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









North Metropolitan Health Service

Annual Report 2025-26

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.

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**

Hon. Meredith Hammat, 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 2026.

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



Karen Gullick
Board Chair
North Metropolitan Health Service
9 October 2026



Robert Toms
Chief Executive
North Metropolitan Health Service
9 October 2026

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Executive summary

Foreword

This year's annual report captures a year of innovation, achievement and collaboration across North Metropolitan Health Service. As we continue to evolve the way we deliver sustainable healthcare and improve access and outcomes for patients across Western Australia, our vision remains clear: to be a transformative leader shaping the future of healthcare.

Our people bring this vision to life every day through their commitment to patient-centred care. This is reflected in the heartfelt comments shared by patients and their loved ones through our feedback channels, the mutual support shown by our people and the many local, national and international accolades our teams have achieved. This reminds us that while innovation and performance matter, it is people and relationships that make the greatest difference.

Collaboration has been key to many new initiatives this year, ranging from implementation of the statewide Winter Strategy and proactive bed management, to helping to eliminate hepatitis C in vulnerable communities across Perth, and rolling out the Hidden Disabilities Sunflower program, which has seen about 800 staff trained to identify and support people living with neurodivergence.

Fostering a culture of innovation and exploring new ways to deliver care in response to the changing needs of our community is a core strength across our services. This year saw the launch of WA's first pulmonary embolism response team at Sir Charles Gairdner Hospital (SCGH) and continued growth of our Hospital in the Home (HiTH) service for medical, surgical and mental health patients. In the past year, 852 medical and surgical patients and 870 mental health patients utilised HiTH, gaining the benefits of receiving essential care in familiar surroundings, whilst saving 17,188 bed days.



The rise in cancer across our community remains a significant health challenge. The $1 million Telethon grant received by SCGH to establish Australia's first Adolescent and Youth Cancer Service in partnership with Child and Adolescent Health Service (CAHS) will bridge a critical gap in care for younger patients.

Our successful Behaviour Evaluation Response Team (BERT) initiative is delivering improvements in the proactive, compassionate management of patients experiencing behavioural distress and reducing violence against our staff. Its expansion to Royal Perth Hospital and Perth Children's Hospital highlight the value of locally-led collaboration across Health Service Providers (HSPs).

Across SCGH, advances in clinical care are creating new possibilities for patients. Australia's first liver perfusion machine is increasing organ donation capacity at SCGH by enabling liver to be rejuvenated, while robotic bronchoscopy is improving the early detection of lung cancer. For patients with epilepsy, neurosurgeons have helped develop an alternative treatment to open brain surgery, giving patients new options for a faster recovery.

King Edward Memorial Hospital (KEMH) became the first hospital in Australia to receive accreditation from the European Society of Gynaecological Oncology, opening new collaboration opportunities and helping us attract the best trainees from around the world.

Foreword

KEMH staff also developed a pre-term prevention checklist that is now used nationally to help reduce rates of early births, demonstrating the contribution our people make to knowledge and practice every day.

Significant progress continued across our major infrastructure and asset management programs, including the completion of the Joondalup Health Campus (JHC) expansion and commencement of the Osborne Park Hospital (OPH) expansion. The SCGH Emergency Department and Intensive Care Unit upgrades are important works that support our clinical care and we look forward to their completion in the next 18 months.

As we move into the future, the QEII Medical Precinct Masterplanning started this year, and will help to ensure these and future works support and enable best practice patient care right across the campus.

The Masterplan will focus on identifying opportunities to optimise health services and support the development of education and research on site.

Relationships underpin our world-class research program, which continues to thrive with 759 active research projects underway. From biobanking and genomics to allied health efficiency studies, the work is translating directly into improved diagnosis, treatment and patient experience - reinforcing our reputation as a leader in health research.

The opening of 60 new medical and surgical beds at Joondalup Health Campus in May, alongside a further 33 Hospital in the Home beds introduced throughout the year, is helping to strengthen capacity across the WA health system. Building works carried out through the Health Asset Maintenance Fund are nearing completion and are an important step towards building a sustainable future.

We continue to maintain a strong focus on digital technology, with virtual care options making service more accessible and the increasing use of AI helping identify opportunities for continuous improvement.

Working closely with consumers and our many stakeholders is key to how we shape the future of healthcare. This year, a new lived experience strategy and inclusion plan, co-designed with consumers, carers and staff, sets a clear pathway for designing, delivering and improving services, underpinned by the important work of our consumer advisory councils. Stronger engagement and participation by consumers in all aspects of health service design and delivery ensures we continue to meet the evolving needs of Western Australians.

Together, these achievements reflect the dedication of our people. We thank each and every NMHS staff member and volunteer for their continued commitment to delivering exceptional care and supporting the communities we serve. We also acknowledge the work of the NMHS Board and thank members for their support, leadership, guidance and oversight throughout the year.

Looking ahead, we remain focused on building a more connected, sustainable and innovative health system that continues to deliver better outcomes for all Western Australians.



Karen Gullick

Board Chair
North Metropolitan
Health Service



Robert Toms

Chief Executive
North Metropolitan
Health Service



Significant Challenges

Managing ageing assets

Work continued throughout 2025-26 on a substantial program of infrastructure maintenance, renewal and upgrade works to support contemporary models of care and maintain essential hospital services. A key challenge remains in managing the scale and complexity of infrastructure investment across multiple hospital sites while ensuring clinical operations remain responsive to patient and service needs.

The delivery of these works has required careful planning and sequencing, particularly where multiple projects were being undertaken simultaneously within operational healthcare facilities. Close collaboration between clinical, operational and infrastructure teams to manage project interdependencies, maintain access to services and minimise disruption to patients, visitors and staff is ongoing.

Older adults awaiting aged care beds

We continue to see a significant increase in older adults presenting at ED at SCGH and JHC, with many patients experiencing delirium, dementia or a mental health issue. The complex needs of these older adults can result in longer assessment times.

Despite the introduction of several different care models for older adults, we continue to see an increase in the number of patients who are medically cleared for discharge but are unable to leave hospital as they wait for an aged care bed or suitable community-based option to become available.

Patient flow

Moving patients through the hospital to provide care in appropriate settings as quickly as possible continues to be a challenge. We have implemented a number of changes and system improvements with some success, and we work collaboratively with other HSPs to ensure we are supporting patients across the whole health system.

Issues contributing to the difficulty with patient flow include the complexity of needs for older adults and the seasonal demands we experienced during winter.

Challenging leasing market

Several of our services experienced challenges in finding suitable premises in locations where there was an identified need to expand services. This impacted services with a delay in opening the BreastScreen WA centre in Bunbury and a dental clinic in Albany. We are pleased to report that all services are now operational.

As we move towards more community-based models of care, careful consideration will need to be given in the early planning and funding stages within the leasing market.

Workforce competition

Workforce shortages in a number of key specialty areas remain an ongoing challenge for our services. This includes medical imaging technologists, dentists, and specialised medical, nursing, and allied health professionals with specific skills in providing services to older adults.

Key Performance
Indicators summary

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

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

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

Table 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	**2025 calendar year**		
	Target	**Actual**	**Variation**
Unplanned hospital readmissions for patients within 28 days for selected surgical procedures			
Knee replacement	≤ 18.8	**21.7**	2.9
Hip replacement	≤ 18.3	**14.6**	3.7
Tonsillectomy and adenoidectomy	≤ 79.2	**115.1**	35.9
Hysterectomy	≤ 44.1	**43.5**	0.6
Prostatectomy	≤ 37.5	**38.6**	1.1
Cataract surgery	≤ 2.2	**1.2**	1.0
Appendicectomy	≤ 27.8	**39.8**	12.0
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	**0.6**	0.4
Survival rates for sentinel conditions			
Stroke			
0 to 49 years	≥ 95.3%	**93.3%**	2.0%
50 to 59 years	≥ 94.7%	**92.4%**	2.3%
60 to 69 years	≥ 94.3%	**92.3%**	2.0%
70 to 79 years	≥ 92.4%	**87.6%**	4.8%
80+ years	≥ 87.2%	**83.8%**	3.4%
Acute myocardial infarction			
0 to 49 years	≥ 98.9%	**98.7%**	0.2%
50 to 59 years	≥ 99.0%	**100.0%**	1.0%
60 to 69 years	≥ 98.3%	**97.6%**	0.7%
70 to 79 years	≥ 96.9%	**96.6%**	0.3%
80+ years	≥ 93.1%	**93.7%**	0.6%
Fractured neck of femur			
70 to 79 years	≥ 98.9%	**98.0%**	0.9%
80+ years	≥ 97.0%	**96.8%**	0.2%

Key Performance Indicators summary

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	**2025 calendar year**		
	Target	**Actual**	**Variation**
Percentage of admitted patients who discharged against medical advice			
Aboriginal patients	≤ 2.78%	**4.28%**	1.50%
Non-Aboriginal patients	≤ 0.99%	**0.80%**	0.19%
Percentage of liveborn term infants with an Apgar score of less than 7 at five minutes post delivery	≤ 1.9%	**2.1%**	0.2%
Readmissions to acute specialised mental health inpatient services within 28 days of discharge	≤ 12%	**9%**	3%
Percentage of post discharge community care within seven days following discharge from acute specialised mental health inpatient services	≥ 75%	**86%**	11%

Effectiveness KPI	2025/26 financial year		
	Target	**Actual**	**Variation**
Percentage of elective waitlist patients waiting over boundary for reportable procedures:			
Category 1 over 30 days	0%	**15%**	15%
Category 2 over 90 days	0%	**24%**	24%
Category 3 over 365 days	0%	**8%**	8%

Outcome 1: Public hospital-based services that enable effective treatment and restorative health care for Western Australians			
Efficiency KPI	**2025/26 financial year**		
	Target	**Actual**	**Variation**
Average admitted cost per weighted activity unit	≤ $8,183	**$8,571**	$388
Average emergency department cost per weighted activity unit	≤ $8,094	**$8,309**	$215
Average non-admitted cost per weighted activity unit	≤ $8,328	**$9,532**	$1,204
Average cost per bed-day in specialised mental health inpatient services	≤ $1,889	**$2,254**	$365
Average cost per treatment day of non-admitted care provided by mental health services	≤ $575	**$483**	$92

Key Performance Indicators summary

Table 1 Actual results versus KPI targets

Outcome 2: Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives			
Effectiveness KPI	**2024-2025 calendar years**		
	Target	**Actual**	**Variation**
Rate of women aged 50–69 years who participate in breast screening	≥ 70%	**48%**	22%

Effectiveness KPI	2025/26 financial year		
	Target	**Actual**	**Variation**
Percentage of patients who have a tooth retreated within 6 months of receiving initial restorative dental treatment			
Adults	< 6.05%	**6.40%**	0.35%
Children	< 2.11%	**1.28%**	0.83%
Percentage of eligible school children who are enrolled in the School Dental Service program	≥ 74%	**70%**	4%
Percentage of eligible people who accessed Dental Health Services	≥ 15%	**13%**	2%

Outcome 2: Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives			
Efficiency KPI	**2025/26 financial year**		
	Target	**Actual**	**Variation**
Average cost per person of delivering population health programs by population health units	≤ $47	**$77**	$30
Average cost per breast screening	≤ $176	**$198**	$22
Average cost per patient visit of WA Health provided dental health programs for			
School children	≤ $377	**$370**	$7
Socio-economically disadvantaged adults	≤ $340	**$400**	$60

Note: For detailed information on each KPI refer to the Key Performance Indicators section of this report.

2025-2026

Year at a Glance

Our hospitals

9,455 ↑ Births

1	5,242 ↓	2,643 ↑	1,570 ↓
SCGH	KEMH	JHC	OPH

188,128 ↑ Presentations to Emergency Departments

76,753 ↓	14,439 ↑	96,936 ↑
SCGH	KEMH	JHC

53,367 ↑ Operations

16,881 ↓	6,958 ↑	17,704 ↑	11,824 ↑
SCGH	KEMH	JHC	OPH

LEGEND ↑ ↓ Arrows denote whether the figure is more, less or equal to last year's figure.

* All figures over the next three pages are accurate as at 20/08/2026. Prior year figures may vary from those published previously due to reasons such as data updates, lags and availability.

Our hospitals and services

Our hospitals experienced an increase in overall activity in 2025-26. Emergency Department presentations continue to be driven by an ageing population with increasing complexity of care. Ambulance ramping hours and average length of episode also increased, demonstrating the ongoing pressure on emergency access.

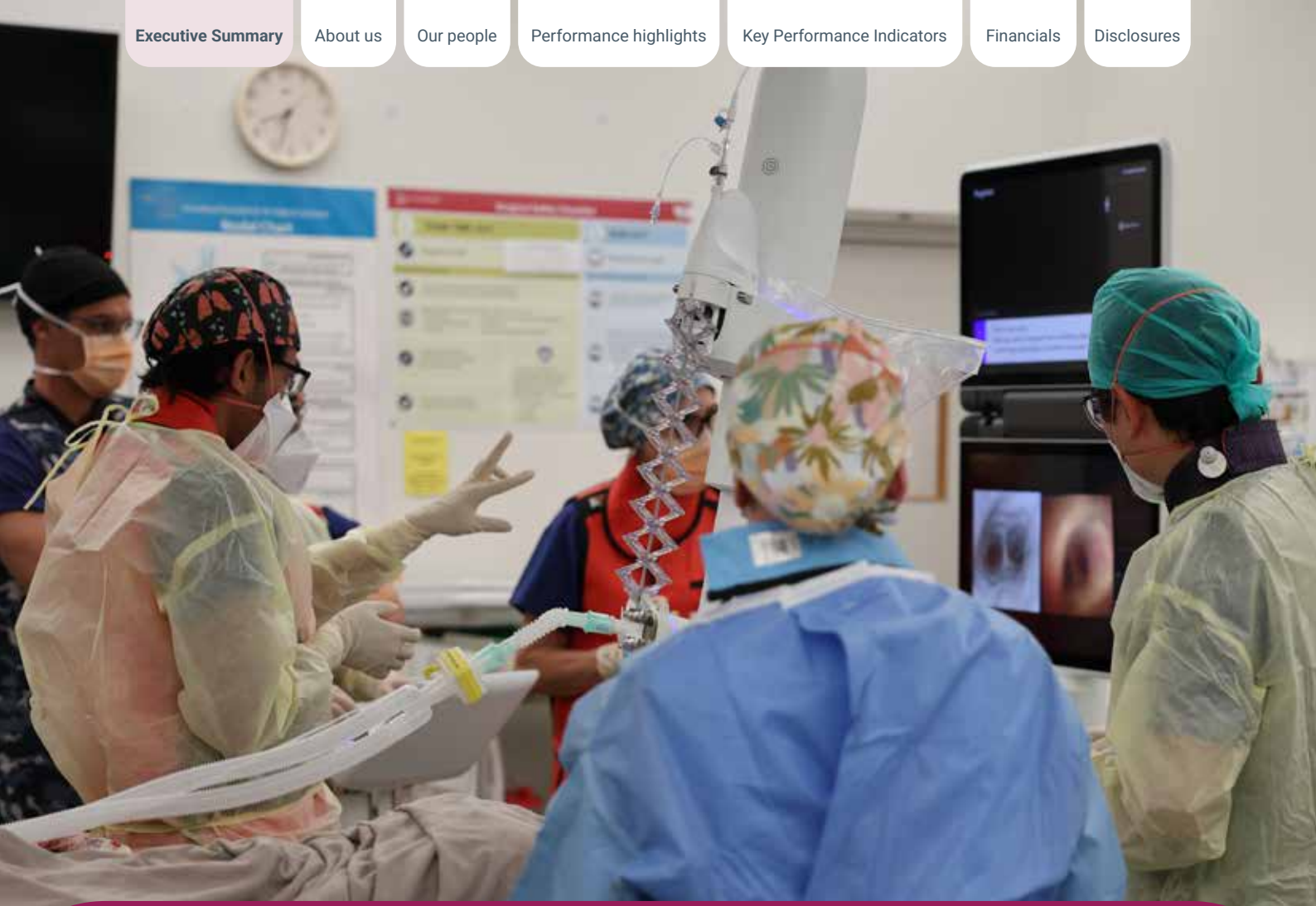
The rise in inpatient services, including elective procedures, was driven largely by increased bed capacity at JHC, which engaged Glengarry Private Hospital to provide palliative care, endoscopy, and gerontology services for NMHS public patients. The opening of 60 new medical and surgical inpatient beds at JHC in May 2026 also contributed to this increase and provides additional capacity in the WA health system.

Ten additional mental health beds were added in 2025-26 to accommodate increased demand in the Joondalup-Wanneroo area.

The number of NMHS inpatient episodes of care delivered through our Hospital in the Home services increased significantly in 2025-26, with additional capacity equivalent to 33 beds added by June. This service provides a double benefit to system capacity in providing care where patients are most comfortable while also increasing internal bed capacity in hospitals.

The increase in outpatient appointments was driven by additional demand for clinics in obstetrics, gynaecology, oncology, radiation oncology, haematology, and Home Link, a hospital substitution service that gives patients access to services such as IV antibiotics, drain management, complex wound management and stomal therapy management to enable early discharge from hospital.

The increase in outpatient and community mental health appointments delivered by videoconference or telephone to NMHS patients was driven by increased utilisation of these modalities of care at KEMH, which exceeded 40% of all attended outpatient appointments in 2025-26. There was also increased utilisation of virtual care by NMHS community mental health services.



Top 10 services by admission numbers

SCGH

1. General/Physical Medicine
2. Emergency Medicine
3. General Surgery
4. Orthopaedics
5. Neurology
6. Cardiology
7. Neurosurgery
8. Respiratory Medicine
9. Oncology
10. Plastic and Reconstructive Surgery

OPH

1. Gerontology
2. Urology
3. Orthopaedics
4. General Surgery
5. Rehab Medicine
6. General/Physical Medicine
7. Vascular Surgery
8. Gastroenterology
9. Ear, Nose and Throat
10. Cardiothoracic Surgery

JHC

1. General/Physical Medicine
2. Obstetrics
3. Emergency Medicine
4. General Practitioner
5. Paediatric Medicine
6. General Surgery
7. Orthopaedics
8. Gerontology
9. Psychiatry
10. Respiratory Medicine

Top 5 countries of birth

(excluding Australia) for people who accessed NMHS services

1. United Kingdom
2. New Zealand
3. India
4. Ireland
5. South Africa

Most common languages other than English spoken by patients:

1. Vietnamese
2. Mandarin
3. Arabic
4. Cantonese
5. Italian

2025-2026 Year at a Glance

Our patients

31,987 ↑
Patients who received cancer treatment

22,643 ↑
Patients cared for with mental health illness

147,009 ↑
Elective services accessed

115
Transplants performed

851,710 ↓
Outpatient appointments provided

243,123 ↑
Telehealth appointments provided

40%
Total inpatients aged over 65 years

10,042 ↑
Number of Aboriginal and Torres Strait Islander people who accessed inpatient services

75,395 ↑
Dental patients – adults

133,482 ↓
Women screened for breast cancer

15,729 ↑
WA tuberculosis control program health professional consultations

2,207 ↑
Humanitarian Entrant Health Service consultations

16,371 ↓
Patients cared for by WA Acquired Brain Injury Rehabilitation Service (WAABIRS)

Top 5 Hospital in the Home services

1. Psychiatry
2. Gerontology
3. General/Physical Medicine
4. Psychogeriatics
5. Haematology

Hospital in the Home medical and surgical 2025-2026*

4,647 ↑
Bed days saved

852 ↑
Total number of unique patients

Hospital in the Home mental health 2025-2026

12,541 ↑
Bed days saved

870 ↑
Total number of unique patients

* The service expanded to include an additional 33 Hospital in the Home beds in 2025-26.

LEGEND ↑ ↓ Arrows denote whether the figure is more, less or equal to last year's figure.



About us

North Metropolitan Health Service

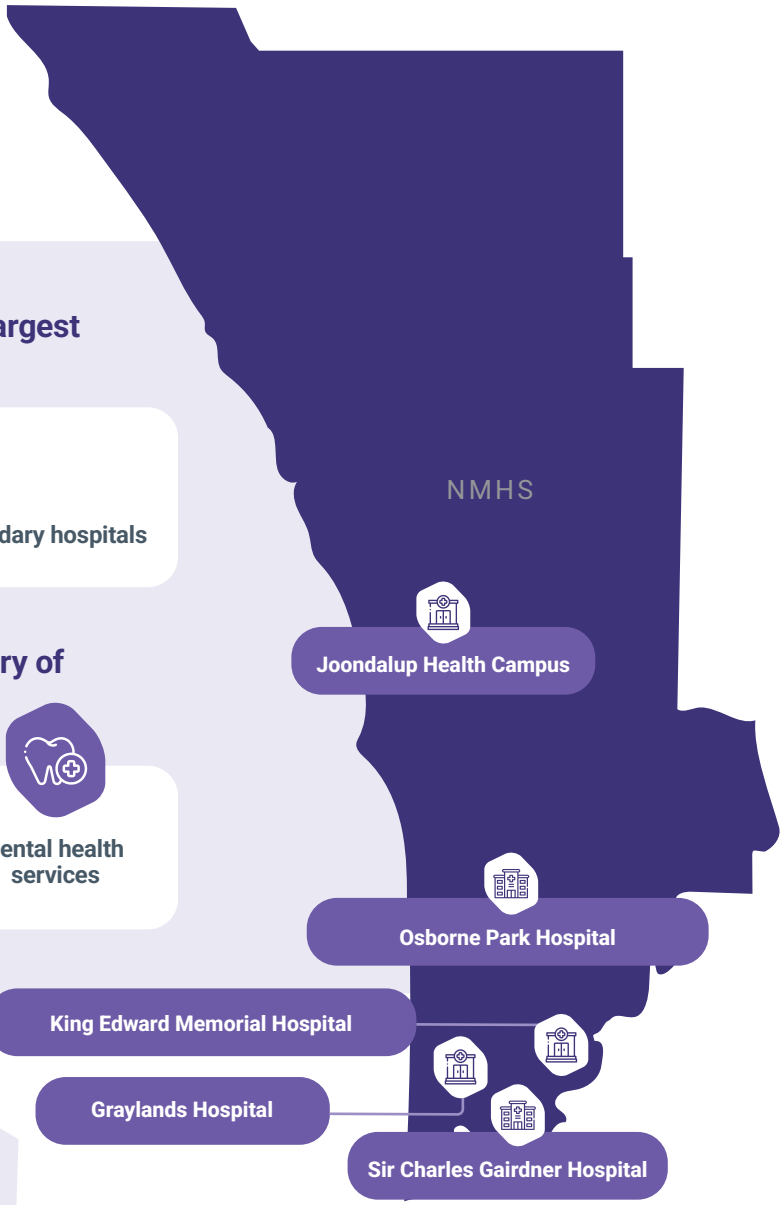
North Metropolitan Health Service is the largest health service in Western Australia, with

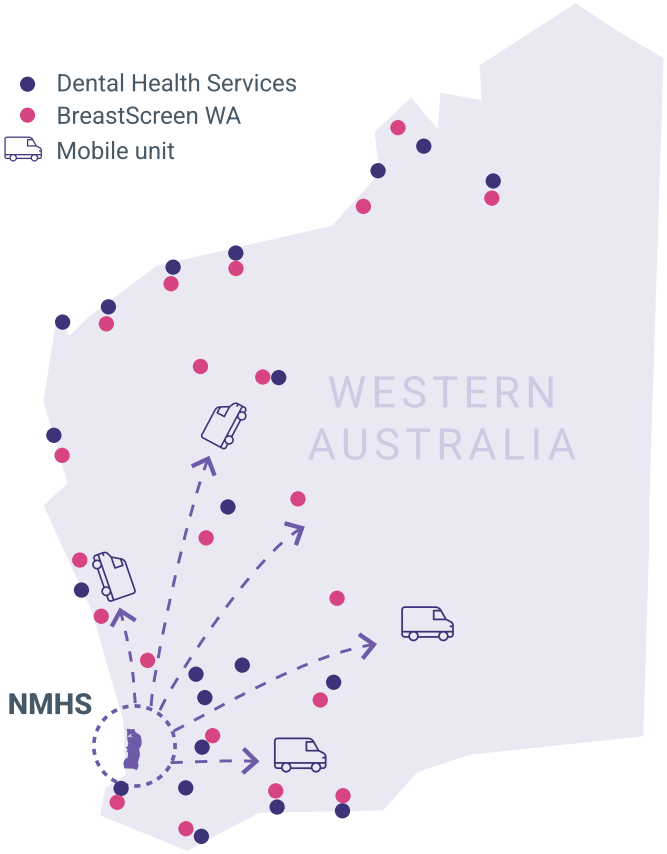
3 Tertiary hospitals

2 Secondary hospitals

plus statewide responsibility for the delivery of

- mental health services
- public health services
- dental health services





993 square kilometres

10.1 Local Government Areas

844,394 total population

NMHS

Who we are

Our hospitals

Our exceptional teams deliver a comprehensive range of tertiary, secondary and specialist services including emergency and critical care, medical, surgical, neurological, mental health and obstetric services for inpatients and outpatients at:

- Sir Charles Gairdner Hospital
- King Edward Memorial Hospital
- Osborne Park Hospital
- Graylands Hospital
- Joondalup Health Campus, delivered by Ramsay Health Care through a public private partnership.

We offer Hospital in the Home care for eligible medical and surgical patients, and virtual consultations to enable access to care for everyone in our communities.

Our medical research and education programs are 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.

Service delivery beyond our catchment

NMHS works collaboratively with all HSPs to support patient care, education, research and clinical pathways.

Our SCGH and OPH teams have strong links with the WACHS Goldfields and Midwest regions to ensure rural and remote patients receive high-quality specialised care.

KEMH and Graylands Hospital provide tertiary specialist and statewide services to regional patients across WA. Telehealth and virtual care support is offered to clinicians and patients in regional and remote areas, as well as education and training support.

Learn more about our hospitals



Our statewide services

We deliver dental health, mental health and public health services to people living across WA, providing essential screening and preventive care, treatment services and emergency care that helps to ease the burden on local hospitals. This includes statewide management of Commonwealth screening programs for cervical, lung and bowel cancer.

Mental Health Services (MHS)

- Child and Adolescent Forensic Service
- Neurosciences Unit
- Specialist Mental Health & Neurodevelopmental
- Youth Detention Service
- State Forensics Mental Health Service
- Start Court and Links Magistrates' Court programs
- WA Eating Disorders Outreach Consultation Service

Public Health

- Boorloo Public Health Unit
- DonateLife
- Humanitarian Entrance Health Service
- WA Acquired Brain Injury Rehabilitation Service (WAABIRS)
- WA Tuberculosis Control Program

Dental Health Services (DHS)

- General Dental Service
- School Dental Service

Sir Charles Gairdner Osborne Park Health Care Group (SCGOPHCG)

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

Women and Newborn Health Service (WNHS)

- Abortion and Reproductive Healthcare Service
- Breastfeeding Centre WA
- BreastScreen WA
- Community Midwifery Program
- Genetic Health WA
- Maternal Fetal Medicine Service
- Menopause Service
- 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

Our statewide services

Mental Health Services

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, Hospital in the Home, and to people in prison.

Adult inpatient services are delivered through Graylands Hospital, SCGH Mental Health Unit and the State Forensic Mental Health Service. The SCGH Mental Health Unit also has a short-term mental health observational area adjacent to the SCGH Emergency Department with six beds and two reclining chairs.

Joondalup Health Campus provides admitted mental health services to patients in the northern corridor including a mental health observation area.

Dedicated facilities for older adults are located at Selby Older Adult Centre and Osborne Older Adult Centre at OPH.

Our Mental Health Hospital in the Home service enables eligible patients to receive care in their home, creating additional capacity equivalent to 32 beds for adults, eight dedicated youth beds and eight dedicated beds for older adults.

Our community mental health centres provide day therapy and outreach programs to patients in our catchment, with centres located in Butler, Mirrabooka, Osborne Park, Subiaco and Wanneroo. This includes the North Metropolitan Eating Disorders Specialist Service.

The Centre for Clinical Interventions (CCI) is a specialised clinical psychology service within NMHS Mental Health that provides evidence-based treatment for adults with complex anxiety, mood and eating disorders, while also conducting applied clinical research to improve psychological interventions.

We support multi-agency initiatives including Start Court, a dedicated court for people experiencing mental illness, and Links, a partnership with the Department of Justice to support youths coming through the Perth Children's Court. In 2025-26, the Links clinical assessment team provided advice, assessment or assistance in 688 cases.

We also support people involved with the justice system through specialised forensic mental health programs. The Community Forensic Mental Health Service provides assertive case management for people on forensic orders with severe and enduring mental illness who present a high risk of serious reoffending, while the Prison In-Reach program delivers psychiatric assessment and treatment within prisons and supports continuity of care through pre-release planning and transition to community mental health services.

Mental Health:
Learn more about our services



Our statewide services

Dental Services

The WA Dental Health Service provides general and urgent dental care to eligible children and adults throughout WA. The service operates 197 dental clinics and 26 mobile dental clinics.

The General Dental Service provides subsidised dental care to adult patients and children aged 0-4 years who have a current Health Care Card or Pensioner Concession Card. As at 30 June 2025, there were 27 public dental clinics in WA - 10 in the metropolitan area and 17 in rural locations, mostly located on WACHS campuses.

In 2025-26, the service cared for 75,395 general dental patients funded by the WA Government and an additional 8,543 patients who received Commonwealth-funded dental care.

The School Dental Service provides universal free general dental care to children enrolled at a WA school from pre-primary to year 11. Services are provided through 140 fixed Dental Therapy Centres (DTC) located in public schools and 25 mobile DTCs covering metropolitan and regional locations.

A new Special Needs Dental Clinic located in Perth opened to patients in August 2025, providing a contemporary facility to improve access to dental care for patients with special needs.

The Smiling Starts Early Childhood Dental Program (Smiling Starts) transitioned from CAHS to the governance of NMHS on 1 December 2025. The program provides free, community-based oral health education and preventive dental care for WA children from birth to the end of kindergarten.

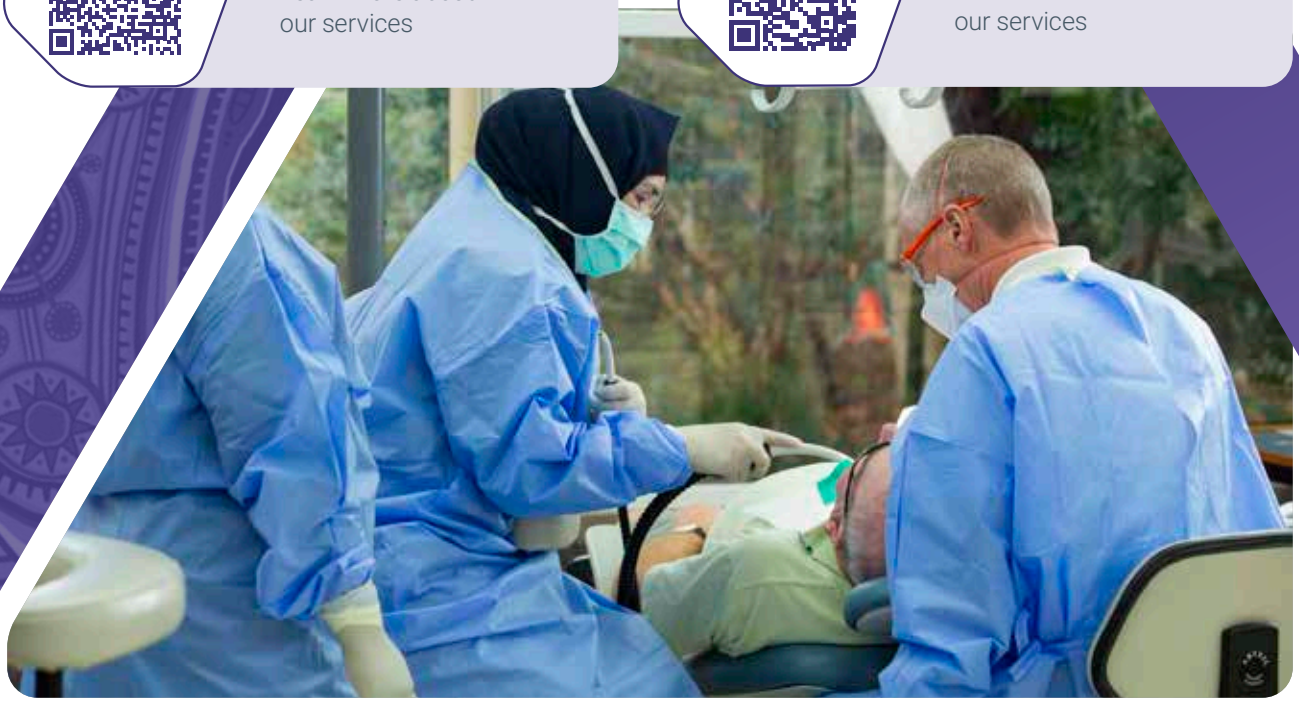
In 2025-26, Smiling Starts delivered services to families with children up to the age of 29 months in the Swan, Kwinana and Armadale zones in the metropolitan area and in the Wheatbelt and South West areas in regional WA. The program will continue to roll out across the state in 2026-27 as the service grows.

BreastScreen WA

BreastScreen WA provides free mammogram and breast screen assessments to asymptomatic women aged 40-74 years. The service has 12 permanent clinics located in the Perth metropolitan area, Mandurah, Bunbury and Albany and five mobile breast screen units. The mobile units visit around 100 rural towns on a two-year rotation while one unit attends areas of high need in metropolitan areas. In 2025-26, BreastScreen delivered a total of 133,482 screens to women across the state.

Dental Health:
Learn more about our services

BreastScreen WA:
Learn more about our services



Our
Public health services

Boorloo Public Health Unit

Boorloo Public Health Unit provides communicable disease control services to NMHS, East Metropolitan Health Service (EMHS) and South Metropolitan Health Service (SMHS) catchments to minimise the spread of communicable diseases that are of public health importance.

Programs include:

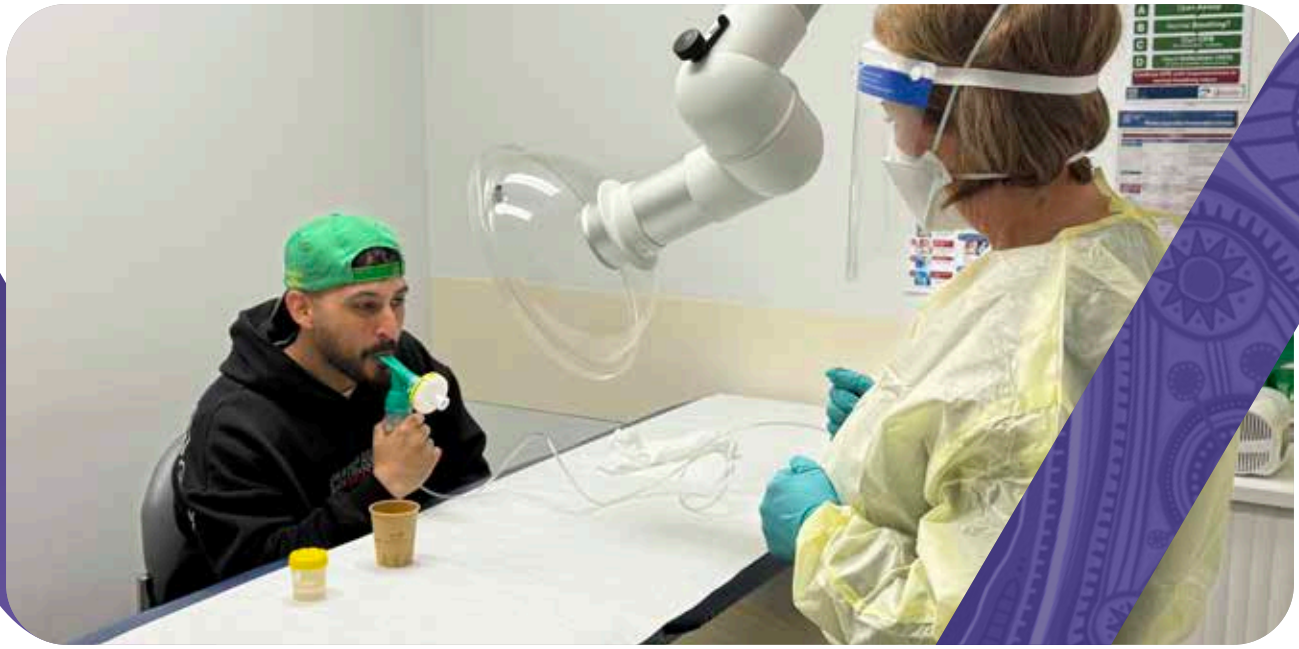
- Communicable disease surveillance; investigation and control
- Outbreak management
- Immunisation service provider support to implement the National Immunisation Program
- Public health specific education to stakeholders (sexual health, immunisation, contact tracing, partner notification)
- Specialist training of public health registrars, nurses, and epidemiologists
- A dedicated Aboriginal health team to offer culturally appropriate care and support
- Supporting access to immunisations for Aboriginal families, including the provision of vaccines in the home and at community venues.

In 2025-26, the service responded to outbreaks and significant infectious disease notifications including multiple measles outbreaks, mpox cases, an increase in pertussis cases and increasing cases of infectious syphilis in metropolitan Perth, with 533 cases reported in 2025-26. Requests for rabies post-exposure prophylaxis (commonly required when bitten by an infected animal overseas) increased from a baseline level of 219 per year in 2019 to 410 as at 30 June 2026.

The service has a key role in supporting the 2026 Winter Strategy and provided influenza vaccinations at community events and home visits to 1,561 people, including Aboriginal people, those from culturally and linguistically diverse (CaLD) backgrounds, and people experiencing homelessness.

NMHS Health Promotion Service

Our Health Promotion service works with local governments and community groups in the NMHS catchment to support the uptake of health promotion related policies, programs and practices in the community. The service focuses on key risk behaviours, such as smoking and vaping, poor diet, harmful alcohol use and physical inactivity, to reduce chronic disease and injury. In 2025-26, the team worked with all local governments in the catchment area to develop local public health plans. More detail about this can be found on page 62.



Our public health services

WA Tuberculosis Control Program

Our WA Tuberculosis Control Program provides comprehensive diagnosis, treatment and case management of active tuberculosis (TB) and leprosy, and surveillance and prevention of TB and leprosy, including BCG vaccination. The program diagnoses about 75 per cent of all cases of TB and 100 per cent of all leprosy cases in WA. The remaining TB cases are diagnosed by physicians in other facilities, but all receive case management and medical oversight through the control program. The service includes an on-site medical assessment, pathology collection and radiology service (chest X-ray), with pathology and radiology services provided by Royal Perth Hospital.

