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

North Metropolitan Health Service
Annual Report 2022-2023

CARE RESPECT INNOVATION TEAMWORK INTEGRITY

Acknowledgement of Country and People

The North Metropolitan Health Service (NMHS) acknowledges the Whadjuk people of the Noongar nation as the Traditional Owners and Custodians of the land on which we work and pays respect to their Elders past, present and future.

NMHS acknowledges that the majority of its business is conducted on Whadjuk Noongar Boodjar and a number of services are conducted statewide. NMHS recognises, respects and values Aboriginal cultures as we walk a new path together.

Using the term – Aboriginal

Within Western Australia, the term "Aboriginal" is used in preference to "Aboriginal and Torres Strait Islander" in recognition that Aboriginal people are the original inhabitants of Western Australia. "Aboriginal and Torres Strait Islander" may be referred to in the national context, and "Indigenous" may be referred to in the international context. No disrespect is intended to our Torres Strait Islander colleagues and community.

(Aboriginal and Torres Strait Islander people are advised that this document may contain images of deceased people.)

Statement of compliance

For year ended 30 June 2023

Hon Amber-Jade Sanderson MLA Minister for Health; Mental Health

In accordance with Section 63 of the *Financial Management Act 2006*, we hereby submit for your information and presentation to Parliament, the Annual Report of the North Metropolitan Health Service for the reporting period ended 30 June 2023.

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

Contents

Foreword

Board Chair's overview

I am delighted to present the North Metropolitan Health Service's performance for the financial year ending 30 June 2023.

The content of the annual report is testament to the support and dedication of staff across our sites and services to provide patient-centred care.

Over the past financial year, the Board has placed great focus on ensuring the organisation is strategically moving forward, following the challenges of the past few years in managing patient care and disruptions to services during the COVID-19 pandemic.

At the core of our decision-making is ensuring the organisation meets its mission, visions and strategic priorities as well as providing safe, high-quality services. We have continued to build on our solid foundations on governance, risk management, safety, culture and financial sustainability over the past year. We also looked to the future to develop innovative strategies to ensure our services continue to meet the future needs of the community.

The Board was pleased to approve a number of programs of works and projects that will help with updating infrastructure and enhancing our services, including updating assets and introducing digital record management.

The achievements highlighted in this annual report are a tribute to the outstanding commitment of our staff to deliver clinical excellence and a positive patient experience.

I extend my thanks to the leadership provided by North Metropolitan Health Service Chief Executive Dr Shirley Bowen and the executive team. I would also like to give thanks to the outstanding work provided by managers and staff across the organisation.

As the NMHS Board Chair, I am very pleased to endorse the 2022-2023 Annual Report.

Clinical Professor David Forbes AM

Board Chair
North Metropolitan Health Service

Chief Executive's report

As one of Western Australia's largest health services, we are committed to providing excellent health care for our patients and our communities.

As demonstrated in this annual report, a range of strategic programs and activities were developed and initiated over the past year as part of our vision of being a trusted partner, delivering excellent health care for our people and our communities.

Post the COVID-19 pandemic, we have investigated ways to address access block and enhance patient flow, with a particular emphasis on discharge processes.

In particular, we have focused on providing timely access to our emergency departments, enhancing access to elective surgery and commencing our journey on outpatient reform.

We have also built on our focus to develop innovative solutions to help achieve our strategic priorities. An example is the development of an application for patients to support triage at Sir Charles Gairdner Hospital's Emergency Department. Anticipated to go live in late 2023, this exciting initiative will enable patients to privately self-register via a mobile device on arrival and the ED team to monitor for any signs of deterioration.

In addition, we continued our focus on moving to electronic processes, with the roll-out of a digital medical records system at King Edward Memorial Hospital (KEMH), electronic dental record development for our dental services and enterprise medical imaging system at SCGH.

KEMH launched an Aboriginal Midwifery Group Practice, working alongside an Aboriginal Health Liaison Officer, known as Strong Links. The program supports women who prefer to be cared for by the same midwife and provides cultural security throughout the pregnancy journey.

Our Mental Health, Public Health and Dental Services achieved a number of milestones over the past months, including the 75-year anniversary for the WA Tuberculosis Control Program, 20-year anniversary for the Centre for Clinical Interventions and 10-year anniversaries for Start Court and Links programs. These milestones exemplify the dedication of our staff to deliver first-class specialist care to the community across a range of areas.

Over the past year, we have been working on a number of wellbeing initiatives and programs to demonstrate we provide a flexible and supportive workplace. This includes a new junior doctor initiative, which received national accolades for its innovative approach to the recruitment and retention and wellbeing of junior doctors.

Providing safe and high quality care is at the heart of all that we do. Our performance against our Key Performance Indicators (KPIs) demonstrates our commitment to providing high standards of care to patients.

Over the next 12 months we will continue to build on the great progress we have made over the past few years. We will also continue to work on the development of the New Women and Babies Hospital Project and the Graylands Redevelopment Project.

I thank all staff for their support and dedication over the past 12 months. It is the dedication of many that enables our health service to achieve our mission of promoting and improving the health of our people and our communities.

Dr Shirley Bowen

Chief Executive
North Metropolitan Health Service

Executive Summary

EXECUTIVE SUMMARY

2022-2023 at a glance

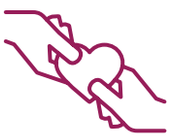
9,449
births

26,157
Cancer patients
received treatment

180,671
Presentations to our **emergency departments**

185,681
Inpatients

123,743
Elective services
accessed



94
Transplants

747,095
Outpatient appointments
provided

19,965
Patients with **mental health illness** were cared for

256,646
Telehealth appointments
provided

NMHS 2022-2023 performance summary

Key performance indicators (KPIs) help NMHS 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.

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

Effectiveness KPIs

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

Surgical procedure	Target	Actual	Category	Target	Actual
Knee replacement	≤ 19.6	20.2	Prostatectomy	≤ 36.1	30.0
Hip replacement	≤ 17.1	17.7	Cataract surgery	≤ 1.5	0.0
Tonsillectomy and adenoidectomy	≤ 85.0	92.4	Appendicectomy	≤ 25.7	28.4
Hysterectomy	≤ 42.3	47.7	*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

Survival rates for sentinel conditions

Stroke			Acute myocardial infarction		
Age group (years)	Target	Actual	Age group (years)	Target	Actual
0 to 49 years	≥ 95.2%	93.1%	0 to 49 years	≥ 99.0%	97.8%
50 to 59 years	≥ 95.3%	89.1%	50 to 59 years	≥ 98.9%	97.5%
60 to 69 years	≥ 94.4%	91.0%	60 to 69 years	≥ 98.1%	98.6%
70 to 79 years	≥ 92.5%	89.6%	70 to 79 years	≥ 97.0%	96.3%
80+ years	≥ 87.1%	84.1%	80+ years	≥ 92.2%	93.4%

Fractured neck of femur			Percentage of admitted patients who discharged against medical advice		
Age group (years)	Target	Actual	Patient group	Target	Actual
70 to 79 years	≥ 99.0%	100.0%	Aboriginal patients	≤ 2.78%	3.81%
80+ years	≥ 97.4%	92.6%	Non-Aboriginal patients	≤ 0.99%	0.71%

Percentage of liveborn term infants with an Apgar score of less than 7 at five minutes post-delivery	≤ 1.9%	1.8%
Readmissions to acute specialised mental health inpatient services within 28 days of discharge	≤ 12%	12%
Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services	≥ 75%	85%

Percentage of elective waitlist patients waiting over boundary for reportable procedures	FY 2022-23 Target	Actual
Category 1 over 30 days	0%	17%
Category 2 over 90 days	0%	31%
Category 3 over 365 days	0%	20%

Efficiency KPIs	FY 2022-23 Target	Actual
Average admitted cost per weighted activity unit	≤ $7,314	$8,014
Average emergency department cost per weighted activity unit	≤ $7,074	$7,242
Average non-admitted cost per weighted activity unit	≤ $6,982	$8,827
Average cost per bed-day in specialised mental health inpatient services	≤ $1,470	$1,730
Average cost per treatment day of non-admitted care provided by mental health services	≤ $441	$496

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

Effectiveness KPIs	2021-2022 calendar years Target	Actual
Rate of women aged 50–69 years who participate in breast screening	≥ 70%	53%

Percentage of people who have a tooth re-treated within 6 months of receiving initial restorative dental treatment	FY 2022-23 Target	Actual
Adults	< 6.05%	5.14%
Children	< 2.11%	1.68%
Percentage of eligible school children who are enrolled in the School Dental Service program	≥ 78%	73%
Percentage of eligible people who accessed Dental Health Services	≥ 15%	14%

Efficiency KPIs	FY 2022-23 Target	Actual
Average cost per person of delivering population health programs by population health units	≤ $48	$84
Average cost per breast screening	≤ $143	$159
Average cost per patient visit of WA Health-provided dental health programs for		
School children	≤ $249	$315
Socio-economically disadvantaged adults	≤ $316	$370

Note: all results are 2022 calendar year unless stated otherwise.


05A
04A
Advanced Life Support for Adults

EXECUTIVE SUMMARY

Safety and quality at a glance

Patient safety indicators are critical for monitoring and evaluating the quality of care and performance of healthcare delivery to our consumers.

The following infographic offers insight into some of our quantitative and qualitative data sources.

QI data

303
activities
completed

493
proposals submitted
and approved

81.3%
hand hygiene
compliance rate

MySay data

10,628
MySay **Inpatient surveys**
completed to date
NPS: +79

36,475
MySay **Outpatient surveys**
completed to date
NPS: +76

1,788
MySay **ED surveys**
completed to date
NPS: +67

Care Opinion

209
stories
about NMHS

77%
would recommend
this service

Top 5
organisation
with the highest number of
"staff listening, learning
and making changes"

Consumer feedback

Complaints	493
Contacts and concerns	1,159
Compliments recorded in the Consumer Feedback Module	1,042
Compliments recorded on the SCGOPHCG local database	2,246
Total compliments	**3,288**

Clinical incidents via CIMS

NMHS non SAC1 incidents	
SAC2	649
SAC3	6,776
Unconfirmed - no SAC assigned yet	348
Non-SAC1 incidents total	**7,821**

SAC1 clinical incidents 2020-2021 — 2022-2023

NMHS SAC1 incidents	NMHS 2020-2021*		NMHS 2021-2022*		NMHS 2022-2023*	
Total reported	145	-	176	-	126	-
Declassified	47	32%	49	28%	29	23%
Investigation completed (excl declassified)	98	68%	127	72%	77	61%
Investigation in progress	0	-	0	-	20	16%
Total completed and in progress	**98**	**-**	**127**	**-**	**97**	**-**
Outcome of completed + SAC1 in progress						
Death	29	30%	21	17%	24	25%
Serious harm	50	51%	84	66%	51	53%
Moderate harm	6	6%	10	8%	14	14%
Minor harm	5	5%	1	1%	3	3%
No harm	8	8%	11	9%	5	5%
Total	**98**	**-**	**127**	**-**	**97**	**-**

**Data includes Joondalup Health Campus.*

EXECUTIVE SUMMARY

Finance

Financial summary

Our annual budget is contained within the approved Minister for Health *Financial Management Act 2006* section 40 Annual Financial Estimates, which were developed based on the initial Service Agreement (2023).

This agreement outlines the health services to be provided by the health service provider during the term of the agreement that are within the overall expense limit set by the Department CEO, as System Manager, in accordance with the State Government's purchasing intentions. In 2022-2023, the total cost of providing state services and health services to the NMHS community was $2.6 billion. Results for 2022-2023 against agreed financial targets (based on the Budget Statements) are presented on the next page. Full details of our financial performance during 2022-2023 are provided in the financial statements.

Our operations – actual results versus budget targets

Total cost of services (expense limit)

Source from Statement of comprehensive income

2023 Target[1] $000

2023 Actual[1] $000

Variation[2] $000
($187,995)

The increase in total cost of services is due to employment costs related to COVID-19 requirements for fit testing and backfilling of staff, a once-off cost of living payments announced by State Government, higher FTE to meet post COVID-19 health services demands, higher operation costs due to inflation and increased consumption of medical and surgical instruments to deliver higher levels of activity.

Net cost of services

Source from Statement of comprehensive income

2023 Target[1] $000

2023 Actual[1] $000

Variation[2] $000
($160,764)

The increase in net cost of services is due to total cost of services negative variance of $188 million offset by higher revenue especially Other fees for services.

Total equity

Source from Statement of financial position

2023 Target[1] $000

2023 Actual[1] $000

Variation[2] $000
$122,263

The increase in total equity is largely due to $125 million increment in revaluation reserve, arising largely from Landgate's valuation of NMHS's land and buildings.

Net increase/ (decrease) in cash held

Source from Statement of cash flows

2023 Target[1] $000

2023 Actual[1] $000

Variation[2] $000
($10,629)

The decrease in cash held is due to additional $147 million cash used in operating activities and additional $4 million cash used in financing activities; offset by additional $113 million cash provided by State Government and $28 million under spending for purchases of non-current assets.

Approved salary expense level

2023 Target[1] $000

2023 Actual[1] $000

Variation[2] $000
($126,877)

The increase in approved salary expense level is due to employment costs related to COVID-19 requirements for fit testing and backfilling of staff, cost of living payments announced by State Government and higher FTE to meet post COVID-19 demands.

Data source: Budget strategy and reporting:
1. As per 2022-23 section 40 Annual Financial Estimates. 2. Further explanations of variances are contained in Note 10 '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	2023 Agreed limit $000	2023 Target / Actual $000	Variation $000
Agreed working cash limit (at budget)	113,571	113,571	-
Agreed working cash limit (at actuals)	117,993	98,691[(a)]	(19,302)

Data source: Funding plan from the NMHS and DHS Service Agreements 2022/23.

(a) The Actual working cash held totals $98,819,185 which includes an amount of $12,411,139 held for Capital Project works, $68,896,511 held for restricted or contractual obligations and a balance of $580,367 held for DGHSU. NMHS therefore has $16,931,169 discretionary cash of which $1,000,000 is quarantined by DHS related to an upgrade to their Electronic Dental Records system.

Expenses by services

Public hospital admitted services	55%
Public hospital non-admitted services	14%
Mental health services	12%
Public hospital emergency services	8%
Public and community health services	6%
Community dental health services	4%
Aged and continuing care services	1%
Health system management - policy and corporate services	0%
Small rural hospital services	0%

Operating expenses

Employee benefits expense	53%
Contracts for services	20%
Patient support costs	16%
Depreciation and amortisation expenses	3%
Other supplies and services	3%
Other expenses	3%
Repairs, maintenance, and consumable equipment	2%

Income other than from State Government

Other fees for services	51%
Patient charges	35%
Other revenue	12%
Other grants and contributions	2%
Donation revenue	0%

Vision, Mission and Values

Excellence in health care for our community

Our Vision

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

Our Mission

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

Our Values

CARE	RESPECT	INNOVATION	TEAMWORK	INTEGRITY
Organisational Behaviour				
We show empathy, kindness and compassion to all	We are inclusive of others and treat everyone with courtesy and dignity	We strive for excellence and are courageous when exploring possibilities for our future	We work together as one team in a spirit of trust and cooperation	We are honest and accountable and deliver as promised
Our Individual Behaviour				
Caring for our patients as well as each other	Acknowledging the different beliefs, culture, views and circumstances of others	Constantly seeking better and more sustainable ways to work	Listening to, respecting and valuing the roles and contributions of others	Being genuine, reliable and trustworthy and treating others equitably
Offering help and support when needed	Communicating with honesty and openness, and listening without judgement	Being proactive in identifying opportunities and proposing solutions for improvement	Fostering cooperation and joint problem solving through open communication and collaboration	Taking responsibility for my actions, behaviour and decisions
Taking care of my own health while also looking out for the safety and wellbeing of others	Trusting others' ability and empowering them accordingly	Continuing to learn, encouraging research and keeping up to date with new developments and best practice	Sharing a sense of pride in achievements and celebrating success	Being professional and leading by example

EXECUTIVE SUMMARY

About North Metropolitan Health Service

Established in 2016, NMHS embraces best practice to deliver safe, high-quality care to patients and the community.

NMHS is one of the largest health services in WA, providing a comprehensive range of adult specialist medical, surgical, mental health and obstetric services across three tertiary hospitals and two secondary hospitals. Additionally, a range of statewide, highly specialised multidisciplinary services is offered from several hospital and clinic sites.

NMHS also oversees the provision of contracted public health services by Joondalup Public Hospital, which is operated under a public private partnership.

Statewide services

NMHS

WA Psycho-Oncology Service

Mental Health, Public Health, Dental Services

Centre for Clinical Interventions

Clinical Rehabilitation Service

Dental Health Services
- General Dental Service and School Dental Service

DonateLife

Humanitarian Entrance Health Service

Links

Metropolitan Communicable Disease Control

Neuroscience Unit

Start Court

State Head Injury Unit

State Forensics Mental Health Service

WA Eating Disorders Outreach Consultation Service

WA Tuberculosis Control Program

Sir Charles Gairdner Osborne Park Health Care Group

Neurological Intervention and Imaging Service of WA

State Sarcoma Service

WA Cancer and Palliative Care Network Clinical Implementation Unit

WA Liver and Kidney Transplant Service

WA Poisons Information Centre

WA Youth Cancer Service

Women and Newborn Service

Abortion and Reproductive Healthcare Service

Breastfeeding Centre WA

BreastScreen WA

Community Midwifery Program

Genetic Services of WA

Maternal Fetal Medicine Service

Menopause Services

Perinatal Loss Service

Sexual Assault Resource Centre

Statewide Perinatal Infant Mental Health Program

WA Cervical Cancer Prevention Program

WA Gynaecologic Cancer Service

WA Register of Developmental Anomalies

Women and Newborn Drug and Alcohol Service

Women's Health Strategy and Programs

Who we are

Sir Charles Gairdner Osborne Park Health Care Group (SCGOPHCG)

Sir Charles Gairdner Hospital (SCGH)

One of Western Australia's largest and leading tertiary hospitals, SCGH provides clinical services to adults, including trauma, emergency and critical care, orthopaedics, general medicine, general surgery and cardiac care. It provides one of the most comprehensive cancer centres in the State and is the principal hospital for neurosurgery and liver transplants.

Opened in 1958, SCGH treated 102,421 inpatients and provided 408,333 outpatient appointments this year.

Osborne Park Hospital (OPH)

OPH was established in 1962 and provides aged care and rehabilitation services, elective surgery, gastroenterology and urology same-day surgical activity, obstetrics and gynaecology. The specialised hospital serves as the lower acuity site for the group.

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

OPH treated 18,371 inpatients and provided 84,594 outpatient appointments this year.

Women and Newborn Health Service (WNHS)

WNHS provides clinical care to women and families. It comprises King Edward Memorial Hospital (KEMH), the Maternity Unit at Osborne Park Hospital and other specialist statewide health services.

Established in 1916, KEMH is the State's largest maternity hospital and the only referral centre for complex, high acuity pregnancies in WA. WNHS employs 1,347 FTE who catered for 12,676 emergency presentations, **treated 16,042 inpatients and provided 164,484 outpatient appointments at KEMH this year**. There were 5,498 births at King Edward Memorial Hospital last year, with 62 per cent of women needing high acuity care. The Maternity Unit at Osborne Park Hospital delivered 1,538 babies in 2022-2023.

EXECUTIVE SUMMARY

Mental Health, Public Health and Dental Services

Mental health

NMHS provides youth, adult, older adult, forensic and statewide mental health services in a variety of settings, including inpatient services, community mental health centres, day therapy, outreach and in people's homes.

Mental health facilities include:

- Graylands Hospital **121 beds**
- Sir Charles Gairdner Hospital Mental Health Service **36 beds**
- Selby Lodge and Osborne Lodge **56 beds**
- State Forensic Mental Health Service - Frankland Centre **30 beds**
- Hospital in the Home (HITH) **48 virtual beds**

243
Mental Health
inpatient beds

48
Hospital in the Home
virtual beds

Public health

A range of services are provided 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, Health Promotion, the WA Tuberculosis Control Program, DonateLife (organ and tissue donation), the State Head Injury Unit and the Humanitarian Entrant Health Service.

Dental health services

Dental Health Services is the largest public dental service in WA, providing 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.

The 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 provides dental care for mental health patients at Graylands Hospital.

Joondalup Health Campus (JHC)

Ramsay Health Care has a service agreement to provide services at JHC through a public private partnership. JHC is one of WA's largest hospitals, serving 45,431 inpatients in 2022-2023. It offers a range of medical and surgical services including critical care, interventional cardiology, maternity, neonatal and paediatric services, mental health services, aged care and rehabilitation.

In 2022-2023, the JHC emergency department responded to 95,923 presentations with a dedicated paediatric area and a 10-bed mental health observation area within the ED. The JHC also contains a purpose-built Mental Health Unit that includes secure accommodation.

45,431
inpatients
in 2022-2023

NMHS strategic plan

NMHS released its strategic plan in 2020, following staff, stakeholder, community, executive and Board engagement.

The strategic plan is based on the Vision of being a trusted partner, delivering excellent health care.

The organisation's mission is to promote and improve the health of our people and our communities.

NMHS focuses on six strategic priorities:

1. Enabling healthy communities
We will build healthy and engaged communities

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

3. Integration and connection
We will build strong connections and partnerships

4. Innovation and adaptive models of care
We will use research, innovation and technology to improve outcomes

5. Trusted, engaged and capable people
We will invest in our people and our culture

6. Sustainable and reliable
We will reduce harm, waste and unwarranted variation

Performance highlights

North Metropolitan Health Service initiatives

HEART program

In July 2022, NMHS introduced the Hospital Emergency Access Response Team (HEART) program. The program aims to reduce ambulance ramping by improving patient flow and access block.

This program is underpinned by three principles:

1. Putting people at the HEART.
2. Providing a holistic approach throughout the patient journey.
3. Engaging with our people and our community to create partnerships and educate.

Initiatives have focused on developing strategies to optimise care outside the hospital, improve the flow of patients through ED, optimise coordination of care through and across NMHS sites and services, promote timely discharging of patients seven days a week and explore innovative approaches to the way care is delivered.

Since its implementation in July 2022, the HEART program has enabled a significant reduction in ramping hours. As at June 2023, there has been a 29% reduction at SGCOPHCG and a 16% reduction at Joondalup Health Campus.

HEART patient flow and discharge initiatives at SCGOPHCG

The HEART Patient Flow and Coordination team initiated and supported several initiatives across SCGOPHCG over the past year. These included running challenges to encourage and support operational teams to engage in patient flow improvement and support discharging patients earlier in the day.

A Patient Support Services Project Working Group has been addressing whole-of-hospital initiatives and supporting efficient patient flow.

The team has worked closely with the Business Information and Performance team to create a Ward Patient Flow Progress dashboard and to update the HEART performance dashboard, to provide improved transparency around patient flow and emergency access measures. The dashboard monitors weekly patient flow performance measures. It also gives ward-based teams easier visibility of their performance in terms of patient flow while at the same time driving improvement ideas.

The HEART dashboard offers high-level program reporting, trend data and length of stay data, providing good visibility of relevant and key high-level patient flow and emergency access metrics for monitoring program and operational progress.

A day-of-care survey was implemented to identify barriers to discharge. Survey results helped to further inform patient flow initiatives and the work of the coordination team.

The HEART Team also supported the following:

- A long stay framework for SCGOPHCG.
- Establishment of long stay committees at OPH and SCGH.
- Creation of the Long Stay Coordinator role.
- Key patient flow process mapping from ED to wards.


Dräger
Fabius GS premium

Emergency Department Innovation Fund (EDIF)

NMHS successfully implemented two programs under the Department of Health's Emergency Department Innovation Fund: Medical Oncology Symptom Urgent Review Clinic (SURC) and Integrated Care for Older Adults. These programs ran from February 2022 to June 2023. Both projects demonstrated positive improvements to emergency access and demand issues.

The Integrated Care for Older Adults program goal was to achieve a contemporary, integrated, accessible model of care for older adults across the catchment; supporting older adults being cared for in the most appropriate location for their care needs; minimising and/or avoiding the need for an ED and/or hospital admission.

The program supported 2,747 patients and undertook 5,899 episodes of care for this patient cohort via a new Frailty Rapid Access Clinic (FRAC), Joondalup Health Campus (JHC) Rapid Acute Clinic for the Elderly (RACE) and a service expansion within Rehabilitation and Aged Care Intervention Liaison Service (RAILS).

