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

Care / Respect / Innovation / Teamwork / Integrity
Kaaradjiny / Ngargal-wirrn / Milka kaaditj / Danjoo Yacker / Karnadji

Annual Report
2023-2024

Acknowledgement of Country

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 and present.

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 2024

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 final Annual Report of the North Metropolitan Health Service for the reporting period ended 30 June 2024.

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

Robert Pulsford
A/Chief Executive
North Metropolitan
Health Service
3 October 2024

Rebecca Strom
Board Chair
North Metropolitan
Health Service
3 October 2024

Contents

Foreword

Board Chair's overview

On behalf of the Board, I am extremely proud to present the North Metropolitan Health Service Annual Report for the financial year ending 30 June 2024.

In outlining our performance and achievements, this report provides an insight into the high quality, consumer-centred services that NMHS provides to our communities.

As I reflect on the year that has been, I would like to thank our staff for their dedication and commitment – putting patients at the heart of everything we do. Quite simply, our health service would not be what it is without your enthusiasm and expertise.

Over the past year, we have continued to gain momentum on key programs aimed at supporting patient flow, reducing our elective surgery waitlist, minimising outpatient waitlists, enhancing service provision, and building our workforce recruitment and retention programs.

There's no doubt that health systems across the world are seeing significant challenges around demand, costs, workforce and technology. We continue to acknowledge and meet these head on, and always seek opportunities to improve our services.

An exciting initiative over the past 12 months has been the development of a new strategic plan – *Unleashing our Potential: The North Metropolitan Health Service Strategic Plan 2024-2027*. The plan sharpens our focus on the provision of holistic person-centred care while using advances in technology, skills and knowledge to develop more contemporary models of care. It further strengthens our commitment to supporting staff wellbeing and career development and reinforces our need to minimise our impact on the climate and environment. We look forward to the journey of becoming '*a transformative leader, shaping the future of health care*'.

My thanks go to the Board for their diligent work and oversight of NMHS this past year, and in particular the invaluable contributions of members we farewelled – Steve Toutountzis, Paula Rogers and Emeritus Professor Paul Norman AM. Special thanks go to outgoing Board Chair, Clinical Professor David Forbes AM, for his inspirational leadership and guidance.

Our Executive team has continued to display the passion, expertise and commitment that we are so proud of, in a year with several leadership changes. Special thanks also to our highly regarded former Chief Executive, Dr Shirley Bowen, for her unwavering focus on providing safe high-quality care. Dr Bowen led the team for two years with insightful and empathetic leadership, and we are excited to continue to partner with Dr Bowen in her new role as Director General of the Department of Health. We are grateful to Joel Gurr and Robert Pulsford, who have ably acted in the Chief Executive role while we undertake the recruitment process for this position.

This Annual Report reflects the great strengths and accomplishments of our organisation, and I thank all those involved in developing, driving and supporting these great outcomes.

Rebecca Strom
Board Chair
North Metropolitan Health Service

Chief Executive's report

North Metropolitan Health Service has greatly benefited from the leadership of outgoing Board Chair Clinical Professor David Forbes AM and former Chief Executive Dr Shirley Bowen over the past few years.

Both Clinical Professor Forbes AM and Dr Bowen proficiently led the organisation through a significant journey of strategic transformation and cultural change.

I was honoured to be appointed as the Acting Chief Executive in late June 2024, and take this opportunity to formally acknowledge their dedication to the organisation and the communities which we serve.

This Annual Report captures the journey of the organisation over the past year, including initiatives and projects aimed at supporting the wellbeing of patients and staff.

One of our key strategic priorities has been enhancing the delivery of timely and excellent health services.

Our highly successful Hospital Emergency Access Response Team (HEART) Program received several awards over the past 12 months, including the prestigious Director General Award for the WA Health Excellence Awards. Since its implementation in July 2022, the HEART Program has led to a significant reduction in ambulance ramping hours and developed a number of initiatives to support patient flow and timely discharges.

Another priority area has been reducing elective surgery waitlist times, which has made considerable gains during this reporting period, thanks to the dedication of our staff.

We have been focussed on progressing our workplace culture, including initiatives to support wellbeing, safety in the workplace and flexible work options over the past year. As part of this, we expanded our Junior Medical Officer Manifesto to include the Women and Newborn Health Service, following its successful launch at the Sir Charles Gairdner Osborne Park Health Care Group in 2023.

We have been reconfiguring beds to support forensic services and preparing the business case for additional forensic beds for the Graylands site, as part of the Graylands Reconfiguration Program.

In August 2023, a world-class Mental Health Unit opened at Joondalup Health Campus to support patients 16 years and over. We have also commenced several new mental health services, including an eating disorder service and Mental Health Youth hub.

This year we welcomed our first surgical robot at Osborne Park Hospital for urology patients and a Hospital in the Home service was launched at Sir Charles Gairdner Hospital to provide patients with acute inpatient care in the comfort of their own home.

The New Women and Babies Hospital Project reached an important milestone in March 2024 with detailed scope and estimated costs submitted to the State Government.

Over the past 12 months, the organisation has been working on a three-year strategic plan to further support the delivery of clinical excellence and positive patient experiences for our community. This planning will help provide a foundation for developing contemporary models of care that support a holistic and person-centred approach that delivers care when, and where, it is needed.

On behalf of the North Executive Team, I thank our 14,124 staff for the outstanding work they do each and every day to deliver safe and high-quality services to our communities.

Robert Pulsford
A/Chief Executive
North Metropolitan Health Service

Executive summary

2023-2024 at a glance

9,505
births

26,937
Cancer patients
received treatment

187,200*
Presentations to our **emergency departments**

194,175*
Inpatients

127,594
Elective services
accessed

100
Transplants

802,124
Outpatient appointments
provided

21,407
Patients cared for with **mental health illness**

212,251
Telehealth appointments
provided

*Compared with NMHS sites, different calculation methodology is used for Joondalup Health Campus.

EXECUTIVE SUMMARY

NMHS 2023-2024 performance summary

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

Table 1 Actual results versus KPI targets

OUTCOME 1: Public hospital-based services that enable effective treatment and restorative health care for Western Australians					
Effectiveness KPI					
Unplanned hospital readmissions for patients within 28 days for selected surgical procedures					
Surgical procedure	**Target**	**Actual**	**Surgical procedure**	**Target**	**Actual**
Knee replacement	≤ 18.7	25.8	Prostatectomy	≤ 34.5	33.8
Hip replacement	≤ 17.1	8.9	Cataract surgery	≤ 1.5	3.0
Tonsillectomy and adenoidectomy	≤ 77.3	120.0	Appendicectomy	≤ 23.9	30.3
Hysterectomy	≤ 42.4	48.5	*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	0.8
Survival rates for sentinel conditions					
Stroke			**Acute myocardial infarction**		
Age group (years)	**Target**	**Actual**	**Age group (years)**	**Target**	**Actual**
0 to 49 years	≥ 95.6%	92.7%	0 to 49 years	≥ 98.9%	100.0%
50 to 59 years	≥ 95.1%	95.5%	50 to 59 years	≥ 99.0%	99.3%
60 to 69 years	≥ 94.7%	91.7%	60 to 69 years	≥ 98.1%	98.1%
70 to 79 years	≥ 92.7%	88.2%	70 to 79 years	≥ 97.1%	97.1%
80+ years	≥ 87.6%	81.8%	80+ years	≥ 92.7%	92.5%
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	≥ 98.9%	99.0%	Aboriginal patients	≤ 2.78%	3.17%
80+ years	≥ 97.5%	94.8%	Non-Aboriginal patients	≤ 0.99%	0.80%

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

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

Table 1 provides a summary of our KPIs and variation from the 2023-2024 targets. All KPIs are for the 2023 calendar year unless otherwise stated.

Effectiveness KPI	Target	Actual
Percentage of liveborn term infants with an Apgar score of less than seven at five minutes post-delivery	≤ 1.8%	1.7%
Readmissions to acute specialised mental health inpatient services within 28 days of discharge	≤ 12%	10%
Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services	≥ 75%	88%
Percentage of elective waitlist patients waiting over boundary for reportable procedures	**2023-2024 Target**	**Actual**
Category 1 over 30 days	0%	17%
Category 2 over 90 days	0%	29%
Category 3 over 365 days	0%	9%
Efficiency KPI	**2023-2024 Target**	**Actual**
Average admitted cost per weighted activity unit	≤ $7,461	$8,168
Average emergency department cost per weighted activity unit	≤ $7,243	$7,988
Average non-admitted cost per weighted activity unit	≤ $7,325	$8,669
Average cost per bed-day in specialised mental health inpatient services	≤ $1,541	$1,973
Average cost per treatment day of non-admitted care provided by mental health services	≤ $507	$522

OUTCOME 2: Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives		
Effectiveness KPI	**2022-2023 calendar years**	
	Target	**Actual**
Rate of women aged 50–69 years who participate in breast screening	≥ 70%	50%
Percentage of people who have a tooth re-treated within six months of receiving initial restorative dental treatment	**FY 2023-2024**	
	Target	**Actual**
Adults	< 6.05%	5.88%
Children	< 2.11%	1.43%
Percentage of eligible school children who are enrolled in the School Dental Service program	≥ 78%	69%
Percentage of eligible people who accessed Dental Health Services	≥ 15%	14%
Efficiency KPI	**FY 2023-2024**	
	Target	**Actual**
Average cost per person of delivering population health programs by population health units	≤ $41	$69
Average cost per breast screening	≤ $161	$177
Average cost per patient visit of WA Health-provided dental health programs for		
School children	≤ $262	$305
Socio-economically disadvantaged adults	≤ $280	$379

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

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

QI data

(data extracted 19/07/2024)

326
activities completed

528
proposals submitted and approved

82.5%
hand hygiene compliance rate

MySay data

(data extracted 16/07/2024)

16,904
MySay **inpatient surveys** completed to date
NPS: +79

51,950
MySay **outpatient surveys** completed to date
NPS: +78

1,864
MySay **ED surveys** completed to date
NPS: +53

Care Opinion

194
stories about NMHS

78%
would recommend this service

Top 3
organisation with the highest number of "staff listening, learning and making changes"

Consumer feedback

(data extracted 16/07/2024)

Complaints	499
Contacts and concerns	699
Compliments recorded in the Consumer Feedback Module	1348
Compliments recorded on the Sir Charles Gairdner Osborne Park Health Care Group local database*	2400
Total compliments	**3748**

**Compliment data extracted on 23/07/2024*

Clinical incidents via Clinical Incident Management System

NMHS Non SAC1 incidents to 30/06/2024

(data extracted 16/07/2024)

SAC2	761
SAC3	8322
Unconfirmed - no SAC assigned yet	250
Non-SAC1 incidents total	**9333**

Improving systems to deliver the best care possible

NMHS clinicians and support staff bring a high level of expertise and commitment to every patient and client at every moment of care. The overwhelming majority of interactions with our health service results in positive experiences and outcomes for patients, carers and their families. However, for a very small number of patients, regrettably, errors have occurred during their care. In some cases, these errors may have contributed to a clinical incident or unintended harm.

Any instance of avoidable harm to a patient has tragic consequences for the patients, their families and health care staff. The importance of transparency, empathy and support for all involved in the aftermath of adverse events is recognised. Open disclosure with the patient/family is essential for building trust, fostering patient-provider relationships and promoting accountability within the healthcare system.

A good patient safety culture includes identifying and reporting clinical incidents and risks. NMHS is committed to ensuring that every clinical incident is an opportunity to learn, understand and make changes to improve care and reduce the likelihood of a similar occurrence in the future. NMHS is committed to providing an open and transparent environment that encourages staff to report incidents when something does not go as expected.

The complexity of health care requires a robust program to identify and reduce the risk of harm to patients and clients. Staff learn about the purpose of identifying, reporting and investigating clinical incidents to assist with learning lessons and developing recommendations to prevent and manage the issues and risks. Additionally, the consumer role in clinical incident investigation is increasingly being recognised as a crucial aspect of ensuring transparency, accountability and improvement in healthcare. Consumers offer a perspective that complements the insights of healthcare providers. Their involvement can provide valuable feedback on the patient experience and advocate for changes. NMHS is working with consumer representatives to develop guidelines to ensure training and support systems are in place for consumers who wish to contribute to this process.

All clinical incidents are categorised based on the severity and reviewed accordingly. A severity assessment code 1 (SAC 1) is the most significant clinical incident that has, or could have, contributed to serious harm or death.

In 2023-2024 NMHS reported and reviewed 147 clinical incidents with a SAC1 rating.

Of the 123 completed reviews, 40 resulted in the incident being approved for declassification by the Department of Health's Patient Safety Surveillance Unit, as it was determined that there were no health care factors that contributed to the adverse patient outcome. At the time of this report, 24 SAC 1 incident reviews are still in progress.

Of the 107 SAC 1 investigations that were completed or remain in progress, the patient outcome* was noted as:

No harm	9
Minor harm	5
Moderate harm	7
Serious harm	64
Death	22

*It is important to note that the patient outcome does not necessarily arise as a direct cause of the incident. There are a number of non healthcare-related factors that may contribute to a patient's outcome.

All SAC1 clinical incidents are subject to a rigorous clinical incident investigation and the reports are reviewed by members of the NMHS Executive and the NMHS Board.

New clinical audit tool to improve audit processes

A new, secure clinical audit tool is being rolled out across all sites and services to improve audit processes.

Measurement, Analysis and Reporting System (MARS) is a cloud-hosted application which serves as a central repository of audit tools, audit data and reporting dashboards.

The adoption of MARS for audits encourages transparency of performance and eliminates the need for specialist knowledge to produce meaningful reports and dashboards. MARS ensures continuity of audit tools and reports with staff movement.

The Consumer Engaged National Standards Audit tool (CENSAs), which is used across many of our sites to measure compliance to key National Standards, has been migrated to MARS. It is being used at Women and Newborn Health Service with plans to transition to Sir Charles Gairdner Osborne Park Health Care Group soon. It is expected CENSAs in MARS will provide a more efficient and improved user experience.

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 2023-24 Service Agreement.

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 2023-2024, the total cost of providing state services and health services to the NMHS community was $2.8 billion. Results for 2023-2024 against agreed financial targets (based on the Budget Statements) are presented on the next page.

Full details of the health service's financial performance during 2023-2024 are provided in the financial statements.

EXECUTIVE SUMMARY

Our operations – actual results versus budget targets

Total cost of services (expense limit)

(sourced from Statement of Comprehensive Income)

2024 Target $000

2024 Actual $000

Variation $000
($289,222)

The increase in total cost of services is largely attributed to the impact of inflationary pressures on the patient support costs by $63 million and contracts for private hospital services by $24 million as well as increases in the salaries and wages costs by $203 million due to changes in public sector wages policy and higher staffing level to meet the demands of increasing activities post COVID-19.

Net cost of services

(sourced from Statement of Comprehensive Income)

2024 Target $000

2024 Actual $000

Variation $000
($281,036)

The increase in net cost of services is due to negative variance of $289 million in total cost of services, offset by higher revenue from patient charges.

Total equity

(sourced from Statement of Financial Position)

2024 Target $000

2024 Actual $000

Variation $000
($34,175)

The decrease in total equity is largely due to $108 million below target capital appropriations received from State Government as a result of changes to capital project deliverables and timelines, offsetting the $76 million increment in land and buildings revaluation reserve.

Net increase in cash held

(sourced from Statement of Cash Flows)

2024 Target $000

2024 Actual $000

Variation $000
$17,311

The increase in cash held is largely due to additional $168 million cash provided by State Government and $82 million under spending for purchase of non-current assets, offsetting the additional $240 million spend in service provision activities.

Approved salary expense level

(sourced from Statement of Comprehensive Income)

2024 Target $000

2024 Actual $000

Variation $000
($203,223)

The increase in approved salary expense level is driven by increased employment costs arising from award agreements, leave entitlements revaluation, higher RiskCover premiums and legislated superannuation increment.

Expenses by services

Public hospital admitted services	55%
Public hospital non-admitted services	13%
Mental health services	13%
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	48%
Patient charges	37%
Other revenue	12%
Other grants and contributions	3%
Donation revenue	0%

EXECUTIVE SUMMARY

Values

CARE *(Kaaradjiny)*	RESPECT *(Ngargal-wirrn)*	INNOVATION *(Milka kaaditj)*	TEAMWORK *(Danjoo Yacker)*	INTEGRITY *(Karnadjil)*
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

Values displayed in both Whadjuk Noongar and English languages. Translations were compiled via the Noongar Translation Project and endorsed by the NMHS Aboriginal Cultural Advisory Group in June 2024.

New strategic plan

Over the past financial year NMHS developed a new strategic plan, known as *Unleashing our Potential: The North Metropolitan Health Service Strategic Plan 2024-2027*, to set out the future direction of the organisation.

The plan acknowledges the changing health landscape and the numerous opportunities for improving and evolving the way we deliver care for our communities. It also reflects our desire to continue being a motivating and inspiring leader across Western Australia and beyond.

The plan was developed in consultation with staff and consumers to ensure the needs and expectations of the community and internal stakeholders were met when determining the future direction of the organisation.

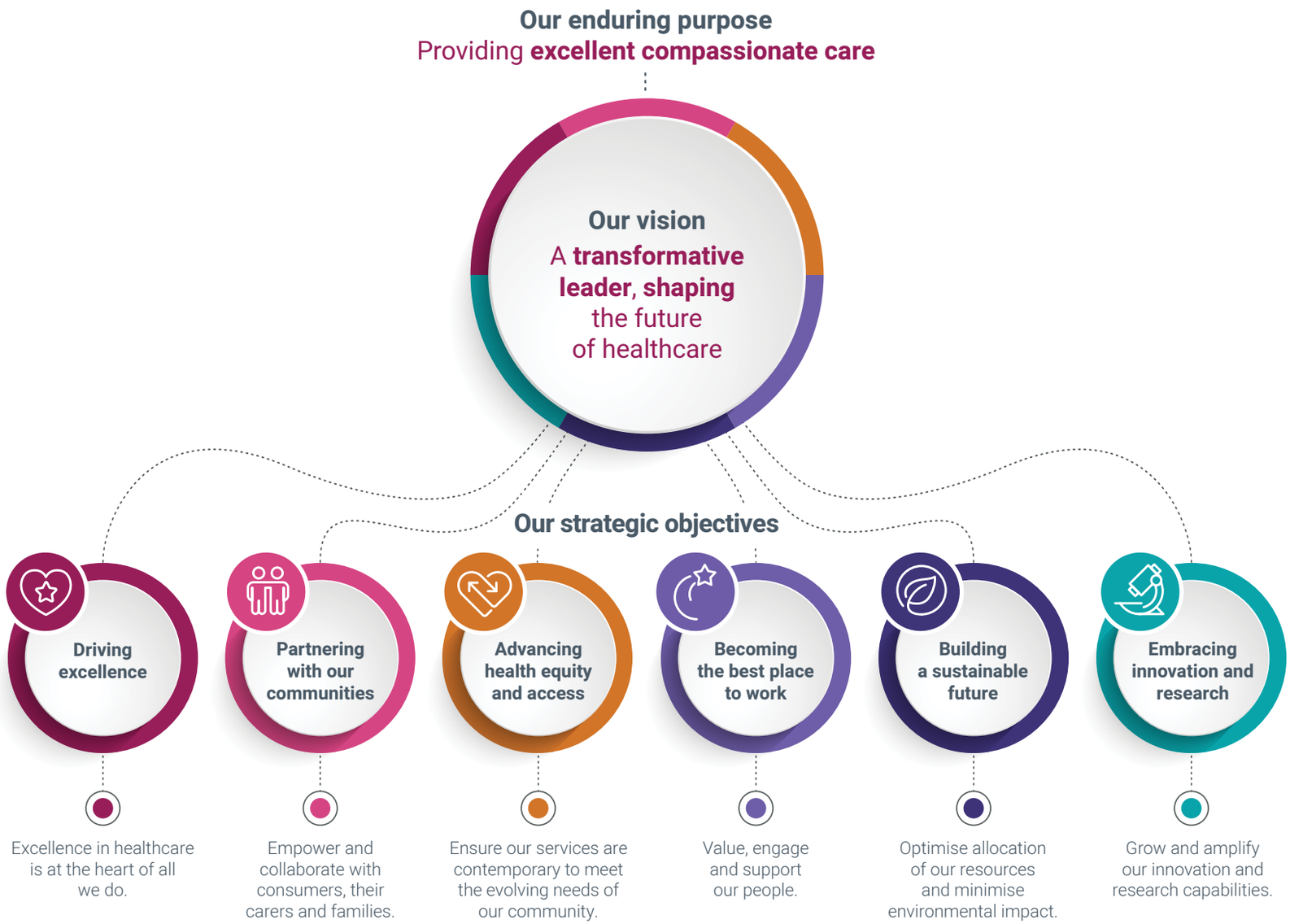
The plan outlines the NMHS purpose, vision, values and strategic objectives over the next three years. The values from the previous strategic plan are unchanged, as they remain relevant and important.

The strategic objectives outlined in the plan are:

1. Driving excellence
2. Partnering with our communities
3. Advancing health equity and access
4. Becoming the best place to work
5. Building a sustainable future
6. Embracing innovation and research

The plan outlines the goals for each strategic objective and how success will be measured.

Strategic plan



About North Metropolitan Health Service

North Metropolitan Health Service is one of the largest health services in Western Australia, with three tertiary hospitals and two secondary hospitals, including:

- Sir Charles Gairdner Hospital
- King Edward Memorial Hospital
- Osborne Park Hospital
- Graylands Hospital
- Joondalup Health Campus.

We deliver a comprehensive range of adult specialist medical, surgical, mental health and obstetric services. Additionally, we offer a range of statewide and specialised multidisciplinary services from our hospital and clinic sites to people living across Western Australia.

Our highly skilled workforce includes more than 14,000 people dedicated to delivering sustainable, quality-health services.

Ramsay Health Care has a service agreement to provide public health services at Joondalup Health Campus through a public private partnership.

Our medical research and education programs are well-renowned and support ongoing innovations in the treatment and care we provide. To support research, we collaborate with various partners with the goal of advancing medical science and improving patient care.