DonateLife

DonateLife WA (DLWA) coordinates all deceased organ and tissue donation activities across the state. DLWA works in partnership with private and public hospitals to provide professional donation services and encourage best practice to optimise organ and tissue donation for transplantation.

DLWA activities include:

- raising awareness about organ and tissue donation
- encouraging discussion about donation
- educating health professionals about the donation process
- offering care and support to donor families.

In 2025, there were 61 deceased organ donors in WA, an increase of 33 per cent compared to 2024. These donors enabled 194 life-saving transplants across Australia. There were also 207 eye donors and 11 tissue donors, enhancing the lives of many Australians through sight restoration and other treatments. The total number of eye and tissue donors was slightly lower than the 232 eye and 10 tissue donors recorded in 2024.



Our public health services

Humanitarian Entrant Health Service

The Humanitarian Entrant Health Service (HEHS) provides holistic health assessments for all refugees who are resettled in WA under the Australian Government's Humanitarian Program. The service also responds to humanitarian crises by seeing clients referred by community organisations who have arrived in WA as displaced persons on temporary visas.

In 2025, the service saw 97 per cent of clients within the targeted timeframe of four to eight weeks from referral date.

Nursing staff played a pivotal role in achieving these outcomes, while simultaneously managing a higher-than-usual number of complex cases.

HEHS works closely with stakeholders to ensure the best possible outcomes for clients, and chairs a quarterly refugee health clinical service meeting to enhance communication between the clinical refugee services within WA Health and the Humanitarian Settlement Program Provider.

HEHS partnered with the WA Primary Health Alliance to deliver a webinar series on refugee health in primary care in 2026, helping to raise awareness of issues in refugee health to improve the experience of patients.

Western Australian Acquired Brain Injury Rehabilitation Service

The Western Australian Acquired Brain Injury Rehabilitation Service (WAABIRS) is the statewide, allied health-led rehabilitation service for people aged between 16 and 65 years who have a recently acquired brain injury (ABI).

In 2025-26, WAABIRS changed its name from the State Head Injury Unit to better reflect its purpose, which is to provide a critical rehabilitation and case coordination service after patients have completed acute and subacute care. Patients can access WAABIRS through their GP, their discharging health service, or self-refer. Based out of SCGH, WAABIRS plays an important role in the integration of health services and long-term support for Western Australians living with ABI. The team provide consultancy, education and sector support across health, community and interagency settings, reinforcing its role as a statewide leader in ABI rehabilitation.

WAABIRS supported 244 patient admissions, with 15,937 occasions of service in 2025-26. Referrals have remained steady, with continued growth in statewide demand, particularly for concussion management. In response to this, the team established a new concussion clinical pathway and updated digital referral processes, clarifying intake and interventions and discharge planning, and reducing wait-times.

"I would like to express my great gratitude for the help I have received from this unit over the last 2½ years. I am currently on a Return-to-Work plan and would not have been able to reach this goal without staff of WAABIRS."

Patient feedback, WAABIRS



Governance

Governance

Responsible Minister

NMHS is responsible to the Hon. Meredith Hammat, Minister for Health and Mental Health, who has overall responsibility for the WA Department of Health. Our major projects team also report to the Hon. John Carey, Minister for Health Infrastructure. During this reporting period, NMHS also had responsibility to the Hon. Sabine Winton as Minister for Preventative Health, the Hon. Simone McGurk as Minister for Aged Care and Seniors, and the Hon. Stephen Dawson as Minister for Medical Research.

Enabling legislation

NMHS was established as a board-governed Health Service Provider by the Health Services (Health Service Provider) Order 2016, made by the Minister under section 32 of the *Health Services Act 2016*.

Accountable authority

As a State Government statutory authority that is governed by a board, NMHS was established under the *Health Services Act 2016*. The board is directly accountable to the public and the Minister for Health, working with the Director General of the Department of Health. Board Chair, Adjunct Associate Professor, Karen Gullick, is the reporting officer for NMHS in 2025-26.

"The board is focused on ensuring NMHS continues to build on the progress that has been made over the past 10 years by leading a clear and ambitious strategic plan, underpinned by an imperative for continuous improvement that will stand the organisation in good stead to manage healthcare in the 21st century."

Board Chair A/Prof Karen Gullick

Shared responsibilities

NMHS works collaboratively with the Department of Health, Mental Health Commission, Infrastructure WA, Department of Housing and Works, WA Country Health Service (WACHS), South Metropolitan Health Service (SMHS), East Metropolitan Health Service (EMHS), Child and Adolescent Health Service (CAHS) and Department of Justice, together with other government and non-government agencies, to deliver health services and programs to the people of Western Australia.

Our Board

The NMHS Board celebrated its 10th anniversary on 1 July 2026.

The Health Services Act came into effect on 1 July 2016, establishing the North Metropolitan Health Service as a separate statutory authority governed by its own board.

The Act replaced the outdated *Hospital and Health Services Act 1927* and placed greater focus on delivering better health, better care and better value to local communities.

As part of this, the Act enabled the creation of five health service provider boards, which are legally responsible and accountable for the delivery of safe, high-quality, efficient and economical health services for their health service area.

Significant work was undertaken in the first few years of the NMHS Board's existence to provide greater accountability and strategic governance.

Today, the NMHS Board continues to lead the strategic direction of the organisation as well the provision of a safe environment for NMHS staff to deliver safe, high-quality, efficient and economical health services to its local community.

Board Chair A/Prof Karen Gullick said it was important to recognise and acknowledge all the board members who had contributed to the success of the organisation over the past 10 years.

"The board is focused on ensuring NMHS continues to build on the progress that has been made over the past 10 years by leading a clear and ambitious strategic plan, underpinned by an imperative for continuous improvement that will stand the organisation in good stead to manage healthcare in the 21st century," she said.

Governance

NMHS Board

As at 30 June 2026



Adjunct Associate Professor Karen Gullick

Board Chair



Rebecca Strom

Deputy Board Chair

Member, Board Audit and Risk Committee

Member, Board Finance Committee



Jahna Cedar OAM

Chair, Board People, Culture and Sustainability Committee

Member, Board Safety, Quality and Consumer Engagement Committee



Associate Professor Mathew Coleman

Member, Board Safety, Quality and Consumer Engagement Committee

Member, Board People, Culture and Sustainability Committee



Anthony (Tony) Evans

Chair, Board Audit and Risk Committee

Member, Board Finance Committee



Renae Farmer

Chair, Board Finance Committee

Member, Board People, Culture and Sustainability Committee



Angela Komninos

Member, Board Audit and Risk Committee

Member, Board Safety, Quality and Consumer Engagement Committee



Associate Professor Lewis MacKinnon

Chair, Board Safety, Quality and Consumer Engagement Committee Chair

Member, Board Finance Committee



Dr Ian Rogers

Member, Board People, Culture and Sustainability Committee

Member, Board Safety, Quality and Consumer Engagement Committee

View the biographies of our Board of Directors



Our people

Our Executive team

NMHS Board



Robert Toms
Chief Executive

- Office of the Chief Executive
- General Counsel



Dr Jodi Graham
NMHS Winter Commander



Dr Tina Bertilone
Executive Director Public Health and Clinical Excellence



Michelle Gillam
Executive Director People and Culture



Scott Godar
A/ Chief Corporate Operations Officer



Renee De Prazer
A/Executive Director SCGHOPHCG



Claire Chapman-Diaz
Executive Director Commissioning & Redevelopment



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



Graham Martindale
A/Area Director Nursing and Midwifery Services



Ian Sheldrake
Executive Director Strategy and Transformation



Jeffrey Williams
Executive Director Women and Newborn Health Service



Dr Simon Wood
A/Area Director Clinical Services

Our workforce

Total number of employees
14,829

We perform in a range of occupations:

41.0% Nursing & midwifery

17.1% Medical support services (Allied health and support staff)

16.3% Administration & clerical

15.8% Medical services (doctors)

9.9% Hotel & site services

We have worked at NMHS for...

52.2%	Less than 5 years
15.9%	5 years to less than 10 years
11.5%	10 years to less than 15 years
9.8%	15 years to less than 20 years
4.8%	20 years to less than 25 years
5.7%	25+ years



35.8% Full time

54.3% Part time

9.9% Casual



67.9% Permanent

22.2% Fixed term

9.9% Casual

Our workforce

We range in age

20.0%
Gen Z (1996-2015)

41.3%
Gen Y (1981-1996)

28.6%
Gen X (1965-1980)

10.1%
Baby boomers (1946-1964)

21.3%
were born overseas*

0.71%
are Aboriginal or Torres Strait Islanders

Top 10 languages

spoken at home other than English*

1. Malayalam
2. Tagalog (Filipino)
3. Mandarin
4. Hindi
5. Cantonese
6. Nepali
7. Vietnamese
8. Punjabi
9. Shona
10. Afrikaans

Top 5 countries of birth

(other than Australia)

1. England
2. India
3. Philippines
4. New Zealand
5. South Africa

* This information is indicative only, as data is solely based on employees declaring this information.



Celebrating
excellence

We are immensely proud of our people who have been recognised by their peers and professional organisations in award programs across WA, Australia and globally. Here are some of the many awards our people have won over the past year:

2026 WA Nursing and Midwifery Excellence Awards

NMHS is extremely proud of our WANMEA winners, who were acknowledged for their outstanding contributions across our services, reflecting professionalism, compassion and commitment every day.

Lifetime Achievement Honour: Graeme Boardley and Dr Catherine Stoddart

Excellence in Registered Nursing: Mary-Anne Lynch, DonateLife WA

Excellence in Education: Fiona Kane, KEMH

Excellence in Research: Professor Mary Steen, Curtin University





Learn more about our winners and finalists

Celebrating excellence

7News Health Hero: Sue Morey OAM - SCGH Nurse Practitioner in Respiratory Medicine

Sue was nominated by a patient she treated for more than three decades following a double lung transplant the patient had as a teenager.

Sue spent nearly 40 years as a respiratory nurse and has watched the developments of respiratory medicine for pulmonary TB, asbestos related diseases, asthma, cystic fibrosis and lung transplantation and interventional endobronchial procedures.

After many years of dedicated service, Sue retired from her role as nurse practitioner at the end of 2025 as the longest serving registered nurse at SCGH.

Her focus on putting patients first and fostering a supportive environment made a lasting impact.

We extend our deepest gratitude for her outstanding contributions and wish her every happiness in her well-deserved retirement.



Two national awards for State Forensic Mental Health Service

NMHS State Forensic Mental Health Service won gold at the 2025 Australian Crime and Violence Prevention Awards for their work with Start Court, and received the Innovation in Public Mental Health Services Award at the Mental Health Service-Learning Network conference.

The dedicated team was acknowledged for making a difference in the community by supporting offenders in the court system who have mental health issues. It was the only public mental health service recognised at the conference.

The award recognised the focus that Start Court places on peer support workers to help people appearing before the court with their mental health recovery.

Start Court offers an alternative to traditional court processes for offenders facing mental health challenges, substance use issues, and unmet psychosocial needs. The courtroom is designed to create a less intimidating atmosphere. Start Court is a voluntary program and aims to address the overrepresentation of people with mental health issues in the justice system, providing an alternative sentencing option.



Start Court is underpinned by a partnership model with the Mental Health Commission, Department of Justice, Outcare, WA Police, Legal Aid, Mental Health Law Centre, Aboriginal Legal Services, G4S, and North Metro Community Alcohol and Drug Services.

Peers are a critical link to facilitate participant engagement in the Start Court program and help show that recovery is possible.

Celebrating excellence

2025 WA Health Excellence Awards

NMHS teams were recognised at the 2025 WA Health Excellence Awards held in October 2025, taking out five categories and one of our nurses was named Health Hero of the Year.

Excellence in Mental Health: Youth Hospital in the Home, Mental Health Services.

The Youth Hospital in the Home team provides a safe, effective alternative to inpatient admissions by delivering intensive, short-term psychiatric care in the home environment.

Excellence in Preventive Care: Hepatitis C Elimination Drive in Perth, Public Health Services.

The Boorloo (Perth) Public Health Unit implemented a structured hepatitis C follow-up program in the community with an allocated public health registrar to lead the project.

Excellent in Workplace Wellbeing and Culture: Women's Health Strategy and Programs, WNHS.

The team developed the NMHS Family and Domestic Violence (FDV) Framework in recognition of FDV being a significant public health issue affecting both consumers and staff.

Excellence in Primary Health Care Integration: Complex Care Team, WNHS.

The team embedded a complex care model that provides multidisciplinary care for patients with complex needs across maternity, gynaecology and pregnancy choices services.

Excellence in Person-Centred Care: Clinician Awareness and Response Enhancement for Family and Domestic Violence, SCGH.

The Clinician Awareness and Response Enhancement for FDV in the SCGH Emergency Department has seen a 68 per cent increase in the number of victim-survivors engaging with safety planning and social work, improved medical FDV documentation and enhanced care and experience for victim-survivors accessing SCGH ED.

Excellence in Sustainability: Audiology Advanced Scope Practitioner Project, a collaboration between NMHS, SMHS and EMHS.

This initiative empowers senior audiologists to independently manage suitable ear, nose and throat patients under approved protocols, reducing wait times, improving access to care, and ensuring sustainable use of health resources across WA.



Celebrating excellence

NMHS AI research recognised on the international stage

The NMHS Business Information and Performance team achieved international recognition for its innovative use of Artificial Intelligence (AI) in improving patient care.

The team's research paper, Transforming Patient Care: Automated Mapping of Hospital Patient Episodes Using Process Mining with Sequential Probability Analysis, was accepted and presented at the 37th Patient Classification System International Conference held in October 2025 in Quebec, Canada.

The paper was awarded the runner-up innovation prize at the conference, recognising NMHS's pioneering contribution to advancing data-driven approaches in healthcare.

The paper is based on the team's AI proof-of-concept project, Optimised Patient Treatment Pathway, which explores how data and automation can reveal patterns in patient care across different hospital services. The approach helps identify efficient and high-quality care pathways, supporting better clinical planning and resource use.

By turning complex patient data into clear, visual maps, the project offers new insights into how patients move through hospital services - from emergency and wards to pathology, imaging and pharmacy - highlighting opportunities to improve patient outcomes and hospital efficiency.

The project has attracted interest from international researchers, and discussions are underway with the University of Montreal to explore future collaboration and further development of this exciting AI-driven approach to healthcare improvement.

SCGH Airways team blows away competition

The SCGH Airways team won four awards at the bi-national Thoracic Society of Australia and New Zealand annual conference in March 2026.

Sanjay Ramakrishnan was awarded the Asthma Australia Peter Van Asperen Early Career Grant for his investigation into whether early use of more affordable biologic therapies can prevent asthma attacks, potentially shifting care worldwide from treating flare ups to prevention.

Brooke Kyle was awarded Best Presentation (Nursing) for 'an evaluation of Australia's first nurse led post Emergency Department follow up clinic that translates guideline based asthma and Chronic Obstructive Pulmonary Disease (COPD) care into practice'.

Anna Bonadeo was awarded Best Poster Award (Nursing) for 'a nurse-led initiative evaluating whether the Test of Adherence to Inhalers (TAI) questionnaire reflects actual adherence to treatment in asthma and COPD patients as measured by Medication Possession Rate data'.

Alice Crawford was awarded Best Poster Award (Medical) for 'early recognition and diagnosis of inducible laryngeal obstruction greatly changing outcomes for people with difficult-to-treat asthma'.

Rounding out a successful few months for the team, junior researcher Maddie Carr won a research award from the Asia-Pacific Society for Respirology (APSR) for her work highlighting that many Australians see their GP with respiratory symptoms for years before starting preventer therapy or being diagnosed with asthma or COPD.



Celebrating excellence



WNHS Midwife and Nurse of the Year

Women and Newborn Health Service (WNHS) nurses and midwives were honoured at the inaugural Midwife and Nurse of the Year Awards held in May 2026.

Jennifer Leverington was named WNHS Midwife of the Year and Marina Mickelson was named WNHS Nurse of the Year.

The two awards, which recognise excellence in leadership, professional practice and innovation across midwifery and nursing, received 27 nominations.

A recognised leader in midwifery, Jennifer was also recognised in the Excellence in Innovation category for her substantial contribution at the national level.

She founded the Australian Maternal Fetal Medicine Midwives Group, maintains a central role in the Australian Preterm and Early Term Birth Collaborative and has introduced many initiatives to improve clinical and psychological outcomes for our complex patients.

Marina is a midwife and nurse practitioner and was recognised for Excellence in Professional Practice for her advocacy of women's choice, providing sexual health education. She plays a crucial role in improving access to early abortion care and follow up.

Marina was one of the first nurse practitioners to undertake the approved training for voluntary assisted dying and has cared for many patients through their end-of-life journey, including providing advice and support to patients and clinicians at KEMH.

WNHS Midwife of the Year:

Excellence in Leadership: Michelle Molony

Excellence in Professional Practice: June Soe

Excellence in Innovation: Jenni Leverington

WNHS Nurse of the Year

Excellence in Leadership: Melanie Mosey

Excellence in Professional Practice: Marina Mickelson

Excellence in Innovation: Natalie Williams

Celebrating excellence

SCGH Interventional Cardiologist becomes third global proctor

Dr Wen Yeow, Interventional Cardiologist at SCGH, was recognised as one of the only three proctors worldwide in the field of minimal access tricuspid valve replacement.

The procedure is performed on one of the four valves that control blood flow through the heart. Tricuspid valve regurgitation is a condition where the tricuspid valve fails to close properly, causing some blood to flow the wrong way.

The recognition celebrates Dr Yeow's commitment to innovation and improving treatment options for patients with tricuspid valve regurgitation.

Dr Yeow helped to introduce this technology at SCGH, working in collaboration with the Cardiovascular Medicine and Cardiovascular Invasive Laboratory teams.



King's Birthday Honours

Two former SCGH leaders were recognised in the King's Birthday 2026 Honours List.

Clinical Associate Professor William Mcauliffe received a Medal of the Order of Australia (OAM) in the General Division for his work in endovascular clot retrieval, which sits at the heart of acute stroke care.

Dr Mcauliffe served as an Interventional Neuroradiologist at SCGH and was Deputy Head of Department of the Neurological Intervention and Imaging Service of WA (NIISwa).

Dr David Joske received a Member of the Order of Australia (OA) in the General Division for pioneering the use of integrative cancer treatments.

Dr Joske, a clinical haematologist, served as the Head of Haematology at SCGH from 1994 to 2012. He identified that many cancer patients sought complementary therapies alongside their conventional treatments, which led to the development of the Solaris Cancer Care Foundation.

The first organisation of its kind in Australia, Solaris is dedicated to providing support and access to safe, free and supervised complementary therapies to those receiving cancer care.

Parkinson's Service recognition

Dr Barry Vieira was awarded the prestigious 2025 Janet McLeod Health Professional Award from Parkinson's WA, for the development of the Parkinson's Service at Osborne Park Hospital.

The Parkinson's Service covers statewide referrals and provides a comprehensive approach to diagnosing and managing Parkinson's in older adults.

Dr Vieira is highly recognised for his outstanding contribution to clinical excellence, leadership, education, and culture in caring for individuals living with Parkinson's.

National recognition for our Clinical Documentation Specialists

NMHS Clinical Documentation Specialists team was named Team of the Year at the Clinical Documentation Improvement Australia Awards. The team was recognised for:

- Improving documentation culture that supports safer patient care
- Supporting clinicians through education and collaboration
- Driving timely, high quality documentation through proactive reviews.

Clinical Documentation Improvement Specialist Denise Lou received the Rising Star Award.

Celebrating excellence

Occupational Therapy Awards

Two SCGOPHCG occupational therapists were recognised at the WA Occupational Therapy Association Awards held in September.

Erryn Siva won the Clinical Excellence Award for her work in the SCGH Lymphoedema service, while Vera Riley was granted a Life Member Award in recognition of her service to the WA Occupational Therapy Association and more than 40 years' service to the profession.

Clinical Association Award for Excellence

SCGH WA Liver and Kidney Transplant Service Surgical Registrar Dr Nara Mukerji, was awarded the Clinical Association Award for Excellence as a Junior Doctor.

The award is presented annually to a junior doctor working across SCGOPHCG who consistently demonstrates excellence and lives our values.



ACHSM Mentor Award

SCGOPHCG Acting Executive Director Renee de Prazer was awarded the Australasian College of Health Service Management (ACHSM) 2026 Mentor Award.

A member of the ACHSM WA Branch Council, Renee was recognised for her exceptional commitment to mentoring and professional development.



Rotary Nurse of the Year Awards

Rob Mundy, a clinical nurse at SCGH and Gemma Hadwell, a nurse manager at OPH, were named the overall winners of the 2026 Rotary Nurse of the Year awards.

The awards recognise nurses - who are nominated by their colleagues - for demonstrating innovation and excellence in health care by advancing the profession, building partnerships or making a difference in their area of practice.

OPH Karrinyup Rotary Nurse of the Year

Excellence in Leadership: Gemma Hadwell

Excellence in Professional Practice: Liam Turner

Excellence in Innovation: Charlotte McGivern / Lee Park

SCGH Olive Anstey Nurse of the Year

Excellence in Leadership: Rob Mundy

Excellence in Professional Practice: Annabel Ley

Excellence in Innovation: Janelle McAllan

Celebrating excellence

NMHS GEM Awards

Go the Extra Mile (GEM) Awards recognise and celebrate individual and collective achievements across NMHS. Some of our winners' stories are shared in more detail throughout this report. The 2025 GEM Award winners were:

Driving Innovation
Sexual Assault Resource Centre, WNHS

Making NMHS the best place to work
Candice Chow, SCGH

Excellence in Clinical Care
ED Family and Domestic Violence Working Group, SCGH

Outstanding Leader
Anita Coutinho, WNHS

Excellence in Health Support Care
Palko Juhas, MHS

Promoting Diversity
Lanny Hoskin, NMHS

Green Champion
Facilities Management Team, NMHS

Researcher of the Year
Associate Professor Kristie Harper, SCGH

Improving Consumer Experience
Kelly Caspersz, WNHS

Rising Star Award
Boris Ray, Facilities Management team, NMHS

Strengthening Partnerships
Kaylene Bowes-Smith, BreastScreen WA, WNHS

Volunteer of the Year
Liz Urquhart and Yvonne Tate, OPH

Chief Executive Award and Board Award

The Ward G52 team at SCGH received the Chief Executive Award and the Board Award for their extraordinary act of compassion in arranging a wedding for a terminally ill patient nearing end of life. The team worked together to honour a deep wish of the patient, delivering more than clinical expertise, but also compassionate, person-centred care.







Celebrating excellence

Long service awards

We are extremely proud to have many staff members who have given decades of service to our hospitals and health services.

At the GEM awards, we celebrate and thank staff who have been with us for 10, 20, 30, 40 and 50 years.

In 2025 we recognised the outstanding commitment of six employees who have been with us for 50 years, 24 employees who have been with us for 40 years, 92 employees who have been with us for 30 years and 274 employees who have been with us for 20 years.

Maria Godwell and Jan Orlicz, pictured, are two of our 50-year service recipients and both work at Dental Health Services.

We commend and thank each of our award recipients for their service and dedication.



Our values

CARE
(Kaaradjiny)

RESPECT
(Ngargal-wirrn)

INNOVATION
(Milka Kaaditj)

TEAMWORK
(Danjoo Yacker)

INTEGRITY
(Karnadjil)



Meet Shyam Rozare

Shyam started as a shift engineer at SCGH 14 years ago. Today he oversees Facilities Management across NMHS.

I moved from Melbourne to join Charlies as a shift engineer in 2012. I couldn't have imagined back then that my career journey would take me where it has!

I have learned everything about leadership from the people around me and by accepting training opportunities. I have been fortunate to do leadership and coaching courses and a Diploma in Leadership and Management.

Our sites have changed a lot during my time here - the SCGH Central Energy Plant, Cancer Centre, Pathwest Building and Perth Children's Hospital, then the OPH redevelopment... and all the work underway today to modernise our hospitals is incredible.

As a team, we've had to change the way we work. Every site used to have its own processes. We have brought the teams together and put consistent processes in place. Everything is discussed and ideas are shared. The integration of the team, and the culture which comes with that, has been the biggest and most positive change.

We are seeing so much investment in infrastructure redevelopment and asset replacement, and systems and technological changes. It is a very exciting time to be here!



Delivering on our Strategic Plan

Performance highlights

Delivering on our Strategic Plan

We have continued to make positive strides towards delivering on our Strategic Plan, which sets out the direction of our organisation to deliver on our vision of being a transformative leader, shaping the future of healthcare.

Launched in 2024, the plan outlines six strategic objectives to guide our evolution as we adapt to new environments and respond to the changing needs of our patients. The highlights of achievement against each objective are described over this chapter.

Strategic plan

Our enduring purpose: Providing excellent compassionate care

Our vision

A transformative leader, shaping the future of healthcare

Our strategic objectives

Driving excellence
Excellence in healthcare is at the heart of all we do.

Partnering with our communities
Empower and collaborate with consumers, their carers and families.

Advancing health equity and access
Ensure our services are contemporary to meet the evolving needs of our community.

Becoming the best place to work
Value, engage and support our people.

Building a sustainable future
Optimise allocation of our resources and minimise environmental impact.

Embracing innovation and research
Grow and amplify our innovation and research capabilities.

Delivering on our Strategic Plan:

Driving excellence

In 2025-26, our teams led several groundbreaking trials, surgical procedures and interventions, contributing to global knowledge bases and informing best practice. Every one of these achievements was underpinned by collaboration, either with consumers and multidisciplinary teams, as well as various NMHS services, HSPs and government agencies. Our pursuit of driving excellence contributes to the bigger picture of system-wide excellence for the people of Western Australia.

Proactive patient management through winter

NMHS worked in close collaboration with the Department of Health and other HSPs to develop and implement the 2026 Winter Strategy. The system-wide initiative focuses on prevention, patient flow, bed capacity and caring for older people to help keep care moving and protect the safety of Western Australians during the busiest months of the year.

Dr Jodi Graham was appointed Winter Commander for NMHS to coordinate our response and link with the Department of Health and other HSPs. With high numbers of vulnerable patients and one of WA's largest catchment populations, there was a strong focus on working collaboratively to respond to increased pressure on the system, proactively manage patient flow and support timely care.

Initiatives included establishing our winter care and bed turnaround teams, which focused on enhancing discharge timeliness and capacity with programs such as Home by Lunch. An NMHS Incident Management Team (IMT) was established to align patient flow with existing emergency management processes, recognising that when one metropolitan hospital is under significant pressure the impact affects all sites.

The impact of our teams was evident beyond our hospital walls. Public health outreach focused on improving access to influenza vaccination for priority communities, while our coordinated approach to maternity demand and escalation processes strengthened how we supported women and babies during periods of increased activity.

SCGH first in Australia to use liver perfusion technology

A new liver perfusion machine at SCGH is helping surgeons to save lives by increasing the rate of liver transplants in WA.

SCGH is the first hospital in Australia to use the technology, which involves cold and warm perfusion to revitalise the donated liver.

The technology allows the liver to be rejuvenated; in turn, increasing the capacity of donation, where previously livers could not be revitalised.

The cold perfusion infuses cold oxygenated fluid into the liver, recovers the liver and prevents complications, especially in the bile ducts. The warm perfusion then infuses oxygenated blood at body temperature allowing surgeons to further improve and assess if the liver is suitable to transplant.

The new method could increase the number of liver transplants in WA by 70 per cent.



Driving excellence

Updated Clinical Governance Framework

NMHS launched its updated Clinical Governance Framework in January 2026, which aims to foster a strong safety culture and equip individuals with practical guidance to apply it to diverse healthcare settings.

Following a comprehensive review, the framework ensures a unified approach for clinical governance across both clinical and corporate domains with a focus on empowerment and accountability.

The new framework outlines five fundamental domains that are central to enhancing the safety and quality of patient care, including:

1. Partnering with consumers
2. Informed decision-making and collaboration
3. Prioritising patient safety, quality and improvement systems
4. Supporting clinical performance and effectiveness
5. Ensuring a safe environment for the delivery of care.

Led by the Public Health and Clinical Excellence team, the framework was developed in partnership with staff who provided insights and ideas.

Additions to the framework include:

1. Practical guidance for our people detailing how to apply the framework
2. Outlined roles and responsibilities
3. Governance coverage of artificial intelligence
4. Integration of relevant legislative and policy requirements under the WA Health Clinical Governance, Safety and Quality Policy Framework
5. Clearer structure aligned to the National Model Clinical Governance Framework developed by the Australian Commission of Safety and Quality in Health Care (ACSQHC).

In line with the ACSQHC Guide for Healthcare Services launched in 2024, the NMHS framework reinforces the importance of listening and responding to consumers as fundamental to good clinical governance, and designing services and policies that meet the needs of the community.

The framework aligns with the priorities set out in the NMHS Consumer Experience and Clinical Excellence 2025-2029 Strategy, Digital Health Strategy 2025-2028, Climate and Sustainable Strategy 2025-2027, and Diversity and Inclusion Plan 2022-2025.



Driving excellence

KEMH achieves Australia's first ESGO accreditation

KEMH became the first hospital in Australia to receive accreditation from the European Society of Gynaecological Oncology (ESGO) in May 2026.

ESGO accreditation is the benchmark for excellence in gynaecology oncology across Europe and around the world, which makes this outstanding recognition of the exceptional care our teams provide to women.

This international recognition demonstrates that our gynaecological oncology care meets the highest standards of excellence, further strengthening its reputation as a leading centre for women's health, nationally and globally.

Following a rigorous assessment by visiting surgeons from Europe, the assessors described the service as "one of the best" they had seen, highlighting the outstanding care and training delivered by the team.

This accreditation will help to facilitate collaboration with colleagues around the world for research and attract the best trainees globally to KEMH.

Using AI to detect heart disease

Research fellow Professor Joshua Lewis and his global team have proven AI algorithm can help detect the signs of heart disease before symptoms arise using DEXA bone density scans. The scans, which are taken to identify osteoporosis and typically only reviewed by one specialist, can show calcium build up in the abdominal aorta years before it causes heart attack. The results could mean that about 700,000 Australians who have a DEXA bone scan annually could also learn about their heart health using the same machine.

Robotic bronchoscopy milestone

A robotic bronchoscopy that commenced operations at SCGH in July 2025 is improving diagnosis of early lung cancer in patients by 50 per cent.

The groundbreaking technology is also helping reduce repeat procedures and improve diagnostic precision. Clinicians are able to go deeper into the lung to mark lesions and guide surgeons to more accurately remove cancerous nodules as small as 4mm.

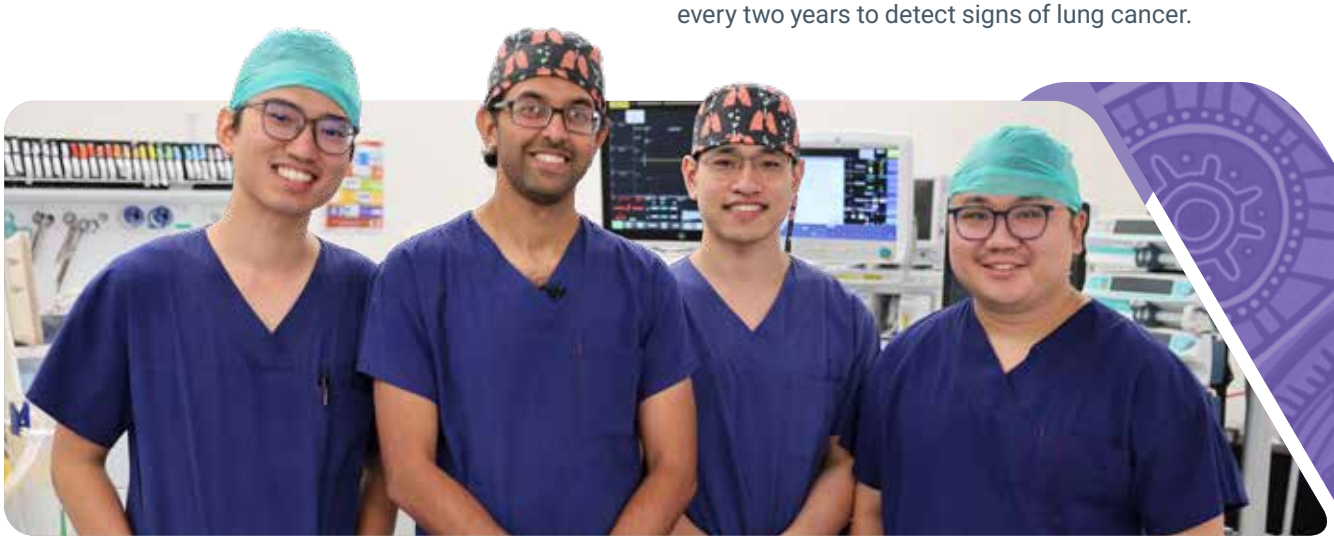
Minister for Medical Research, the Hon. Stephen Dawson, visited SCGH in May to mark the milestone of 100 patients having had a robotic bronchoscopy.

"This Western Australian-first program has already benefited the lives of 100 people, and I congratulate and thank all those involved at Sir Charles Gairdner Hospital for driving the vision and delivering leading-edge patient outcomes," Minister Dawson said.

Professor Rajesh Thomas leads the Lung Cancer and Advanced Bronchoscopy Program at SCGH and was awarded the Future Health Research and Innovation (FHRI) Fund Enabling grant for the Robotic Bronchoscopy program in 2025. He was also awarded the FHRI-Raine Clinician Research Fellowship to optimise robotic bronchoscopy techniques to improve lung cancer diagnosis and treatment.

The bronchoscopy robot equipment was made possible thanks to funding from the FHRI Fund and generous donations by the McCusker Charitable Foundation, Charlies Foundation for Research and the Institute for Respiratory Health.

The service is supporting the National Lung Cancer Screening Program, through which eligible Australians aged 50 to 70 years can have a low-dose CT scan every two years to detect signs of lung cancer.



Driving excellence

New treatment for drug-resistant epilepsy

SCGH neurosurgeons Dr Arjun Chandran and Dr Hari Ramakonar undertook a Laser Interstitial Thermal Therapy trial for the treatment for drug-resistant epilepsy. This new approach gives patients a minimally invasive alternative to open brain surgery. The therapy also enables faster recovery, with many patients discharged the following day – significantly advancing patient care and outcomes.



Liver Cancer Collaborative receives grant

The Liver Cancer Collaborative (LCC) has been extended for another four years, following $7.8 million funding for its innovative research program that aims to beat primary liver cancer.

Led by clinicians from the Hepatology Department at SCGH, LCC brings together more than 50 researchers, clinicians and data specialists to drive a new era of precision medicine.

Coordinated through the Harry Perkins Institute of Medical Research, the project, known as Defeating Primary Liver Cancer, includes clinicians at SCGH, Royal Perth Hospital and Fiona Stanley Hospital.

LCC has built a world-leading biobank of primary liver cancer specimens and blood samples, linked with comprehensive, longitudinally collected clinical data. This has been achieved through collaboration across WA's tertiary hospitals, universities and research institutes.

Phase two of the project will focus on four main research streams, Biomarker Discovery, Novel Therapeutics, Clinical Translation and Emerging Technologies, to improve outcomes for patients with primary liver cancer.

The grant funding consists of $4 million from the Cancer Research Trust (CRT) and $3.8 million in partner contributions, recognising the major successes achieved during the first five years of CRT funding for the program.

Rates of primary liver cancer have increased steadily in Australia by up to five per cent each year for the past three decades. It is one of the fastest growing causes of cancer-related deaths in Australia.

The average survival after diagnosis is only 12 months and patients often present at an advanced stage when treatment options are limited.

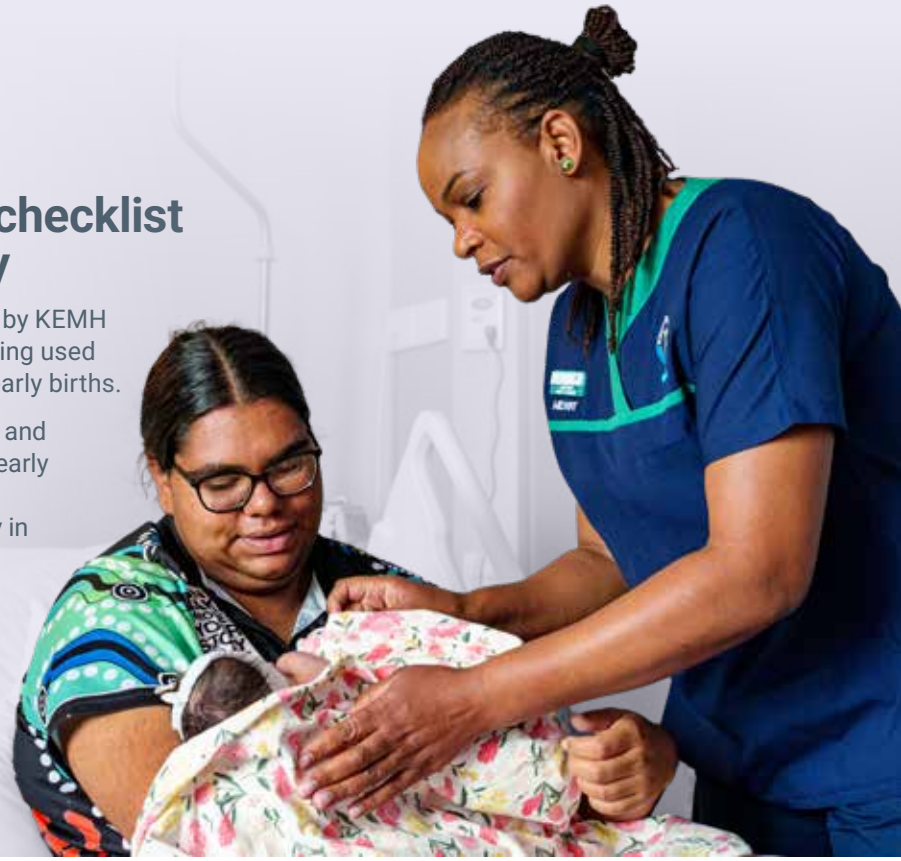
Driving excellence

Preterm birth prevention checklist now being used nationally

A preterm birth prevention checklist developed by KEMH Clinical Midwife Jennifer Leverington is now being used across the country to help reduce the rates of early births.

The evidence-based checklist provides a simple and practical framework to support midwives in the early identification of risk factors, facilitate timely and effective interventions and promote consistency in care across all maternity settings.

The checklist was developed in partnership with the Australian Preterm and Early Term Birth Prevention Program - Every Week Counts, with support from hospital midwives across the country to support improvements in care.



Telethon grant to help establish Australia's first Adolescent and Youth Cancer Service at SCGH

SCGH was awarded a $1 million Telethon grant to establish Australia's first Adolescent and Youth Cancer Service in partnership with CAHS to bridge a critical gap in care for young patients moving out of the children's health system.

