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

ANNUAL REPORT 2020

Care | Respect | Innovation | Teamwork | Integrity

Acknowledgement of Country and People

We acknowledge the Noongar people as the traditional owners and custodians of the land on which we work, and pay respect to their elders both past and present. North Metropolitan Health Service recognises, respects and values Aboriginal cultures as we walk a new path together.

Using the term – Aboriginal

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

Written permission has been obtained for all staff and patient images used in this report.

Aboriginal readers are warned photographs within this publication may contain images of deceased persons that may cause sadness or distress.

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

Contents

Statement of compliance

For year ended 30 June 2020

Hon. Roger Cook MLA
Deputy Premier; Minister For Health; Mental Health

In accordance with section 63 of the *Financial Management Act 2006*, we hereby submit for your information and presentation to Parliament, the annual report of the North Metropolitan Health Service for the financial year ended 30 June 2020.

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

Tony Dolan
Chief Executive
North Metropolitan Health Service
18 September 2020

Hon. Jim McGinty AM
Board Chair
North Metropolitan Health Service
18 September 2020

Foreword

On behalf of the North Metropolitan Health Service (NMHS), we are proud to present the 2019/20 Annual Report.

At the core of the NMHS Strategic Plan 2017 – 2021 is the belief that as a Health Service, we focus our efforts on strategies that will deliver the best outcomes for our patients and the best working environment for our employees.

This belief has been strengthened with the unprecedented challenges arising from the COVID-19 pandemic.

Rising to the challenges of 2019/20, we:

- introduced telehealth technology to 99 new services
- doubled the proportion of all outpatient activity provided by telehealth between January (18.25 per cent) and June (37.75 per cent)
- increased telehealth consultations for country patients to 67 per cent
- completed construction of the new Sir Charles Gairdner Hospital Emergency Department Fast-track treatment area delivered a successful preventive response to COVID-19
    - opened two dedicated COVID-19 testing clinics
    - implemented innovative workforce wellbeing programs including Mental Health First Aid to better support our employees
    - developed flexible workforce models to support COVID-19 activities
    - achieved or exceeded hand hygiene targets in all areas
    - commenced 14 COVID-related research projects and clinical trials, including collaboration on four studies to develop COVID-19 vaccines and therapeutic interventions
- retained a strong research focus, with 948 publications in peer-reviewed journals, commenced 267 new research projects, joining our 703 continuing projects
- maintained core competency, wellbeing and resilience training, and implemented critical care upskilling training for 302 nurses
- achieved actual savings of $22,986,519, as of April 2020, as a result of the Sustainable and Accountable Futures Program
- commenced works to replace or upgrade assets across all sites including plans to move King Edward Memorial Hospital to the Queen Elizabeth II (QEII) Medical Centre, expand Osborne Park Hospital ($24.9 million), redevelop Joondalup Health Campus and start works under the $32 million Works Stimulus Package.

While supporting high standards of service delivery, the Board and Executive identified several areas for improvement, including the expansion of digital technologies and empowering engagement with consumers. In addition, we have a critical role to play in the achievement of the Sustainable Health Review goals by contributing to the overall health and wellbeing of our workforce and the WA community.

We confirmed our commitment to developing our people and providing the tools they require to conduct their work. The investment is paying off, with improved staff engagement under the 'Our People' strategy, strong participation in the Innovative Future Program and the appointment of 103 People Engagement and Culture Ambassadors across the service. The 2020 Minister for Health Survey saw an organisation-wide increase in engagement of 6 per cent, with

Foreword (cont.)

100 per cent of questions scoring better or equal to the 2019 survey. Pride in NMHS is also increasing, with 70 per cent of our team proud to tell others where they work, and 62 per cent indicating they would recommend NMHS as a great place to work, an increase of 6 per cent from 2019.

We are particularly proud of the professionalism and commitment shown by all our staff during COVID-19. We saw NMHS and WA Health staff unite as one exceptional team to manage the crisis in this State. In the most difficult of circumstances, they managed the demands of their profession with the needs of their families and the community with great composure. They are an inspiration to us all.