Following the success of these initiatives, RAILS and FRAC have been converted to business-as-usual activity-based funding. Further funding was received for the expansion of FRAC and RAILS from five to seven days per week through the mid-year review funding allocation.

The highly successful SURC has supported ED demand management by offering an alternate model of care for cancer patients who are experiencing side effects or complications related to their cancer treatment. At the three-month evaluation the service had resulted in the avoidance of 240 potential ED presentations. Feedback through an anonymous patient experience survey illustrated patients had high trust in the service and were very satisfied with the care they received. SURC will now continue as business-as-usual.

2,747
Patients served
by the Integrated Care for Adults Program

5,899
Episodes of care
for this patient cohort

Emergency Care Navigation Centre

With ambulance ramping being a whole of hospital effort, NMHS has been working across the whole patient journey to implement an Emergency Care Navigation (ECN) Program, funded by the Emergency Access Reform program.

NMHS implemented an Emergency Care Navigation Centre (ECNC) in July 2023, within SCGH Emergency Department for walk-in patients. The ECNC is enabled by the new Neurology Rapid Access Clinic (NRAC) and an expansion of Integrated Older Adults Services. In late 2023 NMHS is expected to launch the My Emergency Visit app to further enhance the patient's Emergency Department experience and the operation of the ECNC.

My Emergency Visit

The My Emergency Visit (MEV) application is a great example of NMHS's values of innovation and teamwork, demonstrating what can be achieved when different parts of the organisation work together to enhance care.

Over the past year a team involving the medical consultant who initiated the MEV idea, ED staff, the HEART program and the Innovation and Development team have worked together to design and build a minimum viable product with potential to transform ED waiting room management, facilitate patient self-registration and improve the triaging process for both patients and clinicians.

The app is designed to support the 60 per cent of people who transport themselves to the ED. Using a QR code which leads to the MEV app, patients will be able to privately self-register on arrival by providing personal details, reason for presenting to hospital as well as critical medical information, including medicine use, frailty and pain scores and a photo of the presenting problem. The ED team will access a digital observation chart of people in the waiting room to monitor signs of deterioration and send personalised text messages to patients advising them of wait times and further information required to support their care.

Seven-Day Hospital Project at SCGH

NMHS received funding from Department of Health to provide enhanced and additional allied health, pharmacy and radiology services as part of a Weekend Discharge project. The aim of this project is to move towards a seven-day hospital model, where care is not dependent on the day of the week.

The project promotes consistent patient flow over a seven-day period and facilitates the timely discharge of patients, particularly on the weekend. This has included enhanced allied health staffing on weekends (physiotherapy, occupational therapy and social work), expanded hospital-wide services (dietetics, speech and aged care assessment teams) as well as enhanced weekday clinical psychology staffing.

Pharmacy has expanded its weekday services to areas without a designated pharmacist, expanded clinical pharmacy services in key inpatient areas and increased weekend pharmacy service.
In addition, magnetic resonance imaging services were expanded on Saturdays and computed tomography staffing was enhanced at OPH.
A Coordinator of Nursing and OPH Discharge Coordinator were appointed to help monitor patient flow.

People and culture

Your Voice in Health survey

The Your Voice in Health survey demonstrated the majority of staff have good engagement with the organisation and there has been improvement since the previous survey in 2021.

Nearly 7,000 comments for the open-ended questions were received and NMHS's overall Employee Engagement Index (EEI) was 63 per cent, which is one per cent higher than the previous survey. EEI is improving for medical, nursing and midwifery and corporate/support services. Allied health was the highest scoring occupational cohort at 65 per cent.

Overall, the main concern of those surveyed was about wellbeing, which the organisation will continue to work on as a key focus.

NMHS is committed to improving its workplace and while the overall results were encouraging, it is recognised there is still work to do. Three of the highest positive scoring questions directly align with the values of Innovation, Respect and Teamwork, which shows that the organisation is succeeding in its focus to embed its values in everyday behaviour and practices.

Junior medical officers

Launched in early 2023, the innovative Junior Medical Officers (JMO) Manifesto was developed in consultation and collaboration with junior doctors to support the wellbeing of doctors in training at SCGH.

It focuses on more flexible work arrangements and has led to the remarkable uptake of junior doctor roles at the hospital. The JMO Manifesto has pushed traditional rostering boundaries and challenged the health workforce to embrace a more flexible work-life balance.

NMHS was recognised as the foremost employer of choice by junior doctors in the AMA (WA) Hospital Health Check survey 2023. NMHS also received a prestigious innovation award at the national Health Roundtable showcase for its innovative approach to the recruitment and retention of junior doctors.

The manifesto focuses on creating part-time opportunities for doctors, enshrining a culture of psychological safety, creating a streamlined overtime approval process, taking leave as part of the heart of our business and implementing a medical workforce on-call, along with a below-the-line pathway for reporting.

It has led to 35 new part-time opportunities and junior doctors are reporting greater satisfaction across SCGOPHCG. In addition, 94 per cent of interns have chosen to renew their contracts to further their medical careers.

The trial streamlined overtime process will be made permanent at SCGOPHCG. This process will also be extended for a pilot at the Women and Newborn Health Service and Mental Health Public Health and Dental Services in late 2023.

The JMO Manifesto has been developed in collaboration with junior medical officers and doctors in training, SCGH RMO Society, senior clinicians and the Australian Medical Association.

NMHS Nursing and Midwifery Flexible Rostering Project

NMHS launched the Nursing and Midwifery Flexible Rostering Project in February 2023 to explore how to offer improved flexibility in shift work for level one, two and enrolled nursing and midwifery staff. The aim of the project is to be able to consider individual staff circumstances when scheduling rosters while still meeting operational needs.

Having seen considerable change to work environments and dynamics over recent years, it has been timely to implement a review of traditional rostering patterns for nurses and midwives. The organisation recognises the importance of staff work-life balance and how this equilibrium impacts outcomes for our patients. By considering and improving how rostering practices impact our staff, the strategy aims to retain staff and grow nursing and midwifery numbers.

The project involves extensive engagement and discussion with nurses and midwives and continues to make good progress at exploring how NMHS can make changes to the traditional three-shift rostering system to provide greater flexibility.

Pilot areas have been chosen at each site and local working groups have been set up to progress plans. Guiding principles are being developed to enable increased flexibility to meet nursing and midwifery needs in balance with service needs.

PERFORMANCE HIGHLIGHTS

> Aboriginal employment

NMHS acknowledges that to grow its Aboriginal workforce, it must create a culturally aware and safe environment.

It is doing this by focussing on improving cultural awareness, providing development opportunities and clear and supported career pathways for existing employees.

Aboriginal Cancer Nurse Coordinator

Cancer Network Western Australia (CNWA) has appointed Deborah Jacobs as the first metropolitan-based Aboriginal Cancer Nurse Coordinator to support outcomes for Aboriginal cancer patients, carers and their families.

The position was implemented by the CNWA to assist Aboriginal cancer patients with navigating the health system and providing cancer coordination and support for their cancer treatment.

Aboriginal Health Champions Program

In October 2022 NMHS launched its Aboriginal Health Champions Program, designed to identify and recognise employees who go the extra mile to ensure Aboriginal people feel welcome and comfortable accessing and using our services.

Being admitted to hospital can raise concerns and be a significant source of apprehension for patients and their support networks. Making people feel safe and understood is an important factor in helping ensure they have confidence in our health service and will complete the required treatment.

The Aboriginal Health Champions will assist in helping create environments which are culturally sensitive to Aboriginal patients and their families. They are encouraged to complete the Aboriginal Patient Centred Care training offered by the Department of Health.

The program offers benefits such as improved communication between non-Aboriginal and Aboriginal people and improved cultural awareness and security for Aboriginal patients and their families, visitors, carers and employees.

Diversity and inclusion

NMHS places great focus on diversity and inclusion and draws from the NMHS Workforce Diversity and Inclusion Strategy 2022-2025, NMHS Multicultural Plan 2021-2024 and Disability Access and Inclusion Plan 2022-2027.

A diversity survey was done and a workshop held to develop requested initiatives. Workshop participants became the founding members of the NMHS Diversity and Inclusion brains trust. The group includes those with lived experience of disability and/or being Culturally and Linguistically Diverse (CaLD) to connect and discuss diversity and inclusion issues and initiatives as well as intersectionality. The group is also utilised for staff wanting to gain feedback on policies and initiatives from those with lived experience on the topic.

An equity statement was developed to sit alongside the employee benefits of working at NMHS to attract more diverse job candidates. Among various initiatives, job advert templates now have a photo header representing the diversity of people who work at NMHS, an equity and inclusion statement, an affirmation that NMHS upholds the social model of disability and a request for contact if adjustments to participate in recruitment are required. Implementing values-based recruitment ensures candidates understand and are aligned with NMHS core values.

LGBTQIA+

NMHS Pride Network members joined the LGBTQIA+ Data Working Group to assist in reviewing and improving WA Health data standards when recording a patient's details. The network is providing lived experience examples as part of the consultation and ensuring the updates are inclusive of everyone.

Employees have been encouraged to wear a pronoun badge and include their pronouns in email signatures as part of several initiatives highlighting their importance.

As part of Pride celebrations, 45 NMHS employees, including two Executive Directors, marched in the 2022 Perth Pride parade to demonstrate NMHS is a safe and inclusive space for employees and consumers.

Progress Pride flags were raised at our sites, signalling to the LGBTQIA+ community that they are seen and welcome at NMHS to work and to access sites and services. The Pride Network more than doubled its membership over the past year, gaining 211 new members. Activities to celebrate the International Day Against Homophobia, Biphobia, Intersex Discrimination and Transphobia (IDAHOBIT) were also held across NMHS.

An LGBTQIA+ Ally guide has been created which outlines ally basics, includes a five-point spectrum of allyship and ways to increase your allyship. Hundreds of staff have signed a pledge to be an ally for LGBTQIA+ people.

Disability

Over the past year the NMHS Disability Access and Inclusion Plan (DAIP) 2022-2027 was developed, with feedback from community consultation and a number of good news stories and events were coordinated.

A two-year implementation plan (2022-2024) was also developed. NMHS co-hosted the International Day of People with Disability event with the Disability Health Network in November. The event was also an opportunity to launch the revised Hospital Stay Guidelines, the NMHS Disability Action and Inclusion Plan 2022-2027 and a Staff Disability and Allies Network.

> "As an educator and ally I have recently received feedback from staff who report the ED and SCGH to be one of the most inclusive workplaces they have ever worked in. They were thinking about resigning, but due to ongoing support and commitment from the management team around diversity and inclusion they have decided to continue employment in ED! The teamwork in the department is second to none. I love working within such a progressive, supportive and inclusive team."

Employee Wellbeing Strategy 2022-2027

Creating a healthy workplace is a shared responsibility. While individuals make daily choices around their health and wellbeing, NMHS focuses on creating an environment and culture that supports healthy decision making and where our employees thrive. The Employee Wellbeing Strategy 2022-2027 outlines the NMHS commitment to supporting the wellbeing of our people and cultivating a values-aligned culture.

The strategy was developed to ensure wellbeing is seen as integral to everything we do and positively impacts on the diverse individual needs of all employees. It goes beyond meeting legal requirements, to encourage an aspirational, one-team approach aligned to our values and incorporates a full spectrum of awareness, elimination of risk, prevention of harm, intervention and evaluation.

Key strategy priorities have included improving general employee wellbeing, reducing the occurrence and impact of workplace stressors and creating a safe and healthy work environment and culture where wellbeing is seen as everyone's responsibility.

Employee wellbeing psychologists and 50 peer support officers provide support, and a series of workshops were held over the year.

Sustainability

Climate and Sustainability Program

The Climate and Sustainability Program has been making changes to the way staff think about these issues in projects across NMHS.

Thanks to a project by Graylands Hospital facilities manager Simon Marsh, staff who make home visits are now driving electric vehicles. The five cars have on-site charging stations and the building management system has been updated to track the cars and charge levels.

Over the past year the program has been working to introduce organic waste streams to NMHS sites. KEMH's organic food waste is now being turned into fertiliser. Food from meal trays and all other organic matter from the catering area is being collected, including unopened food or drink cartons and packages. Working with waste to energy company Veolia, the food is separated from the packaging and turned into compost which NMHS can buy back as garden fertiliser.

OPH is also recycling its organic waste and the project will eventually be rolled out at SCGH.

As part of the Wildlife Hospital Expired Goods Donation project, expired medical products at SCGH, such as gloves, are being collected and donated to a local wildlife hospital. While they can't be used on humans, they are safe to be used on wildlife. From single packets to whole boxes, this initiative gives a second life to expired goods while helping support the care of injured local wildlife.

Plastic Oceans Australia put out the call for submissions from healthcare providers to work with them on a reducing single use plastics project called EPIC. KEMH won one of the two Australian submissions and worked with the group for 18 months on a series of audits and projects to reduce single use plastics in the hospital, which concluded this year.

5
electric vehicles
for staff who make home visits

Ride for Life

More than 150 WA health staff strapped on their helmets and joined in the inaugural 10-kilometre Ride for Life in May as part of the Climate and Sustainability Program.

Those who didn't ride, walked the route from East Perth to the QEII Medical Centre in Nedlands. The event offered a fun way to unify and collaborate across hospital service providers on an important issue as well as an opportunity to catch up with colleagues and encourage fitness.

It was the first time an Australian location has participated in this global event, which aims to raise awareness amongst health professionals about climate and environmental sustainability and mobilise health care professionals to advocate to policy makers, educate patients and the community on the link between healthcare and climate change.

The event contributed to the program's focus to educate and inform health professionals on how they can play a role in achieving the WA Government's goal of an 80 per cent reduction in carbon emissions by 2030 and to be carbon emission free by 2050.

150 staff
cycled 10km
in Ride for Life

Innovation

Innovation is one of NMHS's values. A range of programs were supported over the past year by the Innovative Future (IF) program.

It aims to bring out the best creative ideas and inspire staff to experiment, generate something new or solve long-standing problems to inspire positive changes. The program's goals are to deliver excellent health care for our communities, invest in staff and culture and help NMHS thrive and transform.

It is recognised that innovation doesn't happen in a vacuum. The kernel of an idea takes teamwork to bring it to fruition and these projects have taken at least one team and, in most cases, several teams from across NMHS to create a successful solution.

Increased pharmacy support

Two five-month pilots were launched in April 2023 at SCGH to explore closer collaboration between nurses and pharmacists to expand the level of patient care.

The first pilot was undertaken in the ED and one ward, where pharmacy staff are being utilised in the non-traditional role of clinical pharmacy support technician.

WA's aging population tends to have multiple comorbidities and complex medication requirements, providing a challenging environment for medical teams to manage. The pilot is intended to reduce nursing time spent on medication management and decrease non-clinical tasks for nursing staff, allowing more time for direct patient care.

The pilot is an opportunity to expand the pharmacy scope of practice and provide wider career opportunities and professional growth in pharmacy.

A second pilot in the Medical Assessment Unit involved two Partnered Charting Pharmacists working alongside medical teams to chart patient medication. The pilot aims to provide greater efficiency and coordinated patient care and a reduction in medication-related incidents and re-admissions.

Collection made easy

The orange locker boxes near the SCGH Outpatient Pharmacy (OP) are not for mail but a way for patients to collect their medications outside OP operating hours. In an Australian-first and based on Australia Post's parcel lockers, eligible patients can collect their medication any time between 5am to 9.30pm from a designated box.

Launched in July 2022 as part of the IF program, the boxes have been extremely popular with patients and have alleviated issues over wait times, parking challenges and charges and restricted pharmacy operating hours.

Once loaded by OP, QR codes are sent to patient mobiles to allow medication collection at their discretion, taking a patient-centred approach to medication supply.

IdeaScale

IdeaScale is an innovation management solution that uses crowdsourcing to help NMHS find and develop the next big thing.

It is a platform that allows community participants to generate, aggregate and prioritise ideas in a manageable online setting. The administrators and moderators evaluate and implement those ideas based on NMHS needs. They are a key part of the crowd that moves the great ideas from a member base to reality.

IdeaScale is now in the process of designing and building a Health Innovation Project Register, which could potentially be used across all health service providers, as well as hosting the WA Country Health Service Chief Executive's Challenge. IdeaScale is fostering collaboration internally and with other HSPs, in line with the teamwork value.

Sports orthopaedics day surgery transition

To help manage bed flow and unnecessary stays in hospital, it was suggested to convert traditional sport orthopaedic procedures for cruciate ligament reconstructions and arthroscopic shoulder surgeries from overnight admissions to day-surgery cases. This would be preceded by rehabilitation focused on preoperative patient education and their readiness for surgery.

The pilot for the day surgery model was approved and preoperative rehabilitation with patients started in late January. The first patient day surgeries successfully started mid-February.

Operating theatre staff and surgeons have received education on the new processes. Evaluation and process improvements are underway, with ongoing work to streamline and embed processes.

Overnight admissions transition to **day surgery**

> Digital strategies

Prediction tool improves patient safety

The NMHS Business Information and Performance (BIP) team, in partnership with the University of Notre Dame Australia's Institute for Health Research, developed a model to predict a patient's risk of developing a healthcare-associated urinary tract infection (UTI). Healthcare associated UTIs are the second most frequent hospital acquired complication at NMHS.

In collaboration with NMHS Safety, Quality, Governance and Consumer Engagement team, the predictive model was trialled at SCGH on wards G52 and G66 between March and May 2023. Displayed and printed resources were designed to increase vigilance and serve as a visual reminder for staff and patients and consumers were engaged in the design of a patient information leaflet. Preliminary trial data suggests healthcare associated UTIs reduced by 60 per cent on one ward, with an overall reduction of 34 per cent.

With funding and support from the Innovation and Development team, BIP and PhD graduates participating in the Industry and Research Engagement Program have expanded the modelling to include prediction of other types of complication. This modelling considers variables for patient cohorts across NMHS sites so risk mitigation strategies can be individually tailored. In the future, the capacity for prediction modelling can be further expanded with electronic medical records, so more variables and patient data can be analysed in real time.

This is the first of its kind application of machine learning in the WA health system to predict the risk of undesirable patient outcomes and prompt timely intervention. To-date, no such tools or prediction models have been developed specific to WA patients.

UTIs reduced overall by **34%**

Information and communication technology

The Department of Radiation Oncology at SCGH is now using Limbus AI, a computer program for contouring during the cancer pre-treatment process.

The program automatically and accurately scans the affected area and requires only minor manual adjustments which will significantly improve the clinical workflow, thereby reducing patient wait times, increase patient throughput and quality of care.

Mental Health, Public Health and Dental Services

Mental health care for older patients

"My family would like to thank the medical team at Selby Lodge, an older adult inpatient and community mental health services in Shenton Park, for the dedicated care they gave my mum over the months she spent as an inpatient. Mum suffered badly from dementia and she was a risk to others and herself. She had to be flown down from Geraldton and spent her time on a ward with a lot of restrictions. As a family we were kept informed every step of the way, with changes to medications, change in behaviours and other medical issues she faced. Mum was treated with respect and dignity at all times and the staff were happy to share information when we visited or rang us out of hours for a chat. We send our sincere gratitude to everyone at Selby, who help so many others living with mental health issues like mum had."

Family of Selby Lodge patient

Youth Mental Health Programs and Advisory Group

Youth Axis celebrated its 10-year anniversary in June 2023.

The service began in 2013 to work with young people aged 16 to 24 years who were coming to the attention of emergency and support services but finding it difficult to access treatment. Young people experiencing an emerging emotionally unstable personality disorder or who are ultra-high risk for psychosis receive up to six months treatment from a multidisciplinary team to aid in their recovery and improve function. Based in Wembley, the service covers the Perth metropolitan area and has a holistic, youth-friendly approach to care.

Start Court's 10-year anniversary

Celebrating a 10-year milestone in 2023, the Start Court began as a pilot program in 2013 to address the overrepresentation of offenders with mental health issues in court.

It's a voluntary program that addresses core issues impacting an individual's appearance in court. The program usually takes around six months to complete and successful participation in the Start Court may be taken into account during sentencing.

Based in the Perth Magistrates Court, the key to its success is therapeutic jurisprudence, teamwork and a holistic approach to care. Clients can access mental health expertise, drug and alcohol services and psychosocial solutions to help them heal and recover. Mental health clinicians from NMHS work alongside a magistrate and staff from Outcare, community corrections, drug and alcohol services, police prosecutors and lawyers.

The court has demonstrated a reduction in mental health issues and drug use, improvement in quality of life and a reduction in offending rates. The key to success is the teamwork that addresses all the client's needs, which can include helping them navigate the complex system they are in or assisting them with housing, training and employment.

By May 2023 there have been 3,302 referrals to the Start Court, almost 900 joined the program and 510 completed the full program since its inception.

Links celebrates a decade

State Forensic Mental Health Service staff celebrated the 10-year anniversary of Links, a support service for young people who appear before the Perth Children's Court. Links started as a pilot project and has grown to assess around 400 young people each year.

Links features a team of community support coordinators who help young people address issues such as school engagement, transport and relationships.

Young people between 10 and 17 years appearing before the court with a mental health concern can be referred to Links and are offered a voluntary mental health assessment. The outcomes of the assessment guide the management of the young person's court proceedings and care.

Both Links and the Start Court are partnerships between the Department of Justice and the Mental Health Commission, with support from the Department of Health, service provider Outcare and agencies such as NMHS.

Valued role

Clinical Nurse Specialist Lisa Carr helped start the Links program and is proud of what the service has achieved. She says Links works because of the involvement of three different groups – the Department of Health, the Department of Justice and Outcare. NMHS staff work closely with these and other services and agencies in the children's court.

> "I am passionate about Links," says Lisa. "I get a lot of job satisfaction and feel valued in my role. Every day is different, sometimes we see one or two young people and then other days the Magistrate will refer up to five young people."

PERFORMANCE HIGHLIGHTS

WA Tuberculosis Control Program turns 75

In March 2023, the WA Tuberculosis Control Program (WATBCP) celebrated the milestone of 75 years of delivering specialist care to the community.

Tuberculosis (TB) continues to be one of the most common communicable diseases worldwide and the second most fatal infection after COVID. Throughout the pandemic, as resources were diverted to COVID, TB deaths increased around the world. In WA the locked borders and sustained healthcare resulted in the decline of TB prevalence. Then as global travel and trade returns to pre-pandemic levels, so too does the risk of transmission and the need for sustained surveillance, prevention and control.

The WATBCP provides a statewide public health service to those at risk of developing TB, newly diagnosed TB cases and people who have been in contact with cases. Based at the Anita Clayton Centre in Perth, the service provides medical assessment, testing, case management, expert advice and contact tracing services.

With access to quality healthcare, TB is preventable and curable. The centre provides specialist staff, free medication and detailed contact tracing to minimise and contain the spread of the disease. All patients diagnosed with TB in WA are supported by a TB case manager and specialist physician who provide comprehensive patient-centred care for six to 24 months.

The team's ongoing work raises awareness of TB by providing education to the public and health colleagues, with a focus on achieving zero transmission through testing and preventive treatment.

World-renowned CCI celebrates milestone

Late in 2022, the Centre for Clinical Interventions (CCI) staff celebrated the 20th anniversary of the service.

The specialised clinical psychology service was established to treat patients with complex anxiety and eating disorders. Their core areas of business are psychological therapy, evaluation and research, training and resources.

The CCI is world-renowned and has become a significant mental health resource for clinicians, consumers and carers around the world. Its work includes having more than 250 research papers published in peer-reviewed journals, CCI papers have been cited more than 17,000 times and the CCI website has had more than 10 million downloads.

The centre's current projects include a group program for people with eating disorders and improving access to treatment for people with severe anxiety. Plans include helping patients with PTSD, OCD and binge eating disorders.

Therapy helps eating disorders

A short, intensive clinical psychology eating disorder program at the Centre for Clinical Interventions has enjoyed a 100 per cent retention rate since its launch.

The cognitive behavioural therapy session for eating disorders, called CBT-Ten, involved five female participants. Face-to-face group sessions with clinical psychologists ran weekly for 10 weeks. The shorter program has had similar results to traditional treatment programs, which run for much longer.

