the walls, light filled spacious areas, and a calming view of surrounding bushland. Here our teams can deliver a high level of person-centred care and a focus on recovery in partnership with consumers, their families, and carers.

View from the rooftop terrace on the new WACMHS site

Your Experience Survey

Capturing the patient experience is critical to monitoring and improving the level of care we deliver to our consumers.

The **Your Experience Survey (YES)**[16] is a nationally developed consumer feedback survey designed to provide a comprehensive and meaningful understanding of consumer experience of Mental Health Services (MHS) across WA Health Service Providers. Conducted annually, it canvasses consumers aged 11 years and over in both inpatient and community settings. The most recent snapshot, which took place from October to December 2021, revealed our mental health patients had highly positive experiences with our services and staff. The outcomes specifically showed:

- the greatest proportion of our MHS consumers surveyed found their experience of care with us to be 'very good' or 'excellent' and reported that they would be 'likely' or 'very likely' to recommend the service to their family or friends
- consumers praised the empathy and compassion they received from the staff involved in their care saying they were kind, understanding, and easy to talk to
- consumers felt there was a strong collaboration among staff which increased their confidence in the care they received
- consumers highlighted that being involved in their own care was something they highly valued and their experience was greatly improved when they were central to discussion and decisions about their care
- consumers felt empowered through learning more about mental health, wellbeing, and coping skills

Our Aboriginal Health Liaison Officers who support our mental health consumers

Creative arts as therapy

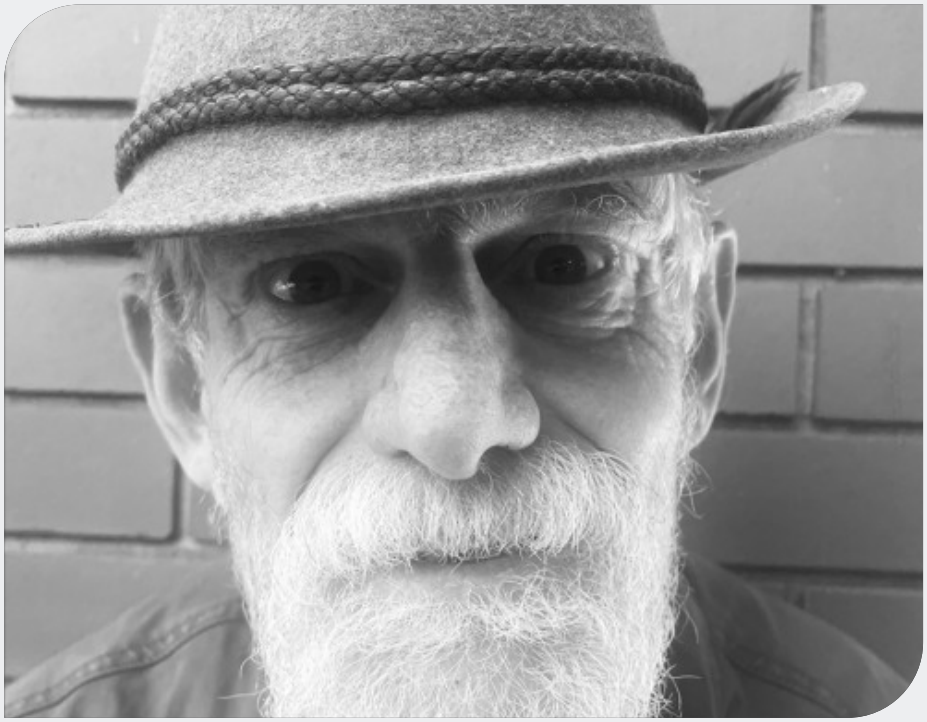
The Creative Expression Centre for Arts Therapy (CECAT) is a State-wide community mental health service located at Graylands Hospital.

Services provided include arts therapy and arts psychotherapy, which utilise the creative processes of art making, music making, and/or writing to improve and enhance emotional and physical well-being. This therapy provides an alternative to talking therapies, with a primary focus of resolving trauma and mood related disorders and the effect this has on a person's functioning. This approach to therapy is also more inclusive of consumers with kinaesthetic-tactile and visual learning styles.

CECAT staff work with consumers individually and in groups using a range of creative mediums and processes to assist in the recovery of young people and adults with a primary diagnosis of mental illness. Targeted therapeutic interventions are provided while developing emotional resilience, self-understanding, self-acceptance, and creative problem solving.

One of our Senior Occupational Therapists, with a talent for instruments, music production and sound engineering, has worked hard to set up a small recording studio at CECAT, allowing consumers to explore and develop their musical self-expression and assisting them to gain greater insight, self-knowledge and acceptance of their individuality.

While in this type of therapy the creative process is more important in the consumer's mental health recovery than what is produced, we are proud to highlight some of the incredible tracks our team have assisted in producing. See and hear an example of their creativity by scanning the QR code.



Mark Dark, one of our talented CECAT clients

Our women and newborn patients

Osborne Park Rehabilitation and Neonatal Nursery Project

Construction of the Osborne Park Rehabilitation and Neonatal Nursery (OPRNN) Project was a key priority for the State Government. Operationalisation of the facilities are now complete, with the development of a new Level 2A nursery, Maternity Assessment Unit, Therapy Hub, and 16-bed rehabilitation ward. For our patients this means:

Improved patient experience and service efficiency

- patients can transfer from Sir Charles Gairdner Hospital (SCGH) to Osborne Park Hospital (OPH) to commence rehabilitation sooner
- amputee patients can receive inpatient/ outpatient rehabilitation services in one location
- increased capacity for OPH to provide a step-down service to SCGH, supporting improved availability of tertiary beds as well as improving admissions from the community
- improved staffing and equipment utilisation by centralising therapy.

Improved models of care and service delivery to benefit patients and the community

- a fit-for-purpose therapy hub to accommodate post-operative rehabilitation therapy services for both inpatients and outpatients in a centralised and contemporary facility, improving clinical outcomes and reducing length of stay
- a modern 16-bed rehabilitation ward and inpatient facilities to improve service delivery and reduce length of stay providing better patient experience
- a six-cot Level 2A neonatal facility will enable OPH to provide low dependency care and assist in redirecting neonatal activity from King Edward Memorial Hospital (KEMH) back to OPH, providing women and neonates with care closer to home
- women with low to moderate risk pregnancies can have their babies from 34 weeks closer to home meaning fewer babies will need to be transferred to other hospitals for specialist care, keeping them in the same hospital as their mothers.

Newborn baby Ryker Vallen Rumball and his proud parents

Joondalup Breastfeeding Clinic

The Breastfeeding Centre of WA (BFC) provides breastfeeding information and support for families in WA. Appointments at the Breastfeeding Centre are available to mothers and babies who attended KEMH. Our team of lactation consultants provide breastfeeding information and support for families and health professionals via telephone counselling service and an outpatient service for mothers and babies for their pregnancy and birth. Attending the centre enables a mother and her baby/babies to spend up to one and a half hours with the help of a lactation consultant to overcome breastfeeding difficulties. This service has now been expanded, with the opening of the Joondalup Breastfeeding Clinic, to enable women in the northern suburbs corridor to also have access to this support.

Obstetric Telehealth

In March 2022, the routine antenatal schedule at KEMH was adjusted to accommodate Telehealth and reduced face-to-face visits when clinically appropriate. This allowed women to continue to access antenatal care during the pandemic restrictions. Face-to-face consultations continued to be arranged according to clinical need, with all women seen face-to-face at important points of their pregnancy care journey. Using Telehealth enabled us to ensure women had continued access to quality healthcare and have their concerns addressed while minimising their potential exposure to COVID-19.

Protecting the Neonatal Intensive Care Unit

The protection of our most vulnerable patients, including those in the Neonatal Intensive Care Unit (NICU) at KEMH, was one of our key priorities in managing the risk of COVID-19 in our hospitals. Using the 'A Block protects B Block' philosophy, KEMH was able to lock down the front entrance for screening all people entering A Block before they accessed B Block where the most vulnerable patients were situated. This demonstrated our outstanding collaboration with Child Adolescent Health Service, and as a result of implementing such a robust system of screening, KEMH was able to maintain tertiary level clinical services to one of our most vulnerable areas during the pandemic with no COVID-19 outbreaks within the service.

A Unified Approach

The KEMH Critical Infrastructure Project was well underway this year, and the recently completed renovation of lift 4 was an exciting addition to the B Block foyer. The newly refurbished version features our stunning 'A Unified Approach' artwork which is representative of the commitment our Women and Newborn Health Service (WNHS) has made to working as a team, with respect and integrity, to deliver a culturally safe and inclusive service. Artists included both Aboriginal and non-Aboriginal staff of WNHS.

Located on the ceiling of the lift, the artwork contains:

- paths to represent the woman's journey to and from WNHS
- circles to represent the services at WNHS
- turtles to represent good health and wellbeing
- leaves to represent medicine
- signatures of staff who made the commitment

'A Unified Approach' artwork

Our patients living with disability

We are committed to ensuring that people living with a disability, their families, and carers receive excellent care and can fully access our services, facilities, and information.

This year we progressed numerous initiatives within the seven outcome areas of our Disability Access and Inclusion Plan (DAIP) 2017-2022 (refer to **Disability Access and Inclusion Plan section**). Some highlights included:

Changing Places

This year SCGH became the first accredited **Changing Places** facility in a WA public hospital. The Changing Places facility is a universally accessible toilet for people with complex care needs and provides suitable facilities for people who cannot use standard accessible toilets. It provides circulation space for up to two carers and includes an ambulant toilet, shower, hand basin, privacy screen, height-adjustable adult-sized change table and a constant-charging ceiling track hoist system. Additionally, we opened a new parents' room, public bathrooms, and changerooms, and Universally Accessible Toilets (UAT) at multiple sites at SCGH, including E Block Watling Walk, E Block Outpatients, C Block, and G Block.

BreastScreens

At BreastScreen WA, longer appointment times have been made available for patients living with disability and two additional radiographers have been made available for patients with additional needs. We improved accessibility to mobile units and clinics, including fitting mobile trucks with hydraulic lifts for wheelchair access and ensured all clinics were fitted with accessible toilet facilities and parking bays. We now also include iPads in each mobile clinic so that clients in regional and remote areas can communicate with interpreters via video call or Microsoft Teams, and provide walkers to sit on if required during screening.

Osborne Park Hospital hearing amplifiers

Osborne Park Hospital (OPH) purchased five hearing amplifiers for Occupational Therapy patients which made it easier for people with hearing loss to engage with therapists and other patients. The devices were very well received by patients who may not yet be using hearing aids, have a lost a hearing aid, or need new batteries. The devices are easy to use as they are larger and easier to manage than hearing aids and provide strong amplification. The Occupational Therapy team, nursing, and medical staff have found the hearing amplifiers have assisted them to provide better quality assessment and interventions for patients with hearing difficulties.

FAVERO cots

OPH purchased two FAVERO cots enabling easy access to baby for those patients unable to physically reach their baby with the usual bedside cot.

Hydraulic lift for wheelchair access at BreastScreen mobile truck

Lady of the Ramp

This year, disability advocate and Paralympian Elizabeth Mills was acknowledged for her 20 years campaigning for disability-friendly access improvements at Sir Charles Gairdner Hospital (SCGH).

Self-identifying as the 'lady of the ramp', Elizabeth provides an invaluable perspective as a consumer representative on the SCGH Disability Access and Inclusion Plan (DAIP) Committee through her lived experience as a person, and patient, living with a physical disability.

At the age of just 15 months, Elizabeth contracted polio and as a result wears a leg brace on her right leg. In 1998, she moved into a new house, slipped over in the bathroom, and broke her left ankle. On a follow up visit to the plaster clinic at SCGH, Elizabeth's wheelchair kept slipping on the bathroom floor, so she had to call for help to use the bathroom.

"I filled in a complaint form and, as a result, I was invited to a forum run by SCGH. I was then invited to sit on the Consumer Advisory Council. I heard about the DAIP committee at one of these meetings and joined in June 2001," said Elizabeth.

"I catch public transport and have helped improve the many bus stops on the campus. I have also campaigned for improvements to disabled toilets. SCGH now has a Changing Places Toilet, and a disabled toilet with push button door access. Upgrades to disabled toilets are being planned for the Outpatients Departments on both floors in E block," Elizabeth informed.

"I visit several departments as a patient and let the DAIP Committee know if I see a problem. It is gratifying to see that SCGH does listen and makes the necessary changes!"

Social Work Head of Department Mary Joyce and Director Allied Health Kim Brookes acknowledged Elizabeth's significant contribution to improving the patient and visitor experience at the September DAIP Committee meeting.

Elizabeth Mills centre, with Social Work Head of Department Mary Joyce and Director Allied Health Kim Brookes

Our elderly patients

Geriatric, Acute and Rehabilitation Medicine Outpatient Clinics and Day Therapy Unit

In May this year, the SCGH Geriatric, Acute and Rehabilitation Medicine (GARM) outpatient clinics and Day Therapy Unit relocated from QEIIMC to F Block at Osborne Park Hospital (OPH). Aligned to the Sir Charles Gairdner Osborne Park Health Care Group (SCGOPHCG) Reconfiguration Project, SCGH clinic nursing and clerical staff have re-located to OPH to become a single center of excellence for geriatric ambulatory care within our service and to provide seamless high-quality person-centred care for our older patients. The specific purpose of this service is to:

- provide rapid referral access for elderly outpatients requiring geriatric review
- improve collaboration with the Geriatric Assessment Team in the Emergency Department (ED) and assist in avoiding the need for admission from the ED
- provide urgent clinic appointments for frail elderly patients referred from General Practitioners

Alongside greater access to staff, resources, and therapies, our patients will also experience a streamlined patient journey, increased appointment availability and choice, an accessible location, and free parking close to the clinics.

One of our GARM Consultant Geriatricians

Dignified end of life

Voluntary Assisted Dying (VAD) became a legal option available to eligible Western Australians on 1st July 2021.

Across the State, demand from Western Australians has exceeded what was anticipated. We have supported consumers, and their families who were seeking this choice, by working collaboratively with the two State-wide Services for VAD to ensure seamless, well-coordinated care throughout the process.

Patients are reliant on participating medical practitioners to be able to access VAD. Professional participation in VAD is voluntary and a small number of practitioners have worked incredibly hard to support patients across our service. Our staff caring for people exploring VAD have demonstrated exemplary care, empathy, and respect for their choice, while supporting each other in this new and sometimes challenging aspect of end of life care. To date we have supported 89 individuals in seeking access to information about VAD.

The wife of a patient who opted to participate in VAD has requested to share the following words about their experience with the service:

"My husband was diagnosed with a terminal illness. After extensive treatment we were told there was nothing further that could be done to treat the illness. We had heard of VAD through a family friend. What an amazing journey. From the first contact with the doctor and the VAD coordinator, we knew we had a team who was there to support us through the process. The pharmacists who came to the house and showed my husband what he needed to do were also so caring. Everyone in the VAD team talked us through everything clearly and were with us every step of the way. The paperwork was seamless, and documents were easy to read and understand. It was a brave decision for my husband, but an easy one, as he was in so much pain and who knew what he would have to go through to the end without VAD. He had the chance to say goodbye to those he wanted to see, and our kids, in-laws, and my husband's best mate were with him on the day. It was so peaceful and those of us left behind knew it was so brave of him to do it, and so right for him and us. I can't thank the team and the process enough. I feel calm, although I miss him everyday."

'A way of life' identified by a consumer who experienced the VAD process. The piece shows the path of a life, with the beginning represented by the emu's egg, through the day-to-day experiences of working, and progresses up the road into the dreaming at the end of physical life.

How we cared for our staff

Protecting our frontline security staff

In 2017 the Minister for Health made a commitment to the protection of frontline security staff, by endorsing a strategy for all Health Service Providers to ensure anti-stab vests and mobile duress alarms were provided to at risk staff and patient cohorts in hospital and community health settings.

All key milestones of this strategy have now been achieved across our service, with all Election Commitment funding for the protection of frontline security staff fully utilised in the provision of 74 anti-stab vests and 270 personal duress alarms to identified at-risk staff.

Security staff at SCGH

COVID-19 actions and staff wellbeing

As demand for our services grew, our determination to stay true to our values did not waiver.

Supporting and protecting the health and wellbeing of our staff during the pandemic was a priority. This included:

- facilitating their vaccination
- ensuring the appropriate use of PPE via an extensive program of fit testing
- screening patients and visitors to prevent infection
- implementing furlough arrangements to cover and support staff unable to come to work
- facilitating working from home access where appropriate
- remote onboarding and training courses
- the provision of free Rapid Antigen Tests (RATs)
- implementing numerous initiatives and providing resources to support employee wellbeing

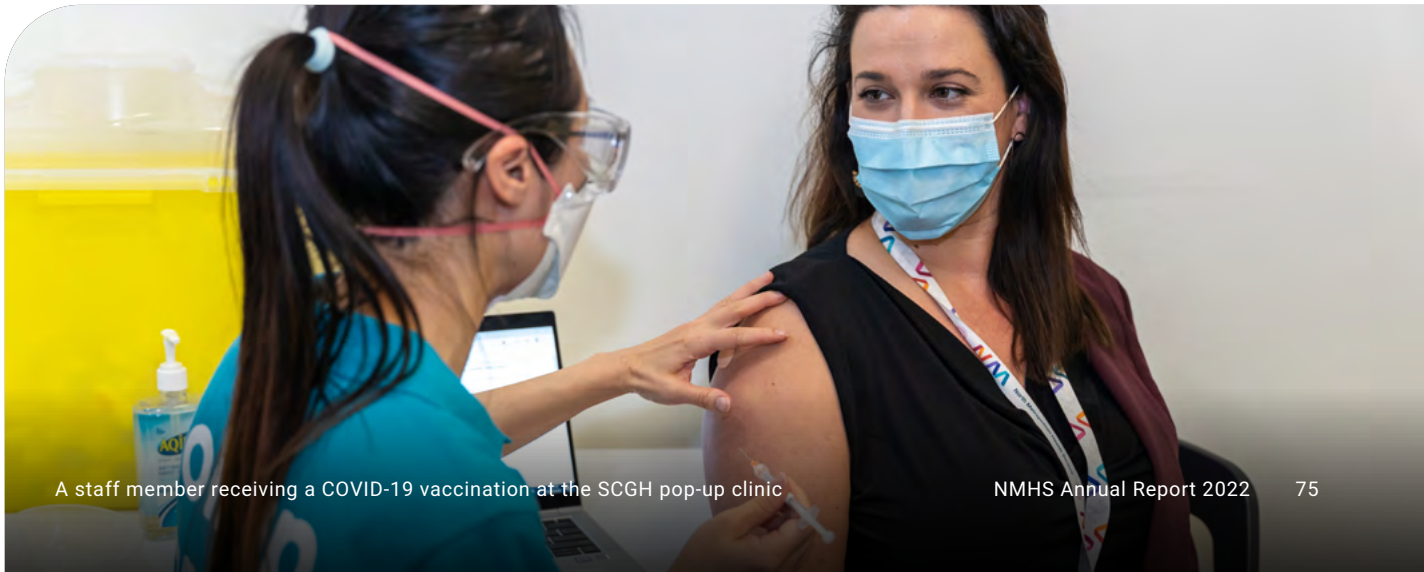
Staff vaccination

The initial roll out of COVID-19 vaccines by the NMHS COVID-19 Vaccination Program, under the governance of our Public Health service, commenced in March 2021. In accordance with the national plan, the initial focus was on frontline Health Care Workers.

This included staff working in the highest risk areas such as the Sir Charles Gairdner Osborne Park Health Care Group G54 Respiratory Ward, Intensive Care Unit, Emergency Departments, COVID-19 Clinics, the Joondalup Health Campus Intensive Care Unit, Emergency Departments, COVID-19 Testing Clinic, Respiratory Wards, and King Edward Memorial Hospital Emergency Centre. As more vaccines became available, and eligibility criteria expanded, more clinics were added to the busy schedule.

The highest period of activity for our health service occurred in June 2021 in response to the **WA Mandatory vaccination policy**[17] for all WA health system employees. There was a steady number of vaccines administered to staff in the latter half of 2021, with an increase in December 2021, reflecting health staff becoming eligible to receive their COVID-19 booster vaccinations in line with **Australian Technical Advisory Group on Immunisation (ATAGI)**[18] recommendations.

This financial year, the Program provided over 17,365 staff vaccinations, including 10,827 COVID-19 vaccinations and 6,538 influenza vaccinations. Staff also had the opportunity to receive their vaccinations in the community at their General Practitioner, pharmacies, and Rollup for WA clinics. In accordance with the WA Mandatory Vaccination Policy, 99% of our staff have now been triple vaccinated, with only 1% of staff requiring an exemption.



A staff member receiving a COVID-19 vaccination at the SCGH pop-up clinic

Fit testing

Fit testing commenced throughout WA public hospitals in January 2021 and shortly after, on 5 February 2021, it was mandated by the WA Department of Health that front line staff be required to wear a P2 or N95 respirator and have a fit test to ensure they are wearing the correct brand and size.

To date, our Fit Test team have fit tested 11,571 staff, approximately 94%, including students and contractors. Further, our Infection and Prevention Control service developed a roaming team to ensure staff working in remote areas such as our Dental Services and BreastScreen WA clinics had access to fit testing. The work is set to continue, with annual fit testing becoming a mandatory requirement for all WA Department of Health staff who are required to wear a P2 or N95 respirator as part of their role.