We would like to thank the people in NMHS who have made these positive results possible during the year and look forward to the progress we will make in 2020/21 and future years.

Tony Dolan
Chief Executive

Hon. Jim McGinty AM
Board Chair

Kaya

Executive summary

Our goals

Vision

Excellence in health care for our community

Mission

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

Values

Care | Respect | Innovation | Teamwork | Integrity

Strategies

- Strive for better patient health outcomes by **continuously improving clinical excellence**
- Further develop centres of excellence to retain a strong **teaching, training, research and innovation** focus
- **Strengthen our engagement and partnership** with patients, carers, staff and our community
- Enable, **empower and engage our workforce**
- Enhance our clinical services through **professional and efficient corporate support**

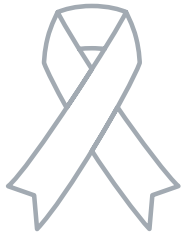
At a glance

How we made a difference in 2019/20

101
Transplant patients
43 kidney, 38 bone marrow and 20 liver

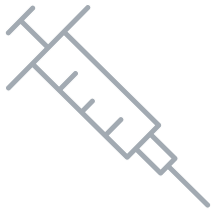
9245
Births

16,511
Mental health patients cared for



26,016
Cancer patients received treatment

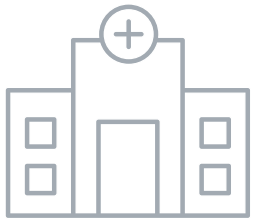
38,984
WA Poisons Information Centre calls



85,372
Patients underwent elective surgery

139,899
School Dental Service patients

171,201
People presented to emergency department



234,655
People presented for visits and appointments

701,255
Outpatient appointments provided

At a glance (cont.)

Safety, quality and engagement snapshot

>80% Hand hygiene **compliance rate**

4399 registered compliments vs **457** complaints

100% response rate on Care Opinion Australia

682 quality improvement projects commenced 2019/20

77% recommendation rate on Care Opinion Australia

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

An **employer of choice** for **Graduate Registered Nurses and Midwives** recruited through GradConnect

Successful accreditation by the **Australian Council of Healthcare Services (ACHS)** to the National Safety and Quality in Health Service Standards

- **Sir Charles Gairdner Hospital**
- **Mental Health, Public Heath and Dental Services (Public Health accreditation)**

At a glance (cont.)

Research snapshot

Research is integral to the delivery of quality health outcomes as well as advancing safer and more effective health care.

Our Strategic Plan provides a roadmap to optimise the attraction and retention of high-calibre researchers and to foster growth and excellence.

We achieve this through a focus on four pillars:

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

$44.2 million
received in grants and sponsorships for NMHS projects approved in 2019/20*

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

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

55	WNHS
805	SCGOPHCG
88	MHPHDS

Current NMHS research projects*

267	new projects
703	continuing projects
14	COVID-related studies

*Data Source: Research Governance Service (RGS). Sources of funding may include commercial, university, and state or federal government grants. All figures are estimations and were based on information that was available at the time of data entry. The actual funding that is received by NMHS may differ. Does not include monies received for projects underway that obtained approved prior to 30 June 2019.

At a glance (cont.)

COVID-19 snapshot*

19,796
COVID-19 Tests Performed

Critical care admissions
14 ICU

30,467
Episodes of contact tracing

$1.1m
additional PPE sourced

2
Dedicated testing clinics

8
Additional ventilators sourced

589
Positive cases

40%
increase in telehealth activity

71 COVID-19
Hospital admissions

Pandemic education

PPE awareness training**

JHC	650	SCGH	2542	OPH	344	MHPHDS	930

Critical care upskills

JHC	212	SCGH	90

Refreshers for former ICU nurses

JHC	38	SCGH	29

Research

14 COVID-related clinical trials or studies

Site works

- 2 COVID clinics **created**
- ED Fast-Track **relocated** to larger space with 5 new consult rooms
- ED isolation room **upgraded** to negative pressure
- Additional 29-bed ED observation area **created**
- Central hospital PPE storage area **created**

*As of 30 June 2020. ** PPE training incorporated correct donning and doffing procedures and all staff were encouraged to attend. PPE training continues with the introduction of train the trainer programs, which is to be rolled out across the services commencing the week of the 15 September.