The program is novel in approaching how people learn and how they embed that learning. CBT-Ten involves testing out fears and experimenting so clients can learn new ways of relating to their beliefs about food, eating disorder behaviours and body image. Patient outcomes included a reduction in symptoms, depression and anxiety.

Before the group sessions, the CBT-Ten program was trialled with more than 100 clients individually. With the shorter program it is hoped more patients can be helped.

Electronic Dental Record Development

Dental Health Services has launched an Electronic Dental Record (EDR). What began as an accounting package for dental fees management, known as the Patient Management System, has transformed into the Dental Information Management system (DenIM).

The system now includes a large patient database and integrated appointment book, dental charting, treatment planning, clinical notes, medical and medication history and document management modules.

Producing a bespoke, tailor-made and fit-for-purpose product that is available to all DHS adult and School Dental Service clinics and mobiles state-wide was all done in-house. The EDR has been rolled out in modules with online education packages developed by DHS and used for staff training, supported by a DenIM test environment which enables staff to practice using it in various clinical scenarios.

Mother's care

"Recently, after being raced to hospital with excruciating back pain, a tumour was discovered on our mother's spine, and she was rushed from one hospital to Sir Charles Gairdner for an urgent operation. From surgeons to cleaners to nurses and consultants we could not fault a single one of the workers we have had contact with from Charlies. To every one of the staff working on Ward G66, especially the nurses and physios, you are kind, compassionate and thankfully extremely experienced! And we can't thank you enough! We've felt at ease that she has been in the right hands for her care."

Family of SCGH patient

Sir Charles Gairdner Osborne Park Health Care Group (SCGOPHCG)

NMHS Outpatient Reform (OPR) Program

NMHS provides outpatient services across four sites, covering 50 specialties. Demand for outpatient care remained high this year, including 650,000 outpatient appointments and more than 200,000 appointments by telephone or videocall, making it easier to access outpatient services.

In 2022, the NMHS Outpatient Reform (OPR) Program was launched to improve access to care for patients and to reduce the amount of time patients wait for care. The program aims to achieve timely and equitable access to care, optimised demand, optimised capacity and excellent safety and quality.

OPR encompasses all outpatient services, with an initial focus on SCGOPHCG and WNHS in the first year. More than 370,000 outpatient appointments were delivered this year across SCGH, more than 77,000 at OPH and more than 150,000 at WNHS.

The first phase of the program focussed on improving the basics. The SCGOPHCG team has been working to improve data quality and ensure waitlist accuracy, optimising access to and utilisation of outpatient physical capacity with a view to improving timely access to patient care.

WNHS have been working on implementing Digital Medical Records at KEMH, improving data quality through a waitlist review and improving outpatient clinic utilisation.

650,000
Outpatient appointments

200,000
Tele and video appointments

Updated Ward C14 at SCGH

The staged opening of Ward C14 officially started on 15 June, bringing 25 new single rooms to SCGH.

Twenty beds will be used for general medicine and five new beds for immunology, dermatology, rheumatology and endocrinology. The design and planning for the new ward has considered cultural, wellbeing, access and inclusion needs.

Ward C14 has the ability to function as two separate isolation wards in pandemic mode when needed. The ward contains three bariatric bedrooms with full room coverage ceiling hoists and eight regular rooms with ceiling hoists, while four of the ward beds can become isolation rooms.

It also has a kitchen, an allied health functional assessment space as well as new areas for staff, including a unisex, universally accessible bathroom and collegiate staff hub.

Funding for the ward was provided by the State Government.

25 **New single rooms**

Modular ward opens at Osborne Park Hospital

As part of a State Government commitment to delivering more hospital beds, a new modular ward was built at Osborne Park Hospital. The 30-bed ward cares for patients requiring rehabilitation following an amputation.

The new facility includes a gymnasium, therapy pod, dining room, 10 single bedrooms, 10 double rooms, staff offices and reception facilities, all seamlessly connected to the existing hospital.

The additional hospital capacity was made possible by modular construction and a fast-tracked approvals process that cut delivery time down from years to just over six months. As a first of their kind for the State, they mark a new era for the public health system – a fast-tracked solution to help future-proof hospitals. The ward was officially opened on 1 July 2022 and began receiving patients the following week.

60 years of service at OPH

Osborne Park Hospital celebrated 60 years of service to the community last year. On 18 October 2022 staff planted six native trees – one for each decade – and buried a time capsule to be dug up on the hospital's 100th birthday.

When it opened its doors on the 29 March 1962, OPH served the general medical and maternity needs of the City of Stirling catchment. It treated 1,300 patients in its first year. Sixty years on, OPH now has 192 beds, includes surgical and rehabilitation services and is home to almost 600 staff who cared for more than 103,000 patients in 2021.

New pain management clinic

After more than 20 years at SCGH, a new pain management clinic at OPH was established in early 2023 to provide services to approximately 5,000 inpatients and outpatients annually.

The multi-disciplinary unit comprises medical, nursing, physiotherapy, occupational therapy, clinical psychology, psychiatry and addiction medicine clinical streams. The new premises have enabled the clinic to expand its services, with procedures performed in the neighbouring Osborne Park Hospital theatre complex.

The clinic is a Level 1 accredited training unit and part of the Statewide Pain Training Program. It is currently the only public unit in WA that provides specific training in interventional pain procedures.

Officially opened in July 2023, the clinic is named after pain medicine physician Dr Roger Goucke OAM who served as Head of Department for more than 24 years and has been recognised internationally for service to the field.

Cardiothoracic Surgery Unit celebrates 30 years of service

The Cardiothoracic Surgery Unit at SCGH was recognised in March 2023 for 30 years of service to the WA community. The team provide a comprehensive service for all adult cardiac, aortic and lung conditions, excluding transplantation.

For the celebration, the team caught up with Stephen Murray, the patient who received the first coronary artery bypass graft at the hospital. Joining him was the unit's first surgeon, Dr Mark Newman and current Head of Department and the unit's first anaesthetist Dr Neville Gibbs, who are both still providing quality care to patients in the unit.

30 Years

From day one, the unit has provided first class care and demonstrated a high achievement and standard when benchmarked against other units in Australia over many years of service.

Women and Newborn Health Service

KEMH patient Digital Medical Records roll-out

A Digital Medical Records (DMR) system was launched in June 2023 at WNHS and is being used for all patient records. The implementation is part of the WA Health Digital Strategy and initial phasing of the Electronic Medical Records program.

The implementation at WNHS provides a transition from traditional paper-based medical records to digital records. The DMR system gives clinicians access to a universal view of a patient's medical history, which is critical to delivering best practice health care. Clinicians can enter information electronically and view scanned forms, as well as a variety of clinical notes, assessments, medical histories, diagnostic test results and other patient information.

Works offer greater support

As part of the $35.4 million critical infrastructure upgrades at KEMH a number of works projects were undertaken over the past year, including construction of two new theatres, fire remediation works, facade works, lifts and switchboard upgrades.

Funded by the State and Commonwealth Government, the works are designed to support the provision of high-quality care to patients while the new Women and Babies Hospital is being built.

$35.4
million
critical infrastructure upgrades at KEMH

Patient thanks for Midwifery Group Practice

"Words cannot properly describe the gratitude we have for Maddi, Lolitta and Ginny from MGP-5 as well as Taylor from the labour ward and all the doctors and midwives, other medical, administration support and food and beverage staff that assisted in the birth of our son. Every single person we dealt with was phenomenal. The most kind, caring, knowledgeable and confident people. They made us feel comfortable and secure. We, without reservation, recommend the Midwifery Group Practice (and its expansion) at KEMH based on our experience."

KEMH patient

National Midwife of the Year — Paula Wells

A member of King Edward Memorial Hospital's Midwifery Group Practice (MGP) was named Australian Midwife of the Year.

Paula Wells, who provides antenatal, intrapartum and postnatal care to a mixed risk group of women, has been part of the MGP since its inception in 2016.

Her experience in a similar program was integral to MGP's development, guiding the team through start-up and helping to lead and support student, graduate, registered and clinical midwives. She is also on the panel to interview graduate midwives who apply to join MGP for the second half of their graduate year. She then helps mentor successful graduates. Additionally, Paula consults with multi-disciplinary teams to ensure safe, appropriate women-centred care and develops and facilitates childbirth education classes.

> "My greatest passion in midwifery is continuity of midwifery care," Paula says. "I truly believe that every woman, no matter what variations may occur during her pregnancy, labour, birth or postnatal period, deserves a known midwife to support her and her family through this journey."

It's the reason why Paula has spent most of her midwifery career in the MGP model of care, where she can see the difference it makes to women and their babies, including more positive birth experiences and decreased pre-term births.

Paula represents the MGP team in quality improvement projects, clinical trials and pilot projects to enhance the care of women and babies, such as the implementation of the Antenatal Risk Questionnaire and a new tool for screening of family and domestic violence. She has built partnerships with universities, educating midwifery students about MGP.

On top of her full-time clinical load, Paula is an executive committee member of the Australian College of Midwives (ACM), the country's peak professional body. She provides ongoing commitment to running conferences, fundraising activities and demonstrates consistent proactive support of WA midwives. Her deep-rooted passion has motivated other midwives to join ACM activities.

But it is her passion for the MGP model that really drives Paula, who is constantly advocating for wider access to the program.

Stronger links

Aboriginal women experience higher rates of adverse maternal and perinatal outcomes than non-Aboriginal women. NMHS is committed to improving outcomes for Aboriginal women and their families, in consultation and collaboration with the Aboriginal community.

The Strong Links Program commenced in April 2023, alongside an Aboriginal specific Midwifery Group Practice (AMGP). The program is a women-centred, Aboriginal Health Liaison Officer-led service. The outreach service, including home visits, initiates contact with family to engage women and conducts follow-ups regarding non-attendance. It works in conjunction with other services such as housing agencies, drug and alcohol counselling, mental health, domestic violence and other appropriate agencies.

The AMGP model of care is a primary health, midwifery model of care for women who prefer to be cared for by the same midwife in a culturally safe way throughout their pregnancy journey at WNHS, enabling the building of strong, trusting relationships along with support from an Aboriginal Grandmother Liaison and consultant obstetrician, where required.

Stakeholders and consumers assisted in the design and development of the program to ensure it is tailored to the specific needs of Aboriginal women and their families. Engagement with them will continue as part of ongoing evaluation and improvement.

Abortion and Reproductive Healthcare Service

To address the inequity of provision and access to contraception and abortion services across the state, WNHS requested funding for the establishment of a public abortion service at KEMH. Following the successful submission in December 2022, the Abortion and Reproductive Healthcare Service was formalised and expanded in April 2023.

WNHS is perfectly placed to provide multidisciplinary, comprehensive care in a trauma-informed, culturally sensitive and inclusive manner. Its priority is to ensure access for the most complex and vulnerable women and those women who are unable to negotiate the care they need. The service prioritises the most vulnerable of the community including where the pregnancy is over 20 weeks gestation, where there are medical and/or social comorbidities that present a significant risk and where the patient is under 14 years of age.

WA Trophoblastic Centre

In January 2023 the WA Trophoblastic Centre was established, creating a central registry and specialised clinical service within the WA Gynaecological Cancer Service to provide patients with gestational trophoblastic disease (GTD) a gold standard of care. GTD is a group of placental-related disorders derived from a pregnancy.

The service consists of a trophoblastic diseases patient registry, a multidisciplinary clinic involving nursing, oncology and psychology staff, a trophoblastic diseases multidisciplinary team and a specific clinic for the administration of low-risk chemotherapy (methotrexate).

In addition to ensuring that affected women are registered with the service, the clinic provides specialised follow-up, discharge reviews and long-term follow-up and ongoing registration, particularly as patients are at risk of recurrence.

Donor Conception Information Service

In January 2023 NMHS, in partnership with the Department of Health's Reproductive Technology Unit, created the Donor Conception Information Service.

This service is for donor conceived persons, donors and parents to access information, counselling and support services. Support is provided by qualified WNHS social workers based at KEMH.

e-Prescribing

ePrescribing was initially piloted in the Diabetic Service at KEMH in late 2022, providing the blueprint for roll-out to the rest of the organisation.

It benefits patients by using technology to produce prescriptions so critical scripts are not missed, improved legibility to minimise mistakes and aids the transition to digitisation by the organisation. ePrescribing has resulted in equity of access to prescriptions for WNHS patients across face-to-face and telehealth appointments.

The partnership between pharmacy and clinicians has shown a progressive uptake since implementation in late May, supported by effective internal communication. The small technology pilot's success has augured well for ongoing digitisation and staff acceptance of new technology usage at WNHS.

Major infrastructure projects

Women and Babies Hospital Project

In April 2023 the WA Government announced the new $1.8 billion Women and Babies Hospital project would change site location from the Queen Elizabeth II Medical Centre in Nedlands to the Fiona Stanley Hospital precinct in Murdoch.

In addition to the new hospital, the project now supports the expansion of obstetrics, gynaecology, oncology and neonatal services, and new theatres, at Osborne Park Hospital. A new Family Birth Centre will be built at OPH and there will be an expansion of neonatal beds at Perth Children's Hospital.

In November and December 2022, consumer focus groups on patient pathways were independently facilitated to inform future planning. In June 2023, further clinical consultation workshops commenced with staff from NMHS, South Metropolitan Health Service and the Child and Adolescent Health Service.

Joondalup Health Campus redevelopment

Construction of the new 102-bed Mental Health Unit (MHU) at Joondalup Health Campus started with the final concrete pour in August 2022 and was completed in August 2023.

The new unit will more than double the current capacity of Joondalup's MHU and for the first time, will cater for youth (16 to 24-year-olds) and older adults (65 years and over).

Features include an innovative, light-filled environment with multiple recreation zones, a large, shared lounge, dining areas, visitor spaces, landscaped courtyards, activity areas and a gymnasium. A purpose-built recovery hub will allow patients to connect with family and friends, community groups and peer support.

Consumers, carers and clinicians contributed ideas for the design of the new building, including careful consideration of how design could best support patients in their recovery. The unit is part of the $256.7 million expansion of Joondalup Health Campus, expected to finish in early 2025.

Graylands Reconfiguration and Forensic Taskforce project

The State Government made a $218.9 million investment in stage one of the Graylands Reconfiguration and Forensic Taskforce project, which encompasses the construction of 53 forensic mental health beds, including a five-bed child and adolescent unit.

$218.9 million investment

Joondalup Health Campus (JHC)

Undergraduate Cadetship Program

In March, more than a dozen student nurses from Marr Mooditj Aboriginal Training Corporation visited JHC to hear first-hand about Ramsay Health Care's new national Undergraduate Cadetship Program. It provides Aboriginal and Torres Strait Islander student nurses in WA with hands-on clinical experience, support and supervision.

During clinical placements, cadets are simultaneously given the opportunity for employment as an assistant in nursing or midwifery, a personal care assistant or support services worker at a Ramsay hospital.

At the completion of their studies, students are guaranteed an interview for ongoing employment as part of Ramsay's popular graduate program, which allows them to choose from a range of specialties.

Ramsay Health Care Australia Chief Nurse and Clinical Services Director, Dr Bernadette Eather, said the program would help develop students into "leading nurses and midwives of the future". The program aims to provide a comprehensive professional pathway for nurses and midwives, to develop and mentor nurses and midwives to upskill and excel in their careers.

New parking

To meet current and future demand for public parking, in October the 768-bay public car park (P1) at JHC opened.

The car park, which is part of the $269.4 million State and Commonwealth Government-funded redevelopment of JHC, will increase the public parking on the site by 540 bays, to a total of more than 2,700 bays.

540 bays
will be added

Governance

GOVERNANCE

Enabling legislation

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

Communication between NMHS and the Minister for Health, Parliamentary representatives, Ministers and WA Health is governed by a Communication Agreement, with clear lines of accountability and responsibility.

Responsible Minister

NMHS is responsible to Hon Amber-Jade Sanderson MLA; Minister for Health; Mental Health, who has overall responsibility for WA Health and provides direction to the DG and to HSPs.

Accountable authority

NMHS is a statutory authority governed by the NMHS Board, as specified in section 32 (1) (d) of the *Health Services Act 2016* (WA). The NMHS Board is directly accountable to the public through the Minister for Health and works with the Director General (DG) of the Department of Health (DoH), the System Manager.

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 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 NMHS activities.

Shared responsibilities with other agencies

NMHS works closely with DoH (System Manager), the Mental Health Commission (MHC), other health service providers and many government and non-government agencies to deliver programs and services to achieve better health outcomes for the community of the north metropolitan region of WA.

Agency reviews

NMHS has not participated in any reviews during 2022-2023.

NMHS Board

Clinical Professor David Forbes AM

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 (RACP) 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.

Ms Rebecca Strom

Deputy Board Chair

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.

GOVERNANCE

Mrs Jahna Cedar OAM

Board Member

A Nyiyaparli/Yindjibarndi woman from the Pilbara region, Jahna is recognised as a strong Indigenous community leader. For more than 20 years she has advocated for equal rights and reconciliation on behalf of Indigenous people, representing their interests at the United Nations in New York on three occasions. An executive director at IPS Management Consultants, Jahna holds a Diploma of Business Management, Bachelor of Business Management and Master of Business Administration. In 2017, she was named Business News' 40under40 First Among Equals, taking the top honour in a field of business and community leaders. In 2020, she was awarded the Medal of the Order of Australia for service to the WA Indigenous community. In 2022, she was named the Western Australian recipient of the Australian Awards for Excellence in Women's Leadership. The awards celebrate exceptional female leaders, particularly those who have made outstanding contributions to equality.

Ms Angela Edwards

Board Member

Angela has an extensive background in human resources, industrial relations, change management, organisational development and stakeholder management. She is currently General Manager – Human Resources, Crown Perth. Angela is also a board member of the not-or-profit cancer support group, Blue Dot Army.

Mr Anthony (Tony) Evans

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, AHPRA 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 and a postgraduate Diploma in Education and is a Fellow of CPA Australia, the Governance Institute of Australia and the Australian Institute of Company Directors.

Dr Hilary Fine

Board Member

Hilary has been a 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 more than 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. Until recently, she was a senior sessional member on the State Administration Tribunal and a clinical advisor at AHPRA.

Ms Karen Gullick

Board Member

Karen brings decades of experience in health management to the Board. She has spent more than 30 years in leadership roles in health care organisations in the public and private sectors, most recently as the Director of Clinical Services at Hollywood Private Hospital. She was also the Director of Nursing and Midwifery at St John of God Hospital in Bunbury. A practising registered nurse, Karen is a Master of Science (Nursing), a Fellow of the Australasian College of Health Service Managers, and a graduate of the Australian Institute of Company Directors. She sits on the Juniper Aged Care Board and was previously on the GenesisCare Hollywood Joint Venture Board.

Professor Paul Norman AM

Board Member

Paul is a current Consultant Vascular Surgeon at the Fiona Stanley Hospital 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. He is a Doctor of Surgery, Fellow of the Royal Australasian College of Surgeons, Fellow of the Royal College of Surgeons and has a Bachelor of Medicine and Surgery and Bachelor of Science (Hons).

GOVERNANCE

Ms Paula Rogers

Board Member

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 the Art Gallery of WA (AGWA) Foundation Council.

Paula has worked in a variety of senior roles in Western Australia and was appointed Chief Executive Officer of the Committee for Perth in January 2023. Prior to this, Paula was employed in roles including State Director of the Committee for Economic Development of Australia (CEDA), Managing Director and event management CEO and publisher. Paula holds a Bachelor of Social Science from University College Dublin (Ireland), has completed the AICD Company Directors Course and continues to be a Member of the Australian Institute of Company Directors (AICD).

Mr Steve Toutountzis

Board Member

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.

NMHS Executive Team

As at 30 June 2023

There were position changes across the North Executive Team throughout the financial year 2022-2023.

Dr Shirley Bowen
Chief Executive

Dr Jodi Graham
Executive Director Sir Charles Gairdner Osborne Park Health Care Group

Diane Barr
Executive Director Women and Newborn Health Service

Dr Theresa Marshall
Executive Director Mental Health, Public Health and Dental Services

Dr George Eskander
Area Director Clinical Services

Annie Thompson
Area Director Nursing and Midwifery

Lara Moltoni
A/Executive Director Safety Quality, Governance and Consumer Engagement

Jordan Kelly
Executive Director Business and Performance

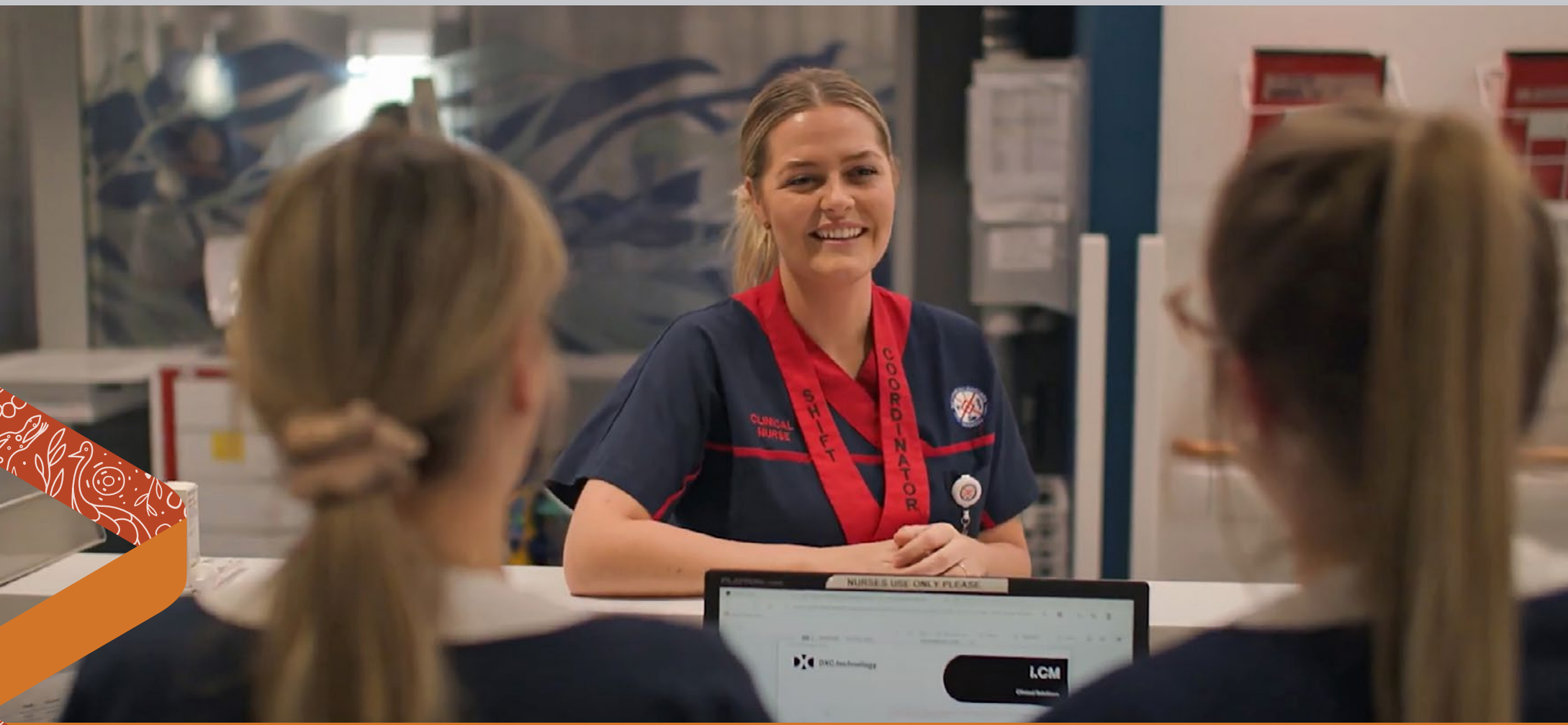
Tanya Adair
Executive Director Major Infrastructure Projects

Joel Gurr
Executive Director Commissioning and Redevelopment

Ian Sheldrake
Executive Director Strategy and Transformation

Scott Goder
A/Executive Director Procurement, Infrastructure and Contract Management

Charles O'Hanlon
Executive Director People and Culture



Disclosures and legal compliance

Audit opinion

Auditor General

INDEPENDENT AUDITOR'S REPORT

2023

North Metropolitan Health Service

To the Parliament of Western Australia

Report on the audit of the financial statements

Qualified 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 2023, 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, except for the effects of the matter described in the Basis for qualified opinion section of my report, 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 2023 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 qualified opinion

The Health Service's main account bank reconciliation for 31 May 2023 included an unreconciled balance of $2,770,196. Subsequently, management made a decision to write-off the unreconciled balance in June 2023 to General administration included under Other Expenditure as per note 3.6 to the financial statements. I was unable to obtain sufficient and appropriate audit evidence to support the write-off. Consequently, I was unable to determine whether any further or alternate adjustments might have been necessary.