Statewide services

NMHS

- WA Psycho-Oncology Service

Sir Charles Gairdner Osborne Park Health Care Group

- Neurological Intervention and Imaging Service of WA
- State Sarcoma Service
- Cancer Network WA
- WA Liver and Kidney Transplant Service
- WA Poisons Information Centre
- WA Youth Cancer Service
- Voluntary Assisted Dying Medication Dispensing Service

Women and Newborn Service

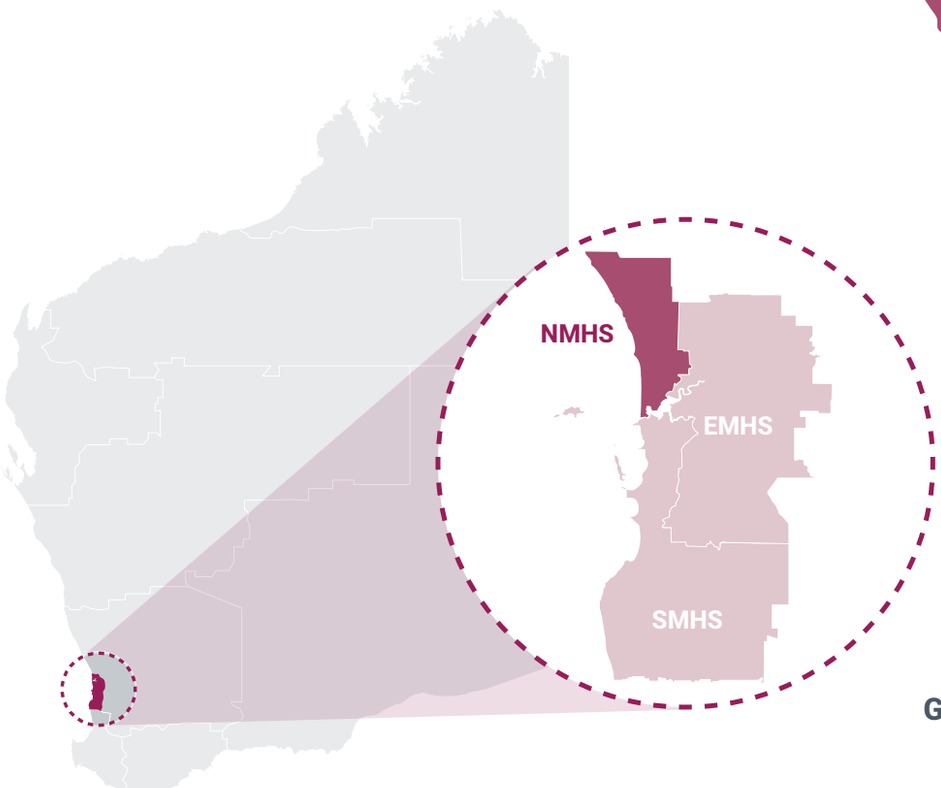
- Abortion and Reproductive Healthcare Service
- Breastfeeding Centre WA
- BreastScreen WA
- Community Midwifery Program
- Genetic Health WA
- Maternal Fetal Medicine Service
- Menopause Services
- Perinatal Loss Service
- Sexual Assault Resource Centre
- Statewide Perinatal and Infant Mental Health 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

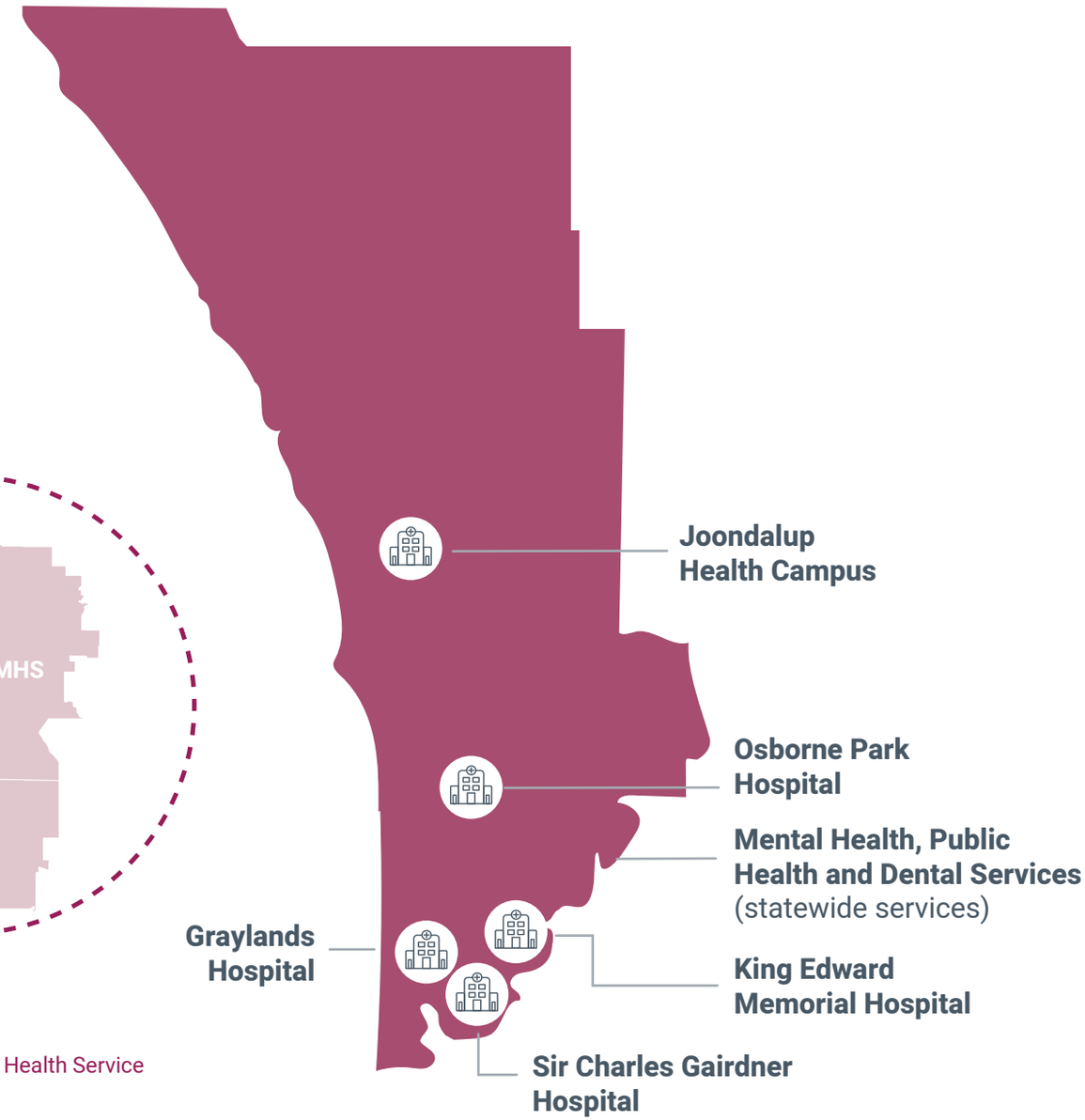
Mental Health, Public Health and Dental Services

- Centre for Clinical Interventions
- Clinical Rehabilitation Service
- General Dental Service
- School Dental Service
- DonateLife
- Humanitarian Entrance Health Service
- Metropolitan Communicable Disease Control
- Neuroscience Unit
- State Head Injury Unit
- State Forensics Mental Health Service
- WA Eating Disorders Outreach Consultation Service
- WA Tuberculosis Control Program

NMHS map

Square kilometres: **993**
Local government areas: **10.5**





EMHS: East Metropolitan Health Service **SMHS:** South Metropolitan Health Service

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 111,658 inpatients and provided 434,975 outpatient appointments this year. There were 77,030 emergency presentations.

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 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.

OPH treated 14,105 inpatients and provided 69,089 outpatient appointments this year.

EXECUTIVE SUMMARY

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.

There were 5,552 births at KEMH, with 62 percent of women needing high acuity care. The Maternity Unit at Osborne Park Hospital supported the birth of 1,582 babies, with 56 percent of women needing higher acuity care.

WNHS treated 20,823 inpatients and provided 209,073 outpatient appointments. There were 12,546 emergency presentations.

Mental Health, Public Health and Dental Services (MHPHDS)

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:

Inpatient Adult Mental Health

- Graylands Hospital: **109 beds**
  - Acute **51 beds**
  - Hospital Extended Care Service **58 beds**
- Sir Charles Gairdner Hospital Mental Health Service: **36 beds**
  - Mental Health Unit **30 beds**
  - Mental Health Observation Area **6 beds and 2 chairs**

Older Adult Mental Health: **56 beds**
- Selby Older Adult **32 beds**
- Osborne Older Adult **24 beds**

State Forensic Mental Health Service: **45 beds**
- Frankland Centre **30 beds**
- Dryandra Ward **15 beds**

Hospital in the Home (HITH): **48 virtual beds**
- Youth HITH **8 beds**
- Older Adult HITH **8 beds**
- Adult HITH **32 beds**

Mental Health inpatient beds: **243 beds**

(Dryandra is included in State Forensics Mental Health Service.)

Community Adult Mental Health Services
(Located in Butler, Mirrabooka, Osborne Park, Subiaco and Wanneroo)
– 2,470 consumers connected to various teams

Public Health

A range of services is 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 Boorloo (Perth) Public Health Unit (formerly known as Metropolitan Communicable Disease Control Program), 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 statewide School Dental Service as well as Public Dental Clinics which provide general and urgent dental care for people who possess a current Health Care or Pension Concession Card. Dental Health Services also provides care to clients of the Department of Communities, residents in metropolitan aged care and those in Department of Justice facilities, as well as 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 44,314 public inpatients in 2023-2024. 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 2023-2024, the JHC Emergency Department (ED) responded to 97,624 presentations with a dedicated paediatric area and a 10-bed mental health observation area within the ED. JHC also contains a purpose-built Mental Health Unit that includes secure accommodation.

Performance highlights

North Metropolitan Health Service

HEART program

The Hospital Emergency Access Response Team (HEART) Program, launched in 2022, continues to focus on working with operational teams across NMHS to reduce ambulance ramping by improving patient flow and creating early access to beds for patients waiting in the Emergency Department.

In January and February 2024, NMHS recorded the lowest number of ambulance ramping hours for the past two years. In addition, patient flow measures across SCGH, OPH and JHC, including earlier discharge times, reached record highs.

Designed around several key themes, the HEART program aims to provide an innovative approach to improving access to care by improving patient flow and discharge practices, supporting the ED and investigating alternative models of care to ensure patients are getting the care they need in the right place, at the right time.

Since its implementation, the program has supported a marked improvement in patient flow at SCGOPHCG. In 2024, the focus shifted to improvement opportunities at other sites.

At the 2023 WA Health Excellence Awards, the HEART program team won the Excellence in Safety and Quality category as well as the prestigious 2023 Director General's Award in recognition of its outcomes.

Predictive analytics tool rolled out

A predictive analytics tool is helping to reduce hospital acquired complications (HACs), such as infections and falls, by integrating predictive analytics into clinical practice to improve patient outcomes.

The proposed Modelling Risks and Outcome Prediction tool integrates sophisticated algorithms, real-time data analytics, visualisations and patient-specific parameters. It facilitates early identification, risk assessment and outcome prediction for various HACs.

To support the project, an in-house machine learning software was customised for data collections, an action card system created to prompt clinical interventions and a real-time bedside tool established for patient monitoring.

An initial three-month trial in 2023 showed a 48 percent reduction in urinary tract infections (UTIs). A project has been initiated to roll out the tool to additional wards across NMHS.

Digital initiatives

NMHS has been exploring the many ways to embrace digital health to support staff and enhance our services into the future.

Staff have been looking at artificial intelligence; specifically, how machine learning and automation can support decision making and access to timely, detailed information to enhance quality care at our sites.

Artificial Intelligence has been used to predict capacity constraints in the SCGH ED to enhance the mobilisation of resources and advanced planning. There is also a project underway to use AI to assist with predicting the incidence of sepsis in ED.

Several key initiatives to support services are in motion, including switching from paper-based records to digital medical records (DMR) at all sites and progression towards electronic medical records, starting with SCGH ICU. We are exploring how we can support clinicians to tap into DMR data to support decision-making and enhance models of care.

We also will be increasing our focus on virtual healthcare and its use across the organisation. We are expanding our rollout of e-prescribing in our outpatient clinics and ED. This will make prescribing safer and improve our ability to deliver telehealth appointments to more patients.

Partnership Model supports quality care

In November 2023, the Partnership Model was launched, which provides guidance to staff and consumers on how we can work together to continuously improve the quality of care and experience of consumers and carers.

A diverse range of consumers, carers, staff and executive leaders helped to develop the model.

It provides principles and tools to support staff and consumers to collaborate on the design, delivery and evaluation of services.

The model has assisted with consumer representatives being recruited to committees and projects across the organisation, as well as a review of the Community Advisory Councils.

NMHS Nursing and Midwifery Flexible Rostering Project

The NMHS Nursing and Midwifery Flexible Rostering Project was launched in February 2023 to identify ways to update the traditional rostering system to provide greater flexibility for nurses and midwives.

A more flexible rostering pattern is designed to support a healthy work-life balance, provide flexible options for those re-entering the workforce and identify any gaps for recruitment.

Highlights from the past year included:

- A successful trial in OPH's Ward 5 based on changing shift start times and consistent morning or afternoon shifts. Positive feedback from the three-month trial has found the earlier morning shifts enabled staff to attend to family responsibilities. The trial will continue for a further three months in 2024.
- At KEMH a trial was undertaken of modified self-rostering of its maternity outpatients to enable staff to select the days and clinics they prefer to work, while also enabling continuity of care. Midwives returning from parental leave were able to work reduced hours on set days and shifts, working across areas where needed. Gynaecology outpatients is now working toward set shifts and clinics to improve working as a multidisciplinary team.
- A dashboard has been developed to capture flexible working arrangements.

Neurokin supporting neurodiverse colleagues at NMHS

A staff-led initiative is supporting neurodiverse colleagues and educating others to understand the benefits and challenges of a neurodiverse workforce.

Founded by Dr Sarah Bernard, a SCGH-based physician with autism and ADHD, Neurokin has grown thanks to the work of a committed neurodivergent leadership team, including nurse manager Kathryn Boon.

The peer support group has now expanded to include nurses, doctors and staff at other health service providers.

The group meets regularly and organises events to help support each other. It covers such topics as reasonable adjustments in the workplace and dealing with feelings of loneliness.

Neurokin has partnered with WA Disability Health Network and the Staff with Disabilities and Allies Network and welcomes any staff member who identifies as neurodivergent.

Dr Bernard said that by encouraging a strengths-based, neurodiversity-affirming approach across health services, Neurokin hopes to build perseverance, resilience and confidence in its membership group.

"Neurokin also recognises that a more inclusive, diverse healthcare service benefits both staff and patients," she said.

"This concept has been strongly embraced by NMHS Executive who recognise the importance of inclusivity and diversity and value a health workforce which represents the community it serves."

First Climate and Sustainability Strategy under development

The organisation is developing its first Climate and Sustainability Strategy, following an extensive staff consultation process. The strategy aims to embed climate and sustainability into policies and practice and build on the success of initiatives already underway.

Recent examples include:

- **Infrastructure and Asset Management seeking sustainable options**

  Infrastructure and Asset Management teams across sites have sought to reduce emissions by optimising existing infrastructure and asset operation. Insulation repairs for various chilled water and hot water pipes have been undertaken to reduce heat and energy loss and more than 2,000 light fittings have been replaced with energy-efficient LEDs, providing better light and energy efficiency.

- **Reduction in giving set use trial**

  The SCGH Intensive Care Unit recently completed a 12-month trial for the reduction of intravenous lines. By extending the line change interval from three to seven days, in line with current evidence, the trial resulted in a reduced carbon footprint with 948 fewer lines being used, reduced patient discomfort and saved staff time due to fewer line changes. The trial's success will see the change in practice continue.

- **Think Before You Glove pilot**

  Think Before You Glove, a project piloted at SCGH, educates staff on appropriate and inappropriate non-sterile glove use and emphasises good hand hygiene. When fully implemented, it is expected to decrease glove usage by about 30 percent, reducing plastic waste and landfill and increasing cost savings.

- **Pharmacycle pilot**

  SCGH and OPH are piloting the Pharmacycle Program to recycle used and empty medicinal blister packs. Under this program, any blistered medicines returned to pharmacy that are no longer suitable for use are deblistered using automated and manual machines. The medicines are then safely disposed of, with deblistered packs sent for further component separation and recycling.

- **Removal of desflurane from statewide medicines formulary**

  A 2022 NMHS-initiated project to remove desflurane as an anaesthetic gas in theatres, which resulted in annual savings of 540 tonnes of CO_2 equivalent and $180,000, was expanded statewide. This led to desflurane being removed from the statewide Medicines Formulary in October, making Western Australia the first public health jurisdiction in Australia to make this commitment. Desflurane has 2,540 times more global warming potential than an equivalent mass of carbon dioxide and creates 50 to 60 times more carbon emissions than other short-acting anaesthetic agents.

- **Medical imaging at OPH and SCGH**

  A new enterprise medical imaging system was rolled out at OPH and SCGH over the reporting period. IntelePACS replaces several prior systems as part of a broader enterprise medical imaging platform. The change in software offers several benefits, including enabling electronic searches for practice imaging undertaken privately rather than relying on physically transported hardcopy images.

Sir Charles Gairdner Osborne Park Health Care Group

First surgical robot for NMHS

The first surgical robot for NMHS began operations at OPH in January 2023 and has helped to reduce wait lists at the hospital.

The robot is initially treating prostate and kidney cancer patients but may be expanded to other areas. Benefits can include a shorter stay in hospital, improved or similar return to full urinary and erectile function, less blood loss and fewer complications post-surgery.

Urology robots are less invasive than open surgery, with the technology enabling surgeons to make precision incisions to reduce the impact on surrounding muscles and tissues.

With robotic surgery, the movements of the surgeon's hands are replicated by the robotic arms of the robot enabling the same dexterity of open surgery without requiring a large incision through skin and tissues.

Initiatives improve flow in Emergency Department

Two new initiatives have contributed to a reduction in ambulance ramping hours and improved patient flow in the SCGH ED.

An Emergency Care Navigation Centre (ECNC) has been established and trialled to improve the management, flow, safety and experience of patients in the ED waiting room.

The ECNC is operated by senior medical and nursing staff who use digital systems to gain enhanced oversight of observations, investigations and other patient information to enable expedited assessment, treatment and referral of ED patients.

As part of this, a My Emergency Visit (MEV) app was trialled at SCGH ED to support triaging efficiencies and enhance the patient ED experience.

MEV allows patients entering the ED to register themselves on the system by answering a few quick questions via their mobile phone. The idea for the app was initiated by ED medical consultants and developed in close collaboration with senior ED clinical staff and consumers.

The ECNC and MEV app were initiated and managed by the Innovation team, under the HEART program, and have been funded by the State Government under the Emergency Access Reform Program.

SCGOPHCG transitions to ePrescribing

Prescribers across SCGOPHCG began transitioning to electronic prescribing in March 2024, with more than 600 prescriptions being generated each week in outpatient clinics and the Emergency Department in the initial four months.

Electronic prescribing provides many benefits to patients, including:

- improved information sharing for better clinical decision making
- improved visibility of prescriptions that have been issued using the platform
- reduced risk of medication errors from misinterpretation of orders by the pharmacist or patient
- seamless use of telehealth, allowing instant delivery of prescriptions to patients digitally where appropriate to enable timely medication access
- automated transfer of medication profiles to notification and clinical summary discharge software, reducing transactions and duplication.

Assistant in Nursing program

Twenty-five undergraduate nursing students have completed the Assistant in Nursing (AIN) program in SCGH's Emergency Department (ED) since the workforce initiative was launched in May 2023.

Feedback from staff and students has been overwhelmingly positive. The program aims to provide an accelerated pathway for newly qualified nurses wanting to work in critical care by allowing them to gain valuable exposure to these areas before the completion of their degree.

The AIN workforce supports our ED nursing workforce in maintaining quality and timely patient care, which improves patient flow and contributes to a safe workplace. The students in the program are offered the opportunity to apply for AIN positions in ED.

Hospital in the Home service

The Hospital in the Home (HITH) service at SCGH is transforming the way patients can receive care.

Through the program, eligible patients can receive care twice daily in the comfort of their home from a multidisciplinary team, including doctors, nurses, physiotherapists, occupational therapists, social workers and pharmacists.

HITH launched in February 2024 to provide patients with acute inpatient care at home seven days a week, with overnight telephone support available.

The team provides treatment and monitors the patient's condition while enabling the patient to remain in a familiar environment.

In the first three months of operation, HITH assisted 80 patients, saving a total of 378 hospital bed days if the same patients had been treated on site. The program has received a 100 percent satisfaction result from its patients.

Following its success, HITH has been gradually expanding its bed capacity. It is expected to increase from 10 beds to 20 beds in July 2024.

Quick discharges at the Neurology Rapid Access Clinic

Following preparation, the Neurology Rapid Access Clinic (NRAC) opened at SCGH in July 2024, enabling eligible patients to bypass inpatient admissions, resulting in faster discharges.

The NRAC provides new outpatient pathways for patients presenting to the ED with transient ischemic attacks, minor strokes or transient neurological symptoms.

Eligible patients receive expedited access to outpatient MRIs and rapid access to neurology-led clinic appointments within five days of presentation.

Health and legal partnership

An innovative partnership that provides free legal advice to vulnerable inpatients commenced at SCGH and OPH in late 2023.

The health justice partnership enables lawyers from Legal Aid WA to speak directly with patients at SCGH, with Northern Suburbs Legal Services providing the same service at OPH.

Lawyers attend the hospitals once a week to provide free legal advice to inpatients who meet certain criteria and have been referred by the Social Work Department.

SCGH celebrates 65 years

Staff celebrated the 65th anniversary of SCGH in September 2023 with an event featuring a photographic display of iconic images from the hospital's history.

The hospital commenced operations as the Perth Chest Hospital in August 1958, when a convoy of army ambulances transferred 68 tuberculosis patients from the Wooroloo Sanatorium to the site. It was officially opened on 1 September 1958 by Premier Bert Hawke.

Five years later, the Perth Chest Hospital was renamed to honour His Excellency, the Governor of Western Australia, Sir Charles Gairdner.

Cancer Council WA Researcher of the Year

Professor Chan Cheah, a Clinical Haematologist at SCGH, was named the 2023 Cancer Council WA Researcher of the Year award for his clinical research in lymphoma and chronic lymphocytic leukaemia.

At the forefront of clinical research, Professor Cheah has been the lead investigator on numerous clinical trials and has contributed to 150 peer-reviewed publications in leading journals.

Professor Cheah, who was also awarded Cancer Council WA Early Career Cancer Researcher of the Year in 2018, said he was honoured to be named Cancer Council WA's 2023 Cancer Researcher of the Year.

> "In five years, we have created one of the most successful haematology clinical research programs in the country, delivering cutting-edge treatments to WA patients years before commercial availability," he said.

"More than one thousand Western Australians are diagnosed with a blood cancer each year, and thousands more are living with the disease.

"While some are cured using chemotherapy, many are not. They need better treatments and clinical trials are the fastest way to deliver them."

Cancer Council WA CEO, Ashley Reid, said Professor Cheah's work has had a huge impact on blood cancer research, with enormously improved access to clinical trials and cutting-edge therapeutics for Western Australians.

"Professor Cheah is one of the most prominent lymphoma researchers internationally," he said.

"It is so encouraging to see passionate cancer researchers, such as Professor Cheah, striving to ensure the best possible outcomes for cancer patients and making such an important contribution to the global effort to defeat cancer."

Women and Newborn Health Service

BreastScreen WA celebrates 35 years of service

BreastScreen WA celebrated 35 years providing free screening mammograms to WA women in 2024.

In 1989, the first BreastScreen WA screening clinic opened in Cannington, operating one x-ray machine and screening 4,687 women in its first year.

Today BreastScreen WA has 12 permanent clinic sites and four mobile screening units and screens almost 130,000 women a year.

Family domestic violence service trial

The Sexual Assault Resource Centre (SARC) has been trialling a family and domestic violence service to support survivors. It forms part of a $4.5 million pilot by the WA Government to boost convictions through expert reports and court testimony.

SARC prepares medical reports and provides court testimony following referral from WA Police for the Office of the Director of Public Prosecutions. The first phase of the project focused on expert witness reporting and testimony for the Department of Public Prosecutions and staff recruitment.

The team has been working towards phase two, which commences on 1 July 2024 and includes working with the WA Police Special Crime Division to establish care and referral pathways. In addition, work has commenced with the Department of Justice to establish key performance and research indicators to assist with evaluating the program.

Midwifery graduate program wins national award

The NMHS Midwifery Graduate Program received the Maternity Service of the Year Award from the 2024 Australian College of Midwives Midwifery Awards.

The program offers outstanding opportunities for newly-qualified midwives to experience a wide scope of clinical practice opportunities and gain exposure to the full range of career pathways across the women's health continuum.

Placements in a variety of units ensure the organisation is growing a workforce capable of meeting consumer need. Innovative programming to address national midwifery workforce shortages has seen this dynamic program more than double its intake from 24 graduates in 2019 to 60 in 2023.

Infrastructure upgrades at KEMH

As part of the $35.4 million critical infrastructure upgrades at KEMH, several works took place over the past year.

Fire remediation works and upgrades to all lifts were completed. Façade works continued, with restoration on A Block due for completion in November 2024.

Works on the construction of two new theatres were undertaken over the reporting period and are expected to approach practical completion in late 2024.

Genomic sequencer to help diagnose rare diseases

A state-of-the-art diagnostic tool will help more Western Australian children be tested for rare conditions, thanks to an initiative led by Genetic Health WA and PathWest.