Contact tracing

With embedded community transmission at the start of 2022, and ever-increasing case numbers, contact tracing within hospitals was vital to ensure patient and staff safety. A central contact trace team to manage staff contact tracing was established in March 2022 with Infection Prevention and Control continuing to manage both staff and patient contact tracing. IT systems were developed rapidly to allow staff to simultaneously notify the contact trace team and their line manager of their exposure or COVID-19 illness. In addition, a Power BI dashboard was developed to be able to see the impact COVID-19 had on our workforce.

As the close contact definition changed, and furlough requirements were adjusted, an exemption process was implemented to allow correct approvals to take place in a timely manner and therefore see staff meeting criteria return to the workplace, which helped to ease the burden of furloughed workers. Any staff member who was furloughed as a close contact or a positive case was contacted prior to their expected return to work date to ensure that health care workers who might potentially transmit the virus were not returning to the workplace prematurely.

Staff health – COVID-19 fitness for work

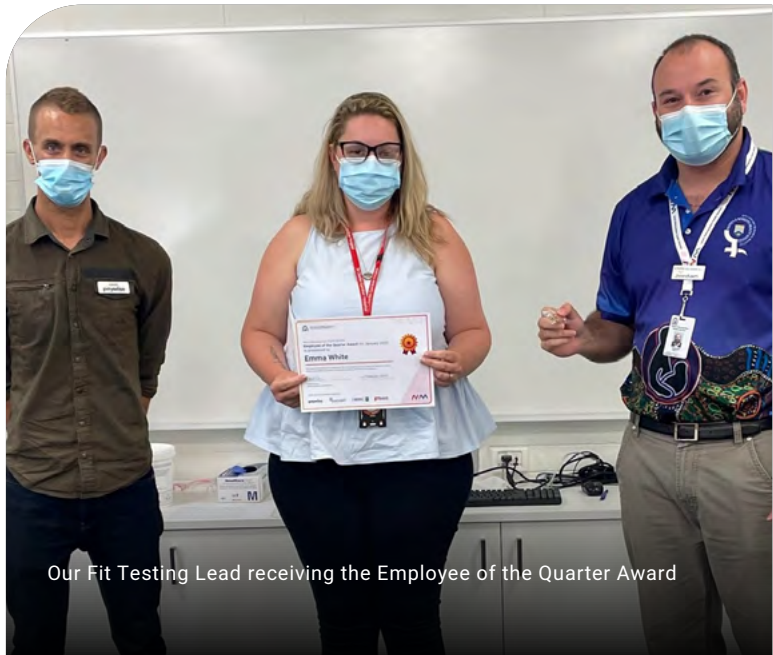
In accordance with the *Work Health and Safety Act 2020*, we have an obligation to provide a healthy and safe working environment for all workers and are committed to the prevention of occupational injury and illness. It was recognised that some staff in our workplaces may have underlying chronic health conditions which could place them at increased risk of severe illness if they contracted COVID-19. A COVID-19 Fitness for Work process was developed by the Occupational Safety and Health (OSH) team to conduct a risk assessment and gather further information to determine whether workplace adjustments were required for staff working within our health service.

Employee Wellbeing Psychologists

In April 2022, we employed two Clinical Psychologists to support staff wellbeing.

The Wellbeing Psychologists have provided numerous services and support across our organisation including:

- development of evidence-based self-help resources including a COVID-19 staff wellbeing hub page
- proactive wellbeing check-ins for furloughed workers
- resources outlining professional support for internal and external staff
- development of a Managers' toolkit which provides practical information for Managers on supporting and promoting staff wellbeing
- tailored support and advice to Managers/ Supervisors to support their teams
- provision of face-to-face and virtual team-based psychoeducation sessions on topics such as burnout, stress management, and moral distress/injury.



Our Fit Testing Lead receiving the Employee of the Quarter Award

Peer Support Officers

Our Peer Support Program was developed as an important mechanism to help create and support a mentally healthy workplace. The program was designed to provide early intervention to our staff who were experiencing work related or personal stress. Our Peer Support Officers are employees from all disciplines, areas, and work locations across our health service. They are trained to listen, identify, and assist staff who need support and can connect them to professional support services for further assistance or help them find the resources to manage their overall wellbeing.

COVID-19 wellbeing care packs

COVID-19 wellbeing care packs were distributed to our Sir Charles Gairdner Hospital frontline clinical staff who were facing high workloads and doing additional shifts.

Wellbeing workshops

Our Corporate Wellbeing Program also undertook a number of health and wellbeing initiatives to engage staff in fun and healthy activities including:

- **Fit February** – a team walking challenge
- **Tune up June** – a list of resources to check in with yourself and look after your own health
- **Augustation** – staff from different areas getting to know each other by creating edible food that represented their work area
- **Corporate Bingo** – to improve staff engagement and enjoyment in the workplace

In conjunction with the Sir Charles Gairdner Osborne Park Health Care Group Wellbeing Committee, the Wellbeing and Staff Support Activities and Programs (WaSSAaP) team provided staff the opportunity to participate in a monthly virtual wellbeing workshop covering a range of topics. These included staying connected, finding balance through mindfulness, managing your energy, coping with change, growth mindset, and laughter yoga. Women and Newborn Health Service (WNHS) Wellness provided mind, body, and spirit strategies to ensure wholistic approach to WNHS wellness and Mental Health, Public Health and Dental Services strategies include:

- developing a comprehensive workplace wellbeing approach that frames the existing and developing wellbeing activities of sites and services, while respecting their unique organisational history, workforce and priority needs
- improving employee functioning across seven domains of workplace wellbeing (physical, mental/emotional, social and community connection, cultural & spiritual, financial, occupational/work, and intellectual)
- developing and promoting initiatives that reduce the occurrence and impact of workplace stressors that increase risks to staff wellbeing, burnout, and loss
- enhancing and supporting a workplace culture that supports staff wellbeing

Fitness passport

The Fitness Passport Program was launched to our staff on 13 June 2022. It includes a discounted gym membership that provides its members with unlimited access to over 60 gyms and pools across the North Metropolitan area. Over 350 staff have signed up to date and are accessing the benefits of this program.

One of our Peer Support Officers

How we cared for our community

COVID-19 vaccination

Throughout the year our Public Health vaccination team did some outstanding work in not only vaccinating our eligible staff against COVID-19, but also providing vaccinations to the general population. In total, our team provided 39,517 COVID-19 vaccinations this financial year covering 10,827 staff, 2,240 inpatients, 7,143 people in custody, and 19,307 people in the community. The team administered vaccinations to people at our metropolitan prisons, mental health hostels, homeless facilities, on the streets for rough sleepers, and for people in their homes for those that are unable to access community clinics. They set up pop-up clinics in shopping centres, at the airport for Fly-in-fly-out (FIFO) workers, in our hospitals for outpatients and antenatal patients, and even combined clinics at fun community and multicultural events to take the 'sting' out of the experience and help overcome concern.

The Roll up for WA team

Mental health

The staff at Osborne Park Community Mental Health (OPCMH) engaged in a rewarding campaign to help their clients overcome the hurdles in their path to vaccination, giving 55 clients their first dose on 23 September 2021 at the Osborne Park site. This was followed up with a further event in October 2021 where they hosted their second-dose clinic at Osborne Park Hospital and a day at Tranby Crisis Support where they vaccinated at least 199 people who would not otherwise have had the opportunity to be vaccinated. The OPCMH vaccination clinic for mental health clients was such a success that it was presented as a model for how to organise and operate clinics of its kind for implementation by other groups. OPCMH were invited to make a joint presentation with the Chief Psychiatrist to discuss 'A Successful Model of COVID-19 Vaccination Clinics in the Mental Health Community', which was conducted on 9 November 2021 to an audience of more than 50 people from a variety of settings including community mental health and other non-government organisations.

For those mental health patients, both within and outside our catchment area, who wanted to be vaccinated but were unable to attend a clinic, our team offered the option to provide the vaccine to them at home.

Aboriginal communities

The team also focused on improving access to vaccination opportunities for our Aboriginal communities by setting up clinics to create accessible and less intimidating environments for vaccination, such as NAIDOC events and the Whadjuk Northside Aboriginal Community Centre where they hosted a sausage sizzle and other activities.

Collaboration in the country

'ello Sister

On a humid 38-degree day in January, 55-year-old clinical nurse Melissa Daines stepped from a plane in Port Hedland, excited but anxious.

'My heart was racing. I'd never done country nursing before,' she said.

Melissa was one of 30 NMHS nurses and midwives to answer the WA Country Health Service's State-wide call for help from country towns suffering critical staff shortages in 2021/22.

COVID-19 had brought lock-downs and closed the border, blocking the usual flow of healthcare workers from other states and from across the Tasman. The Kimberley and Pilbara regions were particularly hard hit.

The staff situation was not an emergency, it was critical,' said former Acting Chief Executive of NMHS, Tony Dolan.

Melissa's first six week deployment was at South Hedland Hospital and her second, extended to three months, was at Kununurra District Hospital.

'As well as incredible patient experiences, I got to travel, see a part of the country I'd never been to before and earn extra money on shift work that I couldn't get in the metropolitan area,' she said.

'The autonomy in the workplace was great, my colleagues were lovely and both deployments were a big adventure.'

'You need to be pretty strong and just get on with it.' said Melissa, whose speciality in the UK before coming to Perth to live in 2010 was strokes and rehabilitation.

'But I loved it. I really enjoyed the patients and the opportunity to brush up on my clinical skills, which was my main reason for going.'

Melissa enjoyed the small-town community spirit compared to the anonymity of work in a big city hospital. 'You'd go to the shop and see somebody you'd looked after. They'd say 'ello Sister. They all called you 'Sister'.'

The hours-long mourning rituals for an old Aboriginal woman impressed her deeply. 'It was heart-breaking really – so different from the city where things would be wound up quickly because the bed would be needed.'

Melissa said her husband Robert, a former customs officer in the UK, and her two adult daughters were very supportive of her country deployments. *'It was bit of a role reversal but Robert just said it was my turn. He was great about it.'*

The WA Country Health Service organised the diaspora of nurses throughout the state. We celebrate the nurses and midwives who will continue answer the call in support of regional and remote areas throughout 2022.

NMHS nurse Melissa Daines with patient Ruth at Kununurra District Hospital

Our Aboriginal community

This year we continue to focus on a future when we are able to meet the KPI for 'Percentage of admitted Aboriginal patients who discharged against medical advice'.

Whilst unsuccessful meeting the target this year, we recognise the extensive work our Aboriginal Health and Liaison Officers (AHLOs) have done in following up on these patients and are proud to report that our performance on this measure has been gradually improving since 2018. We aim to continue to improve our level of care provided to our Aboriginal patients and hope to do better in meeting this target in the years to come through the implementation of our **Aboriginal Health and Wellbeing Strategy 2022-2025**[19].

Standing Strong

Having an amputation is life changing. With the assistance of one of our Innovative Futures grants, our team at Sir Charles Gairdner Osborne Park Health Care Group were able to take a huge leap in addressing the gap in culturally appropriate education resources for Aboriginal people who require amputation procedures. This year the team launched the 'Stranding Strong' animated video and brochure which aims to help Aboriginal patients understand what to expect throughout their amputation journey. The resources have been specifically designed to provide improved education for Aboriginal patients as they learn to adjust and adapt to new ways of doing things so they can return to a full and happy life after an amputation. The video can be viewed by scanning the QR code below.

The creators of the 'Standing Strong' resource

Don’t lose your voice

In August we officially launched the video “Don’t lose your voice - Rosie’s story,” the first laryngectomy resource developed specifically for Aboriginal patients. The video was produced by one of our Speech Pathologists who was awarded funding through the Charlies Foundation for Research "Bright Ideas Grant Program", with assistance from many of our other staff including our AHLOs.

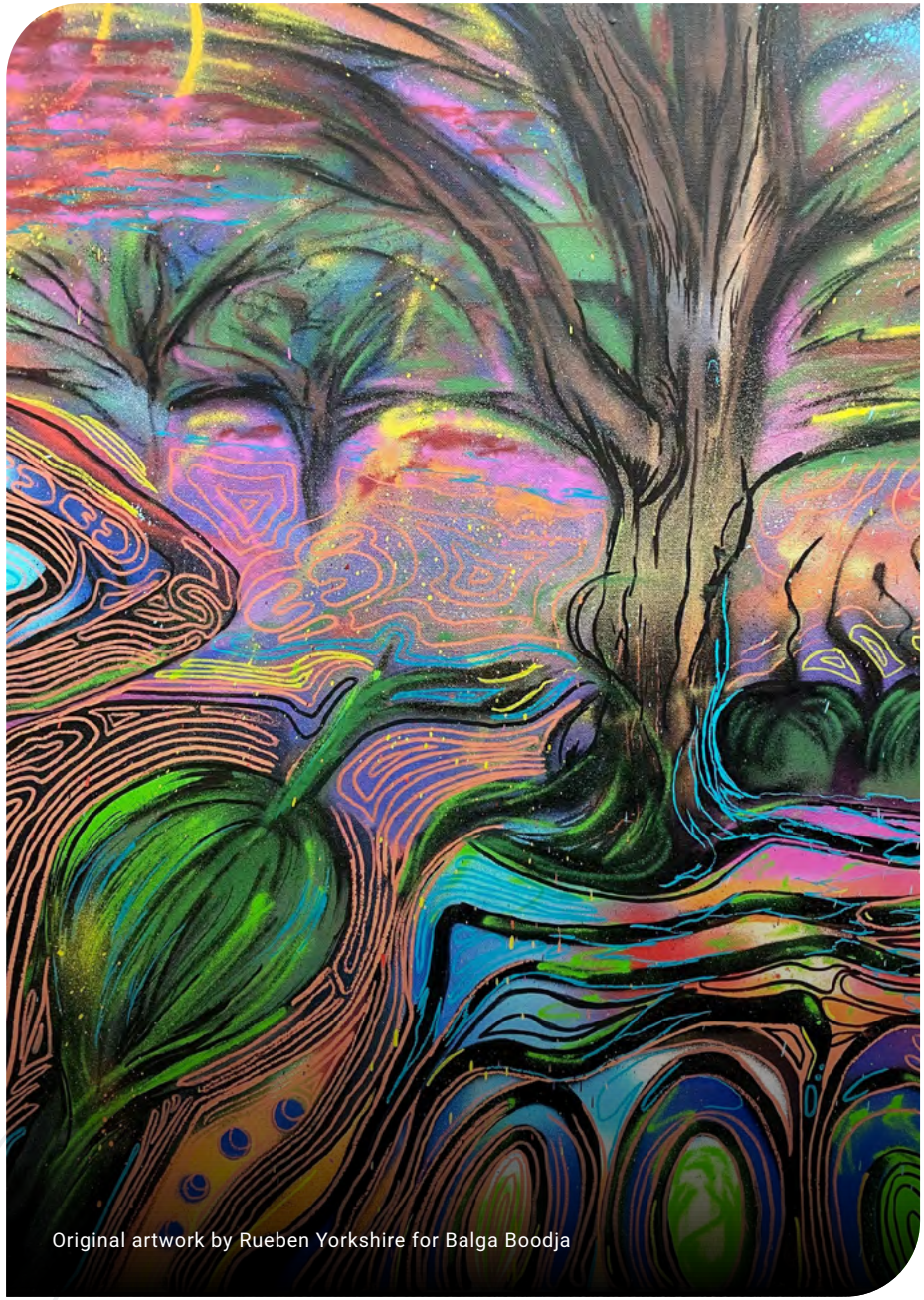
In the video, Rosie Charlie, who had her voice box removed in 2014, proudly shares her experience of having a laryngectomy from diagnosis to treatment and beyond. She bravely tells her story with the hope of helping others who are faced with the terrifying news of having their voice box removed. The video can be viewed by scanning the QR code below.

Rosie Charlie, a proud Yarra woman originally from Broome, who bravely shares her laryngectomy story for the Aboriginal community

Balga Boogja walk trail

On 27 November 2021 the Balga Boodja Walk Trail was officially opened. The trail is the result of the fantastic efforts of our Health Promotion team collaborating with multiple other agencies to create an inclusive, engaging, and healthy public attraction for the Balga community. The trail has been signposted along Balga Avenue which is lined with artwork, interactive multimedia, and nature.

Balga is a vibrant community with diversity at its core. It has a significant population of Aboriginal people as well as migrants from non-English speaking countries. The agencies involved with this project spoke extensively with local residents, both through community workshops and one-on-one, to form a vision of what could be created for their benefit and enjoyment. The trail aims to provide an opportunity for pleasant physical activity, to bring the community together in a positive way, and to provide an enriching cultural experience for visitors. Along with the beautiful artwork created by talented emerging Noongar artist, Rueben Yorkshire, the trail's signage includes QR codes that link to videos of Aboriginal Elders telling stories. These stories provide a connection for the younger generation and an opportunity for them to appreciate and acknowledge future generations of Aboriginal Elders.



Original artwork by Rueben Yorkshire for Balga Boodja

Our environment

The power of us

Sustainability is one of our key **Strategic Priorities**. As we aim to reduce, treat, and safely dispose of healthcare and organisational waste, while prioritising and promoting environmental health and sustainability, we are focusing on educating our people about our waste system to make sure we don't miss any opportunities to recycle.

In July 2022 we launched our second 'Power of Us' Climate and Sustainability Program Campaign where we focussed on waste. The campaign was hugely successful, resulting in over 125 staff pledges to become sustainability leads and get involved by changing their actions and becoming sustainable, more than 25 nominations for keep cups, and great turn outs at all of our guest speaker events. Multiple recycle hubs were created throughout departments as well as over 25 items listed on our new Swap service webpage. In addition, a variety of ideas were submitted to keep us thinking sustainably. The Campaign was run across all sites and services, designed to unite us as a team, harness our collective power, and promote sustainable leadership throughout our health service.

Engagement in Plastic-free Innovation for Change program

From January 2022, WNHS KEMH partnered with Plastic Oceans Australia and the Climate and Health Alliance to pilot the Engagement in Plastic-free Innovation for Change (EPIC) program to reduce single use plastics across the site. Industry led solutions are being adopted to improve practices and reduce healthcare's overall contribution to the landfill crisis. This exciting project, a first of its kind for health care providers, has been made possible with the support of Minderoo Foundations Flourishing Ocean Initiative.

Electric vehicles

The State Government developed the **State Electric Vehicle Strategy** for Western Australia[20] to prepare for the transition to low and zero emission electric vehicles and maximise the benefits to our state.

In line with the strategy, we became the first Health Service Provider (HSP) to secure an electric vehicle fleet which is based at Graylands Hospital. Graylands Hospital was chosen as the inaugural fleet location due to the high demand for fleet vehicles at the site and available space to house the electric charging infrastructure needed.

As a result of COVID-19, there was an increased demand from clinical departments to utilise fleet vehicles for in-home visits in an effort to reduce the need for patients to attend a hospital. There has also been an increase in fleet demand due to several new services coming on stream as a result of increased funding from the State Government.

One of our new electric vehicles at Graylands Hospital

Our future

Our plan

As we look to the future, our focus is on setting up for success, identifying early priorities, and building momentum in the new normal of living with COVID-19.

With this, we shift into Horizon 2 of our **Strategic Plan** – consistently excellent health care service. In order to deliver consistently excellent health care, we will anticipate and respond to the needs of those we serve, focus more on public health and community health services, and develop our collective capabilities. We will build foundations for excellence in teaching, training, research, infrastructure, and innovation, and continuously improve our environmental and financial performance.

Many people recognise that for every decision made about services or treatments provided, there is a cost and trade-off for the WA community that cannot be ignored. Expectations may be beyond that which the public sector can deliver and honest discussions need to be had to consider the best use of public funding and about cost drivers and how decisions are made. We need to see shifts in behaviour and people doing things differently and the better use of resources to get the best value for the health of all Western Australians[21]. With this in mind, and while we have numerous strategies to achieve our goals across all sites and services, we outline four of our key programs that continue to address the demand for health and mental health services, WA hospital's emergency capacity, and infrastructure and major hospital developments below. We look forward to reporting our progress on these, and others, in the years to come.

Hospital Emergency Access Response Taskforce

This year we experienced high levels of ambulance ramping as it occurred across the WA health system. It is our priority to do all we can to optimise the flow of patients through our hospitals, ensure the provision of timely, safe, quality care to patients, and reduce the pressure being felt by our staff, with the ultimate goal of eliminating ambulance ramping at our Emergency Departments. While these are not new or unique issues to us, or the health system in general, we have set ourselves the challenge to learn from our past experiences in health system reform, including the four-hour rule, and undertake a phased and innovative approach to achieve sustained, transformational change for our health service.

To achieve this, the Hospital Emergency Access Response Taskforce (HEART) Program will be mobilised with the audacious goal of eliminating ambulance ramping across our health service. The Program is looking to rapidly improve patient flow and address major access blocks to ensure our patients receive the right care, in the right place, at the right time while we provide safe, quality care at all times. In addition to improving and reforming how we deliver care and optimise patient flow across the entire inpatient journey, we will be mobilising an Outpatient Reform and Elective Surgery Recovery and Reform Program aligned to HEART. Optimising access and flow across these cohorts will further support achievement of our HEART Program goal and improve the patient and staff experience across our sites and services.

Graylands Reconfiguration and Forensic Taskforce

The cross-government Graylands Reconfiguration and Forensic Taskforce (the Taskforce), independently chaired by Hon. Jim McGinty AM, was established by Government in early 2021 with responsibility for oversight and planning for the reconfiguration of services and closure of facilities at Graylands Hospital (Graylands) and Selby Older Adult Mental Health (Selby). The Taskforce undertook a significant amount of work in 2021 to quantify the number and types of beds required to meet the needs of Western Australians over the next 10 years. This work included needs-based demand modelling and investigating land to house a new and expanded forensic mental health hospital.