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.

Audit opinion continued

Responsibilities of the Board for the financial statements

The Board is responsible for:

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

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

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

Auditor's responsibilities for the audit of the financial statements

As required by the *Auditor General Act 2006*, my responsibility is to express an opinion on the financial statements. The objectives of my audit are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatements, 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

Cash and cash equivalents

I identified significant control weaknesses in the design and implementation of North Metropolitan Health Service's monthly bank reconciliation processes. These weaknesses significantly increased the risk that fraud or errors will not be detected in a timely manner throughout the financial year.

Network security controls

I identified significant weaknesses in network security controls and controls over unauthorised connection of devices at the North Metropolitan Health Service. These weaknesses could compromise the confidentiality, integrity and availability of key systems and information. These weaknesses also exposed the WA Health 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 Board are those policies and procedures established 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 the State's financial reporting framework (the overall control objectives).

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

In my opinion, except for the possible effects of the matters described in the Basis for qualified opinion paragraph, in all material respects, the controls exercised by the North Metropolitan Health Service are sufficiently adequate to provide reasonable assurance that the receipt, expenditure and investment of money, the acquisition and disposal of property and the incurring of liabilities have been in accordance with the State's financial reporting framework during the year ended 30 June 2023.

The Board's responsibilities

The Board is responsible for designing, implementing and maintaining controls to ensure that the receipt, expenditure and investments 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 Engagement 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.

Audit opinion continued

Limitations of controls

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

Report on the audit of the key performance indicators

Opinion

I have undertaken a reasonable assurance engagement on the key performance indicators of the North Metropolitan Health Service for the year ended 30 June 2023. 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 2023.

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 controls 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 Instructions 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 management relating to the report 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 ASQM 1 *Quality Management for Firms that Perform Audits or Reviews of Financial Reports and Other Financial Information, or Other Assurance or Related Services Engagements*, the Office of the Auditor General maintains a comprehensive system of quality management 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 2023, but not the financial statements, key performance indicators and my auditor's report.

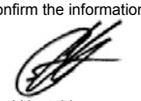
My opinions on the financial statements, controls and key performance indicators do not cover the other information and accordingly I do not express any form of assurance conclusion thereon.

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

The auditor's report relates to the financial statements and key performance indicators of the North Metropolitan Health Service for the year ended 30 June 2023 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.



Carl Huxtable
Acting Deputy Auditor General
Delegate of the Auditor General for Western Australia
Perth, Western Australia
21 September 2023

DISCLOSURES AND LEGAL COMPLIANCE

Certification of financial statements

For the year ended 30 June 2023

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 2023 and financial position as at 30 June 2023.

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

Clinical Professor David Forbes AM
Board Chair
North Metropolitan Health Service
19 September 2023

Steve Toutountzis
Board Finance Committee Chair
North Metropolitan Health Service
19 September 2023

Pratthana Hunt
Chief Finance Officer
North Metropolitan Health Service
19 September 2023

Statement of comprehensive income

For the year ended 30 June 2023

	Notes	2023 $'000	2022 $'000
COST OF SERVICES			
Expenses			
Employee benefits expense	3.1	1,385,280	1,276,488
Contracts for services	3.2	510,261	495,018
Patient support costs	3.3	408,170	371,031
Finance costs	7.2	1,207	698
Depreciation and amortisation expense	5.1, 5.2, 5.3, 5.4	77,251	70,993
Repairs, maintenance and consumable equipment	3.4	48,337	63,496
Other supplies and services	3.5	89,182	90,216
Other expenses	3.6	85,506	67,845
Total cost of services		**2,605,194**	**2,435,785**
INCOME			
Revenue			
Patient charges	4.2	73,116	65,168
Other fees for services	4.3	105,757	87,423
Other grants and contributions	4.4	4,106	1,905
Donation revenue		361	734
Other revenue	4.5	25,814	21,457
Total revenue		**209,154**	**176,687**
Total income other than income from State Government		**209,154**	**176,687**
NET COST OF SERVICES		**2,396,040**	**2,259,098**
Income from State Government			
Department of Health - Service Agreement - State Component	4.1	1,358,348	1,213,634
Department of Health - Service Agreement - Commonwealth Component	4.1	626,618	639,391
Mental Health Commission - Service Agreement	4.1	293,830	273,523
Income from other state government agencies	4.1	2,850	1,009
Assets (transferred)/assumed	4.1	(1,257)	256
Services received free of charge	4.1	117,408	119,090
Royalties for Regions Fund	4.1	382	808
Total income from State Government		**2,398,179**	**2,247,711**
SURPLUS/(DEFICIT) FOR THE PERIOD		**2,139**	**(11,387)**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.10	129,537	111,439
Total other comprehensive income		**129,537**	**111,439**
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**131,676**	**100,052**

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 2023

	Notes	2023 $'000	2022 $'000
ASSETS			
Current Assets			
Cash and cash equivalents	7.3	20,222	29,037
Restricted cash and cash equivalents	7.3	78,185	76,765
Receivables	6.1	56,530	53,674
Inventories	6.3	11,435	12,193
Other current assets	6.4	3,550	2,523
Total Current Assets		**169,922**	**174,192**
Non-Current Assets			
Restricted cash and cash equivalents	7.3	28,462	28,462
Amounts receivable for services	6.2	1,053,996	974,907
Infrastructure, property, plant and equipment	5.1	1,291,340	1,146,002
Right-of-use assets	5.2	28,967	23,795
Service concession assets	5.3	395,772	325,133
Intangible assets	5.4	1,162	3,461
Total Non-Current Assets		**2,799,699**	**2,501,760**
TOTAL ASSETS		**2,969,621**	**2,675,952**
LIABILITIES			
Current Liabilities			
Payables	6.5	179,348	185,282
Capital grant liabilities	6.6	311	4,295
Lease liabilities	7.1	2,909	2,729
Employee related provisions	3.1	289,545	281,683
Other current liabilities	6.7	1,537	1,834
Total Current Liabilities		**473,650**	**475,823**
Non-Current Liabilities			
Lease liabilities	7.1	29,521	23,993
Employee related provisions	3.1	64,161	59,377
Total Non-Current Liabilities		**93,682**	**83,370**
TOTAL LIABILITIES		**567,332**	**559,193**
NET ASSETS		**2,402,289**	**2,116,759**
EQUITY			
Contributed equity	9.10	1,962,833	1,808,979
Reserves	9.10	427,885	298,348
Accumulated surplus/(deficit)		11,571	9,432
TOTAL EQUITY		**2,402,289**	**2,116,759**

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 2023

	Notes	Contributed equity $'000	Reserves $'000	Accumulated surplus/(deficit) $'000	Total equity $'000
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
Distribution to owners		-	-	-	-
Total		99,992	**-**	**-**	99,992
Balance at 30 June 2022		**1,808,979**	**298,348**	**9,432**	**2,116,759**
Balance at 1 July 2022		1,808,979	298,348	9,432	2,116,759
Surplus/(deficit)		-	-	2,139	2,139
Other comprehensive income		-	129,537	-	129,537
Total comprehensive income for the year		**-**	**129,537**	**2,139**	**131,676**
Transactions with owners in their capacity as owners:	9.10				
Capital appropriations administered by Department of Health		121,667	-	-	121,667
Other contributions by owners		34,096	-	-	34,096
Distributions to owners		(1,909)	-	-	(1,909)
Total		153,854	**-**	**-**	153,854
Balance at 30 June 2023		**1,962,833**	**427,885**	**11,571**	**2,402,289**

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 2023

	Notes	2023 $'000	2022 $'000
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriation		2,202,553	2,056,656
Capital appropriations administered by Department of Health		121,667	99,992
Royalties for Regions fund		382	808
Net cash provided by State Government		**2,324,602**	**2,157,456**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(1,366,440)	(1,265,859)
Supplies and services		(1,030,873)	(956,196)
Finance costs		(1,207)	(699)
Receipts			
Receipts from customers		66,889	65,140
Other grants and contributions		4,106	1,905
Donations received		309	734
Other receipts		126,775	100,542
Net cash used in operating activities	7.3.2	**(2,200,441)**	**(2,054,433)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Payment for purchase of non-current physical and intangible assets		(127,857)	(94,383)
Receipts			
Proceeds from sale of non-current physical assets		(6)	78
Net cash used in investing activities		**(127,863)**	**(94,305)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Payments for principal element of lease		(3,693)	(3,339)
Net cash used in financing activities		**(3,693)**	**(3,339)**
Net increase/(decrease) in cash and cash equivalents		(7,395)	5,379
Cash and cash equivalents at the beginning of the year		134,264	128,885
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.3.1	**126,869**	**134,264**

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 2023

1 Basis of Preparation

North Metropolitan Health Service (The Health Service) is a WA Government entity and is controlled by the State of Western Australia, which is the ultimate parent. The Health Service is a not- for-profit entity (as profit is not its principal objective). A description of the nature of its operations and its 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 19 September 2023.

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 Health Service 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.

2 Health Service outputs

How the Health Service operates

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

2.1 Health Service objectives

Mission

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

Services

The Health Service provides the following services:

1. Public Hospital Admitted Services

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

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

2. Public Hospital Emergency Services

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

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

3. Public Hospital Non-Admitted Services

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

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

Notes to the financial statements continued

For the year ended 30 June 2023

2.1 Health Service objectives (continued)

4. Mental Health Services

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

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

5. Aged and Continuing Care Services

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

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

6. Public and Community Health Services

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

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

7. Community Dental Health Services

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

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

8. Small Rural Hospital Services

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

9. Health System Management – Policy and Corporate Services

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

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

Notes to the financial statements continued

For the year ended 30 June 2023

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	
	2023	2022	2023	2022	2023	2022	2023	2022	2023	2022
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
COST OF SERVICES										
Expenses										
Employee benefits expense	709,199	648,139	76,487	68,221	200,501	170,542	236,191	211,300	13,454	13,604
Contracts for services	344,389	334,128	89,757	91,090	22,404	19,853	25,592	26,305	6,732	4,347
Patient support costs	231,259	213,297	16,080	14,872	105,182	89,400	12,276	10,204	3,621	2,518
Finance costs	65	2	1	-	128	8	744	535	8	2
Depreciation and amortisation expense	46,819	42,224	4,034	3,603	11,296	9,978	8,295	7,968	74	102
Repairs, maintenance and consumable equipment	17,684	20,714	1,297	1,603	7,204	8,784	5,185	5,031	212	269
Other supplies and services	52,211	53,178	5,665	5,431	13,986	15,274	1,200	1,000	113	182
Other expenses	30,529	21,667	2,453	1,778	10,997	5,693	12,377	8,852	445	285
Total cost of services	**1,432,155**	**1,333,349**	**195,774**	**186,598**	**371,698**	**319,532**	**301,860**	**271,195**	**24,659**	**21,309**
INCOME										
Revenue										
Patient charges	56,973	48,161	1,768	1,171	9,131	10,441	894	838	-	-
Other fees for services	31,654	25,334	-	-	64,585	51,915	117	132	-	-
Other grants and contributions	76	168	3	4	175	219	-	-	-	1
Donation revenue	9	6	-	-	4	3	-	5	-	-
Other revenue	1,163	1,142	45	52	6,192	5,060	481	315	2	1
Total revenue	**89,875**	**74,811**	**1,816**	**1,227**	**80,087**	**67,638**	**1,492**	**1,290**	**2**	**2**
Total income other than income from State Government	**89,875**	**74,811**	**1,816**	**1,227**	**80,087**	**67,638**	**1,492**	**1,290**	**2**	**2**
NET COST OF SERVICES	**1,342,280**	**1,258,538**	**193,958**	**185,371**	**291,611**	**251,894**	**300,368**	**269,905**	**24,657**	**21,307**

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

Notes to the financial statements continued

For the year ended 30 June 2023

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	
	2023	2022	2023	2022	2023	2022	2023	2022	2023	2022
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
INCOME FROM STATE GOVERNMENT										
Department of Health - Service Agreement - State Component	831,951	729,716	127,982	106,667	156,990	148,486	10,183	7,968	22,924	19,392
Department of Health - Service Agreement - Commonwealth Component	440,386	439,489	69,719	67,114	92,070	86,419	(151)	-	4,705	4,783
Mental Health Commission - Service Agreement	-	-	-	-	-	-	293,830	273,523	-	-
Income from other state government agencies	-	112	-	4	-	52	-	6	1,010	548
Assets (transferred)/assumed	54	256	-	-	-	-	-	-	-	-
Services received free of charge	74,437	74,172	8,007	7,630	18,499	18,410	-	-	-	-
Royalties for regions fund	-	-	-	-	-	-	-	-	-	-
Total income from State Government	**1,346,828**	**1,243,745**	**205,708**	**181,415**	**267,559**	**253,367**	**303,862**	**281,497**	**28,639**	**24,723**
SURPLUS/(DEFICIT) FOR THE PERIOD	**4,548**	**(14,793)**	**11,750**	**(3,956)**	**(24,052)**	**1,473**	**3,494**	**11,592**	**3,982**	**3,416**

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

Notes to the financial statements continued

For the year ended 30 June 2023

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	
	2023	2022	2023	2022	2023	2022	2023	2022	2023	2022
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
COST OF SERVICES										
Expenses										
Employee benefits expense	71,697	68,391	71,963	70,660	-	-	5,788	25,631	1,385,280	1,276,488
Contracts for services	20,866	18,172	521	727	-	396	-	-	510,261	495,018
Patient support costs	19,460	21,934	20,292	18,794	-	-	-	12	408,170	371,031
Finance costs	217	139	44	12	-	-	-	-	1,207	698
Depreciation and amortisation expense	3,594	4,141	3,139	2,977	-	-	-	-	77,251	70,993
Repairs, maintenance and consumable equipment	13,754	23,398	3,000	3,675	-	-	1	22	48,337	63,496
Other supplies and services	11,112	9,784	4,902	4,639	-	-	(7)	728	89,182	90,216
Other expenses	20,291	22,816	8,398	6,551	-	-	16	203	85,506	67,845
Total cost of services	**160,991**	**168,775**	**112,259**	**108,035**	**-**	**396**	**5,798**	**26,596**	**2,605,194**	**2,435,785**
INCOME										
Revenue										
Patient charges	-	-	4,350	4,557	-	-	-	-	73,116	65,168
Other fees for services	6,273	5,534	3,128	4,508	-	-	-	-	105,757	87,423
Other grants and contributions	3,852	1,412	-	101	-	-	-	-	4,106	1,905
Donation revenue	348	720	-	-	-	-	-	-	361	734
Other revenue	17,347	14,535	584	352	-	-	-	-	25,814	21,457
Total revenue	**27,820**	**22,201**	**8,062**	**9,518**	**-**	**-**	**-**	**-**	**209,154**	**176,687**
Total income other than income from State Government	**27,820**	**22,201**	**8,062**	**9,518**	**-**	**-**	**-**	**-**	**209,154**	**176,687**
NET COST OF SERVICES	**133,171**	**146,574**	**104,197**	**98,517**	**-**	**396**	**5,798**	**26,596**	**2,396,040**	**2,259,098**

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

Notes to the financial statements continued

For the year ended 30 June 2023

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	
	2023	2022	2023	2022	2023	2022	2023	2022	2023	2022
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
INCOME FROM STATE GOVERNMENT										
Department of Health - Service Agreement - State Component	108,409	108,061	96,029	79,519	-	-	3,880	13,825	1,358,348	1,213,634
Department of Health - Service Agreement - Commonwealth Component	14,727	19,483	2,162	9,690	-	-	3,000	12,413	626,618	639,391
Mental Health Commission - Service Agreement	-	-	-	-	-	-	-	-	293,830	273,523
Income from other state government agencies	1,840	277	-	10	-	-	-	-	2,850	1,009
Assets (transferred)/assumed	(1,311)	-	-	-	-	-	-	-	(1,257)	256
Services received free of charge	10,773	13,897	5,692	4,760	-	-	-	221	117,408	119,090
Royalties for regions fund	-	-	-	-	382	808	-	-	382	808
Total income from State Government	**134,438**	**141,718**	**103,883**	**93,979**	**382**	**808**	**6,880**	**26,459**	**2,398,179**	**2,247,711**
SURPLUS/(DEFICIT) FOR THE PERIOD	**1,267**	**(4,856)**	**(314)**	**(4,538)**	**382**	**412**	**1,082**	**(137)**	**2,139**	**(11,387)**

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

Notes to the financial statements continued

For the year ended 30 June 2023

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	2023 $'000	2022 $'000
Employee benefits expenses	3.1(a)	1,385,280	1,276,488
Employee related provisions	3.1(b)	353,706	341,060
Contracts for services	3.2	510,261	495,018
Patient support costs	3.3	408,170	371,031
Repairs, maintenance and consumable equipment	3.4	48,337	63,496
Other supplies and services	3.5	89,182	90,216
Other expenses	3.6	85,506	67,845

3.1(a) Employee benefits expenses

	2023 $'000	2022 $'000
Wages and salaries	1,260,113	1,165,854
Superannuation - defined contributions plans	125,167	110,634
Total employee benefits expenses	**1,385,280**	**1,276,488**
Add: AASB 16 Non-monetary benefits	1,449	1,473
Less: Employee Contribution	(26)	(28)
Net employee benefits	**1,386,703**	**1,277,933**

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 Health Service.

Employee Contributions: Contributions made to the Health Service by employees towards employee benefits that have been provided by the Health Service. 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.

	2023 $'000	2022 $'000
Current		
Annual leave	143,086	140,131
Time off in lieu	36,981	33,745
Long service leave	107,832	106,226
Deferred salary scheme	1,646	1,581
	289,545	**281,683**
Non-Current		
Long service leave	64,161	59,377
	64,161	**59,377**
Total employee related provisions	**353,706**	**341,060**

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:

	2023 $'000	2022 $'000
Within 12 months of the end of the reporting period	96,770	93,659
More than 12 months after the end of the reporting period	83,297	80,217
	180,067	**173,876**

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.

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:

	2023 $'000	2022 $'000
Within 12 months of the end of the reporting period	25,880	25,494
More than 12 months after the end of the reporting period	146,113	140,109
	171,993	**165,603**

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.

Notes to the financial statements continued

For the year ended 30 June 2023

3.1(b) Employee related provisions (continued)

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:

	2023 $'000	2022 $'000
Within 12 months of the end of the reporting period	593	791
More than 12 months after the end of the reporting period	1,053	790
Carrying amount at end of period	**1,646**	**1,581**

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

	2023 $'000	2022 $'000
Public patients services [(a)]	456,954	437,321
Mental Health	26,726	33,570
Other aged-care services	12,607	13,190
Other contracts	13,974	10,937
Total contracts for services	**510,261**	**495,018**

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

	2023 $'000	2022 $'000
Medical supplies and services	289,434	260,619
Pathology services received free of charge	37,739	36,083
Domestic charges	23,291	25,282
Fees for visiting medical practitioners	16,047	14,431
Fuel, light and power	13,591	11,429
Food supplies	11,803	10,668
Patient transport costs	3,444	2,604
Research, development and other grants	12,821	9,915
Total patient support costs	**408,170**	**371,031**

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

3.4 Repairs, maintenance and consumable equipment

	2023 $'000	2022 $'000
Repairs and maintenance	33,068	39,775
Consumable equipment	15,269	23,721
Total repairs, maintenance and consumable equipment	**48,337**	**63,496**

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

	2023 $'000	2022 $'000
Sanitation and waste removal services	3,270	3,118
Administration and management services	4,195	3,879
Interpreter services	2,128	2,784
Security services	1,313	1,567
Services provided by Health Support Services: [(a)]		
ICT services	52,516	50,650
Supply chain services	10,458	14,518
Financial services	2,799	2,333
Human resource services	11,610	10,139
Other	893	1,228
Total other supplies and services	**89,182**	**90,216**

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

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

Notes to the financial statements continued

For the year ended 30 June 2023

3.6 Other expenses

	2023 $'000	2022 $'000
Communications	3,077	4,369
Computer services	3,778	3,746
Workers' compensation insurance	20,383	14,155
Other insurances	18,667	13,476
Consultancy fees	3,334	7,267
Other employee related expenses	5,820	6,289
Printing and stationery	4,091	3,930
Expected credit losses expense	3,403	800
Freight and cartage	1,620	1,453
Periodical subscriptions	778	655
Motor vehicle expenses	1,797	1,568
General administration	11,721	7,004
Legal expenses	384	259
Rental	2,410	1,647
Loss on disposal of non-current assets	1,683	24
Other	2,560	1,203
Total other expenses	**85,506**	**67,845**

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.

General administration includes $3.2 million parking charges, $2.8 million licence fees, $2.8 million accounting adjustment to cash, and expenses relating to other sundry items including bank fees, subscriptions, membership fee and transport. The $2.8 million adjustment reflects a realignment between the reported cash balance in the general ledger and the bank statement. This misalignment has most likely arisen from historic unreconciled amounts formed over several previous financial years, noting inherent system limitations. Making this adjustment enables the reflection of a demonstrably reconciled reported cash position.

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	2023 $'000	2022 $'000
Income from State Government	4.1	2,398,179	2,247,711
Patient charges	4.2	73,116	65,168
Other fees for services	4.3	105,757	87,423
Other grants and contributions	4.4	4,106	1,905
Other revenue	4.5	25,814	21,457

4.1 Income from State Government

	2023 $'000	2022 $'000
Appropriation received for the period:		
Department of Health - Service Agreement - State Component	1,358,348	1,213,634
Department of Health - Service Agreement - Commonwealth Component		
- Capital grants	3,881	3,245
- Recurrent grants	622,737	636,146
Mental Health Commission - Service Agreement	293,830	273,523
Total appropriation received	**2,278,796**	**2,126,548**
Grants and income from other state government agencies:		
Disability Services Commission	688	715
Recoveries for Insurance Claims from State Government Insurers	1,613	78
Pathology services to other Health Services	38	209
Other specific grants	511	7
Total grants and subsidies	**2,850**	**1,009**
Assets (transferred)/assumed	(1,257)	256
Total assets (transferred)/assumed	**(1,257)**	**256**
Resources received from other public sector entities during the period:		
Department of Finance - government leased accommodation	39	11
Department of Primary Industries and Regional Development - COVID contact tracing	-	143
Department of Education - Dental therapy units rental expense	1,069	78
State Solicitor's Office - legal service	304	-
PathWest - pathology services	37,739	36,083
Services received from Health Support Services (HSS)		
ICT services	52,516	50,650
Supply chain services	10,458	14,518
Financial services	2,799	2,333
Human resources services	11,610	10,139
COVID testing kits	874	5,135
Total received	**117,408**	**119,090**
Regional Community Services Account	382	808
Total Royalties for Regions Fund	**382**	**808**
Total income from State Government	**2,398,179**	**2,247,711**

Notes to the financial statements continued

For the year ended 30 June 2023

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

	2023 $'000	2022 $'000
Inpatient bed charges	51,909	43,730
Inpatient other charges	5,971	5,289
Outpatient charges	15,236	16,149
Total patient charges	**73,116**	**65,168**

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

	2023 $'000	2022 $'000
Recoveries from the Pharmaceutical Benefits Scheme (PBS)	99,764	82,186
Clinical services to other health organisations	4,918	4,210
Non-clinical services to other health organisations	1,075	1,027
Total other fees for services	**105,757**	**87,423**

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

4.4 Other grants and contributions

	2023 $'000	2022 $'000
Research grants	4,106	1,905
	4,106	**1,905**

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

	2023 $'000	2022 $'000
Use of hospital facilities	9,173	7,320
Rent from commercial properties	451	482
Rent from residential properties	127	168
Boarders' accommodation	2,266	1,958
Sale of radiopharmacies	5,014	3,940
Parking	4,973	4,941
Other	3,810	2,648
Total other revenue	**25,814**	**21,457**

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	2023 $'000	2022 $'000
Property, plant and equipment	5.1	1,291,340	1,146,002
Depreciation	5.1.1	66,555	60,794
Right-of-use assets	5.2	28,967	23,795
Depreciation	5.2.1	4,230	4,114
Service concession assets	5.3	395,772	325,133
Depreciation	5.3.1	6,187	5,820
Intangible assets	5.4	1,162	3,461
Amortisation	5.4.1	279	265

Notes to the financial statements continued

For the year ended 30 June 2023

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 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 year	**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)
Disposal	-	-	-	-	-	-	(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.