Director Genetic Services Western Australia Professor Nicholas Pachter teamed up with PathWest's Diagnostic Genomics Head of Department Dr Dimitar Azmanov to secure the $6 million grant from Telethon to buy the machine and fund its operation for the first five years.

A/NMHS Chief Executive Rob Pulsford said it is expected the initiative will allow up to 600 WA babies, children, and adolescents with rare diseases to be assessed per year.

"It is estimated up to 300 of these cases will receive a diagnosis, making a profound difference to the future care of these babies, children and adolescents and their families," he said.

The high-tech Novaseq genomic sequencer can examine a person's genetic makeup to test for more than 6,000 rare diseases, giving much-needed answers for medical mysteries.

Until recently it has not been easy for many Western Australian families to receive a diagnosis for a rare condition.

Professor Pachter from Genetics Health WA said a diagnosis can inform how a condition is inherited in the family and can help parents planning to have further children with reproductive decision-making.

"Making a diagnosis gives certainty and creates a network and community rather than the person feeling isolated," he said.

A Telethon donation of $6 million over the next five years has made the launch of this diagnostic tool possible. The State Government has invested $3 million in crucial support, including a genetic pathologist, clinical geneticist, and genetic counsellor, ensuring comprehensive care for families navigating these challenging journeys.

Mental Health, Public Health and Dental Services

Dental x-rays go digital

A rollout of equipment to digitise dental x-rays is taking place across multiple clinics to enable easier access to medical records.

Known as the Digital Imaging Radiography Project, it includes 200 new radiography scanners that will allow x-rays to be viewed on a computer and shared with other clinics as required.

The project, which began in June 2023, is expected to be completed at the end of 2024.

New Special Needs Dental Clinic

The tender process and planning for the new Special Needs Dental Clinic (SNDC) at the Mt Henry Clinic in Salter Point was completed in the past year and a WA building company has been awarded the construction tender.

The SNDC has been designed to enhance the care and experience of individuals with special needs and their families and carers. It has been specifically designed following stakeholder consultation to feature a low sensory room, covered walkways for wheelchairs, large clinical rooms and other features.

Construction is expected to be completed in late 2025.

PERFORMANCE HIGHLIGHTS

Expanded service provides more support for eating disorders

Following its success in the past year, the North Metropolitan Eating Disorders Specialist Service (NMEDSS) expanded its service to provide more people with specialist treatment for eating disorders.

Originally launched in late 2022, the service now includes specialist multidisciplinary outpatient treatment which complements other services. The larger team includes clinical nursing, dietetics, psychology, psychiatry, physician, exercise physiology and peer support.

The service is now offered five days per week, up from three days per week and is accepting some GP referrals for people on eating disorder care plans.

Based on the success of the program over the past year, NMEDSS is set to expand in the future. There are plans to relocate to permanent accommodation to provide a full suite of services with more referral pathways. The team is also developing a more cohesive approach to transition support so the individual receives a seamless experience.

NMEDSS is available to people aged 16 years and over with a diagnosed eating disorder. The service was developed in coordination with the Mental Health Commission and currently takes referrals from within NMHS.

Staff support inaugural Gift of Life Walk

The inaugural Gift of Life Walk was held at Lake Monger as part of National DonateLife Week 2023.

Held in July each year, DonateLife Week is an opportunity to raise awareness of the importance of organ and tissue donation and to encourage people to register as a donor.

About 80 percent of Australians aged 16 years and over support organ and tissue donation, but less than half have actually registered.

There are about 1,800 people on the organ waitlist, including many waiting for a life-saving heart or kidney.

GroundED digital app helping people with eating disorders

An innovative pilot project providing early access support for people with eating disorders has recently been launched by our Centre for Clinical Interventions (CCI).

GroundED is a digital application and a guided program for eating disorder recovery. It offers immediate education and support for people aged 18 years and over who have been referred to CCI by a medical practitioner.

The innovation project enables CCI clinicians to monitor a consumer's progress before they begin face-to-face treatment.

It has been developed in collaboration with a team of clinical experts and a passionate consumer advisory group.

Creative arts therapy achieving results as a therapeutic process

The Creative Expression Centre for Arts Therapy (CECAT) at Graylands Hospital is harnessing the healing power of creative expression to support patients.

This psychotherapeutic approach uses various creative modalities, making a real difference for consumers and offering another avenue for communication of feelings and emotions.

CECAT Art Therapist Barbara Watson said she regularly sees the great results arts therapy provides and how it helps consumers to express emotions that can be difficult to articulate in words.

“Art therapists use visual arts, drama and movement, music, creative writing, sand play and clay therapy,” she said.

With guidance and support of an art therapist, therapeutic interventions focus on assisting consumers to deepen their self-understanding and develop a positive outlet to express themselves and find a pathway to recover from past trauma.

CECAT client Jane* was first introduced to art therapy after she sustained a significant head injury.

“I started doing art therapy sessions to help me deal with post-traumatic stress disorder (PTSD), anxiety and deep depression,” Jane said.

“I find the stitching sessions very therapeutic. It takes me to a different place; the repetition and rhythm of the stitching helps reduce my PTSD, lowers my anxiety, and relieves the depression and nightmares.”

With a diagnosis of autism, Emma* has struggled to leave her home, but art therapy increased her confidence.

“I’ve learnt to reconnect with the outside world, use public transport because the incentive to attend classes was so strong,” Emma said. “Art therapy worked better for me than any other therapy because I can’t use my words. I have not self-harmed since attending CECAT.”

Art therapists are university trained and the profession is regulated by the Australian, New Zealand and Asian Creative Arts Therapies Association.

**Note: not their real names.*

Major infrastructure projects

New Women and Babies Hospital Project

The $1.8 billion New Women and Babies Hospital Project reached an important milestone in March 2024 when the Project Definition Plan, detailing scope, estimated costs and schedules, was submitted to the State Government.

Procurement activities commenced on the project, with the call for expressions of interest for a managing contractor released in February 2024. The successful managing contractor will work on the design and construction of the New Women and Babies Hospital facilities.

A series of workshops took place between May and August 2023 to seek feedback from clinicians on the benefits, challenges and opportunities for the project. Key findings were outlined in a Clinical Consultation Report published in November 2023.

The voices of women and families were invited during a second round of community engagement in November 2023, which explored similar themes to the clinician workshops.

Graylands Reconfiguration and Forensics Project

Service delivery models (SDM) for male inpatient forensic mental health, as well as child and adolescent inpatient forensic mental health, were developed in early 2024. The SDMs were informed by feedback from a series of workshops involving more than 70 stakeholders, including clinicians, lived experience advocates and subject matter experts.

The SDMs form an important component of the business case for Stage 1 of the project, which is being led by the Department of Health in partnership with NMHS and other agencies.

In preparation for the future reconfiguration of the Graylands Hospital site, all teams relocated from the ageing Moore House ahead of the building's planned decommissioning in late 2024. Initial planning also began on the potential relocation of the Creative Expression Centre for Art Therapy and Neurosciences Unit, with separate business case submissions commencing next year.

Joondalup Health Campus

State-of-the-art mental health unit officially opens

In August 2023 a world-class Mental Health Unit (MHU) opened at Joondalup Health Campus (JHC) as part of the $281.4 million redevelopment project, co-funded by the State and Australian Governments. The 102-bed MHU doubles the capacity of the previous facility and has expanded treatment to youth and older adults for the first time.

The new MHU has four times the floor space of the previous unit and includes 102 individual patient bedrooms. Opening in a staged approach, the MHU includes a psychiatric intensive care unit along with several interior courtyard spaces and venues for recreation and therapy.

The wards have been designed to separately accommodate adult patients, youth patients (16-24 years) and older adult patients (65+ years).

The unit has multiple large and small lounge areas and gyms and features a dedicated recovery hub where patients can connect with community groups and peer supports. An education room is also available to support youth patients to stay engaged with their schooling, to minimise interruption to their daily life.

Redevelopment of public ward block

Another milestone was reached in December 2023 with construction beginning on a 112-bed public ward block, which will accommodate a 30-bed medical and surgical inpatient ward, 16-bed Cardiac Care Unit, and additional spaces for allied health and administrative services.

The ward block will also include 60 beds to be set aside to meet future demand.

The new facility will support the expansion of surgical services also underway at the hospital, including a new operating theatre, catheterisation lab, anaesthetic room, four post-anaesthesia care unit bed bays and five additional pre-surgery holding bays.

Refurbishment works to the existing discharge lounge commenced in April 2024, and all public hospital redevelopment works are expected to be completed in 2025.

HEART Program charts a new course in JHC patient care

Over the past year, NMHS has continued to support JHC as part of the Hospital Emergency Access Response Team (HEART) program.

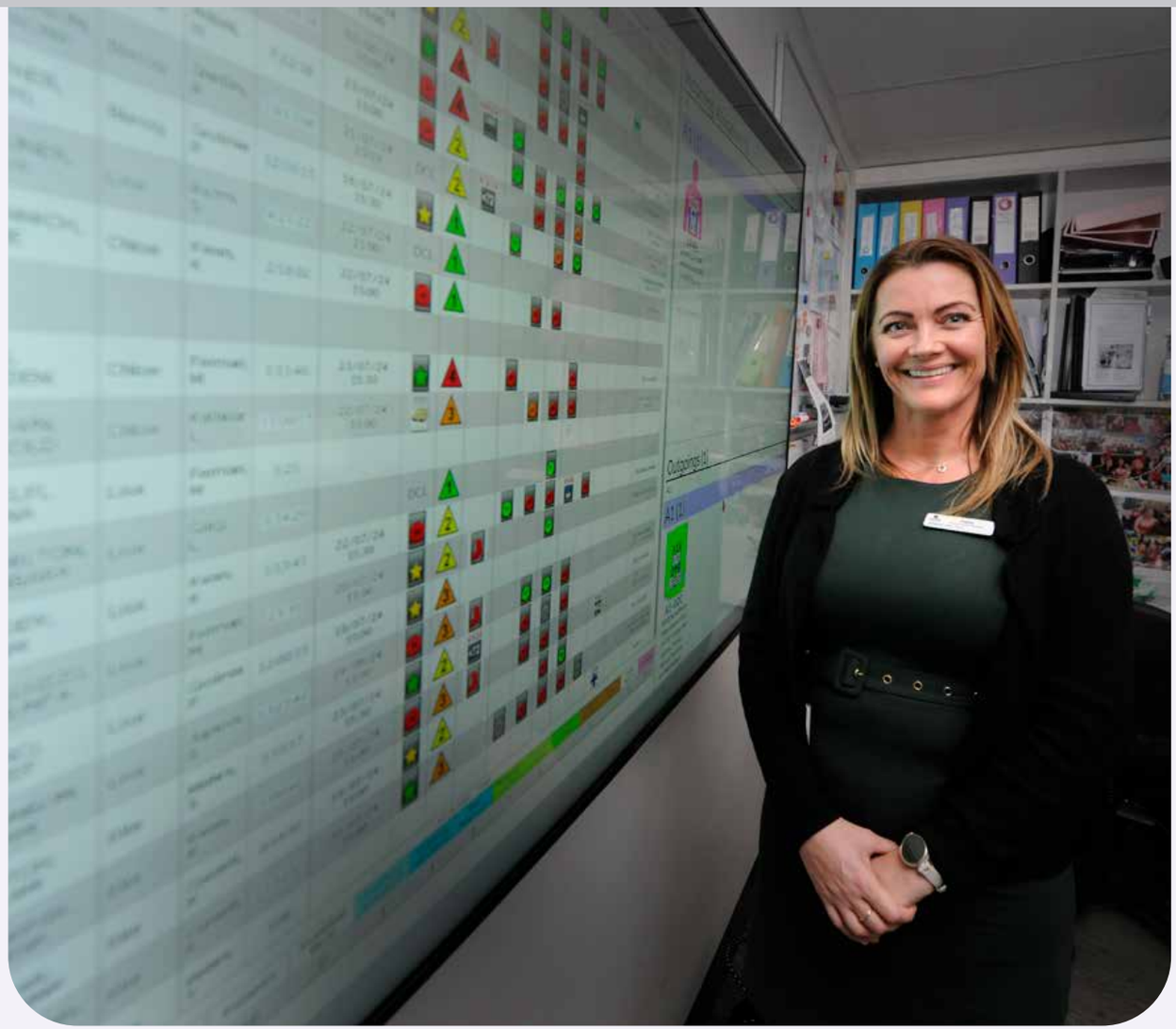
During that time, the NMHS and JHC HEART teams have collaborated and shared findings to improve emergency access across NMHS sites.

In particular, the program has focused on improvements in patient flow and discharge practices, alongside efficiencies in Emergency Department (ED) flow.

Multidisciplinary teams meet daily and identify where delays in discharges may occur. This ensures a patient's time in hospital progresses towards discharge every day.

Additionally, icons have been added to electronic journey boards so patient discharge data is clearly visible and meticulously mapped. For instance, a GOLD icon signifies the commencement of discharge planning on the day prior to departure.

To support this journey, medical nurse navigators have been appointed to work with the multidisciplinary teams in managing patient flow, as well as oversee complex discharges and extended lengths of stay, when necessary.



Results have been significant with a sustained decrease in ED ramping times, increased transfer of care within 30-minute compliance, increased discharge lounge usage and a decreased length of stay for patients identified for the criteria-led discharge program.

The longer-term result is a faster, focused, fulsome healthcare process and an improved patient experience.

Our People

OUR PEOPLE

At North Metropolitan Health Service, we place great priority on investing in our people and our culture. We see our people as more than just employees and provide opportunities for them to learn and grow.

It's all about providing the best possible environment for our staff, including a workplace culture where diversity is valued, cultural backgrounds are respected, and all employees are provided an environment free from discrimination, harassment and unconscious bias.

Making NMHS the Best Place to Work

The Making NMHS the Best Place to Work transformation program was launched in 2023 with the aim of enhancing the working experience for our people.

The program focusses on key initiatives in five priority areas: employee engagement, employee wellbeing, streamlining people development, reforming the way we attract and recruit our people and embedding flexible working arrangements.

The program has supported several key changes and achievements, including a refreshed People and Culture communications and engagement model; updated Flexible Work Arrangements Policy and launch of associated resource toolkit; improved psychological wellbeing resources; progress towards a new Pulse-style staff survey; a review of Learning and Development program and resources; and the establishment of a Talent Acquisition Team.

Events were held across the year to support staff, including:

- **Staff Appreciation Week**

  A week of celebration events to thank our staff for the great work that they do throughout the year.

- **Staff Recognition Awards**

  The Staff Recognition Program was updated and streamlined to recognise and reward our staff at local, site and organisation wide levels.

• Award celebrations

An NMHS-wide inaugural staff awards event was held to celebrate the recipients of the Going the Extra Mile (GEM) Awards, Long Service Awards (20 years and over) and Staff Recognition Awards for 2023.

The 2023 GEM Award winners were:

Award category	Winner
Chief Executive Award	**Justine Huggins (WNHS)**
Empowering, Engaging and Building Inclusion	**Pride Network (NMHS)**
Excellence in Clinical Care	**Endovascular Neurointerventional Unit Team (SCGH)**
Green Champion of the Year	**KEMH Pharmacy and Patient Support Services (KEMH)**
Improving Customer Experience	**Jasmine Greatrex (WNHS)**
Researcher of the Year	**Erin Godecke (SCGH)**

Award category	Winner
Rising Star	**Nicole Owen (SCGH)**
Volunteer of the Year	**Janet Bell (SCGH)**
Driving Innovation	**Aqif Mukhtar (NMHS)**
Excellence in Health Care	**Kathrin Butler (WNHS)**
Strengthening Partnerships	**Aboriginal Health Team / Metropolitan Communicable Disease Directorate**
Board Award	**Aqif Mukhtar (NMHS)**

• Health and Safety Representative Forum

The Health and Safety Representative Forum is an annual event featuring talks, discussions, and demonstrations on health, safety, and wellbeing by internal and external industry experts. This event offers professional development and skill enhancement opportunities and enables health and safety representatives to engage with their peers.

• R U OK? Day

Staff were encouraged to wear yellow and instigate a meaningful conversation with a colleague, as part of activities held for R U OK? Day.

• NMHS Christmas events

Food truck and market stall events were held at NMHS's four main sites during December. This was a great opportunity for staff to gather and enjoy a celebration lunch and purchase last-minute Christmas gifts whilst supporting local businesses. Food platters were provided to regionally-based staff and night shift workers.

• Sorry Day, Reconciliation Week and NAIDOC

Events in recognition of Sorry Day, NAIDOC and Reconciliation Week were held across NMHS, including opening ceremonies, a Welcome to Country, flag-raising, Reconciliation Panel, Yarning Circle, Reconciliation Week display, speeches, traditional dance and a "Sea of Hands". These events and communications raised awareness and understanding of Aboriginal history and culture and the role staff can play to contribute to achieving reconciliation.

Employee wellbeing program expansion

The Employee Wellbeing Strategy 2022-2027 outlines NMHS's commitment to supporting the wellbeing of our people and cultivating a culture aligned to our values.

Key priorities for 2023-2024 included:

- coordinating an organisational response to employee wellbeing and embedding this as a central part of strategic priorities across all departments
- improving the general wellbeing of our employees
- reducing the occurrence and impact of workplace stressors that increase risks to employee wellbeing
- creating a safe and healthy work environment and culture where wellbeing is seen as everyone's responsibility.

To achieve this, the following key programs were supported and expanded:

• Employee wellbeing psychologists

We now have a full contingent of wellbeing psychologists (1.5FTE) available to provide psychological support and guidance for all NMHS employees.

In conjunction with our standard offerings, we successfully piloted the Promoting Resilience in Stress Management program, an evidence-based program designed to help participants develop skills associated with improving resilience and stress management. Following its success, it will now be expanded across NMHS.

• Peer support officers

Our Peer Support Program was designed as a tool to help staff manage the emotional load of their day-to-day role. Studies have shown peer support programs to be a significant factor in mitigating the psychological impact of potentially traumatic events.

We have 62 peer support officers (PSO) who are trained to listen, identify and assist staff needing support. The PSOs can connect staff to professional support services for further assistance or help them find the resources to manage their overall wellbeing. With support from Executive, we aim to achieve a network of PSOs within all departments and sites across NMHS.

• Wellbeing measurement tool

A key priority of the strategy is to use a measurement tool to understand employee wellbeing to support the design of targeted interventions. The Converge International Wellbeing Application will be offered to staff at Osborne Park Hospital and Mental Health following a successful pilot with the Network for Engagement and Wellbeing members.

• Psychosocial risk assessment

Using a systematic approach to identify, manage, and mitigate psychosocial risks and hazards across our organisation is a key priority. The People at Work survey is an evidence-based tool that is being evaluated for suitability at NMHS, as well as internal resource requirements.

• NEW network promotes thriving culture

Network for Engagement and Wellbeing (NEW) is a group of dedicated staff from across NMHS sites who aim to enhance engagement, foster a thriving culture, and promote staff wellbeing. NEW comes together twice a year at an Engagement and Wellbeing Forum, which provides an opportunity to network and brainstorm ideas. Members are provided with information to assist and inspire them to help improve wellbeing and engagement within their own workplaces.

• Employer of choice for Junior Medical Officers

NMHS continues to receive the highest score as an employer of choice for junior medical officers (JMOs). This is the second year NMHS has received the highest score, as well as top rankings across several categories in the 2024 Australian Medical Association Hospital Health Check survey. This achievement is a testament to the dedication of staff and the success of the NMHS JMO Manifesto.

Launched in early 2023 at SCGOPHCG, the manifesto has championed flexible working arrangements, below-the-line pathway reporting, a culture of psychological safety, leave processes and medical workforce on-call arrangements. Its initiatives have led to the creation of 33 part-time positions, increased retention rates and reduced job vacancy rates.

In 2024 the manifesto was rolled out across WNHS, which was positively received by the JMOs.

NMHS will continue its innovative and collaborative approach for supporting future medical leaders, and is strongly committed to providing and embedding a safe, positive and empowering experience for its junior workforce.

NMHS award winners

WA Health Excellence Awards

NMHS won several awards at the 2023 WA Health Excellence Awards in December: the NMHS HEART team; Department of Renal Medicine and Transplantation, SCGH; and Dr David Speers, Consultant Pathologist and Infectious Diseases Physician, SCGH.

The HEART team was also joint winner of the prestigious Director General's Award.

The HEART program develops initiatives to support ambulance ramping, workforce fatigue and provision of timely, safe and quality patient care. It has resulted in a significant reduction in ramping hours with significant additional gains occurring in other emergency access and patient flow measures.

In partnership with the Department of Nephrology and Transplantation at Royal Perth Hospital, the Department of Renal Medicine and Transplantation at SCGH was awarded the Excellence in Rural and Remote Health Care Award. It was recognised for its multidisciplinary approach to addressing disparity in access to kidney transplantation for Aboriginal Australians.

Dr David Speers was awarded the Minister for Health Award, recognising his immense contribution to the WA health system and his significant achievements over the course of his career.

2023 WANMEA

In October 2023, three NMHS staff members won awards at the 2023 WA Nursing and Midwifery Awards:

- Sandra Vinciguerra was the winner of the Nurse of the Year, as well as the Excellence in Primary, Public and Community Care award. Sandra's outstanding work as part of the COVID-19 Vaccination Program at NMHS contributed significantly to the WA health system's response to the pandemic.
- Jodie Atkinson, Midwife Educator and Graduate Program Coordinator at KEMH, won the Excellence in Education award. Jodie empowers others through education in her role, with the KEMH Graduate Program expanding threefold since Jodie's involvement.
- Dr Zoe Bradfield was the winner of the Excellence in Research award. Zoe is a joint Senior Midwifery Research Fellow at Curtin University and NMHS. Leading the intern component of the Graduate Midwifery Program at KEMH, Zoe provides new midwives with the opportunity to develop their skills in quality and research development.

2024 WANMEA

In May 2024, three staff members won awards at the WA Nursing and Midwifery Awards:

- Tasmin Davis, McGrath Early Breast Cancer Nurse, was the winner of the Excellence in Registered Nursing award. Tasmin passionately supports patients through her role in the SCGOPHCG Breast Centre.

- Melissa Lynch was the winner of the Excellence in Aboriginal Health award. Melissa is a proud Noongar woman and an Aboriginal Midwife on the Aboriginal Midwifery Group practice at KEMH. Melissa was acknowledged for being enthusiastic about the provision of culturally safe maternity care for women and their families.
- Sue Morey, Respiratory Nurse Practitioner at SCGH, was added to the Lifetime Achievement Honour Roll. She was recognised for her uncompromising contribution and tireless commitment to improving the care provided to patients suffering from cystic fibrosis, mesothelioma, and asthma, along with other chronic illnesses.

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 the Hon Amber-Jade Sanderson MLA, Minister for Health; Mental Health, who has overall responsibility for WA Health and provides direction to the Director General of the Department of Health and to health service providers.

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 of the Department of Health, 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 cannot 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 the Department of Health (System Manager), the Mental Health Commission, 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.

GOVERNANCE

NMHS Board

As at 30 June 2024

Clinical Professor David Forbes AM

Board Chair

David has had a career in academic paediatrics, working primarily in paediatric gastroenterology and nutrition. 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 headed vocational training at Princess Margaret Hospital for Children (PMH) at different points in his career. For the Royal Australasian College of Physicians, David was a member and then Chair of the Paediatric Physician Training Committee, and the Division of Paediatrics and Child Health Policy and Advocacy Committee. He held roles in health service management as the Chair of Paediatric Medicine at PMH, and as a Clinical Advisor and Acting Chief Medical Officer in the Department of Health. He remains an advocate for Aboriginal, child and mental health.

David joined the NMHS Board in 2018 and was the Deputy Chair from 2018 until 30 June 2020. He served as Board Chair from 1 July 2020 to 30 June 2024.

Ms Rebecca Strom

Deputy Board Chair

Rebecca is a non-executive director and lawyer with experience in the public, private and not-for-profit sectors. She is a former national law firm partner, having worked across Australia in commercial real estate for over 20 years.