In October 2021, the Taskforce presented Government with a high-level concept proposing that the northern part of the Graylands site be retained for an expanded contemporary forensic mental health hospital as well as facilities to provide mental health rehabilitation services for non-forensic consumers.

This report and concept gave rise to the Government decision to support the continued presence of mental health services, including expanded forensic mental health facilities, on the northern part of the Graylands site. Government communicated this in Parliament on 18 November 2021.

This enabled the Taskforce to further develop and refine their concept into a comprehensive Application for Concept Approval which was presented to Government as part of the 2022-23 State Budget. This provided a clear picture of what is needed to rebalance the bed-based mental health system over the next decade and support the resolution of longstanding issues such as the undersupply of forensic beds, bed block, and ambulance ramping. In the recent the State Budget, the Department of Health received $10 million over two years to continue planning and develop business cases for the state-wide reconfiguration of mental health services and Graylands Hospital redevelopment as per the Taskforce's concept.

Graylands Hospital entrance

Women and Newborn Service Relocation Project

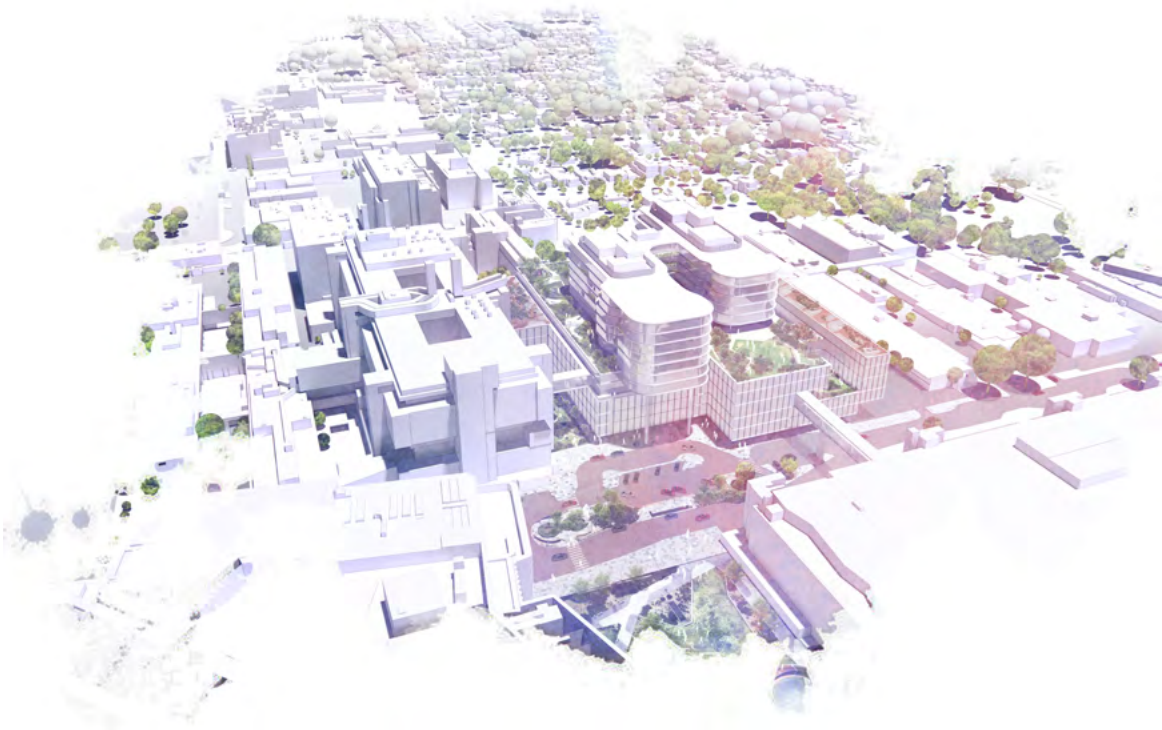
The Women and Newborn Service Relocation Project (WNSRP) is an exciting and transformative project which will create contemporary maternity, neonatal, and gynaecological facilities to serve Western Australian families for future generations.

The relocation of services from King Edward Memorial Hospital to the Queen Elizabeth II Medical Centre (QEIIMC), and some services to community-based locations, will enable opportunities for more contemporary, integrated models of care for women and neonates.

Fully funded by the State Government, the $1.8 billion Project progressed from service delivery planning through to concept design in 2021-22. The concept design is an illustration of how a range of high-level design principles, key functional requirements, and site response priorities could be successfully applied to the new facility. A decision on the final design will be made in a future phase of the project after further stakeholder and community engagement. More than 480 stakeholders, including clinicians, staff, and consumers had input into the development of service delivery models and functional briefs through participation in project User Groups. Many of these participants continued through to the concept design stage, which involved almost 300 stakeholders.

In January 2022 the Minister for Health; Mental Health announced the chosen site for the new hospital, north of Sir Charles Gairdner Hospital (SCGH) G block. Selected following a comprehensive site analysis, consultation and evaluation process, this location allows for future-proofing of the QEIIMC and key linkages between the new hospital, SCGH, and Perth Children's Hospital to enhance patient care outcomes.

In May 2022, the Minister for Health; Mental Health visited QEIIMC for a tour and first-hand view of the selected site and impacted areas of SCGH. The Project team is currently focused on the finalisation of a combined business case and project definition plan, which will be submitted to Government in 2022-23, after which the next phase of design is planned to commence.



Early artist impression of WNSRP

Joondalup Health Campus expansion

In the past financial year much progress has been made on the $256.7 million expansion of Joondalup Health Campus (JHC). The Federal Government committed $158 million to project, which was a 2017 State Election promise.

Upgrades to the Emergency Department, which included 12 new bays configured as a negative-flow area for infectious patients and a Behavioural Assessment Urgent Care Clinic, were completed in November 2021. During 2021-22, the staff car park was expanded with a new level adding an extra 215 parking bays, and construction commenced on a new public multi-storey car park.

Work also commenced on the construction of a new 102-bed Mental Health Unit, which will provide expanded inpatient mental health care to adults aged 25 to 64 years, and also include inpatient services for youths aged 16 to 18 years and older adults over 65 years of age for the first time at JHC. The new state-of-the-art mental health building will help transform and modernise mental health inpatient care in the northern suburbs. When open, the MHU will have 57 adult beds, 10 youth beds, and 10 older adult beds, with another 25 shelled beds for future demand.

The design of the Unit is a result of extensive clinical, architectural, and consumer input, and draws on advances in other units around Australia and internationally. The Unit has been specifically designed to provide a therapeutic environment including multi-purpose lounge and activity areas, outdoor spaces with exercise equipment, and garden space. A contemporary model of care that is recovery based and integrates hospital and community services is being developed in conjunction with consumers and carers.

In addition to the works outlined above, full expansion of Joondalup Health Campus will comprise:

- a new 112 bed public ward block including
  - a 30-bed medical/surgical inpatient ward
  - a 16-bed Cardiac Care Unit (with 6 additional beds and 10 relocated beds)
  - 66 shelled beds to meet future demand
- a Cardiac Catheterisation Laboratory (Cath Lab)
- a new operating theatre
- increased parking bays
- additional upgrades to support infrastructure

Perth's newest Mental Health Unit is under construction at Joondalup Health Campus and will provide a contemporary space for the treatment of people who are acutely mentally unwell

Disclosures and legal compliance

Audit opinion

Auditor General

INDEPENDENT AUDITOR'S REPORT
2022
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 2022, 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 2022 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 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.

Audit opinion

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 the 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.

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 the North Metropolitan Health Service are those policies and procedures established by the Board to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions (the overall control objectives).

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

In my opinion, 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 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 2022.

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.

Audit opinion

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 2022. 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 2022.

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 as the Board determines necessary to enable the preparation of key performance indicators that are free from material misstatement, whether due to fraud or error.

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

Auditor General's 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.

My independence and quality control relating to the reports on financial statements, 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 2022, but not the financial statements, key performance indicators and my auditor's report.

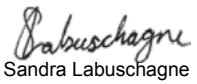
My opinions on the financial statements, controls and key performance indicators does not cover the other information and, accordingly, I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial statements, controls and key performance indicators, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements and key performance indicators, or my knowledge obtained in the audit or otherwise appears to be materially misstated.

If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I did not receive the other information prior to the date of this auditor's report. When I do receive it, I will read it and if I conclude that there is a material misstatement in this information, I am required to communicate the matter to those charged with governance and request them to correct the misstated information. If the misstated information is not corrected, I may need to retract this auditor's report and re-issue an amended report.

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

This auditor's report relates to the financial statements and key performance indicators of the North Metropolitan Health Service for the year ended 30 June 2022 included in the annual report 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 the annual report. If users of the financial statements and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to contact the entity to confirm the information contained in the website version.



Sandra Labuschagne
Deputy Auditor General
Delegate of the Auditor General for Western Australia
Perth, Western Australia
14 September 2022

Certification of financial statements

Disclosures and legal compliance

Financial statements

Certification of financial statements

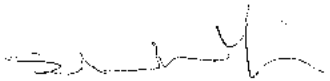
For the reporting period ended 30 June 2022

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 2022 and the financial position as at 30 June 2022.

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

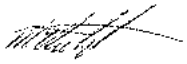
Clinical Professor David Forbes AM
Board Chair
North Metropolitan Health Service

12 September 2022



Steve Toutountzis
Board Member and Finance Committee Chair
North Metropolitan Health Service

12 September 2022



Michael Hutchings
Chief Finance Officer
North Metropolitan Health Service

12 September 2022

Financial statements

Statement of Comprehensive Income

For the year ended 30 June 2022

	Notes	2022 $'000	2021 $'000
COST OF SERVICES			
Expenses			
Employee benefits expense	3.1	1,276,488	1,195,020
Contracts for services	3.2	495,018	486,219
Patient support costs	3.3	371,031	342,814
Finance costs	7.2	698	689
Depreciation and amortisation expense	5.1, 5.2, 5.3, 5.4	70,993	71,528
Loss on disposal of non-current assets	3.7	24	373
Repairs, maintenance and consumable equipment	3.4	63,496	44,503
Other supplies and services	3.5	90,216	79,118
Other expenses	3.6	67,821	59,134
Total cost of services		**2,435,785**	**2,279,398**
INCOME			
Revenue			
Patient charges	4.2	65,168	66,197
Other fees for services	4.3	87,423	81,345
Other grants and contributions	4.4	1,905	2,501
Donation revenue		734	629
Other revenue	4.5	21,457	21,695
Total revenue		**176,687**	**172,367**
Total income other than income from State Government		**176,687**	**172,367**
NET COST OF SERVICES		**2,259,098**	**2,107,031**
Income from State Government			
Department of Health - Service Agreement - State Component	4.1	1,213,634	1,177,916
Department of Health - Service Agreement - Commonwealth Component	4.1	639,391	538,389
Grants and subsidies from Mental Health Commission	4.1	273,523	252,074
Grants from other state government agencies	4.1	1,009	1,078
Assets (transferred)/assumed	4.1	256	788
Services received free of charge	4.1	119,090	105,490
Royalties for Regions Fund	4.1	808	-
Total income from State Government		**2,247,711**	**2,075,735**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(11,387)**	**(31,296)**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.10	111,439	13,306
Total other comprehensive income		**111,439**	**13,306**
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**100,052**	**(17,990)**

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 2022

	Notes	2022 $'000	2021 $'000
ASSETS			
Current Assets			
Cash and cash equivalents	7.3	29,037	52,472
Restricted cash and cash equivalents	7.3	76,765	53,927
Receivables	6.1	53,674	48,054
Inventories	6.3	12,193	7,465
Other current assets	6.4	2,523	2,907
Total Current Assets		**174,192**	**164,825**
Non-Current Assets			
Restricted cash and cash equivalents	7.3	28,462	22,486
Amounts receivable for services	6.2	974,907	904,003
Infrastructure, property, plant and equipment	5.1	1,146,002	1,079,871
Right-of-use assets	5.2	23,795	20,724
Service concession assets	5.3	325,133	254,708
Intangible assets	5.4	3,461	922
Total Non-Current Assets		**2,501,760**	**2,282,714**
TOTAL ASSETS		**2,675,952**	**2,447,539**
LIABILITIES			
Current Liabilities			
Payables	6.5	185,282	177,282
Capital grant liabilities	6.6	4,295	7,757
Lease liabilities	7.1	2,729	2,629
Employee related provisions	3.1	281,683	264,527
Other current liabilities	6.7	1,834	1,889
Total Current Liabilities		**475,823**	**454,084**
Non-Current Liabilities			
Lease liabilities	7.1	23,993	20,248
Employee related provisions	3.1	59,377	56,492
Total Non-Current Liabilities		**83,370**	**76,740**
TOTAL LIABILITIES		**559,193**	**530,824**
NET ASSETS		**2,116,759**	**1,916,715**
EQUITY			
Contributed equity	9.10	1,808,979	1,708,987
Reserves	9.10	298,348	186,909
Accumulated surplus/(deficit)		9,432	20,819
TOTAL EQUITY		**2,116,759**	**1,916,715**

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 2022

	Notes	Contributed equity $'000	Reserves $'000	Accumulated deficit $'000	Total equity $'000
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
Distribution to owners		-	-	-	-
Total		58,812	**-**	**-**	58,812
Balance at 30 June 2021		**1,708,987**	**186,909**	**20,819**	**1,916,715**
Balance at 1 July 2021		1,708,987	186,909	20,819	1,916,715
Surplus/(deficit)		-	-	(11,387)	(11,387)
Other comprehensive income		-	111,439	-	111,439
Total comprehensive income for the year		**-**	**111,439**	**(11,387)**	**100,052**
Transactions with owners in their capacity as owners:	9.10				
Capital appropriations administered by Department of Health		99,992	-	-	99,992
Total		99,992	**-**	.	99,992
Balance at 30 June 2022		**1,808,979**	**298,348**	**9,432**	**2,116,759**

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 2022

	Notes	2022 $'000	2021 $'000
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriation		2,056,656	1,897,170
Capital appropriations administered by Department of Health		99,992	58,812
Royalties for Regions fund		808	-
Net cash provided by State Government		**2,157,456**	**1,955,982**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(1,265,859)	(1,173,415)
Supplies and services		(956,196)	(903,957)
Finance costs		(699)	(689)
Receipts			
Receipts from customers		65,140	61,662
Other grants and contributions		1,905	2,502
Donations received		734	546
Other receipts		100,542	131,732
Net cash used in operating activities	7.3.2	**(2,054,433)**	**(1,881,619)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Payment for purchase of non-current physical and intangible assets		(94,383)	(64,296)
Receipts			
Proceeds from sale of non-current physical assets		78	67
Net cash used in investing activities		**(94,305)**	**(64,229)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Payments for principal element of lease		(3,339)	(3,386)
Net cash used in financing activities		**(3,339)**	**(3,386)**
Net increase/(decrease) in cash and cash equivalents		5,379	6,748
Cash and cash equivalents at the beginning of the year		128,885	122,137
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.3.1	**134,264**	**128,885**

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 2022

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.

These annual financial statements were authorised for issue by the accountable authority of the Health Service on 12 September 2022.

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 TIs)**

3 Australian Accounting Standards **(AASs)** 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.

Accounting for Goods and Services Tax (GST)

Income, expenses and assets are recognised net of the amount of goods and services tax (GST), except that the:

(a) amount of GST incurred by the Agency as a purchaser that is not recoverable from the Australian Taxation Office (ATO) is recognised as part of an asset's cost of acquisition or as part of an item of expense; and

(b) receivables and payables are stated with the amount of GST included.

Cash flows are included in the Statement of cash flows on a gross basis. However, the GST components of cash flows arising from investing and financing activities which are recoverable from, or payable to, the ATO are classified as operating cash flows.

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.

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'.

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

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	
	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
COST OF SERVICES										
Expenses										
Employee benefits expense	648,139	617,698	68,221	65,058	170,542	160,725	211,300	202,661	13,604	13,322
Contracts for services	334,128	320,218	91,090	93,852	19,853	27,780	26,305	23,385	4,347	2,998
Patient support costs	213,297	206,393	14,872	12,385	89,400	83,086	10,204	9,735	2,518	1,876
Finance costs	2	12	-	1	8	9	535	502	2	3
Depreciation and amortisation expense	42,224	42,230	3,603	4,006	9,978	9,870	7,968	7,853	102	92
Loss on disposal of non-current assets	93	233	1	13	2	53	-	4	-	-
Repairs, maintenance and consumable equipment	20,714	17,104	1,603	1,289	8,784	6,338	5,031	4,127	269	171
Other supplies and services	53,178	49,504	5,431	4,980	15,274	13,679	1,000	813	182	45
Other expenses	21,574	17,590	1,777	1,793	5,691	4,110	8,852	9,402	285	231
Total cost of services	**1,333,349**	**1,270,982**	**186,598**	**183,377**	**319,532**	**305,650**	**271,195**	**258,482**	**21,309**	**18,738**
INCOME										
Revenue										
Patient charges	48,161	48,398	1,171	1,308	10,441	10,365	838	917	-	-
Other fees and services	25,334	23,583	-	20	51,915	47,411	132	196	-	-
Other grants and contributions	168	138	4	15	219	166	-	6	1	-
Donation revenue	6	49	-	2	3	20	5	8	-	-
Other revenue	1,142	1,917	52	111	5,060	5,656	315	861	1	-
Total revenue	**74,811**	**74,085**	**1,227**	**1,456**	**67,638**	**63,618**	**1,290**	**1,988**	**2**	**-**
Total income other than income from State Government	**74,811**	**74,085**	**1,227**	**1,456**	**67,638**	**63,618**	**1,290**	**1,988**	**2**	**-**
NET COST OF SERVICES	**1,258,538**	**1,196,897**	**185,371**	**181,921**	**251,894**	**242,032**	**269,905**	**256,494**	**21,307**	**18,738**

2.2 Schedule of Income and Expenses by Service (continued)

	Public Hospital Admitted Patient		Public Hospital Emergency Services		Public Hospital Non-Admitted Services		Mental Health Services		Aged Continuing Care Services	
	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
INCOME FROM STATE GOVERNMENT										
Department of Health - Service Agreement - State Component	729,716	719,172	106,667	109,309	148,486	145,429	7,968	4,419	19,392	17,635
Department of Health - Service Agreement - Commonwealth Component	439,489	359,198	67,114	63,067	86,419	87,999	-	-	4,783	4,708
Grants and subsidies from Mental Health Commission	-	-	-	-	-	-	273,523	252,074	-	-
Grants from other state government agencies	112	285	4	11	52	109	6	-	548	598
Assets (transferred)/assumed	256	442	-	33	-	185	-	-	-	-
Services received free of charge	74,172	70,818	7,630	7,050	18,410	18,279	-	-	-	-
Royalties for regions fund	-	-	-	-	-	-	-	-	-	-
Total income from State Government	**1,243,745**	**1,149,915**	**181,415**	**179,470**	**253,367**	**252,001**	**281,497**	**256,493**	**24,723**	**22,941**
SURPLUS/(DEFICIT) FOR THE PERIOD	**(14,793)**	**(46,982)**	**(3,956)**	**(2,451)**	**1,473**	**9,969**	**11,592**	**(1)**	**3,416**	**4,203**

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

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	
	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
COST OF SERVICES										
Expenses										
Employee benefits expense	68,391	53,824	70,660	70,390	-	-	25,631	11,342	1,276,488	1,195,020
Contracts for services	18,172	16,747	727	843	396	396	-	-	495,018	486,219
Patient support costs	21,934	15,012	18,794	14,293	-	-	12	34	371,031	342,814
Finance costs	139	140	12	22	-	-	-	-	698	689
Depreciation and amortisation expense	4,141	4,895	2,977	2,582	-	-	-	-	70,993	71,528
Loss on disposal of non-current assets	-	28	(72)	42	-	-	-	-	24	373
Repairs, maintenance and consumable equipment	23,398	12,999	3,675	2,449	-	-	22	26	63,496	44,503
Other supplies and services	9,784	5,186	4,639	4,849	-	-	728	62	90,216	79,118
Other expenses	22,816	19,524	6,623	5,995	-	-	203	489	67,821	59,134
Total cost of services	**168,775**	**128,355**	**108,035**	**101,465**	**396**	**396**	**26,596**	**11,953**	**2,435,785**	**2,279,398**
INCOME										
Revenue										
Patient charges	-	-	4,557	5,209	-	-	-	-	65,168	66,197
Other fees and services	5,534	4,712	4,508	5,423	-	-	-	-	87,423	81,345
Other grants and contributions	1,412	2,083	101	93	-	-	-	-	1,905	2,501
Donation revenue	720	550	-	-	-	-	-	-	734	629
Other revenue	14,535	12,705	352	445	-	-	-	-	21,457	21,695
Total revenue	**22,201**	**20,050**	**9,518**	**11,170**	**-**	**-**	**-**	**-**	**176,687**	**172,367**
Total income other than income from State Government	**22,201**	**20,050**	**9,518**	**11,170**	**-**	**-**	**-**	**-**	**176,687**	**172,367**
NET COST OF SERVICES	**146,574**	**108,305**	**98,517**	**90,295**	**396**	**396**	**26,596**	**11,953**	**2,259,098**	**2,107,031**

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	
	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
INCOME FROM STATE GOVERNMENT										
Department of Health - Service Agreement - State Component	108,061	94,009	79,519	78,178	-	396	13,825	9,369	1,213,634	1,177,916
Department of Health - Service Agreement - Commonwealth Component	19,483	11,996	9,690	11,421	-	-	12,413	-	639,391	538,389
Grants and subsidies from Mental Health Commission	-	-	-	-	-	-	-	-	273,523	252,074
Grants from other state government agencies	277	25	10	50	-	-	-	-	1,009	1,078
Assets (transferred)/assumed	-	131	-	-	-	-	-	(3)	256	788
Services received free of charge	13,897	4,874	4,760	4,469	-	-	221	-	119,090	105,490
Royalties for regions fund	-	-	-	-	808	-	-	-	808	-
Total income from State Government	**141,718**	**111,035**	**93,979**	**94,118**	**808**	**396**	**26,459**	**9,366**	**2,247,711**	**2,075,735**
SURPLUS/(DEFICIT) FOR THE PERIOD	**(4,856)**	**2,730**	**(4,538)**	**3,823**	**412**	**-**	**(137)**	**(2,587)**	**(11,387)**	**(31,296)**

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

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	2022 $'000	2021 $'000
Employee benefits expenses	3.1(a)	1,276,488	1,195,020
Employee related provisions	3.1(b)	341,060	321,019
Contracts for services	3.2	495,018	486,219
Patient support costs	3.3	371,031	342,814
Repairs, maintenance and consumable equipment	3.4	63,496	44,503
Other supplies and services	3.5	90,216	79,118
Other expenses	3.6	67,821	59,134

3.1(a) Employee benefits expenses

	2022 $'000	2021 $'000
Wages and salaries	1,165,854	1,094,944
Superannuation - defined contributions plans	110,634	100,076
Total employee benefits expenses	**1,276,488**	**1,195,020**
Add: AASB 16 Non-monetary benefits	1,473	1,760
Less: Employee Contribution	(28)	(36)
Net employee benefits	**1,277,933**	**1,196,744**

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.