Notes to the financial statements continued

For the year ended 30 June 2023

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 2022													
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)
Carrying amount at start of period	**220,350**	**708,123**	**22,071**	**70,508**	**5,490**	**1,913**	**3,197**	**45**	**60,584**	**52,700**	**706**	**315**	**1,146,002**
Additions	-	5,973	33,411	-	1,150	(48)	650	-	19,342	541	2,929	-	63,948
Disposals	-	(267)	-	(151)	(101)	-	(101)	-	(1,028)	(26)	-	-	(1,674)
Transfers of assets from owner	-	32,963	-	-	-	-	-	-	1,133	-	-	-	34,096
Transfers of assets to other agency	-	(2,371)	-	-	-	-	-	-	-	-	-	-	(2,371)
Transfers from /(to) other asset classes	-	-	-	-	-	-	(20)	-	20	-	-	-	-
Revaluation increments/(decrements)	20,379	97,515	-	-	-	-	-	-	-	-	-	-	117,894
Impairment losses	-	-	-	-	-	-	-	-	-	-	-	-	-
Depreciation	-	(42,447)	-	(3,810)	(731)	(366)	(624)	(29)	(14,966)	(3,582)	-	-	(66,555)
Carrying amount at 30 June 2023	**240,729**	**799,489**	**55,482**	**66,547**	**5,808**	**1,499**	**3,102**	**16**	**65,085**	**49,633**	**3,635**	**315**	**1,291,340**
Gross carrying amount	240,729	799,489	55,482	92,920	9,460	3,189	6,150	230	138,677	74,812	3,635	315	1,425,088
Accumulated depreciation	-	-	-	(26,373)	(3,652)	(1,690)	(2,975)	(214)	(73,413)	(25,128)	-	-	(133,445)
Accumulated impairment loss	-	-	-	-	-	-	(73)	-	(179)	(51)	-	-	(303)

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

Notes to the financial statements continued

For the year ended 30 June 2023

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 2022 by the Western Australian Land Information Authority (Valuations and Property Analytics). The valuations were performed during the year ended 30 June 2023 and recognised at 30 June 2023. In undertaking the revaluation, fair value was determined by reference to market values for land: $5.053 million (2022: $4.529 million) and buildings: $0.444 million (2022: $0.367 million). For the remaining balance, fair value of buildings was determined on the basis of current replacement cost and fair value of land was determined on the basis of comparison with market evidence for land with low level utility (high restricted use land).

Notes to the financial statements continued

For the year ended 30 June 2023

5.1.1 Depreciation and impairment

	2023 $'000	2022 $'000
Depreciation		
Buildings	42,447	39,301
Site infrastructure	3,810	3,817
Leasehold improvement	731	451
Computer equipment	366	478
Furniture and fittings	624	584
Motor vehicles	29	31
Medical equipment	14,966	12,539
Other plant and equipment	3,582	3,593
Total depreciation for the period	**66,555**	**60,794**

All surplus assets at 30 June 2023 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.

Leasehold improvements are depreciated over the shorter of the lease term and their useful lives. 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.

5.1.1 Depreciation and impairment (continued)

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

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

5.2 Right-of-use assets

	Land $'000	Buildings $'000	Plant equipment and vehicles $'000	Total $'000
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)	(6,723)	(2,873)	(9,950)
1 July 2022				
Gross carrying amount	715	28,150	4,880	33,745
Accumulated depreciation	(354)	(6,723)	(2,873)	(9,950)
Carrying amount at start of period	**361**	**21,427**	**2,007**	**23,795**
Additions	-	8,317	1,281	9,598
Cost Adjustment	13	(405)	590	198
Disposals	-	(379)	(15)	(394)
Depreciation	(124)	(2,792)	(1,314)	(4,230)
Carrying amount at 30 June 2023	**250**	**26,168**	**2,549**	**28,967**
Gross carrying amount	728	34,174	5,403	40,305
Accumulated depreciation	(478)	(8,006)	(2,854)	(11,338)

Notes to the financial statements continued

For the year ended 30 June 2023

5.2 Right-of-use assets (continued)

Initial recognition

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

The Health Service assesses whether:

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

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

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

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

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

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

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

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

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

Subsequent Measurement

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

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:

	2023 $'000	2022 $'000
Depreciation expense of right-of-use assets	4,230	4,114
Lease interest expense	1,207	698
Expenses relating to variable lease payments not included in lease liabilities	1	6
Short-term leases	-	13
Low-value leases	-	6
Total amount recognised in the statement of comprehensive income	**5,438**	**4,837**

The total cash outflow for leases in 2023 was $4,901,000 (2022: $4,062,000).

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

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

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

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

Notes to the financial statements continued

For the year ended 30 June 2023

5.3 Service concession assets

	Land	Buildings	Buildings under construction	Site infrastructure	Computer equipment	Furniture & fittings	Medical equipment	Other plant & equipment	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
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
Transfer 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)
1 July 2022									
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)
Carrying amount at start of period	**31,800**	**210,672**	**68,700**	**12,631**	**32**	**822**	**457**	**19**	**325,133**
Additions	-	-	65,183	-	-	-	-	-	65,183
Transfers from Work in Progress	-	20,676	(20,676)	-	-	-	-	-	-
Revaluation increments/(decrements)	(300)	16,143	-	-	-	-	-	-	15,843
Impairment losses	-	(4,200)	-	-	-	-	-	-	(4,200)
Depreciation	-	(5,547)	-	(334)	(32)	(205)	(67)	(2)	(6,187)
Carrying amount at 30 June 2023	**31,500**	**237,744**	**113,207**	**12,297**	**-**	**617**	**390**	**17**	**395,772**
Gross carrying amount	31,500	237,744	113,207	14,120	128	1,952	5,105	66	403,822
Accumulated depreciation	-	-	-	(1,823)	(128)	(1,335)	(4,715)	(49)	(8,050)

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

Notes to the financial statements continued

For the year ended 30 June 2023

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

	2023 $'000	2022 $'000
Charge for the period		
Buildings	5,547	4,660
Site infrastructure	334	816
Computer equipment	32	32
Furniture and fittings	205	205
Medical equipment	67	98
Other plant and equipment	2	9
Total depreciation for the period	**6,187**	**5,820**

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 2023 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.

Notes to the financial statements continued

For the year ended 30 June 2023

5.4 Intangible assets

	Computer software $'000	Total $'000
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)
Year ended 30 June 2023		
1 July 2022		
Gross carrying amount	4,227	4,227
Accumulated amortisation	(766)	(766)
Carrying amount at start of year	**3,461**	**3,461**
Cost Adjustment	(111)	(111)
Transfers from/(to) other agency	(1,909)	(1,909)
Amortisation expense	(279)	(279)
Carrying amount at 30 June 2023	**1,162**	**1,162**
Gross carrying amount	2,205	2,205
Accumulated amortisation	(1,043)	(1,043)

Initial recognition

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.

Acquired and internally generated intangible assets costing $5,000 or more that comply with the recognition criteria of AASB 138.57 *Intangible Assets* (as noted above), are capitalised.

Costs incurred below these thresholds are immediately expensed directly to the Statement of comprehensive income.

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.

5.4 Intangible assets (continued)

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

	2023 $'000	2022 $'000
Computer software	279	265
Total amortisation for the period	**279**	**265**

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

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

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

Computer software [(a)]	5 years

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

Impairment of intangible assets

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

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

Notes to the financial statements continued

For the year ended 30 June 2023

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	2023 $'000	2022 $'000
Receivables	6.1	56,530	53,674
Amounts receivable for services	6.2	1,053,996	974,907
Inventories	6.3	11,435	12,193
Other current assets	6.4	3,550	2,523
Payables	6.5	179,348	185,282
Capital grant liabilities	6.6	311	4,295
Other liabilities	6.7	1,537	1,834

6.1 Receivables

	2023 $'000	2022 $'000
Current		
Trade receivables	32,524	32,391
Other receivables	728	606
Allowance for impairment of trade receivables	(9,386)	(11,880)
Accrued revenue	23,628	22,733
GST receivable	9,036	9,824
Total current receivables	**56,530**	**53,674**

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

	2023 $'000	2022 $'000
Reconciliation of changes in the allowance for impairment of trade receivables		
Balance at start of period	11,880	13,349
Expected credit losses expense	3,403	800
Net write-back adjustment	107	(76)
Amounts written off during the period	(6,004)	(2,193)
Balance at end of period	**9,386**	**11,880**

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

	2023 $'000	2022 $'000
Current	-	-
Non-current	1,053,996	974,907
Balance at end of period	**1,053,996**	**974,907**

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

	2023 $'000	2022 $'000
Current		
Pharmaceutical stores - at cost	10,205	11,156
Engineering stores - at cost	1,230	1,037
Total inventories	**11,435**	**12,193**

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

	2023 $'000	2022 $'000
Current		
Prepayments	3,550	2,523
Total other current assets	**3,550**	**2,523**

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

	2023 $'000	2022 $'000
Current		
Trade payables	10,499	10,794
Other payables	2,165	2,109
Accrued expenses	126,677	137,747
Accrued salaries	40,007	34,632
Total current payables	**179,348**	**185,282**

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.

Notes to the financial statements continued

For the year ended 30 June 2023

6.6 Capital grant liabilities

	2023 $'000	2022 $'000
Reconciliation of changes in capital grant liabilities		
Opening balance at the beginning of the period	4,295	7,757
Additions / (Reversals)	(103)	(229)
Income recognised in the reporting period	(3,881)	(3,233)
Total capital grant liabilities	**311**	**4,295**
Current	311	4,295
Non-current	-	-
Total capital grant liabilities	**311**	**4,295**

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

	2023 $'000	2022 $'000
Refundable deposits	1,207	1,198
Paid parental leave scheme	214	226
Other	116	410
Total other current liabilities	**1,537**	**1,834**

7 Financing

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

	Notes	2023 $'000	2022 $'000
Lease liabilities	7.1	32,430	26,722
Finance costs	7.2	1,207	698
Cash and cash equivalents	7.3		
Cash and cash equivalents	7.3.1	20,222	29,037
Restricted cash and cash equivalents	7.3.1	106,647	105,227
Reconciliation of net cost of services to net cash used in operating activities	7.3.2	(2,200,441)	(2,054,433)
Capital commitments	7.4	228,894	325,535

7.1 Lease liabilities

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

	2023 $'000	2022 $'000
Lease liabilities		
Current	2,909	2,729
Non-current	29,521	23,993
Total lease liabilities	**32,430**	**26,722**

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.

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.

Notes to the financial statements continued

For the year ended 30 June 2023

7.2 Finance costs

	2023 $'000	2022 $'000
Lease interest expense	1,207	698
Finance costs expensed	**1,207**	**698**

7.3 Cash and cash equivalents

7.3.1 Reconciliation of cash

	2023 $'000	2022 $'000
Cash and cash equivalents	20,222	29,037
Restricted cash and cash equivalents	106,647	105,227
Balance at end of period	**126,869**	**134,264**
Restricted cash and cash equivalents		
Current		
Grants from State and Commonwealth Governments	12,411	18,021
Other specific purposes [(a)]	50,025	47,307
Mental Health Commission funding [(b)]	15,749	11,437
Total current	**78,185**	**76,765**
Non-current		
Accrued salaries suspense account [(c)]	28,462	28,462
Total non-current	**28,462**	**28,462**
Total restricted cash and cash equivalents	**106,647**	**105,227**

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	2023 $'000	2022 $'000
Net cost of services		(2,396,040)	(2,259,098)
Non-cash items:			
Expected credit losses expense	3.6	3,403	800
Depreciation and amortisation expense	5.0	77,251	70,993
Net loss from disposal of non-current assets	3.6	1,683	24
Write-off of receivables	6.1.1	(5,897)	(2,269)
Write down of inventories		354	201
Donation of non-current assets		(52)	-
Services received free of charge	4.1	117,408	119,090
(Increase)/decrease in assets:			
GST receivable		788	(1,510)
Receivables		(1,150)	(2,641)
Inventories		404	(4,929)
Other current assets		(1,027)	384
Increase/(decrease) in liabilities:			
Payables		(5,931)	7,999
Capital grant liabilities		(3,984)	(3,462)
Current employee related provisions		7,862	17,155
Non-current employee related provisions		4,784	2,885
Other current liabilities		(297)	(55)
Net cash used in operating activities		**(2,200,441)**	**(2,054,433)**

7.4 Capital commitments

The commitments below are inclusive of GST where relevant.

	2023 $'000	2022 $'000
Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows:		
Within 1 year	115,121	183,808
Later than 1 year and not later than 5 years	95,080	141,727
	210,201	**325,535**

Notes to the financial statements continued

For the year ended 30 June 2023

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 and liabilities	8.2
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 and leases. 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:

	2023 $'000	2022 $'000
Financial assets		
Cash and cash equivalents	126,869	134,264
Financial assets at amortised cost [a]	1,101,490	1,018,757
Total financial assets	**1,228,359**	**1,153,021**
Financial liabilities		
Financial liabilities measured at amortised cost	211,778	212,004
Total financial liabilities	**211,778**	**212,004**

(a) The amount of financial assets at amortised cost excluded GST recoverable from the ATO (statutory receivable).

(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 2023						
Expected credit loss rate		1.85%	3.14%	8.66%	14.13%	55.77%
Estimated total gross carrying amount at default	32,524	9,940	4,400	1,397	1,005	15,782
Expected credit losses	(9,386)	(184)	(138)	(121)	(142)	(8,801)
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)

Notes to the financial statements continued

For the year ended 30 June 2023

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
2023											
Financial Assets											
Cash and cash equivalents	-	126,869	-	-	126,869	126,869	126,869	-	-	-	-
Receivables [a]	-	47,494	-	-	47,494	47,494	47,494	-	-	-	-
Amounts receivable for services	-	1,053,996	-	-	1,053,996	1,053,996	-	-	-	-	1,053,996
		1,228,359	**-**	**-**	**1,228,359**	**1,228,359**	**174,363**	**-**	**-**	**-**	**1,053,996**
Financial Liabilities											
Payables	-	179,348	-	-	179,348	179,348	179,348	-	-	-	-
Lease liabilities [b]	4.27	32,430	32,430	-	-	44,174	364	755	3,198	14,434	25,423
		211,778	**32,430**	**-**	**179,348**	**223,522**	**179,712**	**755**	**3,198**	**14,434**	**25,423**
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**

Notes to the financial statements continued

For the year ended 30 June 2023

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:

	2023 $'000	2022 $'000
Litigation in progress		
Pending litigation that may be recoverable on settlement of claims from former employee	-	1,061
Number of claims	-	1

8.2.2 Contingent liabilities

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

	2023 $'000	2022 $'000
Litigation in progress		
Pending litigation that is not recoverable from RiskCover insurance and may affect the financial position of the Health Service	-	610
Number of claims	-	3

Contaminated sites

Under the *Contaminated Sites Act 2003,* the Health Service is required to report known and suspected contaminated sites to the Department of Water and Environmental Regulation (DWER). In accordance with the *Contaminated Sites Act 2003*, DWER classifies these sites on the basis of the risk to human health, the environment and environmental values. Where sites are classified as contaminated – remediation required or possibly contaminated – investigation required, the Health Service may have a liability in respect of investigation or remediation expenses.

At the reporting date, the Health Service does not have any suspected contaminated sites reported under the Act.

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
2023				
Assets measured and recognised at fair value:				
Land				
Residential	-	43	-	43
Specialised	-	5,010	267,176	272,186
Buildings				
Residential and commercial car park	-	214	43,170	43,384
Specialised	-	230	993,619	993,849
	-	**5,497**	**1,303,965**	**1,309,462**
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**

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.

Notes to the financial statements continued

For the year ended 30 June 2023

8.3 Fair value measurements (continued)

Fair value measurements using significant unobservable inputs (Level 3)

	Land $'000	Buildings $'000	Total $'000
2023			
Fair value at start of period	247,621	918,428	1,166,049
Additions and transfers from work in progress	-	59,661	59,661
Revaluation increments/(decrements)	19,555	109,374	128,929
Transfers of assets to other agency	-	(2,371)	(2,371)
Disposals	-	(267)	(267)
Depreciation	-	(48,036)	(48,036)
Fair value at end of period	**267,176**	**1,036,789**	**1,303,965**
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**

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.

	Notes
Events occurring after the end of the reporting period	9.1
Changes in accounting policy	9.2
Future impact of Australian Accounting Standards not yet operative	9.3
Key management personnel	9.4
Related party transactions	9.5
Related bodies	9.6
Affiliated bodies	9.7
Special purpose accounts	9.8
Remuneration of auditor	9.9
Equity	9.10
Supplementary financial information	9.11
Disclosure of Trust Accounts	9.12

9.1 Events occurring after the end of the reporting period

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

9.2 Changes in accounting policy

There were no new Australian Accounting Standards effective for the year 2022-23 that applied to the Health Service.

Notes to the financial statements continued

For the year ended 30 June 2023

9.3 Future impact of Australian Accounting Standards not yet operative

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

		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 2022-7	*Editorial Corrections to Australian Accounting Standards and Repeal of Superseded and Redundant Standards* This Standard makes editorial corrections to various Australian Accounting Standards and AASB Practice Statement 2 Making Materiality Judgements. There is no financial impact.	**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 2024**
AASB 2022-10	*Amendments to Australian Accounting Standards – Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities.* This Standard amends AASB 13 including adding authoritative implementation guidance and providing related illustrative examples, for fair value measurements of non-financial assets of not-for-profit public sector entities not held primarily for their ability to generate net cash inflows. The Health Service has not assessed the impact of the Standard.	**1 Jan 2024**

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

		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. It was amended by AASB 2022-8 to take effect for Not-For-Profit insurance contracts from 1 July 2026. The Health Service has not assessed the impact of the Standard.	**1 July 2026**
AASB 2022-9	*Amendments to Australian Accounting Standards – Insurance Contracts in the Public Sector* This Standard amends AASB 17 and AASB 1050 to include modifications with respect to the application of AASB 17 by public sector entities. This Standard also amends the following Standards to remove the temporary consequential amendments set out in AASB 2022-8 since AASB 4 and AASB 1023 do not apply to public sector entities for periods beginning on or after 1 July 2026: (a) AASB 1; (b) AASB 3; (c) AASB 5; (d) AASB 7; (e) AASB 9; (f) AASB 15; (g) AASB 119; (h) AASB 132; (i) AASB 136; (j) AASB 137; (k) AASB 138; (l) AASB 1057; and (m) AASB 1058 There is no financial impact.	**1 Jan 2026**

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

Compensation band ($)	**2023**	**2022**
$10,001 – $20,000	-	1
$30,001 – $40,000	1	-
$40,001 – $50,000	8	7
$80,001 – $90,000	1	1
	10	**9**

	2023 $'000	**2022 $'000**
Short-term employee benefits	434	386
Post-employment benefits	46	39
	480	**425**

Notes to the financial statements continued

For the year ended 30 June 2023

9.4 Key management personnel (continued)

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:

Compensation band ($)	2023	2022
$0 – $50,000	1	-
$50,001 – $100,000	2	2
$100,001 – $150,000	3	-
$150,001 – $200,000	2	2
$200,001 – $250,000	1	5
$250,001 – $300,000	3	1
$300,001 – $350,000	1	1
$400,001 – $450,000	1	1
$450,001 – $500,000	-	1
$550,001 – $600,000	2	-
$600,001 – $650,000	-	1
	16	**14**

	2023 $'000	2022 $'000
Short-term employee benefits	3,185	3,112
Post-employment benefits	336	298
Other long-term benefits	313	337
Total compensation of senior officers	**3,834**	**3,747**

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.

9.5 Related party transactions (continued)

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 (Note 4.1);
- equity contributions (Note 9.11);
- services received free of charge from Health Support Services, PathWest and Department of Finance (Note 4.1);
- lease rentals payments to Department of Finance (Government Office Accommodation and State Fleet) (Note 7.1);
- insurance payments to the Insurance Commission and RiskCover fund (Note 3.6);
- lease rentals payments to Department of Housing (Government Regional Officer Housing) (Note 7.1);
- remuneration for services provided by the Auditor General (Note 9.9);
- superannuation contributions to GESB (Note 3.1(a))

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.

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.

Notes to the financial statements continued

For the year ended 30 June 2023

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.

	2023 $'000	2022 $'000
Balance at start of period	11,437	1,278
Add receipts		
Service delivery arrangement:		
Commonwealth contributions	116,028	96,126
State contributions	177,802	177,397
	293,830	273,523
Less Payments	(289,518)	(263,364)
Balance at end of period	**15,749**	**11,437**

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:

	2023 $'000	2022 $'000
Auditing the accounts, controls, financial statements and key performance indicators	425	379
	425	**379**

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.

	2023 $'000	2022 $'000
Balance at start of period	1,808,979	1,708,987
Contribution by owners		
Capital Appropriations administered by Department of Health	121,667	99,992
Transfer of property, plant and equipment from Department of Health	34,096	-
	1,964,742	**1,808,979**
Distributions to owners		
Transfer of property, plant and equipment to HSS	(1,909)	-
Total contribution by owners	**(1,909)**	**-**
Balance at end of period	**1,962,833**	**1,808,979**

	2023 $'000	2022 $'000
Asset revaluation reserve		
Balance at the start of period	298,348	186,909
Net revaluation increments/(decrements):		
Land	20,079	22,379
Buildings	109,458	89,060
Balance at end of period	**427,885**	**298,348**

9.11 Supplementary financial information

(a) Write-offs

	2023 $'000	2022 $'000
Revenue and debts written off under the authority of:		
The Accountable Authority	2,939	2,269
The Minister	1,711	-
The Treasurer	1,354	-
	6,004	**2,269**

(b) Losses through theft, defaults and other causes

	2023 $'000	2022 $'000
Losses of public monies and public or other property through theft or default	73	2
Less amount recovered	(73)	(2)
Net losses	**-**	**-**

(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:

	2023 $'000	2022 $'000
Department of Justice - dental treatment	1,762	1,919
Disability Services Commission - dental treatment	1,420	1,872
	3,182	**3,791**

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 trust accounts for the purpose of holding patients' private monies.

A summary of the transactions for these trust accounts are as follows:

	2023 $'000	2022 $'000
Balance at the start of period	166	173
Add Receipts	652	690
Less Payments	(652)	(697)
Balance at the end of period	**166**	**166**

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

	2023 $'000	2022 $'000
RF Shaw Foundation		
Balance at start of period	6	1,106
Less Payments	-	(1,100)
Balance at the end of period	**6**	**6**

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.

Notes to the financial statements continued

For the year ended 30 June 2023

10 Explanatory statements

This section explains variations in the financial performance of the Health Service.

	Notes
Explanatory statement for controlled operations	10.1

10.1 Explanatory statement 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 2023, and between the actual results for 2023 and 2022 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 following variance analyses for the:

1. Estimate and actual results for the current year
   - Total Cost of Services of the estimate for the Statement of comprehensive income and Statement of cash flows (1% of $2,417,199,000), and
   - Total Assets of the estimate for the Statement of financial position (1% of $2,845,312,000).
2. Actual results for the current year and the prior year actual
   - Total Cost of Services for the previous year for the Statements of comprehensive income and Statement of cash flows (1% of $2,435,785,000), and
   - Total Assets for the previous year for the Statement of financial position (1% of $2,675,952,000).