Rebecca has brought her significant commercial and governance expertise to the Board since July 2018. Rebecca is currently on the Board of Landgate, including its People, Environment and Sustainability Committee; and the Board of Housing Choices Western Australia, which forms part of a national not-for-profit community housing provider.

She has previously held roles on the Executive, Finance and Property Committee of the Western Australian Planning Commission; the Department of Planning Audit and Risk Committee; and was a member of the WA Netball League Tribunal Panel.

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 was Deputy Board Chair from May 2021 to June 2024 and was appointed Board Chair in July 2024.

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, Jahna 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.

Jahna is a member of the People, Engagement and Culture Committee and the Safety, Quality and Consumer Engagement Committee.

Associate Professor Mathew Coleman

Board Member

Mathew is a highly experienced Consultant Psychiatrist with the WA Country Health Service and a Clinical Academic and Associate Professor in Rural and Remote Mental Health Practice with the Rural Clinical School of WA, at The University of Western Australia. In addition, he is self-employed in private practice as a Consultant Psychiatrist at the Great Southern Specialist Centre in Albany. Within his clinical and academic positions, Mathew largely focuses on the mental health of Australians living in rural and remote communities, including substance use disorders and addiction, youth mental health, Aboriginal cultural safety in mainstream health services and the epidemiology of methamphetamine-related harms in rural and remote WA. Following completion of his medical qualifications, Mathew was awarded fellowship of the Royal Australian and New Zealand College of Psychiatrists in 2013.

Matthew is a member of the People, Engagement and Culture Committee and the Safety, Quality and Consumer Engagement Committee.

Ms Angela Edwards

Board Member

Angela has an extensive background in human resources, industrial relations, change management, organisational development and stakeholder management in both commercial organisations and not-for-profit. She is currently Chief People Officer at the Kids Research Institute Australia.

Angela is also a board member of the not-for-profit cancer support group, Blue Dot Army.

Angela is a member of the Audit and Risk Committee and Chair of the People, Engagement and Culture Committee.

GOVERNANCE

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 Certified Practising Accountants Australia, the Governance Institute of Australia and the Australian Institute of Company Directors.

Tony is Chair of the Audit and Risk Committee and a member of the Finance Committee.

Adjunct Associate Professor Karen Gullick

Board Member

Karen brings significant experience in health leadership and executive roles to the Board. She spent more than 30 years in leadership roles in health care organisations in the public and private sectors in both metropolitan and rural contexts.

A practising registered nurse, Karen has a Master of Science (Nursing), is a Fellow of the Australasian College of Health Service Managers (ACHSM), a Certified Health Executive (CHE), and a graduate of the Australian Institute of Company Directors. She is a member of the Juniper (Uniting Church) Aged Care Board. She jointly coordinates the Fellowship Program in WA for the ACHSM and has been appointed as an Adjunct Associate Professor at Edith Cowan University.

Karen is Chair of the Safety, Quality and Consumer Engagement Committee and a member of the Finance Committee.

Ms Angela Komninos

Board Member

Angela Komninos is the Deputy State Solicitor (Commercial) at the State Solicitor's Office. With 30 years' experience as a commercial lawyer, Angela specialises in large-scale social and economic infrastructure projects, and is expertly skilled in navigating the complexities of public and private partnerships.

Angela has been a key adviser to government on diverse projects, including numerous health projects such as the Joondalup Health Campus Stage 2 Expansion and the in-sourcing of services and expansion of Peel Health Campus. She has extensive experience in providing advice to health service providers on a wide range of matters and her knowledge and experience is leaned on when guiding organisations through strategic reform. Angela acted as the State Solicitor between May 2022 and April 2023, leading Government's key legal office during a period of significant change and reform.

Angela is a member of the Audit and Risk Committee and the Safety, Quality and Consumer Engagement Committee.

Associate Professor Lewis MacKinnon

Board Member

Lewis is a self-employed GP and Principal of Skye Medical Armadale, which he established in 2016. He commenced as Dean of General Practice at Curtin University in 2022, becoming Director of Clinical Placement the following year. Lewis is active in GP networks, specialist taskforces and advisory bodies at departmental, health service provider and college level and active in training of trainee GPs. He is a member of the WA Maternal Mortality Committee.

Following the completion of his medical qualifications, Lewis was awarded fellowship of the Royal College of General Practitioners in the UK and of the Royal Australian College of General Practitioners. He is a member of the Australian Institute of Company Directors and is completing a Master of Business Administration.

Lewis is a member of the Audit and Risk Committee and the Safety, Quality and Consumer Engagement Committee.

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 a member of the Board of Commissioners for Legal Aid Western Australia.

Steve is Chair of the Finance Committee and a member of the Audit and Risk Committee and the Safety, Quality and Consumer Engagement Committee.

Former Board Members

Ms Paula Rogers

Board Member

Paula has significant experience in stakeholder management, communications, events facilitation, marketing and business development. She is the CEO for the Committee for Perth and Director of her own consulting firm. She has been 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 Foundation Council.

Paula has worked in a variety of senior roles in Western Australia including most recently as the State Director of the Committee for Economic Development of Australia. Prior to this, Paula was employed in roles including Managing Director and Event Management CEO and Publisher. Paula holds a Bachelor of Social Science from University College Dublin (Ireland). She is a member of the Australian Institute of Company Directors (AICD) and has completed the AICD course.

End date: 4 August 2023

GOVERNANCE

NMHS Executive Team

As at 30 June 2024

The NMHS Chief Executive Dr Shirley Bowen left the organisation on 3 May 2024 after being appointed Director General of the Department of Health. Joel Gurr acted in the Chief Executive role from May to June 2024 and Robert Pulsford has been acting in the role since 24 June 2024.

NMHS Board

Robert Pulsford
Acting Chief Executive

- Office of the Chief Executive
- General Counsel

Peter Bibrlik

A/Executive Director Major Infrastructure Projects

FUNCTIONS

- Joondalup Health Campus Development Stage 2 (JHCD2)
- New Women and Babies Hospital Project
- Graylands Redevelopment and Forensic Project
- Spinal Cord Injury Service Reconfiguration (SCISR)

Jeffrey Williams

Executive Director Women and Newborn Health Service

FUNCTIONS

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

Dr George Eskander

Area Director Clinical Services

FUNCTIONS

- Medical Education and Research
- Medical Governance
- Medical Workforce

Annie Thompson

Area Director Nursing and Midwifery Services

FUNCTIONS

- Nursing and Midwifery Education and Research
- Nursing and Midwifery Governance
- Nursing and Midwifery Workforce
- WA Cancer and Palliative Care Network Clinical Implementation Unit

Dr Jodi Graham

Executive Director Sir Charles Gairdner Osborne Park Health Care Group

FUNCTIONS

- Osborne Park Hospital
- Sir Charles Gairdner Hospital
- Neurological Intervention and Imaging Service of WA
- Neurosciences Unit
- State Sarcoma Service
- WA Liver and Kidney Transplant Service
- WA Poisons information Line
- WA Youth Cancer Service

Joel Gurr

Executive Director Commissioning & Redevelopment

FUNCTIONS

- Graylands Redevelopment and Forensic Project
- New Women and Babies Hospital Project

Dr Theresa Marshall

Executive Director Mental Health, Public Health and Dental Services

FUNCTIONS

- Area Mental Health Services
- Dental Health Services
- DonateLife WA
- Public Health
- Centre for Clinical Interventions
- Clinical Rehabilitation Service
- Humanitarian Entrance Health Service
- Links
- Boorloo (Perth) Public Health Unit
- Neuroscience Unit
- START Court
- State Head Injury Unit
- State Forensic Mental Health Service
- WA Eating Disorders Outreach Consultation Service
- WA Tuberculosis Control Program

Dr Tina Bertilone

Executive Director Consumer Experience and Clinical Excellence

FUNCTIONS

- Consumer Experience and Engagement
- Medicolegal Services
- Safety and Quality

Jordan Kelly

Chief Corporate Operations Officer

FUNCTIONS

- Audit and Risk
- Business Information and Performance
- Finance
- Contracts and Corporate Services
- Infrastructure and Asset Management

Charles O'Hanlon

Executive Director People and Culture

FUNCTIONS

- Health, safety and wellbeing
- Human resources
- Industrial relations
- Integrity
- People strategy and organisational development

Ian Sheldrake

Executive Director Strategy and Transformation

FUNCTIONS

- Aboriginal Health
- Strategy
- Clinical planning (includes telehealth service)
- Innovation and Development
- HEART program

Disclosures and Legal Compliance

Audit opinion

Auditor General

INDEPENDENT AUDITOR'S REPORT

2024

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 as at 30 June 2024, 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 material 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 2024 and the financial position as 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

During 2022-23, I was unable to obtain sufficient and appropriate audit evidence for an amount of $2,770,196 which was written off in June 2023 to General administration which is included in note 3.6 Other expenses. Consequently, I was unable to determine whether any further or alternate adjustments might have been necessary. My audit opinion on the financial statements for the period ended 30 June 2023 was modified accordingly. My opinion on the current year financial statements is modified because of the possible effect of this matter on the comparability of the General administration line item included in note 3.6 Other Expenses for the current period.

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 misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Australian Auditing Standards will always detect a material misstatement when it exists.

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

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

Report on the audit of controls

Basis of qualified opinion

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 North Metropolitan Health Service 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).

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 controls within the system were suitably designed to achieve the overall controls objectives identified as at 30 June 2024, and the controls were implemented as designed as at 30 June 2024.

The Board's responsibilities

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

Auditor General's responsibilities

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

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

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

Limitations of controls

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

Report on the audit of the key performance indicators

Opinion

I have undertaken a reasonable assurance engagement on the key performance indicators of the North Metropolitan Health Service for the year ended 30 June 2024 reported in accordance with *Financial Management Act 2006* and the Treasurer's Instructions (legislative requirements). 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 report of the North Metropolitan Health Service for the year ended 30 June 2024 are in accordance with the legislative requirements, and 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 2024.

Audit opinion continued

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 Instruction 904 Key Performance Indicators.

Auditor General's responsibilities

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

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

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

My independence and quality 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 2024, 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

This auditor's report relates to the financial statements and key performance indicators of the North Metropolitan Health Service for the year ended 30 June 2024 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.

Aloha Morrissey
Acting Deputy Auditor General
Delegate of the Auditor General for Western Australia
Perth, Western Australia
1 October 2024

Certification of financial statements

For the year ended 30 June 2024

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 2024 and financial position as at 30 June 2024.

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.

Rebecca Strom
Board Chair
North Metropolitan Health Service
27 September 2024

Anthony Evans
Board Finance Committee Chair
North Metropolitan Health Service
27 September 2024

Lorraine Williamson
Chief Finance Officer
North Metropolitan Health Service
27 September 2024

Statement of comprehensive income

For the year ended 30 June 2024

	Notes	2024 $'000	2023 $'000
COST OF SERVICES			
Expenses			
Employee benefits expense	3.1	1,504,628	1,385,280
Contracts for services	3.2	559,149	510,261
Patient support costs	3.3	436,826	408,170
Finance costs	7.2	1,563	1,207
Depreciation and amortisation expense	5.1, 5.2, 5.3, 5.4	83,015	77,251
Repairs, maintenance and consumable equipment	3.4	52,110	48,337
Other supplies and services	3.5	95,104	89,182
Other expenses	3.6	92,060	85,506
Total cost of services		**2,824,455**	**2,605,194**
INCOME			
Revenue			
Patient charges	4.2	79,371	73,116
Other fees for services	4.3	103,646	105,757
Other grants and contributions	4.4	5,633	4,106
Donation revenue		431	361
Other revenue	4.5	26,517	25,814
Total revenue		**215,598**	**209,154**
Total income other than income from State Government		**215,598**	**209,154**
NET COST OF SERVICES		**2,608,857**	**2,396,040**
Income from State Government			
Department of Health - Service Agreement - State Component	4.1	1,440,160	1,358,348
Department of Health - Service Agreement - Commonwealth Component	4.1	700,754	626,618
Mental Health Commission - Service Agreement	4.1	313,092	293,830
Income from other state government agencies	4.1	3,036	2,850
Assets assumed/(transferred)	4.1	68	(1,257)
Services received free of charge	4.1	125,045	117,408
Royalties for Regions Fund	4.1	411	382
Total income from State Government		**2,582,566**	**2,398,179**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(26,291)**	**2,139**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.10	76,121	129,537
Total other comprehensive income		**76,121**	**129,537**
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**49,830**	**131,676**

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

Statement of financial position

As at 30 June 2024

	Notes	2024 $'000	2023 $'000
ASSETS			
Current Assets			
Cash and cash equivalents	7.3	33,577	20,222
Restricted cash and cash equivalents	7.3	76,846	78,185
Receivables	6.1	61,802	56,530
Inventories	6.3	12,158	11,435
Other current assets	6.4	3,849	3,550
Total Current Assets		**188,232**	**169,922**
Non-Current Assets			
Receivables	6.1	34,849	28,462
Amounts receivable for services	6.2	1,133,798	1,053,996
Infrastructure, property, plant and equipment	5.1	1,373,538	1,291,340
Right-of-use assets	5.2	30,565	28,967
Service concession assets	5.3	421,560	395,772
Intangible assets	5.4	929	1,162
Total Non-Current Assets		**2,995,239**	**2,799,699**
TOTAL ASSETS		**3,183,471**	**2,969,621**
LIABILITIES			
Current Liabilities			
Payables	6.5	206,991	179,348
Capital grant liabilities	6.6	-	311
Lease liabilities	7.1	3,489	2,909
Employee related provisions	3.1	314,651	289,545
Other current liabilities	6.7	1,352	1,537
Total Current Liabilities		**526,483**	**473,650**
Non-Current Liabilities			
Lease liabilities	7.1	31,415	29,521
Employee related provisions	3.1	66,570	64,161
Total Non-Current Liabilities		**97,985**	**93,682**
TOTAL LIABILITIES		**624,468**	**567,332**
NET ASSETS		**2,559,003**	**2,402,289**
EQUITY			
Contributed equity	9.10	2,069,717	1,962,833
Reserves	9.10	504,006	427,885
Accumulated surplus/(deficit)		(14,720)	11,571
TOTAL EQUITY		**2,559,003**	**2,402,289**

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 2024

	Notes	Contributed equity $'000	Reserves $'000	Accumulated surplus/ (deficit) $'000	Total equity $'000
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**
Balance at 1 July 2023		1,962,833	427,885	11,571	2,402,289
Surplus/(deficit)		-	-	(26,291)	(26,291)
Other comprehensive income		-	76,121	-	76,121
Total comprehensive income for the year		**-**	**76,121**	**(26,291)**	**49,830**
Transactions with owners in their capacity as owners:	9.10				
Capital appropriations administered by Department of Health		106,884	-	-	106,884
Other contributions by owners		-	-	-	-
Distributions to owners		-	-	-	-
Total		106,884	-	-	106,884
Balance at 30 June 2024		**2,069,717**	**504,006**	**(14,720)**	**2,559,003**

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 2024

	Notes	2024 $'000	2023 $'000
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriation		2,377,238	2,202,553
Capital appropriations administered by Department of Health		106,883	121,667
Royalties for Regions fund		411	382
Net cash provided by State Government		**2,484,532**	**2,324,602**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(1,464,358)	(1,366,440)
Supplies and services		(1,094,016)	(1,030,873)
Finance costs		(1,563)	(1,207)
Receipts			
Receipts from customers		80,991	66,889
Other grants and contributions		5,633	4,106
Donations received		394	309
Other receipts		120,610	126,775
Net cash used in operating activities	7.3.2	**(2,352,309)**	**(2,200,441)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Payment for purchase of non-current physical and intangible assets		(110,130)	(127,857)
Receipts			
Proceeds from sale of non-current physical assets		9	(6)
Net cash used in investing activities		**(110,121)**	**(127,863)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Payments for principal element of lease		(3,699)	(3,693)
Payments to accrued salaries account		(6,387)	-
Net cash used in financing activities		**(10,086)**	**(3,693)**
Net increase/(decrease) in cash and cash equivalents		12,016	(7,395)
Cash and cash equivalents at the beginning of the year		98,407	105,802
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.3.1	**110,423**	**98,407**

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 2024

1 Basis of Preparation

North Metropolitan Health Service (The Health Service) is a Western Australian 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 27 September 2024.

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

Basis of preparation

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

Judgements and estimates

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

Contributed equity

AASB Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities* requires transfers in the nature of equity contributions, other than as a result of a restructure of administrative arrangements, to be designated as contributions by owners (at the time of, or prior to, transfer) before such transfers can be recognised as equity contributions. Capital appropriations have been designated as contributions by owners by TI 955 *Contributions by Owners made to Wholly Owned Public Sector Entities* and will be 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 operates under an Outcome Based Management framework (OBM). The OBM framework is determined by WA Health and replaces the former activity based costing framework for annual reporting from 2017/18 and beyond. This framework describes how outcomes, activities, services and key performance indicators (KPIs) are used to measure the Health Service's performance towards achieving its mission.

The key services of the Health Service under the OBM framework are listed below:

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 'Mental Health Services'.

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 'Mental Health Services'.

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 'Mental Health Services'.

Notes to the financial statements continued

For the year ended 30 June 2024

2.1 Health Service objectives (continued)

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.

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.

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.

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.

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.

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 2024

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	
	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
COST OF SERVICES										
Expenses										
Employee benefits expense	778,093	709,199	83,286	76,487	214,491	200,501	256,230	236,191	16,296	13,454
Contracts for services	362,987	344,389	102,452	89,757	22,466	22,404	41,805	25,592	6,899	6,732
Patient support costs	252,168	231,259	18,032	16,080	103,853	105,182	14,686	12,276	3,134	3,621
Finance costs	92	65	1	1	167	128	933	744	12	8
Depreciation and amortisation expense	49,768	46,819	4,563	4,034	11,606	11,296	10,207	8,295	83	74
Repairs, maintenance and consumable equipment	28,852	17,684	2,056	1,297	7,613	7,204	6,115	5,185	252	212
Other supplies and services	50,030	52,211	7,746	5,665	12,361	13,986	13,741	1,200	1,144	113
Other expenses	35,486	30,529	3,007	2,453	11,405	10,997	13,291	12,377	462	445
Total cost of services	**1,557,476**	**1,432,155**	**221,143**	**195,774**	**383,962**	**371,698**	**357,008**	**301,860**	**28,282**	**24,659**
INCOME										
Revenue										
Patient charges	65,285	56,973	2,020	1,768	6,943	9,131	602	894	-	-
Other fees for services	30,140	31,654	-	-	62,412	64,585	121	117	-	-
Other grants and contributions	1,783	76	6	3	59	175	-	-	2	-
Donation revenue	4	9	-	-	1	4	5	-	-	-
Other revenue	2,704	1,163	59	45	5,656	6,192	392	481	-	2
Total revenue	**99,916**	**89,875**	**2,085**	**1,816**	**75,071**	**80,087**	**1,120**	**1,492**	**2**	**2**
Total income other than income from State Government	**99,916**	**89,875**	**2,085**	**1,816**	**75,071**	**80,087**	**1,120**	**1,492**	**2**	**2**
NET COST OF SERVICES	**1,457,560**	**1,342,280**	**219,058**	**193,958**	**308,891**	**291,611**	**355,888**	**300,368**	**28,280**	**24,657**

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 2024

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	
	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
INCOME FROM STATE GOVERNMENT										
Department of Health - Service Agreement - State Component	871,803	831,951	133,435	127,982	171,422	156,990	29,860	10,183	22,008	22,924
Department of Health - Service Agreement - Commonwealth Component	504,630	440,386	71,939	69,719	102,286	92,070	-	(151)	4,735	4,705
Mental Health Commission - Service Agreement	-	-	-	-	-	-	313,092	293,830	-	-
Income from other state government agencies	-	-	-	-	-	-	-	-	157	1,010
Assets assumed/(transferred)	-	54	-	-	-	-	-	-	-	-
Services received free of charge	73,123	74,437	10,065	8,007	17,691	18,499	12,391	-	932	-
Royalties for regions fund	-	-	-	-	-	-	-	-	-	-
Total income from State Government	**1,449,556**	**1,346,828**	**215,439**	**205,708**	**291,399**	**267,559**	**355,343**	**303,862**	**27,832**	**28,639**
SURPLUS/(DEFICIT) FOR THE PERIOD	**(8,004)**	**4,548**	**(3,619)**	**11,750**	**(17,492)**	**(24,052)**	**(545)**	**3,494**	**(448)**	**3,982**

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 2024

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	
	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
COST OF SERVICES										
Expenses										
Employee benefits expense	83,679	71,697	71,732	71,963	-	-	821	5,788	1,504,628	1,385,280
Contracts for services	21,290	20,866	854	521	396	-	-	-	559,149	510,261
Patient support costs	21,320	19,460	23,633	20,292	-	-	-	-	436,826	408,170
Finance costs	303	217	55	44	-	-	-	-	1,563	1,207
Depreciation and amortisation expense	3,736	3,594	3,052	3,139	-	-	-	-	83,015	77,251
Repairs, maintenance and consumable equipment	4,175	13,754	3,047	3,000	-	-	-	1	52,110	48,337
Other supplies and services	4,430	11,112	5,577	4,902	-	-	75	(7)	95,104	89,182
Other expenses	19,229	20,291	8,943	8,398	-	-	237	16	92,060	85,506
Total cost of services	**158,162**	**160,991**	**116,893**	**112,259**	**396**	**-**	**1,133**	**5,798**	**2,824,455**	**2,605,194**
INCOME										
Revenue										
Patient charges	-	-	4,521	4,350	-	-	-	-	79,371	73,116
Other fees for services	7,158	6,273	3,815	3,128	-	-	-	-	103,646	105,757
Other grants and contributions	3,783	3,852	-	-	-	-	-	-	5,633	4,106
Donation revenue	421	348	-	-	-	-	-	-	431	361
Other revenue	17,287	17,347	417	584	-	-	2	-	26,517	25,814
Total revenue	**28,649**	**27,820**	**8,753**	**8,062**	**-**	**-**	**2**	**-**	**215,598**	**209,154**
Total income other than income from State Government	**28,649**	**27,820**	**8,753**	**8,062**	**-**	**-**	**2**	**-**	**215,598**	**209,154**
NET COST OF SERVICES	**129,513**	**133,171**	**108,140**	**104,197**	**396**	**-**	**1,131**	**5,798**	**2,608,857**	**2,396,040**

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 2024

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	
	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
INCOME FROM STATE GOVERNMENT										
Department of Health - Service Agreement - State Component	118,140	108,409	92,133	96,029	-	-	1,359	3,880	1,440,160	1,358,348
Department of Health - Service Agreement - Commonwealth Component	7,478	14,727	9,686	2,162	-	-	-	3,000	700,754	626,618
Mental Health Commission - Service Agreement	-	-	-	-	-	-	-	-	313,092	293,830
Income from other state government agencies	2,873	1,840	6	-	-	-	-	-	3,036	2,850
Assets assumed/(transferred)	68	(1,311)	-	-	-	-	-	-	68	(1,257)
Services received free of charge	4,517	10,773	6,326	5,692	-	-	-	-	125,045	117,408
Royalties for regions fund	-	-	-	-	411	382	-	-	411	382
Total income from State Government	**133,076**	**134,438**	**108,151**	**103,883**	**411**	**382**	**1,359**	**6,880**	**2,582,566**	**2,398,179**
SURPLUS/(DEFICIT) FOR THE PERIOD	**3,563**	**1,267**	**11**	**(314)**	**15**	**382**	**228**	**1,082**	**(26,291)**	**2,139**

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 2024

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	2024 $'000	2023 $'000
Employee benefits expenses	3.1(a)	1,504,628	1,385,280
Employee related provisions	3.1(b)	381,221	353,706
Contracts for services	3.2	559,149	510,261
Patient support costs	3.3	436,826	408,170
Repairs, maintenance and consumable equipment	3.4	52,110	48,337
Other supplies and services	3.5	95,104	89,182
Other expenses	3.6	92,060	85,506

3.1(a) Employee benefits expenses

	2024 $'000	2023 $'000
Wages and salaries	1,363,449	1,260,113
Superannuation - defined contributions plans	141,179	125,167
Total employee benefits expenses	**1,504,628**	**1,385,280**
Add: AASB 16 Non-monetary benefits	1,631	1,449
Less: Employee Contribution	(26)	(26)
Net employee benefits	**1,506,233**	**1,386,703**

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.