Overview

North Metropolitan Health Service

Since our establishment in 2016, NMHS has embraced best practice to deliver improved clinical outcomes in the face of rising challenges for all health care providers.

NMHS has a budget of $2.16 billion and 8,943 full-time equivalent (FTE) staff to serve a population of 738,640 people (about 28 per cent of Western Australia's total population) within a catchment area of almost 1,000 square kilometres.

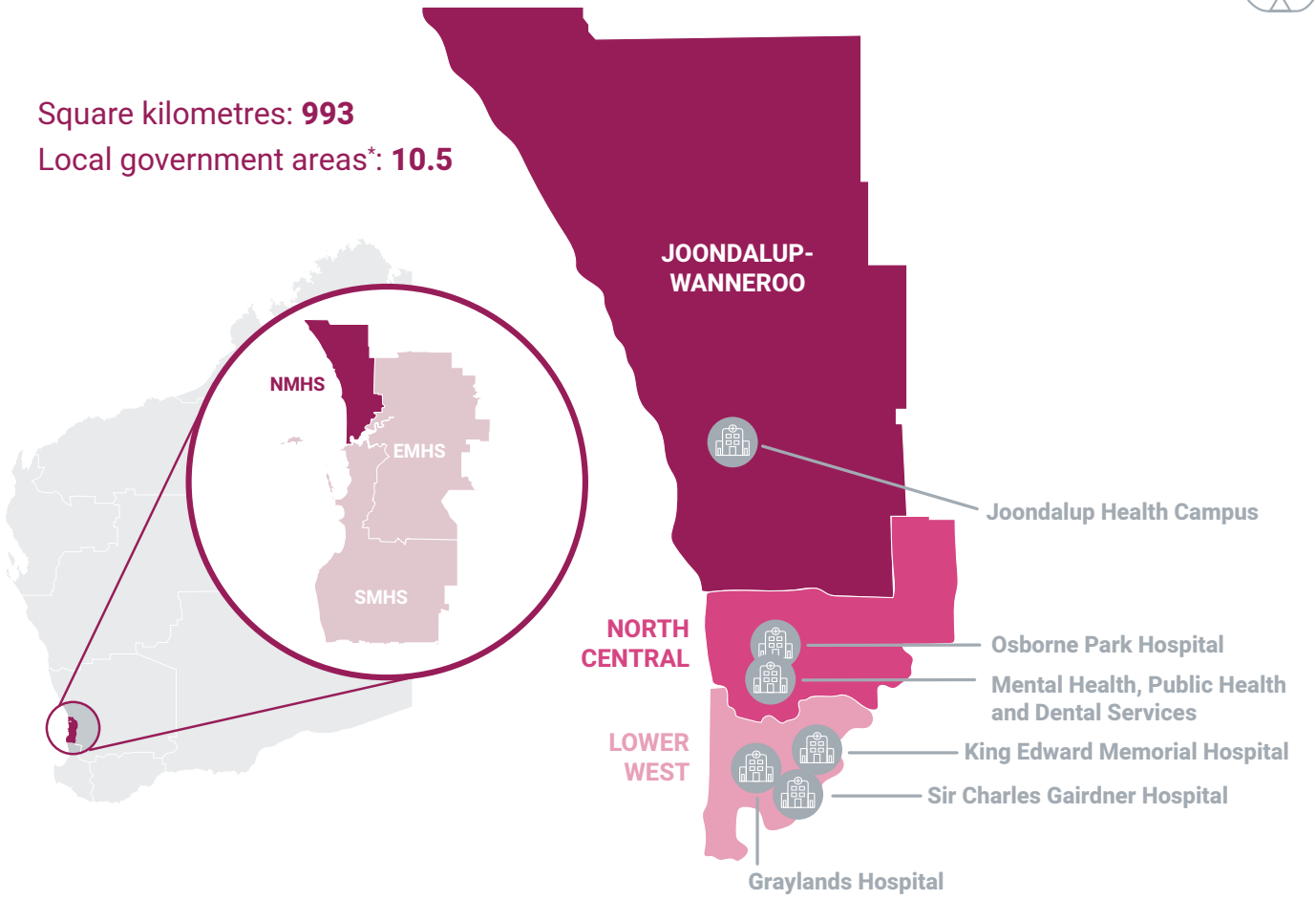
The population we serve is projected to increase by 22 per cent between 2019 and 2030, and the number aged 65 years and older will increase by 49 per cent over the same period.