10.1.1 Statement of Comprehensive Income Variances

	Variance Notes	Estimate 2023 $'000	Actual 2023 $'000	Actual 2022 $'000	Variance between actual and estimate $'000	Variance between actual results for 2023 and 2022 $'000
COST OF SERVICES						
Expenses						
Employee benefits expense	1	1,258,403	1,385,280	1,276,488	126,877	108,792
Contracts for services		513,163	510,261	495,018	(2,902)	15,243
Patient support costs	2, a	347,013	408,170	371,031	61,157	37,139
Finance costs		683	1,207	698	524	509
Depreciation and amortisation expense		74,705	77,251	70,993	2,546	6,258
Repairs, maintenance and consumable equipment		50,940	48,337	63,496	(2,603)	(15,159)
Other supplies and services		100,811	89,182	90,216	(11,629)	(1,034)
Other expenses		71,481	85,506	67,845	14,025	17,661
Total cost of services		**2,417,199**	**2,605,194**	**2,435,785**	**187,995**	**169,409**
INCOME						
Revenue						
Patient charges		71,219	73,116	65,168	1,897	7,948
Other fees for services		89,981	105,757	87,423	15,776	18,334
Other grants and contributions		-	4,106	1,905	4,106	2,201
Donation revenue		-	361	734	361	(373)
Other revenue		20,723	25,814	21,457	5,091	4,357
Total revenue		**181,923**	**209,154**	**176,687**	**27,231**	**32,467**
Total income other than income from State Government		**181,923**	**209,154**	**176,687**	**27,231**	**32,467**
NET COST OF SERVICES		**2,235,276**	**2,396,040**	**2,259,098**	**160,764**	**136,942**
INCOME FROM STATE GOVERNMENT						
Department of Health - Service Agreement - State Component	3, b	1,157,277	1,358,348	1,213,634	201,071	144,714
Department of Health - Service Agreement - Commonwealth Component		676,322	626,618	639,391	(49,704)	(12,773)
Mental Health Commission - Service Agreement		295,564	293,830	273,523	(1,734)	20,307
Income from other state government agencies		-	2,850	1,009	2,850	1,841
Assets (transferred)/assumed		-	(1,257)	256	(1,257)	(1,513)
Services received free of charge		104,521	117,408	119,090	12,887	(1,682)
Royalties for Regions Fund		1,592	382	808	(1,210)	(426)
Total income from State Government		**2,235,276**	**2,398,179**	**2,247,711**	**162,903**	**150,468**
Surplus/(deficit) for the period		**-**	**2,139**	**(11,387)**	**2,139**	**13,526**
Other comprehensive income						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve		-	129,537	111,439	129,537	18,098
Total other comprehensive income		**-**	**129,537**	**111,439**	**129,537**	**18,098**
Total comprehensive income for the period		**-**	**131,676**	**100,052**	**131,676**	**31,624**

Notes to the financial statements continued

For the year ended 30 June 2023

10.1.2 Statement of Financial Position Variances

	Variance Notes	Estimate 2023 $'000	Actual 2023 $'000	Actual 2022 $'000	Variance between actual and estimate $'000	Variance between actual results for 2023 and 2022 $'000
ASSETS						
Current assets						
Cash and cash equivalents		30,399	20,222	29,037	(10,177)	(8,815)
Restricted cash and cash equivalents		61,048	78,185	76,765	17,137	1,420
Receivables		53,674	56,530	53,674	2,856	2,856
Inventories		12,193	11,435	12,193	(758)	(758)
Other current assets		8,263	3,550	2,523	(4,713)	1,027
Total Current Assets		**165,577**	**169,922**	**174,192**	**4,345**	**(4,270)**
Non-current assets						
Restricted cash and cash equivalents		34,438	28,462	28,462	(5,976)	-
Amounts receivable for services		1,049,612	1,053,996	974,907	4,384	79,089
Infrastructure, property, plant and equipment	c	1,262,668	1,291,340	1,146,002	28,672	145,338
Right-of-use assets		19,306	28,967	23,795	9,661	5,172
Service concession assets	4, d	310,249	395,772	325,133	85,523	70,639
Intangible assets		3,462	1,162	3,461	(2,300)	(2,299)
Total non-current assets		**2,679,735**	**2,799,699**	**2,501,760**	**119,964**	**297,939**
Total assets		**2,845,312**	**2,969,621**	**2,675,952**	**124,309**	**293,669**
LIABILITIES						
Current liabilities						
Payables		180,289	179,348	185,282	(941)	(5,934)
Capital grant liabilities		1,063	311	4,295	(752)	(3,984)
Lease liabilities		3,494	2,909	2,729	(585)	180
Employee related provisions		283,737	289,545	281,683	5,808	7,862
Other current liabilities		1,939	1,537	1,834	(402)	(297)
Other provisions		10,265	-	-	(10,265)	-
Total current liabilities		**480,787**	**473,650**	**475,823**	**(7,137)**	**(2,173)**
Non-current liabilities						
Lease liabilities		23,718	29,521	23,993	5,803	5,528
Employee related provisions		59,377	64,161	59,377	4,784	4,784
Other provisions		1,404	-	-	(1,404)	-
Total non-current liabilities		**84,499**	**93,682**	**83,370**	**9,183**	**10,312**
Total liabilities		**565,286**	**567,332**	**559,193**	**2,046**	**8,139**
NET ASSETS		**2,280,026**	**2,402,289**	**2,116,759**	**122,263**	**285,530**
EQUITY						
Contributed equity		1,977,320	1,962,833	1,808,979	(14,487)	153,854
Reserves		302,706	427,885	298,348	125,179	129,537
Accumulated surplus/(deficit)		-	11,571	9,432	11,571	2,139
Total equity		**2,280,026**	**2,402,289**	**2,116,759**	**122,263**	**285,530**

10.1.3 Statement of Cash Flows Variances

	Variance Notes	Estimate 2023 $'000	Actual 2023 $'000	Actual 2022 $'000	Variance between estimate and actual $'000	Variance between actual results for 2023 and 2022 $'000
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriation		2,054,458	2,202,553	2,056,656	148,095	145,897
Capital appropriations administered by Department of Health	5	155,969	121,667	99,992	(34,302)	21,675
Royalties for Regions Fund		1,592	382	808	(1,210)	(426)
Net cash provided by State Government		**2,212,019**	**2,324,602**	**2,157,456**	**112,583**	**167,146**
Utilised as follows:						
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits		(1,252,426)	(1,366,440)	(1,265,859)	(114,014)	(100,581)
Supplies and services		(982,016)	(1,030,873)	(956,196)	(48,857)	(74,677)
Finance costs		(683)	(1,207)	(699)	(524)	(508)
Receipts						
Receipts from customers		71,219	66,889	65,140	(4,330)	1,749
Other grants and contributions		-	4,106	1,905	4,106	2,201
Donations received		-	309	734	309	(425)
Other receipts	e	110,704	126,775	100,542	16,071	26,233
Net cash used in operating activities		**(2,053,202)**	**(2,200,441)**	**(2,054,433)**	**(147,239)**	**(146,008)**
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Payment for purchase of non-current physical and intangible assets	6,f	(156,074)	(127,857)	(94,383)	28,217	(33,474)
Receipts						
Proceeds from sale of non-current physical assets		-	(6)	78	(6)	(84)
Net cash used in investing activities		**(156,074)**	**(127,863)**	**(94,305)**	**28,211**	**(33,558)**
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Payments for principal element of lease		491	(3,693)	(3,339)	(4,184)	(354)
Net cash used in financing activities		**491**	**(3,693)**	**(3,339)**	**(4,184)**	**(354)**
Net increase/(decrease) in cash and cash equivalents		3,234	(7,395)	5,379	(10,629)	(12,774)
Cash and cash equivalents at the beginning of the year		128,627	134,264	128,885	5,637	5,379
Cash transferred to other health agencies as part of demergers		(5,976)	-	-	5,976	-
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**125,885**	**126,869**	**134,264**	**984**	**(7,395)**

Notes to the financial statements continued

For the year ended 30 June 2023

10 Explanatory statement for controlled operations (continued)

Major Estimate and Actual (2023) Variance Narratives:

1) Employee benefits expense

Actual is higher than Estimate due to COVID-19 related employment costs, cost of living payments and the pay increase announced by WA Government in addition to higher FTE to meet post-COVID-19 demands.

2) Patient support costs

Actual is higher than Estimate due to additional funding received and costs associated with COVID-19, significant increase in CPI for goods and services including utilities, increased consumption of medical & surgical instruments to deliver higher levels of activity and additional PBS drugs and pathology costs.

3) Department of Health - Service Agreement - State Component

Additional cash in respect of budget transfers including COVID, Cost of living, Cost of Awards, Riskcover, Specific Projects relating to Emergency Access Response. Reallocation of funding from Non-Patient Revenue from Government to cash appropriation.

4) Service concession assets

Actual is higher than Estimate due to net revaluation gain of $15.8M for land and buildings and new additions of $20.7M as well as additional buildings under construction works worth $44.5M, offsetting depreciation charges of $6.2M.

5) Capital appropriations administered by Department of Health

Actual is lower than Estimate as the transfer of a modular building worth $34.0M to Osborne Park Hospital from Department of Health is treated as an equity contribution by the government.

6) Payment for purchase of non-current physical and intangible assets

Actual is lower than Estimate as no cash payment is required for the transfer of a modular building worth $34.0M to Osborne Park Hospital from Department of Health.

10 Explanatory statement for controlled operations (continued)

Major Actual (2023) and Comparative (2022) Variance Narratives:

a) Patient support costs

Increased drug expenses including PBS, higher costs of protective clothing and purchase of outsourced services to reduce waitlist and increase bed capacity.

b) Department of Health - Service Agreement - State Component

Additional cash versus prior year in respect of budget transfers relating to COVID, Cost of living, Cost of award, Riskcover, Specific projects relating to Emergency Access Response, higher Joondalup Health Campus contract.

c) Infrastructure, property, plant and equipment

The increase in Infrastructure, property, plant and equipment balance by $145.3M is largely due to revaluation gains of $117.9M for buildings and land as well as total additions of $98.0M, offsetting depreciation charges of $66.6M.

d) Service concession assets

The increase in Service Concession Assets balance by $70.6M is due to increase in buildings under construction balance by $44.5M related to Joondalup Health Campus Stage 2 development and addition of buildings of $20.7M as well as net revaluation gains for buildings and land of $15.8M.

e) Other receipts

Other receipts have increased by $26.2M largely due to higher PBS recoveries received during the year compare to previous year.

f) Payment for purchase of non-current physical and intangible assets

The payment for purchase of non-current physical and intangible assets has increased by $33.5M in line with additional capital works carried out at Sir Charles Gairdner Hospital and the new Women and Babies Hospital relocation project.

Performance management framework

Outcome-based management framework

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

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

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

Outcome 1

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

- **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

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

Changes to OBM framework

The OBM framework was implemented for annual reporting from 2017/18. There were no material changes to the framework in 2022/23.

Shared responsibilities with other agencies

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

WA Government goal:

Strong communities, safe communities and supported families

WA Health goal:

Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians

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

Effectiveness KPIs

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

Efficiency KPIs

Service 1 Public hospital admitted services
- 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 re-treated within 6 months of receiving initial restorative dental treatment
- Percentage of eligible school children who are enrolled in the School Dental Service program
- Percentage of eligible people who accessed Dental Health Services

Efficiency KPIs

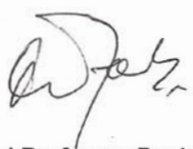
Service 6 Public and community health service
- Average cost per person of delivering population health programs by population health units
- Average cost per breast screening

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

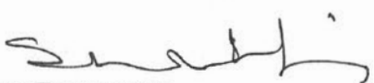
Certification of key performance indicators

For the year ended 30 June 2023

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 2023.



Clinical Professor David Forbes AM
Board Chair
North Metropolitan Health Service
19 September 2023



Steve Toutountzis
Board Finance Committee Chair
North Metropolitan Health Service
19 September 2023

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 2 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 2022 calendar 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[1]. These readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

Readmission reduction is a common focus of health systems worldwide as they seek to improve the quality and efficiency of healthcare delivery, in the face of rising healthcare costs and increasing prevalence of chronic disease.[2]

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 2022 targets for each surgical procedure in Table 2. Performance is achieved by a result below, or equal to, the target.

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

Results

In 2022, the rate of unplanned readmissions within 28 days achieved target for prostatectomy and cataract surgery (Table 2). 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 7 knee replacement patients who readmitted, reasons for admission include monitoring and observation, pain management, bleeding and swelling. Patients are treated conservatively; no further surgical intervention was required, and no specific contributing factors were identified.

There were 8 readmissions for hip replacement of which most were for a wash out. Medical history was a contributing factor for some patients' readmission.

Of the 17 tonsillectomy and adenoidectomy patients who were readmitted, most had post-operative bleeding and were admitted for conservative management without the need for further intervention. Post-operative bleeds cannot be predicted and occurs due to a variety of reasons such as patient risk factors, co-morbidities, and compliance with post-operative advice. It should be noted that some NMHS sites have a differing patient cohort and case-mix where tonsillectomies and adenoidectomies are exclusively undertaken on adults where post operative complication rates are higher than those observed in children. Adult tonsillectomies are sometimes undertaken as part of more complex ENT surgeries (e.g., for malignancy) leading to increased bleeding, pain and or complications and therefore increasing the rate of readmissions compared to children.

Hysterectomy had 23 readmissions of which some were related to bleeding or infection. Patients are safety netted to return if complications occur.

There were 7 readmissions for prostatectomy procedures across sites, the most common reason was for haematuria and required a bladder washout.

There were no cataract readmissions.

Appendicectomy had 21 readmissions of which some were for infection or pain management. Admissions can be for conservative management and patients are often discharged home on oral antibiotics.

1. Australian Institute of Health and Welfare (2009). Towards national indicators of safety and quality in health care. Cat. no. HSE 75. Canberra: AIHW. Available at: https://www.aihw.gov.au/reports/health-care-quality-performance/towards-national-indicators-of-safety-and-quality/contents/table-of-contents
2. Australian Commission on Safety and Quality in Health Care. Avoidable Hospital Readmissions: Report on Australian and International indicators, their use and the efficacy of interventions to reduce readmissions. Sydney: ACSQHC; 2019. Available at: https://www.safetyandquality.gov.au/publications-and-resources/resource-library/avoidable-hospital-readmission-literature-review-australian-and-international-indicators

Table 2 Unplanned hospital readmissions for patients within 28 days for selected surgical procedures (per 1000 separations), 2018–22

	Calendar year						
Surgical procedure	**2018** (per 1,000)	**2019** (per 1,000)	**2020** (per 1,000)	**2021** (per 1,000)	**2022** (per 1,000)	**Target** (per 1,000)	**Target met**
Knee replacement	27.0	13.1	34.9	23.4	20.2	≤ 19.6	✗
Hip replacement	14.4	14.7	7.2	14.2	17.7	≤ 17.1	✗
Tonsillectomy and adenoidectomy	102.7	149.2	157.2	150.0	92.4	≤ 85.0	✗
Hysterectomy	51.9	40.2	38.3	54.6	47.7	≤ 42.3	✗
Prostatectomy	48.9	46.5	25.4	42.8	30.0	≤ 36.1	✓
Cataract surgery	1.1	1.2	1.6	2.1	0.0	≤ 1.5	✓
Appendicectomy	33.5	46.9	33.6	27.3	28.4	≤ 25.7	✗

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

DISCLOSURES AND LEGAL COMPLIANCE

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

Percentage of elective waitlist patients waiting over boundary for reportable procedures

Rationale

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

Elective surgical services delivered in the WA health system are those deemed to be clinically necessary. Excessive waiting times for these services can lead to deterioration of the patient's condition and/or quality of life, or even death . 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 statewide performance target for the provision of elective services. For reportable procedures, the target requires that no patients (0%) on the elective waiting lists wait longer than the clinically recommended time for their procedure, according to their urgency category.

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 2022/23 target is 0 per cent. Performance is achieved by a result equal to the target.

Results

In 2022/23, all urgency categories for elective surgery wait list patients waiting over boundary did not meet target (Table 3) and is reflective of system-wide pressures on demand, capacity, staff furlough and patient flow/access as a result of COVID-19.

Backlog from elective surgery restrictions due to COVID-19 and continued overarching pressures on emergency departments led to the total over boundary count peaking at the end of 2021/22.

Compared to 2018/19, demand for all Category 1 elective surgery has increased by 58 percent.

Continued backlog has led to further delays for patients in all categories and were further impacted by patient-initiated deferral or nonattendance for COVID-19 related factors, staff furlough, increased service demands, capacity, infrastructure limitations.

To address and clear the backlog of elective surgeries, NMHS sites and services have developed initiatives and plans. These include additional theatre sessions and lists scheduled, waitlist audits, outsourcing, engaging with other health entities, however, remains highly dependent on workforce availability.

Performance and strategies continue to be regularly monitored.

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

Table 3 Percentage of elective waitlist patients waiting over boundary for reportable procedures, 2018/19–2022/23

	Financial year						
Urgency category	**2018/19** (%)	**2019/20** (%)	**2020/21** (%)	**2021/22** (%)	**2022/23** (%)	**Target** (%)	**Target met**
Category 1 over 30 days	8	8	11	15	17	0	✕
Category 2 over 90 days	8	13	14	26	31	0	✕
Category 3 over 365 days	5	8	5	10	20	0	✕

Data source: Elective Services Waitlist Data Collection.

DISCLOSURES AND LEGAL COMPLIANCE

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

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

Rationale

Staphylococcus aureus bloodstream infection is a serious infection that may be associated with the provision of healthcare. *Staphylococcus aureus* is a highly pathogenic organism and even with advanced medical care, infection is associated with prolonged hospital stays, increased healthcare costs and a marked increase in morbidity and mortality (SABSI mortality rates are estimated at 20-25%).[4]

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 2022 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 2022, HA-SABSI per 10 000 occupied bed-days in public hospitals achieved target (Table 4).

Promotion of methods to prevent and control *Staphylococcus aureus* particularly around hand hygiene and intravascular devices have assisted in achieving target.

The processes and reminders in place have helped to ensure continued performance.

4. van Hal, S. J., Jensen, S. O., Vaska, V. L., Espedido, B. A., Paterson, D. L., & Gosbell, I. B. (2012). Predictors of mortality in Staphylococcus aureus Bacteremia. Clinical microbiology reviews, 25(2), 362–386. doi:10.1128/CMR.05022-11

Table 4 Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10 000 occupied bed-days, 2018–22

	Calendar year						
	2018 (per 10 000)	2019 (per 10 000)	2020 (per 10 000)	2021 (per 10 000)	2022 (per 10 000)	Target (per 10 000)	Target met
HA-SABSI	1.0	0.8	0.6	0.5	0.5	≤ 1.0	✔

Data source: 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 2022 targets for each condition in Table 5, Table 6 and Table 7. Performance is achieved by a result above, or equal to, the target.

Results

In 2022, the survival rates for patients with stroke did not achieve target for all age groups (Table 5) and 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 and has previously received international recognition for meeting the highest standards in stroke treatment and care.

There is coordinated care across departments, rehabilitation at home and outpatient care and audits of key performance parameters. Cases are reviewed and discussed, monitoring is ongoing and strategies underway to improve outcomes include revising stroke unit pathways.

Table 5 Survival rate for stroke, 2018-22

	Calendar year						
Age group (years)	**2018** (%)	**2019** (%)	**2020** (%)	**2021** (%)	**2022** (%)	**Target** (%)	**Target met**
0 to 49	92.8	94.6	94.4	93.7	93.1	≥ 95.2	✕
50 to 59	92.2	91.5	92.6	91.3	89.1	≥ 95.3	✕
60 to 69	93.1	88.4	89.9	91.6	91.0	≥ 94.4	✕
70 to 79	88.7	91.3	87.6	89.2	89.6	≥ 92.5	✕
80+	84.6	86.7	85.8	85.3	84.1	≥ 87.1	✕

Data source: Hospital Morbidity Data Collection.

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

Survival rates for sentinel conditions (continued)

The survival rates for patients with AMI achieved target for age groups 60 to 69 and 80+ (Table 6). 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 6 Survival rate for acute myocardial infarction, 2018–22

	Calendar year						
Age group (years)	**2018 (%)**	**2019 (%)**	**2020 (%)**	**2021 (%)**	**2022 (%)**	**Target (%)**	**Target met**
0 to 49	96.9	98.9	98.6	100.0	97.8	≥ 99.0	✗
50 to 59	97.9	99.0	99.4	98.8	97.5	≥ 98.9	✗
60 to 69	97.7	97.8	99.1	98.6	98.6	≥ 98.1	✓
70 to 79	96.3	97.7	97.1	94.0	96.3	≥ 97.0	✗
80+	91.2	88.4	90.5	90.9	93.4	≥ 92.2	✓

Data source: Hospital Morbidity Data Collection.

Survival rates for patients with FNOF achieved target for age group 70 to 79 while age group 80+ did not meet target (Table 7). Cases are reviewed and discussed to identify opportunities for further improved patient outcomes.

Table 7 Survival rate for fractured neck of femur, 2018–22

	Calendar year						
Age group (years)	**2018 (%)**	**2019 (%)**	**2020 (%)**	**2021 (%)**	**2022 (%)**	**Target (%)**	**Target met**
70 to 79	95.9	97.7	98.0	96.9	100.0	≥ 99.0	✓
80+	95.2	96.2	97.1	95.5	92.6	≥ 97.4	✗

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[5] and have been found to cost the health system 50% more than patients who are discharged by their physician.[6]

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)[7]. 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[8].

Target

Please see the 2022 targets for Aboriginal and non-Aboriginal patients in Table 8. Performance is achieved by a result below, or equal to, the target.

Results

In 2022, the percentage of admitted patients who DAMA achieved target for non-Aboriginal patients while Aboriginal patients did not meet target (Table 8). Review of cases 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 DAMA often occurs outside standard business hours when the service is unavailable. To ensure these patients are followed up, the Aboriginal Health Liaison team receive an electronic alert when this occurs. Performance and processes continue to be monitored and reviewed.

Appropriate follow up processes are in place and DAMA performance continues to be monitored.

5. Yong et al. Characteristics and outcomes of discharges against medical advice among hospitalised patients. Internal medicine journal 2013:43(7):798-802.
6. Aliyu ZY. Discharge against medical advice: sociodemographic, clinical and financial perspectives. International journal of clinical practice 2002;56(5):325-27.
7. Australian Institute of Health and Welfare 2020. Aboriginal and Torres Strait Islander Health Performance Framework 2020 summary report. Cat no. IHPF 2. Canberra: AIHW.
8. https://www.closingthegap.gov.au/national-agreement

Table 8 Percentage of admitted patients who discharged against medical advice, 2018–22

	Calendar year						
	2018 (%)	2019 (%)	2020 (%)	2021 (%)	2022 (%)	Target (%)	Target met
Aboriginal	3.81	3.73	3.92	3.46	3.81	≤ 2.78	✗
Non-Aboriginal	0.75	0.80	0.76	0.74	0.71	≤ 0.99	✓

Data source: Hospital Morbidity Data Collection.

DISCLOSURES AND LEGAL COMPLIANCE

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

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 one, five and (if required by the protocol) ten minutes after birth to determine how well the infant is adapting outside the mother's womb. Apgar scores range from zero to two for each condition with a maximum final total score of ten. The higher the Apgar score the better the health of the newborn infant.

This outcome measure can lead to the development and delivery of improved care pathways and interventions to improve the health outcomes of Western Australian infants and aligns to the National Core Maternity Indicators (2021) Health, Standard 17/12/2021.

Target

The 2022 target for liveborn term infants with an Apgar score of less than 7 at five minutes post-delivery is ≤ 1.9 per cent. Performance is achieved by a result below, or equal to, the target.

Results

In 2022, the percentage of liveborn infants with an Apgar score of less than 7 at five minutes post-delivery achieved target (Table 9). Ongoing education, review and monitoring is in place to determine opportunities for improved practice.

Table 9 Percentage of liveborn term infants with an Apgar score of less than 7 at five minutes post-delivery, 2018–22

	Calendar year						
Live births	**2018** (%)	**2019** (%)	**2020** (%)	**2021** (%)	**2022** (%)	**Target** (%)	**Target met**
Apgar Score < 7	2.0	1.5	1.7	1.7	1.8	≤ 1.9	✔

Data source: 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.[9]

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 2022 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 2022, the rate of readmissions to acute specialised mental health inpatient service within 28 days of discharge achieved target (Table 10). 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 and often readmit as part of their management or crisis plan to prevent further deterioration.

Compared to 2021, performance has improved following proactive review of cases by clinical experts to ensure patients were provided quality care and any systematic issues identified can be quickly escalated and rectified. All readmissions continue to be reviewed regularly to establish if there are opportunities for further improvements in the discharge planning process.