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.

	2022 $'000	2021 $'000
Current		
Annual leave [a]	140,131	129,347
Time off in lieu [a]	33,745	30,185
Long service leave [b]	106,226	103,270
Deferred salary scheme [c]	1,581	1,725
	281,683	**264,527**
Non-Current		
Long service leave [b]	59,377	56,492
	59,377	**56,492**
Total employee related provisions	**341,060**	**321,019**

(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:

	2022 $'000	2021 $'000
Within 12 months of the end of the reporting period	93,659	105,291
More than 12 months after the end of the reporting period	80,217	54,241
	173,876	**159,532**

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:

	2022 $'000	2021 $'000
Within 12 months of the end of the reporting period	25,494	17,556
More than 12 months after the end of the reporting period	140,109	142,206
	165,603	**159,762**

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.

3.1(b) Employee related provisions (continued)

(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:

	2022 $'000	2021 $'000
Within 12 months of the end of the reporting period	791	1,035
More than 12 months after the end of the reporting period	790	690
Carrying amount at end of period	**1,581**	**1,725**

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

	2022 $'000	2021 $'000
Public patients services [(a)]	437,321	426,976
Mental Health	33,570	32,687
Other aged-care services	13,190	12,451
Other contracts	10,937	14,105
Total contracts for services	**495,018**	**486,219**

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.

3.3 Patient support costs

	2022 $'000	2021 $'000
Medical supplies and services	260,619	240,706
Pathology services received free of charge	36,083	34,941
Domestic charges	25,282	23,032
Fees for visiting medical practitioners	14,431	14,376
Fuel, light and power	11,429	11,348
Food supplies	10,668	8,628
Patient transport costs	2,604	2,286
Research, development and other grants	9,915	7,497
Total patient support costs	**371,031**	**342,814**

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

3.4 Repairs, maintenance and consumable equipment

	2022 $'000	2021 $'000
Repairs and maintenance	39,775	30,862
Consumable equipment	23,721	13,641
Total repairs, maintenance and consumable equipment	**63,496**	**44,503**

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

	2022 $'000	2021 $'000
Sanitisation and waste removal services	3,118	2,777
Administration and management services	3,879	2,353
Interpreter services	2,784	1,882
Security services	1,567	746
Services provided by Health Support Services: [(a)]		
ICT services	50,650	51,460
Supply chain services	14,518	6,824
Financial services	2,333	2,786
Human resource services	10,139	9,461
Other	1,228	829
Total other supplies and services	**90,216**	**79,118**

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.

3.6 Other expenses

	2022 $'000	2021 $'000
Communications	4,369	4,357
Computer services	3,746	2,249
Workers' compensation insurance	14,155	13,192
Other insurances	13,476	12,636
Consultancy fees	7,267	4,262
Other employee related expenses	6,289	4,541
Printing and stationery	3,930	3,818
Expected credit losses expense	800	662
Freight and cartage	1,453	1,722
Periodical subscriptions	655	772
Motor vehicle expenses	1,568	1,361
General administration	7,004	6,574
Legal expenses	259	105
Rental	1,647	1,339
Other	1,203	1,544
Total other expenses	**67,821**	**59,134**

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 as 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 or 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.

3.7 Loss on disposal of non-current assets

	2022 $'000	2021 $'000
Loss on disposal of non-current assets	24	373
	24	**373**

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	2022 $'000	2021 $'000
Income from State Government	4.1	2,247,711	2,075,735
Patient charges	4.2	65,168	66,197
Other fees for services	4.3	87,423	81,345
Other grants and contributions	4.4	1,905	2,501
Other revenue	4.5	21,457	21,695

4.1 Income from State Government

	2022 $'000	2021 $'000
Appropriation received for the period:		
Department of Health - Service Agreement - State Component	1,213,634	1,177,916
Department of Health - Service Agreement - Commonwealth Component		
- Capital grants	3,245	2,308
- Recurrent grants	636,146	536,081
Grants and subsidies from Mental Health Commission	273,523	252,074
Total appropriation received	**2,126,548**	**1,968,379**
Grants and income from other state government agencies:		
Disability Services Commission	715	598
Recoveries for Insurance Claims from State Government Insurers	78	206
Pathology services to other Health Services	209	31
Other specific grants	7	243
Total grants and subsidies	**1,009**	**1,078**
Assets transferred in	256	788
Total assets assumed	256	788
Resources received from other public sector entities during the period:		
Department of Finance - government leased accommodation	11	18
Department of Primary Industries and Regional Development - COVID contact tracing	143	-
Department of Education - COVID contact tracing	78	-
PathWest - pathology services	36,083	34,941
Services received from Health Support Services (HSS)		
ICT services	50,650	51,460
Supply chain services	14,518	6,824
Financial services	2,333	2,786
Human resources services	10,139	9,461
COVID testing kits	5,135	-
Total received	**119,090**	**105,490**
Regional Community Services Account	808	-
Total Royalties for Regions Fund	**808**	**-**
Total income from State Government	**2,247,711**	**2,075,735**

Following the update to Treasurer's Instruction 1102, revenue is recognised based on the immediate funding source.

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

	2022 $'000	2021 $'000
Inpatient bed charges	43,730	44,507
Inpatient other charges	5,289	4,822
Outpatient charges	16,149	16,868
Total patient charges	**65,168**	**66,197**

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

	2022 $'000	2021 $'000
Recoveries from Commonwealth Government	82,186	76,408
Clinical services to other health organisations	4,210	3,531
Non-clinical services to other health organisations	1,027	1,406
Total other fees for services	**87,423**	**81,345**

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

For example, recoveries from the Pharmaceutical Benefits Scheme (PBS) represent 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.

4.4 Other grants and contributions

	2022 $'000	2021 $'000
Research grants	1,905	2,501
	1,905	**2,501**

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

4.5 Other revenue

	2022 $'000	2021 $'000
Use of hospital facilities	7,320	7,284
Rent from commercial properties	482	335
Rent from residential properties	168	258
Boarders' accommodation	1,958	2,100
RiskCover insurance premium rebate	-	1,945
Sale of radiopharmacies	3,940	3,513
Parking	4,941	4,787
Other	2,648	1,473
Total other revenue	**21,457**	**21,695**

Other revenue items 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.

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	2022 $'000	2021 $'000
Property, plant and equipment	5.1	1,146,002	1,079,871
Depreciation	5.1.1	60,794	58,172
Right-of-use assets	5.2	23,795	20,724
Depreciation	5.2.1	4,114	4,589
Service concession assets	5.3	325,133	254,708
Depreciation	5.3.1	5,820	8,637
Intangible assets	5.4	3,461	922
Amortisation	5.4.1	265	130

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 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 year	**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
Disposal	-	-	-	-	-	(7)	(197)	-	(457)	(584)	-	-	(1,245)
Transfers 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)

	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 2021													
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)
Carrying amount at start of period	**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**
Additions	-	-	13,624	-	3,981	27	623	-	20,063	431	-	-	38,749
Cost Adjustment	-	-	-	-	-	325	(3)	-	208	6	(1,706)	5	(1,165)
Disposals	-	-	-	-	-	-	(38)	-	(67)	(2)	-	-	(107)
Transfers from work in progress	-	22,041	(22,041)	-	-	-	-	-	-	-	-	-	-
Transfers from /(to) other asset classes	-	-	(2,092)	-	-	340	-	-	(340)	-	69	-	(2,023)
Revaluation increments/(decrements)	19,079	88,419	-	-	-	-	-	-	-	-	-	-	107,498
Impairment losses		(16,027)	-	-	-	-	-	-	-	-	-	-	(16,027)
Depreciation	-	(39,301)	-	(3,817)	(451)	(478)	(584)	(31)	(12,539)	(3,593)	-	-	(60,794)
Carrying amount at 30 June 2022	**220,350**	**708,123**	**22,071**	**70,508**	**5,490**	**1,913**	**3,197**	**45**	**60,584**	**52,700**	**706**	**315**	**1,146,002**
Gross carrying amount	220,350	708,123	22,071	93,251	8,579	3,395	5,954	229	126,046	74,556	706	315	1,263,575
Accumulated depreciation	-	-	-	(22,743)	(3,089)	(1,482)	(2,684)	(184)	(65,283)	(21,805)	-	-	(117,270)
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 cost or at 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 2021 by the Western Australian Land Information Authority (Valuations and Property Analytics). The valuations were performed during the year ended 30 June 2022 and recognised at 30 June 2022. In undertaking the revaluation, fair value was determined by reference to market values for land: $4.529 million (2021: $4.215 million) and buildings: $0.367 million (2021: $0.34 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).

5.1.1 Depreciation and impairment

	2022 $'000	2021 $'000
Depreciation		
Buildings	39,301	37,149
Site infrastructure	3,817	3,817
Leasehold improvement	451	483
Computer equipment	478	342
Furniture and fittings	584	519
Motor vehicles	31	24
Medical equipment	12,539	12,219
Other plant and equipment	3,593	3,619
Total depreciation for the period	**60,794**	**58,172**

All surplus assets at 30 June 2022 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.

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.

5.1.1 Depreciation and impairment (continued)

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 2020				
Gross carrying amount	677	23,014	3,062	26,753
Accumulated depreciation	(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 depreciation	(229)	(4,555)	(2,681)	(7,465)
1 July 2021				
Gross carrying amount	706	23,597	3,886	28,189
Accumulated depreciation	(229)	(4,555)	(2,681)	(7,465)
Carrying amount at start of period	**477**	**19,042**	**1,205**	**20,724**
Additions	-	4,971	1,586	6,557
Cost Adjustment	9	14	700	723
Disposals	-	(37)	(58)	(95)
Depreciation	(125)	(2,563)	(1,426)	(4,114)
Carrying amount at 30 June 2022	**361**	**21,427**	**2,007**	**23,795**
Gross carrying amount	715	28,150	4,880	33,745
Accumulated depreciation	(354)	(6,722)	(2,873)	(9,949)

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

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.

5.2 Right-of-use assets (continued)

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.

5.2.1 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.

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

	2022 $'000	2021 $'000
Depreciation expense of right-of-use assets	4,114	4,589
Lease interest expense	698	689
Expenses relating to variable lease payments not included in lease liabilities	6	48
Short-term leases	13	59
Low-value leases	6	-
Total amount recognised in the statement of comprehensive income	**4,837**	**5,385**

The total cash outflow for leases in 2022 was $4,062,000 (2021: $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.

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 2020									
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)
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)
1 July 2021									
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)
Carrying amount at start of period	**28,500**	**181,609**	**29,930**	**13,447**	**64**	**1,027**	**114**	**17**	**254,708**
Additions	-	-	55,825	-	-	-	441	11	56,277
Transfers from Work in Progress	-	17,055	(17,055)	-	-	-	-	-	-
Revaluation increments/(decrements)	3,300	16,668	-	-	-	-	-	-	19,968
Depreciation	-	(4,660)	-	(816)	(32)	(205)	(98)	(9)	(5,820)
Carrying amount at 30 June 2022	**31,800**	**210,672**	**68,700**	**12,631**	**32**	**822**	**457**	**19**	**325,133**
Gross carrying amount	31,800	210,731	68,700	14,120	128	1,952	5,105	66	332,602
Accumulated depreciation	-	(59)	-	(1,489)	(96)	(1,130)	(4,648)	(47)	(7,469)

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

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

5.3.1 Depreciation and impairment of service concession assets

	2022 $'000	2021 $'000
Charge for the period		
Buildings	4,660	3,969
Site infrastructure	816	337
Computer equipment	32	32
Furniture and fittings	205	719
Medical equipment	98	3,549
Other plant and equipment	9	31
Total depreciation for the period	**5,820**	**8,637**

5.3.1 Depreciation and impairment of 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
Computer equipment	4 to 10 years
Furniture and fittings	5 to 20 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 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 2022 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 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)
Year ended 30 June 2022			
1 July 2021			
Gross carrying amount	1,462	-	1,462
Accumulated amortisation	(540)	-	(540)
Carrying amount at start of year	**922**	**-**	**922**
Additions	781	-	781
Transfers from /(to) other asset classes	2,023	-	2,023
Amortisation expense	(265)	-	(265)
Carrying amount at 30 June 2022	**3,461**	**-**	**3,461**
Gross carrying amount	4,227	-	4,227
Accumulated amortisation	(766)	-	(766)

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

	2022 $'000	2021 $'000
Computer software	265	130
Total amortisation for the period	**265**	**130**

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.

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	2022 $'000	2021 $'000
Receivables	6.1	53,674	48,054
Amounts receivable for services	6.2	974,907	904,003
Inventories	6.3	12,193	7,465
Other current assets	6.4	2,523	2,907
Payables	6.5	185,282	177,282
Capital grant liabilities	6.6	4,295	7,757
Other liabilities	6.7	1,834	1,889

6.1 Receivables

	2022 $'000	2021 $'000
Current		
Trade receivables	32,391	34,326
Other receivables	606	472
Allowance for impairment of trade receivables	(11,880)	(13,349)
Accrued revenue	22,733	18,291
GST receivable	9,824	8,314
Total current receivables	**53,674**	**48,054**

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

	2022 $'000	2021 $'000
Reconciliation of changes in the allowance for impairment of trade receivables		
Balance at start of period	13,349	29,944
Expected credit losses expense	800	804
Amounts written off during the period	(2,269)	(17,399)
Balance at end of period	**11,880**	**13,349**

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

	2022 $'000	2021 $'000
Current	-	-
Non-current	974,907	904,003
Balance at end of period	**974,907**	**904,003**

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

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

6.3 Inventories

	2022 $'000	2021 $'000
Current		
Pharmaceutical stores - at cost	11,156	6,954
Engineering stores - at cost	1,037	511
Total inventories	**12,193**	**7,465**

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

	2022 $'000	2021 $'000
Current		
Prepayments	2,523	2,907
Total other current assets	**2,523**	**2,907**

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

	2022 $'000	2021 $'000
Current		
Trade payables	10,794	10,036
Other payables	2,109	17,145
Accrued expenses	137,747	120,443
Accrued salaries	34,632	29,658
Total current payables	**185,282**	**177,282**

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 Capital grant liabilities

	2022 $'000	2021 $'000
Current	4,295	7,757
Non-current	-	-
Total capital grant liabilities	**4,295**	**7,757**

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

6.7 Other current liabilities

	2022 $'000	2021 $'000
Refundable deposits	1,198	1,188
Paid parental leave scheme	226	203
Other	410	498
Total other current liabilities	**1,834**	**1,889**

7 Financing

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

	Notes	2022 $'000	2021 $'000
Lease liabilities	7.1	26,722	22,877
Finance costs	7.2	698	689
Cash and cash equivalents	7.3		
Cash and cash equivalents	7.3.1	29,037	52,472
Restricted cash and cash equivalents	7.3.1	105,227	76,413
Reconciliation of net cost of services to net cash used in operating activities	7.3.2	(2,054,433)	(1,881,619)
Capital commitments	7.4	325,535	282,194

7.1 Lease liabilities

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

	2022 $'000	2021 $'000
Lease liabilities		
Current	2,729	2,629
Non-current	23,993	20,248
Total lease liabilities	**26,722**	**22,877**

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.

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

	2022 $'000	2021 $'000
Lease interest expense	698	689
Finance costs expensed	**698**	**689**

7.3 Cash and cash equivalents

7.3.1 Reconciliation of cash

	2022 $'000	2021 $'000
Cash and cash equivalents	29,037	52,472
Restricted cash and cash equivalents	105,227	76,413
Balance at end of period	**134,264**	**128,885**
Restricted cash and cash equivalents		
Current		
Grants from State and Commonwealth Governments	18,021	8,982
Other specific purposes [(a)]	47,307	43,667
Mental Health Commission funding [(b)]	11,437	1,278
Total current	**76,765**	**53,927**
Non-current		
Accrued salaries suspense account [(c)]	28,462	22,486
Total non-current	**28,462**	**22,486**
Balance at end of period	**105,227**	**76,413**

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.

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

	Notes	2022 $'000	2021 $'000
Net cost of services		(2,259,098)	(2,107,028)
Non-cash items:			
Expected credit losses expense	3.6	800	804
Depreciation and amortisation expense	5	70,993	71,526
Net loss from disposal of non-current assets	3.7	24	374
Net donation of non-current assets		-	(83)
Services received free of charge	4.1	119,090	105,490
(Increase)/decrease in assets:			
GST receivable		(1,510)	291
Receivables		(4,910)	19,268
Inventories		(4,728)	(398)
Other current assets		384	(823)
Increase/(decrease) in liabilities:			
Payables		7,999	7,578
Capital grant liabilities		(3,462)	4,853
Current employee related provisions		17,155	21,462
Non-current employee related provisions		2,885	(4,834)
Other current liabilities		(55)	(99)
Net cash used in operating activities		**(2,054,433)**	**(1,881,619)**

7.4 Capital commitments

The commitments below are inclusive of GST where relevant.

	2022 $'000	2021 $'000
Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows:		
Within 1 year	183,808	95,280
Later than 1 year and not later than 5 years	141,727	186,914
	325,535	**282,194**

8 Risks and Contingencies

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

	Notes
Financial risk management	8.1
Contingent assets	8.2.1
Contingent liabilities	8.2.2
Fair value measurements	8.3

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.

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:

	2022 $'000	2021 $'000
Financial assets		
Cash and cash equivalents	134,264	128,885
Financial assets at amortised cost	1,018,757	943,743
Total financial assets	**1,153,021**	**1,072,628**
Financial liabilities		
Financial liabilities measured at amortised cost	212,004	200,159
Total financial liabilities	**212,004**	**200,159**

(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 2022						
Expected credit loss rate		0.78%	1.62%	3.92%	16.50%	62.48%
Estimated total gross carrying amount at default	32,391	8,040	3,468	1,579	789	18,515
Expected credit losses	(11,880)	(63)	(56)	(62)	(130)	(11,569)

			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)

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
2022											
Financial Assets											
Cash and cash equivalents	-	134,264	-	-	134,264	134,264	134,264	-	-	-	-
Receivables [(a)]	-	43,850	-	-	43,850	43,850	43,850	-	-	-	-
Amounts receivable for services	-	974,907	-	-	974,907	974,907	-	-	-	-	974,907
		1,153,021	**-**	**-**	**1,153,021**	**1,153,021**	**178,114**	**-**	**-**	**-**	**974,907**
Financial Liabilities											
Payables	-	185,282	-	-	185,282	185,282	185,282	-	-	-	-
Lease liabilities [(b)]	2.54	26,722	26,722	-	-	33,310	322	641	2,552	10,853	18,942
		212,004	**26,722**	**-**	**185,282**	**218,592**	**185,604**	**641**	**2,552**	**10,853**	**18,942**
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	-	-	-	-
Lease liabilities [(b)]	2.33	22,877	22,877	-	-	28,572	291	587	2,409	8,791	16,494
		200,159	**22,877**	**-**	**177,282**	**205,854**	**177,573**	**587**	**2,409**	**8,791**	**16,494**

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

(b) The nominal amounts disclosed are the calculated undiscounted cash flow of lease liabilities. The nominal value of lease liabilities for 2021 has been restated from $22,877 million to $28,572 million.

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:

	2022 $'000	2021 $'000
Litigation in progress		
Pending litigation that may be recoverable on settlement of claims from former employee	1,061	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:

	2022 $'000	2021 $'000
Litigation in progress		
Pending litigation that is not recoverable from RiskCover insurance and may affect the financial position of the Health Service	610	800
Number of claims	3	2

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
2022				
Assets measured and recognised at fair value:				
Land				
Residential	-	39		39
Specialised	-	4,490	247,621	252,111
Buildings				
Residential and commercial car park	-	167	18,378	18,545
Specialised	-	200	900,050	900,250
	-	**4,896**	**1,166,049**	**1,170,945**
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**

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.