SCGH Youth Cancer Services Medical Lead Dr Hetal Dholaria said adolescents and young adults had very different needs compared to younger children or older adults, and were often navigating education, employment, relationships, fertility concerns, and independence at the same time as a cancer diagnosis.

"This new program will create a model specifically designed around that life stage," she said. "It will assist with access to age-appropriate clinical trials, specialist neuropsychology support, organ-protective therapies, and access to targeted therapies while allowing continuity of care."



WA's first Pulmonary Embolus Response Team

The first Pulmonary Embolus Response Team (PERT) in WA was launched at SCGH in February 2026.

PERT provides a structured, rapid response and evidence-based approach to the assessment and management of patients with suspected or confirmed Pulmonary Embolus (PE) – a life-threatening medical emergency caused by a blood clot that travels from elsewhere in the body. PEs are the second most common reason patients are admitted to the respiratory ward at SCGH.

Despite advances in diagnostic imaging and therapeutic options, management of PE remains highly variable, particularly in complex or high-risk cases requiring multidisciplinary input.

Internationally, PERT models have been shown to improve decision-making efficiency, optimise the use of advanced therapies, and potentially improve patient outcomes through coordinated care among emergency medicine, respiratory, cardiology, radiology, and critical care specialists.

Driving excellence

Stroke survivors benefit from WA-first at Joondalup Health Campus

Joondalup Health Campus became the first hospital in WA to appoint nurse practitioners to its stroke ward, enabling greater access to stroke clinical expertise in Perth's north.

Providing additional clinical leadership on the ward, the nurse practitioners are also leading outpatient clinics to improve access to timely follow-up care and help reduce delays for patients awaiting outpatient review supporting early diagnosis, secondary prevention and assist with stroke education and research.

Australian NPs require a master's degree, at least 5,000 hours of advanced clinical practice, and endorsement by the Nursing and Midwifery Board of Australia.

The Stroke Service at JHC comprises an inpatient ward and outpatient clinics for medical and allied health appointments. Patients have access to on-site CT and MRI scans as well as rehabilitation services through a co-located functional training unit and gymnasium. A multi-disciplinary team meet weekly to coordinate patient care.

JHC was one of 15 health services across the country to be granted funding from the Australian Stroke Alliance in early 2026 to engage an after-hours Clinical Nurse Coordinator, providing senior-level nursing for stroke patients presenting to the hospital's emergency department and supporting the timely transfer of patients from other sites to JHC for rehabilitation.

Smiling Starts Early Childhood Dental Program

The Smiling Starts Early Childhood Dental Program, which aims to build awareness of the importance of oral health for children up to the end of kindergarten, expanded into the Armadale zone in early 2026.

The program includes oral health education, screening and minimally invasive treatments to eligible Western Australian children.

Smiling Starts dental teams comprise dental and oral health therapists and dental assistants who provide outreach services in community settings. These services support families who may not otherwise access oral health care by offering education, opportunistic screening, and early intervention in safe, child-friendly environments.



Driving excellence

Driving improvements across emergency access

Our Health Access Reform and Transformation (HEART) Emergency Access program continues to drive improvement across emergency access and inpatient capacity through targeted initiatives.

In 2025-26, initiatives included:

ED bed allocation

A new proactive approach to reduce the amount of time a patient waits in ED to be admitted to an inpatient ward, including the implementation of a new Admission and Bed Allocation Policy in December 2025. An evaluation will be completed in late 2026 to measure the impact of this initiative.

'Waiting for What'

This campaign aims to improve the proactive management of discharge delays and is now managed by the SCGOPHCG Patient Flow unit, with support from the divisional leadership teams.

Optimal medical ward rounding for patient flow

Pilot commenced in February 2026 across three specialities at SCGH, specifically focusing on improved discharges by 12pm, improved number of weekend discharges, improved accuracy of predicted vs actual discharges and improved use of the transit ward. Following the successful pilot, key elements are being rolled out across all wards at SCGH and OPH.

Patient transport optimisation

Streamlining transport efficiency by implementing new transport models and referral processes to improve patient flow, reduce length of stay and maximise transport capacity. This includes the development and implementation of new outpatient transport eligibility criteria, introduction of an electronic referral form and the establishment of a booking prioritisation system.

7-Day Hospital

The 7-Day Hospital Initiative provides expanded radiology, pharmacy and allied health services to support patient treatment and discharge seven days a week, improving patient flow through the hospital and timely access to care. The Department of Health has completed an evaluation report demonstrating system-wide benefits. Further investigation is required to identify the most appropriate options for the program's ongoing delivery and sustainability.

Home by Lunch

In April 2026, we rolled out Home by Lunch, a NMHS initiative aimed at improving patient flow and reducing delays in the patient discharge process.

It focuses on enhancing the discharge process, giving staff capacity to identify and address discharge delays to optimise patient flow.

- Planning early to identify likely discharges at handover and ward rounds
- Acting early by starting discharge paperwork, scripts, and transport plans
- Communicating regularly to keep patients informed
- Addressing barriers early.

The initiative recognises that discharging a patient from hospital to home is a collaborative effort among healthcare providers, patients and their families.

A Home by Lunch Challenge was in place across SCGOPHCG during July and August, with wards competing to improve their discharge percentages by 12pm.

Driving excellence

Digital advances

The NMHS Digital Medical Record Project continued to be rolled out across all sites, with SCGH going live in August 2025. Continued roll-out to remaining sites is expected to be complete in 2027.

Work has also progressed on the planning for clinical transformation that will be required to support the rollout of a statewide Electronic Medical Record (EMR) program, following the initial rollout in the SCGH intensive care unit.

This offers a contemporary digital solution for ICU departments across the state, improving clinical practice through clinical decision support tools and creating more detailed and integrated records for a range of clinical functions in one place.

The project is a partnership between the Department of Health and HSPs to better connect WA Health clinicians and consumers with clinical information and transform how we all experience health care across the state.



Hepatitis C elimination drive in Perth

The Boorloo (Perth) Public Health Unit continued its work to eliminate hepatitis C in Perth, building on the success of a pilot project in 2024 that won the team a WA Health Excellence Award last year.

Hepatitis C is a significant public health issue in WA that contributes to liver disease, cancer, and preventable deaths, especially among Aboriginal people and those who inject drugs. The virus contributes to an estimated 20 to 30 per cent of cirrhosis and hepatocellular carcinoma cases and accounts for dozens of liver transplants annually, despite being curable.

Identifying that the uptake of curative treatments had declined due to stigma, poor care transitions, and fragmented systems, the team sought to address those gaps. They introduced a proactive follow up program, whereby public health staff engaged directly with people living with hepatitis C and their clinicians to ensure effective linkage to care. Referral pathways were developed in partnership with two key community organisations - HepatitisWA and Peer-Based Harm Reduction WA. The team also established multidisciplinary partnerships with high-performing health services and the Department of Justice, given that about one-third of hepatitis C notifications originate from prisons.

Key process improvements were embedded into routine workflows from January 2024 and are ongoing. Since 2024, 82 per cent of community cases completed appropriate management. Cost-effectiveness was demonstrated, with $950,000 in averted societal costs. With scalability, the program has the potential to accelerate hepatitis C elimination by up to 15 years.

Driving excellence

Driving change in behaviour de-escalation

The Behaviour Evaluation and Review Team (BERT) is a trauma-informed, person-centred model of care that focuses on identifying the underlying causes of behavioural escalation to support clinical teams to implement proactive strategies before behaviours reach crisis point.

The service launched in February 2025 and works with patients, families and multidisciplinary teams to develop individualised Behaviour Engagement Plans and 'top five' strategies, with practical management strategies to improve both patient and staff experiences.

During its first 12 months of operation, BERT provided comprehensive care to 483 patients and delivered more than 3,200 multidisciplinary consultations and occasions of service. This included 2,772 specialist nursing consultations and 441 allied health interventions.

During the evaluation period, almost 80 per cent of urgent BERT responses resulted in successful de-escalation, helping reduce the need for restrictive practices and supporting safer outcomes for patients and staff. Referrals were mostly received from general medicine and high-acuity inpatient areas.

The 12-month evaluation identified meaningful improvements in workplace safety and clinical practice. Workers' compensation claims related to workplace violence and aggression decreased by 19 per cent, average days lost per injury reduced by 55 per cent, and costs associated with workplace violence lost-time injuries fell by approximately 50 per cent, representing an estimated saving of $621,000. The use of security specials also decreased substantially, generating estimated savings of almost $700,000.

Clinical practice improvements were also observed, including increased completion of cognitive screening, Behaviour Engagement Plans and 'top five' strategies, supporting more consistent and proactive management of patients experiencing behavioural distress. Restrictive practice following Code Black responses reduced by 15 per cent during the evaluation period.

BERT has developed a comprehensive education program to support staff capability and confidence in responding to behavioural escalation, including mandatory training programs, the BERT Education Series and simulation-based learning. Staff feedback



Driving excellence

has been positive, highlighting increased confidence, reflective practice and a growing culture of person-centred engagement and early intervention.

BERT has established collaborative relationships with Royal Perth Hospital and Perth Children's Hospital. The team presented service outcomes at both state and national forums and was invited to contribute to the Australian Commission on Safety and Quality in Health Care Behaviours of Concern Workshop. BERT is also partnering with Edith Cowan University on various research projects and publications to further strengthen the evidence base for specialised behavioural support services in acute healthcare settings. Plans are underway to extend the service to OPH following completion of a site and service options review.

80%
of urgent BERT responses resulted in successful de-escalation

19%
decrease in workers' compensation claims related to workplace violence and aggression

55%
reduction in average days lost per injury

50%
decrease in costs associated with workplace violence lost-time injuries

$1.3m+
Total savings

Meet Olivia Marcinkowski

KEMH clinical midwife, Olivia Marcinkowski, became Australia's first endorsed midwife to gain certification as a credentialled diabetes educator in November 2025.

I am passionate about education and worked as a teacher before retraining as a nurse and midwife in my 30s.

I became an endorsed midwife in 2022 but was always interested in diabetes after my daughter was diagnosed with type 1 diabetes.

Becoming a credentialled diabetes educator means I can provide additional support to women who have gestational, type 1 and type 2 diabetes – all of which are increasing in our community.

About 20 years ago, women with type 1 diabetes couldn't have children, but now with advances in technology, insulin pumps and continuous glucose monitoring capabilities – and the right care – they're able to have healthy babies.

Combining midwifery and diabetes educator skillsets means more continuity of care for patients. I can give patients the information they need to make an informed choice about their



individual situation, and I can support our clinical teams with prescribing to reduce time pressures on everyone. It's about working as a team.

Our focus is to give better patient-centric care, which is what endorsement and credentialing allows.

We now have several people in our team who have become credentialled diabetes educators and more than 50 endorsed midwives at KEMH – thought to be Australia's largest publicly employed endorsed midwifery workforce.

Delivering on our Strategic Plan:

Advancing health equity and access

We continued to expand our services and programs to increase health equity and access for people who are disadvantaged, vulnerable, elderly or living in remote areas.

Virtual healthcare, home and community services, together with continuous engagement with patients and families about how services can better meet their needs, are core elements to this strategic priority.

In addition to large-scale initiatives, such as service expansions, our teams advance equity and access by meeting the individual needs of patients wherever possible. Some examples include:

- Graylands Hospital nursing and Aboriginal health teams worked together to enable a patient receiving extended care to return to Country for his mother's funeral. Staff who accompanied the patient recognised the impact of his disconnection from family and land following a long absence. They understood the need for Aboriginal people to be a part of Sorry Business and how this can make a positive impact on their ongoing care.
- DonateLife WA implemented Donation after Circulatory Death withdrawal within operating theatres, which reduces the time pressures associated with transferring the organ donor to the retrieval theatre. It also gives families time to say goodbye in a calmer environment. Options are being explored to deliver this service in Bunbury for donors living in the South West, as all potential donors living in this region need to be transferred to a metropolitan donation hospital, presenting logistical challenges for grieving families and reducing the organ and tissue donor pool in WA.

Hospital in the Home

Our successful Hospital in the Home (HiTH) service increased its capacity in June 2026 and expanded services to include post-surgical care as well as medical care. HiTH now has 50 beds in the community.

The service enables eligible patients from SCGH and OPH to receive care in the comfort of their home, following clinical assessment by medical, nursing, allied health and pharmacy teams.

The Mental Health Service operates a separate Hospital in the Home (HiTH) service for eligible patients to receive daily mental health care in their home.

In the past year, 852 medical and surgical patients and 870 mental health patients utilised HiTH, saving 17,188 bed days across our hospitals.

Sexual Assault Resource Centre marks 50 years

The Sexual Assault Resource Centre (SARC) marked its 50-year anniversary in 2026. The centre was the first of its kind in Australia when it opened and only the second in the world.

SARC provides 24/7 clinical forensic medical and trauma-informed crisis response for victim-survivors of sexual assault and family and domestic violence (FDV) injury management. This includes counselling services, comprehensive emergency forensic exams, and aftercare for people aged 13 years and older. Expert advice supports the prosecution of serious cases through the clinical forensic service.

The service also provides medical and clinical advice and training to health practitioners across all HSPs in WA, with a formal partnership in place to support country health practitioners. Early evidence kits, developed by the service to enable the collection of early forensic evidence in a less invasive way, are regarded as international best practice.

In 2025-26, the service cared for 2,633 victim-survivors and provided 14,500 episodes of care. In 2025-26, the service managed more than 26,000 specialist calls relating to consultations, training and counselling, ranging in duration from 15 minutes to 1.5 hours.

Advancing equity and access

Women's Health Centres

NMHS manages 28 service agreements under the Community Women's Health Services program, supporting the delivery of women's health centres, sexual assault support services, and unplanned pregnancy counselling services across WA.

Women's Health Centres provide accessible, community-based services for priority populations including Aboriginal women, women living in regional, rural and remote areas, women from CaLD backgrounds, newly arrived refugee and migrant women, women with disability, women experiencing social and economic disadvantage, and women who identify as lesbian, bisexual or transgender.

Services provided by Women's Health Centres include general practitioner and physiotherapy clinics, health promotion and education programs, health screening, advocacy, counselling, peer support groups, family planning services, sexual assault support services and crisis intervention.

The Women's Health Strategy and Program team in WNHS maintains a strategic partnership with the Women's Health Centres in the community to ensure seamless partnerships and the continuation of care in the community for priority women's health conditions and issues. The team develops and supports policies and guidelines, training programs and clinical initiatives to improve the health and wellbeing of women across WA.

Centres are located across metropolitan and regional WA, including Mandurah, Rockingham, Fremantle, Gosnells, Midland, Mirrabooka, Joondalup, Northbridge, Port Hedland, Tom Price, Geraldton, Bunbury, Kalgoorlie and Karratha.

Key achievements in 2025-26 include:

- Administration of the first year of the State Government's $14 million election commitment for Women's Health Centres, with an initial $2 million allocation distributed to all the centres' service providers during 2025-26. Funding will continue to be rolled out over four years to strengthen service delivery and improve access to women's health services across the state.
- Advocacy and program development work that contributed to the State Government's $3 million election commitment to uplift Sexual Assault Support Services funding to be implemented over two years to enhance service capacity and support for victim-survivors.

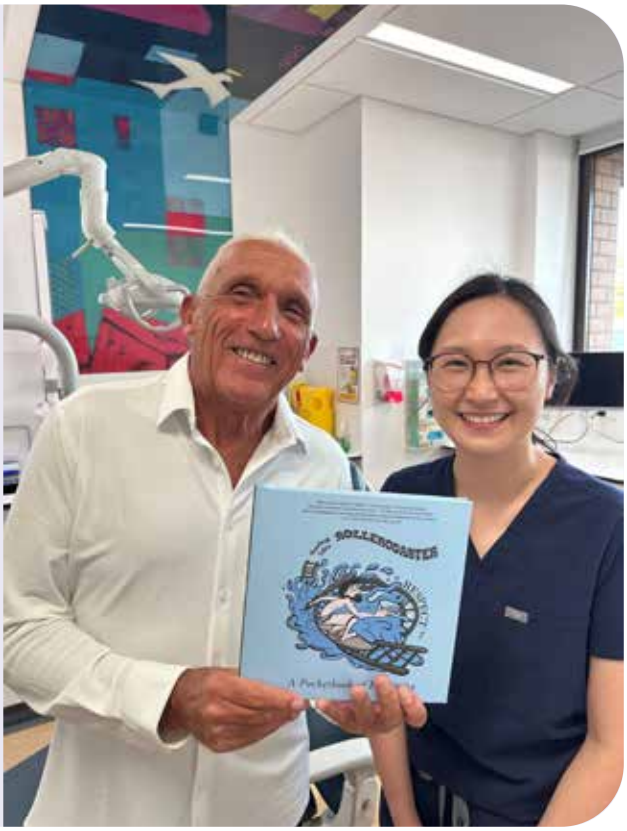
Restoring smiles and confidence

A former patient of the WA Dental Health Service has credited the Fremantle Dental Clinic for helping to turn his life around when he was homeless.

Mike Marshall experienced profound hardship as a child and teenager, and became homeless after falling victim to cybercrime while in his 60s.

In need of extensive dental care, Mike learned that he could receive free treatment through the state dental service from people at the shelter where he was staying.

In a book about his life experiences, Mike said the dental service not only restored his smile but also his confidence, which ultimately led to him securing a job that turned his life around.



Advancing equity and access

Optimising access to care in the community for older adults

Our well-established Integrated Older Adult Model of Care aims to optimise care in the community by providing specialist Emergency Department assessment, supported discharge, home visiting, residential aged care in-reach (medical and nursing), and specialised multidisciplinary outpatient services.

A State Government election commitment to establish an Older Adult Health Hub will further strengthen our existing model of care, providing a preventative, community-based model of care to help people in our catchment to remain living independently for as long as possible and avoid unnecessary hospitalisations.

Work to establish the Hub progressed in 2025-26, with service planning and suppliers confirmed ahead of the Hub opening in June 2026. Services provided onsite include:

- Memory and cognition clinics
- Bone health clinics
- Care navigation

The Hub has been designed to complement existing services in place to support older adults in the community, which include:

Geriatric Assessment Team (GAT), which facilitates the early, supported discharge of older, frail patients from the SCGH ED back to their own home or residential aged care facility (including transitional care). GAT coordinates direct admissions from the ED to dedicated beds at SCGH or direct transfer to OPH.

Day Therapy Unit, which provides general geriatric medicine and specialist outpatient clinics including falls, fragile bones, memory and continence. Clinic appointments and community home visits focus on issues that can impact an older person's independence and safety. Therapy interventions are provided as both one-on-one and group programs.

Aged care assessment team and community visiting geriatric assessment team, which sees health and community care clinicians visit older people at home to assess their physical, functional and medical needs.

Frailty Rapid Access Clinic (FRAC), which helps older people living at home to access the health and medical services they need to avoid visits to the ED. Patients in the SCGH and OPH catchment can be referred to FRAC for multidisciplinary assessments.

Geriatric and Rehabilitation Medicine Care Navigation Service, which ensures older adults are directed to the most appropriate service in the shortest time possible. The service is now permanently funded under an activity-based model.

Rehabilitation Aged Care Intervention and Liaison Service, which is an established multidisciplinary outpatient team providing care to older adults in the community seven days a week.

Geriatric Residential Outreach, which provides in-person geriatrician care for older adults in residential aged care facilities in certain locations. Additional funding in 2024-25 supported expansion across NMHS resulting in greater coverage of these facilities.



Advancing equity and access

Supporting neurodivergent people during pregnancy

A new training package to provide increased support for neurodivergent people during their perinatal journey was launched by the Statewide Perinatal and Infant Mental Health Program.

Neurodivergent people have an increased risk of mental health conditions during pregnancy and require specific support to navigate their perinatal experience.

The free program provides clinicians with a deeper understanding and awareness of neurodivergent needs to help support more affirmed and compassionate person-centred care.

With one in five women experiencing mental health conditions, enhanced awareness will lead to a more positive pregnancy and birth and post-partum experiences, reducing the risk of trauma-based mental health issues.

We worked closely with consumers to enhance the content of the training package and resources, learning from their insights and experiences.

New diagnostic technology for swallowing disorders in Mid-West

A virtual technology collaboration between SCGH and WACHS is enabling people in the Mid-West experiencing swallowing difficulties to receive feedback and diagnoses in real time.

The WACHS Speech Pathology and medical imaging departments at Geraldton Health Campus livestream the procedure to speech pathologists at NMHS, where they can view the diagnostic procedure and create treatment plans on the spot.

The virtual service enables specialists to identify problems such as aspiration or choking risks and recommend strategies, texture-modified diets, and rehabilitation exercises to strengthen the swallow and improve safety and quality of life for those people affected.

Specialists use Videofluoroscopic Swallow Studies (VFSS), a dynamic X-ray to capture the movement of food and fluids through the throat into the oesophagus, to diagnose swallowing disorders like dysphagia, which affects around one million Australians.

The TeleVFSS service demonstrates that collaboration between regional and metropolitan teams, and the use of technology and translational research, can build sustainable models of care that deliver high-quality, equitable health outcomes for people across WA.

BreastScreen WA extends services to Melaleuca Women's Prison

BreastScreen WA extended its visits to Melaleuca Women's Prison in March 2026.

The BreastScreen WA team worked closely with the Department of Justice to plan the logistics of how they could provide the service at the centre, given the size of the screening bus. Screening is already provided at Bandyup Women's Prison, with both teams determined to find a way to provide other women in custody with access to care.



Advancing equity and access

Therapeutic programs to support mental health care

The State Forensic Mental Health Service rolled out new therapeutic activities to support patient-centred care, with a walking group, self-care nights and games to eligible patients.

The activities have made a positive impact on communication between patients and staff, strengthening rapport and building trust, while also improving patients' self-esteem and physical activity level, and reinforcing a sense of normalcy.

A newly-renovated occupational therapy kitchen at Graylands Hospital is supporting consumers to practice self-care and learn new skills as part of their rehabilitation journey. The home-style kitchen provides opportunities for people to share and retain their culinary skills while socialising.

At Graylands Hospital, self-care/pamper nights are held for patients each fortnight, combining the positive effects of self-care with the power of social support and a sense of community. Integrating pampering and self-care into a group environment improves wellbeing, emotional regulation, confidence, communication and interpersonal skills, and strengthens social connections, all of which are vital for mental health recovery.

In our older adult mental health services, therapy staff continue to proactively identify opportunities for music engagement for older adults, including exploring partnerships with schools, volunteers, community groups, and external providers. The West Australian Symphony Orchestra (WASO) provides an annual visit and the Creative Expressions Centre for Arts Therapy (CECAT) hosted a one-off music session for patients this year.

The Selby Older Adult Mental Health Service (OAMHS) facilitates a weekly music group using online platforms to engage patients in a range of music-related activities, including singalong, use of percussion instruments, concerts, and music quizzes. Osborne OAMHS patients benefit from weekly visits from a registered music therapist, made possible through donations by the Levitt Fund.

Nurse-led model of care tackling tuberculosis

The WA Tuberculosis Control Program (WATBCP) implemented a nurse-led model of care for patients diagnosed with TB. The model of care aims to optimise workforce capacity by delegating appropriate aspects of care to skilled nursing staff, enabling medical clinicians to prioritise more complex cases and ultimately improving patient flow, access, and timeliness of care.

The team travelled to the Kimberley region throughout the year to conduct surveillance and contact tracing for leprosy, while also educating local healthcare workers to identify TB and leprosy to support timely case detection and prompt follow-up. Visits to regional and remote areas aim to build local capacity for early case detection, support collaborative case management, and provide education while strengthening contact tracing activities.

With assistance from the Public Health Intelligence team at Boorloo Public Health Unit, WATBCP developed a new data system to improve case recording and reporting. The guidelines for TB control in WA were also updated in July 2025.

Improving quality of care for men diagnosed with prostate cancer

A population-based clinical registry is helping improve quality of care provided to men diagnosed with prostate cancer, with 100 participants joining since it launched in July 2025.

SCGH Head of Urology Dr Melvin Kuan is carrying out groundbreaking work as a principal investigator with the Prostate Cancer Registry of WA (PCOR-ANZ).

The registry allows doctors and researchers to identify population-wide trends in diagnosis and treatment practices for prostate cancer.

It also helps to track survival rates and understand what effect different treatments have on the quality of life for men. This helps to reduce the current variation in treatment and outcomes by benchmarking outcomes that matter to men, as well as providing helpful information to men about the risks and benefits of different treatment options available.

The information is beneficial to urology clinicians working at SCGH, as it allows them to understand the uptake of evidence-based practice, as well as collect up-to-date information about patterns of care and measuring outcomes that matter to patients.

Delivering on our Strategic Plan:

Partnering with our communities

Forging strong partnerships with consumers, carers and a diverse range of organisations enables us to enhance the quality of our services, be responsive to the changing needs of our catchment, and lead advances in research and innovation.

Consumer feedback

Consumer feedback helps us to improve the quality of our services. We provide various methods for consumers to give feedback including via phone, email or letter, sharing a story anonymously via Care Opinion, or completing a consumer feedback survey.

	Number of surveys completed in 2024-25	Number of surveys completed in 2025-26	NPS score 2025-26 with + or - on 2024-25 score
MySay Inpatients	17058	16287	+77
MySay Outpatients	52674	51639	+80
MySay Emergency Department	1967	2068	+42

Care Opinion

	2024-25	2025-26
Number of stories	252	238
Recommendation percentage	79	79
Ranking of note	Top 3 organisation with the highest number of “staff listening, learning and making changes”	



Partnering with our communities

We would like to express heartfelt gratitude to Sir Charles Gairdner Hospital. For all the medical journey since early March and previous frequent trips to hospital.

Our heartfelt gratitude with support to all the medical team of doctors and specialists from coronary, nephrology and renal departments.

SCGH **Sir Charles Gairdner Hospital**

The King Eddie's team have, by far, [been] the kindest and most caring health professionals I have ever come across. Every single person who I interacted with was absolutely amazing. My doctors gave me space to share my experience, showed empathy and genuine determination to deliver me the best care possible and constantly reassured me that together we would find a solution.

KEMH **KEMH**

I had to present my wife to the emergency department at approximately 8.00pm on a busy waiting room Boxing Day evening…. My wife was very quickly admitted to the emergency ward and the nurses and doctors were amazing in dealing with our situation. A very big thank you to everyone who was involved and I am proudly telling everybody who will listen about the wonderful staff at Joondalup.

JHC **Joondalup Health Campus**

Fantastic service received from a school dental clinic in Geraldton. Staff were absolutely above level of performance in every aspect. As a parent, I felt so happy and grateful to the care received at the clinic.

DS **Dental Service**

It was great having my own Aboriginal Midwife. From pregnancy to labour to birth I don't think I'd be able to go through that process again without having an Aboriginal Midwife Group to be there for me. It was a very friendly experience from the start and it also gave me confidence to know I was doing the right thing in labour, at the birth of my newborn and also during the home visits.

AH **Aboriginal Health**

Words can't express how grateful I am for the service BreastScreen WA provides for women living in WA. I attended my regular screenings from age 50 and on my second screening, at age 52, BreastScreen WA identified a small DCIS cancer in my right breast. I had a right breast mastectomy in January 2024, and I am currently recovering from my left breast mastectomy. The work you do is invaluable and I will be forever grateful for my early diagnosis. It made all the difference in my prognosis.

BSWA **BreastScreen WA**

Partnering with our communities

Celebrating our volunteers

Volunteers make an invaluable contribution to our hospitals and programs, supporting patients, visitors and staff in different ways.

Following a decline in numbers during COVID, a concerted effort has gone into rebuilding our volunteer program at SCGH and OPH. Today, 220 volunteers are trained and onboarded, and support the two hospitals in roles ranging from engaging with patients in ED to providing concierge services, operating the buggy transport service, helping patients to prepare to return home, running the auxiliary retail outlets, and delivering falls education to patients and staff.

At OPH, a volunteer-led sewing group creates cushions for patient therapy and personal items bags for people who use wheelchairs.

The concierge team at SCGH are amongst our most visible volunteers, providing directions and a warm welcome to hundreds of people every day.

Janet and Swee are familiar faces on the concierge desk, having clocked up 16 years of service between them.

"I didn't want to sit around the house all day when I retired, so I went along to Joondalup library where they had a list of organisations where people could volunteer. Charlies was on that list and 10 years later I'm still here!" Janet said.

"A lot of the people we help are the oldies. It can be hard for them if they've been dropped off at the entrance and need to find their way around. I enjoy helping out because one day I'll be in their shoes and I hope that people are here to help me."

Swee was inspired to volunteer in 2021 after her own experience as a patient receiving cancer treatment at the hospital.

"It was so hard having cancer. When I finished treatment, I said I'm going to help others because this hospital has been so good to me."

"We do what we can to offer directions, make people feel supported and be a friendly face for people who are having a bad day."

Both women volunteer two or three days a week and have built strong relationships with patients, families and staff. Janet also helps in the SCGH charity shop.

"We love seeing everyone when we're here – there's a real social connection with the staff and other volunteers, and you get to know some of the patients and families quite well," Janet said.



Consumer Feedback via Datix CFM (extracted 21/07/2026)

	FY24	FY25	FY26
Complaint	531	613	849
Contacts and Concerns	1042	1013	1518
Compliments – Datix CFM and externally recorded	3749	4317	3816

Data from FY24 and FY25 have been updated from previous years as backlogs have been remedied.

Partnering with our communities

Consumer Advisory Councils

Our Consumer Advisory Councils play a vital role in embedding consumer voice and experience into our systems and processes.

The appointment of Jenny Bedford as the inaugural consumer representative to the NMHS Board Safety, Quality and Consumer Engagement Committee was a significant milestone for consumer engagement, and will ensure the consumer voice is heard at the highest levels of leadership and governance at NMHS.

Significant work has also been undertaken to recruit two consumer and carer representatives to the NMHS Executive Team (NET) Committee. This committee provides high level strategic advice to the Chief Executive.

Other highlights include the development of training resources to assist in onboarding of new council members, training consumer representatives to sit on SAC1 clinical incident panels, and the introduction of a new online platform to strengthen our engagement with and governance of the Community Partnership Network (CPN).

Greater cultural diversity within our CPN to better represent the profile of our consumers at NMHS has been achieved through targeted outreach to community organisations.



SCGOPHCG Community Advisory Council

The SCGOPHCG Community Advisory Council continued to strengthen consumer partnerships and influence service improvement through active engagement in patient experience, accessibility and quality initiatives. The council remains focused on ensuring the consumer voice informs service planning, quality improvement and patient experience initiatives across SCGOPHCG.

Key projects and focus areas included:

- Advocating for enhanced consumer engagement resources and executive sponsorship to support meaningful consumer participation.
- Providing consumer input into major infrastructure projects, with a focus on wayfinding, accessible parking and minimising impacts on patients and visitors.
- Recommenced Ward Walks and developing a consumer-led emergency department observation tool to identify opportunities to improve patient experience, dignity and accessibility.
- Reviewing outpatient communications and access and inclusion tools to improve consumer-centred care and accessibility.
- Promoting improvements in patient transfer experiences and consumer feedback processes, including greater focus on positive feedback, compassionate communication and Care Opinion engagement.

The council also supported the implementation of a standardised consumer remuneration framework across NMHS committees, recognising and valuing consumer contributions. Three council members are undergoing SAC 1 Clinical Incident Management training to improve consumer input into SAC 1 investigations.

Partnering with our communities

Mental Health Services (MHS)

The Mental Health Service Consumer Advisory Council was reinvigorated with the appointment of a new chair and 10 new members in 2025-26. The dynamic and diverse group is committed to helping improve mental health outcomes by ensuring the health experience and journey of consumers, their carers and families is person-centred and trauma informed. Members collaborated with staff on the following projects:

- Behavioural Pyramid Poster Co-design workshops with staff from the workplace violence and aggression team, clinicians and representatives from Consumers of Mental Health WA.
- Consultation workshops to co-design the Lived Experience Strategy and Lived Experience Inclusion Plan.
- Clinical Research Centre for a research grant submission – Transforming Youth Mental Health Care Pathways in WA using Linked Data.
- Review and provide feedback on complaint response letters to enhance consumer perspective.
- Regular review of compliments to understand areas of excellent care.
- Established linkages and information sharing with MH community clinics.

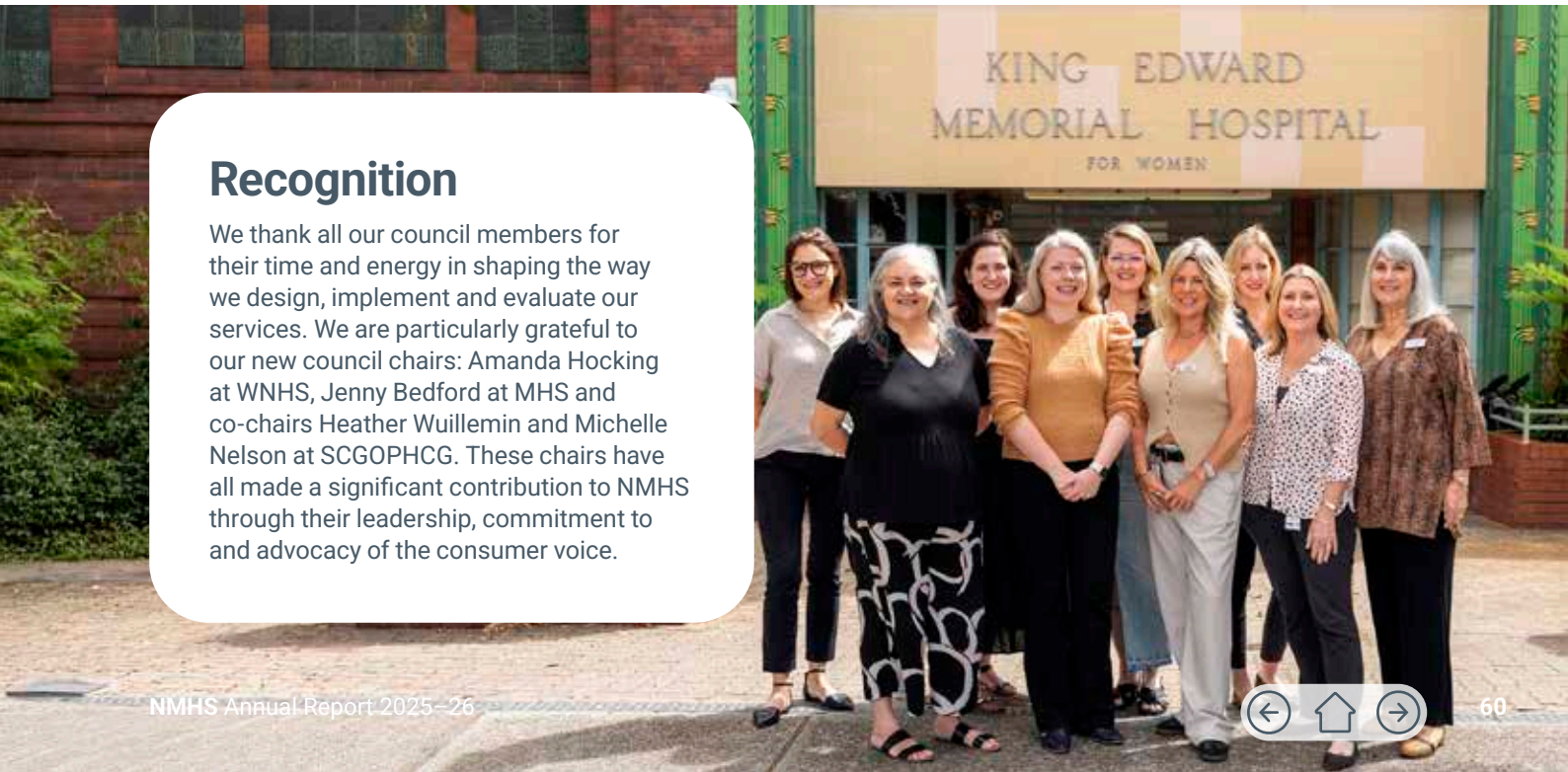
Council members also completed a Public and Patient Engagement Evaluation Tool (PPEET) Survey to support the MH service to evaluate how effectively it is partnering with consumers and carers on the council.

Women and Newborn Health Service (WNHS)

The WNHS Community Advisory Council welcomed four new members, including increased Aboriginal consumer representation, enhancing lived experience insight and diversity.

Key projects included:

- Continued implementation of the WNHS crèche review recommendations, supporting improvements in accessibility, cultural appropriateness and family experience.
- A consumer-led hand hygiene and cleanliness audit to enhance infection prevention and environmental safety.
- Review and refinement of patient information to improve clarity, cultural safety and trauma-informed communication.
- Participation in the mock admission activity to identify opportunities to strengthen communication, wayfinding and patient touchpoints.
- Continued input to new Women and Babies Hospital planning and service development through active involvement in consumer user groups.



Recognition

We thank all our council members for their time and energy in shaping the way we design, implement and evaluate our services. We are particularly grateful to our new council chairs: Amanda Hocking at WNHS, Jenny Bedford at MHS and co-chairs Heather Wuillemin and Michelle Nelson at SCGOPHCG. These chairs have all made a significant contribution to NMHS through their leadership, commitment to and advocacy of the consumer voice.

Partnering with our communities

Drawing on lived experience in mental health

The NMHS Mental Health Lived Experience (Peer) Workforce comprises people employed in roles that draw directly on their own lived or living experiences of mental health challenges, recovery, and/or supporting loved ones through these experiences.

Over the past year, NMHS Mental Health Service has strengthened the foundations for lived experience to be more visible, better supported and more influential across service planning, workforce development and consumer, carer and family engagement. This work aims to change how services listen, learn and respond.

In 2025-26, a new Lived Experience Strategy and Lived Experience Inclusion Plan were co-designed by more than 45 people, at least half of whom were consumers or carers.

The strategy and inclusion plan provides a clearer pathway for consumer, carer, family and lived experience workforce voices to influence how services are designed, delivered and improved. It also strengthens the expectation that lived experience is not an optional extra, but a necessary part of good mental health service planning and decision-making.

Alongside this strategic work, NMHS Mental Health Service has continued to increase support and opportunities for the existing peer worker workforce. Regular workforce connection and co-reflection have created space for peer workers to share practice wisdom, strengthen role clarity and support each other in work that can be both meaningful and personally demanding. This has helped build a stronger workforce identity while recognising the importance of wellbeing, supervision and career development.

NMHS Mental Health Service has also taken steps to grow the future lived experience workforce. A partnership with North Metropolitan TAFE enabled three lived experience peer work students to complete placements across inpatient, community and eating disorder settings. These placements provided students with real-world exposure to lived experience practice, while giving teams the opportunity to better understand the value, scope and contribution of peer work.

Lived experience has been central to co-design activity across the service, including a project to develop behavioural pyramid posters addressing workplace violence and aggression. This work brought together lived experience perspectives and service knowledge to create resources that speak more directly to the human impact of safety, respect and communication.