NMHS provides a comprehensive range of adult specialist medical and surgical services in WA, delivered across three tertiary hospitals and two secondary hospitals, all fully accredited.

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

Square kilometres: **993**

Local government areas*: **10.5**



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

Our Operations

Our annual budget is contained within the approved Minister for Health *Financial Management Act 2006* section 40 Annual Financial Estimates, which were developed based on the initial (2020) Service Agreement.

This agreement outlines the health services we are to provide during the term of the agreement that are within the overall expense limit set by the Department of Health Director General as System Manager, in accordance with the State Government's purchasing intentions.

In 2019/20, the total cost of providing state services and health services to the NMHS community was $2.16 billion. Results for 2019/20 against agreed financial targets (based on the Budget Statements) are presented in the figure below.

Full details of the our financial performance during 2019/20 are provided in the financial statements.

Actual results versus budget targets

desired result | undesired result

Total cost of services ($000)

(expense limit)

sourced from Statement of comprehensive income

2020 Target[1]: **$2 128 947**

2020 Actual: **$2 161 549**

Variation[2]: **$32,602**

Net cost of services ($000)

sourced from Statement of comprehensive income

2020 Target[1]: **$1 152 432**

2020 Actual: **$1 140 223**

Variation[2]: **$12,209**

Total equity ($000)

sourced from Statement of financial position

2020 Target[1]: **$1 924 301**

2020 Actual: **$1 869 601**

Variation[2]: **$54,700**

Net increase in cash held ($000)

sourced from Statement of cash flows

2020 Target[1]: **$12 833**

2020 Actual: **$21 201**

Variation[2]: **$8368**

Approved salary expense level ($000)

2020 Target[1]: **$1 138 117**

2020 Actual: **$1 144 530**

Variation[2]: **$6413**

Explanation of variance – key factors

- Expenditure on continuing and additional services for which funding had not been included in the initial target but was either the subject of budget adjustments throughout the year and at Mid-year Review or recovered through Own Source Revenue.
- Higher dispensing of drugs under the Pharmaceutical Benefits Scheme, offset by recovery of this expenditure through Own Source Revenue.
- Costs incurred to manage the COVID-19 pandemic.

- Commonwealth and Other Grants received for services that were not included in the initial target but were the subject of budget adjustments throughout the year and at Mid-year Review.

- Negative variation in contributed equity of $65.3 million relating to lower capital appropriation; and
- $23.7 million decrement in revaluation reserve, arising largely from Landgate's valuation of NMHS's land and buildings as at 30 June 2020; offset by
- $25.8 million increase in accumulated surplus for the year; and
- $16.9 million in equity transfer to CAHS.

- $23.7 million less spending on purchases of fixed assets; and
- $5.0 million more Service Appropriations received; offset by
- $20.3 million less Capital Appropriations received.

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

Data source: Budget strategy and reporting:

(1) As per 2019/20 section 40 Annual Financial Estimates.

(2) Further explanations of variances are contained in Note 9.12 'Explanatory statement' to the Financial statements.