8.3 Fair value measurements (continued)

Fair value measurements using significant unobservable inputs (Level 3)

	Land $'000	Buildings $'000	Total $'000
2022			
Fair value at start of period	225,556	834,260	1,059,816
Additions and transfers from work in progress	-	39,037	39,037
Revaluation increments/(decrements)	22,065	89,025	111,090
Depreciation	-	(43,894)	(43,894)
Fair value at end of period	**247,621**	**918,428**	**1,166,049**
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**

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 (Level 3 fair values)

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

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.

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

On 31 July 2022, the Western Australia government announced enhancements to the public sector wages policy to include a one-off $2,500 cost of living payment. As a result of this announcement, the members of the Australian Medical Association working for the Health Service will receive an aggregate estimated payout of $3,325,000 in the new financial year.

9.2 Changes in accounting policy

The following standards are operative for reporting periods ended on or after 30 June 2022:

- AASB 1060 – General Purpose Financial Statements – Simplified Disclosures for For-Profit and Not-for-Profit Tier 2 Entities
- AASB 2020-5 Amendments to Australian Accounting Standards – Insurance Contracts
- AASB 2020-7 Amendments to Australian Accounting Standards – Covid-19-Related Rent Concessions: Tier 2 Disclosures
- AASB 2021-1 – Amendments to Australian Accounting Standards – Transition to Tier 2: Simplified Disclosures for Not-for-Profit Entities
- AASB 2021-3 Amendments to Australian Accounting Standards – Covid-19-Related Rent Concessions beyond 30 June 2021

The Health Service considers the above standards do not have material impact on these financial statements.

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 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**
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**

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

		Operative for reporting periods beginning on/after
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 2021-6	*Amendments to Australian Accounting Standards – Disclosure of Accounting Policies: Tier 2 and Other Australian Accounting Standards* This standard amends This standard amends: (a) AASB 1049, to require entities to disclose their material accounting policy information rather than their significant accounting policies; (b) AASB 1054 to reflect the updated accounting policy terminology used in AASB 101 Presentation of Financial Statements; and (c) AASB 1060 to required entities to disclose their material accounting policy information rather than their significant accounting policy and to clarify that information about measurement bases for financial instruments is expected to be material to an entity's financial statements. There is no financial impact.	**1 Jan 2023**
AASB 2021-7	*Amendments to Australian Accounting Standards – Effective Date of Amendments to AASB 10 and AASB 128 and Editorial Corrections*. This standard further defers (to 1 January 2025) the amendments to AASB 10 and AASB 128 relating to the sale or contribution of assets between an investor and its associated or joint venture. The standard also includes editorial corrections. There is no financial impact.	**1 Jan 2022**

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

	2022	2021
Compensation band ($)		
$10,001 – $20,000	1	1
$40,001 – $50,000	7	9
$60,001 – $70,000	-	1
$80,001 – $90,000	1	-
	9	**11**

	2022 $'000	2021 $'000
Short-term employee benefits	386	446
Post-employment benefits	39	42
	425	**488**

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:

	2022	2021
Compensation band ($)		
$50,001 – $60,000	-	1
$60,001 – $70,000	1	-
$90,001 – $100,000	1	-
$150,001 – $160,000	1	-
$190,001 – $200,000	1	1
$200,001 – $210,000	1	-
$210,001 – $220,000	-	1
$220,001 – $230,000	2	-
$230,001 – $240,000	-	1
$240,001 – $250,000	2	2
$250,001 – $260,000	1	-
$260,001 – $270,000	-	1
$320,001 – $330,000	-	1
$340,001 – $350,000	1	-
$430,001 – $440,000	1	-
$460,001 – $470,000	1	-
$490,001 – $500,000	-	1
$500,001 – $510,000	-	1
$580,001 – $590,000	-	1
$600,001 – $610,000	1	-
	14	**11**

9.4 Key management personnel (continued)

	2022 $'000	2021 $'000
Short-term employee benefits	3,112	2,803
Post-employment benefits	298	249
Other long-term benefits	337	323
Total compensation of senior officers	**3,747**	**3,375**

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.

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.

	2022 $'000	2021 $'000
Balance at start of period	1,278	367
Add receipts		
Service delivery arrangement:		
Commonwealth contributions	96,126	87,631
State contributions	177,397	162,032
Other	-	2,411
	273,523	252,074
Less Payments	(263,364)	(251,163)
Balance at end of period	**11,437**	**1,278**

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:

	2022 $'000	2021 $'000
Auditing the accounts, controls, financial statements and key performance indicators	379	330
	379	**330**

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.

	2022 $'000	2021 $'000
Balance at start of period	1,708,987	1,650,175
Contribution by owners		
Capital Appropriations administered by Department of Health	99,992	58,812
	1,808,979	**1,708,987**
Balance at end of period	**1,808,979**	**1,708,987**

	2022 $'000	2021 $'000
Asset revaluation reserve		
Balance at the start of period	186,909	173,603
Net revaluation increments/(decrements):		
Land	22,379	155
Buildings	89,060	13,151
Balance at end of period	**298,348**	**186,909**

9.11 Supplementary financial information

(a) Write-offs

	2022 $'000	2021 $'000
Revenue and debts written off under the authority of the Accountable Authority	2,269	17,399
	2,269	**17,399**

(b) Losses through theft, defaults and other causes

	2022 $'000	2021 $'000
Losses of public monies and public or other property through theft or default	2	96
Less amount recovered	(2)	(57)
Net losses	**-**	**39**

(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:

	2022 $'000	2021 $'000
Department of Justice - dental treatment	1,919	1,410
Disability Services Commission - dental treatment	1,872	1,643
	3,791	**3,053**

9.12 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:

	2022 $'000	2021 $'000
Balance at the start of period	173	195
Add Receipts	690	850
Less Payments	(697)	(872)
Balance at the end of period	**166**	**173**

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

	2022 $'000	2021 $'000
RF Shaw Foundation		
Balance at start of period	1,106	1,225
Less Payments	(1,100)	(119)
Balance at the end of period	**6**	**1,106**

Trust Accounts are used by the Health Service to account for funds that the Health Service 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.

10 Explanatory statements for controlled operations

This explanatory section explains variations in the financial performance of the Health Service undertaking transactions under its own control, as represented by the primary financial statements.

All variances between annual estimates (original budget) and actual results for 2022, and between the actual results for 2022 and 2021 are shown below. Narratives are provided for key major variances which vary more than 10% from their comparative and that the variation is more than 1% of the:

- Total Cost of Services based on the lower of the estimate or the prior year actual for the Statement of Comprehensive Income and Statement of Cash Flows (1% of $2,187,989,000), and
- Total Assets based on the lower of the estimate or the prior year actual for the Statement of Financial Position (1% of $2,447,539,000).

Statement of Comprehensive Income Variances

	Variance Notes	Estimate 2022 $'000	Actual 2022 $'000	Actual 2021 $'000	Variance between actual and estimate $'000	Variance between actual results for 2022 and 2021 $'000
COST OF SERVICES						
Expenses						
Employee benefits expense	1	1,130,442	1,276,488	1,195,020	146,046	81,468
Contracts for services		486,871	495,018	486,219	8,147	8,799
Patient support costs	2	331,058	371,031	342,814	39,973	28,217
Finance costs		615	698	689	83	9
Depreciation and amortisation expense		68,630	70,993	71,528	2,363	(535)
Loss on disposal of non-current assets		412	24	373	(388)	(349)
Repairs, maintenance and consumable equipment	3	41,007	63,496	44,503	22,489	18,993
Other supplies and services		71,853	90,216	79,118	18,363	11,098
Other expenses		57,101	67,821	59,134	10,720	8,687
Total cost of services		**2,187,989**	**2,435,785**	**2,279,398**	**247,796**	**156,387**
INCOME						
Revenue						
Patient charges		71,586	65,168	66,197	(6,418)	(1,029)
Other fees for services		65,954	87,423	81,345	21,469	6,078
Other grants and contributions		-	1,905	2,501	1,905	(596)
Donation revenue		36	734	629	698	105
Other revenue		18,991	21,457	21,695	2,466	(238)
Total revenue		**156,567**	**176,687**	**172,367**	**20,120**	**4,320**
Total income other than income from State Government		**156,567**	**176,687**	**172,367**	**20,120**	**4,320**
NET COST OF SERVICES		**2,031,422**	**2,259,098**	**2,107,031**	**227,676**	**152,067**
INCOME FROM STATE GOVERNMENT						
Department of Health - Service Agreement - State Component	4	1,045,087	1,213,634	1,177,916	168,547	35,718
Department of Health - Service Agreement - Commonwealth Component	5,a	715,209	639,391	538,389	(75,818)	101,002
Grants and subsidies from Mental Health Commission	6	180,126	273,523	252,074	93,397	21,449
Grants from other state government agencies		837	1,009	1,078	172	(69)
Assets (transferred)/assumed		-	256	788	256	(532)
Services received free of charge	7	89,755	119,090	105,490	29,335	13,600
Royalties for Regions Fund		410	808	-	398	808
Total income from State Government		**2,031,424**	**2,247,711**	**2,075,735**	**216,287**	**171,976**
Surplus/(deficit) for the period		**-**	**(11,387)**	**(31,296)**	**(11,389)**	**19,909**
Other comprehensive income						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve		-	111,439	13,306	111,439	98,133
Total other comprehensive income		**-**	**111,439**	**13,306**	**111,439**	**98,133**
Total comprehensive income for the period		**-**	**100,052**	**(17,990)**	**100,050**	**118,042**

Statement of Financial Position Variances

	Variance Notes	Estimate 2022 $'000	Actual 2022 $'000	Actual 2021 $'000	Variance between actual and estimate $'000	Variance between actual results for 2022 and 2021 $'000
ASSETS						
Current assets						
Cash and cash equivalents		53,176	29,037	52,472	(24,139)	(23,435)
Restricted cash and cash equivalents		46,560	76,765	53,927	30,205	22,838
Receivables		48,054	53,674	48,054	5,620	5,620
Inventories		7,465	12,193	7,465	4,728	4,728
Other current assets		2,907	2,523	2,907	(384)	(384)
Total Current Assets		**158,162**	**174,192**	**164,825**	**16,030**	**9,367**
Non-current assets						
Restricted cash and cash equivalents		28,274	28,462	22,486	188	5,976
Amounts receivable for services		972,634	974,907	904,003	2,273	70,904
Infrastructure, property, plant and equipment		1,151,777	1,146,002	1,079,871	(5,775)	66,131
Right-of-use assets		18,883	23,795	20,724	4,912	3,071
Service concession assets	8, b	247,718	325,133	254,708	77,415	70,425
Intangible assets		922	3,461	922	2,539	2,539
Total non-current assets		**2,420,208**	**2,501,760**	**2,282,714**	**81,552**	**219,046**
Total assets		**2,578,370**	**2,675,952**	**2,447,539**	**97,582**	**228,413**
LIABILITIES						
Current liabilities						
Payables		177,174	185,282	177,282	8,108	8,000
Capital grant liabilities		1,636	4,295	7,757	2,659	(3,462)
Lease liabilities		2,558	2,729	2,629	171	100
Employee related provisions		264,529	281,683	264,527	17,154	17,156
Other current liabilities		1,890	1,834	1,889	(56)	(55)
Total current liabilities		**447,787**	**475,823**	**454,084**	**28,036**	**21,739**
Non-current liabilities						
Lease liabilities		18,964	23,993	20,248	5,029	3,745
Employee related provisions		56,492	59,377	56,492	2,885	2,885
Total non-current liabilities		**75,456**	**83,370**	**76,740**	**7,914**	**6,630**
Total liabilities		**523,243**	**559,193**	**530,824**	**35,950**	**28,369**
NET ASSETS		**2,055,127**	**2,116,759**	**1,916,715**	**61,632**	**200,044**
EQUITY						
Contributed equity		1,881,073	1,808,979	1,708,987	(72,094)	99,992
Reserves		174,053	298,348	186,909	124,295	111,439
Accumulated surplus/(deficit)		-	9,432	20,819	9,432	(11,387)
Total equity		**2,055,126**	**2,116,759**	**1,916,715**	**61,633**	**200,044**

	Variance Notes	Estimate 2022 $'000	Actual 2022 $'000	Actual 2021 $'000	Variance between estimate and actual $'000	Variance between actual results for 2022 and 2021 $'000
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriation		1,872,628	2,056,656	1,897,170	184,028	159,486
Capital appropriations administered by Department of Health	c	106,146	99,992	58,812	(6,154)	41,180
Royalties for Regions Fund		410	808	-	398	808
Net cash provided by State Government		**1,979,184**	**2,157,456**	**1,955,982**	**178,272**	**201,474**
Utilised as follows:						
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits	1	(1,124,654)	(1,265,859)	(1,173,415)	(141,205)	(92,444)
Supplies and services		(897,656)	(956,196)	(903,957)	(58,540)	(52,239)
Finance costs		(615)	(699)	(689)	(84)	(10)
Receipts						
Receipts from customers		71,586	65,140	61,662	(6,446)	3,478
Other grants and contributions		-	1,905	2,502	1,905	(597)
Donations received		36	734	546	698	188
Other receipts	d	84,945	100,542	131,732	15,597	(31,190)
Net cash used in operating activities		**(1,866,358)**	**(2,054,433)**	**(1,881,619)**	**(188,075)**	**(172,814)**
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Payment for purchase of non-current physical and intangible assets	c	(106,558)	(94,383)	(64,296)	12,175	(30,087)
Receipts						
Proceeds from sale of non-current physical assets		-	78	67	78	11
Net cash used in investing activities		**(106,558)**	**(94,305)**	**(64,229)**	**12,253**	**(30,076)**
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Payments for principal element of lease		(1,355)	(3,339)	(3,386)	(1,984)	47
Net cash used in financing activities		**(1,355)**	**(3,339)**	**(3,386)**	**(1,984)**	**47**
Net increase/(decrease) in cash and cash equivalents		4,913	5,379	6,748	466	(1,369)
Cash and cash equivalents at the beginning of the year		128,885	128,885	122,137	-	6,748
Cash transferred to other health agencies as part of demergers		(5,788)	-	-	5,788	-
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**128,010**	**134,264**	**128,885**	**6,254**	**5,379**

10 Explanatory statements for controlled operations (continued)

Major Estimate and Actual (2022) Variance Narratives:

1) Employee benefits expense
   - Additional funding received for service provision including funding for COVID, escalation not fully funded and increase in FTE to support service provision - $146.0M; FTEs were engaged as part of NMHS's response to COVID-19, with these FTEs engaged to support vaccination service provision, COVID-19 clinics, and management of COVID-19 in hospital settings

2) Patient support costs
   - Additional funding received throughout the financial year including COVID, escalation not fully funded - $40.0M; COVID-19 expenditure is associated with additional Personal Protective Equipment needed by staff at NMHS, and additional pathology testing

3) Repairs, maintenance and consumable equipment
   - Actual expenses are higher than Estimate mainly due to additional funding for maintenance works on buildings and plant & equipment and for the purchases of medical and computing equipment

4) Department of Health - Service Agreement - State Component
   - Additional cash in respect of budget transfers - $150.0M
   - Additional cash received from Department of Health above budget levels - $17.8M
   - Reduced cash in respect of Commonwealth received in lieu from prior year - $1.6M
   - Increase in depreciation accruals - $2.3M

   NMHS received additional Activity Based Funding over the course of the financial year resulting from the Mid-year Review and Budget processes, noting the original estimates are based on the initial budget allocation received by NMHS; additionally, NMHS received supplementary State funding towards its COVID-19 related costs in recognition of these input cost pressures

5) Department of Health - Service Agreement - Commonwealth Component
   - Funding of $77.4M advised by Department of Health in Service Agreement as being of Commonwealth source was subsequently recorded as Mental Health Commission Grants & Subsidies

   NMHS received additional Commonwealth funding towards its COVID-19 related costs.

6) Grants and subsidies from Mental Health Commission
   - Funding of $77.4M advised by Department of Health in Service Agreement as being of Commonwealth source was subsequently recorded as Mental Health Commission Grants & Subsidies
   - Additional funding from Mental Health Commission Agreement - $16.0M with this funding provided by the Commission towards a range of community mental health programs

7) Services received free of charge
   - Actual is higher than Estimate mainly due to additional $14.0M of costs incurred by Health Support Services (HSS) to support the Finance, Human Resources, Information Technology and Supply & Procurement functions of the Health Service as a result of COVID;
   - Additional fundings of $5.4M for the supply of rapid antigen test kits and $10.0M to support expanded cost of service provisions by HSS and Pathwest also resulted in higher Actual than Estimate

8) Service concession assets
   - The Actual service concession assets balance is higher than Estimate due to revaluation gain of $20.0M for land and buildings as well as additional buildings under construction works worth $55.8M at Joondalup Health Campus Stage 2 development

Major Actual (2022) and Comparative (2021) Variance Narratives:

a) Department of Health - Service Agreement - Commonwealth Component
- Additional funding for COVID - $23.0M
- Additional funding for ABF activities - $73.1M

b) Service concession assets
- The increase in service concession assets balance by $70.4M is due to revaluation gain of $20.0M for land and buildings as well as additional buildings under construction works worth $55.8M at Joondalup Health Campus Stage 2 development, offset by depreciation charges of $5.8M

c) Capital appropriation administered by Department of Health and Payment for purchase of non-current physical and intangible assets
- The increase in capital appropriations administered by Department of Health compared with last year is largely due to the JHC Stage 2 development as evidenced by additions of nearly $55.8M in building works in progress during the year

d) Other receipts
- Other receipts decreased in line with lower receipts from non-patient receivables and accrued income

Certification of key performance indicators

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

Disclosures and Legal Compliance

Certification of Key Performance Indicators

For the reporting period ended 30 June 2022

We hereby certify that 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 2022.

Clinical Professor David Forbes AM
Board Chair
North Metropolitan Health Service

Date 12.9.2022

Steve Toutountzis
Board Member and NMHS Board Finance Committee Chair
North Metropolitan Health Service

Date 12-9-2022

Detailed information in support of key performance indicators

The following pages outline detailed information in support of our performance against the Outcome Based Management (OBM) Framework (see 'Outcome Based Management Framework' section).

Tables 1 to 16 – Outcome 1

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

Tables 17 to 23 – Outcome 2

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

Material changes in KPI definitions and cost allocation methodologies in accordance with the OBM framework are noted where applicable. The latest available data has been used to report performance, which in some instances means results are for the 2021 calendar year as opposed to the financial year.

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[22].These readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

Readmission rate is considered a global performance measure, as it potentially points to deficiencies in the functioning of the overall healthcare system. Along with 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 seven surgeries selected for this indicator are based on those in the current National Healthcare Agreement Unplanned Readmission performance indicator (NHA PI 23).

Target

Please see the 2021 targets for each surgical procedure in Table 1. Performance is achieved by a result below, or equal to, the target.

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

Results

In 2021, the rate of unplanned readmissions within 28 days achieved target for hip replacement (Table 1). All other surgical procedure indicators did not meet target. The number of surgical procedures completed fluctuate, 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 nine knee replacement patients that readmitted, some were admitted for monitoring and observation or for pain management. To assist in monitoring patient outcome measures, sites participate in the Australian Orthopaedic Association Joint Registry.

There were six readmissions for hip replacement of which some were for infection and some were admitted for conservative wound management. Cases are reviewed, tabled and discussed; outcomes did not indicate any clinical concerns.

Of the 27 tonsillectomy and adenoidectomy patients that readmitted, most had post-operative bleeding and were admitted for monitoring and were discharged without the need for further intervention. To improve patient outcomes, updated pre- and post- operative patient information have been implemented. This includes outlining the expected and acceptable blood loss post-operation in the post-operative material.

Hysterectomy had 29 readmissions and high complexity and co-morbidities were recognised as a significant influencing factor. Readmissions continue to be proactively addressed in collaboration with relevant areas to identify opportunities for improvement related to data collection and clinical practice.

There were 11 readmissions for prostatectomy procedures across sites, most were for haematuria monitoring and did not require further surgical treatment.

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

Appendicectomy had 23 readmissions of which some were for infection or pain management. Patients are often monitored overnight, treated conservatively and discharged home. Processes for antibiotic prescription and management of post-operative pain are being reviewed.

Table 1: Unplanned hospital readmissions for patients within 28 days for selected surgical procedures (per 1,000 separations), 2017–21

	Calendar year						
Surgical procedure	**2017** (per 1,000)	**2018** (per 1,000)	**2019** (per 1,000)	**2020** (per 1,000)	**2021** (per 1,000)	**Target** (per 1,000)	**Target met**
Knee replacement	36.1	27.0	13.1	34.9	23.4	≤ 23.0	×
Hip replacement	21.3	14.4	14.7	7.2	14.2	≤ 17.1	✓
Tonsillectomy and adenoidectomy	112.4	102.7	149.2	157.2	150.0	≤ 81.8	×
Hysterectomy	45.5	51.9	40.2	38.3	54.6	≤ 42.3	×
Prostatectomy	45.5	48.9	46.5	25.4	42.8	≤ 36.1	×
Cataract surgery	2.0	1.1	1.2	1.6	2.1	≤ 1.1	×
Appendicectomy	18.4	33.5	46.9	33.6	27.3	≤ 25.7	×

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

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[23]. 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.

Ambulatory Surgery Initiative cases meeting the definition of a reportable procedure are included in reporting.

Target

The 2021/22 target is zero per cent. Performance is achieved by a result equal to the target.