Looking ahead

NMHS Mental Health Service remains committed to strengthening lived experience roles, creating meaningful development pathways, and embedding consumer, carer, family and workforce voices in the decisions that shape services.



Partnering with our communities

Working with local governments

The Health Promotion Service played a key role in the creation of the Stirling Alcohol and Other Drugs Action Plan (2025-2028), which the City of Stirling launched in October 2025.

The action plan shapes its governance framework and priorities on alcohol, young people and families, and vaping.

Advice and support provided by the Health Promotion Service has included informing the new governance and strategic framework; helping build capacity, commitment and connections among participating community members and organisations; and contributing project funding and reviewing submissions.

Throughout 2025-26, the service supported all north metropolitan local governments to develop local public health plans, and formalised partnership agreements with the City of Joondalup and Town of Cambridge. Through these partnerships, staff are helping to interpret population health data, align plans with strategic priorities and recommend evidence-based approaches.

The initiative was recognised at the statewide Injury Prevention and Safety Awards in July 2025, taking out the Outstanding Achievement by a Local Government in Injury Prevention or Recovery Award.

Addressing nutrition challenges for Aboriginal people

Using the principles of co-design, our Health Promotion team worked with local Aboriginal people to identify solutions to improve community access to healthy food. Ideas were formed through a series of yarning sessions, with two groups supported to seek external funding to create a community cookbook and establish a Family Healing Program at Banksia Grove Community Centre, which is now operating independently and includes a weekly cook-up and physical activities for families.

Alongside this, a co-design model for health promotion was developed to guide future work, which was endorsed by the community. Staff presented the model at the National Preventive Health Conference in Tasmania in May 2026.

Automating immunisation catch up plans

Boorloo Public Health Unit collaborated with Perth Children's Hospital to use an automated system to create immunisation catch-up plans for all inpatients. It will now become much easier for children who have missed immunisations, particularly those impacted during COVID, to get back on track.

There were 1914 requests made for childhood immunisation catch-up plans in 2025-26, while 865 outreach home vaccination visits were conducted through the Moorditj kids program, which reaches families who would otherwise be unable to access immunisation services.



Partnering with our communities

Brain Crew launched to support young people

A new approach to supporting children and adolescents living with a parent with chronic acquired brain injury was launched by the WA Acquired Brain Injury Rehabilitation Service.

The project provides psychoeducation telehealth for young people. The conclusions drawn from a feasibility study indicated the program will provide invaluable support to families affected by ABI.

The expanded education offerings have improved patient and carer understanding of ABI, supporting better engagement and self-management.

WAEDOCS Inaugural Symposium

The WA Eating Disorders Outreach and Consultation Service (WAEDOCS) held its first annual symposium, bringing together experts from across the country in May 2026.

Leading clinicians and researchers explored the intersection of Disorders of the Gut-Brain Interactions (DGBI), eating disorders and neurodiversity through an integrative, neuro-affirming lens, under the theme - Integrative Care: Exploring the intersection of disorders of the gut-brain interaction, neurodiversity and eating disorders.

St John Ambulance partnership

A new partnership between SCGH and St John Ambulance (SJA) Extended Care Paramedics (ECP) created new pathways for paramedics to refer urgent older adult patients to the most suitable service within Geriatric Acute and Rehabilitation Medicine rather than defaulting to ED.

This includes arranging urgent Frailty Rapid Access Clinic (FRAC) appointments, urgent nursing or allied health home visits, or direct inpatient admissions where necessary.

SCGOPHCG Geriatric Acute and Rehabilitation Medicine team has also supported SJA ECPs with clinical placements, broadening their awareness of what referrals can be managed outside the ED in a community setting. The relationships ensure that ECPs are equipped with advanced assessment skills and referral pathways to optimise patient outcomes.

Since February 2024, 102 referrals have been received through the new pathways.



Partnering with our communities

Westside Collaboration Space

NMHS became a key partner in the Westside Collaboration Space, an initiative supported by the Future Health Research and Innovation Fund to establish a dedicated, future-ready innovation hub within the Harry Perkins Institute at the QEII Medical Centre.

Led by the University of Western Australia and the Harry Perkins Institute, the consortium also includes CAHS, PathWest, Perth BioDesign, MTPConnect and other QEII precinct tenants, enabling cross-sector collaboration and innovation across the health and research ecosystem.

The Westside Collaboration Space aims to foster collaboration across disciplines and institutions, creating an environment where ideas can be shared, tested and translated into practical outcomes that benefit patients and the wider community.

The facility will provide purpose-built spaces for meetings, workshops and collaborative projects, supporting partnerships that drive research and innovation, leading to improved health outcomes.

Far North Huntington's mobile clinic

Supported by a grant from the State Government's Disability Innovation Fund, the Mental Health Services Neuroscience Unit held a Far North Clinic in the Kimberley to support people with cognitive impairment or neurological conditions, particularly Huntington's disease.

In collaboration with Huntington's Australia and not-for-profit organisation Connectivity, the team provided specialist care, resources, training and advocacy, and strengthened community links through mobile clinics held in Kununurra and Halls Creek.

As the number of Huntington's disease cases in the region increases, the team is focused on providing culturally sensitive treatment for people with the disease.

Far North Community Services delivered training to new staff and will train Kununurra Hospital staff in the new year.

The team yarned with staff and met many of the community's men for the first time. They also delivered donations of clothes and shoes.

The October clinic was the final of four clinics held over two years. A community and mobile team are beginning a long-term collaboration to build a sustainable model of care.



Partnering with our communities

Culturally responsive maternity care

The Osborne Park Hospital's Lorikeets Midwifery Group Practice supported 201 babies born to mothers from 53 countries in its first year since commencing in 2025.

The group has worked closely with the broader multidisciplinary team, including medical staff and social work, to provide comprehensive support through a continuity-of-care model built on strong midwife-patient relationships.

The group has grown into a strong, collaborative and highly effective model of care, continuing to deliver positive outcomes for women.



GEM Awards – Strengthening Partnerships

Kaylene Bowes-Smith won the Strengthening Partnerships GEM Award for her impact in leading BreastScreen WA's Aboriginal Breast Screening Program.

A proud Noongar woman, Kaylene's dedicated approach over the past four years has seen, screening rates amongst Aboriginal women increase by 26.5 per cent in the metropolitan area and 22.6 per cent in regional and remote areas.

Understanding the diverse languages, cultures and customs of each Aboriginal community is key to Kaylene's culturally-informed approach.

She identifies local sensitivities, such as women's business or sorry business, and creates tailored schedules for visits by the mobile screening units that respect cultural considerations and timing.

In communities facing greater challenges in breast cancer awareness, Kaylene works with elders and influential community members to provide education and encourage participation, helping to increase uptake.



Partnering with our communities

Strengthening connections in Mirrabooka

Mirrabooka Adult Community Mental Health Service (CMHS) partnered with Medicare Mental Health Service to promote pathways to care and wellbeing with a pop-up stall at the local square during Harmony Week.

The event promoted diversity and unity with a variety of stallholders from services in the local area. Attendees enjoyed family-friendly activities including face painting and batik art. They also connected with local community and health services, and had access to information translated into preferred language.

The Mirrabooka Adult CMHS team provides evidence-based, specialised mental health services and case management, developing practical and achievable care plans in collaboration with consumers, families, carers and other service providers to promote sustained recovery.



Supporting our communities

Beyond healthcare services, we support the community through staff-led donation appeals and fundraising activities. Our annual NMHS Spread the Cheer charity appeal provides packs of personal items for people experiencing homelessness or domestic violence through Dandelions WA. In winter, our staff donated the equivalent of 1,241 meals to Foodbank. Many of our teams also support charities that are linked to their service.

The annual Charlies Giving Day raised more than $89,000 from staff and their networks over a 24-hour period in August.

Led by the Charlies Foundation, funds raised through the initiative went back into the hospital to support research, purchase new equipment and enhance the hospital environment.

The generous donations have been put towards:

- New equipment and technology the Medical Physics Department can use to treat cancer with more precision.
- Renovating healing spaces such as gardens and patient areas in the Cancer Centre to bring comfort and calm to cancer patients.
- Advancing research by the Immunology department to reduce and prevent side effects for transplant recipients.
- Education and resources for allied health staff to deliver new therapy programs such as dance therapy for cardiac patients.
- Essential items such as warm clothing that the Aboriginal Liaison Office can provide for Aboriginal patients.





Delivering on our Strategic Plan:

Becoming the best place to work

Our strategic priority to become a great place to work goes beyond recognising the work of our people, and challenges us to consider how we value, engage and support our people.

A strong focus for our People and Culture team in 2025-26 was strengthening cultural safety to support the varied cultures, beliefs, socioeconomic circumstances, educational backgrounds and lifestyles of our colleagues and the communities we serve.

NMHS culture program

During 2026, an organisation wide consultation was undertaken to co-design the desired future culture, aligned to three cultural identities: People First, Patient Centric and Achievement Driven.

Through a series of consultations, staff and leaders across sites identified cultural strengths, gaps and priority areas for improvement, and defined the behaviours, systems and ways of working required to support a positive workplace culture.

The culture program will continue to inform development of organisational values and behaviours, with a focus on embedding sustainable cultural change across NMHS.

Meet Jessica Snaas – ED Registrar



Jessica Snaas has worked in the Emergency Department at SCGH for the past four years, after moving to Perth from London.

Emergency medicine is a bit different in Australia compared to the UK. Here we do more to work up patients and are more involved in providing critical care, such as intubations and advanced access. This means patients receive more timely care as their critical care is escalated quickly. In the UK these interventions are considered specialist skills and are often left to anaesthetics or intensivists, which can delay treatment.

There are different disease patterns here and the patient presentations mostly involve complex illness as Charlies is the state centre for cancer care, stroke and neurosurgery.

Providing care for Aboriginal patients demands a shift in traditional emergency care to a holistic approach that is focused on cultural safety, with strong relationship building at the forefront. It has been a part of my Australian medical practise that I respect immensely by better understanding the multifaceted social determinants that impact a patient's journey through our system.

The most positive aspect of moving here has been the work life balance and being able to prioritise this. A combination of fixed shift patterns and increased staffing with fair rostering makes this possible.

Becoming the best place to work

Promoting diversity and inclusion

NMHS continued to implement its Diversity and Inclusion Strategy, focusing on attracting, supporting and retaining a diverse workforce reflective of the community we serve, and to build a productive and inclusive culture where diversity is welcomed.

Key achievements in 2025-26 included:

A guide developed to facilitate inclusive and accessible recruitment practices for culturally and linguistically diverse people.

Rollout of the Hidden Disabilities Sunflower Initiative pilot program, which provides training for staff to understand how they can support people with hidden disabilities. Staff and consumers can choose to wear a sunflower as a voluntary way to discreetly communicate their needs and signal that they may require extra understanding, time or assistance.

Aboriginal yarning circles, bespoke cultural education programs and an Aboriginal employee forum.

Monthly Pride Network meetings and annual events to recognise and celebrate our LGBTQIA+ community, including IDAHOBIT, Pride Fair Day and Pride Parade.

The NMHS Multicultural Plan and disability access and inclusion initiatives are key to our Diversity and Inclusion Strategy, and are reported on in the Disclosures and Legal Compliance chapter on page 177.

Reforming how we attract and recruit staff

In line with the Public Sector Commissioner's new recruitment framework, NMHS is reforming recruitment practices to improve the experience for candidates and hiring managers. The changes will strengthen governance while streamlining processes to deliver more timely, consistent and transparent outcomes.

The reform program emphasises merit-based selection, standardised processes and clear accountability across the recruitment lifecycle. Improved pre-recruitment planning, greater use of priority employment pathways and expanded use of talent pools are supporting more efficient decision-making and workforce placement.

NMHS continues to work in partnership across the system to align policy, tools and guidance, and to build capability among hiring managers to effectively navigate the new framework.

Retention and attraction initiatives

NMHS progressed workforce initiatives to strengthen attraction and retention across the organisation. Aligned to broader workforce strategy priorities, these initiatives support NMHS's position as an employer of choice and contribute to a sustainable, skilled workforce.

Key focus areas included targeted attraction strategies, workforce pipeline development, and initiatives that support employee development, career progression and a positive workplace culture. Delivery is undertaken in partnership with clinical services and corporate teams to ensure alignment with organisational priorities.

Work also commenced on improving the coordination and visibility of initiatives, reducing duplication and enabling more effective planning and delivery.



Becoming the best place to work

Embedding flexible working

NMHS is embedding flexible working as a core component of its employment value proposition through an updated Flexible Work Arrangements (FWA) Policy and rollout of a standardised FWA app. This approach provides a consistent, transparent and auditable process for requesting and managing flexible work arrangements, supporting fair and equitable decision-making.

The model supports a contemporary approach to work by enabling flexibility in when, where and how work is performed, while maintaining alignment with operational and service delivery requirements. A strong emphasis on manager capability, procedural fairness and balancing organisational and employee needs is supporting improved employee wellbeing, engagement and retention.



People and Culture Events

NMHS delivered a comprehensive annual program of workforce engagement, recognition and wellbeing initiatives aligned to key national and sector events.

Activities included NAIDOC Week, RUOK? Day, International Women's Day, Harmony Week and IDAHOBIT, supporting awareness, inclusion and psychological safety across the organisation.

Organisation-wide initiatives such as Fit February and Wellbeing Month promoted staff wellbeing and team participation, while recognition programs such as the Going the Extra Mile (GEM) Awards and site-based Employee of the Season awards celebrated workforce contribution across all NMHS sites.

NMHS also participated in PrideFEST, including Fair Day and the Pride Parade, demonstrating a strong commitment to inclusion and visibility for LGBTQIA+ staff, patients and communities.







Becoming the best place to work

NMHS Aboriginal Employment Unit

The Aboriginal Employment Unit continued to strengthen cultural capability and support Aboriginal workforce development across NMHS through targeted training, engagement and workforce initiatives.

> "I felt so connected to the stories and symbols. It was a privilege to learn from Christine and express our learning through art." – **Participant**
>
> "The Yarning Circle was so powerful. It reminded me that healing is not just physical—it's emotional and spiritual too." – **Participant**
>
> "Thank you so much for today! This has really helped me feel energised about the future." – **Participant**
>
> "It was a great day to celebrate culture and build relationships to have that network of people when living away from home and country." – **Participant**

Aboriginal Employee Forum July 2025

The Aboriginal Employee Forum was a full-day event aligned with the NMHS strategic priority of Retention and Development, with a focus on strengthening personal wellbeing to support professional growth. The forum was open to all NMHS Aboriginal staff.

The event showcased three Aboriginal-owned organisations: Dadajaal All Things Cultural (Welcome to Country), Goreng Cultural Artist (cultural workshop), and Good Binji Wellness (wellness sessions). The day opened with a Welcome to Country by Daniel Garlett, which set a culturally respectful and inclusive tone.

The morning cultural workshop encouraged staff to explore Aboriginal and Noongar stories and symbolism through collaborative art, fostering connection and cultural reflection. The afternoon wellness session focused on holistic wellbeing, with yarning circles supporting emotional, spiritual, and social connection.

Staff engagement was high, with participants valuing the opportunity to connect, reflect, and build relationships in a supportive environment. Feedback highlighted increased wellbeing, strengthened cultural connection, and a renewed sense of empowerment.

It also reinforced the importance of providing culturally safe spaces to support retention and development of Aboriginal staff.



Becoming the best place to work

Aboriginal Cadet and Graduate Programs

The Aboriginal Cadet Program and Aboriginal Graduate Program are Department of Health-led initiatives to support Aboriginal employment pathways within NMHS. Annual recruitment drives continued to strengthen workforce development, with cadet recruitment undertaken in April 2026 and graduate recruitment in May 2026.

NMHS supported four Aboriginal cadets in 2025-26, with an additional five recruits to be placed across the service.

The cadet program continues to deliver strong outcomes, providing paid, study-aligned work experience while strengthening career pathways and workforce capability. Participants reported improved ability to balance study, work, and wellbeing, particularly for students living away from home.

Cadets demonstrated strong engagement and performance across clinical areas, with positive feedback highlighting their adaptability, work ethic, and contribution to teams.

The program remains an important pathway for developing a skilled Aboriginal workforce and supporting long-term employment outcomes, including aspirations to work in regional and under-served communities.

Aboriginal Health Practitioners

Aboriginal health practitioners (AHPs) play a critical role in improving health outcomes for Aboriginal communities in WA. In January 2026, a dedicated AHP project officer was recruited to a six-month contract to develop a business case and implementation plan to embed and sustain the AHP workforce within NMHS.

The project identifies the frameworks, structures, and supports required, including clinical and cultural supervision, student placement pathways, and resource requirements.

The initiative supports NMHS priorities by enhancing culturally safe care, strengthening employment and career pathways for Aboriginal health students, and progressing actions under the NMHS Aboriginal Employment Action Plan 2024–2027. It also contributes to building a skilled AHP workforce to support effective and culturally responsive healthcare delivery across NMHS.

Renal tours at SCGH

In partnership with Marr Mooditj Training, two renal tours were delivered to AHP students at SCGH, providing structured clinical exposure to dialysis, end-stage kidney disease management, and transplant services. Across both sessions, students gained valuable insight into multidisciplinary renal care and the critical role of AHPs in supporting Aboriginal patient outcomes.

A consistent highlight was the opportunity for students to yarn with an Aboriginal patient undergoing dialysis. This lived experience learning significantly enhanced understanding, with students identifying it as the most meaningful component of the tours and a key factor in connecting clinical knowledge to real-world impact.

Engagement levels were high across both cohorts, with 100 per cent of students reporting increased knowledge of renal care. The tours also supported workforce pathway development, with increased interest in working in WA health.

Students were actively involved throughout the tour, asking questions and engaging with staff across clinical areas. The session concluded with increased confidence, strong interest in future excursions, and a deeper understanding of the role AHPs play in improving health outcomes for Aboriginal communities.

> “It was valuable to learn things I can take back to my community.” - **Participant**

> “Hearing the patient’s story really brought everything together and made the learning meaningful.” – **Participant**

Becoming the best place to work

Career Events

The Aboriginal Employment Unit (AEU) took part in a range of career and community events, including the Aboriginal Health Council WA Aboriginal Youth Conference, Boorloo Deadly Jobs Expo, Moorditj Koort (Closing the Gap), Polly Farmer Expo, SkillsWest Employment and Careers Expo, and the WA Health Career Fair. These engagements created culturally safe and welcoming spaces for Aboriginal students, jobseekers, and community members to explore career pathways and connect directly with NMHS. About 25 people registered their interest in working with us.

A key highlight was participation in the Marr Mooditj Training Graduation in December 2025, celebrating Aboriginal student achievements and strengthening relationships with a valued training provider. The event provided an opportunity to engage directly with graduates, promote employment pathways, and support transition into the workforce.

Participants valued the opportunity to engage with staff, ask questions, and learn from real career journeys, helping to make pathways feel more accessible and achievable.

The events were highly engaging, fostering meaningful conversations and strengthening relationships between WA Health and Aboriginal communities. Attendees reported increased confidence in navigating employment opportunities and a clearer understanding of available supports.

Staff were actively involved across all events, contributing to discussions, sharing experiences, and promoting culturally responsive recruitment approaches. The collective impact of these events has strengthened the Aboriginal workforce network and reinforced AEU's commitment to supporting Aboriginal employment outcomes.



Becoming the best place to work

Meet Storm Motohata

Storm Motohata is a Djugun, Yawuru and Nyul Nyul woman from the Kimberley region and established the NMHS Aboriginal Employment Unit (AEU).

The AEU is a dedicated team providing vital support to Aboriginal staff at NMHS. We walk alongside staff throughout their employment journey, offering mentoring, cultural support, advocacy and guidance. We also work closely with hiring managers to ensure Aboriginal perspectives, cultural responsibilities and lived experiences are understood, respected and valued within the workplace.

Aboriginal staff bring unique strengths to NMHS through their deep cultural knowledge, strong community connections and commitment to improving outcomes for Aboriginal people. These strengths extend far beyond formal role descriptions and contribute significantly to the overall organisational culture of NMHS, and the quality of care provided across our health services.

Many Aboriginal employees serve as trusted cultural navigators, helping to build understanding and relationships between health services and Aboriginal patients, families and communities. Their ability to bridge cultural knowledge systems strengthens both patient outcomes and organisational capability.

This work reflects the strong sense of responsibility many Aboriginal people hold towards family, community and Country. Aboriginal employees often carry important cultural obligations while also contributing their professional expertise within NMHS. It can be difficult for Aboriginal people who come into healthcare wanting to help drive change. A lot of burnout comes from the frustration of knowing things can be improved, and the disappointment that comes from community when we can't deliver.

Many Aboriginal people choose to work in healthcare because they are passionate about creating positive change for future generations. Valuable insights, innovative thinking and lived experience are brought forward that can help shape more culturally responsive services. When Aboriginal voices are heard, respected and included in decision-making, organisations are better positioned to meet the needs of Aboriginal communities and build stronger relationships founded on trust and respect.

Every Aboriginal employee who joins NMHS receives a welcome email introducing the AEU and the support available to them. One of our proudest achievements is the establishment of the Aboriginal Forum, which brings Aboriginal employees together to connect, share knowledge, build networks and celebrate collective success. The forum reflects the strength of our Aboriginal workforce and creates opportunities for learning, collaboration and cultural connection.



Storm (centre) with members of the AEU team.

Becoming the best place to work

Learning and development

Promoting continuous learning and growth

We promote continuous learning and growth and strive to build the capability of our people. Professional development courses at NMHS have been significantly redeveloped to enhance relevance, quality, and alignment with workforce needs. Mental Health First Aid (MHFA) remains a popular offering, with consistently high enrolments. The program enables staff to develop the knowledge and skills required to effectively support individuals experiencing a mental health concern or crisis.

As a Registered Training Organisation, we offer a nationally-accredited Diploma in Leadership and Management. This has been restructured to enhance the learning experience for future leaders across NMHS. The new model strengthens peer connections, builds confidence through shared assessment milestones, and enhances collaboration with key stakeholders across NMHS. In 2025-26, 30 students completed the diploma and 60 new students enrolled in the course.

We are committed to providing a safe environment for both patients and employees and ensuring employees have the skills and knowledge required to adhere to legislative and policy requirements. About 100 inductions have been held to welcome and support new staff into NMHS in the past 12 months.

The inductions are held for all the different sites across NMHS, with large numbers of nursing, medical, allied health and Patient Support Services staff inducted into the organisation. Other mandatory training includes modules in accountable and ethical decision making, Aboriginal cultural awareness, emergency procedures, manual tasks, clinical deterioration and basic life support and management of aggression.

In addition, NMHS provides leadership development initiatives, including the North Space Leadership Forum and Medical Leadership Program. NMHS leaders can also attend programs run by the Institute of Health Leadership, such as Shaping Health Systems and Coaching skills.

Medical Leadership Program: February – June 2026

The Medical Leadership Program targets current and aspiring medical heads of department with the purpose of building capable and confident medical leaders and supporting safe, high quality, patient-centred care.

Session evaluations are consistently positive for relevance, practical take aways and interaction.



"When Aboriginal voices are heard, respected and included in decision-making, organisations are better positioned to meet the needs of Aboriginal communities and build stronger relationships founded on trust and respect."

Becoming the best place to work

North Space Leadership Forum

As part of our approach to building leadership capability and promoting connection and networking opportunities across our organisation, NMHS organises leadership forums twice a year centred around a key leadership topic of interest.

The aim of the forum is to provide a platform for learning, information sharing, consultation, engagement and networking with approximately 200 NMHS leaders attending.

Mandatory training reform

NMHS implemented a single, organisation wide mandatory training matrix in January 2026, replacing site based frameworks to ensure consistent, role based compliance with legislative, policy and safety requirements.

The reform strengthens executive oversight and system wide governance, reduces duplication, and delivers workforce efficiency, with an estimated 4,000 training hours saved annually while maintaining accreditation, compliance and patient safety.

Work is progressing to identify further opportunities to reduce duplication and increase efficiency, including greater system alignment to recognise prior learning and optimise training frequencies based on risk and relevance.

Supporting graduates

Helena Bartlett is a Registered Nurse who joined SCGH's graduate program in 2025.

I applied to the SCGH graduate program because of the unique support program it has in place for new nurses. The transition from being a student to a nurse on a ward is really daunting, and I wanted to work somewhere that I knew I would be supported.

My first rotation was in the cardiothoracic, vascular and urology unit, which sees a lot of complex cases. The first six months was a very steep learning curve!

The dedicated graduate support team made a huge difference. Experienced staff regularly check in on graduates and there is a direct phone number we can call if we need help and other staff are busy. If I felt overwhelmed or unsure of what steps to take, I could ring the number and an experienced nurse would either talk me through the problem or come up to the ward to help. Having this level of support at our fingertips makes a huge difference to building our skills and confidence.



Delivering on our Strategic Plan:

Building a sustainable future

New Women and Babies Hospital Project

The landmark New Women and Babies Hospital Project has continued to progress with the global design and infrastructure construction company Webuild (appointed by the WA Government in May 2025). The project is under construction with activities continuing at both the Osborne Park Hospital and new Women and Babies Hospital site locations.

This project will expand services and choice for women, newborns and families across three sites, replacing the century-old King Edward Memorial Hospital.

The project includes:

- a new Women and Babies Hospital located at the Fiona Stanley Hospital precinct in Murdoch.
- two new family birth centres – one north and one south of the river.
- the expansion of maternity and neonatology services, birthing suites and theatres at Osborne Park Hospital.
- the expansion of neonatology services at Perth Children's Hospital.

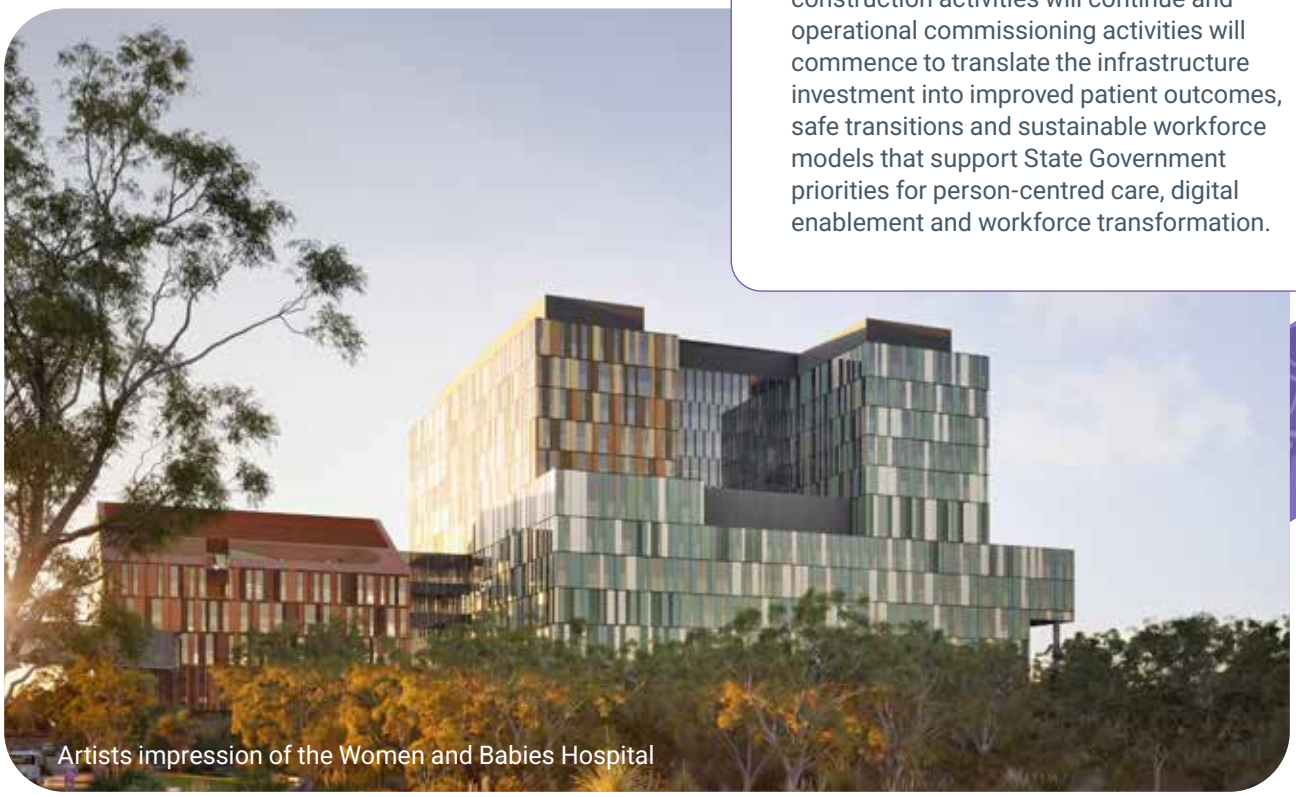
The Office of Major Infrastructure Delivery (Department of Transport) is the lead agency for the design and construction elements of this project, and the Health team works collaboratively facilitating stakeholder engagement to align the design with the needs of staff and patients.

Site investigations and construction works have commenced at OPH and the Women and Babies Hospital, with significant piling foundation works and associated concrete pours being completed.

The project team has also undertaken a significant number of stakeholder consultations, workshops and meetings between 2025-26 with stakeholders from NMHS, SMHS, CAHS and consumers to provide input and feedback to benefit the design process.

Looking ahead

As the design processes are finalised, construction activities will continue and operational commissioning activities will commence to translate the infrastructure investment into improved patient outcomes, safe transitions and sustainable workforce models that support State Government priorities for person-centred care, digital enablement and workforce transformation.



Artists impression of the Women and Babies Hospital

Building a sustainable future



Cyclotron to supercharge WA's cancer-fighting capacity

The new radiochemistry laboratories and cyclotron facility (RAPID Labs) at SCGH marked a major expansion in molecular imaging and radiopharmaceutical capability for WA.

The expanded facility includes a second cyclotron and new radiopharmaceutical laboratories that will increase local production capacity for radiopharmaceuticals used in PET and SPECT imaging for research and clinical applications, such as diagnosis and treatment of many cancers, Alzheimer's disease and dementia, epilepsy, stroke, Parkinson's disease, heart diseases, thyroid disorders and more.

The project includes state-of-the-art laboratories and a second cyclotron machine, providing improved access to radiopharmaceutical products, which are administered to patients with cancer, neurological, heart and other conditions undergoing PET imaging.

PET imaging is critical to both diagnose and monitor treatment response and disease progression. Unlike other scans, which only show the structure of a body, a PET image shows how the body is working. They provide greater sensitivity and accuracy to diagnose and map cancers.

The radioactive dye created by the cyclotron highlights cancer cells in a patient with PET imaging critical to both diagnose and monitor disease progression.

The project represents a significant collaboration between the WA Node of the National Imaging Facility (NIF), UWA, NMHS, National Imaging Facility through the Australian Government's National Collaborative Research Infrastructure Strategy, and a range of philanthropic and research partners.

WA NIF and UWA funded and established a dedicated research radiopharmaceutical laboratory within the new facility, providing researchers with access to advanced infrastructure to support the development and translation of new imaging agents and therapies 'from bench to bedside'.

It has the potential to triple the capacity to provide PET scans, improving health outcomes for Western Australians with cancer.

Final milestone of JHC public expansion

The opening of 60 new beds at JHC in May 2026 marked the final milestone of the project.

New facilities include 30 new medical beds and 30 new surgical beds, more emergency department beds, mental health, and cardiac patients, a new theatre, two new interventional catheterisation laboratories, expanded pre- and post-operative facilities, a new discharge lounge, additional parking, and expanded supporting facilities.

The project was jointly funded by the State and Australian Governments and provides increased capacity across the WA health system.

Health Asset Maintenance Fund (HAMF)

In August 2025, the State Government announced $50 million for the Health Asset Maintenance Fund (HAMF) to deliver priority maintenance and capital projects at three metropolitan hospitals, including SCGH. The fund is for a targeted program of works to address priority maintenance and infrastructure renewal. SCGH received $37 million to deliver 15 work packages addressing roof integrity, water ingress, electrical, mechanical, and hydraulic systems upgrades, lift replacement, asbestos removal, pan rooms and public, staff and patient amenities. Works are ongoing with the majority of projects completed and some will continue to late 2026.

Building a sustainable future

OPH expansion progress

Work started on the expansion of OPH, which forms part of the $1.8 billion New Women and Babies Hospital Project and will combine midwifery-led and clinical birthing models with spaces for reflection, celebration and care.

The State Government unveiled artist's impressions in November 2025, with natural light, warm materials, views to landscaped courtyards and single-bed rooms a key focus of the design.

The OPH expansion will include:

- services for maternity, gynaecology and neonatology
- a mother baby unit to support the mental health of expectant and new mothers
- a family birth centre
- obstetrics theatres
- outpatient clinics
- upgrades to essential support services, including pharmacy, pathology, sterilisation, kitchen, and catering.

In addition, a new arrival plaza and canopy will make it easier for patients and visitors to find their way, while giving OPH a fresh, inviting identity.

A four-level designed building also will be constructed onsite to house support services for the campus, including pathology and sterilisation services.

These enhancements aim to strengthen day-to-day operations, double birthing capacity, and improve service delivery, ensuring patients, staff and visitors benefit from a more modern hospital environment.

The facility is scheduled to open in 2029.





Building a sustainable future

Graylands Campus Project

The Graylands Campus Project progressed during 2025-26, as the first stage of the broader Graylands Reconfiguration and Forensic Project. The project will deliver contemporary forensic mental health infrastructure, including a 32-bed adult male forensic inpatient unit, an 8-bed child and adolescent forensic inpatient unit, an integrated patient services and rehabilitation centre and relocation of the Claremont Therapeutic Riding Centre.

ADCO Constructions was appointed in March 2026 under an Early Contractor Involvement model, with concept design progressing during the year. Workforce planning, digital transformation and service development activities also commenced to support future service delivery.

Once complete, the project will improve access to forensic mental health beds and services, support contemporary recovery and rehabilitation-focused care, and provide safer, more fit-for-purpose environments for consumers and staff.



Capital works

In addition to the major redevelopment projects underway, work progressed on a range of capital works projects to expand clinical capacity, maintain existing infrastructure and support safe, contemporary care.

At SCGH, works continued on the Emergency Department redevelopment to expand and improve emergency care facilities, including triage, ambulance access, patient assessment areas and dedicated spaces to support different models of care. The Intensive Care Unit 10 Pod Project also progressed, supporting the planned delivery of additional critical care capacity for patients requiring high acuity care.

Preparations continued for the refurbishment of the Neurological Intervention and Imaging Service of Western Australia, which provides specialist care for vascular diseases of the brain, head, neck and spine. Work also advanced on the additional CT scanner project, which will increase diagnostic imaging capacity and support timely access to critical imaging services.

Capital works in progress in 2025-26 (non HAMF)

Project Name	Estimated completion date
SCGH Intensive Care Unit	2027
SCGH Additional CT Scanner	2028
SCGH Image Guided Theatre	2028
SCGH Emergency Department Upgrade and Behavioural Assessment Urgent Care Centre	2028
Replacement of Biplanar Digital Angiography Units	2029
Albany General Dental Clinic	2029
QEII Medical Centre - cladding	Ongoing
KEMH Critical Infrastructure	Ongoing
Electronic Medical Record rollout	Ongoing
Women and Newborn Service Relocation Project	Ongoing
NMHS Anti-Ligature Remediation Project	Ongoing
Graylands Campus Project (GCP)	Ongoing

Building a sustainable future

Excellence in Sustainability – a collaboration between NMHS, SMHS and EMHS

Audiology Advanced Scope Practitioner Project, which is a collaboration between NMHS, SMHS and EMHS, was the winner of the Excellence in Sustainability category at the WA Health Excellence Awards in November 2025.

The initiative empowers senior audiologists to independently manage suitable ear, nose and throat patients under approved protocols at SCGH, FSH and RPH, reducing wait times, improving access to care, and ensuring sustainable use of health resources.

The project aligned with global trends in advanced allied health roles to tackle healthcare backlogs, proving successful in improving efficiency and patient outcomes.

The award recognised projects that delivered high-value health care. These included delivering outcomes focused, value-oriented health care, ensuring the best possible outcomes to patients for the lowest possible cost, providing high-value health care through reduction of waste, inefficiency and/or unnecessary procedures, and addressing health services' economic, environmental, and social sustainability.

Environmental sustainability

Environmental sustainability remains a focus across NMHS, with progress made against many items outlined in the 2025-26 Climate and Sustainability action plan.

Water symposium

NMHS held a water symposium in May 2026 that brought together other HSPs and Water Corporation to strengthen collaboration, share practical experience and identify realistic actions to provide water security, quality and efficiency across the health system.

Consistent key themes found cooling towers are large water users; water quality and efficiency must be balanced; better data and benchmarking are essential; and early collaboration in new builds supports longer-term management.

Green ward at KEMH

The Green Ward at KEMH continues to pilot new initiatives as Australia's first green maternity ward.

Expanding on its original focus to reduce consumables such as gloves, plastic infant feeding bottles and plastic bags, this year the ward began collecting single-use medical devices to send for re-manufacturing. It is also aiming to trial initiatives to reduce single-use consumables, problematic plastics, harmful chemicals and waste.

Donations

SCGH donated two trolleys of expired medical consumables to the University of Notre Dame Australia for use in simulation environments within the Faculty of Medicine, Nursing, Midwifery and Health Sciences at the University of Notre Dame. The donation gives students valuable exposure to real-world medical equipment.

At OPH, a program that involved the collection and return of single use devices that started in theatres has expanded into other areas of the hospital. More than 10 kilograms of material was diverted from landfill by OPH theatres over a five-month period by promoting eco-friendly recycling practices and stopping single use devices going to landfill. Eligible devices include single use tourniquets, patient transfer mats, blood pressure cuffs, pulse oximeters, belly bands and body positioning straps.



Building a sustainable future

Waste management

The Environmental Services Waste Management team at JHC won the Hospitality in Healthcare Award's 2025 National Sustainability Award.

The hospital has made significant strides in reducing its environmental impact by maximising the diversion of waste from landfill. By successfully implementing 30 distinct waste streams, the hospital achieved 44 per cent diversion rate in the first half of 2025 and was aiming for 50 per cent reduction in 2026. Surplus food is donated to OzHarvest and single use plastics were phased out in catering prior to the WA mandate.

A dedicated stream for single use ECG cables and wires was introduced in JHC's Intensive Care Unit and Emergency Departments, further expanding the hospital's recycling capabilities.

Containers for Change

Across SCGH, the Containers for Change program was expanded in 2025-26 with funds raised going to the Charlies Foundation to help enhance patient care and support medical research.

Carbon emissions savings through virtual care

4,972 tonnes

of CO^2 emissions saved via telehealth appointments

$3.5+ million

dollars saved in petrol usage by patients between December 2025 and June 2026

GEM Awards 2025 - Green Champion

Our Facilities Management team was named Green Champion in the 2025 GEM Awards for its ongoing efforts to drive sustainability across our services.