9. 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

Table 10 Readmissions to acute specialised mental health inpatient services within 28 days of discharge, 2018–22

	Calendar year						
	2018 (%)	2019 (%)	2020 (%)	2021 (%)	2022 (%)	Target (%)	Target met
Readmission rate	16	15	15	15	12	≤ 12	✔

Data source: Hospital Morbidity Data Collection.

DISCLOSURES AND LEGAL COMPLIANCE

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

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

Rationale

In 2017-18, one in five (4.8 million) Australians reported having a mental or behavioural condition.[10] 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 2022 target is ≥ 75 per cent. Performance is achieved by a result above, or equal to, the target.

Results

In 2022, the percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services achieved target (Table 11).

Patients will either receive telephone follow up or are managed through other programs. All records of non-compliance continue to be reviewed and performance continues to be monitored.

10. National Health Survey 2017-18

Table 11 Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services, 2018–22

	Calendar year						
	2018 (%)	2019 (%)	2020 (%)	2021 (%)	2022 (%)	Target (%)	Target met
Post-discharge community care	71	72	84	86	85	≥ 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.

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

Service 1 Public hospital admitted services

Average admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per weighted activity unit (WAU) compared with the State target, as approved by the Department of Treasury and published in the 2022-23 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 2022-23 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

Target

The 2022/23 target is $7,314 per WAU. Performance is achieved by a result below, or equal to, the target.

Results

In 2022/23, the average admitted cost per weighted activity unit did not meet target. The target is based on the initial budget allocation received, and over the course of the year WA Government provided additional budget to meet cost pressures for base wage uplift, cost of living payment, insurance and COVID measures. In addition, general inflationary pressures contributed to the above target unit costs, having an adverse impact on this indicator.

Table 12 Average admitted cost per weighted activity unit, 2018/19–2022/23

	Financial year						
	2018/19 ($)	2019/20 ($)	2020/21 ($)	2021/22 ($)	2022/23 ($)	Target ($)	Target met
Average cost	6,891	7,215	7,080	7,715	8,014	≤ 7,314	✕

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.

DISCLOSURES AND LEGAL COMPLIANCE

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

Service 2 Public hospital emergency services

Average emergency department 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 2022-23 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 2022/23 target is $7,074 per WAU. Performance is achieved by a result below, or equal to, the target.

Results

In 2022/23, the average emergency department cost per weighted activity unit did not meet target. The target is based on the initial budget allocation received, and over the course of the year WA Government provided additional budget to meet cost pressures for base wage uplift, cost of living payment, insurance and COVID measures. In addition, general inflationary pressures contributed to the above target unit costs, having an adverse impact on this indicator.

Table 13 Average emergency department cost per weighted activity unit, 2018/19–2022/23

	Financial year						
	2018/19 ($)	2019/20 ($)	2020/21 ($)	2021/22 ($)	2022/23 ($)	Target ($)	Target met
Average cost	6,066	6,729	6,646	7,129	7,242	≤ 7,074	✕

Data sources: OBM Allocation application; Oracle 11i financial system; Emergency Department Data Collection.

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

Service 3 Public hospital non-admitted services

Average non-admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per WAU compared with the State (aggregated) target, as approved by the Department of Treasury, which is published in the 2022-23 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 2022/23 target is $6,982 per WAU. Performance is achieved by a result below, or equal to, the target.

Results

In 2022/23, the average non-admitted cost per weighted activity unit did not meet target. The target is based on the initial budget allocation received, and over the course of the year WA Government provided additional budget to meet cost pressures for base wage uplift, cost of living payment, insurance and COVID measures. The cost of outpatient activity related to COVID was materially lower in 2021/22 compared with 2022/23. Adjusting for COVID activity would result in a more moderated growth rate in the average cost. In addition, realignment of costs to non-admitted services, general inflationary pressures and a significant increase in pharmaceutical benefits (PBS) drug allocations and have contributed to the above target unit costs.

Table 14 Average non-admitted cost per weighted activity unit, 2018/19–2022/23

	Financial year						
	2018/19 ($)	2019/20 ($)	2020/21 ($)	2021/22 ($)	2022/23 ($)	Target ($)	Target met
Average cost	6,763	7,081	6,785	7,258	8,827	≤ 6,982	✕

Data sources: OBM Allocation application; Oracle 11i financial system; Non-Admitted Patient (NAP) Data Collection.

DISCLOSURES AND LEGAL COMPLIANCE

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

Service 4 Mental health services

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

Rationale

Specialised mental health inpatient services provide patient care in authorised hospitals. 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 2022/23 target is $1,470 per bed-day in specialised mental health inpatient services. Performance is achieved by a result below, or equal to, the target.

Results

In 2022/23, the average cost per bed-day in specialised mental health inpatient did not meet target. The target is based on the initial budget allocation received, and over the course of the year WA Government provided additional budget to meet cost pressures for base wage uplift, cost of living payment and insurance. In addition, services provided to mental health older adults and general inflationary pressures have contributed higher average cost over the previous financial year.

Table 15 Average cost per bed-day in specialised mental health inpatient services, 2018/19–2022/23

	Financial year						
	2018/19 ($)	2019/20 ($)	2020/21 ($)	2021/22 ($)	2022/23 ($)	Target ($)	Target met
Average cost	1,442	1,494	1,439	1,595	1,730	≤ 1,470	✕

Data sources: OBM Allocation application; Oracle 11i financial system; BedState.

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

Service 4 Mental health services

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

Rationale

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

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

Target

The 2022/23 target is $441 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 2022/23, the average cost per treatment day of non-admitted care provided by mental health services did not meet target. The target is based on the initial budget allocation received, and over the course of the year WA Government provided additional budget to meet cost pressures for base wage uplift, cost of living payment and insurance. In addition, new community programs have been implemented including expansion for Community Treatment uplift, the Youth Community Assessment Treatment Team, the Eating Disorder Program and other targeted programs.

Table 16 Average cost per treatment day of non-admitted care provided by mental health services, 2018/19–2022/23

	Financial year						
	2018/19 ($)	2019/20 ($)	2020/21 ($)	2021/22 ($)	2022/23 ($)	Target ($)	Target met
Average cost	425	395	372	412	496	≤ 441	✗

Data sources: OBM Allocation application; Oracle 11i financial system; Mental Health Information 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%.[11]

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 2021–22 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 2021 to 2022, the rate of women aged 50-69 years who participated in breast screening did not meet target (Table 17).

BreastScreen WA operations were adversely affected by the high COVID-19 community infection levels as this led to many clinics being cancelled due to the high levels of staff sick leave. During this time, high appointment cancellations were also experienced. Despite this, BreastScreen was able to screen more women as additional medical imaging technology staff were secured for a period.

The number of screenings is expected to improve as additional assessment capacity is realised with the opening of extra assessment clinic days.

11. Elixhauser A, Costs of breast cancer and the cost-effectiveness of breast cancer screening, Int J Technol Assess Health Care. 1991; 7(4):604-15. Review.

Table 17 Rate of women aged 50 – 69 years who participate in breast screening, 2017–18–2021–22

	Calendar years						
	2017-18 (%)	2018-19 (%)	2019-20 (%)	2020-21 (%)	2021-22 (%)	Target (%)	Target met
Participation rate	56	55	50	50	53	≥ 70	✕

Note: This measure counts the women screened within a 24-month period (1 January 2021 to 31 December 2022) as it is recommended that women in the cohort attend the free screening every two years.

Data sources: BreastScreen WA Register; Australian Bureau of Statistics.

Percentage of adults and children who have a tooth re-treated within 6 months of receiving initial restorative dental treatment

Rationale

This KPI is used to assess, compare and determine the potential to improve dental care for WA clients. This KPI represents the growing recognition that a capacity to evaluate and report on quality is a critical building block for system-wide improvement of healthcare delivery and patient outcomes.

A low unplanned retreatment rate suggests that good clinical practice is in operation. Conversely, unplanned returns may reflect:

- less than optimal initial management
- development of unforeseen complications
- treatment outcomes that have a direct bearing on cost, resource utilisation, future treatment options and patient satisfaction.

By measuring and monitoring this KPI, the level of potentially avoidable unplanned returns can be assessed in order to identify key areas for improvement (i.e. cost-effectiveness and efficiency, initial treatment and patient satisfaction). This KPI is nationally reported in the Australian Council on Healthcare Standards Oral Health Indicators[12]. Its inclusion provides opportunity for benchmarking across jurisdictions.

Target

Please see the 2022/23 targets for adults and children in Table 18. Performance is achieved by a result below the target.

Results

In 2022/23, the percentage of adults and children who have a tooth re-treated within 6 months of receiving initial restorative dental treatment achieved target (Table 18).

Maintained performance was attributable to regular monitoring of clinic/clinician re-treatment rates via the Dental Health Service Clinical Oral Health Advisory Committee, using feedback to improve clinical techniques through provision of training and procedures where issues are identified. Centralised governance of equipment and material contracts through the Dental Health Service Equipment and Materials Management Committee also ensures quality assurance of the standard filling materials used statewide.

12. https://www.achs.org.au/news/australian-clinical-indicator-report-2013-2020,-22nd-edition

Table 18 Percentage of adults and children who have a tooth re-treated within 6 months of receiving initial restorative dental treatment, 2018/19–2022/23

	Calendar year						
	2018/19 (%)	2019/20 (%)	2020/21 (%)	2021/22 (%)	2022/23 (%)	Target (%)	Target met
Adults	6.12	5.76	5.59	5.86	5.14	< 6.05	✓
Children	2.08	2.01	1.93	1.91	1.68	< 2.11	✓

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).

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

Percentage of eligible school children who are enrolled in the School Dental Service program

Rationale

Early detection and prevention of dental health problems in children can ensure better health outcomes and improved quality of life throughout the crucial childhood development years and into adult life. While dental disease is common in children, it is largely preventable through population based interventions and individual practices such as personal oral hygiene, better diet and regular preventive dental care.

The School Dental Service program ensures early identification of dental problems and, where appropriate, provides treatment. By measuring the percentage of school children enrolled, the number of children proactively involved in publicly funded dental care can be determined in order to gauge the effectiveness of the program. This in turn can help identify areas that require more focused intervention and prevention and health promotion strategies to help improve the dental health and wellbeing of children.

Target

The 2022/23 target is ≥ 78 per cent. Performance is achieved by a result above, or equal to, the target.

Results

In 2022/23, the percentage of eligible children who are enrolled in the School Dental Services program did not meet target (Table 19).

Performance was impacted as Dental Health Services experienced challenges in recruiting dental therapists, resulting in the closure of some school clinics and reduced services. Workforce shortages have adversely affected access for patients and the ability to enrol eligible school children, especially in rural locations where there are no incentives to attract clinicians.

Table 19 Percentage of eligible school children who are enrolled in the School Dental Service program, 2018/19–2022/23

	Financial year						
	2018/19 (%)	2019/20 (%)	2020/21 (%)	2021/22 (%)	2022/23 (%)	Target (%)	Target met
Eligible school children who are enrolled in the School Dental program	79	77	77	75	73	≥ 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 preventive 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 people 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 2022/23 target is ≥ 15 per cent. Performance is achieved by a result above, or equal to, the target.

Results

In 2022/23, the percentage of eligible people who accessed Dental Health Services did not meet target (Table 20).

Compared to 2021/22, performance has improved following the gradual lift in restrictions from the WA Health COVID-19 Framework for System Alert and Response.

Despite the improvement, the ability to meet target is reduced due to a new service delivery model that has increased infection prevention and control requirements and ongoing recruitment challenges.

Table 20 Percentage of eligible people who accessed Dental Health Services, 2018/19–2022/23

	Financial year						
	2018/19 (%)	2019/20 (%)	2020/21 (%)	2021/22 (%)	2022/23 (%)	Target (%)	Target met
Eligible people who accessed Dental Health Services	14	14	14	13	14	≥ 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.

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

Service 6 Public and community health services

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

Rationale

Population health units support individuals, families and communities to increase control over and improve their health.

Population health aims to improve health by integrating all activities of the health sector and linking them with broader social and economic services and resources as described in the WA Health Promotion Strategic Framework 2017–2021.[13] This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

The 2022/23 target is $48. Performance is achieved by a result below, or equal to, the target.

Results

In 2022/23, the average cost per person of delivering population health programs did not meet target. The target is based on the initial budget allocation received, and over the course of the year WA Government provided additional budget to meet cost pressures for base wage uplift, cost of living payment, insurance and COVID-19 measures. Transitioning out from elevated COVID-19 response measures and restrictions, as well as the COVID-19 vaccination program, has reduced the cost and is partially offset by resumption of public health programs and the associated inflationary pressures.

13. A draft WA Health Promotion Strategic Framework 2022-2026 was released for public consultation on 7 December 2021 and closed on 18 February 2022. A final copy has not been released. See https://consultation.health.wa.gov.au/chronic-disease-prevention-directorate/draft-wa-health-promotion-strategic-framework-2022/ for further information.

Table 21 Average cost per person of delivering population health programs by population health units, 2018/19–2022/23

	Financial year						
	2018/19 ($)	2019/20 ($)	2020/21 ($)	2021/22 ($)	2022/23 ($)	Target ($)	Target met
Average cost	49	67	64	97	84	≤ 48	✗

Data sources: OBM Allocation application; Oracle 11i financial system; WA Department of Health Epidemiology Directorate

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

Service 6 Public and community health services

Average cost per breast screening

Rationale

Breast cancer remains the most common cause of cancer death in women under 65 years. Early detection through screening and early diagnosis can increase the survival rate of women significantly. Breast screening mammograms are offered through BreastScreen WA to women aged 40 years and over as a preventative initiative.

Target

The 2022/23 target is $143 per breast screening. Performance is achieved by a result below, or equal to, the target.

Results

In 2022/23, the average cost per breast screening did not meet target. The target is based on the initial budget allocation. The actual cost pressures are above budget for base wage uplift, cost of living payment and general inflationary pressures.

Table 22 Average cost per breast screening, 2018/19–2022/23

	Financial year						
	2018/19 ($)	2019/20 ($)	2020/21 ($)	2021/22 ($)	2022/23 ($)	Target ($)	Target met
Average cost	145	156	154	153	159	≤ 143	✕

Data sources: OBM Allocation application; Oracle 11i financial system; Mammography Screening Register; BreastScreen WA

DISCLOSURES AND LEGAL COMPLIANCE

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

Service 8 Community dental health services

Average cost per patient visit of WA Health-provided dental health programs for school children and socio-economically disadvantaged adults

Rationale

Early detection and prevention of dental health problems in children can ensure better health outcomes and improved quality of life throughout the crucial childhood development years and into adult life. The School Dental Service program ensures early identification of dental problems and, where appropriate, provides treatment.

Dental disease places a considerable burden on individuals and communities. While dental disease is common, it is largely preventable through population-based interventions, and individual practices such as personal oral hygiene and regular preventive dental care. Costly treatment and high demand on public dental health services emphasises the need for a focus on prevention and health promotion.

Target

Please see the 2022/23 targets for patient groups in Table 23. Performance is achieved by a result below, or equal to, the target.

Results

In 2022/23, 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 a new service delivery model that has increased infection prevention and control requirements. This has resulted in a reduction in available appointment times and additional costs that have been incurred due the new infection control protocols, increased environmental cleaning consumables, and increasing equipment costs.

Ongoing recruitment challenges have also resulted in a reduction in patient visits, particularly for school children. The number of patient visits for adults have been mitigated by outsourcing services to private dentists.

This combination of factors has led to an increase in the average cost per patient visit.

Table 23 Average cost per patient visit of WA Health-provided dental health programs for school children and socio-economically disadvantaged adults, 2018/19–2022/23

	Financial year						
	2018/19 (%)	2019/20 (%)	2020/21 (%)	2021/22 (%)	2022/23 (%)	Target (%)	Target met
School children	190	230	219	302	315	≤ 249	✕
Socio-economically disadvantaged adults	264	288	284	365	370	≤ 316	✕

Data sources: OBM Allocation application; Oracle 11i financial system; Dental Information Management (DenIM) database.

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

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

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.[14]

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 2022/23 targets for ED patients seen within recommended times by triage category as per the Australasian College for Emergency Medicine are as seen in the table at top right of page. Performance is achieved by a result above, or equal to, the target.

Results

In 2022/23, 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 24).

Compared to prior year (2021/22), ED presentations have decreased by 2.1 percent and results were impacted and limited by workforce shortages and demand pressures, particularly around issues with patient flow.

NMHS sites continue to prioritise the implementation and delivery of initiatives that improve access to emergency care through the NMHS Hospital Emergency Access Response Team (HEART) program. The HEART program is monitored and reported on, and progress is being made.

14. Australasian College for Emergency Medicine. (2013) Policy on the Australasian Triage Scale, Australasian College for Emergency Medicine, Melbourne. Available from: https://acem.org.au/getmedia/484b39f1-7c99-427b-b46e-005b0cd6ac64/P06-Policy-on-the-ATS-Jul13-v04.aspx

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

Table 24 Percentage of emergency department patients seen within recommended times, by triage category, 2018/19–2022/23

	Financial year						
Triage category	2018/19 (%)	2019/20 (%)	2020/21 (%)	2021/22 (%)	2022/23 (%)	Target (%)	Target met
1	100	100	100	100	100	100	✓
2	76	80	78	72	71	≥ 80	✗
3	45	51	40	28	26	≥ 75	✗
4	57	64	54	41	38	≥ 70	✗
5	85	87	82	76	72	≥ 70	✓

Data source: Emergency Department Data Collection.

Compliance with Public Sector Standards and Ethical Codes

NMHS ensures compliance with Western Australian Public Sector Standards and Ethical Codes in the development and maintenance of policies and resources to support practical implementation of the requirements and principles contained within Standards, Codes and the broader, relevant Public Sector Commissioners Instructions.

NMHS supplements system-wide mandatory employment and integrity-based policy frameworks with local policies, procedures and information resources. System-wide and local resources are considerate of NMHS status as a Public Sector entity and our own overarching legislation – primarily the *Health Services Act 2016*.

NMHS seeks to foster a culture in which employees are encouraged to speak up for safety, raise issues or concerns and suggest ideas for improvement. Promotion of this culture and the relevant Public Sector Standards and Ethical Codes occurs through NMHS on-boarding practices, release of various communication resources, staff news forums, and face-to-face and e-learning opportunities.

The Public Sector Code of Ethics is enveloped in the WA Health System Code of Conduct and both Codes align with the NMHS five values of care, respect, innovation, teamwork and integrity. The NMHS Integrity Directorate, supported by the broader People and Culture Division, provides accessible independent, effective and timely advice in relation to both ethical dilemmas and potential breaches of the Code(s). NMHS aims to promote a culture of integrity through proactive and reactive work streams. This is supported by the NMHS Integrity Governance Framework 2021–2024.

The NMHS People and Culture division provides onsite support, information and consultancy and advisory services in all areas covered by the Public Sector Standards in Human Resource management, with support being available to people in leadership roles as well as general employment. Support and processes are designed to be people-centred and ensure a timely, fair, reasonable and consistent approach to performance, conduct and behavioural matters. Matters are appropriately addressed, and decisions are transparent and consider all relevant factors.

Employees may access information resources via the NMHS intranet, leadership teams and corporate support advisory services. A collaborative approach is taken to sharing resources and information with colleagues and teams across NMHS and the WA Health System.

NMHS has established positive working relationships with the WA Public Sector Commission, particularly with the Workforce Policy and Diversity, and Integrity and Risk divisions, which assist open discussions about existing and new standards and ethical codes, proactively planning to meet all public sector requirements in a constantly changing environment.

DISCLOSURES AND LEGAL COMPLIANCE

Code of Conduct

NMHS promotes the WA Health System Code of Conduct in many facets of the daily employee experience. The Code identifies 'CORE' values which go hand in hand with the five NMHS values of care, respect, innovation, teamwork and integrity. These values are fundamental in all our work and the Code translates the values into principles that guide conduct in the workplace.

NMHS emphasises the intent of the Code — to promote a positive workplace culture by providing a framework to support ethical day-to-day conduct and decision making, including promotion of a culture of integrity/ a speak up culture through reporting of any suspected breaches of the Code.

NMHS has a dedicated Integrity Directorate, supported by the broader People and Culture division. It engages with and supports the workforce to embed the intent of the Code, to promote awareness of the Code and expected standards of conduct, and to undertake timely and appropriate assessment and investigation of suspected breaches of the Code. During the 2022-2023 financial year the Integrity Directorate received 154 matters for assessment of potential misconduct and/ or breaches of the Code. Commensurate with the size of NMHS workforce, this indicates a healthy culture of reporting exists within NMHS. It also suggests the majority of NMHS employees are engaged in their roles and the organisational objectives, conducting themselves in a manner that meets or exceeds the principles of the Code.

Breaches of the Code/ behaviour not consistent with the Code are objectively assessed to determine the most appropriate action to be taken. The NMHS disciplinary management model, underpinned by the WA Health System Discipline Policy and the WA Public Sector Standard in Discipline provide procedurally fair processes to assess, investigate and, where breaches of the Code are substantiated, to issue appropriate disciplinary or improvement sanctions. In particular, the efficacy of improvement actions are recognised by NMHS decision makers as valuable in correcting employee behaviour and/ or increasing employee understanding of their responsibilities under the Code.

New NMHS employees are provided a copy of the Code and complete Accountable and Ethical Decision Making – integrity and code of conduct training. This will soon also be provided as regular refresher training for existing employees in accordance with a new WA Public Sector Commissioner's Instruction - Ethical Foundations. Additionally, the Integrity Directorate provides a proactive, centralised and dedicated capacity for detecting, preventing and responding to breaches of the Code, with a view to continually improve workplace integrity culture and prevention of both intentional and unintentional breaches of discipline.

NMHS offers customised integrity education to all employees across NMHS, with a focus on the Code and how this underpins policies/ areas associated with integrity related risks. There is a focus on engaging employees in discussion around ethical workplace conduct and decisions and ensuring employees know where they can seek advice and support. Through promotion and education of the Code we build the capacity of NMHS to resist misconduct, increase integrity resilience and strengthen corruption prevention practices. The Code underpins our work in many areas carrying an integrity related risk such as the fraud and corruption control plan, which provides an integrated organisational response to the risks of fraud and corruption.

The Code is widely available to NMHS employees (electronic and physical copies) on the NMHS intranet, the WA Health website, in posters and policy format circulated around hospitals and corporate sites.

Recruitment and selection

At NMHS, recruitment and selection practices align with the WA Department of Health policy on recruitment, selection and appointment. As a Health Service Provider, NMHS follows a centralised recruitment and selection process facilitated by Health Support Services. This approach ensures consistency and enables monitoring of compliance with the Public Sector Standards for human resource management.

To maintain the integrity of recruitment and selection processes, NMHS adheres to the principles of merit, equity, interest and transparency as mandated by the Public Sector Employment Standard. For recruitment to contracts of six months or longer, NMHS notifies applicants of their right to lodge a breach of Employment Standard claim if they believe that these principles have not been upheld. Upon receiving a claim, NMHS has a period of 15 working days to resolve it internally. If an internal resolution is unsuccessful, the claim is escalated to the Public Sector Commission for review in accordance with the *Public Sector Management (Breaches of Public Sector Standards) Regulations 2005.*

During the period, a total of eight breach of employment standard claims were lodged regarding NMHS recruitment, selection and appointment processes. Out of these claims, three were successfully resolved internally, while the remaining five were referred to the Public Sector Commission.

Following the independent reviews all five claims were dismissed.

Industrial relations

NMHS strives to implement and support flexible, fair and productive work practices.

NMHS industrial relations (IR) consultants maintain close links with professional groups including all WA health system unions, the System Manager Department of Health (DoH) and the WA health system IR network, ensuring contemporary IR practices and approaches are applied.

IR provides expert advice to internal stakeholders and decision-makers on human resource and industrial relations matters, working proactively and collaboratively with HR Business Partners (HRBP) and management. IR coordinates and responds to the interpretation and implementation of industrial instrument provisions and assists in the prevention of industrial disputes.

WA Health system Industrial Agreements renewal and education

A key role for IR is the dissemination and education to HRBPs and line managers on newly registered WA health system industrial agreements. Taking a proactive approach IR delivered 20 presentations to leadership networks including but not limited to:

- New industrial agreement provisions.
- Priority for permanent and direct employment.
- Public sector employment framework.
- Application of parental leave and cultural leave.