	2024 $'000	2023 $'000
Current		
Annual leave	156,816	143,086
Time off in lieu	39,476	36,981
Long service leave	116,664	107,832
Deferred salary scheme	1,695	1,646
	314,651	**289,545**
Non-Current		
Long service leave	66,570	64,161
	66,570	**64,161**
Total employee related provisions	**381,221**	**353,706**

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:

	2024 $'000	2023 $'000
Within 12 months of the end of the reporting period	105,581	96,770
More than 12 months after the end of the reporting period	90,711	83,297
	196,292	**180,067**

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:

	2024 $'000	2023 $'000
Within 12 months of the end of the reporting period	27,999	25,880
More than 12 months after the end of the reporting period	155,235	146,113
	183,234	**171,993**

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 2024

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:

	2024 $'000	2023 $'000
Within 12 months of the end of the reporting period	373	593
More than 12 months after the end of the reporting period	1,322	1,053
Carrying amount at end of period	**1,695**	**1,646**

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

	2024 $'000	2023 $'000
Public patients services [a]	488,355	456,954
Mental Health	41,816	26,726
Other aged-care services	14,847	12,607
Other contracts	14,131	13,974
Total contracts for services	**559,149**	**510,261**

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

	2024 $'000	2023 $'000
Medical supplies and services	307,176	289,434
Pathology services received free of charge	40,893	37,739
Domestic charges	23,278	23,291
Fees for visiting medical practitioners	17,914	16,047
Fuel, light and power	16,376	13,591
Food supplies	13,663	11,803
Patient transport costs	4,206	3,444
Research, development and other grants	13,320	12,821
Total patient support costs	**436,826**	**408,170**

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

3.4 Repairs, maintenance and consumable equipment

	2024 $'000	2023 $'000
Repairs and maintenance	33,245	33,068
Consumable equipment	18,865	15,269
Total repairs, maintenance and consumable equipment	**52,110**	**48,337**

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

	2024 $'000	2023 $'000
Sanitation and waste removal services	3,438	3,270
Administration and management services	4,199	4,195
Interpreter services	3,163	2,128
Security services	1,743	1,313
Services provided by Health Support Services: [a]		
ICT services	54,918	52,516
Supply chain services	10,659	10,458
Financial services	2,894	2,799
Human resource services	13,784	11,610
Other	306	893
Total other supplies and services	**95,104**	**89,182**

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 2024

3.6 Other expenses

	2024 $'000	2023 $'000
Communications	4,530	3,077
Computer services	5,620	3,778
Workers' compensation insurance	22,833	20,383
Other insurances	22,257	18,667
Consultancy fees	3,111	3,334
Other employee related expenses	5,658	5,820
Printing and stationery	4,457	4,091
Expected credit losses expense	3,629	3,403
Freight and cartage	2,005	1,620
Periodical subscriptions	881	778
Motor vehicle expenses	1,607	1,797
General administration	9,792	11,721
Legal expenses	538	384
Rental	2,675	2,410
Loss on disposal of non-current assets	152	1,683
Other	2,315	2,560
Total other expenses	**92,060**	**85,506**

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 Health Service.

General administration includes $3.7 million parking charges, $2.8 million licence fees and expenses relating to other sundry items including bank fees, membership fees, private patients transport expenses and subscription charges.

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	2024 $'000	2023 $'000
Income from State Government	4.1	2,582,566	2,398,179
Patient charges	4.2	79,371	73,116
Other fees for services	4.3	103,646	105,757
Other grants and contributions	4.4	5,633	4,106
Other revenue	4.5	26,517	25,814

4.1 Income from State Government

	2024 $'000	2023 $'000
Appropriation received for the period:		
Department of Health - Service Agreement - State Component	1,440,160	1,358,348
Department of Health - Service Agreement - Commonwealth Component		
- Capital grants	222	3,881
- Recurrent grants	700,532	622,737
Mental Health Commission - Service Agreement	313,092	293,830
Total appropriation received	**2,454,006**	**2,278,796**
Grants and income from other state government agencies:		
Disability Services Commission	-	688
Recoveries for Insurance Claims from State Government Insurers	900	1,613
Pathology services to other Health Services	31	38
Graduate Transition to Practice Program funding from Chief Nursing and Midwifery Office WA	1,080	-
Other specific grants	1,025	511
Total grants and subsidies	**3,036**	**2,850**
Assets assumed/(transferred)	68	(1,257)
Total assets assumed/(transferred)	**68**	**(1,257)**
Resources received from other public sector entities during the period:		
Department of Finance - government leased accommodation	39	39
Department of Education - Dental therapy units rental expense	1,182	1,069
State Solicitor's Office - legal service	370	304
PathWest - pathology services	40,893	37,739
Services received from Health Support Services (HSS)		
ICT services	54,918	52,516
Supply chain services	10,659	10,458
Financial services	2,894	2,799
Human resources services	13,784	11,610
COVID testing kits	306	874
Total received	**125,045**	**117,408**
Regional Community Services Account	411	382
Total Royalties for Regions Fund	**411**	**382**
Total income from State Government	**2,582,566**	**2,398,179**

Notes to the financial statements continued

For the year ended 30 June 2024

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

	2024 $'000	2023 $'000
Inpatient bed charges	60,567	51,909
Inpatient other charges	5,312	5,971
Outpatient charges	13,492	15,236
Total patient charges	**79,371**	**73,116**

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

	2024 $'000	2023 $'000
Recoveries from the Pharmaceutical Benefits Scheme (PBS)	96,772	99,764
Clinical services to other health organisations	5,767	4,918
Non-clinical services to other health organisations	1,107	1,075
Total other fees for services	**103,646**	**105,757**

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

4.4 Other grants and contributions

	2024 $'000	2023 $'000
Research grants	3,322	1,341
Other grants	2,311	2,765
	5,633	**4,106**

4.5 Other revenue

	2024 $'000	2023 $'000
Use of hospital facilities	9,011	9,173
Rent from commercial properties	421	451
Rent from residential properties	120	127
Boarders' accommodation	2,532	2,266
Sale of radiopharmaceuticals	5,800	5,014
Parking	5,386	4,973
Other	3,247	3,810
Total other revenue	**26,517**	**25,814**

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	2024 $'000	2023 $'000
Property, plant and equipment	5.1	1,373,538	1,291,340
Depreciation	5.1.1	70,200	66,555
Right-of-use assets	5.2	30,565	28,967
Depreciation	5.2.1	4,577	4,230
Service concession assets	5.3	421,560	395,772
Depreciation	5.3.1	8,005	6,187
Intangible assets	5.4	929	1,162
Amortisation	5.4.1	233	279

Notes to the financial statements continued

For the year ended 30 June 2024

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 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 year	**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
Disposal	-	(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
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 2024

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 2023													
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)
Carrying amount at start of period	**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**
Additions	-	-	33,765	-	-	25	411	-	19,716	721	1,928	-	56,566
Disposals	-	-	-	-	-	61	-	-	61	(20)	-	-	102
Transfers from work in progress	-	26,084	(26,084)	-	-	-	-	-	(94)	(67)	-	-	(161)
Transfers of assets from owner	-	64	-	-	-	-	-	-	-	-	-	-	64
Revaluation increments/(decrements)	13,687	82,140	-	-	-	-	-	-	-	-	-	-	95,827
Depreciation	-	(45,825)	-	(3,808)	(727)	(368)	(643)	(8)	(15,187)	(3,634)	-	-	(70,200)
Carrying amount at 30 June 2024	**254,416**	**861,952**	**63,163**	**62,739**	**5,081**	**1,217**	**2,870**	**8**	**69,581**	**46,633**	**5,563**	**315**	**1,373,538**
Gross carrying amount	254,416	861,952	63,163	92,920	9,460	3,275	6,564	229	156,101	75,350	5,563	315	1,529,308
Accumulated depreciation	-	-	-	(30,181)	(4,379)	(2,058)	(3,621)	(221)	(86,341)	(28,666)	-	-	(155,467)
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 2024

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 2023 by the Western Australian Land Information Authority (Valuations and Property Analytics). The valuations were performed during the year ended 30 June 2024 and recognised at 30 June 2024. In undertaking the revaluation, fair value was determined by reference to market values for land: $5.564 million (2023: $5.053 million) and buildings: $0.42 million (2023: $0.444 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 2024

5.1.1 Depreciation and impairment

	2024 $'000	2023 $'000
Depreciation		
Buildings	45,825	42,447
Site infrastructure	3,808	3,810
Leasehold improvement	727	731
Computer equipment	368	366
Furniture and fittings	643	624
Motor vehicles	8	29
Medical equipment	15,187	14,966
Other plant and equipment	3,634	3,582
Total depreciation for the period	**70,200**	**66,555**

All surplus assets at 30 June 2024 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 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)
1 July 2023				
Gross carrying amount	728	34,174	5,403	40,305
Accumulated depreciation	(478)	(8,006)	(2,854)	(11,338)
Carrying amount at start of period	**250**	**26,168**	**2,549**	**28,967**
Additions	-	3,361	2,761	6,122
Cost Adjustment	-	(350)	421	71
Disposals	-	-	(18)	(18)
Depreciation	(130)	(3,042)	(1,405)	(4,577)
Carrying amount at 30 June 2024	**120**	**26,137**	**4,308**	**30,565**
Gross carrying amount	728	36,320	7,040	44,088
Accumulated depreciation	(608)	(10,183)	(2,732)	(13,523)

Notes to the financial statements continued

For the year ended 30 June 2024

5.2 Right-of-use assets (continued)

Initial recognition

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

The Health Service assesses whether:

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

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

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

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

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

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

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

This includes all leased assets other than investment property right-of-use 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:

	2024 $'000	2023 $'000
Depreciation expense of right-of-use assets	4,577	4,230
Lease interest expense	1,563	1,207
Expenses relating to variable lease payments not included in lease liabilities	14	1
Short-term leases	-	-
Low-value leases	-	-
Total amount recognised in the statement of comprehensive income	**6,154**	**5,438**

The total cash outflow for leases in 2024 was $5,276,000 (2023: $4,901,000).

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 2024

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 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
Transfer 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)
1 July 2023									
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)
Carrying amount at start of period	**31,500**	**237,744**	**113,207**	**12,297**	**-**	**617**	**390**	**17**	**395,772**
Additions	-	-	52,703	-	263	29	91	414	53,500
Disposals	-	(9,817)	-	-	-	-	-	-	(9,817)
Transfers from Work in Progress	-	94,940	(94,940)	-	-	-	-	-	-
Revaluation increments/(decrements)	-	(9,890)	-		-	-	-	-	(9,890)
Depreciation	-	(7,289)	-	(335)	(37)	(208)	(79)	(57)	(8,005)
Carrying amount at 30 June 2024	**31,500**	**305,688**	**70,970**	**11,962**	**226**	**438**	**402**	**374**	**421,560**
Gross carrying amount	31,500	305,688	70,970	14,120	391	1,983	5,196	481	430,329
Accumulated depreciation	-	-	-	(2,158)	(165)	(1,545)	(4,794)	(107)	(8,769)

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 2024

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.

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

	2024 $'000	2023 $'000
Charge for the period		
Buildings	7,289	5,547
Site infrastructure	334	334
Computer equipment	37	32
Furniture and fittings	209	205
Medical equipment	79	67
Other plant and equipment	57	2
Total depreciation for the period	**8,005**	**6,187**

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 2024 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 2024

5.4 Intangible assets

	Computer software $'000	Total $'000
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**
Additions	(111)	(111)
Transfers from /(to) other asset classes	(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)
Year ended 30 June 2024		
1 July 2023		
Gross carrying amount	2,205	2,205
Accumulated amortisation	(1,043)	(1,043)
Carrying amount at start of year	**1,162**	**1,162**
Cost Adjustment	-	-
Transfers from/(to) other agency	-	-
Amortisation expense	(233)	(233)
Carrying amount at 30 June 2024	**929**	**929**
Gross carrying amount	2,205	2,205
Accumulated amortisation	(1,276)	(1,276)

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

	2024 $'000	2023 $'000
Computer software	233	279
Total amortisation for the period	**233**	**279**

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 2024

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	2024 $'000	2023 $'000
Receivables	6.1	96,651	84,992
Amounts receivable for services	6.2	1,133,798	1,053,996
Inventories	6.3	12,158	11,435
Other current assets	6.4	3,849	3,550
Payables	6.5	206,991	179,348
Capital grant liabilities	6.6	-	311
Other liabilities	6.7	1,352	1,537

6.1 Receivables

	2024 $'000	2023 $'000
Current		
Trade receivables	28,442	32,524
Other receivables	795	728
Allowance for impairment of trade receivables	(12,399)	(9,386)
Accrued revenue	34,774	23,628
GST receivable	10,190	9,036
Total current receivables	**61,802**	**56,530**
Non-current		
Accrued salaries account [(a)]	34,849	28,462
Total non-current receivables	**34,849**	**28,462**
Total receivables	**96,651**	**84,992**

(a) Funds transferred to Treasury for the purpose of meeting the 27th pay in a reporting period that generally occurs every 11 years. This account is classified as non-current except for the year before the 27th pay year.

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.

Accrued salaries account contains amounts paid annually into the Treasurer's special purpose account. It is restricted for meeting the additional cash outflow for employee salary payments in reporting periods with 27 pay days instead of the normal 26. No interest is received on this account.

The account has been reclassified from 'Restricted cash and cash equivalents' to 'Receivables' as it is considered that funds in the account are not cash but a right to receive the cash in future. Comparative amounts have also been reclassified.

6.1.1 Movement in the allowance for impairment of trade receivables

	2024 $'000	2023 $'000
Reconciliation of changes in the allowance for impairment of trade receivables		
Balance at start of period	9,386	11,880
Expected credit losses expense	3,629	3,403
Net write-back adjustment	667	107
Amounts written off during the period	(1,283)	(6,004)
Balance at end of period	**12,399**	**9,386**

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

	2024 $'000	2023 $'000
Current	-	-
Non-current	1,133,798	1,053,996
Balance at end of period	**1,133,798**	**1,053,996**

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

	2024 $'000	2023 $'000
Current		
Pharmaceutical stores - at cost	10,847	10,205
Engineering stores - at cost	1,311	1,230
Total inventories	**12,158**	**11,435**

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

	2024 $'000	2023 $'000
Current		
Prepayments	3,849	3,550
Total other current assets	**3,849**	**3,550**

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

Notes to the financial statements continued

For the year ended 30 June 2024

6.5 Payables

	2024 $'000	2023 $'000
Current		
Trade payables	11,221	10,499
Other payables	2,725	2,165
Accrued expenses	141,467	126,677
Accrued salaries	51,578	40,007
Total current payables	**206,991**	**179,348**

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

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

6.6 Capital grant liabilities

	2024 $'000	2023 $'000
Reconciliation of changes in capital grant liabilities		
Opening balance at the beginning of the period	311	4,295
Additions / (Reversals)	(89)	(103)
Income recognised in the reporting period	(222)	(3,881)
Total capital grant liabilities	**-**	**311**
Current	-	311
Non-current	-	-
Total capital grant liabilities	**-**	**311**

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

	2024 $'000	2023 $'000
Refundable deposits	1,222	1,207
Paid parental leave scheme	279	214
Other	(149)	116
Total other current liabilities	**1,352**	**1,537**

7 Financing

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

	Notes	2024 $'000	2023 $'000
Lease liabilities	7.1	34,904	32,430
Finance costs	7.2	1,563	1,207
Cash and cash equivalents	7.3		
Cash and cash equivalents	7.3.1	33,577	20,222
Restricted cash and cash equivalents	7.3.1	76,846	78,185
Reconciliation of net cost of services to net cash used in operating activities	7.3.2	(2,352,309)	(2,200,441)
Capital commitments	7.4	269,713	210,201

7.1 Lease liabilities

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

	2024 $'000	2023 $'000
Lease liabilities		
Current	3,489	2,909
Non-current	31,415	29,521
Total lease liabilities	**34,904**	**32,430**

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 2024

7.2 Finance costs

	2024 $'000	2023 $'000
Lease interest expense	1,563	1,207
Finance costs expensed	**1,563**	**1,207**

7.3 Cash and cash equivalents

7.3.1 Reconciliation of cash

	2024 $'000	2023 $'000
Cash and cash equivalents	33,577	20,222
Restricted cash and cash equivalents	76,846	78,185
Balance at end of period	**110,423**	**98,407**
Restricted cash and cash equivalents		
Current		
Grants from State and Commonwealth Governments	10,346	12,411
Other specific purposes [(a)]	56,234	50,025
Mental Health Commission funding [(b)]	10,266	15,749
Total current	**76,846**	**78,185**
Total restricted cash and cash equivalents	**76,846**	**78,185**

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.

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	2024 $'000	2023 $'000
Net cost of services		(2,608,857)	(2,396,040)
Non-cash items:			
Expected credit losses expense	3.6	3,629	3,403
Depreciation and amortisation expense	5.0	83,015	77,251
Net loss from disposal of non-current assets	3.6	152	1,683
Write-off of receivables	6.1.1	(616)	(5,897)
Write down of inventories		322	354
Donation of non-current assets		(36)	(52)
Services received free of charge	4.1	125,045	117,408
(Increase)/decrease in assets:			
GST receivable		(1,154)	788
Receivables		(7,131)	(1,150)
Inventories		(1,045)	404
Other current assets		(299)	(1,027)
Increase/(decrease) in liabilities:			
Payables		27,643	(5,931)
Capital grant liabilities		(311)	(3,984)
Current employee related provisions		25,108	7,862
Non-current employee related provisions		2,410	4,784
Other current liabilities		(184)	(297)
Net cash used in operating activities		**(2,352,309)**	**(2,200,441)**

7.4 Capital commitments

The commitments below are inclusive of GST where relevant.

	2024 $'000	2023 $'000
Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows:		
Within 1 year	263,975	115,121
Later than 1 year and not later than 5 years	5,361	95,080
Later than 5 years	377	-
	269,713	**210,201**

Notes to the financial statements continued

For the year ended 30 June 2024

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:

	2024 $'000	2023 $'000
Financial assets		
Cash and cash equivalents	110,423	98,407
Financial assets at amortised cost [a]	1,220,259	1,129,952
Total financial assets	**1,330,682**	**1,228,359**
Financial liabilities		
Financial liabilities measured at amortised cost	241,895	211,778
Total financial liabilities	**241,895**	**211,778**

(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 2024						
Expected credit loss rate		3.01%	4.05%	10.54%	23.21%	75.29%
Estimated total gross carrying amount at default	28,442	6,742	3,134	1,195	2,180	15,191
Expected credit losses	(12,399)	(203)	(127)	(126)	(506)	(11,437)
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)

Notes to the financial statements continued

For the year ended 30 June 2024

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
2024											
Financial Assets											
Cash and cash equivalents	-	110,423	-	-	110,423	110,423	110,423	-	-	-	-
Receivables [a]	-	86,461	-	-	86,461	86,461	86,461	-	-	-	-
Amounts receivable for services	-	1,133,798	-	-	1,133,798	1,133,798	-	-	-	-	1,133,798
		1,330,682	**-**	**-**	**1,330,682**	**1,330,682**	**196,884**	**-**	**-**	**-**	**1,133,798**
Financial Liabilities											
Payables	-	206,991	-	-	206,991	206,991	206,991	-	-	-	-
Lease liabilities [b]	4.80	34,904	34,904	-	-	47,349	435	893	3,793	16,729	25,499
		241,895	**34,904**	**-**	**206,991**	**254,340**	**207,426**	**893**	**3,793**	**16,729**	**25,499**
2023											
Financial Assets											
Cash and cash equivalents	-	98,407	-	-	98,407	98,407	98,407	-	-	-	-
Receivables [a]	-	75,956	-	-	75,956	75,956	75,956	-	-	-	-
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**

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

(b) The nominal amounts disclosed are the calculated undiscounted cash flow of lease liabilities.

Notes to the financial statements continued

For the year ended 30 June 2024

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

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

8.2.2 Contingent liabilities

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
2024				
Assets measured and recognised at fair value:				
Land				
Residential	-	44	-	44
Specialised	-	5,520	280,352	285,872
Buildings				
Residential and commercial car park	-	190	45,396	45,586
Specialised	-	230	1,121,824	1,122,054
	-	**5,984**	**1,447,572**	**1,453,556**
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**

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 2024

8.3 Fair value measurements (continued)

Fair value measurements using significant unobservable inputs (Level 3)

	Land $'000	Buildings $'000	Total $'000
2024			
Fair value at start of period	267,176	1,036,789	1,303,965
Additions and transfers from work in progress	-	121,024	121,024
Revaluation increments/(decrements)	13,176	72,222	85,398
Transfers of assets to other agency	-	64	64
Disposals	-	(9,817)	(9,817)
Depreciation	-	(53,062)	(53,062)
Fair value at end of period	**280,352**	**1,167,220**	**1,447,572**
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**

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 auditors	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 2023-24 that applied to the Health Service.

Notes to the financial statements continued

For the year ended 30 June 2024

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
Operative for reporting periods beginning on/after 1 Jan 2024		
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 2022-5	*Amendments to Australian Accounting Standards – Lease Liability in a Sale and Leaseback* This Standard amends AASB 16 to add measurement requirements for sale and leaseback transactions that satisfy the requirements in AASB 15 to be accounted for as a sale. There is no financial impact	**1 Jan 2024**
AASB 2022-6	*Amendments to Australian Accounting Standards – Non-current Liabilities with Covenants* This Standard amends AASB 101 to improve the information an entity provides in its financial statements about liabilities arising from loan arrangements for which the entity's right to defer settlement of those liabilities for at least twelve months after the reporting period is subject to the entity complying with conditions specified in the loan arrangement. The Standard also amends an example in Practice Statement 2 regarding assessing whether information about covenants is material for disclosure. There 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**
AASB 2023-1	*Amendments to Australian Accounting Standards – Supplier Finance Arrangements* This Standard amends: (a) AASB 107; and (b) AASB 7 as a consequence of the issuance of International Financial Reporting Standard Supplier Finance Arrangements (Amendments to IAS 7 and IFRS 7) by the International Accounting Standards Board in May 2023. There is no financial impact	**1 Jan 2024**
Operative for reporting periods beginning on/after 1 Jan 2025		**Operative for reporting periods beginning on/after**
AASB 2014-10	*Amendments to Australian Accounting Standards – Sale or Contribution of Assets between an Investor and its Associate or Joint Venture* This Standard amends AASB 10 and AASB 128 to address an inconsistency between the two standards. The Health Service has not assessed the impact of the Standard.	**1 Jan 2025**
AASB 2021-7c	*Amendments to Australian Accounting Standards – Effective Date of Amendments to AASB 10 and AASB 128 and Editorial Corrections* This Standard further defers (to 1 January 2025) the amendments to AASB 10 and AASB 128 relating to the sale or contribution of assets between an investor and its associate or joint venture. The standard also includes editorial corrections. The Health Service has not assessed the impact of the Standard.	**1 Jan 2025**
AASB 2023-5	*Amendments to Australia Accounting Standards – Lack of Exchangeability* This Standard amends AASB 121 and AASB 1 to require entities to apply a consistent approach to determining whether a currency is exchangeable into another currency and the sport exchange rate to use when it is not exchangeable. The Standard also amends AASB 121 to extend the exemption from complying with the disclosure requirements for entities that apply AASB 1060 to ensure Tier 2 entities are not required to comply with the new disclosure requirements in AASB 121 when preparing their Tier 2 financial statements. The Health Service has not assessed the impact of the Standard.	**1 Jan 2025**
Operative for reporting periods beginning on/after 1 Jan 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**

Notes to the financial statements continued

For the year ended 30 June 2024

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

	2024	2023
Compensation band ($)		
$20,001 – $30,000	2	-
$30,001 – $40,000	-	1
$40,001 – $50,000	6	8
$50,001 – $60,000	1	-
$80,001 – $90,000	1	1
	10	**10**

	2024 $'000	2023 $'000
Short-term employee benefits	414	434
Post-employment benefits	45	46
	459	**480**

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 Chief Executive (CE) and the heads of services reporting to the CE.