This included:

- Replacing more than 5000 light fittings to more energy efficient LED lights.
- Identifying and replacing damaged lagging to prevent heat losses from pipework.
- Upgrading five old gas-fired hot water units to electric hot water systems.
- Adjusting the schedules of HVAC systems in non-clinical buildings to save 30 running hours a month.
- Increasing flexibility for staff to work from home and utilise Teams for meetings, which prevented more than 500 trips.



Delivering on our Strategic Plan:

Embracing innovation and research

Researchers across NMHS continue to lead innovation and clinical advances that are helping to shape global knowledge and best practice in clinical, surgical, allied health, mental health, and infant and maternal health fields.

Capability building was a priority for NMHS' Innovation team throughout 2025-26, with supports, resources and training developed to empower all staff.

The NMHS Research and Innovation Strategy 2026-2030 was launched in March 2026, which sets the direction for strengthening research excellence and translating innovation to support outcomes for patients and the community.

It was shaped by contributions of more than 200 NMHS staff, consumers and industry partners, and aligns with system-wide directions, including the WA Health and Medical Research Strategy 2023–2033 and the Future Health Research and Innovation Fund (FHRI) Strategy 2025–2030.

The strategy outlines actions to strengthen and leverage the organisation's research and innovation capability, with activity guided by six strategic priorities:

- strong governance, infrastructure and systems
- growing workforce capability and capacity
- enduring partnerships and collaboration networks
- optimised data, digital and technological capabilities
- inspiring connection and engagement
- accelerated translation and impact

Together, these priorities provide a framework to strengthen research capability, support collaboration and ensure that innovation leads to real impact.

The direction and ambition of this strategy was informed by robust stakeholder consultation, aligned with operational needs, and supported by system-wide perspectives.

The strategy sets out our ambition and intent to be a world-class research and innovation ecosystem that drives exceptional patient outcomes and delivers measurable value to the health system.



Embracing innovation and research

NMHS Nursing and Midwifery Advisory Council (NMAC) Innovation Series 2025

The NMAC Innovation Series 2025 aimed to build innovation capability among selected nurses and midwives through five hands-on workshops and real-world practice, using human centred design tools to foster innovation, advance leadership and support collaborative problem solving.

The workshop series centred around one NMAC endorsed challenge statement, "How might we reimagine support for nursing and midwifery staff through a centralised virtual 24/7 hub that advances workforce and digital goals?" The focus was on learning and applying innovation methodologies rather than delivering finalised products.

Teams developed four prototypes that demonstrated potential to enhance efficiency, engagement, and workforce support for nurses and midwives across NMHS.

The workshop package was handed back to NMAC for strategic consideration, providing a clear foundation for decisions on future prioritisation and prototype progression.

Through the experience, participants increased their creative problem-solving capability and confidence in applying design thinking methodology, while cross-site collaboration led to diverse, scalable prototype concepts.

The initiative laid a foundation for NMAC to drive future innovation within the nursing and midwifery workforce focusing on the benefits of collaborative problem-solving.

1. **MaTES – Mentoring and Training for Essential Skills:** A centralised platform to manage mandatory training compliance, supporting capability gaps and skills learning.
2. **Clinical Virtual Support Partner:** An AI-powered agent providing rapid access to clinical information at the point of care.
3. **HELP – Health Escalation and Learning Platform:** A nurse-led, AI-supported platform for clinical escalation and information sharing. Reduce time taken to search for information, redirecting back to patient care.
4. **Clinical Communication Platform:** A role-based mobile communication platform replacing outdated technologies. It improves connectivity and coordination among staff through a unified, accessible interface.



Embracing innovation and research

Endometriosis Gynaecology Model of Care service optimisation

Under the Innovative Improvement Program, the Innovation team partnered with the Endometriosis Gynaecology (EndoGynae) service to identify opportunities to improve patient flow, access, and patient experience across the service pathway. Through facilitated patient journey mapping and a collaborative hackathon process, clinicians explored key pain points and improvement opportunities, while also considering consumer perspectives and experiences throughout the pathway.

The work highlighted challenges relating to long wait times, fragmented care pathways, increasing demand and service capacity pressures, administrative inefficiencies impacting clinician time, and difficulties transitioning appropriate patients to primary care. The project also supported capability building within the service through the application of human-centred design and collaborative improvement methodologies.

Innovative Future Program

In February 2026, the team launched a crowdsourcing campaign to look at ideas for how we could change the way we work. The campaign received 82 applications from staff across sites and services, with more than half proposing adoption of digital solutions and/or workflow improvements.



My Emergency Visit - Phase 2 Development and Deployment

A six-month pilot of phase 2 of the My Emergency Visit (MEV) application started in March 2026. MEV is an innovative solution aimed at enhancing patient management, communication, and care while waiting in ED.

The idea was first pitched by a SCGH Emergency Physician at the 2021 NMHS Innovation Shark Tank event. Now with additional funding, including a Future Health Research and Innovation (FHRI) grant, the MEV application acts as a digital front door, alongside a clinical portal and tracking dashboard that provides clinicians with earlier and improved visibility of waiting room patient information. This includes a digital observation chart supporting early identification of deterioration.

In 2025-26, NMHS collaborated with Health Support Services (HSS) and vendors to develop, integrate with legacy health applications, and deploy phase 2, an enhanced version of the application that could meet the clinical needs of the Emergency Department front of house, including triage and managing expected patients.

2025 WA Health Innovation Showcase

NMHS participated in the third annual WA Health Innovation Showcase in October 2025, with the theme, Problems worth solving: Challenge-led innovation in the WA health system.

This year's event was hosted by EMHS and facilitated in collaboration with other HSPs, including NMHS.

As day one of the 'WA Health Festival of Innovation and Improvement', the showcase highlighted innovation activity happening across WA Health.

NMHS led participants through a journey mapping session, alongside short and long form innovation and pitch presentations.

Embracing innovation and research

Innovation grants dispersed from NMHS IF seed funding

Lead name	Activity title	Program	Activity/ Project Description
Carolyn Bright	What IF Campaign 2026 – Quick Win – Using Virtual Reality for Pain Diversion in Women's Health Care	Innovative Future (IF) Program	This project focused on improving the experience of women undergoing intimate medical procedures who have a history of trauma, procedural anxiety, or needle phobia, and who may experience significant distress that can lead to delayed or avoided care.
Christine Campbell	What IF Campaign 2026 – Quick Win – Digital Peak Flow Monitoring to Support Asthma Diagnosis	Innovative Future (IF) Program	This project addressed limitations in current asthma diagnostic pathways, which rely on resource-intensive testing and low adherence to manual peak flow monitoring. The initiative is exploring the use of TGA approved digital peak flow monitors, enabling patients to record lung function at home and generate reliable digital reports.
Rhian Tamim	What IF Campaign 2026 – Quick Win - Joy Menu for Older Adults	Innovative Future (IF) Program	This project focused on improving the hospital experience for older adult inpatients (65+), particularly those with cognitive impairment, who can experience hospital as disorienting, isolating, and stressful - often leading to distress, disengagement from care, and increased reliance on staff.
Barbara Voight	What IF Campaign 2026 – Quick Win – Strengthening our End of Life care	Innovative Future (IF) Program	This project addressed challenges faced by generalist nursing staff in recognising and managing patients entering the terminal phase, which can lead to distressing experiences for patients, families, and staff.
Krishnan Karthigasu	Endometriosis Gynaecology Model of Care	Innovative Improvement Program	This project focused on optimising the Endometriosis Gynaecology (EndoGynae) model of care to address increasing demand, service complexity, and challenges impacting patient experience and service efficiency.



Embracing innovation and research

NMHS research achievements

Our thriving, world-class research program had 759 active research projects underway in 2025-26, and our researchers achieved more than 748 peer reviewed publications.

The program demonstrated sustained growth in scale, funding and international standing. From biobanking and genomics to allied health efficiency studies, the work is translating directly into improved diagnosis, treatment and patient experience - reinforcing our reputation as a leader in health research. This included new and groundbreaking treatment approaches that support our patients, our systems and our processes. Some of these projects are described in more detail below.

The team achieved a major governance milestone in February 2026, gaining accreditation against the National Clinical Trial Governance Framework with a mean maturity score of 3.0 (Established Systems).

NMHS received $848,740 through the WA Government's Office of Medical Research and Innovation's Research Infrastructure Support (RIS) program for 2025, which is the highest amount awarded to any health service provider. It will support research facilities, equipment and services, along with expanded staffing across the library, research governance offices, clinical trial coordination, research navigation and grants coordination. A further $771,700 was secured for 2026. The Clinical Trials WA Coordination Program has also funded three years of dedicated clinical trial coordinator and clinical nurse roles to help smaller departments build industry-sponsored trial capacity.

Research culture was showcased at the September 2025 Research Expo, themed ‘Research is in our DNA’ and featured new investigator presentations, expert panels and 56 poster submissions spanning SCGH and OPH.

The Centre for Nursing Research supported four projects this year, including studies on cancer patients' perspectives on clinical trials, research priorities for early breast cancer survivors, family-centred care in emergency settings, and a baseline assessment of AI literacy among nurses and midwives across NMHS.



Embracing innovation and research

In hepatology, the Liver Disease Biobank, led by Professors Leon Adams and Michael Wallace, produced validated tools for predicting liver-related death, decompensation and hepatocellular carcinoma risk, alongside trials of new treatments for non-alcoholic steatohepatitis. The immunology team, under Clinical Professor Michaela Lucas, is advancing understanding of drug allergies, hypersensitivity and transplant immune responses, with Professor Lucas also gaining media attention for research into plastic exposure reduction.

The Australian Inherited Retinal Disease Registry and DNA biobank remains the largest resource of its kind, supporting clinicians, researchers and pharmaceutical developers nationally and internationally. Medical Technology and Physics is exploring theranostic applications for mesothelioma and pancreatic cancer imaging and treatment, while the endocrinology team contributed to an international genomic study identifying new genetic regions linked to PCOS.

Nuclear Medicine is establishing Australian reference ranges for Parkinson's disease imaging and contributing to national trials across cardiovascular, prostate, thyroid and brain cancer. The Heart and Vascular Research Institute leads the Australian arm of the global LEADERPAD trial and has launched SCGH's first pulmonary embolism response team, alongside research into venous leg ulcers and frailty in diabetic foot ulcer patients.

Allied health research delivered tangible efficiency and quality-of-life gains. Occupational Therapy studies showed reduced hospital stays and readmissions through early intervention for frail older adults, head and neck cancer and hand therapy patients, while new screening tools promise to cut cognitive assessment time by up to 50 minutes per patient. Physiotherapy is generating feasibility and safety data across stem cell transplant, ICU, brain tumour and spinal surgery cohorts, and dietetics has introduced indirect calorimetry to improve nutritional care in critically ill patients, reducing complications and length of stay.

Pharmacy research at OPH is examining genetic variation in antiplatelet response among Aboriginal patients to enable more personalised prescribing.

Oncology research remains a major pillar. Medical Oncology's trials spanned thyroid, skin, lung and genitourinary cancers, including a landmark Phase 3 result showing cemiplimab significantly reduced recurrence in high-risk cutaneous squamous cell carcinoma. Haematology teams contributed to breakthroughs in targeted therapies for lymphoma, CLL, myeloma and leukaemia, and helped shape the 2026 CLL consensus statement. Radiation Oncology is combining clinical trials with AI-driven workflow innovation and international registry contributions for rare tumours and renal cell carcinoma.

The SCGOPHCG Library provided support throughout the year, including literature searching, research assistance, and the coordination and provision of staff publication information for reporting purposes with minimal staffing.

“From biobanking and genomics to allied health efficiency studies, our research work is translating directly into improved diagnosis, treatment and patient experience - reinforcing our reputation as a leader in health research.”

Embracing innovation and research

Research at KEMH

The Women and Infants Research Foundation (WIRF) announced $260,000 in funding in September 2025 to support research projects aimed at improving the health of women, babies, and families.

The funding, awarded through WIRF's Research Acceleration Awards and the Tony McCartney Gynaecologic Oncology Special Grant, supports five innovative projects being undertaken at KEMH, spanning ovarian cancer, chemotherapy-related side effects, childbirth trauma, rare diseases, and neonatal health.

A WIRF Research Acceleration Award, valued at $45,000, was presented to Dr Kelli MacMillan, a clinical psychologist at KEMH and senior lecturer at Murdoch University, for her project, Screening for childbirth related post-traumatic stress disorder at an Australian women's tertiary hospital.

This first-of-its-kind Australian study aims to improve perinatal service delivery, maternal mental health, and infant outcomes.

A Tony McCartney Gynaecologic Oncology Special Seed Grant, valued at $25,000, was awarded to Natalie Williams, a nurse researcher in gynaecology at KEMH, for her project, The CIPNEX Study: A Hand-Foot Exercise Intervention for Chemotherapy-Induced Peripheral Neuropathy in Gynaecologic Oncology.

Dr Gayatri Jape, a neonatal paediatrician at KEMH, was awarded funding for her project, Implementation of a clinical risk score for predicting the risk of necrotising enterocolitis in preterm infants.



QEII health and biomedical precinct

The WA Government is investing $1.9 million towards advancing a Health and Biomedical Precinct at the QEII Medical Centre.

The precinct is an industry-changing development, driving excellence and supporting collaboration between hospital service providers, universities, and health and medical researchers.

NMHS Chief Executive Robert Toms is a member of the Queen Elizabeth II Precinct Leadership Group (PLG), who joins other representatives from NMHS at working group meetings.

Embracing innovation and research

Mental health research

Mental health research predominantly focuses on non-commercial, non-clinical activities through the Clinical Research Centre (CRC), Centre for Clinical Interventions (CCI) and Neurosciences Unit (NSU).

In 2025-26, the CRC focused on mental health accessibility and workforce supply analysis; youth hospitalisation, community services and transition supports; system planning and pathway development; training; and data-driven decision support. Its work has delivered policy-relevant research, evaluation and analytics to support service improvement and evidence-informed decision-making across mental health services. The team have established a collaborative partnership with the Office of the Chief Psychiatrist to align youth linked-data activity, reduce duplication, and support system-level decision-making.

The NSU focused on improving service accessibility for regional, rural, and remote, and mobility limited individuals, and diagnostic processes for people living with complex neuropsychiatric presentations.



Highlights included:

- Ongoing implementation of the NSU-led Far North Huntington's mobile clinic.
- Contribution to the development of new national Fetal Alcohol Spectrum Disorder Assessment and Diagnostic Guidelines in collaboration with specialist services and stakeholders around Australia.
- Delivery of online memory skills workshop for people with early diagnoses of young-onset dementia. NSU supports clinical neuropsychology intervention via telehealth increasing access to mild cognitive impairment and dementia treatment and care for people living outside of the metropolitan area or those who have limited mobility.
- Assessment and evaluation of the first neurocognitive profiles of a family affected by the rare genetic disorder, Diets-Jongmans syndrome.
- Evaluation of education and upskilling of allied health workers and caregivers of people living with young onset neurodegenerative disorders, as a quality improvement initiative.

The CCI conducts applied research into depression, bipolar disorder, anxiety disorders and eating disorders. In 2025-26, CCI had approximately 40 research projects underway and achieved 23 peer-reviewed publications. Its research publications were cited more than 3,000 times and the team delivered 14 conference presentations. Two Curtin University PhD students undertook internships with the service for the first time.

Embracing innovation and research

Active research projects across NMHS

There are 759 research projects underway across NMHS sites. Cancer, imaging and clinical services account for the largest share of research activity, while allied health research is the primary focus at OPH.

The table below summarises active research across NMHS sites by sponsor and project type.

Active research across NMHS sites by sponsor and project type

Commercially sponsored research	MHSDHS	PH&CE	SCGOPHCG	WNHS	Total
Clinical trials	0	0	104	0	104
Non-clinical trials	0	0	10	0	10
Commercial subtotal	**0**	**0**	**114**	**0**	**114**

Non-commercially sponsored research	MHSDHS	PH&CE	SCGOPHCG	WNHS	Total
Clinical trials	0	1	116	23	140
Non-clinical trials	60	6	325	114	505
Non-commercial subtotal	60	7	441	137	645

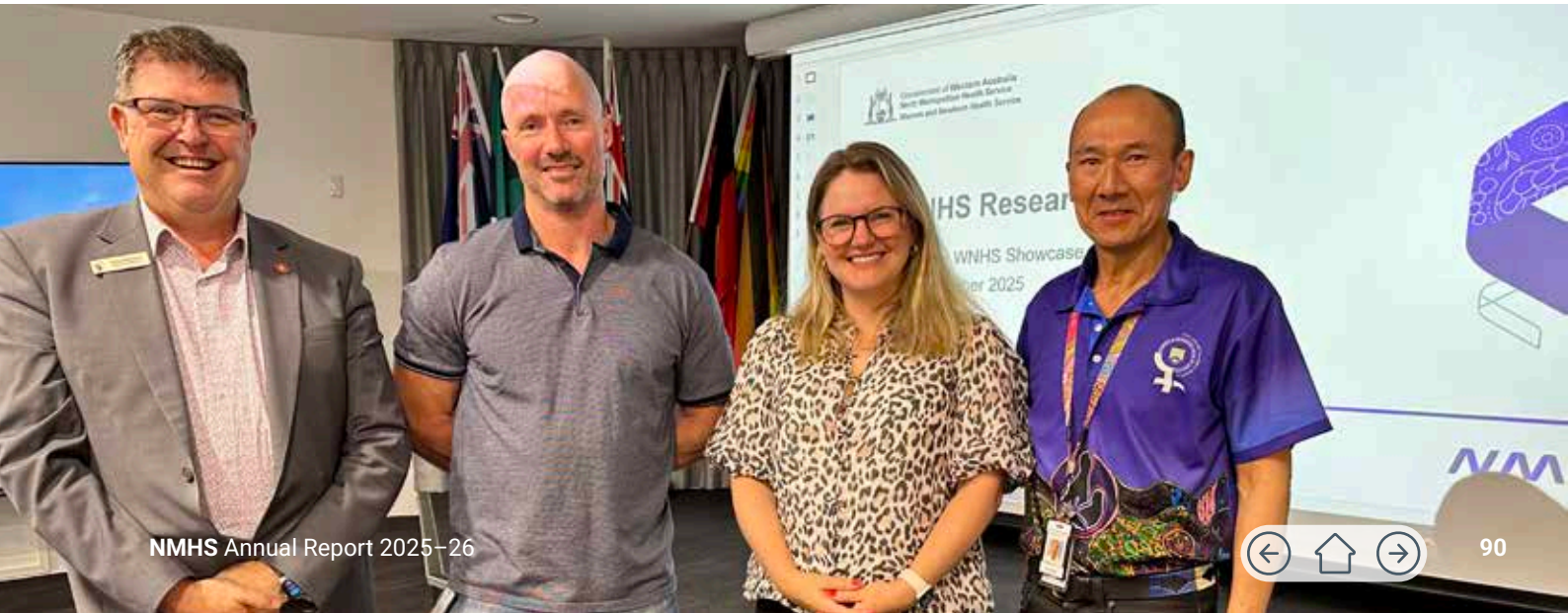
Total	60	7	555	137	759

In 2025-26, newly authorised research projects across all NMHS sites were expected to recruit 4,884 participants over the lifetime of those projects. This includes participants from across mental health and dental health services, public health services, women and newborn services and SCGOPHCG sites.

Over the past four financial years, the performance of NMHS's research governance offices has improved consistently. Research governance services across NMHS are delivered by the SCGOPHCG and WNHS Research Governance Offices, both of which achieved substantial improvements during this period.

Across NMHS, the average time from submission to site authorisation improved by almost 60 per cent, reducing from 183 days in the 2022-23 to 77 days in the 2025-26. The average time for Research Governance Review also improved by 43.1 per cent, reducing from 58 days to 25 days, enabling research projects to commence sooner.

At the service level, SCGOPHCG reduced its average site authorisation time by 58 per cent, from 184 days to 78 days, while WNHS reduced its average site authorisation time by 50 per cent, from 125 days to 62 days. These improvements are attributable to the introduction of the Research Navigation Service at SCGOPHCG, the KEMH Research Hub and ongoing refinements to research governance processes.



Embracing innovation and research

Active research projects across NMHS (continued)

Governance service	Improvement since 2022-23	2025-26 FY Average Site Authorisation Timelines
NMHS (overall)	58% reduction	77 days
SCGOPHCG	58% reduction	78 days
WNHS	50% reduction	62 days

Building on these improvements, the SCGOPHCG Research Governance Office assumed responsibility for research governance services for MHSDHS and PH&CE in June 2024. Following the transition, the average time from submission to site authorisation improved by 52 per cent, reducing from 150 days to 78 days. Research Governance Office review timelines also reduced substantially, from 81 days to 22 days, while average researcher response times decreased from 69 days to 56 days.

MHSDHS & PH&CE transition	Before	After
Average time from submission to site authorisation	150 days	78 days
Research Governance Office review	81 days	22 days
Researcher response	69 days	56 days

Together, these outcomes demonstrate a stronger, more responsive research governance service across NMHS. The sustained improvements in governance performance, combined with the successful transition of additional services, enabled earlier commencement of research and improved access to research opportunities for patients.



Embracing innovation and research

Research and innovation grants

Lead name	Activity title	Program
Ms Louise Cleary	Feasibility of using telepractice to remotely conduct Videofluoroscopic Swallowing Studies (TeleVFSS) to support regional dysphagia management in Western Australia	Charlies Foundation: BrightIdeas Grant
Ms Yee Ching Wong	To assess the feasibility of a two-week intensive inpatient upper limb telerehabilitation program for stroke survivors in a Western Australian hospital	Charlies Foundation: Bright Ideas Grant
Ms Lisa Cowcher	An economic evaluation of an early emergency department allied health frailty service	Charlies Foundation: Bright Ideas Grant
Ms Gabriella La Macchia	Exploring the Implementation Feasibility of an Integrated Radiation Oncology Real World Data Clinical Quality Registry using Automated Processing	Charlies Foundation: Bright Ideas Grant
Dr Tenny Sunny	Top Ten Research Priorities in Breast Cancer Medical Oncology	Charlies Foundation: Bright Ideas Grant
Ms Anneliese McNeil	Turning Insight into Impact: Social Workers and Elder Abuse Response	Charlies Foundation: Bright Ideas Grant
Dr Nathaniel Barry	Identifying impediments to accessing metropolitan cancer services for rural and remote Western Australians	Charlies Foundation: Bright Ideas Grant
Ms Emily Purcell	Improving emergency department (ED) care for women under 50 with family and domestic violence (FDV) related head and facial injuries: A retrospective audit of assessment, treatment and referral practices	Charlies Foundation: Bright Ideas Grant
Ms Clara Leong	Acceptability of a tailored activity task box intervention for patients with behavioural symptoms in hospital.	Charlies Foundation: Bright Ideas Grant
Mrs Janelle Betts	Implementing occupational therapy in intensive care: A mixed methods study	Charlies Foundation: Bright Ideas Grant
Dr Meg Henze	Introducing a multidisciplinary Diabetes Technology Clinic at Sir Charles Gairdner Hospital	Charlies Foundation: Bright Ideas Grant
Dr Richard O'Halloran	Hepatocellular carcinoma diagnosis in Western Australia: a multi-centre retrospective cohort study	Charlies Foundation: Bright Ideas Grant
Ms Tessa Davies	Developing a Pilot Multidisciplinary Functional Neurological Disorder Clinic	Charlies Foundation: Bright Ideas Grant
Dr Aron Chakera	Next-Generation Cardiovascular Risk Prediction from Routinely Collected Data	Charlies Foundation: Ray Florence Shaw
Brendan Luu	Utilising Human Donor Eyes to Histologically Characterise the Influence of Solid Organ Cancers on the Retinal Vasculature	Charlies Foundation: Ray Florence Shaw
Prof Gary Lee	The evaporate multi-center randomized clinical trial: Placing one-way valves in the lungs to help patients with collapsed lungs	Charlies Foundation: Discovery Grant + Peter Thompson
Prof Wai Lim	Health and transplant outcomes of people living with a kidney transplant and advanced cancer	Charlies Foundation: Discovery Grant
Ms Jo Beer	Keeping Your New Kidney Healthy: Understanding Body and Blood Sugar Changes following kidney transplantation	Charlies Foundation: Discovery Grant
Dr Broska Zeynel	Clear Vision, Clean Future: Measuring the Carbon Cost of Eye Procedures at SCGH	Charlies Foundation: Discovery Grant

Embracing innovation and research

Research and innovation grants (continued)

Lead name	Activity title	Program
Dr Dhaval Thakkar	Comparing two navigation techniques to guide flexible scopes to access small, remote lung nodules suspicious of cancer	Charlies Foundation: Discovery Grant
Prof Antonio Celenza	Improving understanding and treatment of sepsis with an innovative laboratory-based human model	Charlies Foundation: Discovery Grant
A/Prof Kathy Zhu	How do co-existing clinical risk factors impact the rate of bone loss?	Charlies Foundation: Discovery Grant
Dr Jan Ho	Developing a research program with stroke survivors and healthcare workers to collect and store clinical information, blood and saliva for a WA stroke study with follow up to 5 years	Charlies Foundation: Discovery Grant
Prof Scott Wilson	Finding the regulatory elements in DNA that control bone-resorbing cells and increase the risk of fragility fractures	Charlies Foundation: Discovery Grant
Clin Prof John Walsh	Testing how individual differences in DNA sequence affect thyroid function and disease	Charlies Foundation: Discovery Grant
Clin Prof Michaela Lucas	Can a simple skin tape test help diagnose and monitor Drug Reactions with Eosinophilia and Systemic Symptoms?	Charlies Foundation: Discovery Grant
Dr Lipi Mishra	Brain wave monitoring to give early warning of dangerous vessel spasm and stroke risk after a brain bleed	Charlies Foundation: Discovery Grant
Prof Leon Adams	Can aspirin reduce the risk of hepatocellular carcinoma (HCC) in subjects with cirrhosis: a multicentre, placebo controlled clinical trial.	NHMRC
Prof Leon Adams	BOD-POD GS-X: An innovative approach to body composition measurements to accommodate a diverse population	UWA
Clin Assoc Prof Michael Wallace	WA's Liver Cancer Collaborative	Cancer Research Trust
Clin Prof Michaela Lucas	Identifying common features of the alloresponse to solid organ transplantation using cell surface proteomics	NHMRC
Clin Prof Michaela Lucas	Assessing safety of OM85 treatment in a mouse model of mismatched bone marrow transplant	WA Child Research Fund
Clin Prof Michaela Lucas	Devising a novel stop and kill strategy to promote transplant tolerance	Raine Priming Grant
Clin Prof Michaela Lucas	Identifying proteins involved in the immune response to transplanted organs	UWA
Clin Prof Michaela Lucas	Plastic Exposure Reduction Transforms Health	Minderoo Foundation
Ms Toni Heinemann	Assessing the feasibility, acceptability and perceived utility of Artificial Intelligence (AI) enabled peer-support interventions for stroke survivors and carers during stroke rehabilitation	FHRI
Ms Brooke Russell	Transforming outpatient cancer care: Assessing the need and feasibility of an advanced practice occupational therapy role in outpatient oncology	Chief Allied health Office

Embracing innovation and research

Research and innovation grants (continued)

Lead name	Activity title	Program
Prof Scott Wilson	Revolutionising discovery and characterisation of genomic elements underlying osteoporosis	NHMRC
A/Prof Julianna Hamzah	LipoPurge, a new frontier in pancreatic cancer treatment	Cancer Council
Dr Sophie Zhao	Researcher Training Programme	FHRI
Prof Shirley Jansen	Leaky legs – Leg Edema Assessment and Knowledge and Gait study	NMHRC
Prof Girish Dwivedi	Healthy Ready program	FHRI
A/Pro Julianna Hamzah & Prof Shirley Jansen	Establishing GMP production of biologic therapeutic for treating patients with atherosclerotic cardiovascular disease	FHRI
Prof Shirley Jansen	LeaderPad global trial: Low dose Colchicine in Patients with Peripheral Artery Disease to Address Residual Vascular Risk	MRFF
Dr Jamie Bellinge	Multimodality imaging of the sympathetic nervous system for cardiovascular disease risk assessment	Royal Perth Hospital Research Foundation
Dr Carolyn Grove	Targeting stem cells in myeloproliferative neoplasms to prevent disease progression	2025 MRFF Stem Cell Therapies
Dr Hetal Dholaria	Bridging the Gap: Advancing Brain Tumour Research and Diagnostic Services for Adolescents and Young Adults in Western Australia	Cancer Council
Dr Louisa Lo	The FERTILE Study: Evaluating ovarian toxicity outcomes following immunotherapy in patients with Triple-Negative Breast Cancer (TNBC)	MRFF
Adjunct Prof Matrin Ebert	SMART: Streamlining GlioblastoMA Radiation Therapy	National Critical Research Infrastructure – Innovative Trials
Dr Marli Smit	Myocardial protective effect of pre-operative melatonin following CABG surgery: A randomized controlled trial	ANZCA
Dr Smitha Bhaduri	Artificial Intelligence–Supported Biopsychosocial Phenotyping for Targeted Interventions in Severe Mental Illness	The Hospital Research Foundation (THRF) Group- FHRI
Dr Nasir Uddin	Pilot Implementation of Multidisciplinary Antipsychotic Stewardship Team for Evidence-based Regiments of Schizophrenia Treatment (MASTERS)	HCF- translational research grants- EOI submitted
Dr Somy Azimi	Impact of integrated youth mental health care models on crisis pathways and outcomes in Western Australia	Raine Priming Grants- EOI submitted
Mrs Kirsty Snelgrove	Mindful Medicine Masters	NMHS IF Campaign- EOI submitted
Dr Nasir Uddin	Transforming Youth Mental Health Care Pathways in Western Australia Using Linked Data	HCF- Health Service research grants- EOI submitted
Dr Somy Azimi	Implementing a Measurement Enabled Specialised Community Mental Health Model: A Longitudinal Evaluation of Integrated Outcomes in Severe Mental Illness	HCF- Health Service research grants- EOI submitted
NMHS	Clinical Research Centre research activities: 2023-2025	Research Infrastructure Support (RIS) Program-FHRI- submitted

Embracing innovation and research

Research and innovation grants (continued)

Lead name	Activity title	Program
Melanie Clark	Enhancing the utility of a remote specialist multidisciplinary clinic for Aboriginal people living with Huntington's disease in far north Western Australia	Cook State Government Innovation Fund Trache 2 & Huntington's Australia
Peter McEvoy	Crisis to calm: delivering a co-designed mental health intervention for young people in Western Australia	Healthway Intervention Research Grant
Peter McEvoy	Development of Low Intensity Psychological Interventions for mental health in primary care	West Australian Public Health Alliance
Peter McEvoy	Emotional labour in healthcare: A targeted intervention for burnout management	East Metropolitan Health Service Nursing and Allied Health Grants
Peter McEvoy	Developing guidelines for safe, ethical practice for eating disorder clinicians with lived experience	Australian Eating Disorders Research and Translation Centre Seed Grant

Neurology research

A $100,000 grant was awarded to SCGH Consultant Neurologist Dr Wai Yan (Wayne) Yau for his research on genetic causes of dystonia in Australian families.

The grant was awarded under the 2025-26 WA Government's FHRI Near Miss Awards: Emerging Leaders Program.

Dystonia is a severely disabling neurological movement disorder that causes muscle spasms that can lead to abnormal posture, involuntary movements, pain and significant physical disability.

"More than 80 genes are associated with this disorder, but fewer than 25 per cent of individuals with primary dystonia receive a genetic diagnosis," Dr Yau said.

"A genetic diagnosis provides patients and their families with crucial information about their disease to inform prognosis, family planning and potential for pre-gestational diagnosis.

"Improved understanding of underlying dystonia mechanisms will enable clinical teams to deliver personalised therapies, such as deep brain stimulation, and will also assist in developing curative treatments.

"We will also investigate the effect of genetic diagnosis on deep brain stimulation surgery outcomes in dystonic cerebral palsy, and



evaluate gene therapy for families with inherited forms of dystonia."

Collaborators in this study include Professor Gina Ravenscroft (Harry Perkins Institute), Dr Mark Davis (PathWest), and Professor Phillipa Lamont (Royal Perth Hospital).

The FHRI WA Near Miss Awards: Emerging Leaders Program is designed to support researchers who have narrowly missed out on securing a highly competitive National Health and Medical Research Council (NHMRC) Investigator Grant.

The 2025-26 round received a record high number of applications by early and mid-career researchers seeking the opportunity to increase the chances of success with a future application to the NHMRC.

Embracing innovation and research

Research partnerships

Our researchers are affiliated with many specialist research partners, who we thank for their ongoing support. Some of these partners include:

- Busselton Population Medical Research Institute
- Centre for Neonatal Research and Education
- Centre for Nursing Research
- Charlies Foundation for Research
- Curtin University Department of Nursing and Midwifery Research
- Curtin University Curtin School of Population Health and Centre for Clinical Research and Education
- Curtin University School of Allied Health
- Edith Cowan University
- Exposure Therapy Consortium (International)
- Genetic Services of Western Australia
- Harry Perkins Institute of Medical Research
- Institute for Respiratory Health
- Keogh Institute for Medical Research
- Linea Research
- Lions Eye Institute
- Murdoch University
- National Institutes of Health
- NHMRC
- Office of Chief Psychiatrist-WA
- PathWest
- Perron Institute for Neurological and Translational Science
- Perth Children's Hospital
- Population Health
- Queen Elizabeth II Medical Centre
- The Hospital Research Foundation
- The Kids Research Institute of Australia
- The University of New England
- The University of Otago
- The University of Western Australia
- The Whole Nine Months – WA Preterm Birth Prevention Initiative
- University of Toronto
- Western Australian Cancer Prevention Program
- Western Australia Country Health Service
- Western Australian Health Translation Network
- Women and Infants Research Foundation



Safety and Quality

Safety and Quality

Our well-established safety and quality program focused on monitoring and responding to clinical risk, improving patient outcomes, and ensuring compliance with legislative and regulatory requirements. Dedicated Safety, Quality and Performance teams within each health service are responsible for supporting organisational compliance with the National Safety and Quality Health Service Standards (NSQHS Standards).

These teams facilitate the implementation and evaluation of service-wide systems for clinical incident management, quality improvement, consumer engagement, and evidence-based clinical governance. At a HSP level, the Safety, Quality and Consumer Experience team works collaboratively with the Clinical Excellence Unit to support clinical governance, accreditation preparedness, policy governance, clinical risk management, and enhanced consumer engagement across NMHS.

A significant achievement during the reporting period was the implementation of the revised NMHS Clinical Governance Framework in early 2026. The framework strengthens partnerships across the organisation to support the delivery of safe, high-quality and effective care, build capability for continuous improvement, and enhance accountability and transparency for consumers and stakeholders. Another key highlight was the successful accreditation of the SCGOPHCG against the NSQHS Standards in February 2026. This achievement provides assurance to consumers, staff and the community that robust safety and quality systems are in place and that NMHS continues to deliver care that meets nationally recognised standards for safety and quality.



Safety and Quality

NMHS Non SAC1 Incidents

	To 30/06/2025*	To 30/06/2026**
SAC 2	710	856
SAC 3	8522	9272
Unconfirmed – no SAC assigned yet	406	295

*2025 figures previously published; **2025-26 figures as at 27/07/26

Improving systems to deliver the best care possible

Providing safe, high-quality care remains a core priority for NMHS. While healthcare is delivered in complex and dynamic environments, NMHS is committed to identifying risks, learning from adverse events and strengthening systems that support patient safety.

Clinical incident reporting and review processes play a critical role in understanding where care delivery can be improved. Information gathered through incident investigations contributes to organisational learning, helping to identify underlying system issues, reinforce effective practices and implement sustainable improvements across services. This approach supports a culture in which staff are encouraged to raise concerns, report incidents and participate in quality improvement activities.

A key focus for NMHS is ensuring that patients, families and carers are treated with respect, honesty and compassion when an adverse event occurs. Meaningful engagement with those affected helps to support understanding of what happened, informs improvement efforts and reinforces NMHS's commitment to safe and patient-centred care.

The contribution of consumers to patient safety continues to grow across the organisation. By incorporating consumer perspectives into review and improvement activities, NMHS gains a broader understanding of the impact of healthcare incidents and opportunities to enhance service delivery. NMHS continued to expand mechanisms for consumer participation in safety and quality processes, supporting more inclusive and informed decision-making by expanding the involvement of Consumer Carer Representatives in clinical incident investigations, and recruiting additional Consumer Carer Representatives to executive-level committees, enhancing consumer involvement in strategic decision-making.

Clinical incidents are assessed according to established severity criteria to ensure that reviews are proportionate to the level of actual or potential harm. The highest classification, Severity Assessment Code 1 (SAC1), applies to incidents that have resulted in, or had the potential to result in, serious harm or death.

During 2025-26, NMHS recorded 129 SAC1 clinical incidents. Of these, 102 investigations have been completed, with 12 subsequently approved for declassification by the Department of Health following determination that factors related to healthcare delivery did not contribute to the final patient outcome. Each SAC1 incident is subject to detailed review and oversight to ensure lessons are identified, recommendations are implemented and opportunities for system-wide improvement are realised.

Through robust governance, continuous learning and a commitment to openness and improvement, NMHS continues to strengthen patient safety and quality of care across all services.

There were 27 SAC1 incident reviews still in progress at the end of this reporting period. Of the 117 SAC1 investigations that were completed or remain in progress, the patient outcome* was noted as:

No harm:	5
Minor harm:	3
Moderate harm:	14
Serious harm:	78
Death:	17

*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.

SAC1 Clinical Incidents (excluding declassified incidents)

	2024-25	2025-26
SAC 1 total	105	117
Death	21	17
Serious harm	69	78
Moderate harm	5	14
Minor harm	3	3
No harm	7	5



Key Performance Indicators

Certification of
Key Performance Indicators

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

Certification of Key Performance Indicators for the year ended 30 June 2026

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 2026.

Adj Assoc Prof Karen Gullick
Board Chair
North Metropolitan Health Service
17 September 2026

Renae Farmer
Board Finance Committee Chair
North Metropolitan Health Service
17 September 2026

North Metropolitan Health Service I Queen Elizabeth II Medical Centre I 2 Verdun St Nedlands WA 6009

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:

Changes to OBM framework

The OBM framework was implemented for annual reporting from 2017/18. There were no material changes to the framework in 2025/26.

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.

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

Detailed information in support of

Key Performance Indicators

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 2025 calendar year.

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

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

Rationale

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

This performance indicator measures the percentage of patients being assessed and treated within the required ATS timeframes. This provides an overall indication of the effectiveness of WA's Emergency Departments which can assist in driving improvements in patient access to emergency care.