Results

In 2021/22, all urgency categories for elective surgery wait list patients waiting over boundary did not meet target (Table 2). During the year, NMHS experienced challenges associated with demand, capacity, staff furlough and health system restrictions.

In 2021, elective surgery was scaled back across the public health system to prepare hospital capacity for COVID-19 from 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.

Elective surgery was also scaled back from 1 September to 30 September with similar restrictions due to continuing overarching pressures across the public health system on emergency departments.

In 2022, elective surgery was scaled back across the public health system to prepare hospital capacity for COVID-19 from 14 March to 8 May. WA Health hospitals were permitted to continue Category 1 elective procedures while reviewing Category 2 elective surgeries and proceeding with cases deemed urgent whilst maintaining a maximum weekly cap of 95 procedures. All Category 3 elective surgeries were postponed during these periods.

Compared to 2018/19, demand for all Category 1 elective surgery has increased by 52 percent. Category 1 was impacted by demand pressures and the reduction in available lists due to reduced capacity related to bed pressures, ageing infrastructure and staff furlough.

Backlog in Category 1 has led to a delay in Category 2 and 3 patients being undertaken.

NMHS sites and services have developed initiatives and plans to clear the backlog of elective surgeries, have additional theatre sessions scheduled where possible, weekend lists and engagement with contracted health entities to address over boundary cases. Performance and strategies continue to be monitored.

Table 2: Percentage of elective waitlist patients waiting over boundary for reportable procedures, 2017/18–2021/22

	Financial year						
Urgency category	**2017-18 (%)**	**2018-19 (%)**	**2019-20 (%)**	**2020-21 (%)**	**2021-22 (%)**	**Target (%)**	**Target met**
Category 1 over 30 days	6	8	8	11	15	0	×
Category 2 over 90 days	7	8	13	14	26	0	×
Category 3 over 365 days	3	5	8	5	10	0	×

Data sources: Elective Services Waitlist Data Collection.

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%[24]).

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 2021 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 2021, HA-SABSI per 10,000 occupied bed-days in public hospitals achieved target (Table 3). Implementation of strategies to promote hand hygiene and aseptic techniques have assisted in achieving target.

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

Table 3: Healthcare-associated Staphylococcus aureus bloodstream infections (HA-SABSI) per 10,000 occupied bed-days, 2017–21

	Calendar year						
	2017 (per 10,000)	2018 (per 10,000)	2019 (per 10,000)	2020 (per 10,000)	2021 (per 10,000)	Target (per 10,000)	Target met
HA-SABSI	0.7	1.0	0.8	0.6	0.5	≤ 1.0	✓

Data sources: Healthcare Infection Surveillance WA Data Collection.

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 three 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 2021 targets for each condition in Table 4, Table 5 and Table 6. Performance is achieved by a result above, or equal to, the target.

Results

In 2021, the survival rates for all stroke patient age group cohorts did not meet target (Table 4). Survival rates are impacted by severity of disease on admission and patients with multiple comorbidities. It should be noted that NMHS provides the Statewide Neurological Intervention and Imaging Service. Strategies to improve outcomes include revising stroke unit pathways, implementing audits of key performance parameters, coordinated care across departments, rehabilitation at home and outpatient care.

Table 4: Survival rate for stroke, 2017–21

	Calendar year						
Age group (years)	**2017 (%)**	**2018 (%)**	**2019 (%)**	**2020 (%)**	**2021 (%)**	**Target (%)**	**Target met**
0 to 49	93.5	92.8	94.6	94.4	93.7	≥ 95.2	×
50 to 59	91.8	92.2	91.5	92.6	91.3	≥ 94.9	×
60 to 69	92.0	93.1	88.4	89.9	91.6	≥ 94.1	×
70 to 79	91.2	88.7	91.3	87.6	89.2	≥ 92.3	×
80+	86.1	84.6	86.7	85.8	85.3	≥ 86.0	×

Data source: Hospital Morbidity Data Collection.

The survival rates for patients with AMI achieved target for age groups 0 to 49, 50 to 59 and 60 to 69 (Table 5). 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 5: Survival rate for acute myocardial infarction, 2017–21	Calendar year						
Age group (years)	**2017 (%)**	**2018 (%)**	**2019 (%)**	**2020 (%)**	**2021 (%)**	**Target (%)**	**Target met**
0 to 49	99.1	96.9	98.9	98.6	100.0	≥ 99.1	✓
50 to 59	98.9	97.9	99.0	99.4	98.8	≥ 98.8	✓
60 to 69	96.9	97.7	97.8	99.1	98.6	≥ 98.1	✓
70 to 79	96.6	96.3	97.7	97.1	94.0	≥ 96.8	×
80+	91.6	91.2	88.4	90.5	90.9	≥ 92.1	×

Data source: Hospital Morbidity Data Collection.

Survival rates for patients with FNOF for all age group cohorts did not meet target (Table 6). Review of cases have been completed and no specific issues were identified.

Table 6: Survival rate for fractured neck of femur, 2017–21	Calendar year						
Age group (years)	**2017 (%)**	**2018 (%)**	**2019 (%)**	**2020 (%)**	**2021 (%)**	**Target (%)**	**Target met**
70 to 79	100.0	95.9	97.7	98.0	96.9	≥ 98.9	×
80+	96.6	95.2	96.2	97.1	95.5	≥ 96.9	×

Data source: Hospital Morbidity Data Collection.

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[25] and have been found to cost the health system 50% more than patients who are discharged by their physician[26].

Between July 2015 and June 2017, Aboriginal patients (3.4%) in WA were over 11 times more likely than non-Aboriginal patients (0.3%) to discharge against medical advice, compared with 6.2 times nationally (3.1% and 0.5% respectively)[27]. 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.

Discharge against medical advice performance measures is also one of the key contextual indicators of Outcome 1 "Aboriginal and Torres Strait Islander people enjoy long and healthy lives" under the new National Agreement on Closing the Gap, which was agreed to by the Coalition of Aboriginal and Torres Strait Islander Peak Organisations, and all Australian Governments in July 2020.

Target

Please see the 2021 targets for Aboriginal and non-Aboriginal patients in Table 7. Performance is achieved by a result below, or equal to, the target.

Results

In 2021, the percentage of admitted patients who DAMA achieved target for non-Aboriginal patients while Aboriginal patients did not meet target (Table 7). Case reviews indicate that Aboriginal patients commonly DAMA due to family/community responsibilities or social factors. Aboriginal Health Liaison Officers are available, however not all patients choose to use the service or when the DAMA occurs outside standard business hours when the service is unavailable. The Aboriginal Health Liaison team receive an electronic alert when DAMA occurs after hours or on the weekend to ensure all patients are followed up. Several strategies have been initiated and are being progressed. Performance and strategies continue to be monitored.

All non-Aboriginal DAMA patients are followed up and performance continues to be monitored.

Table 7: Percentage of admitted patients who discharged against medical advice, 2017–21

	Calendar year						
	2017 (%)	2018 (%)	2019 (%)	2020 (%)	2021 (%)	Target (%)	Target met
Aboriginal	3.36	3.81	3.73	3.92	3.46	≤ 2.78	×
Non-Aboriginal	0.76	0.75	0.80	0.76	0.74	≤ 0.99	✓

Data sources: Hospital Morbidity Data Collection.

Percentage of liveborn 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 1, 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 0 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 (2020) Health, Standard 16/09/2020.

Target

The 2021 target for liveborn term infants with an Apgar score of less than 7 at five minutes post-delivery is ≤ 1.8 per cent. Performance is achieved by a result below, or equal to, the target.

Results

In 2021, the percentage of liveborn infants with an Apgar score of less than 7 at five minutes post-delivery achieved target (Table 8). Clinical audits are reviewed and disseminated for continued quality improvement.

Table 8: Percentage of liveborn term infants with an Apgar score of less than 7 at five minutes post-delivery, 2017–21

	Calendar year						
Live births	**2017 (%)**	**2018 (%)**	**2019 (%)**	**2020 (%)**	**2021 (%)**	**Target (%)**	**Target met**
Apgar Score < 7	1.6	2.0	1.5	1.7	1.7	≤ 1.8	✓

Data sources: Midwives Notification System.

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

Rationale

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

While multiple hospital admissions over a lifetime may be necessary for someone with ongoing illness, a high proportion of readmissions shortly after discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was not adequate to maintain the patient's recovery out of hospital[28].

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 2021 target is ≤ 12 per cent 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 2021, the rate of readmissions to acute specialised mental health inpatient service within 28 days of discharge did not meet target (Table 9). 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. Patients also often readmit as part of their management or crisis plan. Robust processes remain in place and all readmissions continue to be reviewed.

Table 9: Readmissions to acute specialised mental health inpatient services within 28 days of discharge, 2017–21

	Calendar year						
	2017 (%)	2018 (%)	2019 (%)	2020 (%)	2021 (%)	Target (%)	Target met
Readmission rate	18	16	15	15	15	≤ 12	×

Data sources: Hospital Morbidity Data Collection.

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

Rationale

In 2017-18, 1 in 5 (4.8 million) Australians reported having a mental or behavioural condition[29]. 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 2021 target is ≥ 75 per cent. Performance is achieved by a result above, or equal to, the target.

Results

In 2021, the percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services achieved target (Table 10).

All records of non-compliance continue to be reviewed and performance continues to be monitored.

Table 10: Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services, 2017–21

	Calendar year						
	2017 (%)	2018 (%)	2019 (%)	2020 (%)	2021 (%)	Target (%)	Target met
Post-discharge community care	66	71	72	84	86	≥ 75	✓

Note: Comparison to prior years should be approached with caution due to a methodology update. From 2019, the definition is aligned to the national definition and is inclusive of community contacts with patients' carers/next of kin.
Data sources: Mental Health Information Data Collection; Hospital Morbidity Data Collection.

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 2021-22 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 2021-22 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

Target

The 2021/22 target is $6,907 per WAU. Performance is achieved by a result below, or equal to, the target.

Results

In 2021/22, the average admitted cost per WAU did not meet target (Table 11).The target is based on the initial budget allocation received, and over the course of the year additional Activity Based Funding budget allocations are provided via the Mid-year Review and Budget processes. In addition, the impacts of elective surgery restrictions, and reduced activity achievement combined with a focus on COVID-19 capacity and response mean higher costs are retained that have had an adverse impact on this indicator.

Table 11: Average admitted cost per weighted activity unit, 2017/18–2021/22

	Financial year						
	2017-18 ($)	2018-19 ($)	2019-20 ($)	2020-21 ($)	2021-22 ($)	Target ($)	Target met
Average cost	6,793	6,891	7,215	7,080	7,715	≤ 6,907	×

Note: In line with WA Health's Outcome Based Management Framework and aligned to WA Health's 2022/23 Budget Statements, 2021/22 reflects an updated methodology to exclude the allocation of financial products and prior year results have been recast for comparability.
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.

Average emergency department 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 2021-22 Budget Paper No. 2, Volume 1.

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

Target

The 2021/22 target is $6,847 per WAU. Performance is achieved by a result below, or equal to, the target.

Results

In 2021/22, the average emergency department cost per WAU did not meet target (Table 12). The target is based on the initial budget allocation received, and over the course of the year additional Activity Based Funding budget allocations are provided via the Mid-year Review and Budget processes. In addition, reduced activity achievement combined with a focus on COVID-19 capacity and response mean higher costs are retained that have had an adverse impact on this indicator.

Table 12: Average emergency department cost per weighted activity unit, 2017/18–2021/22

	Financial year						
	2017-18 ($)	**2018-19 ($)**	**2019-20 ($)**	**2020-21 ($)**	**2021-22 ($)**	**Target ($)**	**Target met**
Average cost	5,975	6,066	6,729	6,646	7,129	≤ 6,847	×

Note: In line with WA Health's Outcome Based Management Framework and aligned to WA Health's 2022/23 Budget Statements, 2021/22 reflects an updated methodology to exclude the allocation of financial products and prior year results have been recast for comparability.
Data sources: OBM Allocation application; Oracle 11i financial system; Emergency Department Data Collection.

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 2021-22 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 2021/22 target is $6,864 per WAU. Performance is achieved by a result below, or equal to, the target.

Results

In 2021/22, the average non-admitted cost per WAU did not meet target (Table 13). The target is based on the initial budget allocation received, and over the course of the year additional Activity Based Funding budget allocations are provided via the Mid-year Review and Budget processes. In addition, the flow-on impacts of elective surgery restrictions, and reduced activity achievement combined with a focus on COVID-19 capacity and response mean higher costs are retained that have had an adverse impact on this indicator.

Table 13: Average non-admitted cost per weighted activity unit, 2017/18–2021/22

	Financial year						
	2017-18 ($)	**2018-19 ($)**	**2019-20 ($)**	**2020-21 ($)**	**2021-22 ($)**	**Target ($)**	**Target met**
Average cost	7,028	6,763	7,081	6,785	7,258	≤ 6,864	×

Note: In line with WA Health's Outcome Based Management Framework and aligned to WA Health's 2022/23 Budget Statements, 2021/22 reflects an updated methodology to exclude the allocation of financial products and prior year results have been recast for comparability.
Data sources: OBM Allocation application; Oracle 11i financial system; Non-Admitted Patient (NAP) Data Collection.

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

Rationale

Specialised mental health inpatient services provide patient care in authorised 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 2021/22 target is $1,484 per bed-day in specialised mental health inpatient services. Performance is achieved by a result below, or equal to, the target.

Results

In 2021/22, the average cost per bed-day in specialised mental health inpatient services did not meet target (Table 14). The target is based on the initial budget allocation received, and over the course of the year additional Activity Based Funding budget allocations are provided via the Mid-year Review and Budget processes. In addition, reduced activity achievement combined with a focus on COVID-19 capacity and response mean higher costs are retained that have had an adverse impact on this indicator.

Table 14: Average cost per bed-day in specialised mental health inpatient services, 2017/18–2021/22

	Financial year						
	2017-18 ($)	2018-19 ($)	2019-20 ($)	2020-21 ($)	2021-22 ($)	Target ($)	Target met
Average cost	1,421	1,442	1,494	1,439	1,595	≤ 1,484	×

Note: In line with WA Health's Outcome Based Management Framework and aligned to WA Health's 2022/23 Budget Statements, 2021/22 reflects an updated methodology to exclude the allocation of financial products and prior year results have been recast for comparability.
Data sources: OBM Allocation application; Oracle 11i financial system; BedState.

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 2021/22 target is $435 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 2021/22, the average cost per treatment day of non-admitted care provided by mental health services achieved target (Table 15).

Table 15: Average cost per treatment day of non-admitted care provided by mental health services, 2017/18–2021/22

	Financial year						
	2017-18 ($)	2018-19 ($)	2019-20 ($)	2020-21 ($)	2021-22 ($)	Target ($)	Target met
Average cost	464	425	395	372	412	≤ 435	✓

Note: In line with WA Health's Outcome Based Management Framework and aligned to WA Health's 2022/23 Budget Statements, 2021/22 reflects an updated methodology to exclude the allocation of financial products and prior year results have been recast for comparability.
Data sources: OBM Allocation application; Oracle 11i financial system; Mental Health Information Data Collection.

Percentage of emergency department patients seen within recommended times *(unaudited performance indicator)*

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[31].

This performance indicator measures the percentage of patients being assessed and treated within the required ATS time frames. 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 2021/22 targets for ED patients seen within recommended times by triage category as per the Australasian College for Emergency Medicine are as follows:

Results

In 2021/22, 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 16).

Compared to prior year (2020-21), ED presentations have decreased by 4.7 percent. The results were impacted and limited by the WA Health COVID-19 Framework for System Alert and Response, workforce shortages and demand pressures, particularly around issues with patient flow.

Cases are reviewed and NMHS sites continue to focus on strategies to improve emergency access and patient flow and will be further supported by the NMHS Hospital Emergency Access Response Team program and system-wide Emergency Access program.

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.

Table 16: Percentage of emergency department patients seen within recommended times, by triage category, 2016/17–2021/22	Financial year						
Triage category	**2017-18 (%)**	**2018-19 (%)**	**2019-20 (%)**	**2020-21 (%)**	**2021-22 (%)**	**Target (%)**	**Target met**
1	100	100	100	100	100	100	✓
2	80	76	80	78	72	≥ 80	×
3	43	45	51	40	28	≥ 75	×
4	59	57	64	54	41	≥ 70	×
5	92	85	87	82	76	≥ 70	✓

Data source: Emergency Department Data Collection.

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%[30].

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 2020-21 target is ≥ 70 per cent 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 2020 to 2021, the rate of women aged 50-69 years who participated in breast screening did not meet target (Table 17). BreastScreen WA service capacity was significantly reduced in 2020 due to COVID-19.

Services were suspended on 30 March 2020 until a staged restart on 29 April 2020 and did not return to full capacity until June 2020.

During this time, operations were also adversely affected by well above normal levels of cancellations and unattended appointments as clients became concerned about COVID-19 health safety.

BreastScreen WA are testing initiatives to increase the participation of Aboriginal women and are working with the University of Western Australia to develop initiatives to increase the screening of women with obesity.

Table 17: Rate of women aged 50-69 years who participate in breast screening, 2017–18–2020–21

	Calendar years					
	2017-18 (%)	2018-19 (%)	2019-20 (%)	2020-21 (%)	Target (%)	Target met
Participation rate	56	55	50	50	≥ 70	×

Note: This measure counts the women screened within a 24-month period (1 January 2020 to 31 December 2021) as it is recommended that women in the cohort attend the free screening every two years. Population based on the 2020 Western Australia population. ABS estimated resident population for 2021 was not available at time of preparation.
Data sources: BreastScreen WA Register; Australian Bureau of Statistics

Percentage of adults and children who have a tooth retreated 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 2021/22 targets for adults and children in Table 18. Performance is achieved by a result below the target.

Results

In 2021/22, the percentage of adults and children who have a tooth retreated within 6 months of receiving initial restorative dental treatment achieved target (Table 18).

Maintained performance was attributable to training provided to Dental Health Service 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 18: Percentage of adults and children who have a tooth retreated within 6 months of receiving initial restorative dental treatment, 2017/18–2021/22

	Financial year						
	2017-18 (%)	2018-19 (%)	2019-20 (%)	2020-21 (%)	2021-22 (%)	Target (%)	Target met
Adults	6.0	6.1	5.8	5.6	5.9	< 7.7	✓
Children	2.2	2.1	2.0	1.9	1.9	< 2.6	✓

Note: Prior financial 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).

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 wellbeing of Western Australian children.

Target

The 2021/22 target is ≥ 78 per cent. Performance is achieved by a result above, or equal to, the target.

Results

In 2021/22, the percentage of eligible children who are enrolled in the School Dental Service program did not meet target (Table 19).

Performance was impacted by the on-going interventions in response to the COVID-19 pandemic. Engagement with parents to enrol children into the program were impacted by staff absences due to COVID-19 and there were challenges in recruiting dentists and dental therapists in multiple country locations due to the COVID-19 border closures.

Table 19: Percentage of eligible school children who are enrolled in the School Dental Service program, 2017/18–2021/22

	Financial year						
	2017-18 (%)	2018-19 (%)	2019-20 (%)	2020-21 (%)	2021-22 (%)	Target (%)	Target met
Eligible school children who are enrolled in the School Dental program	79	79	77	77	75	≥ 78	×

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.

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 wellbeing of Western Australians with the greatest need.

Target

The 2021/22 target is ≥ 15 per cent. Performance is achieved by a result above, or equal to, the target.

Results

In 2021/22, the percentage of eligible people who accessed Dental Health Services did not meet target (Table 20).

On 3 March 2022, the WA Health COVID-19 Framework for System Alert and Response (SAR) alert level moved to red and Dental Health Service clinics were required to defer routine care and only provide urgent care. Later changes to the SAR alert level allowed for the provision of routine care with compulsory safeguards such as Rapid Antigen Testing and 30-minute fallow time. These safeguards increased appointment time allocations for dental procedures and consequently impacted patient access.

Table 20: Percentage of eligible people who accessed Dental Health Services, 2017/18–2021/22

	Financial year						
	2017-18 (%)	2018-19 (%)	2019-20 (%)	2020-21 (%)	2021-22 (%)	Target (%)	Target met
Eligible people who accessed Dental Health Services	15	14	14	14	13	≥ 15	×

Note: Eligible people are defined as those who hold a current Pension Concession Card (Centrelink) or Health Care Card. Eligible people who access a public dental service or receive treatment through a participating private dental practitioner. Australian Government funded dental health services activity provided through the Child Dental Benefits Schedule is included.
Data sources: Dental Information Management (DenIM) database; Commonwealth Department of Social Services (DSS) Payment Demographic data.

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 2021/22 target is $57. Performance is achieved by a result below, or equal to, the target.

Results

In 2021/22, the average cost per person of delivering population health programs by population health units did not meet target (Table 21). The target is set based on the initial budget allocation received, and over the course of the year additional budget allocations are provided via the Mid-Year review and Budget processes. The costs in 2021/22 are impacted by higher COVID-19 costs relating to vaccine costs.

Table 21: Average cost per person of delivering population health programs by population health units, 2017/18–2021/22

	Financial year						
	2017-18 ($)	2018-19 ($)	2019-20 ($)	2020-21 ($)	2021-22 ($)	Target ($)	Target met
Average cost	49	49	67	64	97	≤ 57	×

Note: In line with WA Health's Outcome Based Management Framework and aligned to WA Health's 2022/23 Budget Statements, 2021/22 reflects an updated methodology to exclude the allocation of financial products and prior year results have been recast for comparability.
Data sources: OBM Allocation application; Oracle 11i financial system; WA Department of Health Epidemiology Directorate.