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:

	2024	2023
Compensation band ($)		
$0 – $50,000	-	1
$50,001 – $100,000	1	3
$100,001 – $150,000	-	2
$150,001 – $200,000	1	2
$200,001 – $250,000	3	1
$250,001 – $300,000	5	3
$300,001 – $350,000	1	1
$400,001 – $450,000	1	1
$500,001 – $550,000	2	-
$550,001 – $600,000	1	2
$600,001 – $650,000	1	-
	16	**16**

	2024 $'000	2023 $'000
Short-term employee benefits	4,227	3,185
Post-employment benefits	471	336
Other long-term benefits	350	313
Termination benefits	216	-
Total compensation of senior officers	**5,264**	**3,834**

9.5 Related party transactions

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

Related parties of the Health Service include:

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

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

Significant Transactions with Government-related entities

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

- income from State Government (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 2024

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.

	2024 $'000	2023 $'000
Balance at start of period	15,749	11,437
Add receipts		
Service delivery arrangement:		
Commonwealth contributions	104,040	116,028
State contributions	209,052	177,802
	313,092	293,830
Less Payments	(318,575)	(289,518)
Balance at end of period	**10,266**	**15,749**

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:

	2024 $'000	2023 $'000
Auditing the accounts, controls, financial statements and key performance indicators	488	425
	488	**425**

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.

	2024 $'000	2023 $'000
Balance at start of period	1,962,833	1,808,979
Contribution by owners		
Capital Appropriations administered by Department of Health	106,884	121,667
Transfer of property, plant and equipment from Department of Health	-	34,096
	2,069,717	**1,964,742**
Distributions to owners		
Transfer of property, plant and equipment to HSS	-	(1,909)
Total contribution by owners	**-**	**(1,909)**
Balance at end of period	**2,069,717**	**1,962,833**

	2024 $'000	2023 $'000
Asset revaluation reserve		
Balance at the start of period	427,885	298,348
Net revaluation increments/(decrements):		
Land	13,688	20,079
Buildings	62,433	109,458
Balance at end of period	**504,006**	**427,885**

9.11 Supplementary financial information

(a) Write-offs

	2024 $'000	2023 $'000
Revenue and debts written off under the authority of:		
The Accountable Authority	1,284	2,939
The Minister	-	1,711
The Treasurer	-	1,354
	1,284	**6,004**

(b) Losses through theft, defaults and other causes

	2024 $'000	2023 $'000
Losses of public monies and public or other property through theft or default	10	73
Less amount recovered	(7)	(73)
Net losses	**3**	**-**

(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:

	2024 $'000	2023 $'000
Department of Justice - dental treatment	843	1,762
Disability Services Commission - dental treatment	412	1,420
	1,255	**3,182**

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:

	2024 $'000	2023 $'000
Balance at the start of period	166	166
Add Receipts	739	652
Less Payments	(752)	(652)
Balance at the end of period	**153**	**166**

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

	2024 $'000	2023 $'000
RF Shaw Foundation		
Balance at start of period	6	6
Less Payments	-	-
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 2024

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 2024, and between the actual results for 2024 and 2023 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 $2,535,233,000), and
   - Total Assets of the estimate for the Statement of financial position (1% of $3,155,477,000).

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 $2,605,194,000), and
   - Total Assets for the previous year for the Statement of financial position (1% of $2,969,621,000).

10.1.1 Statement of Comprehensive Income Variances

	Variance Notes	Estimate 2024 $'000	Actual 2024 $'000	Actual 2023 $'000	Variance between actual and estimate $'000	Variance between actual results for 2024 and 2023 $'000
COST OF SERVICES						
Expenses						
Employee benefits expense	1	1,301,405	1,504,628	1,385,280	203,223	119,348
Contracts for services		535,005	559,149	510,261	24,144	48,888
Patient support costs	2	373,714	436,826	408,170	63,112	28,656
Finance costs		685	1,563	1,207	878	356
Depreciation and amortisation expense		79,803	83,015	77,251	3,212	5,764
Repairs, maintenance and consumable equipment		46,940	52,110	48,337	5,170	3,773
Other supplies and services	3	121,922	95,104	89,182	(26,818)	5,922
Other expenses		75,759	92,060	85,506	16,301	6,554
Total cost of services		**2,535,233**	**2,824,455**	**2,605,194**	**289,222**	**219,261**
INCOME						
Revenue						
Patient charges		70,560	79,371	73,116	8,811	6,255
Other fees for services		118,496	103,646	105,757	(14,850)	(2,111)
Other grants and contributions		-	5,633	4,106	5,633	1,527
Donation revenue		-	431	361	431	70
Other revenue		18,356	26,517	25,814	8,161	703
Total revenue		**207,412**	**215,598**	**209,154**	**8,186**	**6,444**
Total income other than income from State Government		**207,412**	**215,598**	**209,154**	**8,186**	**6,444**
NET COST OF SERVICES		**2,327,821**	**2,608,857**	**2,396,040**	**281,036**	**212,817**
INCOME FROM STATE GOVERNMENT						
Department of Health - Service Agreement - State Component	4	1,294,980	1,440,160	1,358,348	145,180	81,812
Department of Health - Service Agreement - Commonwealth Component	5,a	599,901	700,754	626,618	100,853	74,136
Mental Health Commission - Service Agreement		307,935	313,092	293,830	5,157	19,262
Income from other state government agencies		-	3,036	2,850	3,036	186
Assets assumed/(transferred)		-	68	(1,257)	68	1,325
Services received free of charge		123,801	125,045	117,408	1,244	7,637
Royalties for Regions Fund		1,204	411	382	(793)	29
Total income from State Government		**2,327,821**	**2,582,566**	**2,398,179**	**254,745**	**184,387**
Surplus/(deficit) for the period		**-**	**(26,291)**	**2,139**	**(26,291)**	**(28,430)**
Other comprehensive income						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve		-	76,121	129,537	76,121	(53,416)
Total other comprehensive income		**-**	**76,121**	**129,537**	**76,121**	**(53,416)**
Total comprehensive income for the period		**-**	**49,830**	**131,676**	**49,830**	**(81,846)**

Notes to the financial statements continued

For the year ended 30 June 2024

10.1.1 Statement of Comprehensive Income Variances (continued)

Explanation of significant variances between estimate and actual for 2024 - Statement of comprehensive income

1) Employee benefits expense

The variance in employee benefits is driven by higher costs of service provision, funded by additional appropriations through the NMHS Service Agreement ($152M). The costs relate to expansion of patient services, higher activity delivery compared with target, increased employment costs arising from Award Agreements, leave revaluation, Riskcover premiums, legislated superannuation increment and increased costs of service provision post-COVID. Additional funding for the Emergency Access Reform Program, to support WA Government priorities, was provided during the year.

2) Patient support costs

Additional appropriation was received through the NMHS Service Agreement to support higher cost of service provision through expanded services, consumption of medical and surgical instruments to deliver higher levels of activity, as well as significant increase in CPI for goods and services including utilities. Resources received free of charge relating to PathWest ($41M), were mapped to Other Supplies and Services in the estimate.

3) Other supplies and services

Resources received free of charge relating to PathWest ($41M), were mapped to Other Supplies and services whereas the actual costs are mapped to Patient Support costs. Internal Revenue ($12M) was estimated based on prior experience but eventuated in other categories.

4) Department of Health - Service Agreement - State Component

Following the initial NMHS Service Agreement, additional funding has been received to support the higher cost of service provision, expansion of patient services, specific funding to support WA Government priorities, and increased activity above initial target. Cash supplementation above budget levels was provided at end of year ($76M).

5) Department of Health - Service Agreement - Commonwealth Component

Following the initial NMHS Service Agreement, additional funding has been received to support the higher cost of service provision, expansion of patient services, specific funding to support WA Government priorities, and increased activity above initial target.

Explanation of significant variances between actual results for 2024 and 2023 - Statement of comprehensive income

a) Department of Health - Service Agreement - Commonwealth Component

A component of the additional funds which NMHS received through the Service Agreement and during the year were through the Commonwealth source.

10.1.2 Statement of Financial Position Variances

	Variance Notes	Estimate 2024 $'000	Actual 2024 $'000	Actual 2023 $'000	Variance between actual and estimate $'000	Variance between actual results for 2024 and 2023 $'000
ASSETS						
Current assets						
Cash and cash equivalents		9,574	33,577	20,222	24,003	13,355
Restricted cash and cash equivalents		70,938	76,846	78,185	5,908	(1,339)
Receivables		56,530	61,802	56,530	5,272	5,272
Inventories		11,435	12,158	11,435	723	723
Other current assets		3,813	3,849	3,550	36	299
Total Current Assets		**152,290**	**188,232**	**169,922**	**35,942**	**18,310**
Non-current assets						
Receivables		41,062	34,849	28,462	(6,213)	6,387
Amounts receivable for services		1,133,798	1,133,798	1,053,996	-	79,802
Infrastructure, property, plant and equipment		1,416,756	1,373,538	1,291,340	(43,218)	82,198
Right-of-use assets		26,258	30,565	28,967	4,307	1,598
Service concession assets		384,150	421,560	395,772	37,410	25,788
Intangible assets		1,163	929	1,162	(234)	(233)
Total non-current assets		**3,003,187**	**2,995,239**	**2,799,699**	**(7,948)**	**195,540**
Total assets		**3,155,477**	**3,183,471**	**2,969,621**	**27,994**	**213,850**
LIABILITIES						
Current liabilities						
Payables		177,278	206,991	179,348	29,713	27,643
Capital grant liabilities		-	-	311	-	(311)
Lease liabilities		2,494	3,489	2,909	995	580
Employee related provisions		291,615	314,651	289,545	23,036	25,106
Other current liabilities		1,800	1,352	1,537	(448)	(185)
Total current liabilities		**473,187**	**526,483**	**473,650**	**53,296**	**52,833**
Non-current liabilities						
Lease liabilities		24,951	31,415	29,521	6,464	1,894
Employee related provisions		64,161	66,570	64,161	2,409	2,409
Total non-current liabilities		**89,112**	**97,985**	**93,682**	**8,873**	**4,303**
Total liabilities		**562,299**	**624,468**	**567,332**	**62,169**	**57,136**
NET ASSETS		**2,593,178**	**2,559,003**	**2,402,289**	**(34,175)**	**156,714**
EQUITY						
Contributed equity		2,177,555	2,069,717	1,962,833	(107,838)	106,884
Reserves		415,623	504,006	427,885	88,383	76,121
Accumulated surplus/(deficit)		-	(14,720)	11,571	(14,720)	(26,291)
Total equity		**2,593,178**	**2,559,003**	**2,402,289**	**(34,175)**	**156,714**

Notes to the financial statements continued

For the year ended 30 June 2024

10.1.3 Statement of Cash Flows Variances

	Variance Notes	Estimate 2024 $'000	Actual 2024 $'000	Actual 2023 $'000	Variance between estimate and actual $'000	Variance between actual results for 2024 and 2023 $'000
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriation	6	2,123,014	2,377,238	2,202,553	254,224	174,685
Capital appropriations administered by Department of Health	7	191,753	106,883	121,667	(84,870)	(14,784)
Royalties for Regions Fund		1,204	411	382	(793)	29
Net cash provided by State Government		**2,315,971**	**2,484,532**	**2,324,602**	**168,561**	**159,930**
Utilised as follows:						
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits	8	(1,288,805)	(1,464,358)	(1,366,440)	(175,553)	(97,918)
Supplies and services		(1,029,851)	(1,094,016)	(1,030,873)	(64,165)	(63,143)
Finance costs		(685)	(1,563)	(1,207)	(878)	(356)
Receipts						
Receipts from customers		70,560	80,991	66,889	10,431	14,102
Other grants and contributions		-	5,633	4,106	5,633	1,527
Donations received		-	394	309	394	85
Other receipts		136,852	120,610	126,775	(16,242)	(6,165)
Net cash used in operating activities		**(2,111,929)**	**(2,352,309)**	**(2,200,441)**	**(240,380)**	**(151,868)**
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Payment for purchase of non-current physical and intangible assets	9	(191,753)	(110,130)	(127,857)	81,623	17,727
Receipts						
Proceeds from sale of non-current physical assets		-	9	(6)	9	15
Net cash used in investing activities		**(191,753)**	**(110,121)**	**(127,863)**	**81,632**	**17,742**
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Payments for principal element of lease		(4,984)	(3,699)	(3,693)	1,285	(6)
Payments to accrued salaries account		(12,600)	(6,387)	-	6,213	(6,387)
Net cash used in financing activities		**(17,584)**	**(10,086)**	**(3,693)**	**7,498**	**(6,393)**
Net increase/(decrease) in cash and cash equivalents		(5,295)	12,016	(7,395)	17,311	19,411
Cash and cash equivalents at the beginning of the year		126,869	98,407	105,802	(28,462)	(7,395)
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**121,574**	**110,423**	**98,407**	**(11,151)**	**12,016**

10.1.3 Statement of Cash Flows Variances (continued)

Explanation of significant variances between estimate and actual for 2024 - Statement of cash flow

6) Service appropriation

Actual is higher than estimate by $254M due to additional funding received to support the higher cost of service provision, expansion of patient services, specific funding to support WA Government priorities, and increased activity above initial target.

7) Capital appropriations administered by Department of Health

Actual is lower than estimate by $85M due to changes in the capital project deliverables and outlays which have occurred since the release of the initial estimate. These changes stemmed from the refinement in the project timelines and complications in tendering processes delaying the commencement of some projects.

8) Employee benefits

Actual is higher than estimate by $176M due to expansion of patient services, higher activity delivery compared with target, increased employment costs arising from Award Agreements, leave revaluation, higher Riskcover premiums for workers compensation policy, legislated superannuation increment and increased costs of service provision post-COVID.

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

Actual is lower than estimate by $82M due to changes in the capital project deliverables and outlays which have occurred since the release of the initial estimate. These changes stemmed from the refinement in the project timelines and complications in tendering processes delaying the commencement of some projects.

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 the NMHS 2023-2024 Performance Summary earlier in the report, 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 2017-2018. There were no material changes to the framework in 2023-2024.

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 seven 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 six months of receiving initial restorative dental treatment
- Percentage of eligible school children who are enrolled in the School Dental Service program
- Percentage of eligible people who accessed Dental Health Services

Efficiency KPIs

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

Service 8 Community dental health services
- Average cost per patient visit of WA Health-provided dental health programs for school children and socio-economically disadvantaged adults

Certification of key performance indicators

For the year ended 30 June 2024

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 2024.

Rebecca Strom
Board Chair
North Metropolitan Health Service
27 September 2024

Anthony Evans
Board Finance Committee Chair
North Metropolitan Health Service
27 September 2024

Detailed information in support of key performance indicators

The following pages outline detailed information in support of our performance against the 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 24 – 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 2023 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 2023 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 2023, the rate of unplanned readmissions within 28 days achieved target for hip replacement and prostatectomy (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, can be unrelated to the initial admission 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 13 knee replacement patients that readmitted, common reasons for admission include pain and swelling. More comprehensive advice will be included in patient discharge information.

There were four readmissions for hip replacement for differing reasons. Some admissions were for conservative management.

Of the 27 tonsillectomy and adenoidectomy patients who were readmitted, most had post-operative bleeding and were managed conservatively with medication without the need for further intervention. Post-operative bleeds cannot be predicted and occur for 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 27 readmissions which were often related to bleeding or infection. Patients are conservatively managed, and safety netted to return if complications occur.

There were seven readmissions for prostatectomy procedures across sites, the most common reasons were for haematuria and urinary retention and required insertion of an indwelling urinary catheter and bladder washout.

There were six cataract surgery patients who readmitted; most were for repositioning and were discharged home the same day.

Appendicectomy had 22 readmissions, common reasons were for infection or pain and were treated conservatively with packing, dressings or 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 1,000 separations), 2019–2023

	Calendar year						
Surgical procedure	**2019** (per 1,000)	**2020** (per 1,000)	**2021** (per 1,000)	**2022** (per 1,000)	**2023** (per 1,000)	**Target** (per 1,000)	**Target met**
Knee replacement	13.1	34.9	23.4	20.2	25.8	≤ 18.7	✗
Hip replacement	14.7	7.2	14.2	17.7	8.9	≤ 17.1	✓
Tonsillectomy and adenoidectomy	149.2	157.2	150.0	92.4	120.0	≤ 77.3	✗
Hysterectomy	40.2	38.3	54.6	47.7	48.5	≤ 42.4	✗
Prostatectomy	46.5	25.4	42.8	30.0	33.8	≤ 34.5	✓
Cataract surgery	1.2	1.6	2.1	0.0	3.0	≤ 1.5	✗
Appendicectomy	46.9	33.6	27.3	28.4	30.3	≤ 23.9	✗

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[3]. 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 2023-2024 target is 0 percent. Performance is achieved by a result equal to the target.

Results

In 2023-2024, 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 and patient flow.

Compared to 2019-2020, demand for elective surgery has increased, particularly Category 1 where it has increased by 45 percent.

NMHS sites and services have been developing and implementing strategies to address the growing demand. These include increased theatre sessions and lists scheduled, utilising and diverting activity to alternate NMHS sites and outsourcing. These have helped to significantly reduce the number and proportion of over boundary cases that peaked during COVID-19. Further opportunities continue to be investigated and 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, 2019-2020–2023-2024

	Financial year						
Urgency category	**2019-2020** (%)	**2020-2021** (%)	**2021-2022** (%)	**2022-2023** (%)	**2023-2024** (%)	**Target** (%)	**Target met**
Category 1 over 30 days	8	11	15	17	17	0	✕
Category 2 over 90 days	13	14	26	31	29	0	✕
Category 3 over 365 days	8	5	10	20	9	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 2023 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 2023, HA-SABSI per 10,000 occupied bed-days in public hospitals achieved target (Table 4).

Staff education, review and monitoring are in place to ensure continued performance and determine opportunities for improvement.

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, 2019–2023

	Calendar year						
	2019 (per 10,000)	2020 (per 10,000)	2021 (per 10,000)	2022 (per 10,000)	2023 (per 10,000)	Target (per 10,000)	Target met
HA-SABSI	0.8	0.6	0.5	0.5	0.8	≤ 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 2023 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 2023, the survival rates for patients with stroke achieved target for age group 50 to 59 (Table 5). Survival rates for all other age groups did not meet target and are impacted by severity of disease on admission and patients with multiple comorbidities. It should be noted that NMHS provides the Statewide Neurological Intervention and Imaging Service and has received international recognition for meeting the highest standards in stroke treatment and care.

There is continued 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 patient outcomes include a drug trial designed to reduce brain tissue damage following a stroke.

Table 5 Survival rate for stroke, 2019-2023

	Calendar year						
Age group (years)	**2019** (%)	**2020** (%)	**2021** (%)	**2022** (%)	**2023** (%)	**Target** (%)	**Target met**
0 to 49	94.6	94.4	93.7	93.1	92.7	≥ 95.6	✗
50 to 59	91.5	92.6	91.3	89.1	95.5	≥ 95.1	✓
60 to 69	88.4	89.9	91.6	91.0	91.7	≥ 94.7	✗
70 to 79	91.3	87.6	89.2	89.6	88.2	≥ 92.7	✗
80+	86.7	85.8	85.3	84.1	81.8	≥ 87.6	✗

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 0 to 49, 50 to 59, 60 to 69 and 70 to 79 (Table 6). Survival rate for age group 80+ did not meet target and are impacted by severity of disease on admission and patients with multiple comorbidities. Cases are reviewed and monitoring is ongoing to identify opportunities for further improvement.

Table 6 Survival rate for acute myocardial infarction, 2019–2023

	Calendar year						
Age group (years)	**2019 (%)**	**2020 (%)**	**2021 (%)**	**2022 (%)**	**2023 (%)**	**Target (%)**	**Target met**
0 to 49	98.9	98.6	100.0	97.8	100.0	≥ 98.9	✓
50 to 59	99.0	99.4	98.8	97.5	99.3	≥ 99.0	✓
60 to 69	97.8	99.1	98.6	98.6	98.1	≥ 98.1	✓
70 to 79	97.7	97.1	94.0	96.3	97.1	≥ 97.1	✓
80+	88.4	90.5	90.9	93.4	92.5	≥ 92.7	✗

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). Patients are impacted by severity of disease on admission and patients with multiple comorbidities. Cases are reviewed and discussed to identify opportunities to further improve patient outcomes.

Table 7 Survival rate for fractured neck of femur, 2019–2023

	Calendar year						
Age group (years)	**2019 (%)**	**2020 (%)**	**2021 (%)**	**2022 (%)**	**2023 (%)**	**Target (%)**	**Target met**
70 to 79	97.7	98.0	96.9	100.0	99.0	≥ 98.9	✓
80+	96.2	97.1	95.5	92.6	94.8	≥ 97.5	✗

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. take own leave, left without notice, 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 2017 and June 2019 Aboriginal patients (4.3%) in WA were 7.7 times more likely than non-Aboriginal patients (0.6%) to discharge against medical advice, compared with 4.2 times nationally (3.8% and 0.7% respectively)[7]. This statistic indicates a need for improved responses by the health system to the needs of Aboriginal patients. This indicator is also being reported in the Report on Government Services 2023 under the performance of governments in providing acute care services in public hospitals.[8]

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.

DAMA performance measure 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.[9]

Target

Please see the 2023 targets for Aboriginal and non-Aboriginal patients in Table 8. Performance is achieved by a result below, or equal to, the target.

Results

In 2023, 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 family/ community responsibilities or social factors are common reasons for why Aboriginal patients DAMA. Aboriginal Health Liaison Officer services are available at all NMHS hospitals; however, patients may choose to not use this service or DAMA may occur outside standard business hours when the service is limited. Patients who DAMA are contacted and referred for follow-up where appropriate.

Appropriate processes are in place and DAMA performance and processes continue to be monitored and reviewed to establish any opportunities for improvement.

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. See Table D3.09.3 Discharge against medical advice / Data - AIHW Indigenous HPF. Available at https://www.indigenoushpf.gov.au/measures/3-09-self-discharge-from-hospital/data#DataTablesAndResources
8. For more information see 12 Public hospitals - Report on Government Services 2023 - Productivity Commission (pc.gov.au). Available at https://www.pc.gov.au/ongoing/report-on-government-services/2023/health/public-hospitals
9. https://www.closingthegap.gov.au/national-agreement

Table 8 Percentage of admitted patients who discharged against medical advice, 2019–2023

	Calendar year						
	2019 (%)	2020 (%)	2021 (%)	2022 (%)	2023 (%)	Target (%)	Target met
Aboriginal	3.73	3.92	3.46	3.81	3.17	≤ 2.78	✗
Non-Aboriginal	0.80	0.76	0.74	0.71	0.80	≤ 0.99	✓

Data source: Hospital Morbidity Data Collection.

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 seven at five minutes post-delivery

Rationale

This indicator measures the condition of newborn infants immediately after birth and 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) 10 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 10. The higher the Apgar score the better the health of the newborn infant.

This outcome measure can lead to the development and delivery of improved care pathways and interventions to improve the health outcomes of Western Australian infants and aligns to the National Core Maternity Indicators (2023) Health, Standard 14/07/2023.

Target

The 2023 target for liveborn term infants with an Apgar score of less than seven at five minutes post-delivery is ≤ 1.8 percent. Performance is achieved by a result below, or equal to, the target.

Results

In 2023, the percentage of liveborn infants with an Apgar score of less than seven at five minutes post-delivery achieved target (Table 9). Education, review, and monitoring are ongoing to enable continued performance.