Target

The 2025/26 targets for ED patients seen within recommended times by triage category as per the Australasian College for Emergency Medicine are as follows:

Triage category	Description	Treatment acuity (minutes)	Target (%)
1	Immediate life-threatening	Immediate (≤ 2)	100
2	Imminently life-threatening or important time-critical treatment or very severe pain	≤ 10	≥ 80
3	Potentially life-threatening or situational urgency or humane practice mandates the relief of severe discomfort or distress	≤ 30	≥ 75
4	Potentially serious or situational urgency or significant complexity or severity or humane practice mandates the relief of discomfort or distress	≤ 60	≥ 70
5	Less urgent or clinico-administrative problems	≤ 120	≥ 70

Performance is achieved by a result above, or equal to, the target.

Results

In 2025/26, the percentage of ED patients seen within recommended times for triage category 1 was equal to target and all other triage categories were below target (Table 1).

Compared to 2024/25, ED presentations have increased, particularly Category 1 where it has increased by 18 per cent.

The NMHS Hospital Emergency Access Response Team (HEART) program continues to support NMHS sites in implementing and delivering initiatives to address demand and improve capacity. The progress of the HEART program is routinely monitored and reported on.

* 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

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

Table 1: Percentage of emergency department patients seen within recommended times, by triage category, 2021/22–2025/26

	Financial year					
	2021/22	2022/23	2023/24	2024/25	2025/26	Target
Triage category	(%)	(%)	(%)	(%)	(%)	(%)
1	100	100	100	100	100	100
2	72	71	73	72	68	≥ 80
3	28	26	27	22	21	≥ 75
4	41	38	39	35	35	≥ 70
5	76	72	71	62	63	≥ 70

Data sources: Emergency Department Data Collection.

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[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)[3].

Target

Please see the 2025 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 average statewide results achieved within the previous five calendar years, excluding the most recent calendar year.

Results

In 2025, the rate of unplanned readmissions within 28 days achieved target for hip replacement, hysterectomy and cataract surgery (Table 2). All other surgical procedure indicators did not meet target. The number of surgical procedures completed can fluctuate, readmission cases for most procedures were small, and can be unrelated to the initial admission and results should be interpreted with caution.

Clinical reviews and investigations have been completed for readmissions and no trends or systemic issues have been identified. If any trends are identified, processes and or working groups may be established to address or rectify any issues.

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/summary

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

3 https://meteor.aihw.gov.au/content/index.phtml/itemId/742756

Unplanned hospital readmissions for patients within 28 days for selected surgical procedures (continued)

Of the 11 knee replacement patients that readmitted, common reasons for admission include infection, swelling and pain.

There were eight readmissions for hip replacement for reasons such as constipation, pain or wound issues.

Of the 29 tonsillectomy and adenoidectomy patients who were readmitted, most had post-operative bleeding and were conservatively managed with medication and monitoring without the need for further intervention. Post-operative bleeds cannot be predicted and occurs 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 26 readmissions which were often related to infection or pain and only required conservative management. Favourable performance has been supported by pre-operative planning, multidisciplinary collaboration and introduction of a program designed to enhance recovery.

There were 14 readmissions for prostatectomy procedures across sites. Surgical procedures were often associated with cancer-related conditions and the most common reason for readmission was due to pain and/or infection and required bladder washout and/or antibiotics.

There were three cataract surgery patients who readmitted and performance has improved compared to the prior year.

Appendicectomy had 30 readmissions that were mostly related to pain or infection and were managed conservatively.

Table 2: Unplanned hospital readmissions for patients within 28 days for selected surgical procedures (per 1000 separations), 2021–25

	Calendar year					
	2021	2022	2023	2024	2025	Target
Surgical procedure	(per 1000)	(per 1000)	(per 1000)	(per 1000)	(per 1000)	(per 1000)
Knee replacement	23.4	20.2	25.8	19.3	21.7	≤ 18.8
Hip replacement	14.2	17.7	8.9	16.0	14.6	≤ 18.3
Tonsillectomy and adenoidectomy	150.0	92.4	120.0	84.9	115.1	≤ 79.2
Hysterectomy	54.6	47.7	48.5	47.2	43.5	≤ 44.1
Prostatectomy	42.8	30.0	33.8	46.1	38.6	≤ 37.5
Cataract surgery	2.1	0.0	3.0	2.9	1.2	≤ 2.2
Appendicectomy	27.3	28.4	30.3	19.8	39.8	≤ 27.8

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

Percentage of elective waitlist patients waiting over boundary for reportable procedures

Rationale

Elective surgery refers to planned surgery that can be booked in advance following specialist assessment, resulting in placement of the patient 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

Target

The 2025/26 target is 0 per cent. Performance is achieved by a result equal to the target.

Percentage of elective waitlist patients waiting over boundary for reportable procedures (continued)

deterioration of the patient's condition and/or quality of life, or even death[4]. 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.

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.

Results

In 2025/26, 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 2021/22, demand for elective surgery has increased for all categories, particularly Category 3 where it has increased by 35 percent.

NMHS have a range of strategies underway to reduce waitlist pressures and improve patient access to address the growing demand. These include using alternative models of care, improving theatre efficiencies, additional theatre sessions, training and recruitment. These strategies and performance continue to be closely monitored.

Table 3: Percentage of elective waitlist patients waiting over boundary for reportable procedures, 2021/22–2025/26

	Financial year					
	2021/22	2022/23	2023/24	2024/25	2025/26	Target
Urgency category	(%)	(%)	(%)	(%)	(%)	(%)
Category 1 over 30 days	15	17	17	17	15	0
Category 2 over 90 days	26	31	29	28	24	0
Category 3 over 365 days	10	20	9	7	8	0

Data source: Elective Services Waitlist Data Collection.

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

Rationale

Staphylococcus aureus bloodstream infection is a serious infection that may be associated with the provision of health care. *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%[5]).

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

4 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.

5 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

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

Target

The 2025 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 2025, HA-SABSI per 10 000 occupied bed-days in public hospitals achieved target (Table 4).

Communication strategies, updated policies and procedures, staff education and surveillance are in place as part of infection prevention and management.

Table 4: Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA SABSI) per 10 000 occupied bed-days, 2021–25

	Calendar year					
	2021 (per 10 000)	2022 (per 10 000)	2023 (per 10 000)	2024 (per 10 000)	2025 (per 10 000)	Target (per 10 000)
HA-SABSI	0.5	0.5	0.8	0.8	0.6	≤ 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 2025 targets for each condition in Table 5, Table 6 and Table 7. Performance is achieved by a result above, or equal to, the target.

Survival rates for sentinel conditions (continued)

Results

In 2025, the survival rates for patients with stroke did not meet target for all age groups (Table 5) and are impacted by severity of disease on admission and patients with multiple comorbidities. It should be noted that NMHS provides the Statewide Neurological Intervention and Imaging Service.

Feedback from stroke survivors and carers has helped shape service improvement priorities. Quality of care is aligned with best practice standards and is further supported by multidisciplinary specialist services, participation in the World Stroke Organisation rehabilitation certification program, auditing and implementation of strategies for early recognition and treatment of post stroke complications. Stroke performance and compliance is actively monitored, with case review processes in place to identify opportunities for further improvement.

Table 5: Survival rate for stroke, 2021–25

	Calendar year					
	2021	2022	2023	2024	2025	Target
Age group (years)	(%)	(%)	(%)	(%)	(%)	(%)
0 to 49	93.7	93.1	92.7	95.3	93.3	≥ 95.3
50 to 59	91.3	89.1	95.5	92.1	92.4	≥ 94.7
60 to 69	91.6	91.0	91.7	90.2	92.3	≥ 94.3
70 to 79	89.2	89.6	88.2	86.9	87.6	≥ 92.4
80+	85.3	84.1	81.8	83.1	83.8	≥ 87.2

Data source: Hospital Morbidity Data Collection.

The survival rates for patients with AMI achieved target for age groups 50 to 59 and 80+ (Table 6). Survival rates for all other age groups did not meet target and are impacted by severity of disease on admission and patients with multiple comorbidities.

Cases are reviewed and monitoring is ongoing to identify opportunities for further improvement. Some sites are further expanding their service scope, enabling patients who require emergency intervention treatment to receive care closer to home.

Table 6: Survival rate for acute myocardial infarction, 2021–25

	Calendar year					
	2021	2022	2023	2024	2025	Target
Age group (years)	(%)	(%)	(%)	(%)	(%)	(%)
0 to 49	100.0	97.8	100.0	98.7	98.7	≥ 98.9
50 to 59	98.8	97.5	99.3	99.3	100.0	≥ 99.0
60 to 69	98.6	98.6	98.1	99.1	97.6	≥ 98.3
70 to 79	94.0	96.3	97.1	93.8	96.6	≥ 96.9
80+	90.9	93.4	92.5	90.9	93.7	≥ 93.1

Data source: Hospital Morbidity Data Collection.

Survival rates for sentinel conditions (continued)

Survival rates for patients with FNOF did not meet target for both age groups (Table 7). Patients are impacted by severity of disease on admission and patients with multiple comorbidities.

Quality of care is aligned with best practice standards and is supported by multidisciplinary specialist services. Robust clinical governance and case review processes are in place and are discussed to identify opportunities to further improve patient outcomes.

Table 7: Survival rate for fractured neck of femur, 2021–25

	Calendar year					
	2021	2022	2023	2024	2025	Target
Age group (years)	(%)	(%)	(%)	(%)	(%)	(%)
70 to 79	96.9	100.0	99.0	98.3	98.0	≥ 98.9
80+	95.5	92.6	94.8	96.5	96.8	≥ 97.0

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, missing and not found, or discharge at own risk). Patients who do so have a higher risk of readmission and mortality[6] and have been found to cost the health system 50% more than patients who are discharged by their physician.[7]

The national Aboriginal and Torres Strait Islander Health Performance Framework reports discharge at own risk under the heading 'Self-discharge from hospital'. Between July 2019 and June 2021 Aboriginal patients (4.4%) in WA were 7.5 times more likely than non-Aboriginal patients (0.6%) to discharge at own risk, compared with 5.2 times nationally (3.8% and 0.7% respectively)[8]. 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 under the performance of governments in providing acute care services in public hospitals[9].

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 responsive 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.

The discharge against medical advice 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[10].

Target

Please see the 2025 targets for Aboriginal and non-Aboriginal patients in Table 8. Performance is achieved by a result below, or equal to, the target.

6 Yong et al. Characteristics and outcomes of discharges against medical advice among hospitalised patients. Internal medicine journal 2013:43(7):798-802.
7 Aliyu ZY. Discharge against medical advice: sociodemographic, clinical and financial perspectives. International journal of clinical practice 2002;56(5):325-27.
8 See Table D3.09.3 https://www.indigenoushpf.gov.au/measures/3-09-self-discharge-from-hospital/data#DataTablesAndResources
9 For more information see https://www.pc.gov.au/ongoing/report-on-government-services
10 https://www.closingthegap.gov.au/national-agreement

Percentage of admitted patients who discharged against medical advice (continued)

Results

In 2025, the percentage of admitted patients who DAMA achieved target for non-Aboriginal patients while Aboriginal patients did not meet target (Table 8).

Family/community responsibilities and not wanting to wait were common reasons for why Aboriginal patients DAMA. Aboriginal Health Liaison Officer services are available at NMHS hospitals; however, patients may choose to not use this service. Patients who DAMA are contacted, and follow-up plans are organised where appropriate. Strategies such as updated policies, increased promotion of AHLO service and establishing a trial of additional DAMA safety checklist are in place.

Performance, cases and patient feedback continue to be monitored and reviewed for improvement opportunities.

Table 8: Percentage of admitted patients who discharged against medical advice, 2021–25

	Calendar year					
	2021	2022	2023	2024	2025	Target
	(%)	(%)	(%)	(%)	(%)	(%)
Aboriginal	3.46	3.81	3.17	3.98	4.28	≤ 2.78
Non-Aboriginal	0.74	0.71	0.80	0.82	0.80	≤ 0.99

Data source: Hospital Morbidity Data Collection.

Percentage of liveborn term infants with an Apgar score of less than 7 at five minutes post delivery

Rationale

This indicator 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) ten minutes after birth to determine how well the infant is adapting outside the mother's womb. Apgar scores range from zero to two for each condition with a maximum final total score of ten. The higher the Apgar score the better the health of the newborn infant.

This outcome measure can lead to the development and delivery of improved care pathways and interventions to improve the health outcomes of Western Australian infants and aligns to the National Core Maternity Indicators (2025) Health, Standard 04/12/2024.

Target

The 2025 target for liveborn term infants with an Apgar score of less than 7 at five minutes post-delivery is 1.9 per cent. Performance is achieved by a result below, or equal to, the target.

Percentage of liveborn term infants with an Apgar score of less than 7 at five minutes post delivery (continued)

Results

In 2025, the percentage of liveborn infants with an Apgar score of less than seven at five minutes post-delivery did not meet target (Table 9).

Ongoing staff education and comprehensive clinical governance processes are in place. Regular monitoring and review of outcomes demonstrated stable performance and outcomes and supports continuous improvement.

It should be noted that NMHS has the State's largest maternity hospital and is the only referral centre for complex, high acuity pregnancies in WA.

Table 9: Percentage of liveborn term infants with an Apgar score of less than 7 at five minutes post-delivery, 2021–25

	Calendar year					
	2021	2022	2023	2024	2025	Target
Live births	(%)	(%)	(%)	(%)	(%)	(%)
Apgar Score < 7	1.7	1.8	1.7	1.8	2.1	≤ 1.9

Data source: Midwives Notification System.

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

Rationale

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

While multiple hospital admissions over a lifetime may be necessary for someone with ongoing illness, a high proportion of readmissions shortly after discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was not adequate to maintain the patient's recovery out of hospital[11]. 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 2025 target is 12 per cent readmissions within 28 days to an acute specialised mental health inpatient service. Performance is achieved by a result below, or equal to, the target.

11 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

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

Results

In 2025, the rate of readmissions to acute specialised mental health inpatient services within 28 days of discharge achieved target (Table 10). This indicator looks at total readmissions and it should be noted that some readmission cases are planned or are warranted as part of accepted best practice protocols.

Patients are given appropriate discharge planning and may readmit as part of their management or crisis plan. Readmissions continue to be reviewed, and performance continues to be monitored.

Table 10: Readmissions to acute specialised mental health inpatient services within 28 days of discharge, 2021–25

	Calendar year					
	2021	2022	2023	2024	2025	Target
	(%)	(%)	(%)	(%)	(%)	(%)
Readmission rate	15	12	10	9	9	≤ 12

Data source: Hospital Morbidity Data Collection.

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

Rationale

In 2022, one in four (6.6 million) Australians reported having a mental or behavioural condition[12]. 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 2025 target is 75 per cent. Performance is achieved by a result above, or equal to, the target.

Results

In 2025, 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. Non-compliant records continue to be reviewed, and performance continues to be monitored.

12 National Health Survey, 2022

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

Table 11: Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services, 2021–25

	Calendar year					
	2021 (%)	2022 (%)	2023 (%)	2024 (%)	2025 (%)	Target (%)
Post-discharge community care	86	85	88	89	86	≥ 75

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

Service 1: Public hospital admitted services

Average admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per WAU compared with the State target, as approved by the Department of Treasury and published in the 2025-26 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 2025-26 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

Target

The 2025/26 target is $8,183 per WAU. Performance is achieved by a result below, or equal to, the target.

Results

In 2025/26, the average admitted cost per weighted activity unit did not meet the target (Table 12). Higher unit costs reflected increased workforce costs associated with higher patient acuity and maintaining nurse-to-patient ratios, together with award and contract escalation.

In addition, NMHS increased outsourced service capacity during the winter period to meet elevated demand and maintain timely access to care. While activity levels continued to increase, growth in activity was insufficient to fully offset the impact of expenditure growth, resulting in a higher cost per weighted activity unit than both the target and the 2024-25 result.

Table 12: Average admitted cost per weighted activity unit, 2021/22–2025/26

	Financial year					
	2021/22 ($)	2022/23 ($)	2023/24 ($)	2024/25 ($)	2025/26 ($)	Target ($)
Average cost	7,715	8,014	8,168	8,348	8,571	≤ 8,183

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.

Service 2: Public hospital emergency services

Average emergency department cost per weighted activity unit

Rationale

This indicator is a measure of the cost per WAU compared with the State target as approved by the Department of Treasury, which is published in the 2025-26 Budget Paper No. 2, Volume 1.

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

Target

The 2025/26 target is $8,094 per WAU. Performance is achieved by a result below, or equal to, the target.

Results

In 2025-26, the average emergency department cost per weighted activity unit did not meet the target (Table 13). Higher unit costs reflected increased workforce costs due to cost of award increases, contract escalation, and additional capacity required to safely manage emergency department demand and winter pressures. The continuation of the 7-day hospital service, providing expanded Radiology, Pharmacy and Allied Health services, further increased costs while supporting patient flow, timely discharge and access to care. As expenditure growth outpaced activity growth, the average cost per WAU was $8,309 against the target of $8,094.

Table 13: Average emergency department cost per weighted activity unit, 2021/22–2025/26

	Financial year					
	2021/22 ($)	2022/23 ($)	2023/24 ($)	2024/25 ($)	2025/26 ($)	Target ($)
Average cost	7,129	7,242	7,988	7,659	8,309	≤ 8,094

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

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 2025-26 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 2025/26 target is $8,328 per WAU. Performance is achieved by a result below, or equal to, the target.

Average non-admitted cost per weighted activity unit (continued)

Results

In 2025-26, the average non-admitted cost per weighted activity unit did not meet the target (Table 14). Higher unit costs reflected increased workforce costs associated with service demand, award outcomes and cost escalation across a range of non-admitted services.

Additional funding provided during the year to support increased service delivery costs contributed to expenditure growth exceeding activity growth, resulting in a higher cost per weighted activity unit than the target.

Table 14: Average non-admitted cost per weighted activity unit, 2021/22–2025/26

	Financial year					
	2021/22	2022/23	2023/24	2024/25	2025/26	Target
	($)	($)	($)	($)	($)	($)
Average cost	7,258	8,827	8,669	9,067	9,532	≤ 8,328

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

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 2025/26 target is $1,889 per bed-day in specialised mental health inpatient services. Performance is achieved by a result below, or equal to, the target.

Results

In 2025-26, the average cost per bed day in specialised mental health inpatient services did not meet the target (Table 15). Higher costs reflected increased workforce costs associated with service demand, patient acuity and award outcomes.

During the year supplementary allocations were provided by the Mental Health Commission to support specialised mental health inpatient services and cost pressures associated with service delivery. As expenditure growth exceeded growth in bed days, the average cost per bed day was above the target.

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

Table 15: Average cost per bed-day in specialised mental health inpatient services, 2021/22–2025/26

	Financial year					
	2021/22 ($)	2022/23 ($)	2023/24 ($)	2024/25 ($)	2025/26 ($)	Target ($)
Average cost	1,595	1,730	1,973	2,153	2,254	≤ 1,889

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

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.

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.

Efficient functioning of public community mental health services is essential to ensure that finite funds are used effectively to deliver maximum community benefit. 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 2025/26 target is $575 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 2025-26, the average cost per treatment day of non-admitted care provided by mental health services achieved target (Table 16). During the year, service funding allocations were realigned to better reflect service delivery outcomes. In addition, improvements in data capture resulted in an increase in recorded treatment days. The growth in reported activity exceeded expenditure growth, contributing to a lower average cost per treatment day.

Table 16: Average cost per treatment day of non-admitted care provided by mental health services, 2021/22–2025/26

	Financial year					
	2021/22 ($)	2022/23 ($)	2023/24 ($)	2024/25 ($)	2025/26 ($)	Target ($)
Average cost	412	496	522	533	483	≤ 575

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

Percentage of eligible people who accessed Dental Health Services

Rationale

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

To facilitate equity of access to dental health care for all Western Australians, dental treatment services (including both emergency care and non-emergency care) are provided through subsidised dental programs to eligible people in need. This indicator measures the level of access to these subsidised dental health services by monitoring the proportion of all eligible people receiving the services.

Measuring the use of dental health services provided to eligible people can help identify areas that require more focused intervention and prevention and health promotion strategies to help ensure the improved dental health and wellbeing of Western Australians with the greatest need.

Target

The 2025/26 target is ≥ 15 per cent. Performance is achieved by a result above, or equal to, the target.

Results

In 2025/26, the percentage of eligible people who accessed Dental Health Services did not meet target (Table 17).

The number of eligible people continues to increase each year, while the number accessing services has remained relatively stable. The ability to meet target continues to be impacted by workforce shortages arising from dental recruitment challenges which have resulted in fewer available appointments across various school clinics. Workforce recruitment strategies are currently being reviewed.

Table 17: Percentage of eligible people who accessed Dental Health Services, 2021/22–2025/26

	Financial year					
	2021/22 (%)	2022/23 (%)	2023/24 (%)	2024/25 (%)	2025/26 (%)	Target (%)
Eligible people who accessed Dental Health Services	13	14	14	13	13	≥ 15

Note: Eligible people are defined as those who hold a current Pension Concession Card (Centrelink) or Health Care Card. Eligible people who access a public dental service or receive treatment through a participating private dental practitioner.
Australian Government funded dental health services provided through the National Partnership Agreement is not included.
Data sources: Dental Information Management (DenIM) database; Commonwealth Department of Social Services (DSS) Payment Demographic data.

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 2024–25 target is ≥ 70 per cent of women aged 50–69 years who participate in breast screening. Performance is achieved by a result above, or equal to, the target.

Results

From 2024 to 2025, the percentage of women aged 50-69 years who participated in breast screening did not meet target (Table 18).

Participation rates over the past five years have been relatively stable, however the number of women aged 50-69 years residing in WA has increased each year. The participation and population of women outside the targeted age group has also increased and the high demand for screening has led to longer wait times and reduced participation as delays to rescreen are extended.

BreastScreen WA have been implementing a number of initiatives as an endeavour to increase capacity and address workforce issues. These include proactively offering cancelled appointment slots to program clients, reviewing bulk cancellation processes to help maintain high appointment rates, developing an international recruitment strategy to attract qualified Medical Imaging Technologists to Western Australia and working with state counterparts with the intention to deliver a 12-month Graduate Diploma of Mammography program in 2027.

Table 18: Rate of women aged 50 – 69 years who participate in breast screening, 2021-2025

	Calendar year					
	2021	2022	2023	2024	2025	Target
	(%)	(%)	(%)	(%)	(%)	(%)
Participation rate	50	53	50	49	48	≥ 70

Note: This measure counts the women screened within a 24-month period (1 January 2024 to 31 December 2025) 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.

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.

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

Rationale

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

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

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

By measuring and monitoring this KPI, the level of potentially avoidable unplanned returns can be assessed in order to identify key areas for improvement (i.e. cost-effectiveness and efficiency, initial treatment and patient satisfaction). This KPI is nationally reported in the Australian Council on Healthcare Standards Oral Health Indicators[14]. Its inclusion provides opportunity for benchmarking across jurisdictions.

Target

Please see the 2025/26 targets for adults and children in Table 19. Performance is achieved by a result below the target.

Results

In 2025/26, the percentage of children who have a tooth re-treated within 6 months of receiving initial restorative dental treatment achieved target (Table 19) while adults did not meet target.

Dental Health Service continues to monitor clinic/clinician re-treatment rates through the Clinical Oral Health Advisory and Quality and Risk Committees.

Table 19: Percentage of adults and children who have a tooth re-treated within 6 months of receiving initial restorative dental treatment, 2021/22–2025/26

	Financial year					
	2021/22	2022/23	2023/24	2024/25	2025/26	Target
	(%)	(%)	(%)	(%)	(%)	(%)
Adults	5.86	5.14	5.88	6.21	6.40	< 6.05
Children	1.91	1.68	1.43	1.42	1.28	< 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).

14 Australian Clinical Indicator Report 2015-2022, 24th Edition https://www.achs.org.au/news/acir2015-22

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

Rationale

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

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

Target

The 2025/26 target is ≥ 74 per cent. Performance is achieved by a result above, or equal to, the target.

Results

In 2025/26, the percentage of eligible children who are enrolled in the School Dental Services program did not meet target (Table 20).

Our School Dental Service continues to be impacted by the challenges of dental therapist recruitment. This has resulted in less available appointments at some clinics and less promotion and visibility of the service. To improvement enrolments, Dental Health Service has been directly contacting schools with low enrolment numbers to promote the service.

Table 20: Percentage of eligible school children who are enrolled in the School Dental Service program, 2021/22–2025/26

	Financial year					
	2021/22 (%)	2022/23 (%)	2023/24 (%)	2024/25 (%)	2025/26 (%)	Target (%)
Eligible school children who are enrolled in the School Dental program	75	73	69	67	70	≥ 74

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.

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 2025/26 target is $47. Performance is achieved by a result below, or equal to, the target.

Results

In 2025-26, the average cost per person of delivering population health programs by population health units did not meet the target (Table 21). Additional funding received during the year to support Commonwealth-funded agreements and immunisation programs, together with increased State Government funding to support Women's Community Health programs, contributed to higher program expenditure.

As expenditure growth exceeded population growth, the average cost per person was $77 compared with the target of $47.

Table 21: Average cost per person of delivering population health programs by population health units, 2021/22–2025/26

	Financial year					
	2021/22	2022/23	2023/24	2024/25	2025/26	Target
	($)	($)	($)	($)	($)	($)
Average cost	97	84	69	65	77	≤ 47

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

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 preventive initiative.

Target

The 2025/26 target is $176 per breast screening. 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.

Average cost per breast screening (continued)

Results

In 2025-26, the average cost per breast screening did not meet the target (Table 22). Higher costs reflected award and CPI increases, additional fuel excise costs and increased regional screening costs. Lower screening volumes due to recruitment challenges together with one-off expenditure on health promotion activities, and equipment maintenance contributed to a higher average cost per breast screening.

Table 22: Average cost per breast screening, 2021/22–2025/26

	Financial year					
	2021/22 ($)	2022/23 ($)	2023/24 ($)	2024/25 ($)	2025/26 ($)	Target ($)
Average cost	153	159	177	183	198	≤ 176

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

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 2025/26 targets for patient groups in Table 23. Performance is achieved by a result below, or equal to, the target.

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

Results

In 2025/26 the average cost per patient visit of WA Health-provided dental health programs for school children achieved target (Table 23) while socio-economically disadvantaged adults did not meet target.

The cost of delivering services has increased and remains 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 impacted the average cost per patient visit.

Table 23: Average cost per patient visit of WA Health-provided dental health programs for school children and socio-economically disadvantaged adults, 2021/22–2025/26

	Financial year					
	2021/22 ($)	2022/23 ($)	2023/24 ($)	2024/25 ($)	2025/26 ($)	Target ($)
School children	302	315	305	322	370	≤ 377
Socio-economically disadvantaged adults	365	370	379	406	400	≤ 340

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



Financials

Audit opinion

Auditor General

INDEPENDENT AUDITOR'S REPORT

2026

North Metropolitan Health Service

To the Parliament of Western Australia

Report on the audit of the financial statements

Opinion

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

- the statement of financial position as at 30 June 2026, 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, the financial statements are:

- based on proper accounts and present fairly, in all material respects, the operating results and cash flows of the Health Service for the year ended 30 June 2026 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 opinion

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

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

Responsibilities of the Board for the financial statements

The Board is responsible for:

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

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.

Audit opinion (continued)

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

Opinion

I have undertaken a reasonable assurance engagement on the design and implementation of controls exercised by the Health Service. The controls exercised by the 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, in all material respects, the controls exercised by the Health Service are sufficiently adequate to provide reasonable assurance that the controls within the system were suitably designed to achieve the overall control objectives identified as at 30 June 2026, and the controls were implemented as designed as at 30 June 2026.

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.

Audit opinion (continued)

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 Health Service for the year ended 30 June 2026 reported in accordance with the *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 Health Service for the year ended 30 June 2026 is in accordance with the legislative requirements, and the key performance indicators 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 2026.

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 3 Financial Sustainability – Requirement 5 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 Health Service'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 3 - Requirement 5 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.

Audit opinion (continued)

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

The Board is responsible for the other information. The other information is the information in the entity's annual report for the year ended 30 June 2026, 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 Health Service for the year ended 30 June 2026 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 Health Service to confirm the information contained in the website version.



Aloha Morrissey
Acting Auditor General
Perth, Western Australia
18 September 2026

Certification of financial statements

Government of Western Australia
North Metropolitan Health Service

Certification of financial statements for the year ended 30 June 2026

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 financial year ended 30 June 2026 and financial position as at 30 June 2026.

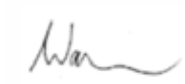
At the date of signing, we are not aware of any circumstances which would render the particulars included in the financial statements misleading or inaccurate.



Adj Assoc Prof Karen Gullick
Board Chair
North Metropolitan Health Service
17 September 2026



Renae Farmer
Board Finance Committee Chair
North Metropolitan Health Service
17 September 2026



Wayne Millen
A/Chief Finance Officer
North Metropolitan Health Service
17 September 2026

Statement of Comprehensive Income

For the year ended 30 June 2026

	Notes	2026 $'000	2025 $'000
COST OF SERVICES			
Expenses			
Employee benefits expense	3.1	1,794,769	1,660,203
Contracts for services	3.2	640,585	608,018
Patient support costs	3.3	516,685	477,689
Finance costs	7.2	1,664	1,774
Depreciation and amortisation expense	5.1, 5.2, 5.3, 5.4	109,532	90,622
Repairs, maintenance and consumable equipment	3.4	68,208	60,280
Other supplies and services	3.5	105,514	102,905
Other expenses	3.6	101,804	102,960
Total cost of services		**3,338,761**	**3,104,451**
INCOME			
Revenue			
Patient charges	4.2	90,392	84,075
Other fees for services	4.3	135,727	122,872
Other grants and contributions	4.4	4,991	6,639
Donation revenue		545	973
Other revenue	4.5	25,846	29,918
Total revenue		**257,501**	**244,477**
Total income other than income from State Government		**257,501**	**244,477**
NET COST OF SERVICES		**3,081,260**	**2,859,974**
Income from State Government			
Department of Health - Service Agreement - State Component	4.1	1,705,839	1,644,559
Department of Health - Service Agreement - Commonwealth Component	4.1	792,030	684,982
Mental Health Commission - Service Agreement	4.1	381,223	350,166
Income from other state government agencies	4.1	5,083	5,149
Assets assumed/(transferred)	4.1	-	973
Services received free of charge	4.1	146,376	136,885
Royalties for Regions Fund	4.1	410	411
Total income from State Government		**3,030,961**	**2,823,125**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(50,299)**	**(36,849)**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.10	175,319	338,608
Total other comprehensive income		**175,319**	**338,608**
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**125,020**	**301,759**

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

Statement of Financial Position

As at 30 June 2026

	Notes	2026 $'000	2025 $'000
ASSETS			
Current Assets			
Cash and cash equivalents	7.3	57,798	51,482
Restricted cash and cash equivalents	7.3	74,983	64,108
Receivables	6.1	77,489	73,835
Inventories	6.3	13,982	13,714
Other current assets	6.4	5,370	4,391
Total Current Assets		**229,622**	**207,530**
Non-Current Assets			
Receivables	6.1	60,699	44,974
Amounts receivable for services	6.2	1,316,866	1,222,852
Infrastructure, property, plant and equipment	5.1	1,772,517	1,635,118
Right-of-use assets	5.2	27,814	29,374
Service concession assets	5.3	586,836	539,906
Intangible assets	5.4	1,785	2,122
Total Non-Current Assets		**3,766,517**	**3,474,346**
TOTAL ASSETS		**3,996,139**	**3,681,876**
LIABILITIES			
Current Liabilities			
Payables	6.5	260,780	230,059
Lease liabilities	7.1	4,277	4,023
Employee related provisions	3.1	389,807	365,615
Other current liabilities	6.6	5,082	1,217
Total Current Liabilities		**659,946**	**600,914**
Non-Current Liabilities			
Lease liabilities	7.1	26,710	30,500
Employee related provisions	3.1	59,779	55,963
Total Non-Current Liabilities		**86,489**	**86,463**
TOTAL LIABILITIES		**746,435**	**687,377**
NET ASSETS		**3,249,704**	**2,994,499**
EQUITY			
Contributed equity	9.10	2,333,639	2,203,454
Reserves	9.10	1,017,933	842,614
Accumulated deficit		(101,868)	(51,569)
TOTAL EQUITY		**3,249,704**	**2,994,499**

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 2026

	Notes	Contributed equity $'000	Reserves $'000	Accumulated surplus/ (deficit) $'000	Total equity $'000
Balance at 1 July 2024		2,069,717	504,006	(14,720)	2,559,003
Surplus/(deficit)		-	-	(36,849)	(36,849)
Other comprehensive income		-	338,608	-	338,608
Total comprehensive income for the year		**-**	**338,608**	**(36,849)**	**301,759**
Transactions with owners in their capacity as owners:	9.10				
Capital appropriations administered by Department of Health		133,737	-	-	133,737
Other contributions by owners		-	-	-	-
Distributions to owners		-	-	-	-
Total		133,737	-	-	133,737
Balance at 30 June 2025		**2,203,454**	**842,614**	**(51,569)**	**2,994,499**
Balance at 1 July 2025		2,203,454	842,614	(51,569)	2,994,499
Surplus/(deficit)		-	-	(50,299)	(50,299)
Other comprehensive income		-	175,319	-	175,319
Total comprehensive income for the year		**-**	**175,319**	**(50,299)**	**125,020**
Transactions with owners in their capacity as owners:	9.10				
Capital appropriations administered by Department of Health		130,185	-	-	130,185
Other contributions by owners		-	-	-	-
Distributions to owners		-	-	-	-
Total		**130,185**	**-**	**-**	**130,185**
Balance at 30 June 2026		**2,333,639**	**1,017,933**	**(101,868)**	**3,249,704**

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 2026

	Notes	2026 $'000	2025 $'000
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriation		2,790,161	2,595,802
Capital appropriations administered by Department of Health		130,185	133,742
Royalties for Regions fund		410	411
Net cash provided by State Government		**2,920,756**	**2,729,955**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(1,756,978)	(1,610,835)
Supplies and services		(1,268,093)	(1,199,618)
Finance costs		(1,664)	(1,774)
Receipts			
Receipts from customers		77,074	79,350
Other grants and contributions		4,992	6,639
Donations received		376	511
Other receipts		173,802	143,460
Net cash used in operating activities	7.3.2	**(2,770,491)**	**(2,582,267)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Payment for purchase of non-current physical and intangible assets		(113,008)	(128,478)
Receipts			
Proceeds from sale of non-current physical assets		9	121
Net cash used in investing activities		**(112,999)**	**(128,357)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Payments for principal element of lease		(4,351)	(4,039)
Payments to accrued salaries account		(15,724)	(10,125)
Net cash used in financing activities		**(20,075)**	**(14,164)**
Net increase/(decrease) in cash and cash equivalents		17,191	5,167
Cash and cash equivalents at the beginning of the year		115,590	110,423
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.3.1	**132,781**	**115,590**

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 2026

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 15 September 2026.

Statement of compliance

The financial statements constitute general purpose financial statements that have been prepared in accordance with Australian Accounting Standards, the Framework, Statement of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board as applied by Treasurer's instructions. Several of these are modified by Treasurer's instructions to vary application, disclosure, format and wording.

The *Financial Management Act 2006* and Treasurer's instructions are legislative provisions governing the preparation of financial statements and take precedence over Australian Accounting Standards, the Framework, Statement of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board. Where modification is required and has had a material or significant financial effect upon the reported results, details of that modification and the resulting financial effect are disclosed in the notes to the financial statements.

Basis of preparation

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

Judgements and estimates

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

Accounting for Goods and Services Tax (GST)

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

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

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

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

Contributed equity

AASB Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities* requires transfers in the nature of equity contributions, other than as a result of a restructure of administrative arrangements, to be designated 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 8 – Requirement 8.1(i) and will be credited directly to Contributed Equity.