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 2021/22 target is $144 per breast screening. Performance is achieved by a result below, or equal to, the target.

Results

In 2021/22, the average cost per breast screening did not meet target (Table 22).

Table 22: Average cost per breast screening, 2017/18–2021/22

	Financial year						
	2017-18 ($)	2018-19 ($)	2019-20 ($)	2020-21 ($)	2021-22 ($)	Target ($)	Target met
Average cost	152	145	156	154	153	≤ 144	×

Note: In line with WA Health's Outcome Based Management Framework and aligned to WA Health's 2022/23 Budget Statements, 2021/22 reflects an updated methodology to exclude the allocation of financial products and prior year results have been recast for comparability.
Data sources: OBM Allocation application; Oracle 11i financial system; Mammography Screening Register; BreastScreen WA.

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 2021/22 targets for patient groups in Table 23. Performance is achieved by a result below, or equal to, the target.

Results

In 2021/22, the average cost per patient visit of WA Health-provided dental health programs did not meet target for school children and socio-economically disadvantaged adults (Table 23).

Performance was impacted by the on-going interventions in response to the COVID-19 pandemic. On 3 March 2022, the WA Health COVID-19 Framework for System Alert and Response Framework (SAR) alert level moved to red and Dental Health Service clinics were required to defer routine care and only provide urgent care. Later changes to the SAR alert level allowed for the provision of routine care with compulsory safeguards such as Rapid Antigen Testing and 30 minute fallow time. These safeguards increased appointment time allocations for dental procedures and consequently impacted patient access.

Staff absences due to COVID-19 and challenges in recruiting dentists and dental therapists in multiple country locations due to the COVID-19 border closures also contributed to fewer patient visits.

It is difficult for Dental Health Services to respond to immediate changes that negatively impact service provision as costs are largely fixed in advance.

Table 23: Average cost per patient visit of WA Health-provided dental health programs for school children and socio-economically disadvantaged adults, 2017/18–2021/22	Financial year						
Average cost	**2017-18 ($)**	**2018-19 ($)**	**2019-20 ($)**	**2020-21 ($)**	**2021-22 ($)**	**Target ($)**	**Target met**
School children	193	190	230	219	302	≤ 235	×
Socio-economically disadvantaged adults	263	264	288	284	365	≤ 321	×

Note: In line with WA Health's Outcome Based Management Framework and aligned to WA Health's 2022/23 Budget Statements, 2021/22 reflects an updated methodology to exclude the allocation of financial products and prior year results have been recast for comparability.
Data sources: OBM Allocation application; Oracle 11i financial system; Dental Information Management (DenIM) database.

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. We did not receive any Ministerial Directives during the 2021/22 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

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.

Capital works

Major Asset Investment Program works in progress 2021/22

Notes:
1. The information above is based upon the 2022/23 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. The above table excludes all state-wide projects

Initiative	Estimated total cost	Estimated Expenditure to 30/6/22	Estimated Total to Completion	Project Status
	(a)	(b)	=(a)- (b)	
	$'000	$'000	$'000	
Replacement of Biplanar Digital Angiography Units	3,800	350	3,450	Ongoing
Refurbishment works for Biplanar Units at SCGH	7,634	0	7,634	New / Ongoing
Joondalup Health Campus Development stage 2	254,503	90,165	164,338	Ongoing
King Edward Memorial Hospital Critical Infrastructure	34,023	7,552	26,471	Ongoing
New Women and Newborn Hospital	10,222	1,827	8,395	Ongoing
Reconfiguring the Western Australian Spinal Cord Injury Service	574	174	400	Ongoing
Sarich Neuroscience Research Institute Centre.	35,265	34,854	411	Completed
Sir Charles Gairdner Hospital – 24 Hospital Beds	18,500	8,400	10,100	Ongoing
Sir Charles Gairdner Hospital – Cardiac Catheter Laboratory and Interventional Radiology Rooms Upgrade	8,851	7,835	1,016	Ongoing
Sir Charles Gairdner Hospital – ED Upgrade and Behavioural Assessment Urgent Care Centre	21,014	1,685	19,329	Ongoing
Sir Charles Gairdner Hospital – GMP Laboratories and Cyclotron	31,769	3,664	28,105	Ongoing
Sir Charles Gairdner Hospital – Image Guided Theatre	12,100	500	11,600	Ongoing
Special Needs Dental Clinic Relocation	3,270	350	2,920	Ongoing
Cladding – QEII Medical Centre	16,027	0	16,027	New / Ongoing
Albany General Dental Clinic	10,490	0	10,490	New / Ongoing
Sir Charles Gairdner Hospital – ICU	16,678	0	16,678	New / Ongoing

Employee disclosures

Industrial relations

We strive to implement and support flexible, fair, and productive work practices.

Our Industrial Relations (IR) consultants maintain close links with professional groups including all WA Department of Health Unions, the System Manager Department of Health, and the WA Health system IR network, ensuring contemporary IR practices and approaches are applied in NMHS.

In the past year, ongoing support and industrial advice was provided regarding application of industrial instrument provisions, consultation frameworks related to change management projects, and the implementation of Health Worker (Restrictions on Access) Directions.

Major activities in 2021/22 included:

COVID-19 health worker mandatory vaccination directions

A key IR focus was the requirement for mandatory vaccination against COVID-19 across our sites and services.

This required significant resources in support of WA system-wide vaccination requirements, consulting and working in collaboration with the WA Department of Health and other Health Service Providers to apply a robust process to ensure vaccination compliance across our workforce. The IR team implemented the COVID-19 Mandatory Vaccination and Vaccination Program Policy, including drafting correspondence, policy, and guidelines within a constantly changing landscape and providing advice and leadership for our executives and managers. IR also delivered training sessions and workshops for managers and executives to ensure a consistent application of the requirements.

WA Health system Industrial Agreements negotiations and renewal

Another key IR matter for us was negotiating for several replacement WA Department of Health industrial agreements expiring in 2022, including those covering nurses, midwives, doctors, and patient support services staff.

The IR team facilitated stakeholder forums with executives and managers relating to industrial agreement provisions and areas for reform. IR provided feedback including reform initiatives arising from consultation with the WA Department of Health and attended subsequent state-wide Bargaining Consultative Workshops to discuss stakeholder feedback.

Conversion to Permanency Provisions

We are committed to the permanent and direct employment of staff. Dedicated resources within IR continue to apply conversion to permanency assessments for eligible fixed-term contract and casual employees using industrial agreement provisions. Advice and support are also provided to executives and managers on other mechanisms for permanent employment, such as provisions under the Commissioner's Instruction No.2, Filling a Public Sector Vacancy. Measures have been implemented to ensure the continued focus for the reduction of insecure employment engagements and the priority for permanent employment.

Employment profile

The following table shows the number of our full-time equivalent (FTE) employees for 2021/22.

Total FTE employees by category

Category	Definition	2021/22	%
Nursing and midwifery	All nursing and midwifery occupations, excluding agency nurses and midwives	3,299	35.7%
Administration and clerical	All clerical-based occupations including patient-facing (ward) clerical support employees	1,607	17.4%
Medical support	All allied health and scientific/technical related occupations	1,448	15.7%
Medical salaried and sessional	All medical occupations including interns, registrars and specialist medical practitioners	1,316	14.2%
Hotel services	Includes catering, cleaning, stores/supply laundry and transport occupations	789	8.5%
Dental clinic assistants	Dental clinic assistants	308	3.3%
Site services	Engineering, garden and security-based occupations	199	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	132	1.4%
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care	112	1.2%
Agency nursing and midwifery	Workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest	20	0.2%
Other occupations	Including, but not limited to, Aboriginal and ethnic health employees	8	0.1%
Total FTE employees	9,239	100	19,329

Recognition and awards

Our Staff Recognition Program (SRP) allows high performing employees to receive the recognition they deserve from management and their peers. We have an SRP to recognise and reward dedicated individuals, teams and volunteers who help to 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 North Executive Team. The SRP is sponsored by our Platinum sponsors Paywise, Smartsalary, HESTA, and P&N Bank, and is delivered in three streams:

- NMHS Going the Extra Mile Awards
- Employee of the Month, Season, and Quarter Awards
- Long Service Awards.

NMHS Going the Extra Mile 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 service every day. In its third year, the GEM Awards continued to draw nominations from appreciative colleagues who could shine a light on their outstanding peers.

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, enhancing the patient experience, establishing strong partnerships and engagement, and driving innovation.

The GEM Awards provide a valuable opportunity to showcase the great work being done throughout our service and celebrate our exceptional staff. The 2022 GEM finalists will be celebrated at an event on 29 July, with a total of 38 finalists.

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 our 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 Osborne Park Hospital – 4 awards (quarterly)
- Mental Health, Public Health, Dental Service – 6 awards (Noongar Aboriginal seasons – bi-monthly)
- Sir Charles Gairdner Hospital and Women and Newborn Health Service – 12 awards (monthly)

NMHS Long Service Awards

Our Long Service Awards recognise staff members who have completed continuous service at any of our sites or services in 10, 20, 30 and 40-year increments. We recognised 612 employees in 2021.

10 years – 405
20 years – 132
30 years – 60
40 years – 15

Our 2021 MHPHDS Long Service Award Winners

Employee development

In line with our Strategic Priority of 'trusted, engaged and capable people', we are striving to create a learning organisation. We are committed to building the capability of our people, including leaders and managers, to drive a high performing values-based culture to meet current and future challenges.

All employees have the opportunity to participate in professional development and career aspiration conversations as part of a Performance Development Review and create a Development Plan. Training and development opportunities are planned based on identified development needs.

In addition, all employees undertake mandatory training to address risks to both patients and staff, to better provide safe and sustainable health care, and a safe working environment. Mandatory training includes modules in accountable and ethical decision making, Aboriginal cultural awareness, emergency procedures, manual tasks, clinical deterioration and basic life support, hand hygiene, and management of aggression.

Our Learning and Development team works in partnership with each site education and training committee to focus on training and developing skills and capabilities which support our health service and the community.

NMHS provides in-house training and education to ensure staff have the appropriate skills and knowledge to fulfill their clinical and non-clinical roles. This equates to thousands of training sessions each year, at all our metropolitan sites, as well as to regional staff within WA, such as Broome, Busselton, Albany, Geraldton, and Kalgoorlie.

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. Where physical training was essential, it was modified to comply with safe-practice and social distancing rules and with full PPE as required. There was also significant focus on refreshing COVID-19 related training to ensure our people were well-prepared to deal with any subsequent outbreaks. Induction training increased more than two and a half times the normal rate to manage the increased demand for healthcare staff. In the first quarter of 2022, over 650 new staff were inducted into the organisation.

We provided a wide range of in-house training and leadership development programs to employees as well as brokering external training as required. As a Registered Training Organisation, we offered nationally recognised programs such as the Diploma of Leadership and Management with over 100 staff participants.

Additional programs supported our managerial and supervisory staff. This training focused on equipping managers with the leadership skills required to recruit, manage, and develop their staff. An online program for people managers was developed to build capability in the practicalities of people management.

In addition, more than 450 of our staff completed the 12-hour Mental Health First Aid training, a course focused on recognising and supporting colleagues inside (and outside) the workplace, and staff also have access to the Recognise, Respond and Refer (early identification and intervention on health and wellbeing issues) eLearning package. Other programs include training in communication skills, emotional intelligence, job application and interview skills, recruitment, and stress resilience.

Over 200 eLearning packages have been sourced, developed and maintained on the online Moodle platform. A dedicated eLearning team develops new eLearning training and continually updates existing packages as well as being available to offer online support and respond to questions. We have been preparing for a new Learning Management System, MyLearning, which is planned to be rolled out in late 2022.

Workers compensation

We have a system in place to manage Workers Compensation claims and the provision of injury management services to facilitate early treatment and return to work. We also focus on education and promotion of health and wellbeing to help prevent injuries occurring.

Injury Management Consultants (IMCs) are engaged with injured workers and their managers immediately upon notification of a potential injury, to provide timely support and offer suitable pathways including our Early Intervention Program (EIP) or claiming for Workers Compensation (WC). The EIP, which provides funding and coordination of early treatment for workers with work related injuries, has been running for several years. Reporting has shown increased worker uptake of this initiative, positive feedback from users, and beneficial outcomes. Our IMCs manage most our WC claims in-house and follow evidence informed best practice to achieve return to work outcomes in a supportive, collaborative model in line with medical evidence. Early results are showing positive outcomes in an extremely challenging environment.

Employee rehabilitation programs extend to non-compensable injuries where there is a risk of exacerbation in the workplace or a requirement to provide expert advice to facilitate the employee's safe return to work, which is supported by our Occupational Health Physician and OSH Clinic staff following the Fitness for Work Referral pathway.

We have worked to improve the management of electronic records, case notes, and relevant information for injury management, early intervention and Fitness for Work programs. This will enable in-depth interrogation of data to further inform improvement activities in the Injury Management and Work Health and Safety spaces.

Injury Management is supported by a Wellbeing Team who coordinate and implement proactive initiatives to promote health and wellbeing and prevent injury such as a Peer Support Network. We have also implemented a formal process for Critical Incident Debriefing to alleviate stress from traumatic workplace incidents. We are working to improve the understanding of psychosocial risk factors and implementing preventative and first response controls to reduce and address the impact on workers.

Our methods and proactive approach have resulted in a significant decrease in worker's compensation claims from 311 in 2020-21 to 251 in 2021/22.

Number of NMHS Workers Compensation claims 2021/22

Nursing & midwifery services/dental clinic	110
Administration and clerical	25
Medical (support)	27
Hotel services	65
Maintenance	18
Medical (salaried)	6

Claims by body location

Head	19
Lower limbs	46
Multiple locations	22
Neck	5
Non-physical locations (e.g. nervous, digestive)	18
Trunk (including back)	6
Unspecified locations	0
Upper limbs	60

Total 251

Governance disclosures

Board and committee remuneration

Board/Committee	Total renumeration ($)
NMHS Board	378,861
WNHS Community Advisory Council	13,151
SCGH Community Advisory Council	5,205
Mental Health Consumer Advisory Committee	280

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	12	3 years	75,987	83,585
Deputy Chair	Rebecca Strom	Per annum	12	3 years	41,792	45,971
Member	Angela Edwards	Per annum	12	3 years	41,792	45,971
Member	Anthony Evans	Per annum	5	3 years	17,681	19,449
Member	Hilary Fine	Per annum	12	3 years	41,792	45,971
Member	Paul Norman	Per annum	12	3 years	41,792	45,971
Member	Steve Toutountzis	Per annum	12	3 years	41,792	45,971
Member	Paula Rogers	Per annum	12	3 years	41,792	45,971
					Total	**378,861**

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	Sonja Whimp	Per hour	12 months (Chair since Aug-22)	Sessional	35	4,788
Deputy Chair	Joanne Beedie	Per hour	12 months (Deputy chair since Aug-22)	Sessional	35	1,068
Member	Nicole Woods	Per hour	12 months	sessional	35	735
Member	Amanda Hocking	Per hour	12 months	sessional	35	700
Member	Caitlin Kameron	Per hour	12 months	sessional	35	490
Member	Gail Yarran	Per hour	12 months	sessional	35	210
Member	Gemma Cadby	Per hour	6 months	sessional	35	630
Member (Carer)	Jenny Bedford	Per hour	12 months	sessional	35	455
Member	Angela Cooney	Per hour	12 months	sessional	35	720
Member	Jacquie Garton-Smith	Per hour	12 months	Sessional	35	720
Member	Pamela Thompson	Per hour	12 months	Sessional	35	720
Member	Sarah Paton	Per hour	12 months	Sessional	35	480
Member	Anne McRae	Per hour	12 months	Sessional	35	945
Member	Yien Peng Chin	Per hour	12 months	Sessional	35	480
					Total	**13,151**

SCGH Community Advisory Council

Position title	Member name	Type of remuneration	Period of membership	Term of appointment/ tenure	Base salary/ sitting fees	Gross/actual remuneration for financial year
Chair	Tanya Basile	Nil	12	Sessional	-	-
Deputy Chair	Christine Cullen	Nil	12	Sessional	-	-
Member	Anne-Marie Fanning	Nil	12	Sessional	-	-
Member	Carole Kagi	Per hour	6	Sessional	$35	$210
Member	Carolyn Boyd	Per hour	1	Sessional	$35	$35
Member	Elizabeth Mills	Per hour	5	Sessional	$35	$175
Member	Howard Lance	Per hour	6	Sessional	$35	$210
Member	Jay Jay Jegathesan	Per hour	7	Sessional	$35	$245
Member	Judy Russell	Per hour	2	Sessional	$35	$70
Member	Karen Tambree	Per hour	6	Sessional	$35	$210
Member	Oluwaseun Bakare	Per hour	2	Sessional	$35	$105
					Total	**$1,260**

Mental Health Consumer Advisory Committee

Position Title	Member Name	Type of remuneration*	Period of membership, months**	Term of Appointment / Tenure***	Base Salary / Sitting Fees	Gross/actual remuneration ($)
Chair	Alan Alford	No Payment	12 years	2 years	35	
Deputy Chair	Phoebe RM Kingston	No Payment	5 years	2 years	35	
Member	Seamus P Murphy	Per hour	6 years	2 years	35	70
Member	Virgina Caterall	Per hour	3 years	2 years	35	140
Member	Sonja Whimp	Per hour	3 years	2 years	35	70
Member	Ronnie Deng	No Payment	3 years	2 years	35	
Member	Lynett M Murphy	No Payment	3 years	2 years	35	
Member	Nathan Issel	No Payment	4 years	2 years	35	
Member	Shauna Gaebler	No Payment	6 years	2 years	35	
Member	Mei Huang	No Payment	5 years	2 years	35	
Member	Marisha H Gerovich	No Payment	2 year	2 years	35	
Member	Lachlan Rodenburg	No Payment	2 year	2 years	35	
					Total	**280**

Board and Committee Attendance and eligibility 2021/22

Board

Meeting No.	1	2	3	4	5	6	7	8	9	10	11			
Board Members	30 July 2021	27 August 2021	24 September 2021	29 October 2021	26 November 2021	28 January 2022	25 February 2022	25 March 2022	29 April 2022	27 May 2022	24 June 2022	No. Attended	% Attended	Comments
Clinical Professor David Forbes (Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11	100%	
Dr Hilary Fine	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11	100%	
Ms Rebecca Strom (Deputy Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11	100%	
Professor Paul Norman	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10	91%	
Mr Steve Toutountzis	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11	100%	
Ms Angela Edwards	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	10	91%	
Ms Kim Farmer	✓	×	✓	✓	✓	✓	×	✓	✓	✓	✓	9	82%	
Ms Paula Rogers	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11	100%	
Mr Tony Evans	-	-	-	-	-	-	×	✓	✓	✓	✓	4	80%	Commenced February 2022
No. Attended	7	7	8	7	8	8	7	9	9	9	9			

Finance Committee

Meeting No.	1	2	3	4	5	6	7	8	9	10	11			
Board Members	**26 July 2021**	**23 August 2021**	**20 September 2021**	**25 October 2021**	**22 November 2021**	**20 December 2021**	**21 February 2022**	**21 March 2022**	**26 April 2022**	**23 May 2022**	**20 June 2022**	**No. Attended**	**% Attended**	**Comments**
Mr Steve Toutountzis (Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11	100%	
Ms Rebecca Strom	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11	100%	
Ms Paula Rogers	-	-	✓	✓	✓	✓	✓	✓	✓	✓	×	8	89%	Commenced as a member on 20/09/2021
Ms Kim Farmer	✓	×	-	-	-	-	-	-	-	-	-	1	50%	Ceased as a member on 20/09/2021
Attended	3	2	3	3	3	3	3	3	3	3	2			

PEC Committee

Meeting No.	1	2	3	4	5	6	7	8	9			
Board Members	**21 July 2021**	**18 August 2021**	**15 September 2021**	**18 October 2021**	**17 November 2021**	**15 December 2021**	**16 February 2022**	**20 April 2022**	**15 June 2022**	**No. Attended**	**% Attended**	**Comments**
Dr Hilary Fine (Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓	10	100%	
Ms Angela Edwards	✓	×	×	✓	✓	✓	✓	✓	×	7	70%	
Ms Kim Farmer	✓	✓	✓	✓	✓	✓	×	✓	✓	10	100%	
Ms Paula Rogers	×	✓	✓	✓	✓	✓	✓	×	✓	8	80%	
Mr Tony Evans	-	-	-	-	-	-	-	-	×	-	-	Commenced as a member effective 15/06/2022
Attended	3	3	3	4	4	4	3	3	3			

Audit and Risk Committee

Meeting No.	1	2	3	4	5	6			
Board Members	**18 August 2021**	**13 October 2021**	**8 December 2021**	**8 February 2022**	**12 April 2022**	**7 June 2022**	**No. Attended**	**% Attended**	**Comments**
Ms Rebecca Strom	✓	✓	✓	✓	✓	✓	6	100%	
Mr Steve Toutountzis	✓	✓	✓	✓	✓	✓	6	100%	
Ms Angela Edwards	×	✓	✓	✓	✓	✓	5	83%	
Prof Paul Norman	×	✓	✓	✓	✓	✓	5	83%	
Mr Tony Evans	-	-	-	-	-	✓	1	100%	Commenced as a Committee member effective 07/06/2022
Attended	2	4	4	4	4	5			

Safety, Quality and Consumer Engagement

Meeting No.	1	2	3	4	5	6	7	8	9	10	11			
Board Members	**26 July 2021**	**23 August 2021**	**20 September 2021**	**25 October 2021**	**22 November 2021**	**20 December 2021**	**21 February 2022**	**21 March 2022**	**26 April 2022**	**23 May 2022**	**20 une 2022**	**No. Attended**	**% Attended**	**Comments**
Prof. Paul Norman (Chair)	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	9	82%	
Dr Hilary Fine	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11	100%	
Mr Steve Toutountzis	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	11	100%	
Ms Kim Farmer	-	-	✓	✓	✓	×	×	✓	×	×	×	4	45%	Commenced as a member 20/09/2021
Attended	2	3	4	4	4	3	3	4	3	3	2			

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 2021/22 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 five working days and refund the total amount of expenditure.