IR also created a suite of business tools in relation to change management processes and flexible work arrangements for HRBPs and line managers.

Job security reviews and targets for agency and casual usage

NMHS is 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 agreements provisions. More than 840 reviews were conducted within the 90-day time frame as required by industrial provisions.

Advice and support are provided to executives and managers on other mechanisms for permanent employment, such as provisions under Commissioner's Instruction No.2, Filling a Public Sector Vacancy.

Development of initiatives and strategies have commenced for the coming financial year to implement progression towards targets set in industrial agreements for the minimisation of insecure employment engagements such as agency and casual.

Employee profile

Who we are

We are **13,348** people dedicated to delivering, and supporting the delivery, of sustainable, quality health services to our patients and promoting and improving health outcomes in our community.

8,297
Permanent

1,614
Fixed Term

1,614
Casuals

50% of us have worked at NMHS for over **five years**

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

Nursing & Midwifery	**5,523**
Hotel & Site Services	**1,357**
Medical Services	**2,050**
Medical Support Services	**2,283**
Administration & Clerical	**2,135**

10,169 of us are **female**

3,179 of us are **male**

We range in **age**:

1,485
Gen Z
1996-2015

5,440
Gen Y
1981-1996

4,242
Gen X
1965-1980

2,181
Baby boomers
1946-1964

Culturally and Linguistically Diverse
We come from many cultures, with **1,640** of us identifying as culturally and linguistically diverse.

DISCLOSURES AND LEGAL COMPLIANCE

Employee development

NMHS is striving to create a learning organisation. It is committed to building the capability of our people, including leaders and managers, to drive a high performing values-driven culture to meet current and future challenges.

An exciting innovation has been the implementation of the new learning management system. MyLearning commenced in March 2023, which led to more than 6,300 NMHS employees accessing the system in the first three months. The system provides staff with access to personalised training records and current training opportunities. It also hosts more than 200 eLearning programs developed in-house to align with local learning requirements, as well as access to the shared catalogues across WA Health.

In the past 12 months there have been 100 inductions to welcome and support new staff into NMHS. Inductions are held for each site. Record numbers of nursing, medical, allied health and patient support services staff have been inducted into the organisation.

Mandatory training is undertaken by all staff to reduce risk related to both patients and staff. More than 2,500 mandatory training sessions were conducted. Modules include accountable and ethical decision making, Aboriginal cultural awareness, emergency procedures, clinical deterioration, cyber security, manual tasks and management of aggression. These sessions are conducted at all NMHS metropolitan sites, as well as to regional staff in locations such as Broome, Busselton, Albany, Geraldton and Kalgoorlie.

NMHS employees are provided with opportunities to further their professional skills and knowledge with a wide range of undergraduate, graduate training and leadership development programs for employees. As a Registered Training Organisation, NMHS offers nationally recognised programs such as the Diploma of Leadership and Management which currently has nearly 200 active students.

In 2023 the HLT23215 Certificate II Health Support Services was launched with an intake of participants from Patient Support Services at SCGH and OPH. This qualification reflects the role of staff who provide support for the effective functioning of health services. It is intended that the program will become an important employment pathway for attracting new Aboriginal staff.

In addition, the Mental Health First Aid training program began, with three-year refresher programs planned to commence in the latter part of 2023.

Programs were also held to support managerial and supervisory staff. This training focuses on providing managers with the leadership skills required to recruit, manage, and develop their staff. There are 15 courses available and additional or customised courses are developed on request.

NMHS has successfully coordinated and delivered a diverse range of leadership programs through the Institute for Health Leadership. These programs have been specifically designed to enhance the leadership capabilities of both clinical and non-clinical managers and leaders at all levels within our organisation. They provide valuable opportunities for professional development, equipping participants with the necessary skills and knowledge to excel in their roles and deliver values-aligned and system-focused leadership.


The Belly Mapping
VAGINAL
BIRTH
arning together!

DISCLOSURES AND LEGAL COMPLIANCE

Work health and safety

NMHS places priority on the care and wellbeing of employees and strives to provide a safe and healthy workplace.

NMHS has been responding to the changes in work health and safety (WHS) legislation by completing actions raised in a gap audit during the 2020-2021 financial year. These actions include progress towards best practice WHS systems, benchmarked across several Australian government health services and other industries. This work, in collaboration with Department of Health, has established positions to address the *Work Health and Safety Act 2020* and subsidiary obligations.

The establishment of due diligence activities has strengthened WHS awareness across all levels of NMHS, with targeted programs being developed. These activities are addressing all aspects of the due diligence framework incorporated in legislation and have driven changes already in WHS outcomes.

A consultative approach to resolution of safety risks is adopted to ensure hazards are addressed and incidents are investigated, to promote a positive safety culture.

NMHS regularly provides information about safety, health and wellbeing and promotes activities to ensure staff 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 through the intranet pages.

All NMHS sites facilitate WHS management and consultation through:

- Election of safety representatives
- 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.

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

- Wellbeing (including programs by clinical psychologists such as critical incident debriefing, manager assist)
- Workplace violence and aggression (prioritising development of consistent training across NMHS services)
- Ergonomics and human factors (including ergonomics, workflow, and equipment assessment)
- Employee fitness for work
- Psychosocial injury management, with updated risk assessment methodology.

Measures	Results 2020/21[1]	Results 2021/22	Results 2022/23	Targets[1]	Comments towards targets
	Base year	Prior year	Current reporting year		
Number of fatalities	0	0	0	0	Target met
Lost time injury and disease incidence rate[2]	2.9	2.3	3.4	0 or 10% reduction (2.07)	Target not met
Lost time injury severity rate[2]	36.47	46	47	0 or 10% reduction (41.4)	Target not met
Claim severity rate[3]	51.9	40.2	44.7	0 or 10% reduction (36.2)	Target not met
Percentage of injured workers returned to work[i] within 13 weeks[4]	57%	47%	47.8%	N/A	N/A
Percentage of injured workers returned to work[ii] within 26 weeks[4]	66%	57%	65.9%	Greater than or equal to 80%	Target not met
Percentage of managers trained in occupational safety, health and injury management responsibilities, including refresher training within 3 years[5]	55%	53%	57%	Greater than or equal to 80%	Target not met Compliance has increased, training model has been simplified to enable higher engagement levels.

Notes:

1. Target is 10% improvement on base year 2018/19. 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 requirements 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.

Injury management

A system for managing workers' compensation claims and workplace injuries at NMHS facilitates early treatment and return to work. Injury Management Consultants (IMCs) work across multiple sites with shared portfolios to ensure the business is well supported at all times. They partner with the Health and Safety Consultants, Wellbeing Team and Human Resources business partners when needed to optimise injury outcomes.

A dedicated IMC engages with injured staff and their managers following notification of an injury to provide timely support and offer assistance through the Early Intervention Program (EIP) and Workers Compensation pathways. The EIP, which provides funding and coordination of early treatment for staff with work related injuries, continues to have good uptake and is effective in reducing workers' compensation costs. Physiotherapy and psychological counselling are the most frequently used services and enable NMHS to link staff in with preferred treatment providers to optimise recovery. The EIP budget has been fully utilised in 2022-2023 and will be increased in 2023-2024 to meet the growing demand. IMCs continue to manage most workers compensation claims in-house, following evidence informed best practice, to achieve return to work outcomes using a supportive, collaborative approach.

NMHS had a 16 per cent increase in workers' compensation claims in 2022-2023 and 291 claims were lodged, which was up from 251 claims in 2021-2022. Of these claims, 28 were COVID related, following the cessation of COVID leave in March 2023. A record number of claims (76) were settled in 2022-2023, which may present as increased average claims costs as NMHS was able to wrap up these long tail claims. Earlier finalisation of claims contributes positively to premium renewal adjustments by ensuring actual costs are reflected rather than projected costs.

Employee rehabilitation programs continue to be offered for non-compensable injuries where there is a risk of exacerbation in the workplace. NMHS encouraged the use of the Fitness for Work (FFW) pathway if expert advice is needed to ensure a safe return to work.

Injury Management is supported by the Wellbeing team who coordinate and implement proactive programs to promote health and wellbeing. They include the Peer Support Network, Fitness Passport program, psychoeducation sessions and wellbeing workshops. The team also provide critical incident debriefing to alleviate stress following traumatic workplace events.

NMHS workers compensation claims 2022-2023	
Nursing and midwifery services/dental clinic assistants	144
Administration and clerical	22
Medical (support)	29
Hotel services	45
Maintenance	19
Medical (salaried)	5
Total	264

Claims by body location	
Head	16
Lower limbs	47
Multiple locations	32
Neck	4
Non-physical locations (psychological)	27
System locations (e.g. nervous, digestive)	25
Trunk (including back)	48
Unspecified locations	0
Upper limbs	65
Total	264

Disability Access and Inclusion Plan

NMHS is committed to ensuring that people living with disability, their families, and carers can fully access our services, facilities, and information.

Highlights of the year for each of the seven outcome areas of the NMHS Disability Access and Inclusion Plan (DAIP) 2022-2027, are outlined below.

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

Two additional hearing amplifiers are now in use in outpatient areas of OPH. This increases the accessibility of information provided verbally to patients.

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

As part of the new Special Needs Dental Clinic a wayfinding review of the Mt Henry Complex was undertaken. Discussions with consumer groups also identified requirements such as a low-sensory waiting room, covered car bays and access walkways and additional service requirements such as nitrous gas and patient hoists in treatment rooms.

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.

A video was produced about the admission process for adult inpatient mental health services. This is now available as an alternative to the printed admission pack.

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

The WA Cervical Cancer Prevention Program (WACCPP) worked in partnership with SECCA (Sexuality Education Counselling and Consultancy Agency) to design and develop a cervical cancer prevention resource for people with disability, which involved rigorous community and stakeholder consultation.

Complaints and safeguarding

Outcome 5: People with disability have the same opportunities as other people to make complaints to a public authority

The NMHS Consumer Liaison Service (CLS) Network commenced a review of the accessibility of feedback and complaint mechanisms at NMHS. The CLS Network will now engage with consumers to plan, develop and implement site-specific and NMHS-wide strategies to enhance accessibility.

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 were specifically consulted when reviewing Telehealth appointment letters. Changes included a simplification of language and layout as well as inclusion of the TIS icon and contact number.

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

NMHS staff member Kat Johns established and facilitates the Staff with Disability and Allies Network (SDAN) which is open to staff from all health service providers. SDAN, together with the Disability Health Network, hosted a morning tea to celebrate Autism Acceptance Day.

DISCLOSURES AND LEGAL COMPLIANCE

Ministerial directives

Treasurer's Instruction 903 (12) requires the disclosure of information about Ministerial Directives relevant to the setting of desired outcomes or operational objectives, the achievement of desired outcomes or operational objectives, investment activities and financing activities.

NMHS did not receive any Ministerial Directives during the 2022-2023 financial year.

Record-keeping

The NMHS Recordkeeping Plan (RKP) 2021 identifies which records are created by NMHS and how the organisation manages it records.

The RKP provides an accurate reflection of the recordkeeping program with NMHS, including information regarding the NMHS recordkeeping systems, disposal arrangement, policies, practices, and processes, with the RKP the primary means of providing evidence of compliance with the *State Records Act 2000* and the implementation of best practice recordkeeping within the organisation.

There are several record management systems used to manage administrative, functional, and healthcare records within NMHS.

Healthcare records management systems within NMHS are well established, with robust processes, policy, and procedures. To further support the recordkeeping practices of healthcare records NMHS is currently implementing a Digital Medical Record (DMR) project. The DMR will enable clinicians to have real-time access to a digital medical record for each patient regardless of which public health site the patient visits, enabling them to work more efficiently and effectively without the delays and risks associated with copying, storing, and retrieving hard copy records.

NMHS has implemented the following activities to ensure that all staff are aware of their recordkeeping responsibilities and compliance with the RKP:

- Online Recordkeeping Awareness Training (RAT) has been deployed through the NMHS Learning and Development portal for all staff including non-TRIM users. This is a mandatory training course to be completed upon starting with NMHS.
- Non-Technical Community of Practice education sessions available to all NMHS staff focusing on records management principles.
- Face-to-face and virtual TRIM training sessions available to all NMHS staff.
- NMHS Records Management hub page on the intranet provides recordkeeping resources and is used to publish recordkeeping information to highlight issues or to bring recordkeeping matters to the attention of staff.

NMHS is committed to the continuous improvement of our recordkeeping culture, tools, and practices to ensure compliance with the *State Records Act 2000*, with a review of the NMHS RKP scheduled for 2024.

Freedom of information

The *Freedom of Information Act 1992* (FOI Act) provides the public with a general right of access to State and Local Government records and provides a means for the public to ensure personal information held by State and Local Government agencies is accurate, complete, up to date and is not misleading.

The NMHS Information Statement 2023 contains an overview of the business functions of NMHS, including a summary of how these functions affect members of the public and patients. It also describes the types of records NMHS holds and the methods available for the public to obtain information held by NMHS.

Information on how to access records is available via the NMHS website. Requests for patient records are received and managed at individual hospital sites.

Statistics about FOI applications are provided to the Office of the Information Commissioner as required by section 111(3)(a) of the FOI Act and are published in its annual report.

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 2022/23 financial year.

Use of credit cards for personal expenditure

NMHS officers are issued with corporate credit cards (purchasing cards) when their functions require this facility. Purchasing cards provide a clear audit trail 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.

Eight 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, 2022/23

	Aggregate amount ($)
Reporting period	329.25
Settled by the due date (within 5 working days)	235.26
Settled after the period (after 5 working days)	93.99
Outstanding at balance date	-

Pricing policy

NMHS charges for goods and services rendered on a partial or full cost recovery basis in compliance with the *Health Insurance Act 1973*, the Addendum to National Health Reform Agreement (NHRA) 2020-25, the HSA 2016 and the WA Health Funding and Purchasing Guideline 2016-17. These fees and charges are determined though the WA Health costing and pricing authorities and approved by the Minister for Health.

Guidelines for rules in relation to fees and charges are outlined in the WA Health Fees and Charges Manual. This is a mandatory document in the WA Health Financial Management Policy Framework and binding to all HSPs under the HSA 2016. The current list of fees and charges were gazetted on 28 June 2022 and published in the WA Health Fees and Charges Manual on 1 July 2022.

Advertising and sponsorship

In accordance with section 175Z of the *Electoral Act 1907*, Health Service Providers are required to report total advertising expenditure. In 2022/23, the total expenditure was $199,667, compared with $134,201 in 2021-22. The organisations from which advertising services were procured and the amount paid to each organisation are shown in the below table.

Category	Name of Person, Agency or Organisation	$
Advertising agencies		
	Amcom Pty Ltd	1,156
	Brandconnect (WA)	2,837
	Brimill Unit Trust	771
	City of Perth	1,364
	Digital Impressions	2,553
	Gatecrasher Advertising Pty Ltd	4,488
	Healthcare Australia Pty Ltd	9,500
	Initiative Media Australia Pty Ltd	5,787
	Joshua Dass	1,068
	Medical Forum Pty Ltd	6,897
	Nicholas Bucknell	1,841
	Park House Studios	9,013
	Quality Press WA	727
	Rohen White	4,895
	Shelby Consulting Pty Ltd	11,555
	Suki Gill	6,220
	Telstra Corporation Limited	5,521
	Telstra Limited	8,869
	The Association For Perioperative Practice	8,031
	The Australasian College For Emergency Medicine	1,100
	Thryv Australia Pty Ltd	650
	Worldwide East Perth	167
Sub-total		**$95,010**
Media advertising organisations		
	Carat Australia Media Services Pty Ltd	102,093
	Facebook	2,564
	Subtotal	**$104,657**
Total		**$199,667**

Capital works

Capital works completed 2022-2023

Project Name	Estimated total cost ($'000)
Infection Prevention and Control System	2,185
Reconfiguring the Western Australian Spinal Cord Injury Service (SCI)	2,170
AS4187 Sterilisation	827

Capital works in progress in 2022-2023

Project Name	Estimated total cost ($'000)	Actual expenditure to 30/6/2023 ($'000)	Estimated cost to complete ($'000)	Estimated completion date
Sarich Neuroscience Research Institute Centre	35,528	34,659	869	Ongoing
Election Commitment - Joondalup Health Campus Development Stage 2 (JHCD2)	269,398	155,959	113,439	Ongoing
Election Commitment - Osborne Park Hospital	24,886	24,334	552	Nov 2024
North Metropolitan Health Service Critical Infrastructure project	1,742	1,524	218	Ongoing
Automated Controlled Substance Storage	800	467	333	Ongoing
King Edward Memorial Hospital Critical Infrastructure	34,647	9,379	25,268	Mar 2025
SCGH Redevelopment of the Watling Walk Retail Precinct	1,480	1,272	208	Ongoing
SCGH GMP Laboratories and Cyclotron	33,944	13,192	20,752	Apr 2025
SCGH Cardiac Catheter Laboratory and Interventional Radiology Rooms Upgrade	9,100	9,244	58	Sep 2023
Stop the Violence	361	323	38	Ongoing
SCGH Emergency Department Upgrade and Behavioural Assessment Urgent Care Centre	30,658	2,948	27,710	Feb 2027
Emergency Asset Investment Program (AIP) Works	894	791	103	Ongoing

Capital works in progress in 2022-2023

Project Name	Estimated total cost ($'000)	Actual expenditure to 30/6/2023 ($'000)	Estimated cost to complete ($'000)	Estimated completion date
SCGH Image Guided Theatre	12,100	398	11,702	Mar 2026
Relocation of Special Needs Dental Clinic	3,270	370	2,900	Dec 2025
SCGH - 24 additional beds	23,039	18,084	4,955	Aug 2024
QEII Medical Centre - Cladding	16,029	-	16,029	Ongoing
Replacement of Biplanar Digital Angiography Units	3,800	65	3,735	Nov 2026
Sir Charles Gairdner Hospital ICU	23,382	773	22,609	Feb 2026
Electronic Medical Record (EMR)	2,200	2,924	773	Ongoing
Women and Newborn Service Relocation Project	10,222	5,620	4,602	Ongoing
Refurbishment works for Biplanar Units at SCGH	7,634	303	7,331	Nov 2026
Albany General Dental Clinic	10,490	72	10,418	Unknown
SCGH CT Scanner	12,890	20	12,870	Jan 2027

Notes: Date of completion is calculated to be Practical Completion estimates plus one year defect liability period.
Albany General Dental Clinic is unknown as the project does not have confirmation.

Appendices

APPENDICES

Board and committee attendance and eligibility 2022-2023

		Board		Audit and Risk Committee		Safety and Quality Committee		Finance Committee		People, Engagement and Culture Committee	
Number of meetings held		10		5		11		12		6	
Position Title	Member name	Eligibility to attend	Attended	Eligibility to attend	Attended	Eligibility to attend	Attended	Eligibility to attend	Attended	Eligibility to attend	Attended
Chair	David Forbes	10	10								
Deputy Chair	Rebecca Strom	10	8	5	5			12	11		
Member	Jahna Cedar	6	5			3	2			2	1
Member	Angela Edwards	10	8	5	3					6	5
Member	Tony Evans	10	7	5	4			11	7		
Member	Hilary Fine	10	8			11	9			5	4
Member	Karen Gullick	9	9			9	9	10	10		
Member	Paul Norman	10	9			11	10			6	4
Member	Paula Rogers	10	8					12	11	6	5
Member	Steve Toutountzis	10	10	5	5	11	11	12	12		

Board and committee remuneration

NMHS Board

Position title	Member name	Type of remuneration	Period of membership (months)	Term of appointment/ tenure	Base salary/sitting fees	Gross/actual remuneration for financial year
Chair	David Forbes	Per annum	12	3 years	$75,987	$75,986.56
Deputy	Rebecca Strom	Per annum	12	3 years	$41,792	$41,791.88
Member	Jahna Cedar	Per annum	9	3 years	$28,933	$28,932.84
Member	Angela Edwards	Per annum	12	3 years	$41,792	$41,791.88
Member	Anthony Evans	Per annum	12	3 years	$41,792	$41,791.88
Member	Hilary Fine	Per annum	12	3 years	$41,792	$41,791.88
Member	Karen Gullick	Per annum	11	3 years	$36,970	$36,969.74
Member	Paul Norman	Per annum	12	3 years	$41,792	$41,791.88
Member	Paula Rogers	Per annum	12	3 years	$41,792	$41,791.88
Member	Stefanos Toutountzis	Per annum	12	3 years	$41,792	$41,791.88
					Total	**$434,432.30**

APPENDICES

Board and committee remuneration

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 for financial year
Member	Affinee Lai	Per meeting	1	Sessional	$75	$75
Member	Andy Pittway	Per meeting	1	Sessional	$75	$75
Member	Lisa Dunn	Per meeting	1	Sessional	$75	$75
Member	Howard Lance	Per meeting	1	Sessional	$75	$75
Member	Isabella Choate	Per meeting	1	Sessional	$75	$75
Member	Jenny Bedford	Per meeting	1	Sessional	$75	$75
Member	Joanne Khan	Per meeting	1	Sessional	$75	$75
Member	Lou Wilson	Per meeting	1	Sessional	$75	$75
Member	Sophia Stavrianos	Per meeting	1	Sessional	$75	$75
Member	Teresa Hall	Per meeting	1	Sessional	$75	$75
					Total	**$750**

Board and committee remuneration

SCGOPHCG 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 for financial year
Chair	Carole Kagi	Per meeting	12	2 years	$35 per hour	$780
Deputy	Elizabeth Mills	Per meeting	12	2 years	$35 per hour	$670
Member	Howard Lance	Per meeting	12	2 years	$35 per hour	$960
Member	Jegatheva Jegathesan	Per meeting	12	2 years	$35 per hour	$530
Member	Judy Russell	Per meeting	4	2 years	$35 per hour	$350
Member	Karen Tambree	Per meeting	4	2 years	$35 per hour	$280
Member	Oluwaseun Bakare	Per meeting	12	2 years	$35 per hour	$350
					Total	**$3,920**

Women & Newborn Community Advisory Council

Position title	Member name	Type of remuneration	Period of membership (months)	Term of appointment/tenure	Base salary/sitting fees (01/07/22 – 31/03/23)	Base salary/sitting fees (01/04/23 – 30/05/23)	Gross/actual remuneration for financial year
Chair	Sonja Whimp	Per meeting	12	Sessional	$35.00 per hour	$75.00 per hour	$1,090
Deputy	Joanne Beedie	Per meeting	12	Sessional	$35.00 per hour	$37.50 per hour	$425
Member	Ann McRae	Per meeting	12	Sessional	$35.00 per hour	$37.50 per hour	$570
Member	Amanda Hocking	Per meeting	12	Sessional	$35.00 per hour	$37.50 per hour	$575
Member	Caitlin Kameron	Per meeting	12	Sessional	$35.00 per hour	$37.50 per hour	$540
Member	Nicole Woods	Per meeting	12	Sessional	$35.00 per hour	$37.50 per hour	$505
Member	Jenny Bedford*		12				
						Total	**$3,705**

*Jenny Bedford remunerated by Carers WA.

Acronyms

AHLO	Aboriginal health liaison officer
CAHS	Child and Adolescent Health Service
CaLD	Culturally and linguistically diverse
DAIP	Disability Access and Inclusion Plan
DHS	Dental Health Services
ED	Emergency Department
EIP	Early Intervention Program
FOI	Freedom of Information
FTE	Full-time equivalent
HITH	Hospital in the Home
HSP	Health service provider
IMC	Injury management consultant
IR	Industrial relations
KEMH	King Edward Memorial Hospital
KPI	Key performance indicator
MHPHDS	Mental Health, Public Health and Dental Services
MHS	Mental Health Services
NMHS	North Metropolitan Health Service
NPS	Net promoter score
OBM	Outcome based management
OPH	Osborne Park Hospital
PMH	Princess Margaret Hospital for Children
SAC	Severity assessment code
SCGOPHCG	Sir Charles Gairdner Osborne Park Health Care Group
SCGH	Sir Charles Gairdner Hospital
TB	Tuberculosis
VAD	Voluntary Assisted Dying
WNHS	Women and Newborn Health Service

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
www.nmhs.health.wa.gov.au

Joondalup Public Hospital*

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
www.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

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

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