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

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:

	Notes
Health Service objectives	2.1
Schedule of Income and Expenses by Service	2.2

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 2026

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 2026

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	
	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
COST OF SERVICES										
Expenses										
Employee benefits expense	935,293	859,736	110,778	91,973	264,211	244,825	289,748	278,482	19,731	20,099
Contracts for services	411,067	401,209	105,052	98,391	28,604	25,835	53,250	50,687	2,526	9,328
Patient support costs	298,384	268,520	18,915	20,243	118,199	115,973	23,944	20,625	3,097	3,038
Finance costs	100	97	1	2	185	189	899	963	22	25
Depreciation and amortisation expense	69,098	54,671	6,482	4,979	14,116	12,361	11,626	10,996	82	85
Repairs, maintenance and consumable equipment	28,291	31,368	2,833	2,794	13,085	10,084	6,885	6,644	458	579
Other supplies and services	53,815	54,058	5,739	8,401	15,889	14,048	16,492	14,239	1,054	2,011
Other expenses	38,810	41,198	3,630	3,625	12,625	13,092	14,133	14,569	407	1,001
Total cost of services	**1,834,858**	**1,710,857**	**253,430**	**230,408**	**466,914**	**436,407**	**416,977**	**397,205**	**27,377**	**36,166**
INCOME										
Revenue										
Patient charges	75,895	69,901	2,520	2,241	6,664	6,427	722	853	-	-
Other fees for services	55,007	35,696	4	-	68,603	74,017	93	80	-	-
Other grants and contributions	205	223	9	-	72	42	-	-	3	3
Donation revenue	-	40	-	1	1	3	5	8	-	-
Other revenue	2,505	3,085	54	62	8,431	7,345	370	510	-	3
Total revenue	**133,612**	**108,945**	**2,587**	**2,304**	**83,771**	**87,834**	**1,190**	**1,451**	**3**	**6**
Total income other than income from State Government	**133,612**	**108,945**	**2,587**	**2,304**	**83,771**	**87,834**	**1,190**	**1,451**	**3**	**6**
NET COST OF SERVICES	**1,701,246**	**1,601,912**	**250,843**	**228,104**	**383,143**	**348,573**	**415,787**	**395,754**	**27,374**	**36,160**

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

	Public Hospital Admitted Patient		Public Hospital Emergency Services		Public Hospital Non-Admitted Services		Mental Health Services		Aged Continuing Care Services	
	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
INCOME FROM STATE GOVERNMENT										
Department of Health - Service Agreement - State Component	1,027,611	998,951	141,265	149,626	249,963	221,246	10,035	9,786	20,752	24,319
Department of Health - Service Agreement - Commonwealth Component	575,479	479,181	96,995	67,231	93,784	119,222	-	-	4,819	5,889
Mental Health Commission - Service Agreement	-	-	-	-	-	-	381,223	350,166	-	-
Income from other state government agencies	600	1,610	35	-	103	1	28	-	5	-
Assets assumed/(transferred)	-	854	-	40	-	79	-	-	-	-
Services received free of charge	79,463	74,183	8,354	12,019	20,963	17,313	24,343	19,490	1,026	1,433
Royalties for regions fund	-	-	-	-	-	-	-	-	410	411
Total income from State Government	**1,683,153**	**1,554,779**	**246,649**	**228,916**	**364,813**	**357,861**	**415,629**	**379,442**	**27,012**	**32,052**
SURPLUS/(DEFICIT) FOR THE PERIOD	**(18,093)**	**(47,133)**	**(4,194)**	**812**	**(18,330)**	**9,288**	**(158)**	**(16,312)**	**(362)**	**(4,108)**

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

	Public and Community Health Services		Community Dental Services		Small Rural Hospital Services		Health System Management - Policy and Corporate Services		Total	
	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
COST OF SERVICES										
Expenses										
Employee benefits expense	95,706	88,536	78,952	76,185	-	-	350	367	1,794,769	1,660,203
Contracts for services	38,824	21,771	1,262	797	-	-	-	-	640,585	608,018
Patient support costs	30,037	24,069	24,109	25,221	-	-	-	-	516,685	477,689
Finance costs	355	391	102	107	-	-	-	-	1,664	1,774
Depreciation and amortisation expense	4,025	4,007	4,103	3,523	-	-	-	-	109,532	90,622
Repairs, maintenance and consumable equipment	12,484	4,899	4,172	3,912	-	-	-	-	68,208	60,280
Other supplies and services	6,500	4,075	6,025	6,073	-	-	-	-	105,514	102,905
Other expenses	18,365	19,655	13,833	9,689	-	-	1	131	101,804	102,960
Total cost of services	**206,296**	**167,403**	**132,558**	**125,507**	**-**	**-**	**351**	**498**	**3,338,761**	**3,104,451**
INCOME										
Revenue										
Patient charges	-	-	4,591	4,653	-	-	-	-	90,392	84,075
Other fees for services	7,521	8,877	4,499	4,202	-	-	-	-	135,727	122,872
Other grants and contributions	4,373	6,371	329	-	-	-	-	-	4,991	6,639
Donation revenue	539	838	-	83	-	-	-	-	545	973
Other revenue	14,280	18,835	206	78	-	-	-	-	25,846	29,918
Total revenue	**26,713**	**34,921**	**9,625**	**9,016**	**-**	**-**	**-**	**-**	**257,501**	**244,477**
Total income other than income from State Government	**26,713**	**34,921**	**9,625**	**9,016**	**-**	**-**	**-**	**-**	**257,501**	**244,477**
NET COST OF SERVICES	**179,583**	**132,482**	**122,933**	**116,491**	**-**	**-**	**351**	**498**	**3,081,260**	**2,859,974**

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 2026

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	
	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
INCOME FROM STATE GOVERNMENT										
Department of Health - Service Agreement - State Component	148,768	139,983	107,091	100,068	-	-	354	580	1,705,839	1,644,559
Department of Health - Service Agreement - Commonwealth Component	11,267	3,773	9,686	9,686	-	-	-	-	792,030	684,982
Mental Health Commission - Service Agreement	-	-	-	-	-	-	-	-	381,223	350,166
Income from other state government agencies	4,217	3,534	95	4	-	-	-	-	5,083	5,149
Assets assumed/(transferred)	-	-	-	-	-	-	-	-	-	973
Services received free of charge	5,406	5,566	6,821	6,881	-	-	-	-	146,376	136,885
Royalties for regions fund	-	-	-	-	-	-	-	-	410	411
Total income from State Government	**169,658**	**152,856**	**123,693**	**116,639**	**-**	**-**	**354**	**580**	**3,030,961**	**2,823,125**
SURPLUS/(DEFICIT) FOR THE PERIOD	**(9,925)**	**20,374**	**760**	**148**	**-**	**-**	**3**	**82**	**(50,299)**	**(36,849)**

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

3 Use of our funding

Expenses incurred in the delivery of services

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

	Notes	2026 $'000	2025 $'000
Employee benefits expenses	3.1(a)	1,794,769	1,660,203
Employee related provisions	3.1(b)	449,586	421,578
Contracts for services	3.2	640,585	608,018
Patient support costs	3.3	516,685	477,689
Repairs, maintenance and consumable equipment	3.4	68,208	60,280
Other supplies and services	3.5	105,514	102,905
Other expenses	3.6	101,804	102,960

3.1(a) Employee benefits expenses

	2026 $'000	2025 $'000
Employee benefits	1,611,440	1,498,027
Superannuation - defined contributions plans	183,329	162,176
Total employee benefits expenses	**1,794,769**	**1,660,203**
Add: AASB 16 Non-monetary benefits	1,787	1,793
Less: Employee Contribution	(17)	(25)
Net employee benefits	**1,796,539**	**1,661,971**

Employee benefits include wages, salaries and social contributions, accrued and paid leave entitlements and paid sick leave, and non-monetary benefits recognised under accounting standards other than AASB 16 (such as medical care, housing, cars and free or subsidised goods or services) for employees.

Superannuation is the amount recognised in profit or loss of the Statement of comprehensive income comprising of employer contributions paid to the Gold State Super (concurrent contributions), West State Super, GESB Super or other superannuation funds.

AASB 16 non-monetary benefits are non-monetary employee benefits predominantly relating to the provision of vehicle and housing benefits that are recognised under AASB 16 which are excluded from the employee benefits expense.

Employee Contributions are 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.

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

3.1(b) Employee related provisions

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

	2026 $'000	2025 $'000
Current		
Annual leave	186,474	171,779
Time off in lieu	45,476	42,989
Long service leave	155,689	148,783
Deferred salary scheme	2,168	2,064
	389,807	**365,615**
Non-Current		
Long service leave	59,779	55,963
	59,779	**55,963**
Total employee related provisions	**449,586**	**421,578**

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

	2026 $'000	2025 $'000
Within 12 months of the end of the reporting period	126,754	117,259
More than 12 months after the end of the reporting period	105,196	97,509
	231,950	**214,768**

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

Pre-conditional and conditional long service leave provisions are classified as non-current liabilities because the Health Service has the 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:

	2026 $'000	2025 $'000
Within 12 months of the end of the reporting period	40,479	38,684
More than 12 months after the end of the reporting period	174,989	166,062
	215,468	**204,746**

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 2026

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

	2026 $'000	2025 $'000
Within 12 months of the end of the reporting period	1,192	413
More than 12 months after the end of the reporting period	976	1,651
Carrying amount at end of period	**2,168**	**2,064**

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

	2026 $'000	2025 $'000
Public patients services [(a)]	579,645	543,944
Mental Health	45,503	50,653
Other contracts	15,437	13,421
Total contracts for services	**640,585**	**608,018**

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

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

3.3 Patient support costs

	2026 $'000	2025 $'000
Medical supplies and services	383,150	350,631
Pathology services received free of charge	50,936	45,594
Domestic charges	25,220	25,273
Fees for visiting medical practitioners	19,419	19,033
Fuel, light and power	17,266	17,172
Food supplies	14,560	14,001
Patient transport costs	4,481	4,571
Research, development and other grants	1,653	1,414
Total patient support costs	**516,685**	**477,689**

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

3.4 Repairs, maintenance and consumable equipment

	2026 $'000	2025 $'000
Repairs and maintenance	53,526	44,298
Consumable equipment	14,682	15,982
Total repairs, maintenance and consumable equipment	**68,208**	**60,280**

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

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.

3.5 Other supplies and services

	2026 $'000	2025 $'000
Sanitation and waste removal services	4,152	3,561
Administration and management services	3,161	4,073
Interpreter services	3,719	3,109
Security services	910	803
Services provided by Health Support Services: [(a)]		
ICT services	65,245	61,117
Supply chain services	12,131	11,308
Financial services	2,779	3,192
Human resource services	13,516	14,372
Other	(99)	1,370
Total other supplies and services	**105,514**	**102,905**

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

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

3.6 Other expenses

	2026 $'000	2025 $'000
Communications	3,790	3,848
Computer services	5,456	4,935
Workers' compensation insurance	31,636	30,458
Other insurances	25,656	23,026
Consultancy fees	3,629	3,511
Other employee related expenses	6,593	7,096
Printing and stationery	4,614	4,603
Expected credit losses expense	2,358	2,830
Freight and cartage	2,617	2,167
Periodical subscriptions	1,404	1,155
Motor vehicle expenses	1,782	1,422
General administration	6,307	11,081
Legal expenses	569	86
Rental	3,384	3,071
Assets impairment	(968)	1,605
Loss on disposal of non-current assets	719	-
Other	2,258	2,066
Total other expenses	**101,804**	**102,960**

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 is expensed as incurred. This includes leases under Memorandum of Understanding Agreements between the Agency and the Department of Housing and Works for the leasing of office accommodation, where substitution rights held by the Department of Housing and Works. It also includes 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.

General administration includes parking charges, licence fees and expenses relating to other sundry items including bank fees, membership fees, rates and charges and subscription charges.

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

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	2026 $'000	2025 $'000
Income from State Government	4.1	3,030,961	2,823,125
Patient charges	4.2	90,392	84,075
Other fees for services	4.3	135,727	122,872
Other grants and contributions	4.4	4,991	6,639
Other revenue	4.5	25,846	29,918

4.1 Income from State Government

	2026 $'000	2025 $'000
Appropriation received for the period:		
Department of Health - Service Agreement - State Component	1,705,839	1,644,559
Department of Health - Service Agreement - Commonwealth Component - Recurrent grants	792,030	684,982
Mental Health Commission - Service Agreement	381,223	350,166
Total appropriation received	**2,879,092**	**2,679,707**
Grants and income from other state government agencies:		
Recoveries for Insurance Claims from State Government Insurers	1,249	665
Pathology services to other Health Services	32	30
Insurance Commission of Western Australia - patient fees (motor vehicle injuries)	(9)	1,607
Graduate Transition to Practice Program funding from Chief Nursing and Midwifery Office WA	307	1,132
Other specific grants	3,504	1,715
Total grants and subsidies	**5,083**	**5,149**
Assets assumed/(transferred)	-	973
Total assets assumed/(transferred)	**-**	**973**
Resources received from other public sector entities during the period:		
Department of Housing and Works - government leased accommodation	83	66
Department of Education - Dental therapy units rental expense	1,269	1,236
State Solicitor's Office - legal service	417	-
PathWest - pathology services	50,936	45,594
Services received from Health Support Services (HSS)		
ICT services	65,245	61,117
Supply chain services	12,131	11,308
Financial services	2,779	3,192
Human resources services	13,516	14,372
Total received	**146,376**	**136,885**
Regional Community Services Account	410	411
Total Royalties for Regions Fund	**410**	**411**
Total income from State Government	**3,030,961**	**2,823,125**

Service Appropriation is recognised at fair value of consideration received 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 and Finance.

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

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

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.

Resources received free of charge is recognised as income equivalent to the fair value of assets received or the fair value of services received that can be reliably determined and which would have been purchased if not donated.

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

	2026 $'000	2025 $'000
Inpatient bed charges	70,617	65,939
Inpatient other charges	6,020	4,828
Outpatient charges	13,755	13,308
Total patient charges	**90,392**	**84,075**

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

	2026 $'000	2025 $'000
Recoveries from the Pharmaceutical Benefits Scheme	128,045	114,273
Clinical services to other health organisations	6,481	7,485
Non-clinical services to other health organisations	1,201	1,114
Total other fees for services	**135,727**	**122,872**

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

4.4 Other grants and contributions

	2026 $'000	2025 $'000
Research grants	1,462	1,351
Other grants	3,529	5,288
	4,991	**6,639**

4.5 Other revenue

	2026 $'000	2025 $'000
Use of hospital facilities	14,003	10,890
Rent from commercial properties	996	532
Rent from residential properties	193	111
Boarders' accommodation	(13)	5
Cafeteria revenue	2,450	2,588
Sale of radiopharmaceuticals	4,409	6,932
Parking	1,062	5,589
Other	2,746	3,271
Total other revenue	**25,846**	**29,918**

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

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	2026 $'000	2025 $'000
Property, plant and equipment	5.1	1,772,517	1,635,118
Depreciation	5.1.1	91,809	76,562
Right-of-use assets	5.2	27,814	29,374
Depreciation	5.2.1	4,786	4,847
Service concession assets	5.3	586,836	539,906
Depreciation	5.3.1	12,603	8,852
Intangible assets	5.4	1,785	2,122
Amortisation	5.4.1	334	361

5.1 Infrastructure, property, plant and equipment

Year Ended 30 June 2025	Land	Buildings	Buildings under construction	Site infrastructure	Leasehold improvements	Computer equipment	Furniture and fittings	Motor vehicles	Medical equipment	Other plant and equipment	Work in progress	Artworks	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
1 July 2024													
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)
Carrying amount at start of year	**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**
Additions	-	-	54,838	-	-	1,489	398	-	15,738	1,150	6,247	-	79,860
Disposals	-	-	-	-	-	-	-	-	(37)	-	-	-	(37)
Transfers from work in progress	-	2,664	(4,137)	1	1,471	-	-	1	1	-	(1)	-	-
Revaluation increments/(decrements)	10,130	251,520	-	-	-	-	-	-	-	-	-	-	261,650
Impairment losses[(a)]	-	(1,508)	-	(218)	-	(88)	(126)	-	(1,288)	(103)	-	-	(3,331)
Depreciation	-	(51,656)	-	(3,808)	(952)	(512)	(659)	(9)	(15,476)	(3,490)	-	-	(76,562)
Carrying amount at 30 June 2025	**264,546**	**1,062,972**	**113,864**	**58,714**	**5,600**	**2,106**	**2,483**	**-**	**68,519**	**44,190**	**11,809**	**315**	**1,635,118**
Gross carrying amount	264,546	1,062,972	113,864	92,703	10,931	4,666	6,896	230	161,376	75,970	11,809	315	1,806,278
Accumulated depreciation	-	-	-	(33,989)	(5,331)	(2,557)	(4,217)	(230)	(91,839)	(31,652)	-	-	(169,815)
Accumulated impairment loss	-	-	-	-	-	(3)	(196)	-	(1,018)	(128)	-	-	(1,345)

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

(a) Recognised in the Statement of comprehensive income. Where an asset measured at cost is written down to recoverable amount, an impairment loss is recognised in profit or loss. Where a previously revalued asset is written down to recoverable amount, the loss is recognised as a revaluation decrement in other comprehensive income.

Year Ended 30 June 2026	Land	Buildings	Buildings under construction	Site infrastructure	Leasehold improvements	Computer equipment	Furniture and fittings	Motor vehicles	Medical equipment	Other plant and equipment	Work in progress	Artworks	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
1 July 2025													
Gross carrying amount	264,546	1,062,972	113,864	92,703	10,931	4,666	6,896	230	161,376	75,970	11,809	315	1,806,278
Accumulated depreciation	-	-	-	(33,989)	(5,331)	(2,557)	(4,217)	(230)	(91,839)	(31,652)	-	-	(169,815)
Accumulated impairment loss	-	-	-	-	-	(3)	(196)	-	(1,018)	(128)	-	-	(1,345)
Carrying amount at start of year	**264,546**	**1,062,972**	**113,864**	**58,714**	**5,600**	**2,106**	**2,483**	**-**	**68,519**	**44,190**	**11,809**	**315**	**1,635,118**
Additions	-	-	91,070	-	-	160	83	30	13,459	243	2,957	7	108,009
Disposals	-	-	-	-	-	-	(54)	-	(649)	(48)	-	-	(751)
Transfers(from)/to work in progress	-	45,740	(45,740)	-	-	-	-	-	-	-	-	-	-
Transfers of assets to other agency	-	-	-	-	-	-	(7)	-	-	-	-	-	(7)
Transfers from /(to) other asset classes	-	-	(17,154)	-	-	-	-	-	-	-	-	-	(17,154)
Revaluation increments/(decrements)	49,169	87,248	-	-	-	-	-	-	-	-	-	-	136,417
Impairment reversal to Equity	-	1,508	-	218	-	-	-	-	-	-	-	-	1,726
Impairment reversal/(losses) [(a)]	-	-	-	-	-	(34)	92	-	880	30	-	-	968
Depreciation	-	(66,315)	-	(3,808)	(973)	(489)	(569)	(3)	(15,669)	(3,983)	-	-	(91,809)
Carrying amount at 30 June 2026	**313,715**	**1,131,153**	**142,040**	**55,124**	**4,627**	**1,743**	**2,028**	**27**	**66,540**	**40,432**	**14,766**	**322**	**1,772,517**
Gross carrying amount	313,715	1,131,153	142,040	92,920	10,931	4,779	6,638	208	173,746	76,144	14,766	322	1,967,362
Accumulated depreciation	-	-	-	(37,796)	(6,304)	(3,000)	(4,504)	(181)	(106,533)	(35,589)	-	-	(193,907)
Accumulated impairment loss	-	-	-	-	-	(36)	(106)	-	(673)	(123)	-	-	(938)

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

(a) Recognised in the Statement of comprehensive income. Where an asset measured at cost is written down to recoverable amount, an impairment loss is recognised in profit or loss. Where a previously revalued asset is written down to recoverable amount, the loss is recognised as a revaluation decrement in other comprehensive income

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

5.1 Infrastructure, property, plant and equipment (continued)

Initial recognition

Items of infrastructure, property, plant and equipment costing $5,000 or more are measured initially at cost. Where an asset is acquired for no cost or significantly less than fair value , the cost is valued at its fair value at the date of acquisition.

Items of infrastructure, property, plant and equipment 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).

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; and
- buildings

Land is carried at fair value.

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

Infrastructure, 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 (Landgate). The effective date was at 1 July 2025, with valuations performed during the year ended 30 June 2026 and recognised at 30 June 2026.

In addition, for buildings under the current replacement cost basis, estimated professional and project management fees are included in the valuation of current use assets.

These valuations are undertaken annually to ensure that the carrying amount of the assets do not differ materially from their fair value at the end of the reporting period.

In undertaking the revaluation, fair value was determined by reference to market values for land: $7.6 million (2025: $6.4 million) and buildings: $1 million (2025: $0.6 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 2026

5.1.1 Depreciation and impairment

	2026 $'000	2025 $'000
Depreciation		
Buildings	66,315	51,656
Site infrastructure	3,808	3,808
Leasehold improvements	973	952
Computer equipment	489	512
Furniture and fittings	569	659
Motor vehicles	21	9
Medical equipment	15,669	15,476
Other plant and equipment	3,965	3,490
Total depreciation for the period	**91,809**	**76,562**

All surplus assets at 30 June 2026 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.

Useful lives

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

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

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

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

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

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

Impairment

Non-financial assets, including items of infrastructure, 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.

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

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

Year Ended 30 June 2025	Land $'000	Buildings $'000	Plant equipment and vehicles $'000	Total $'000
1 July 2024				
Gross carrying amount	728	36,320	7,040	44,088
Accumulated depreciation	(608)	(10,183)	(2,732)	(13,523)
Carrying amount at start of period	**120**	**26,137**	**4,308**	**30,565**
Additions	-	1,696	1,522	3,218
Cost Adjustment	-	589	164	753
Disposals	-	(281)	(34)	(315)
Depreciation	(120)	(3,272)	(1,455)	(4,847)
Carrying amount at 30 June 2025	**-**	**24,869**	**4,505**	**29,374**
Gross carrying amount	-	37,761	7,504	45,265
Accumulated depreciation	-	(12,892)	(2,999)	(15,891)
Year Ended 30 June 2026				
1 July 2025				
Gross carrying amount	-	37,761	7,504	45,265
Accumulated depreciation	-	(12,892)	(2,999)	(15,891)
Carrying amount at start of period	**-**	**24,869**	**4,505**	**29,374**
Additions	-	220	459	679
Cost Adjustment	-	2,710	205	2,915
Disposals	-	(199)	(169)	(368)
Depreciation	-	(3,314)	(1,472)	(4,786)
Carrying amount at 30 June 2026	**-**	**24,286**	**3,528**	**27,814**
Gross carrying amount	-	28,568	7,671	36,239
Accumulated depreciation	-	(4,282)	(4,143)	(8,425)

Initial recognition

At the commencement date of the lease, the Health Service recognises 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 corresponding lease liabilities in relation to these right-of-use assets have been disclosed in note 7.1 *Lease liabilities*.

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

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

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

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.

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:

	2026 $'000	2025 $'000
Depreciation expense of right-of-use assets	4,786	4,847
Lease interest expense	1,664	1,774
Expenses relating to variable lease payments not included in lease liabilities	4	13
Total amount recognised in the statement of comprehensive income	**6,454**	**6,634**

The total cash outflow for leases in 2026 was $6,019,000 (2025: $5,813,000).

As at 30 June 2026 there were no indications of impairment to right-of-use assets.

5.3 Service concession assets

Year Ended 30 June 2025	Land $'000	Buildings $'000	Buildings under construction $'000	Site infrastructure $'000	Computer equipment $'000	Furniture & fittings $'000	Medical equipment	Other plant & equipment $'000	Total $'000
1 July 2024									
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)
Carrying amount at start of period	**31,500**	**305,688**	**70,970**	**11,962**	**226**	**438**	**402**	**374**	**421,560**
Additions	-	-	48,092	-	-	-	422	-	48,514
Transfers from Work in Progress	-	95,267	(95,268)	-	-	1	-	-	-
Revaluation increments/(decrements)	4,100	74,584	-	-	-	-	-	-	78,684
Depreciation	-	(8,122)	-	(334)	(40)	(210)	(84)	(62)	(8,852)
Carrying amount at 30 June 2025	**35,600**	**467,417**	**23,794**	**11,628**	**186**	**229**	**740**	**312**	**539,906**
Gross carrying amount	35,600	467,417	23,794	14,120	391	1,984	5,618	481	549,405
Accumulated depreciation	-	-	-	(2,492)	(205)	(1,755)	(4,878)	(169)	(9,499)
Year Ended 30 June 2026									
1 July 2025									
Gross carrying amount	35,600	467,417	23,794	14,120	391	1,984	5,618	481	549,405
Accumulated depreciation	-	-	-	(2,492)	(205)	(1,755)	(4,878)	(169)	(9,499)
Carrying amount at start of period	**35,600**	**467,417**	**23,794**	**11,628**	**186**	**229**	**740**	**312**	**539,906**
Additions	-	-	3,449	-	-	-	1,303	453	5,205
Disposals	-	-	-	(1)	(1)	-	-	-	(2)
Transfers from Work in Progress	-	25,954	(25,954)	-	-	-	-	-	-
Transfers from /(to) other asset classes	-	-	17,154	-	-	-	-	-	17,154
Revaluation increments/(decrements)	5,400	31,776	-	-	-	-	-	-	37,176
Depreciation	-	(11,540)	-	(334)	(40)	(210)	(325)	(154)	(12,603)
Carrying amount at 30 June 2026	**41,000**	**513,607**	**18,443**	**11,293**	**145**	**19**	**1,718**	**611**	**586,836**
Gross carrying amount	41,000	513,607	18,443	14,119	390	1,984	6,921	934	597,398
Accumulated depreciation	-	-	-	(2,826)	(245)	(1,965)	(5,203)	(323)	(10,562)

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 2026

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; and
- buildings

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

5.3.1 Depreciation and impairment of service concession assets

	2026 $'000	2025 $'000
Charge for the period		
Buildings	11,540	8,122
Site infrastructure	334	334
Computer equipment	40	40
Furniture and fittings	210	210
Medical equipment	325	84
Other plant and equipment	154	62
Total depreciation for the period	**12,603**	**8,852**

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.

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

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 2026 there were no indications of impairment to service concession assets.

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

5.4 Intangible assets

Year ended 30 June 2025	Computer software $'000	Works in progress $'000	Total $'000
1 July 2024			
Gross carrying amount	2,205	-	2,205
Accumulated amortisation	(1,276)	-	(1,276)
Carrying amount at start of year	**929**	**-**	**929**
Cost Adjustment	1,551	3	1,554
Amortisation expense	(361)	-	(361)
Carrying amount at 30 June 2025	**2,119**	**3**	**2,122**
Gross carrying amount	3,756	3	3,759
Accumulated amortisation	(1,637)	-	(1,637)
Year ended 30 June 2026			
1 July 2025			
Gross carrying amount	3,756	3	3,759
Accumulated amortisation	(1,637)	-	(1,637)
Carrying amount at start of period	**2,119**	**3**	**2,122**
Cost Adjustment	**-**	(3)	(3)
Amortisation expense	(334)	-	(334)
Carrying amount at 30 June 2026	**1,785**	**-**	**1,785**
Gross carrying amount	3,756	-	3,756
Accumulated amortisation	(1,971)	-	(1,971)

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.

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

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

	2026 $'000	2025 $'000
Computer software	334	361
Total amortisation for the period	**334**	**361**

At as 30 June 2026, there were no intangible assets not yet available for use.

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 not an integral part of the related hardware.

Impairment of intangible assets

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

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

6 Other assets and liabilities

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

	Notes	2026 $'000	2025 $'000
Receivables	6.1	138,188	118,809
Amounts receivable for services	6.2	1,316,866	1,222,852
Inventories	6.3	13,982	13,714
Other current assets	6.4	5,370	4,391
Payables	6.5	260,780	230,059
Other liabilities	6.6	5,082	1,217

6.1 Receivables

	2026 $'000	2025 $'000
Current		
Trade receivables	41,235	35,046
Other receivables	1,808	1,425
Allowance for impairment of trade receivables	(10,835)	(13,111)
Accrued revenue	32,511	39,052
GST receivable	12,770	11,423
Total current receivables	**77,489**	**73,835**
Non-current		
Accrued salaries account [(a)]	60,699	44,974
Total non-current receivables	**60,699**	44,974
Total receivables	**138,188**	**118,809**

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

(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.

The Health Service recognises a loss allowance for expected credit losses (ECLs) on a receivable not held at fair value through profit or loss. Please refer to note 3.6 for Expected credit losses expense.

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.

6.1.1 Movement in the allowance for impairment of trade receivables

	2026 $'000	2025 $'000
Reconciliation of changes in the allowance for impairment of trade receivables		
Balance at start of period	13,111	12,399
Expected credit losses expense	2,358	2,830
Net write-back adjustment	(2,554)	4
Amounts written off during the period	(2,080)	(2,122)
Balance at end of period	**10,835**	**13,111**

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

	2026 $'000	2025 $'000
Non-current	1,316,866	1,222,852
Balances at end of period	**1,316,866**	**1,222,852**

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 financial assets at amortised cost and are considered not impaired (i.e. there is no expected credit loss of the holding accounts).

6.3 Inventories

	2026 $'000	2025 $'000
Current		
Pharmaceutical stores - at cost	12,696	12,565
Engineering stores - at cost	1,286	1,149
Total inventories	**13,982**	**13,714**

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.

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

6.4 Other current assets

	2026 $'000	2025 $'000
Current		
Prepayments	5,370	4,391
Total other current assets	**5,370**	**4,391**

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

6.5 Payables

	2026 $'000	2025 $'000
Current		
Trade payables	20,468	17,919
Other payables	429	725
Accrued expenses	170,186	150,205
Accrued salaries	69,697	61,210
Total current payables	**260,780**	**230,059**

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 Other current liabilities

	2026 $'000	2025 $'000
Refundable deposits	1,224	1,226
Paid parental leave scheme	356	278
Other	3,502	(287)
Total other current liabilities	**5,082**	**1,217**

7 Financing

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

	Notes	2026 $'000	2025 $'000
Lease liabilities	7.1	30,987	34,523
Finance costs	7.2	1,664	1,774
Cash and cash equivalents	7.3		
Cash and cash equivalents	7.3.1	57,798	51,482
Restricted cash and cash equivalents	7.3.1	74,983	64,108
Reconciliation of net cost of services to net cash used in operating activities	7.3.2	(2,770,491)	(2,582,267)
Capital commitments	7.4	95,355	264,765

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

7.1 Lease liabilities

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

	2026 $'000	2025 $'000
Lease liabilities		
Current	4,277	4,023
Non-current	26,710	30,500
Total lease liabilities	**30,987**	**34,523**

Initial measurement

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 2026

7.2 Finance costs

	2026 $'000	2025 $'000
Lease interest expense	1,664	1,774
Finance costs expensed	**1,664**	**1,774**

Finance cost is the interest component of lease liability repayments.

7.3 Cash and cash equivalents

7.3.1 Reconciliation of cash

	2026 $'000	2025 $'000
Cash and cash equivalents	57,798	51,482
Restricted cash and cash equivalents	74,983	64,108
Balance at end of period	**132,781**	**115,590**
Restricted cash and cash equivalents		
Current		
Other specific purposes [(a)]	65,717	54,842
Mental Health Commission funding [(b)]	9,266	9,266
Total current	**74,983**	**64,108**
Total restricted cash and cash equivalents	**74,983**	**64,108**

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.

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

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

	Notes	2026 $'000	2025 $'000
Net cost of services		(3,081,260)	(2,859,974)
Non-cash items:			
Expected credit losses expense	3.6	2,358	2,830
Depreciation and amortisation expense	5	109,532	90,622
Net loss from disposal of non-current assets	3.6	719	(95)
Adjustment to receivables	6.1.1	(4,634)	(2,118)
Write down of inventories		306	313
Donation of non-current assets		(169)	(462)
Assets impairment	5.1	(968)	1,605
Services received free of charge	5.1,5.2,5.3,5.4	146,376	136,886
Lease re-assessment adjustments		(2,410)	-
(Increase)/decrease in assets:			
GST receivable[(a)]		(1,347)	(1,233)
Receivables		(30)	(11,512)
Inventories		(575)	(1,878)
Other current assets		(978)	(542)
Increase/(decrease) in liabilities:			
Payables[(a)]		30,719	23,069
Current employee related provisions		24,189	50,966
Non-current employee related provisions		3,816	(10,608)
Other current liabilities		3,865	(136)
Net cash used in operating activities		**(2,770,491)**	**(2,582,267)**

(a) Note that the ATO receivable/payable in respect of GST and the receivable/payable in respect of the sale/purchase of non-current assets are not included in these items as they do not form part of the reconciling items.

7.4 Capital commitments

The commitments below are inclusive of GST where relevant.

	2026 $'000	2025 $'000
Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows:		
Within 1 year	86,715	238,744
Later than 1 year and not later than 5 years	8,640	26,021
Later than 5 years	-	-
	95,355	**264,765**

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

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

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.

Expected credit losses for patient receivables were calculated using segmented patient debtor categories, such as private, overseas and workers' compensation debtors, with loss rates applied based on the historical loss experience of each category.

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.

(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:

	2026 $'000	2025 $'000
Financial assets		
Cash and cash equivalents	132,781	115,590
Financial assets at amortised cost [a]	1,442,284	1,330,238
Total financial assets	**1,575,065**	**1,445,828**
Financial liabilities		
Financial liabilities measured at amortised cost[b]	291,767	264,582
Total financial liabilities	**291,767**	**264,582**

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

(b) The amount of financial liabilities at amortised cost excludes GST payable to the ATO (statutory payable).

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

(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 2026						
Expected credit loss rate		2.50%	6.13%	17.04%	26.16%	67.89%
Estimated total gross carrying amount at default	41,235	17,528	5,739	1,725	3,058	13,185
Expected credit losses	(10,835)	(438)	(352)	(294)	(800)	(8,951)
30 June 2025						
Expected credit loss rate		2.46%	5.23%	16.16%	26.31%	73.29%
Estimated total gross carrying amount at default	35,045	10,844	4,625	1,299	2,136	16,141
Expected credit losses	(13,111)	(267)	(242)	(210)	(562)	(11,830)

(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
2026											
Financial assets											
Cash and cash equivalents	-	132,781	-	-	132,781	132,781	132,781	-	-	-	-
Receivables [a]	-	125,418	-	-	125,418	125,418	125,418	-	-	-	-
Amounts receivable for services	-	1,316,866	-	-	1,316,866	1,316,866	-	-	-	-	1,316,866
		1,575,065	**-**	**-**	**1,575,065**	**1,575,065**	**258,199**	**-**	**-**	**-**	**1,316,866**
Financial liabilities											
Payables	-	260,780	-	-	260,780	260,780	260,780	-	-	-	-
Lease liabilities [b]	5.38	30,987	30,987	-	-	40,746	540	979	4,203	14,518	20,506
		291,767	**30,987**	**-**	**260,780**	**301,526**	**261,320**	**979**	**4,203**	**14,518**	**20,506**
2025											
Financial assets											
Cash and cash equivalents	-	115,590	-	-	115,590	115,590	115,590	-	-	-	-
Receivables [a]	-	107,386	-	-	107,386	107,386	107,386	-	-	-	-
Amounts receivable for services	-	1,222,852	-	-	1,222,852	1,222,852	-	-	-	-	1,222,852
		1,445,828	**-**	**-**	**1,445,828**	**1,445,828**	**222,976**	**-**	**-**	**-**	**1,222,852**
Financial liabilities											
Payables	-	230,059	-	-	230,059	230,059	230,059	-	-	-	-
Lease liabilities [b]	5.01	34,523	34,523	-	-	46,143	493	1,322	3,850	16,542	23,936
		264,582	**34,523**	**-**	**230,059**	**276,202**	**230,552**	**1,322**	**3,850**	**16,542**	**23,936**

(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 2026

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).

The following table represents the Health Service's assets measured at fair value:

	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
Assets measured and recognised at fair value:				
2026				
Land				
Residential	-	50	-	50
Specialised	-	7,586	347,079	354,665
Buildings				
Residential and commercial car park	-	258	57,927	58,185
Specialised	-	700	1,585,875	1,586,575
	-	**8,594**	**1,990,881**	**1,999,475**
Assets measured and recognised at fair value:				
2025				
Land				
Residential	-	45	-	45
Specialised	-	6,360	293,741	300,101
Buildings				
Residential and commercial car park	-	49	55,387	55,436
Specialised	-	400	1,474,553	1,474,953
	-	**6,854**	**1,823,681**	**1,830,535**

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

There were no transfers between Levels 1, 2 or 3 during the current and previous periods.

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.

Fair value measurements using significant unobservable inputs (Level 3)

	Land $'000	Buildings $'000	Total $'000
2026			
Fair value at start of period	293,741	1,529,940	1,823,681
Additions and transfers from work in progress	-	71,694	71,694
Revaluation increments/(decrements)	53,338	105,815	159,153
Impairment	-	1,321	1,321
Depreciation	-	(64,968)	(64,968)
Fair value at end of period	**347,079**	**1,643,802**	**1,990,881**
2025			
Fair value at start of period	280,352	1,167,220	1,447,572
Additions and transfers from work in progress	-	97,931	97,931
Revaluation increments/(decrements)	13,389	325,881	339,270
Impairment	-	(1,322)	(1,322)
Depreciation	-	(59,770)	(59,770)
Fair value at end of period	**293,741**	**1,529,940**	**1,823,681**

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 Landgate 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. 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 Landgate. 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 (presumed to be the highest and best use), which recognises that restrictions or limitations have been placed on their use and disposal when they are not determined to be surplus to requirements. These restrictions are imposed by virtue of the assets being held to deliver a specific community service.

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

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

After the reporting date, the State Government announced the establishment of a new Health Service Provider for women, newborn and children's services, expected to commence in July 2027. Under the announced arrangements, King Edward Memorial Hospital, currently part of North Metropolitan Health Service, is expected to transfer to the new Health Service Provider.

This is a non-adjusting event after the reporting period. The financial impact, if any, has not yet been determined.

9.2 Changes in accounting policy

The following standards are first applied for the reporting period ended on 30 June 2026:

- AASB 2023-5 – Amendments to Australia Accounting Standards – Lack of Exchangeability
- AASB 2024-4a – Amendments to Australian Accounting Standards – Effective Date of Amendments to AASB 10 and AASB 128
- AASB 2026-1 – Amendments to Australian Accounting Standards – Disclosures about Uncertainties in the Financial Statements

These standards have no impact on the Health Service.

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 9 – Requirement 4 *Application of Australian Accounting Standards and Other Pronouncements* or by an exemption from TI 9. Where applicable, the Health Service plans to apply the following Australian Accounting Standards from their application date.

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

Operative for reporting periods beginning on 1 Jan 2026	
AASB 2024-2	*Amendments to Australian Accounting Standards – Classification and Measurement of Financial Instruments* This Standard amends AASB 7 and AASB 9 as a consequence of the issuance of Amendments to the Classification and Measurement of Financial Instruments (Amendments to IFRS 9 and IFRS 7) by the International Accounting Standards Board in May 2024. There is no financial impact.
AASB 2024-3	*Amendments to Australian Accounting Standards – Annual Improvements Volume 11* This Standard amends AASB 1, AASB 7, AASB 9, AASB 10 and AASB 107 as a consequence of the issuance of Annual Improvements to IFRS Standards – Volume 11 by the International Accounting Standards Board in July 2024. There is no financial impact.
AASB 2025-1	*Amendments to Australian Accounting Standards – Contracts Referencing Nature-dependent Electricity* The Standard makes amendments to AASB 7 and AASB 9 as a consequence of the issuance of IFRS *Contracts Referencing Nature-dependent Electricity* (Amendments to IFRS 9 and IFRS 7) by the International Accounting Standards Board in December 2024. There is no financial impact.
Operative for reporting periods beginning on 1 Jan 2028	
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 requirements in AASB 10 and those in AASB 128 (August 2011), in dealing with the sale or contribution of assets between an investor and its associate or joint venture. There is no financial impact.
AASB 18 (NFP /super)	*Presentation and Disclosure in Financial Statements (Appendix D) [for not-for-profit and superannuation entities]* This Standard replaces AASB 101 with respect to the presentation and disclosure requirements in financial statements applicable to not-for-profit and superannuation entities This Standard is a consequence of the issuance of IFRS 18 Presentation and Disclosure in financial Statements by the International Accounting Standards Board in April 2024. This Standard also makes amendments to other Australian Accounting Standards set out in Appendix D of this Standard. There is no financial impact.
AASB 2024-4b	*Amendments to Australian Accounting Standards – Effective Date of Amendments to AASB 10 and AASB 128 [deferred AASB 10 and AASB 128 amendments in AASB 2014-10 apply]* This Standard defers (to 1 January 2028) 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. There is no financial impact.

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

9.4 Key management personnel

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

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

Compensation band of members of the accountable authority

	2026	2025
Compensation band ($)		
$30,001 – $40,000	-	1
$40,001 – $50,000	7	6
$50,001 – $60,000	-	1
$70,001 – $80,000	-	1
$80,001 – $90,000	1	-
	8	**9**

	2026 $'000	2025 $'000
Short-term employee benefits	370	394
Post-employment benefits	44	45
	414	**439**

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:

	2026	2025
Compensation band ($)		
$50,001 – $100,000	2	1
$100,001 – $150,000	3	-
$150,001 – $200,000	5	1
$250,001 – $300,000	2	7
$300,001 – $350,000	2	4
$450,001 – $500,000	1	-
$500,001 – $550,000	1	1
$550,001 – $600,000	2	1
$600,001 – $650,000	1	1
	19	**16**

	2026 $'000	2025 $'000
Short-term employee benefits	4,501	4,205
Post-employment benefits	526	474
Other long-term benefits	384	430
Total compensation of senior officers	**5,411**	**5,109**

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

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:

- superannuation contributions to GESB (Note 3.1 (a))
- insurance payments to the Insurance Commission and RiskCover fund (Note 3.6)
- lease rentals payments to Department of Housing and Works (Government Office Accommodation, State Fleet and Government Regional Officer Housing) (Note 3.6 and Note 7.1);
- income from State Government (Note 4.1);
- equity contributions (Note 10);
- remuneration for services provided by the Auditor General (Note 9.9);
- service provided free of changes to other WA public sector entities (Note 11(c))

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 2026

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.