Table 9 Percentage of liveborn term infants with an Apgar score of less than seven at five minutes post-delivery, 2019–2023

	Calendar year						
Live births	**2019** (%)	**2020** (%)	**2021** (%)	**2022** (%)	**2023** (%)	**Target** (%)	**Target met**
Apgar Score < 7	1.5	1.7	1.7	1.8	1.7	≤ 1.8	✔

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.[10] Rapid readmissions place pressure on finite beds and may reduce access to care for other consumers in need.

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 2023 target is ≤ 12 percent 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 2023, the rate of readmissions to acute specialised mental health inpatient services within 28 days of discharged 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. Performance continues to be monitored and all readmissions continue to be reviewed regularly to ensure any systematic issues identified can be quickly escalated and rectified, quality care is provided and to establish if there are opportunities for further improvements.

10. 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, 2019–2023

	Calendar year						
	2019 (%)	2020 (%)	2021 (%)	2022 (%)	2023 (%)	Target (%)	Target met
Readmission rate	15	15	15	12	10	≤ 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 2017-2018, one in five (4.8 million) Australians reported having a mental or behavioural condition.[11] 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 the 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 2023 target is ≥ 75 percent. Performance is achieved by a result above, or equal to, the target.

Results

In 2023, the percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services achieved target (Table 11).

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

11. 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, 2019–2023

	Calendar year						
	2019 (%)	2020 (%)	2021 (%)	2022 (%)	2023 (%)	Target (%)	Target met
Post-discharge community care	72	84	86	85	88	≥ 75	✔

Data sources: Mental Health Information Data Collection; Hospital Morbidity Data Collection.

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

Rationale

The Australasian College for Emergency Medicine developed the Australasian Triage Scale (ATS) to ensure that patients presenting to emergency departments are medically assessed, prioritised according to their clinical urgency and treated in a timely manner.[12]

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 2023-2024 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 2023-2024, 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 12).

Compared to prior year (2022-2023), ED presentations have increased by 3.3 percent and results continue to be impacted and limited by capacity and demand pressures, particularly around patient flow.

The NMHS Hospital Emergency Access Response Team (HEART) program supports NMHS sites to continue implementing and delivering initiatives to improve access, reduce demand and increase capacity. The HEART program continues to be monitored and reported on.

12. 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 12 Percentage of emergency department patients seen within recommended times, by triage category, 2019-2020–2023-2024

	Financial year						
Triage category	2019-2020 (%)	2020-2021 (%)	2021-2022 (%)	2022-2023 (%)	2023-2024 (%)	Target (%)	Target met
1	100	100	100	100	100	100	✓
2	80	78	72	71	73	≥ 80	✗
3	51	40	28	26	27	≥ 75	✗
4	64	54	41	38	39	≥ 70	✗
5	87	82	76	72	71	≥ 70	✓

Data source: Emergency Department 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 2023-2024 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 2023-2024 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

Target

The 2023-2024 target is $7,461 per WAU. Performance is achieved by a result below, or equal to, the target.

Results

In 2023-2024, the average admitted cost per weighted activity unit did not meet target (Table 13). The target is based on the initial budget allocation received, and over the course of the year WA Government provided additional budget for activity, uplift in unit price of activity and cost pressures. In addition, general inflationary cost pressures, insurance and higher costs contributed to the above target unit cost, having an adverse impact on this indicator.

Table 13 Average admitted cost per weighted activity unit, 2019-2020–2023-2024

	Financial year						
	2019-2020 ($)	2020-2021 ($)	2021-2022 ($)	2022-2023 ($)	2023-2024 ($)	Target ($)	Target met
Average cost	7,215	7,080	7,715	8,014	8,168	≤ 7,461	✕

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.

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 weighted activity unit (WAU) compared with the State target as approved by the Department of Treasury, which is published in the 2023-2024 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 2023-2024 target is $7,243 per WAU. Performance is achieved by a result below, or equal to, the target.

Results

In 2023-2024, the average emergency department cost per weighted activity unit did not meet target (Table 14). The target is based on the initial budget allocation received, and over the course of the year WA Government provided additional budget for activity, uplift in unit pricing for activity and cost pressures. In addition, general inflationary, insurance and higher costs contributed to the above target unit cost, having an adverse impact on this indicator.

Table 14 Average emergency department cost per weighted activity unit, 2019-2020–2023-2024

	Financial year						
	2019-2020 ($)	2020-2021 ($)	2021-2022 ($)	2022-2023 ($)	2023-2024 ($)	Target ($)	Target met
Average cost	6,729	6,646	7,129	7,242	7,988	≤ 7,243	✕

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 2023-2024 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 2023-2024 target is $7,325 per WAU. Performance is achieved by a result below, or equal to, the target.

Results

In 2023-2024, the average non-admitted cost per weighted activity unit did not meet target (Table 15). The target is based on the initial budget allocation received, and over the course of the year WA Government provided additional budget for higher activity, uplift in unit price of activity and cost pressures. In addition, general inflationary cost, insurance, and higher costs contributed to the above target unit cost, having an adverse impact on this indicator. The unit cost in 2023-2024 is lower than the previous financial year as a higher level of activity was achieved.

Table 15 Average non-admitted cost per weighted activity unit, 2019-2020–2023-2024

	Financial year						
	2019-2020 ($)	2020-2021 ($)	2021-2022 ($)	2022-2023 ($)	2023-2024 ($)	Target ($)	Target met
Average cost	7,081	6,785	7,258	8,827	8,669	≤ 7,325	✕

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

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 2023-2024 target is $1,541 per bed-day in specialised mental health inpatient services. Performance is achieved by a result below, or equal to, the target.

Results

In 2023-2024, the average cost per bed-day in specialised mental health inpatient did not meet target (Table 16). High occupancy rates continued throughout 2023-2024 and NMHS delivered above target inpatient activity in specialised acute mental health wards. In addition, inflationary cost pressures in goods and services, employment cost pressures as part of public sector wages policy and the superannuation guarantee levy increase all contributed to the above-target unit cost.

Table 16 Average cost per bed-day in specialised mental health inpatient services, 2019-2020–2023-2024

	Financial year						
	2019-2020 ($)	2020-2021 ($)	2021-2022 ($)	2022-2023 ($)	2023-2024 ($)	Target ($)	Target met
Average cost	1,494	1,439	1,595	1,730	1,973	≤ 1,541	✕

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 2023-2024 target is $507 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 2023-2024, the average cost per treatment day of non-admitted care provided by mental health services did not meet target (Table 17). General inflationary cost pressures in goods and services as well as cost of award employment cost pressures contributed to the above target unit costs having an adverse impact on this indicator.

Table 17 Average cost per treatment day of non-admitted care provided by mental health services, 2019-2020–2023-2024

	Financial year						
	2019-2020 ($)	2020-2021 ($)	2021-2022 ($)	2022-2023 ($)	2023-2024 ($)	Target ($)	Target met
Average cost	395	372	412	496	522	≤ 507	✕

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%.[13]

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 2022-2023 target is ≥ 70 percent 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 2022 to 2023, the rate of women aged 50-69 years who participated in breast screening did not meet target (Table 18).

BreastScreen WA operations were adversely impacted by cancelled screening clinics due to COVID-19 community infection levels affecting staff and clients.

As an endeavour to increase screening numbers, BreastScreen WA has employed Radiology staff during school hours for a number of shifts. BreastScreen WA is also in the process of procuring an additional screening mobile to increase screening numbers in metropolitan and rural areas.

13. 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 18 Rate of women aged 50 – 69 years who participate in breast screening, 2018-2019–2022-2023

	Calendar years						
	2018-2019 (%)	2019-2020 (%)	2020-2021 (%)	2021-2022 (%)	2022-2023 (%)	Target (%)	Target met
Participation rate	55	50	50	53	50	≥ 70	✗

Note: This measure counts the women screened within a 24-month period (1 January 2022 to 31 December 2023) 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.

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

Percentage of adults and children who have a tooth re-treated within six 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.[14] Its inclusion provides opportunity for benchmarking across jurisdictions.

Target

Please see the 2023-2024 targets for adults and children in Table 19. Performance is achieved by a result below the target.

Results

In 2023-2024, the percentage of adults and children who have a tooth re-treated within six months of receiving initial restorative dental treatment achieved target (Table 19).

Maintained performance was attributable to regular monitoring of clinic/clinician re-treatment rates by the Dental Health Service Clinical Oral Health Advisory Committee. Feedback is provided 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 across the state.

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

Table 19 Percentage of adults and children who have a tooth re-treated within six months of receiving initial restorative dental treatment, 2019-2020–2023-2024

	Financial year						
	2019-2020 (%)	2020-2021 (%)	2021-2022 (%)	2022-2023 (%)	2023-2024 (%)	Target (%)	Target met
Adults	5.76	5.59	5.86	5.14	5.88	< 6.05	✓
Children	2.01	1.93	1.91	1.68	1.43	< 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).

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 schoolchildren enrolled, the number of children proactively involved in publicly funded dental care can be determined in order to gauge the effectiveness of the program. This in turn can help identify areas that require more focused intervention and prevention and health promotion strategies to help improve the dental health and well-being of children.

Target

The 2023-2024 target is ≥ 78 percent. Performance is achieved by a result above, or equal to, the target.

Results

In 2023-2024, the percentage of eligible children who are enrolled in the School Dental Services program did not meet target (Table 20).

Access to care for enrolled school children across the state continues to be impacted by workforce shortages due to challenges in public dental workforce recruitment and has resulted in less available appointments at various school clinics.

Table 20 Percentage of eligible school children who are enrolled in the School Dental Service program, 2019-2020–2023-2024

	Financial year						
	2019-2020 (%)	2020-2021 (%)	2021-2022 (%)	2022-2023 (%)	2023-2024 (%)	Target (%)	Target met
Eligible school children who are enrolled in the School Dental program	77	77	75	73	69	≥ 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.

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

Percentage of eligible people who accessed Dental Health Services

Rationale

Oral health, including dental health, is fundamental to overall health, wellbeing and quality of life, with poor oral health likely to exist when general health is poor and vice versa. This makes access to timely dental treatment services critical in reducing the burden of dental disease on individuals and communities, as it can enable early detection, diagnosis and the use of 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 them.

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 2023-2024 target is ≥ 15 percent. Performance is achieved by a result above, or equal to, the target.

Results

In 2023-2024, the percentage of eligible people who accessed Dental Health Services did not meet target (Table 21).

Compared to 2022-2023, performance has been maintained despite an increase of over 7,000 eligible people who can access services.

The ability to meet target continues to be impacted by public dental workforce shortages that have resulted in fewer available appointments at various school clinics; as well as an updated service delivery model following COVID-19 that has resulted in reduced available appointment times due to increased infection control protocols.

Additional outsourcing for adult patients to the private sector is occurring to lessen the impact of current workforce shortages.

Table 21 Percentage of eligible people who accessed Dental Health Services, 2019-2020–2023-2024

	Financial year						
	2019-2020 (%)	2020-2021 (%)	2021-2022 (%)	2022-2023 (%)	2023-2024 (%)	Target (%)	Target met
Eligible people who accessed Dental Health Services	14	14	13	14	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 2022–2026.[15] This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

The 2023-2024 target is $41. Performance is achieved by a result below, or equal to, the target.

15. WA Health Promotion Strategic Framework 2022-2026. https://www.health.wa.gov.au/Reports-and-publications/WA-Health-Promotion-Strategic-Framework.

Results

In 2023-2024, the average cost per person of delivering population health programs by population health units did not meet target (Table 22). The target is based on the initial budget allocation received, and over the course of the year WA Government provided additional budget for public health programs including the Organ Tissue Donation Program and essential vaccines. General inflationary pressures contributed to higher costs.

Table 22 Average cost per person of delivering population health programs by population health units, 2019-2020–2023-2024

	Financial year						
	2019-2020 ($)	2020-2021 ($)	2021-2022 ($)	2022-2023 ($)	2023-2024 ($)	Target ($)	Target met
Average cost	67	64	97	84	69	≤ 41	✗

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 2023-2024 target is $161 per breast screening. Performance is achieved by a result below, or equal to, the target.

Results

In 2023-2024, the average cost per breast screening did not meet target (Table 23). The target is based on the initial budget allocation. Population growth, requirements to provide additional assessment, general inflationary pressures and higher cost contributed to the above target unit costs.

Table 23 Average cost per breast screening, 2019-2020–2023-2024

	Financial year						
	2019-2020 ($)	2020-2021 ($)	2021-2022 ($)	2022-2023 ($)	2023-2024 ($)	Target ($)	Target met
Average cost	156	154	153	159	177	≤ 161	✕

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

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 2023-2024 targets for patient groups in Table 24. Performance is achieved by a result below, or equal to, the target.

Results

In 2023-2024, 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 24).

The cost of delivering services has increased and is further impacted by the updated service delivery model following COVID-19 where increased infection prevention and control requirements have resulted in reduced available appointment times and increased environmental cleaning consumable and equipment costs.

Ongoing workforce shortages have also resulted in reduced patient visits due to fewer available appointments, noting that the number of visits also fluctuates depending on the patients' clinical requirements and complexity of care provided. To mitigate the workforce shortages, additional outsourcing for adult patients to the private sector is occurring.

This combination of factors has led to not meeting the average cost per patient visit targets.

Table 24 Average cost per patient visit of WA Health-provided dental health programs for school children and socio-economically disadvantaged adults, 2019-2020–2023-2024

	Financial year						
	2019-2020 (%)	2020-2021 (%)	2021-2022 (%)	2022-2023 (%)	2023-2024 (%)	Target (%)	Target met
School children	230	219	302	315	305	≤ 262	✕
Socio-economically disadvantaged adults	288	284	365	370	379	≤ 280	✕

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

DISCLOSURES AND LEGAL COMPLIANCE

Employee engagement

Survey demonstrates significant improvements

In 2023, WA Health conducted a *Your Voice in Health* employee engagement survey in which NMHS recorded a significant overall improvement.

Each NMHS site has created an action plan and changes are being undertaken in response to survey feedback.

The three key themes arising from the survey included flexible working, wellbeing and professional and career development. Several initiatives, including the Compassionate Leadership and Career Conversations programs, have been developed in response to the Your Voice in Health feedback.

Employee profile

Who we are

We are **14,124** 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.

8,737
Permanent

3,760
Fixed term

1,627
Casuals

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

Nursing & midwifery	5,935
Hotel & site services	1,415
Medical services	2,142
Medical support services	2,361
Administration & clerical	2,271

10,743 of us are **female**

3,381 of us are **male**

We range in **age**:

1,959
Gen Z
1996-2015

5,853
Gen Y
1981-1996

4,335
Gen X
1965-1980

1,977
Baby boomers
1946-1964

47% of us have worked at NMHS for over **five years**

Culturally and linguistically diverse
We come from many cultures, with **1,819** of us identifying as culturally and linguistically diverse.

Employee development

NMHS promotes continuous learning and growth, striving to build the capability of our people to support a high-performing culture, personal development and career fulfilment.

This includes induction, onboarding processes, training that enables safe and effective work aligned to the National Safety and Quality Health Service Standards and continued professional development.

As a Registered Training Organisation, we offer a nationally accredited Diploma in Leadership and Management and short courses to develop leadership skills and personal effectiveness such as Courageous Conversations, Emotional Intelligence and Habits of Highly Effective People.

We support the wellbeing of our staff by offering Mental Health First Aid training and the RRR program – Recognise, Respond and Refer: Early identification and intervention on health and wellbeing issues.

Leadership development

In addition to placement on programs offered by the Institute for Health Leadership, such as the Aboriginal LEAD program and Executive Coaching, NMHS also developed bespoke leadership programs in partnership with external providers.

Programs offered in the past year include Medical Education Program, Compassionate Leadership, Career Conversations and the North Space Leadership Forum in which NMHS leaders are provided a platform for learning, information sharing, consultation, engagement and networking.

Diversity and inclusion

NMHS has implemented several initiatives from the Diversity and Inclusion Strategy as part of making NMHS the best place to work. The aim is to attract a diverse talent pool to the organisation and provide development and support throughout the employment lifecycle.

Our strategies aim to create an engaging and supportive workplace to attract and retain staff and build an environment in which diverse individuals are respected, connected and empowered to contribute to organisational success. The strategies also aim to remove barriers to progression, such as unconscious bias, racism and discrimination.

Educational resources to support in removing unconscious bias, discrimination and harassment have been developed this year and recruitment and selection training has been updated. This ensures consideration of equity and diversity inclusive recruitment practices. We encourage staff to complete the Equity, Diversity and Inclusion training suite covering education on all diversity cohorts.

Culturally and linguistically diverse (CaLD)

NMHS is a diverse workplace with more than 120 cultures identified among staff members.

We celebrate the diversity of our colleagues with events throughout the year, such as Harmony Week. During Harmony Week, events promoting a greater sense of inclusiveness, respect and belonging were held across NMHS sites. A workshop was held with a representative sample of our CaLD employees to identify strategies to help attract and retain CaLD employees.

In addition, we offer Diverse WA and CaLD eLearning modules to increase knowledge, awareness and understanding. In line with good practice, Committee Chairs are encouraged to seek employees from CaLD backgrounds to participate on all committees and working groups to ensure equitable representation of diversity.

Aboriginal employment

The NMHS Aboriginal Health and Wellbeing Strategy 2022-2025 aims to improve health outcomes for Aboriginal people through improving access to culturally secure services, promoting engagement of Aboriginal community and consumers and increasing the Aboriginal representation in the NMHS workforce.

A workshop was conducted with Aboriginal staff representatives and the NMHS Aboriginal Cultural Advisory Group in July 2023 to identify strategies for increasing the employment of Aboriginal people and addressing barriers to support positive engagement. As a result of the workshop, and in order to grow our Aboriginal workforce and create a culturally safe and secure work environment for Aboriginal people, we have established an Aboriginal Employment Team in June 2024. The purpose of the team will be to establish more career pathways and improve organisational ability to attract, recruit and retain Aboriginal employees.

We ran ‘Our Time’ workshops for the professional and personal development of Aboriginal staff in November 2023 and June 2024. NMHS continues to run an Aboriginal Cadetship program and commenced participation in the new WA Health Aboriginal Graduate Program. The role of Aboriginal Health Practitioner was also successfully established within NMHS.

DISCLOSURES AND LEGAL COMPLIANCE

Disability

New resources and education to increase knowledge and enable better support for people with disability have been developed. The updated Hospital Stay Guidelines were introduced to inform people with disability and their support networks, disability service providers and hospital staff of their respective roles and responsibilities throughout a person's stay in hospital.

A Workplace Adjustments Guide was implemented and Workplace Adjustments Training offered to explain what workplace adjustments are and how to support them successfully. This includes examples to improve accessibility and how to access financial help available through the Australian Government's Employment Assistance Fund.

Recruitment and selection training has been updated to include an example of using Section 66R, making reasonable adjustments, such as providing additional time for a candidate to demonstrate their skills in the recruitment process, and information on the course of action the recruiting manager takes if contacted by an applicant with disability.

In addition, staff were invited to attend a lunch and learn session at each of our major sites, either physically or virtually, to celebrate International Day of People with Disability (IDPwD).

Promotions to staff included:

- encouraging staff to join the Staff with Disability and Allies Network (SDAN) as a forum for WA Health employees with disability or for those who wish to support health staff with disability to connect and share ideas for improvement
- accessing Neurokin, a peer support group for healthcare workers who identify as neurodivergent
- training and education, including the Disability Inclusion eLearning package, to increase understanding and enable better support of people with disability.

LGBTQIA+

NMHS is committed to ensuring that all people, no matter their sexual orientation or gender identity, have access to safe health services and an inclusive workplace. The NMHS Pride Network is a group of employees who identify as LGBTQIA+ and allies who have provided a safe and welcoming space for LGBTQIA+ employees, visitors and patients.

Active since 2020, the Pride Network meets monthly to promote and advance inclusivity, advocating to raise the profile of LGBTQIA+ needs to executive and staff, and coordinating celebrations across NMHS to raise awareness of key annual days such as IDAHOBIT, Pride and Wear it Purple Day.

The Pride Network was the recipient of a Going the Extra Mile (GEM) Award for the category 'Empowering, Engaging and Building Inclusion and Improving Culture'.

The organisation participated in the 2023 Pride WA Fair Day and marched in the Pride Parade to promote our commitment to being a safe and welcoming space for all people, no matter their sexual orientation or gender identity. This public demonstration of support not only creates an inclusive culture for existing employees, but also positions NMHS as an employer of choice for LGBTQIA+ people.

To celebrate IDAHOBIT 2024, morning teas and stands were held across NMHS sites to promote inclusivity, with staff encouraged to show their support by wearing rainbow colours and undertaking the LGBTQIA+ Diversity and Inclusion training. With a focus on increasing awareness and understanding, education flyers about IDAHOBIT and "Use of pronouns in the workplace" were distributed, along with rainbow pins, rainbow shoelace beads, and pronoun and ally badges to make NMHS a more inclusive and welcoming space for members of the LGBTQIA+ community.

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 (HSS). This approach ensures consistency and enables monitoring of compliance with the Public Sector Standards for human resource management.

In 2024, a new NMHS Talent Acquisition function commenced to support and drive initiatives as part of the NMHS 2023-2024 Job Security Action Plan. The NMHS Talent Acquisition Team is working with HSS and other stakeholders to streamline recruitment and implement a new strategic recruitment model.

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.

In 2023-2024, 2,996 new employees were recruited. NMHS trialled assessment centres to improve the candidate offer in the areas of Social Work, Podiatry and Facilities Management: Trade Professionals.

During the 2023-2024 period, one breach of employment standard claim was lodged regarding NMHS recruitment, selection and appointment processes. The breach of employment standard claim was referred to the Public Sector Commission. Following the independent review, this claim was dismissed.

Compliance with Public Sector Standards and Ethical Codes

NMHS continued its commitment to ensure the highest standards of ethical behaviour and professional conduct through compliance with the Western Australian Public Sector Standards and Ethical Codes, enveloped in the WA Health System *Code of Conduct* (the Code). We ensured our practices complied with relevant Public Sector Commissioner's Instructions, and our overarching legislation, primarily the *Health Services Act 2016*.

The Integrity Education Team continued to strengthen education and training programs aimed at improving the culture of integrity, encouraging ethical practice and appropriate standards of conduct and behaviour as outlined in the Code. Support was provided to staff through education, consultation and information regarding ethical conduct and decision making. We worked with other health service providers to ensure consistent integrity messaging and system-wide advice.

During 2023-2024, NMHS continued to support staff to comply with the relevant standards and codes through the provision of several initiatives, including:

- 75 face-to-face integrity education sessions across NMHS
- Accountable and Ethical Decision Making (AEDM) training to members of staff and ensuring compliance with the Public Sector Commissioner's Instruction No. 40 – Ethical Foundations for the completion of mandatory refresher AEDM training after three years
- 8,627 NMHS employees completed AEDM initial/refresher training
- recruitment training to ensure recruitment processes and employment decisions complied with the Public Sector Commissioner's Instructions: Employment Standard and Filling a Public Sector Vacancy, as well as onsite support, information, consultancy and advisory services in all areas covered by the Public Sector Standards in human resource management.

Code of Conduct

NMHS has a dedicated Integrity Directorate, supported by the broader People and Culture division, which 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.

The Integrity Directorate provides accessible independent, effective and timely advice in relation to both ethical dilemmas and potential breaches of the Code to our staff, fostering a speak up - look up culture.

In 2023-2024, the Code and our NMHS values of care, respect, innovation, teamwork and integrity were further promoted with a view of continuous improvement of workplace culture.

Initiatives included:

- promoting the NMHS Integrity Governance Framework 2021-2024
- providing face-to-face and e-learning opportunities
- conducting discipline investigations in accordance with the *Health Services Act 2016* and the Public Sector Commissioner's Instructions
- AEDM initial and refresher training
- continuing our program of conducting corruption-prevention health checks across key parts of our business
- releasing mixed media integrity resources
- conducting staff news forums.