Nine of our cardholders recorded personal purchases on their Purchasing Card. All of these cardholders declared a personal expenditure and all monies were refunded in full as indicated in the table. No referrals for disciplinary action were instigated during the reporting period.

Personal use credit card expenditure by NMHS cardholders 2021/2022

Credit card personal use expenditure	Aggregate amount ($)
Reporting period	628.01
Settled by the due date (within 5 working days)	157.05
Settled after the period (after 5 working days)	470.96
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 2021/22, the total expenditure was $134,201, compared with $80,453 in 2020-21. The organisations from which advertising services were procured and the amount paid to each organisation are shown in the below table.

2021/22 NMHS advertising expenditure by provider

Category	Provider	$
Advertising agencies	Brandconnect (WA)	24,896
	Clip Media Motion	1,455
	Find a Radiographer	350
	Park House Studios	28,540
	Rae De Lune	1,838
	Richard Lochlan Beilby	800
	Seamless Merchandising Matters Pty Limited	1,531
	Sensis Pty Ltd	795
	Shire of Christmas Island	230
	Telstra Corporation Limited	31,892
	The Australasian College for Emergency Medicine	1,100
	Thryv Australia Pty Ltd	3,245
	Subtotal	**96,670**
Market research organisations	CareOpinion Australia	418
	Subtotal	**418**
Media advertising organisations	Carat Australia Media Services Pty Limited	31,499
	Facebook	893
	Speirins Media Pty Ltd	4,721
	Subtotal	37,113
	Total	**134,201**

Freedom of information

The broad objective of the *Freedom of Information 1992 Act* (FOI Act) is to give the community access to information held by the WA Government.

Members of the public can request access to documents we hold via an FOI application. Applications for patient records are received and managed at individual hospital sites. Information on how to access records is available via **our 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

To support our employees in understanding and complying with the principles of workplace behaviour and conduct, as defined in the Western Australian Public Sector Standards in Human Resource Management and Commissioner's Instructions, a comprehensive set of WA Department of Health and NMHS policies and guidelines are available. Employees may access these information resources via our 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 Public Sector Commission Discipline Standard, the *Health Services Act 2016* and the WA Health Discipline Policy specify 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 potential breaches of discipline are objectively assessed and investigated by experienced staff to determine the most appropriate action which should be taken. This ensures matters are appropriately assessed and investigated and decisions are consistent and transparent.

At NMHS, we seek a culture where staff can feel comfortable in reporting suspicions of wrongdoing and provide assurances that we will support any staff member who makes a report, in good faith, of unethical behaviour.

Recruitment and selection

Our recruitment and selection processes are managed in accordance with the whole of Health policy on Recruitment and Selection and are administratively supported by Health Support Services.

To ensure the integrity of selection processes, they must comply with the Public Sector Employment Standard on Recruitment and Selection. Consequently, all processes provide applicants with the opportunity to lodge a Breach of Standard claim if they are not satisfied that the Standard has been met.

In 2021/22, nine Breach of Standard claims were lodged relating to recruitment, selection and appointment processes. Of these, six were resolved internally, and three were sent to the Public Sector Commission for review, two of which were subsequently dismissed and one resolved.

Grievance resolution

Safe and supportive workplaces are fundamental to the provision of quality patient care. Grievance policies and processes provide an important mechanism by which workplace conflict can be resolved to support a healthy workplace culture.

We are covered by the WA Department of Health Grievance Resolution Policy and any parties to a workplace grievance receive a copy of this policy, along with the NMHS Guidelines for Resolving Employee Grievances. The policy and guidelines comply with the Public Sector Standards in Human Resource Management – Grievance Resolution Standard, the Public Sector Code of Ethics and the WA Department of Health Code of Conduct.

Code of conduct

We promote behaviour consistent with the WA Department of Health Code of Conduct Policy (the Code) which defines the standards for ethical and professional conduct throughout the WA health system.

All NMHS staff are responsible for ensuring their behaviour reflects the standards of conduct embodied in the Code which also requires staff to report any suspected breaches. Staff are educated on the requirements of the Code via numerous online and face to face mandatory training modules.

We have a dedicated Integrity Directorate that centralises the integrity assessment and the investigation of possible misconduct matters, including assessing potential breaches of the Code in conjunction with the WA Department of Health Discipline Policy. In 2021/2022, a total of 310 matters were received for assessment for potential misconduct and/or breaches of the Code by the Integrity Directorate. This was a significant increase from last year's figures largely due to COVID-19 related matters and disciplinary processes associated with the mandate for health staff to be double and triple vaccinated, as well as increased awareness of where to report potential breaches as a result of education. In total 352 matters were finalised, including matters which may have been opened in the previous financial year.

Of equal importance to having disciplinary processes that allow for appropriate sanction of unacceptable behaviours, is that the processes are procedurally fair. It is a common law requirement that when a person's interests may be adversely affected by an official decision, that person is given sufficient information about the allegation(s) against them, an opportunity to be heard, and that the decision-maker acts without bias or self-interest, basing their decisions on evidence. These requirements form the principles of procedural fairness, and underpin a range of decision-making processes, including employee disciplinary processes.

We also promote an ethical culture and utilises a program of proactive integrity education. Our Integrity Directorate provides a proactive and dedicated resource which considers organisational capacity and cultures, with a view to continually improve workplace integrity-culture and corruption resistance. The Corruption Prevention and Integrity Education team within the Integrity Directorate provides tailored integrity education to all of our staff. This integrity education and guidance focusses 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 of our Integrity education sessions.

Recordkeeping plan

Records are assets which allow the government to function effectively. They provide evidence of actions taken and decisions made and support us to account for our actions.

The *State Records Act* 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 full review of the plan completed and submitted to the State Records Office of Western Australia on the 1st of September 2021. The State Records Office accepted and approved this Review of our recordkeeping plan on the 21st of September 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.

To ensure a high level of record management compliance, statistical analysis and reports have been developed to monitor use of the electronic records management system. This information is provided to managers to support further improvements.

Disability access and inclusion plan

As demonstrated in our NMHS Disability Access and Inclusion Plan (DAIP) 2017-2022, we are committed to ensuring that people living with disability, their families, and carers can fully access our services, facilities, and information. In 2021/2022, we progressed numerous initiatives within the seven 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

- The State Head Injury Unit continued to work with Aboriginal Health Liaison Officers at Sir Charles Gairdner Hospital to improve access to culturally safe rehabilitation services following acquired brain injury for Aboriginal patients.
- At BreastScreen WA, longer appointment times were made available for patients with disabilities and two additional radiographers were made available for patients with additional needs.

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

- Universal Accessible Toilets were installed at multiple sites at Sir Charles Gairdner Hospital, including E Block Watling Walk, E Block Outpatients, C Block and G Block.
- BreastScreen WA improved accessibility to mobile units and clinics, including fitting mobile trucks with hydraulic lifts for wheelchair access.
- Wanneroo Adult and Older Adult Community Mental Health Services, Butler and Lower West Adult Mental Health Services have all been custom designed to incorporate accessible features, including ramps, lifts, parking, and bathrooms.

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 are able to access it

- The 'Standing Strong' project developed culturally appropriate educational material for Aboriginal patients requiring an amputation.
- A video and patient education resource for Aboriginal people undergoing a laryngectomy features the story of Rosie Charlie and her experience losing her voice box in 2014.
- At Sir Charles Gairdner Hospital a virtual clinic for interpreting services now includes access to Auslan interpreters.

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

- Osborne Park Hospital purchased five hearing amplifiers for Occupational Therapy patients which has made it easier for people with hearing loss to engage with therapists and other patients.
- At King Edward Memorial Hospital, patients with complex needs are provided with an individualised overall Comprehensive Care Plan which will address their needs during the journey from referral/outpatient to inpatient and discharge.
- Osborne Park Hospital purchased two FAVERO cots enabling easy access to baby for those patients unable to physically reach their baby with the usual bedside cot.

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, are available to enable patients, carers and their family 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 CareOpinion, an independent site where people can anonymously share their stories about their experience of care. CareOpinion has an accessible website and people have the option to tell their story with visual aids or verbally to a CareOpinion 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

- People with disability have been consulted on numerous initiatives across our sites and services, including the NMHS Partnership Model, the Women and Newborn Health Service Relocation Project and the relocation of the Special Needs Dental Clinic.
- Elizabeth Mills was recognised for her 20 years voluntary service with the Sir Charles Gairdner Hospital DAIP committee.

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

- Our newly launched NMHS Workforce Diversity and Inclusion Strategy 2022-2025 aims to attract and retain people with disability. We are partnering with National Disability Services (NDS) to increase the rate of people with disability being employed in the public sector. NDS has provided accessible recruitment training and educates project participants on a broad range of topics including job access and reasonable adjustments at monthly meetings.
- Community Mental Health Services have created Peer Support Worker positions where people with lived experience of psychiatric disability obtain employment.

WA Multicultural Policy Framework

We developed a Multicultural Plan whose aim is to encourage and facilitate people from Culturally and Linguistically Diverse (CaLD) backgrounds to reach their highest potential within our workplace and ensure our services are inclusive and accessible for everyone, irrespective of their first language or cultural heritage.

NMHS Multicultural Plan 2021-2024

Our key achievements against the three policy priority areas:

1. Harmonious and Inclusive Communities

- Promotion of educational resources has resulted in a 40% increase in completion of the Office of Multicultural Interests Diverse WA eLearning. The number of staff completing the WA Health Language Service Policy eLearning doubled from the previous year. A new 30-minute Cultural and linguistic diversity module was released in May.
- A new intranet page promotes the benefits of diversity and inclusion to staff. The page features a calendar which lists cultural celebration and education days as well as information about relevant upcoming events, training and resources.
- CaLD people are provided opportunity to participate in consultation processes, including the relocation of Women and Newborn Health Service and the development of a NMHS Consumer Partnership model
- Multiple free healthcare related training/workshop opportunities were advertised on the intranet for staff to build their cultural awareness
- Harmony Week was used to educate and celebrate the diversity of our staff. The Workforce division created a Cultural Cookbook to show the breadth of backgrounds of staff – 50% of people who contributed a recipe were born overseas and 67% of their parents were born in a country other than Australia.

2. Culturally responsive policies, programs and services

- All Workforce Policies have been reviewed from a culturally diverse lens to ensure they are accessible and inclusive.
- The WA Cancer and Palliative Care Network Clinical Implementation Unit developed a Cultural Safety Action Plan to create a culturally safe and welcoming workplace environment for CaLD staff, clients, and broader networks.
- We are increasingly facilitating the use of interpreters. At Sir Charles Gairdner Hospital, Social Work, Language Services and Telehealth created a virtual clinic for interpreting services that reduces the risk of waste and increased costs from missed or late appointments and prevents risk of cross infection of interpreters to patients in medical environments.
- BreastScreen WA now include iPads in each mobile clinic so that clients in regional and remote areas can communicate with interpreters via video call or Teams.

- We are increasing access to translated resources. We developed a COVID-19 Screening Questions factsheet in eight languages. At Osborne Park Hospital, Physiotherapists now have access to HEP2GO which can translate exercise information for patients into multiple languages. Our Women and Newborn Health Service developed numerous family and domestic violence resources in multiple languages.
- We have improved access to feedback and complaint processes for CaLD patients. The MySay Healthcare Survey for inpatients has been translated into five languages and will be rolled out across our sites and services from July 2022.
- The Humanitarian Entrant Health Service (HEHS) provides a free and voluntary holistic health assessment service for all refugees and humanitarian entrants who are resettled in Western Australia (WA) under the Commonwealth Government's Refugee and Humanitarian Program and Special Humanitarian Program. In 2021-22, the HEHS provided health assessments and support to 440 clients from Afghanistan, Burma, Bolivia, Cuba, Guatemala, Venezuela, Colombia, Honduras, Iraq, Iran, Syria, Tibet, Burundi, and Ethiopia.
- A Female Genital Cutting/Mutilation (FGC/M) and cervical screening guide for practitioners was developed in consultation with relevant experts to support healthcare providers in offering cervical screening to individuals affected by FGC/M.
- We commenced a Quality Improvement activity to explore response rate and patient experience of the CaLD population who were inpatients during 2020-2021.

3. Economic, social, cultural, civic and political participation

- A diversity survey was created with specific questions around countries of birth, religion, and languages spoken at home to gain a better understanding of our employees.
- Multiple actions to both retain and attract CaLD employees were included in the NMHS Diversity and Inclusion Strategy which was launched in May 2022.
- CaLD employee terminations were monitored through exit interviews with any emerging patterns examined and actioned as relevant.
- The new CaLD Hub webpage is regularly updated with free workshops around diversity in healthcare and health equity seminars and information on how to access interpreter services and translated resources for consumers.

Government policy

Priority start policy

As at 30 June 2022, NMHS has no active capital works contracts of value greater than $5 million inclusive of GST.

Occupational safety and health, and injury management

We prioritise the care and wellbeing of our staff and strive to provide a safe and healthy workplace for our people.

In the past year, we have been preparing for the introduction of the new Work, Health and Safety (WHS) legislation by conducting an audit to identify gaps and developing an action plan to support continual improvement towards WHS best practice. This also included benchmarking NMHS systems and performance against several Australian government health services and other industries.

The establishment of clear WHS policies, goals and strategies, the articulation of employee responsibilities and the development of preventive programs enables a proactive approach to WHS and forms components of the Work Health and Safety Management framework.

The framework also reinforces Executive and Management commitment to Work Health and Safety through:

- demonstrating leadership in safety across all levels of NMHS
- prioritising WHS cultural improvements
- implementing safety improvements
- measuring safety performance

A consultative approach to the resolution of safety risks is adopted in order to ensure that hazards are addressed and incidents are investigated, thereby promoting a positive safety culture. NMHS regularly provides information about safety, health and wellbeing and promotes activities to ensure that all workers have access to current and relevant information, particularly when it applies to their roles and the healthcare environment. Health and safety policies, procedures, guidelines and other related information are available to workers through HealthPoint and intranet pages.

All NMHS sites facilitate WHS management and consultation through:

- the election of Safety representatives
- the establishment of WHS committees and working groups
- hazard/incident reporting and investigation
- routine workplace inspections
- resolution of issues process
- implementation of regular audits, risk assessments and control measures

WHS committees meet regularly to discuss and resolve work health and safety issues. Committee members are available to management and employees to support discussion and resolution of WHS issues. This ensures issues are formally recognised and actions are communicated back to the employee and Safety representative.

During COVID-19 surges, training for managers and supervisors was impacted. Training has now recommenced with a targeted approach.

NMHS have priority programs in place to reduce key risks, such as:

- Workplace Violence and Aggression
- Manual Tasks
- Employee Fitness for Work
- Psychosocial injury

Measures	Results 2019-20 (1) Base year	Results 2020-21 Prior year	Results 2021-22 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	2.9	2.3	0 or 10% reduction (2.07)	Target not met, however significant reduction on previous year
Lost time injury and severity rate[2]	39.23	36.47	46	0 or 10% reduction (35.31)	Target met
Further information regarding impacts on claim severity is detailed below[3]	45.5	51.9	40.2	38.3	54.6
Percentage of injured workers returned to work (i) within 13 weeks[4]	59%	57%	47%	N/A	N/A
Percentage of injured workers returned to work (ii) within 26 weeks[4]	69%	66%	57%	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[5]	51%	55%	53%	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. The performance reporting examines a three-year trend and, as such, the comparison base year is two 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). Data adjusted each year to reflect modifications to pended claims (either accepted or declined).
3. 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. We have seen an increase in complicating factors, such as burnout and increased long term workplace stress, and difficulty covering staff who are unfit for work or are requirement to work in a supernumerary capacity, lengthening the time to return to work for some cases.
4. 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'.
5. 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

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2 https://ww2.health.wa.gov.au/Articles/A_E/Coronavirus/COVID19-Framework-for-System-Alert-and-Response

3 https://ww2.health.wa.gov.au/~/media/Files/Corporate/Policy-Frameworks/Clinical-Governance-Safety-and-Quality/Policy/Clinical-Incident-Management-Policy-2019/Clinical-Incident-Management-Policy-2019.pdf

4 https://ww2.health.wa.gov.au/Articles/S_T/Sentinel-events

5 Total employee headcount as at 30 June 2022. Payroll FTE was 9,534 including agency and con-tractor staff.

6 https://www.nmhs.health.wa.gov.au/~/media/HSPs/NMHS/Documents/NMHS-Aboriginal-Health--and-Wellbeing-Strategy-2022-2025.pdf

7 https://www.welcomehere.org.au/

8 WA Population projection; WA Tomorrow December 2018 scaled to Treasury Budget projection April 2021.

9 Includes patients carried over from previous financial year.

10 https://www.nmhs.health.wa.gov.au/Hospitals-and-Services/Public-Health/Aboriginal-Health#:~:text=Aboriginal%20Health%20Strategy%20aims%20to%20improve%20health%20outcomes,increasing%20the%20Aboriginal%20representation%20in%20the%20NMHS%20workforce.

11 https://www.nmhs.health.wa.gov.au/Research/Research-Strategy

12 https://ww2.health.wa.gov.au/Improving-WA-Health/Sustainable-health-review-delivery/Final-report

13 Excluding Joondalup Health Campus.

14 https://www.careopinion.org.au/

15 https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Sustainable%20Health%20Review/Final%20report/sustainable-health-review-final-report.pdf#page=65

16 https://www.mhc.wa.gov.au/reports-and-resources/reports/your-experience-of-service-yes-survey/

17 https://www.wa.gov.au/government/announcements/mandatory-covid-19-vaccination-policy-wa-workforces

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19 https://www.nmhs.health.wa.gov.au/~/media/HSPs/NMHS/Documents/NMHS-Aboriginal-Health--and-Wellbeing-Strategy-2022-2025.pdf

20 https://www.wa.gov.au/service/environment/environment-information-services/electric-vehicle-strategy#:~:text=Electric%20Vehicle%20Strategy.%20The%20State%20Government%20has%20developed%2celectric%20vehicles%20and%20hydrogen%20fuel%20cell%20electric%20vehicles.?msclkid=593236c4c53411ecad5abf8807023105

21 https://ww2.health.wa.gov.au/Improving-WA-Health/Sustainable-health-review-delivery/Final-report

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[28] 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**

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Acronyms

ABI	Acquired Brain Injury
AHLO	Aboriginal Health Liaison Officer
AICD	Australian Institute of Company Directors
ATAGI	Australian Technical Advisory Group on Immunisation
BFC	Breastfeeding Centre of WA
CAHS	Child and Adolescent Health Service
CaLD	Culturally and Linguistically Diverse
CAMI	Childbirth and Mental Illness
CECAT	Creative Expression Centre for Arts Therapy
DAIP	Disability Access and Inclusion Plan
DHS	Dental Health Services
ED	Emergency Department
EIP	Earluy Intervention Program
FOI	Freedom of Information
FTE	Full-time Equivalent
GARM	Geriatric, Acute and Rehabilitation Medicine
HEHS	Humanitarian Entrant Health Service
HITH	Hospital in the Home
HSP	Health Service Provider
IMC	Injury Management Consultant
IPC	Infection Prevention and Control
IR	Industrial Relations
JCMHS	Joondalup Community Mental Health Service
KEMH	King Edward Memorial Hospital
KPI	Key Performance Indicator
MCDC	Metropolitan Communicable Disease Control
MHPHDS	Mental Health, Public Health and Dental Services
MHS	Mental Health Services
NICU	Neonatal Intensive Care Unit
NMHS	North Metropolitan Health Service

NPS	Net Promoter Score
OBM	Outcome Based Management
OOS	Occasions of Service
OPCMH	Osborne Park Community Mental Health
OPH	Osborne Park Hospital
OPRNN	Osborne Park Rehabilitation and Neonatal Nursery
OSH	Occupational Safety and Health
PMH	Princess Margaret Hospital for Children
PPE	Personal Protective Equipment
RAT	Rapid Antigen Test
SAC	Severity Assessment Code
SAR	System Alert and Response
SCCOPHCG	Sir Charles Gairdner Osborne Park Health Care Group
SCGH	Sir Charles Gairdner Hospital
SCGH MHU	Sir Charles Gairdner Hospital Mental Health Unit
SE	Sentinel Event
SHIU	State Head Injury Unit
SRP	Staff Recognition Program
TB	Tuberculosis
UAT	Universally Accessible Toilets
VAD	Voluntary Assisted Dying
WACMHS	Wanneroo Adult Community Mental Health Service
WANDAS	Women and Newborn Drug and Alcohol Service
WAPHA	WA Primary Health Alliance
WaSSAaP	Wellbeing and Staff Support Activities and Programs
WATBCP	WA Tuberculosis Control Program
WC	Worker's Compensation
WNHS	Women and Newborn Health Service
WNSRP	Women and Newborn Service Relocation Project

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

This document can be made available in alternative formats on request.