	2026 $'000	2025 $'000
Balance at start of period	9,266	10,266
Add receipts		
Service delivery arrangement:		
Commonwealth contributions	141,134	119,177
State contributions	240,089	230,711
	381,223	349,888
Less Payments	(381,223)	(350,888)
Balance at end of period	**9,266**	**9,266**

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:

	2026 $'000	2025 $'000
Auditing the accounts, controls, financial statements and key performance indicators	566	532
	566	**532**

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.

	2026 $'000	2025 $'000
Balance at start of period	2,203,454	2,069,717
Contribution by owners		
Capital Appropriations administered by Department of Health	130,185	133,737
	2,333,639	**2,203,454**
Balance at end of period	**2,333,639**	**2,203,454**

	2026 $'000	2025 $'000
Asset revaluation reserve		
Balance at the start of period	842,614	504,006
Net revaluation increments/(decrements):		
Land	54,569	14,230
Buildings	120,750	324,378
Balance at end of period	**1,017,933**	**842,614**

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

9.11 Supplementary financial information

(a) Write-offs

	2026 $'000	2025 $'000
Revenue and debts written off under the authority of:		
The Accountable Authority	2,080	1,468
The Minister	-	654
	2,080	**2,122**

(b) Losses through theft, defaults and other causes

	2026 $'000	2025 $'000
Losses of public monies and public or other property through theft or default	128	131
Less amount recovered	(128)	(131)
Net losses	**-**	**-**

(c) Services provided free of charge

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

	2026 $'000	2025 $'000
Department of Justice - dental treatment	901	804
Disability Services Commission - dental treatment	468	959
	1,369	**1,763**

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:

	2026 $'000	2025 $'000
Balance at the start of period	137	153
Add Receipts	514	529
Less Payments	(504)	(545)
Balance at the end of period	**147**	**137**

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

	2026 $'000	2025 $'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 2026

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 2026, and between the actual results for 2026 and 2025 are shown below. Narratives are provided for key major variances which vary more than 10% from their comparative and which are also more than 1% of the following (as appropriate):

1. Estimate and actual results for the current year:
    - Total Cost of Services of the annual estimates for the Statement of comprehensive income and Statement of cash flows (1% of $3,122,659,000), and
    - Total Assets of the annual estimates for the Statement of financial position (1% of $3,622,862,000).

2. Actual results between the current year and the previous year:
    - Total Cost of Services of the previous year for the Statements of comprehensive income and Statement of cash flows (1% of $3,104,451,000), and
    - Total Assets for the previous year for the Statement of financial position (1% of $3,681,876,000).

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

10.1.1 Statement of comprehensive income variances

	Variance Notes	Estimate 2026 $'000	Actual 2026 $'000	Actual 2025 $'000	Variance between actual and estimate $'000	Variance between actual results for 2026 and 2025 $'000
COST OF SERVICES						
Expenses						
Employee benefits expense		1,657,818	1,794,769	1,660,203	136,951	134,566
Contracts for services		631,275	640,585	608,018	9,310	32,567
Patient support costs		495,741	516,685	477,689	20,944	38,996
Finance costs		645	1,664	1,774	1,019	(110)
Depreciation and amortisation expense		99,931	109,532	90,622	9,601	18,910
Repairs, maintenance and consumable equipment		51,765	68,208	60,280	16,443	7,928
Other supplies and services		84,134	105,514	102,905	21,380	2,609
Other expenses		101,350	101,804	102,960	454	(1,156)
Total cost of services		**3,122,659**	**3,338,761**	**3,104,451**	**216,102**	**234,310**
INCOME						
Revenue						
Patient charges		88,864	90,392	84,075	1,528	6,317
Other fees for services		128,840	135,727	122,872	6,887	12,855
Other grants and contributions		1,730	4,991	6,639	3,261	(1,648)
Donation revenue		-	545	973	545	(428)
Other revenue		33,522	25,846	29,918	(7,676)	(4,072)
Total revenue		**252,956**	**257,501**	**244,477**	**4,545**	**13,024**
Total income other than income from State Government		**252,956**	**257,501**	**244,477**	**4,545**	**13,024**
NET COST OF SERVICES		**2,869,703**	**3,081,260**	**2,859,974**	**211,557**	**221,286**
INCOME FROM STATE GOVERNMENT						
Department of Health - Service Agreement - State Component		1,659,320	1,705,839	1,644,559	46,519	61,280
Department of Health - Service Agreement - Commonwealth Component	1,a	699,942	792,030	684,982	92,088	107,048
Mental Health Commission - Service Agreement		372,936	381,223	350,166	8,287	31,057
Income from other state government agencies		-	5,083	5,149	5,083	(66)
Assets assumed/(transferred)		-	-	973	-	(973)
Services received free of charge		137,095	146,376	136,885	9,281	9,491
Royalties for Regions Fund		410	410	411	-	(1)
Total income from State Government		**2,869,703**	**3,030,961**	**2,823,125**	**161,258**	**207,836**
Surplus/(deficit) for the period		**-**	**(50,299)**	**(36,849)**	**(50,299)**	**(13,450)**
Other comprehensive income						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve		-	175,319	338,608	175,319	(163,289)
Total other comprehensive income		**-**	**175,319**	**338,608**	**175,319**	**(163,289)**
Total comprehensive income for the period		**-**	**125,020**	**301,759**	**125,020**	**(176,739)**

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

Major estimate and actual (2026) variance narratives:

1) Department of Health – Service Agreement – Commonwealth Component

The variance between estimate and actual of $92.1 million (13%) is due to additional funding received to support the higher cost of service provision, expansion of patient services and increased activity levels.

Major actual (2026) and comparative (2025) variance narratives:

a) Department of Health – Service Agreement – Commonwealth Component

The fundings for Commonwealth Component of the Service Agreement with Department of Health have increased by $107.0 million (16%) due to higher cost of service provision, expansion of patient services and increased activity levels.

10.1.2 Statement of financial position variances

	Variance Notes	Estimate 2026 $'000	Actual 2026 $'000	Actual 2025 $'000	Variance between actual and estimate $'000	Variance between actual results for 2026 and 2025 $'000
ASSETS						
Current assets						
Cash and cash equivalents		18,293	57,798	51,482	39,505	6,316
Restricted cash and cash equivalents		81,977	74,983	64,108	(6,994)	10,875
Receivables		73,835	77,489	73,835	3,654	3,654
Inventories		13,715	13,982	13,714	267	268
Other current assets		4,877	5,370	4,391	493	979
Total current assets		**192,697**	**229,622**	**207,530**	**36,925**	**22,092**
Non-current assets						
Receivables		60,295	60,699	44,974	404	15,725
Amounts receivable for services		1,322,782	1,316,866	1,222,852	(5,916)	94,014
Infrastructure, property, plant and equipment	2	1,522,948	1,772,517	1,635,118	249,569	137,399
Right-of-use assets		29,363	27,814	29,374	(1,549)	(1,560)
Service concession assets	3	492,657	586,836	539,906	94,179	46,930
Intangible assets		2,120	1,785	2,122	(335)	(337)
Total non-current assets		**3,430,165**	**3,766,517**	**3,474,346**	**336,352**	**292,171**
Total assets		**3,622,862**	**3,996,139**	**3,681,876**	**373,277**	**314,263**
LIABILITIES						
Current liabilities						
Payables		230,060	260,780	230,059	30,720	30,721
Lease liabilities		4,023	4,277	4,023	254	254
Employee related provisions		366,138	389,807	365,615	23,669	24,192
Other current liabilities		1,703	5,082	1,217	3,379	3,865
Total current liabilities		**601,924**	**659,946**	**600,914**	**58,022**	**59,032**
Non-current liabilities						
Lease liabilities		30,500	26,710	30,500	(3,790)	(3,790)
Employee related provisions		55,960	59,779	55,963	3,819	3,816
Total non-current liabilities		**86,460**	**86,489**	**86,463**	**29**	**26**
Total liabilities		**688,384**	**746,435**	**687,377**	**58,051**	**59,058**
NET ASSETS		**2,934,478**	**3,249,704**	**2,994,499**	**315,226**	**255,205**

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

EQUITY					
Contributed equity	2,294,965	2,333,639	2,203,454	38,674	130,185
Reserves	842,614	1,017,933	842,614	175,319	175,319
Accumulated surplus/(deficit)	(203,101)	(101,868)	(51,569)	101,233	(50,299)
Total equity	**2,934,478**	**3,249,704**	**2,994,499**	**315,226**	**255,205**

Major estimate and actual (2026) variance narratives:

2) Infrastructure, property, plant and equipment

The variance between estimate and actual of $249.6 million (16%) is mostly due to the revaluation gains for land and buildings of $136.4 million and the additions and cost adjustments totalling $108.0 million during the year.

3) Service concession assets

The variance between estimate and actual of $94.2 million (19%) is largely due to the revaluation gains for land and buildings of $37.2 million and the additions and cost transfers totalling $22.3 million during the year.

Major actual (2026) and comparative (2025) variance narratives: Nil.

Notes to the Financial Statements (continued)

For the year ended 30 June 2026

10.1.3 Statement of cash flows variances

	Variance Notes	Estimate 2026 $'000	Actual 2026 $'000	Actual 2025 $'000	Variance between actual and estimate $'000	Variance between actual results for 2026 and 2025 $'000
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriation		2,633,997	2,790,161	2,595,802	156,164	194,359
Capital appropriations administered by Department of Health		130,437	130,185	133,742	(252)	(3,557)
Royalties for Regions Fund		410	410	411	-	(1)
Net cash provided by State Government		**2,764,844**	**2,920,756**	**2,729,955**	**155,912**	**190,801**
Utilised as follows:						
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits		(1,642,498)	(1,756,978)	(1,610,835)	(114,480)	(146,143)
Supplies and services		(1,227,170)	(1,268,093)	(1,199,618)	(40,923)	(68,475)
Finance costs		(645)	(1,664)	(1,774)	(1,019)	110
Receipts						
Receipts from customers		88,864	77,074	79,350	(11,790)	(2,276)
Other grants and contributions		-	4,992	6,639	4,992	(1,647)
Donations received		-	376	511	376	(135)
Other receipts		162,362	173,802	143,460	11,440	30,342
Net cash used in operating activities		**(2,619,087)**	**(2,770,491)**	**(2,582,267)**	**(151,404)**	**(188,224)**
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Payment for purchase of non-current physical and intangible assets		(130,437)	(113,008)	(128,478)	17,429	15,470
Receipts						
Proceeds from sale of non-current physical assets		-	9	121	9	(112)
Net cash used in investing activities		**(130,437)**	**(112,999)**	**(128,357)**	**17,438**	**15,358**
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Payments for principal element of lease		-	(4,351)	(4,039)	(4,351)	(312)
Payments to accrued salaries account		-	(15,724)	(10,125)	(15,724)	(5,599)
Net cash used in financing activities		**-**	**(20,075)**	**(14,164)**	**(20,075)**	**(5,911)**
Net increase/(decrease) in cash and cash equivalents		15,320	17,191	5,167	1,871	12,024
Cash and cash equivalents at the beginning of the year		160,565	115,590	110,423	(44,975)	5,167
Cash transferred to Treasury		(15,321)	-	-	15,321	-
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**160,564**	**132,781**	**115,590**	**(27,783)**	**17,191**

Major estimate and actual (2026) variance narratives: Nil.

Major actual (2026) and comparative (2025) variance narratives: Nil.



Disclosures and Legal Compliance

Compliance with Public Sector Standards and Commissioner's Instructions

NMHS continued to support compliance with the Public Sector Standards, including the Employment Standard and Filling a Public Sector Vacancy, through the provision of recruitment training, advisory services and practical support to selection panels. This was complemented by guidance to ensure employment decisions were transparent, merit-based and aligned with legislative and policy requirements.

In 2025-26, the Integrity team continued to promote and embed NMHS values and expected standards of conduct across the workforce. This included reinforcing expectations that staff identify, disclose and appropriately manage conflicts of interest, and report suspected breaches of the Code of Conduct. The team maintained responsibility for the assessment and investigation of disciplinary matters in accordance with the *Health Services Act 2016*, Commissioner's Instructions, and applicable policies; progressed implementation of improvement actions arising from corruption prevention and maturity assessments; and expanded integrity education offerings, including new or updated modules and targeted communications to staff who undertake procurement and contract management activities.

As at 30 June 2026, 96 per cent of staff had completed Accountable and Ethical Decision Making (AEDM) training, and 89 per cent had completed triennial AEDM-Refresher training. AEDM and AEDM-R remain mandatory for all staff to ensure compliance with integrity training requirements in Commissioner's Instruction 40: Ethical Foundations.

During the reporting period, the Integrity team received 159 new reports of potential misconduct. All matters were assessed in accordance with established triage processes, including consideration by the NMHS Multi-Disciplinary Assessment Committee where appropriate, to ensure consistent and timely management. Disciplinary processes continued to be undertaken in line with the *Health Services Act 2016*, Commissioner's Instructions and system-wide and NMHS policies.

Grievance claims and Employment Standard matters were managed in accordance with Public Sector Commission requirements. During the reporting period, 12 breach of Employment Standard claims were lodged. Of these, eight were resolved internally and subsequently withdrawn, while one claim remained under consideration at the end of the reporting period. Three claims were referred to the Public Sector Commission for further review. In addition, five breach of standard claims relating to grievance resolution, performance management, termination or redeployment standards were received and managed in accordance with relevant legislative and policy frameworks.

Workplace health, safety and injury management

NMHS is committed to protecting the health, safety and wellbeing of our staff, patients and visitors across all sites. This is supported through proactive risk management, continuous monitoring, and the implementation of strategies to identify, evaluate, manage and mitigate workplace hazards and risks.

Key priorities and achievements in 2025-26 included:

- Strengthening psychosocial risk management through the implementation of Psychosocial Risk Management Guidelines, e-learning modules, a manager response toolkit and screening tool. Targeted initiatives addressed healthcare-specific psychosocial risks, including fatigue and vicarious trauma, to support a safer and healthier workplace.
- Rolling out Psychological First Aid Training to equip leaders with the skills and confidence to recognise signs of distress, provide an appropriate initial response, and support staff experiencing psychological stress or adversity. The training promotes fostering psychologically safe workplaces, early intervention, and connecting staff with appropriate support services when needed.
- Establishing the NMHS Workplace Violence and Aggression (WVA) Committee to support implementation of the Stop the Violence Strategy and strengthen compliance with Department of Health WVA Policy requirements.
- Delivering Work Health and Safety (WHS) due diligence training for the NMHS Board and Executive Team, focused on WHS Officer obligations. This was supported by an assessment of current understanding and governance strategy implementation.
- Conducting the three-yearly Health and Safety Representative (HSR) election, resulting in the election of 262 HSRs across NMHS. This was accompanied by a review and restructure of WHS Committees, increasing the number of committees from six to 11 to strengthen consultation, engagement and oversight of health and safety matters, including high-consequence incidents.

Workplace health, safety and injury management (Continued)

Health and wellbeing snapshot

344
Fit for work referrals undertaken.

3,114
Pre-employment health assessments performed.

418
Hazards reported/ potential incidents averted.

6,950
Reported Code Black incidents.

66
New safety reps trained across NMHS sites, bringing our total number of elected reps to 262.

85
Peer support officers trained in psychological first aid, to support staff experiencing challenges with work, relationships, or other life stressors.

Injury management

Our Injury Management (IM) and Early Intervention (EI) programs continue to deliver positive outcomes for both injured employees and the health service.

The IM system ensures that employees who sustain a workplace injury receive timely support through the EI program or the workers' compensation pathway, helping to optimise recovery and facilitate an early and safe return to work. The EI program provides funding and rapid access to treatment for both physical and psychological injuries through preferred treatment providers. Where ongoing treatment or more complex medical intervention is required, employees are supported through the workers' compensation process.

During the year, the team contacted almost 2,000 injured employees to offer support and assistance. Of those contacted, 80 per cent did not require early intervention treatment or access to the workers' compensation pathway. A total of 116 employees accepted EI treatment, and only 13 subsequently required further treatment through the workers' compensation claim pathway. This demonstrates the effectiveness of early support in addressing injuries before more intensive intervention is needed.

The number of workers' compensation claims lodged during 2025-26 remained stable at 291. Return-to-work outcomes also remained strong, with 67 per cent of injured claimants returning to work within 26 weeks. While this is lower than the 76 per cent achieved in the previous year, the reduction is largely attributable to COVID-19-related claims from the 2024 calendar year. These claims generally involved shorter recovery periods and faster returns to work, which positively skewed the 2024-25 return-to-work results. Variability in this year's data is also reflective of new reporting requirements and definitions, and some previous figures have been re-calculated to enable comparison.

Number of workers compensation claims 2025-2026

	2023-24	2024-25	2025-26
Nursing and midwifery services	187	146	133
Dental clinic assistants	18	9	10
Administration and clerical	16	23	22
Medical (support)	22	26	36
Hotel services	57	59	60
Maintenance	27	19	22
Medical (salaried)	13	10	8
Total	340	292	291

**Data above for prior years has been updated for comparison and to reflect new reporting requirements and definitions.*

Workplace health, safety and injury management (continued)

Psychosocial risk management

Managing psychosocial risks is a key component of NMHS's commitment to ensuring a safe and healthy workplace. In line with the *Work Health and Safety Act 2020* (WA) and *Work Health and Safety Regulations 2022*, significant work has been undertaken to strengthen the identification, assessment and management of psychosocial hazards across the organisation, recognising the unique challenges and complexities of healthcare environments.

Key initiatives delivered or progressed in 2025-26 included:

- Implementing the NMHS Guideline: Psychosocial Hazards in the Workplace (Management of), providing a structured framework to support the consistent identification, assessment and management of psychosocial risks.
- Developing and launching e-learning training to build organisational capability in recognising, preventing and managing psychosocial hazards and promoting a proactive approach to risk management.
- Publishing the Psychosocial Hazards Response Toolkit, a practical resource to support managers in responding to psychosocial hazard concerns and implementing appropriate risk control measures. The toolkit will continue to be enhanced as organisational knowledge and practice evolve.
- Progressing development of a Manager Screening Tool to assist managers in identifying potential psychosocial risks within their work areas and support timely assessment and intervention.
- Strengthening the focus on healthcare-specific psychosocial risks, including fatigue and vicarious trauma, to support the proactive identification and management of risks commonly experienced in healthcare settings.

These initiatives contribute to a stronger organisational approach to psychosocial risk management and support the creation of safe, respectful and psychologically healthy workplaces across NMHS.

Performance reporting

Measures	Results - Base year*	2024-25	2025-26	Targets	Comments about outcome
Number of fatalities	0	0	0	0	
Incidence of work-related injury or illness	33.06	27.87	27.37	Reduce by 2% per year and 15% by 2033 compared with 2023	Almost 2% reduction
Incidence rate of serious claims with one or more weeks' lost time	13.20	12.26	11.00	Reduce by 2.5% per year and 20% by 2033 compared with 2023	Achieved
Incidence rate of claims resulting in permanent impairment	2.64	3.52	3.10	Reduce by 2% per year and 15% by 2033 compared with 2023	Achieved
Incidence rate of work-related respiratory disease	0.49	0.19	0.09	Reduce by 2.5% per year and 20% by 2033 compared with 2023	Achieved
Managers and supervisors trained in:					
1. work health and safety as relevant to the PCBU's risk profile; and	45%	54%	55.5%	Greater than or equal to 80% of cohort trained within last two (2) years	
2. injury management	45%	54%	55.5%	Greater than or equal to 80% of cohort trained within last five (5) years	

*Base year is 2023-24.

Workplace health, safety and injury management (continued)

Measures	Results - Base year*	2024-25	2025-26	Targets	Comments about outcome
Percentage of workers returned to work on full duties and hours (i) within 13 weeks	56%	60.0%	50.24%	No target	*Updated methodology 2025-26 only
Percentage of workers returned to work on full duties and hours (ii) within 26 weeks	67%	76.4%	67.6%	Greater than or equal to 70% returned to work within 26 weeks	
Agency has a WHS management system that has been independently assessed in last five years	Yes	Yes	Yes	Yes	

Measures	Results - Base year*	2024-25	2025-26
Consultative systems: Number of health and safety representatives:			
in total	278	309	314
who have attended HSR training	New*	New*	158
shown as a percentage of workers	2%	2%	2%
shown as a ratio to the number of workplaces occupied by the Agency	69:1	77:1	78:1

Name/s of health and safety committees and sub-committees			
2024-25	**2025-26**	**Targets**	**Comments about outcome**
1. NMHS Corporate	1. NMHS Corporate	No target – intended for agency trend information	1.2 New measure for 2026, not available for previous periods at time of reporting
2. Womens and Newborns Service	2. Womens and Newborns Service		1.4 calculated based on 4 main sites
3. Mental Health Service	3. Mental Health Service		
4. Dental Health Service	4. Dental Health Service		
5. Public Health	5. Public Health		
6. SCGOPHCG	6. Acute Services (SCGOPHCG)		
	7. Cancer, Imaging and Clinical Services (SCGOPHCG)		
	8. Surgical Services (SCGOPHCG)		
	9. Specialty and Ambulatory Services (SCGOPHCG)		
	10. SCGOPHCG General		

*Base year is 2023-24.

Asbestos management

Asbestos removal works were undertaken across a number of NMHS sites to support maintenance, refurbishment and infrastructure programs during 2025-26. Asbestos remediation is a normal part of facility upgrades and typically involves the removal of asbestos-containing materials before refurbishment works can proceed.

While this work is undertaken as part of the normal annual maintenance and upgrade program, the additional funding provided through the Health Asset Maintenance Fund (HAMF) enabled NMHS to accelerate both asset renewal and associated asbestos remediation activities across a broader range of projects. This has allowed asbestos-containing materials to be removed earlier as part of planned upgrade works, reducing future constraints on project delivery and supporting safer, more efficient refurbishment outcomes.



Multicultural action plan

The NMHS Multicultural Plan 2025-2027 was developed by internal and external stakeholders to deliver on the three policy priority areas of the WA Multicultural Policy Framework:

1. Harmonious and inclusive communities
2. Culturally responsive policies, programs and services
3. Economic, social, cultural, civic and political participation.

Launched in March 2025, our plan links to the following policies and strategic documents:

- NMHS Strategic Plan 2024-2027
- NMHS Workforce Diversity and Inclusion Strategy 2022-2026
- NMHS Consumer Experience & Clinical Excellence Strategy 2025-2029
- NMHS Partnership Model
- National Safety and Quality Health Service Standards
- National Safety and Quality Primary and Community Healthcare Standards
- Policy Framework for Substantive Equality
- Western Australian Multicultural Policy Framework
- Workforce Diversification and Inclusion Strategy for WA Public Sector Employment 2020-2025

Some of our achievements over the past year include:

Priority 1: Harmonious and inclusive communities

NMHS sites celebrate at least four cultural days of significance each year including Harmony Week, Ramadan, Diwali and Chinese New Year. Days of significance and annual events are published in a calendar and promoted to all employees. Celebrations such as these help promote the benefits of cultural and linguistic diversity.

In celebration of World Day for Cultural Diversity for Dialogue and Development, an event was held for CaLD employees across NMHS to share stories and experiences. Feedback received at this event contributed to the culture program consultation undertaken to strengthen workforce engagement and organisational performance.

A recruitment guide was developed to facilitate inclusive and accessible NMHS recruitment practices for CaLD people. This contributes to reducing racism, discrimination and the effects of unconscious bias at an individual and systemic level.

Multicultural action plan (continued)

Priority 2: Culturally responsive policies, programs and services

A patient experience tool for newly arrived refugees accessing health services at our Humanitarian Entrant Health Service and WA Tuberculosis Control Program has been translated into six languages – Arabic, Burmese, Dari, Kinyarwanda, Spanish and Swahili. The data collected through this tool will be used to improve the patient experience for CaLD consumers.

A suite of Female Genital Cutting and Mutilation (FGC/M) resources were developed in consultation with consumers, including a flipchart, e-learning package, guideline and patient information brochures.

Expert-led training is delivered to employees on a range of topics including family and domestic violence in CaLD communities and FGC/M, with practical insights to enhance knowledge, awareness and practice. Bespoke training was also developed for interpreters to ensure they felt comfortable when providing interpreting services on sensitive topics.

Strategies such as these contribute to developing a culturally competent workforce.

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

NMHS data on CaLD employees is monitored and included in our quarterly workforce profile dashboard report presented to Executive and Board. This contributes to achieving equitable representation of people from CaLD backgrounds in all levels of the workplace.

Mirrabooka Adult Community Mental Health Service partnered with Medicare Mental Health Service to promote wellbeing and pathways to care at the Mirrabooka Square shopping centre during Harmony Week. The event promoted diversity and unity with a variety of stallholders from services in the local area.

The Multicultural Plan includes a number of measures of success which will be monitored to track progress and initiate new actions as required.

Disability Access and Inclusion

The NMHS Disability Access and Inclusion Plan (DAIP) 2022-2027 guides our efforts across all NMHS sites and services. Below are highlights of the year for each of the seven outcome areas of the DAIP.

General services and events

Outcome 1: People with disability have the same opportunities as other people to access the services of, and any events organised by, a public authority.

- Mental health support card: a wallet-sized card that provides emergency first responders with immediate access to important information about a consumer's mental health circumstances. Developed by the Subiaco lived experience advisory group, the card helps people to receive appropriate care and support during a crisis, while providing reassurance to families and carers that they can be contacted when needed. An initial 500 cards have been printed for mental health consumers who voluntarily want to use this resource.
- Formalised screening and referral pathway for young people in youth detention to assess and diagnose neurodevelopmental disorders. More than 90 assessments were undertaken in 2025, with over 50 new diagnoses made.



Buildings and facilities

Outcome 2: People with disability have the same opportunities as other people to access the buildings and other facilities of a public authority.

- Installation of new wayfinding signage and information kiosks at Sir Charles Gairdner Hospital.
- Introduction of buggy service at Osborne Park Hospital providing option for patients and visitors with mobility issues for easier access to/from buildings and carpark areas. The service supports between 20 and 30 people per day.
- Upgrade of existing accessible bathroom at King Edward Memorial Hospital to include sliding doors.

Disability Access and Inclusion (continued)

Information and communications

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

- The Community Adult Mental Health Lived Experience Group is reviewing a consumer information booklet with a view to create an Easy Read version once finalised. This format will be increase accessibility for people with intellectual disability or lower literacy.

Quality of service

Outcome 4: People with disability receive the same level and quality of service from the staff of a public authority as other people receive from the staff of a public authority.

- NMHS-wide celebration of International Day of People with Disability with a North Danjoo Yacker event for staff. The well-attended event featured a presentation from disability advocate Eric Seery, accompanied by his guide dog Nora, who shared his journey about losing his sight from a young age when diagnosed with Stargardt disease. The session also included a powerful deaf awareness training, which included and overview of AUSLAN and best practice communication strategies for clinicians to support individuals who identify as hard of hearing and deaf.
- The Hidden Disabilities Sunflower initiative was pilot tested at SCGOPHCG and training has now been completed by more than 800 staff. Participating staff are now better able to identify and help patients and visitors with an invisible disability. The initiative will be rolled out across all NMHS services.

Complaints and safeguarding

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

- Consumer feedback forms were updated and now allow respondents to identify any accessibility needs.
- Reports on consumer feedback related to disability access and inclusion are made available to support site/service quality improvement activities.

Consultation and engagement

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

- The SCGOPHCG Community Advisory Council developed materials to support the recruitment and retention of members with disability.

Employment, people and culture

Outcome 7: People with disability have the same opportunities as other people to obtain and maintain employment with a public authority.

- Referral pathways have supported people with disability to secure employment across a range of roles, including patient support services, administration support, food services and maintenance support.
- Two lived experience stories were shared on the hub for International Day of People with Disability to help foster a workplace culture that is inclusive and welcoming for people with disability.



Industrial Relations

Industrial Relations (IR) has provided expert representation and advocacy for a range of industrial matters before the WA Industrial Relations Commission (WAIRC), and its constituent authorities such as the Public Sector Appeal Board (PSAB), and for discrimination-related complaints before the Equal Opportunity Commission (EOC) and the Australian Human Rights Commission (AHRC).

Our IR consultants maintain close links with professional groups including all WA system unions, Department of Health, and the WA health system IR network, ensuring contemporary IR practices and approaches are applied.

Major IR activities in 2025-26 are outlined below.

In 2025-26, IR delivered consultation presentations to HR and leadership networks for the following industrial agreements:

- WA Health System - HSUWA – PACTS Industrial Agreement 2024
- WA Health System – Australian Nursing Federation – Registered Nurses, Midwives, Enrolled (Mental Health) and Enrolled (Mothercraft) Nurses Industrial Agreement 2024
- WA Health System – United Workers Union (WA) – Enrolled Nurses, Assistants in Nursing, Aboriginal Health Workers, Ethnic Health Workers, and Aboriginal Health Practitioners Industrial Agreement 2024
- Dental Health Services – Dental Technicians – CSA Industrial Agreement 2024
- WA Health System Engineering and Building Services Industrial Agreement 2025
- WA Health System – Medical Practitioners (Clinical Academics) AMA Industrial Agreement 2026

Further education was provided to assist teams with understanding changes to the *Industrial Relations Act 1979*.

Job security reviews

The IR team continued to monitor and review fixed term and casual contract usage in accordance with agreement provisions, with 100 per cent of reviews completed within the 90-day timeframe. A total of 1,447 were completed in 2025-26 with 104 recommended for conversion.

Ongoing reporting and monitoring of average casual and agency usage for Health Service Union (HSU) cohorts across all areas of NMHS is trending at 4.37 per cent, marginally above the 4 per cent agreement target. Health Support Worker (HSW) cohorts is trending at 18.2 per cent, which is 8.2 per cent over the industrial agreement target of 10 per cent.

Efforts to reduce insecure employment arrangements include the NMHS Job Security Action Plan, which is overseen by an Executive sub-committee. Key strategies are to increase scrutiny on casual and agency appointments in high-volume operational areas and identify areas of long-term temporarily funded positions for review and potential to convert to permanency.

NMHS was selected to pilot a Job Security Working Group to undertake a root cause analysis of insecure employment and barriers to permanency. The initial pilot will focus on barriers to permanency for health support workers and findings will be reported to a sub-committee of the Ministerial Advisory Panel.

Implementation of new Commissioner's Instructions

The implementation of the new Public Sector Commissioner's Instructions (CIs) commencing on 1 July 2026 was a major reform initiative for NMHS HR and IR teams, modernising recruitment and selection across the public sector. These reforms strengthen governance, improve recruitment efficiency, and support transparent, contemporary workforce practices across the public sector.

Various workforce engagement sessions and a range of resources were developed to support adoption across recruiting managers, with a focus on ensuring consistent, compliant and efficient recruitment practices across NMHS.

Joint Consultative Committees

IR continues to actively participate in Joint Consultative Committees (JCCs) across NMHS, engaging with unions including the United Workers Union (UWU), Civil Service Association (CSA), and the four unions party to and bound by the WA Health System Engineering and Building Services Industrial Agreement 2025.

These forums support structured consultation, early issue identification and collaborative engagement on workforce matters. In 2026, NMHS also established its first JCC with the Australian Medical Association (AMA), strengthening consultation arrangements with medical practitioners.

Industrial Relations (continued)

Modernising career pathways for Allied Health Professionals

The WA Health plan to modernise career pathways for allied health professionals represents a significant reform aimed at enhancing career progression across the workforce. The plan draws on an independent review of career pathways and supports development in clinical practice, education, research, leadership and strategy.

The plan's reclassification and structural reform commitments are being implemented across NMHS, contributing to a more contemporary and sustainable allied health workforce.

Record keeping

The NMHS Recordkeeping Plan 2021 outlines how records are managed across NMHS in accordance with the *State Records Act 2000*. The Plan is under review with revisions due to be submitted to the State Records Commission in November 2026.

Healthcare records management systems across NMHS are well established with robust processes, policy, and procedures.

To further support the recordkeeping practices of healthcare records, NMHS has implemented the Digital Medical Record project across all hospital sites, which enables clinicians to have immediate access, via their computer, to consumers' medical records.

In 2025-26, the statewide Intensive Care Unit Electronic Medical Record project was rolled out at SCGH. This offers a contemporary digital solution for ICU departments across the state, improving clinical practice through clinical decision support tools and creating more detailed records for a range of clinical functions in one place.

NMHS Records Management upgraded the approved Electronic Document Records Management System (EDRMS) from HPE Records Manager 8.3 (TRIM) to Content Manager 23.4 during this reporting period, and continues to implement Content Manager as the approved system for corporate records across NMHS. New help sheets and guides were developed to support the implementation of Content Manager and individual training sessions were delivered to 374 staff requesting access to the EDRMS.

All new staff must undertake the mandatory online Recordkeeping Awareness training course to understand their obligations when dealing with agency records and to promote best practice. All current NMHS Records Management policies, procedures and guides are available to staff on the NMHS hub.

A total of 378,800 new records were registered on the EDRMS by all users during this time. The EDRMS currently holds almost two million registered NMHS records.

Regular compliance audits conducted by the NMHS Records Management team ensure corporate records are captured and sentenced appropriately.



Freedom of Information

The *Freedom of Information Act 1992* (WA) (FOI Act) gives all Western Australians a right of access to information held by NMHS. FOI applications can be granted full access, partial access or access may be refused in accordance with the FOI Act.

The NMHS Information Statement includes a summary of how our functions affect members of the public and patients, 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 held by NMHS is available on 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.

In 2025-26, NMHS sites collectively received 3,875 new applications under FOI legislation.

Dental Health Services did not receive any FOI applications but provides dental records to WA Police on request.

SCGOPHCG

159	2877
Non-personal applications	Personal applications

WNHS

12	302
Non-personal applications	Personal applications

Mental Health Service

11	444
Non-personal applications	Personal applications

NNHS corporate

65	5
Non-personal applications	Personal applications



Board attendance

		Board		Audit and Risk Committee		Finance Committee		People, Engagement and Culture Committee		Safety, Quality and Consumer Engagement Committee	
Number of meetings held		11		5		11		6		11	
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	Karen Gullick	11	11			6	5			6	6
Deputy Chair	Rebecca Strom	11	11	2	2	5	5				
Member	Jahna Cedar OAM	11	5					6	6	11	9
Member	Matthew Coleman	11	9					6	5	11	10
Member	Angela Edwards	7	6	3	1			4	4		
Member	Tony Evans	11	8	5	4	11	10				
Member	Renee Farmer	11	11			11	10	6	6		
Member	Angela Komninos	11	10	5	4					11	9
Member	Lewis MacKinnon	11	9	3	3	5	5			11	11
Member	Ian Rogers	11	8					6	6	11	9

Board and committee remuneration

Position Title	Member Name	Type of remuneration	Period of membership in 2025-26 (months)*	Current term of appointment / tenure	Base salary / sitting fees	Actual remuneration for financial year
Chair	Karen Gullick	Per annum	12	1 July 2025 – 30 June 2028	$75,987	$85,105
Deputy	Tony Evans	Per annum	12	1 July 2024 – 30 June 2027	$41,792	$46,807
Member	Jahna Cedar OAM	Per annum	12	1 July 2025 – 30 June 2028	$41,792	$46,807
Member	Matthew Coleman	Per annum	12	1 July 2026 – 30 June 2029	$41,792	$46,807
Member	Renae Farmer	Per annum	12	1 July 2024 – 30 June 2027	$41,792	$46,807
Member	Angela Komninos	Not applicable	12	8 April 2024 – 7 April 2027	-	-
Member	Lewis MacKinnon	Per annum	12	1 July 2026 – 30 June 2029	$41,792	$46,807
Member	Ian Rogers	Per annum	12	1 July 2024 – 30 June 2027	$41,792	$46,807
Member	Rebecca Strom	Per annum	12	1 July 2023 – 30 June 2026	$41,792	$46,807

Consumer Advisory Committee remuneration

	Total remuneration ($)
Mental Health Consumer Advisory Committee	$7050
SCGOPHCG Consumer Advisory Committee	$6112.50
Women and Newborn Community Advisory Committee	$5362.50

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 through 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 Health Services (Fees and Charges) Amendment Order (No.2) 2025, SL 2025/126 was published on 27 June 2025, giving effect to the fees and charges published in the WA Health Fees and Charges Manual on 1 July 2025.

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 2025-26 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.

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

Personal use credit card expenditure by NMHS cardholders 2025-26

	Aggregate amount ($)
Reporting period	553
Settled by the due date (within 5 working days)	360
Settled after the period (after 5 working days)	193
Outstanding at balance date	-

Consultant reporting

No consultants were engaged to provide strategic advice during the reporting period.

Advertising and sponsorship

In accordance with section 174Z of the *Electoral Act 1907*, health service providers are required to report total advertising expenditure. In 2024-25, the total expenditure was $163,857 compared to $226,471 in 2025-26. The organisations from which advertising services were procured and the amount paid to each organisation are shown in the below table.

Name of Person, Agency or Organisation	$
Advertising agencies	
Creative ADM	26,750
Gatecrasher Advertising Pty Ltd	36,107
JCDECAUX Australia Trading Pty Ltd	3,500
Seven Network (Operations) Limited	5,000
Subtotal	71,357
Media advertising organisations	
Carat Australia Media Services Pty Limited	149,081
Facebook	6,033
Subtotal	155,114
Market research organisations	-
Polling organisations	-
Direct mail organisations	-
Total	**226,471**



Acronyms

CaLD	Culturally and Linguistically Diverse
CAHS	Child and Adolescent Health Service
DAIP	Disability Access and Inclusion Plan
DHS	Dental Health Services
ED	Emergency Department
EMHS	East Metropolitan Health Service
FOI	Freedom of Information
FTE	Full-time equivalent
HAC	Hospital acquired complications
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 Indicators
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer and questioning, intersex, asexual and other gender and sexually diverse persons
MARS	Measurement, Analysis and Reporting System
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
QEII	Queen Elizabeth II Medical Centre
SAC	Severity Assessment Code
SCGH	Sir Charles Gairdner Hospital
SCGOPHCG	Sir Charles Gairdner Osborne Park Health Care Group
SMHS	South Metropolitan Health Service
UWA	University of Western Australia
WACHS	Western Australian Country Health Service
WNHS	Women and Newborn Health Services

Contact details

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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 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 Services

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 Services

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.

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