In 2023-2024, the Integrity Directorate received 138 new reports of potential misconduct and/or breaches of the Code.

Suspected breaches of the Code/ behaviour not consistent with the Code were objectively assessed by the Integrity Directorate, and where appropriate, further triaged through the Multi-Disciplinary Assessment Committee to determine the most appropriate action to be taken, ensuring all relevant considerations were appropriately tested in a timely and technically robust manner.

The Multi-Disciplinary Assessment Committee, established in 2020 is chaired by the Executive Director, People and Culture and led by the Director Integrity. It consists of Directors and senior staff from the Human Resources, Industrial Relations, Work Health and Safety and Integrity directorates, as well as invited expert input/attendance from clinical/medical areas to triage and assess alleged misconduct matters referred to the committee.

Disciplinary investigations for suspected breaches were conducted in accordance with the *Health Services Act 2016*, the Public Sector Commissioner's Instructions and system-wide and NMHS policies.

Processes followed the NMHS disciplinary management model, underpinned by the WA Health System Discipline Policy and the WA Public Sector Standard in Discipline, ensuring procedural fairness in the assessment and investigation of each matter.

Industrial relations

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

Our Industrial Relations (IR) consultants maintain close links with professional groups, including all WA health systems unions and the Department of Health, ensuring contemporary IR practices and approaches are applied in NMHS.

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 and management. IR coordinates and responds to the interpretation and implementation of industrial instrument provisions and assists in the prevention of industrial disputes.

Major activities for 2023-2024 are outlined below:

WA Health system Industrial Agreements bargaining consultation

A key role for IR is the dissemination, education and consultation for the bargaining of replacement industrial agreements with HRBPs and line managers. Taking a proactive approach, IR delivered 25 consultation presentations to leadership networks for the following industrial agreements:

- WA Health System - HSUWA – PACTS Industrial Agreement 2022
- WA Health System – United Workers Union (WA) – Enrolled Nurses, Assistants in Nursing, Aboriginal Health Workers, Ethnic Health Workers, and Aboriginal Health Practitioners Industrial Agreement 2022
- WA Health System – United Workers Union (WA) – Hospital Support Workers Industrial Agreement 2022
- WA Health System - Medical Practitioners – AMA Industrial Agreement 2022
- WA Health System – Clinical Academics – AMA Industrial Agreement 2022
- WA Health System – Australian Nursing Federation – Registered Nurses, Midwives, Enrolled (Mental Health) and Enrolled (Mothercraft) Nurses Industrial Agreement 2022

IR also presented education presentations for the following industrial agreements:

- WA Health System – Engineering and Building Services Industrial Agreement 2023; and
- WA Health System – Australian Nursing Federation – Registered Nurses, Midwives, Enrolled (Mental Health) and Enrolled (Mothercraft) Nurses Industrial Agreement 2022

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 775 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.

Ministerial Action Plans for job security were endorsed in July 2023 to reduce the use of temporary arrangements and prioritise permanent engagements. An executive sub-committee was formed in December 2023, and now meets monthly to oversee initiatives. IR examined arrangements in 10 pilot sites reviewing fixed term contracts and casual engagements. External funding arrangements have been identified for further investigation with temporary funded positions that are ongoing. Potential reduction of insecure employment has been identified in establishing permanent leave relief positions.

A key strategy for the reduction of insecure employment was the formation of a centralised Talent Acquisition Team, which commenced in April 2024. The first priority was to focus on United Workers Union WA and Health Service Union of WA workforce recruitment activities that support permanent and direct engagement.

Implementation of permanency for WA Health senior practitioners across NMHS

Following on from industrial commitments to introduce permanency provisions for senior medical practitioners in the replacement WA Health System – Medical Practitioner – AMA Industrial agreement 2022 permanency as a mode of employment was introduced in March 2023.

IR have provided briefings and presentations to site Directors Clinical Services, medical workforce, heads of department, human resources and finance partners. A suite of tools to operationalise permanency for senior medical practitioners has been developed and priority access to a NMHS intranet page has been launched. Over 850 senior medical practitioners are in scope for review. Reviews commenced in April 2023 and will be finalised by March 2025.

Representation and advocacy in disputes before external tribunals

Another key role for IR is the ongoing expert representation of NMHS and advocacy in complaint matters lodged before external tribunals, which IR has continued throughout 2023-2024. IR has provided this function for a range of industrial matters before the Western Australian Industrial Relations Commission and its constituent authorities, the Public Sector Appeal Board and the Industrial Magistrate's Court, as well as for discrimination-related complaints before both the Equal Opportunity Commission and the Australian Human Rights Commission. Where required, IR also works collaboratively with the State Solicitor's Office in providing instructions for disputes involving complex legal arguments in any of these external tribunals.

WA Multicultural Policy Framework

NMHS aims to build and maintain a diverse and inclusive workforce and range of services to meet the needs of our community. The NMHS Multicultural Plan outlines a number of strategies that address the three priority areas of the WA Multicultural Policy Framework. Some highlights from 2023-2024 include:

Priority 1 – Harmonious and inclusive communities

- Harmony Week events were conducted across NMHS sites/services to celebrate cultural diversity and promote a greater sense of inclusiveness, respect and belonging.
- New staff resources were developed to increase understanding of unconscious bias and break down racism and discrimination.

Priority 2 – Culturally responsive policies, programs and services

- Diabetic/Dietetics Service at WNHS worked in partnership with ISHAR Multicultural Women's Health Centre to provide dietetic support for non-Medicare patients diagnosed with gestational diabetes.
- At WNHS an electronic tablet application was introduced which enables fast connection to hard-to-access language interpreters from around the world.
- Staff and consumer representatives discussed how to improve accessibility of feedback and complaint processes for CaLD consumers.
- The State Forensic Mental Health Service held a series of workshops with Cultural Advisory Committees to consult on the screening process and cultural security for a newly established service.

Priority 3 – Economic, social, cultural, civic and political participation

- A workshop was conducted with NMHS CaLD employees to identify strategies to help attract and retain CaLD staff, including more inclusive recruitment practices. Participants provided feedback and suggestions to improve CaLD employees' experience across the employment lifecycle.

NMHS has commenced development of the next Multicultural Plan 2025-2027 and has convened a Working Group that includes CaLD staff and consumer representatives.

Work health and safety

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

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

Information about safety, health and wellbeing is regularly provided to ensure all workers have access to current and relevant information, particularly when it applies to their roles and the healthcare environment. Health and safety policies, procedures, guidelines and other related information are available to workers on the intranet.

Consultation with Health and Safety Representatives continues to be a priority for NMHS. The formal consultation mechanism includes Divisional Link groups in some divisions and seven Work Health and Safety Committees.

NMHS has created an occupational hygienist position which links strongly to the Facilities Management team. This has increased in-house management of occupational exposures, including waterborne biological agencies, indoor air quality, thermal and chemical exposure, and the Water Quality Framework.

NMHS completed an internal audit on Lone Workers Risks in 2023. Since the completion of the audit, an action plan has been implemented, including self-assessment tools, ongoing monitoring and reporting of controls, and development of a high-level business case to address strategic controls.

A priority risk across all areas is workplace violence and aggression. NMHS continues to implement the Stop the Violence Strategy with supporting positions in corporate and operational teams. Targeted approaches assist in addressing hot spot risks, whilst ongoing pre- and post-incident support is developing strategies in the prevention and mitigation spheres.

An internal gap analysis was conducted between current state and the Department of Health Work, Health and Safety Policy Framework. An action plan is in development to address any gaps, utilising the self-assessment tool provided. NMHS have been heavily involved in the Risk Workshops and Consultation Committee facilitated by the Department of Health.

In 2023-2024, NMHS worked through the first work group separation under the new *Work, Health and Safety Act*, requiring consultation with workers, management, Health and Safety Representatives and a union body. This resulted in the establishment of a SCGH Radiology Work Group in January 2024 to address high level specific risks. Engagement in this group is high, with recorded achievement of goals since formal establishment, including progress against a fatigue action plan and escalation of manual tasks risks.

Work Health, Safety and Injury Management Performance Report

Measures	Results 2021-2022	Results 2022-2023	Results 2023-2024	Targets[1]	Comments towards targets
	Base year	Prior year	Current reporting year		
Number of fatalities	0	0	0	0	
Lost time injury and disease incidence rate	2.3	3.4	2.6	0 or 10% reduction (2.07)	Reduction from base year not achieved, however 24% year-on-year reduction achieved
Lost time injury severity rate	46	47	35	0 or 10% reduction (41.4)	Target met
Claim severity rate	40.2	44.7	32	0 or 10% reduction (36.2)	Target met
Percentage of injured workers returned to work within 13 weeks	47%	47.8%	56%	N/A	N/A
Percentage of injured workers returned to work within 26 weeks	57%	65.9%	67%	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	53%	57%	45%	Greater than or equal to 80%	Target not met

DISCLOSURES AND LEGAL COMPLIANCE

Injury management

The system for managing workers' compensation claims and workplace injuries at NMHS continues to work effectively and facilitate early treatment and return to work. Injury Management Consultants work across multiple sites with shared portfolios to ensure the business is well supported at all times. They also partner with the health and safety consultants, wellbeing team and human resource business partners when needed to optimise return-to-work outcomes.

A dedicated IMC engages with injured workers 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 provides funding and coordination of early treatment for workers with work-related injuries. The EIP continues to have good uptake and is effective at supporting staff to recover quickly and remain at work. Physiotherapy and psychological counselling are the most frequently used services and enable us to link workers with preferred treatment providers to optimise recovery.

NMHS received 317 workers' compensation claims during the reporting period, and finalised 380 claims, with either a return to work or settlement of the claim, resulting in a reduction of active claims. NMHS was also able to improve return to work rates within 13 weeks and 26 weeks. This was assisted partly by COVID claimants who recover more quickly than other injuries.

The IM Team has been preparing for new legislation, with the *Workers Compensation and Injury Management Act 2023* coming into effect on 1 July 2024. NMHS continues to collaborate with the regulator, insurer and other agencies to ensure a smooth transition and compliance with the new Act.

Employee rehabilitation programs continue to be offered for non-compensable injuries where there is a risk of exacerbation in the workplace. The Fitness for Work (FFW) pathway is encouraged if expert advice is needed to ensure a safe return to work. This may include a medical assessment by the occupational physician or a functional review by the FFW consultant or FFW clinical psychologist.

Number of NMHS workers compensation claims 2023-2024	
Nursing and midwifery services/dental clinic assistants	174
Administration and clerical	15
Medical (support)	35
Hotel services	54
Maintenance	26
Medical (salaried)	13
Total	**317**

Claims by body location	
Head	20
Lower limbs	45
Multiple locations	37
Neck	8
Non-physical locations (psychological)	26
System locations (e.g. nervous, digestive)	39
Trunk (including back)	46
Unspecified locations	1
Upper limbs	95
Total	**317**

Asbestos awareness and management

Identifying and assessing the risks associated with asbestos-containing material from within government owned and controlled buildings, land and infrastructure

- Annual review of asbestos registers and management plans of all sites/ buildings under NMHS remit is conducted by Prensa, an environmental service contractor. Asbestos registers and management plans are updated accordingly.
- NMHS asbestos registers and management plans define the risk of each identified or assumed asbestos material. Risk rating is consistent across all asbestos registers and management plans with recommendations for each on how to manage or maintain in its current state to not disturb or introduce further risks to NMHS staff, patients, contractors, or visitors.
- If demolition or refurbishment is to occur, a review of the asbestos register and management plan for the area is completed and, where required, intrusive testing is conducted to identify all asbestos.
- When asbestos is identified in any areas that require demolition or refurbishment, all asbestos must be removed prior to works commencing under the strict guidelines in place under the *Work Health and Safety (General) Regulations 2022*.
- Where trade staff may be required to work with asbestos and while undertaking that work, they may disturb the asbestos, they must review the asbestos registers to ensure the material is or isn't asbestos. Where this is not defined, testing of the material is required prior to the works and if the material contains asbestos then appropriate steps must be taken to remove the asbestos prior to works commencing.
- Where removal has occurred, air monitoring is conducted throughout the removal, clearance certification and removal notice must be provided, and this information is passed on to Prensa to update the asbestos registers.

Developing and maintaining plans for the risk-based management of asbestos-containing materials, which includes removal where required

- Asbestos management plans are in place. Identified risks for each known or assumed asbestos material and how to manage these risks are embedded within the plan.
- NMHS does not have a schedule created for the planned removal of asbestos.
- Removal only occurs when demolition, refurbishment or tasks that may disturb asbestos is to occur.
- All removal is captured in the asbestos register once completed.

Asbestos compliance and enforcement (such as improvement notice, prohibition notice, prosecution action, etc.)

- No compliance or enforcement issues in relation to asbestos over the 2023-2024 period to date.

Asbestos awareness, including training, publications, and guidance materials

- Facilities Management conducts annual asbestos awareness sessions for their staff (trade staff, shift engineers).
- There are no current overarching awareness sessions for the remainder of the organisation.
- The Health Safety and Wellbeing Department is creating an organisation-wide awareness package with the intent being that each worker will be required to complete this as a one-off training where they do not work with asbestos.
- Asbestos, either confirmed or assumed, is identified via asbestos identification stickers.

Disability Access and Inclusion Plan

NMHS is committed to ensuring that people living with disability can fully access the services, facilities and information that we provide, and have equitable opportunity in recruitment processes and career progression.

The NMHS Disability Access and Inclusion Plan (DAIP) 2022-2027 guides our efforts across all NMHS sites and services. All agents and contractors of NMHS are informed of the NMHS DAIP as part of the annual reporting process.

Highlights of the year for each of the seven outcome areas of the DAIP are outlined on the following page.

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, NMHS

OPH developed a resource for frontline staff about how to support people with a hearing impairment. WNHS conducted a quality improvement activity to improve wayfinding at KEMH.

Buildings and facilities

Outcome 2: People with disability have the same opportunities as other people to access the buildings and other facilities of NMHS

An accessibility audit was conducted of all buildings owned by Dental Health Services. Action was undertaken by SCGH to make areas of the hospital more comfortable for people with invisible disability.

Accessible Information

Outcome 3: People with disability receive information from NMHS in a format that will enable them to access the information as readily as other people

Picture-based menus on electronic tablets have now been rolled out at SCGH for all patients with communication difficulties. A staff hub page has been developed to support the development of easy-read resources.

Service

Outcome 4: People with disability receive the same level and quality of service from NMHS staff as other people receive

Mental Health hosted the Navigating Complexity Symposium. Attended by more than 60 people, the symposium presented case studies regarding mental health consumers with complex needs and participants had the opportunity to share their diverse experience and expertise.

The National Disability Insurance Scheme (NDIS) Coordination Team (NCT) at SCGOPHCG has led interagency advocacy efforts for patients with life-limiting illness who are excluded from aged and disability services. The NCT has delivered education across sites for staff to better understand the NDIS pathway to support patients.

Complaints

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

A workshop attended by staff and consumers explored how NMHS can improve accessibility to its feedback and complaint processes for people with disability. An online complaint feedback form was developed which asked respondents about accessibility needs.

Consultation

Outcome 6: People with disability have the same opportunities as other people to participate in any public consultation by NMHS

A staff resource was developed to assist greater inclusion, consultation and engagement of people with disability when developing policies and programs. The Health Promotion team engaged with people with disability through the Social Inclusion Mirrabooka and Surrounds Interagency group and Harmony Week Mirrabooka events.

Employment

Outcome 7: People with disability have the same opportunities as other people to obtain and maintain employment with NMHS

NMHS Recruitment and Selection training was updated to include an example of using Section 66R, making reasonable adjustments and the course of action the Recruiting Manager takes if contacted by an applicant with disability.
A Workplace Adjustment Guide was developed to empower staff to seek support for themselves or their staff.

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 2023-2024 financial year.

Recordkeeping

The NMHS Recordkeeping Plan (RKP) 2021 provides an accurate reflection of the recordkeeping program within NMHS and underpins how NMHS's recordkeeping practices comply with the requirements of the *State Records Act 2000.*

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 implementing a Digital Medical Record (DMR) project across hospital sites.

NMHS continues to implement HPE Records Manager (TRIM) as the approved electronic document and records management system for corporate records. Regular compliance audits conducted by the NMHS Records Management team ensure corporate records are captured and sentenced appropriately.

To ensure NMHS staff are aware of their recordkeeping responsibilities, all new staff must undertake the mandatory online Recordkeeping Awareness Training course. Face-to-face and online TRIM training sessions have been developed and are available to all staff, while Non-Technical Community of Practice education sessions focusing on records management principles are available. The NMHS Records Management team provide ongoing advisory services for the retention and disposal of corporate records across NMHS sites and maintain the Records Management intranet page, which brings recordkeeping matters to the attention of staff and provides them with access to recordkeeping resources.

The organisation is committed to manage records in an effective and efficient manner and in accordance with the *State Records Act 2000.* It remains committed to the continuous improvement of the recordkeeping culture, tools, education training programs and practices, with a review of the RKP scheduled for late 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 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 2023-2024 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.

Twelve cardholders recorded personal purchases on their purchasing card. These cardholders declared a personal expenditure and all monies were refunded in full as indicated. No referrals for disciplinary action were instigated during the reporting period.

Personal use credit card expenditure by NMHS cardholders, 2023-2024

	Aggregate amount ($)
Reporting period	3,224.73
Settled by the due date (within five working days)	3,061.80
Settled after the period (after five working days)	162.93
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 was gazetted on 30 June 2023 and published in the WA Health Fees and Charges Manual on 1 July 2023.

Advertising

In accordance with section 175Z of the *Electoral Act 1907*, Health Service Providers are required to report total advertising expenditure. In 2023-2024, the total expenditure was $74,512 compared with $199,667 in 2022-2023. The organisations from which advertising services were procured and the amount paid to each organisation are shown in the table below.

Category	Provider	$
Advertising agency		
	Non Stop Adz	464
Subtotal		**464**
Media advertising organisations		
	Carat Australia Media Services Pty Ltd	27,571
	Initiative Media Australia Pty Ltd	40,653
	Speirins Media Pty Ltd	5,035
	Facebook	789
	Subtotal	**74,512**
Total		**74,512**

Capital works

Capital works completed 2023-2024

Project Name	Estimated total cost ($'000)
Automated Controlled Substance Storage	800
Osborne Park Hospital	21,792
North Metropolitan Health Service Critical Infrastructure project	1,701
SCGH - 24 additional beds	22,224
Stop the Violence	361
Emergency Asset Investment Program (AIP) Works	894

Capital works in progress in 2023-2024

Project Name	Estimated total cost ($'000)	Actual expenditure to 30/6/2024 ($'000)	Estimated cost to complete ($'000)	Estimated completion date
Sarich Neuroscience Research Institute Centre	35,210	34,392	818	Ongoing
Joondalup Health Campus Development Stage 2	277,289	207,178	70,111	Ongoing
King Edward Memorial Hospital Critical Infrastructure	33,789	18,625	15,164	Ongoing
SCGH GMP Laboratories and Cyclotron	35,782	32,030	3,752	Ongoing
SCGH Emergency Department Upgrade and Behavioural Assessment Urgent Care Centre	48,972	3,562	45,410	Ongoing

Capital works in progress in 2023-2024

Project Name	Estimated total cost ($'000)	Actual expenditure to 30/6/2024 ($'000)	Estimated cost to complete ($'000)	Estimated completion date
SCGH Image Guided Theatre	12,090	1,668	10,422	Ongoing
Relocation of Special Needs Dental Clinic	3,270	1,214	2,056	Ongoing
QEII Medical Centre - Cladding	19,759	1,266	18,493	Ongoing
Replacement of Biplanar Digital Angiography Units	3,794	59	3,735	Ongoing
Sir Charles Gairdner Hospital Intensive Care Unit	23,382	2,773	20,609	Ongoing
Electronic Medical Record (EMR)	11,327	8,750	2,577	Ongoing
Refurbishment works for Biplanar Units at SCGH	7,634	753	6,881	Ongoing
Albany General Dental Clinic	10,490	72	10,418	Ongoing
SCGH CT Scanner	12,800	445	12,355	Ongoing
Fit-out NMHS Mental Health Hubs	6,483	5,483	1,000	Ongoing
Bunbury BreastScreen WA clinic relocation	1,044		1,044	New / Ongoing
Service Flow and Reform - Digital Enablement	59		59	New / Ongoing
Criminal Law Mental Impairment Reforms – interim accommodation	435		435	New / Ongoing
Anti-Ligature Remediation Program - Statewide	11,004		11,004	New / Ongoing
Joondalup Health Campus - Cladding	1,000		1,000	New / Ongoing

Appendices

APPENDICES

Board and committee attendance and eligibility

		Board		Audit and Risk Committee		Safety and Quality Committee		Finance Committee		People, Engagement and Culture Committee	
Number of meetings held		11		5		10		11		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	11	10								
Deputy Chair	Rebecca Strom	11	10	5	5			11	11		
Member	Jahna Cedar	11	7			10	8			6	5
Member	Angela Edwards	11	10	5	2					6	6
Member	Tony Evans	11	10	5	4			11	10		
Member	Karen Gullick	11	11			10	9	11	9		
Member	Paul Norman	6	6			6	4			3	3
Member	Paula Rogers	2	2					1	1		
Member	Steve Toutountzis	11	11	5	5	10	9	11	10		
Member	Mathew Coleman	5	4			5	4			3	2
Member	Angela Komninos	2	2	1	0	2	2				
Member	Lewis MacKinnon	11	11	4	4	9	9				

APPENDICES

Board remuneration

NMHS Board

Position title	Member name	Type of remuneration	Period of membership (months)	Term of appointment/tenure (years)	Base salary/sitting fees in 2023-2024 ($)	Total remuneration in 2023-2024 ($)
Chair	David Forbes	Annual	12	3	75,987	84,345
Deputy	Rebecca Strom	Annual	12	3	45,101	50,046
Member	Jahna Cedar	Annual	12	3	41,792	46,389
Member	Matthew Coleman	Annual	6	3	20,668	22,790
Member	Angela Edwards	Annual	12	3	41,792	46,389
Member	Anthony Evans	Annual	12	3	41,792	46,389
Member	Karen Gullick	Annual	12	3	41,792	46,389
Member	Angela Komninos	Annual	3	3	-	-
Member	Lewis Mackinnon	Annual	12	3	40,414	44,953
Member	Paul Norman	Annual	6	3	22,503	24,979
Member	Paula Rogers	Annual	2	3	5,626	6,245
Member	Stefanos Toutountzis	Annual	12	3	41,792	46,389
					Total	**465,303**

Committee remuneration

Committee name	Total remuneration ($)
Mental Health Consumer Advisory Committee	4,725
SCGOPHCG Consumer Advisory Committee	7,687
Women and Newborn Community Advisory Committee	6,440

APPENDICES

Acronyms

CaLD	Culturally and linguistically diverse
DAIP	Disability Access and Inclusion Plan
DHS	Dental Health Services
ED	Emergency Department
FOI	Freedom of Information
FTE	Full-time equivalent
HAC	Hospital acquired complications
HA-SABSI	Healthcare-associated *Staphylococcus aureus* bloodstream infections
HITH	Hospital in the Home
HSP	Health service provider
JHC	Joondalup Health Campus
JMO	Junior medical officer
KEMH	King Edward Memorial Hospital
KPI	Key performance indicator
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer and questioning, intersex, asexual and other gender and sexually diverse persons
MARS	Measurement, Analysis and Reporting System
MHPHDS	Mental Health, Public Health and Dental Services
MHS	Mental Health Services
MHU	Mental Health Unit
NDIS	National Disability Insurance Scheme
NMHS	North Metropolitan Health Service
NPS	Net promoter score
OBM	Outcome based management
OPH	Osborne Park Hospital
PCH	Perth Children's Hospital
PMH	Princess Margaret Hospital for Children
SAC	Severity assessment code
SCGH	Sir Charles Gairdner Hospital

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

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

Locked Bag 2012, Nedlands WA 6009

(08) 6457 3333

nmhs.health.wa.gov.au