Our operations (cont.)

Working cash targets

Financial targets ($000)

Agreed working cash limit (at budget)

2020 Limit: **$99,918**
2020 Target: **$99,918**

Variation: **$0**

Financial targets ($000)

Agreed working cash limit (at actuals)

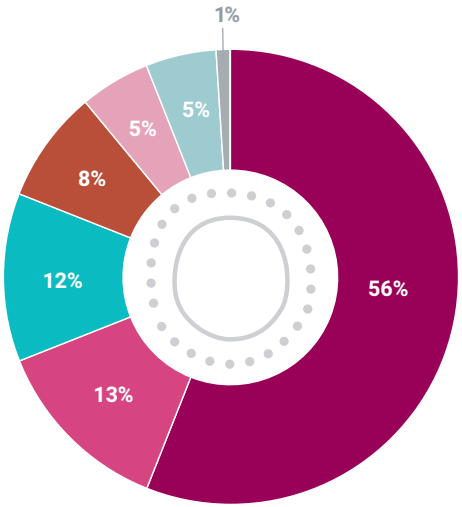
2020 Limit: **$100,148**
2020 Actual: **$103,258**[(a)]

Variation: **$3111**

Data source: Funding plan from the NMHS Service Agreement 2019/20

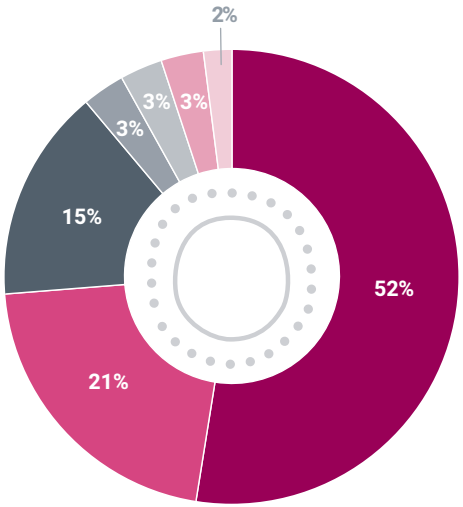
(a) The Actual working cash held totals $103,258,391 which includes an amount of $11,390,664 held for Capital Project works and $47,790,815 held for restricted or contractual obligations. NMHS therefore has $37,667,578 discretionary cash of which $4,674,679 is quarantined by DHS related to an upgrade to their Electronic Dental Records system and $2,507,279 is quarantined by NMHS primarily for research.

Expenses by **services**



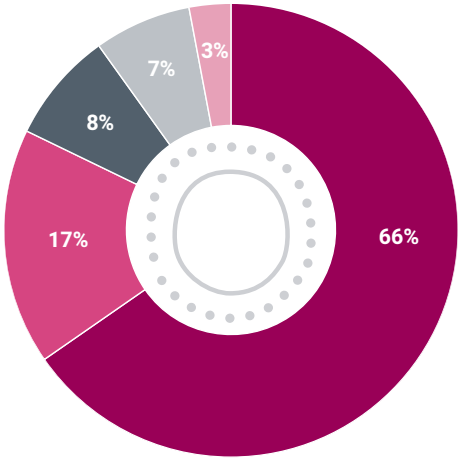
- Public hospital admitted services
- Public hospital non-admitted services
- Mental health services
- Public hospital emergency services
- Public and community health services
- Community dental health services
- Aged and continuing care services

Operating expenses



- Employee benefits expense
- Contracts for services
- Patient support costs
- Other expenses
- Other supplies and services
- Depreciation and amortisation expenses
- Repairs, maintenance and consumable equipment

Income other than income from State Government



- Commonwealth grants and contributions
- Other grants and contributions
- Other fees for services
- Patient charges
- Other revenue

Summary of Key Performance Indicators

KPIs help us assess and monitor the extent to which government outcomes are being achieved. They also provide a means to communicate to the community how we are performing.

Effectiveness indicators provide information that help assess the extent to which outcomes have been achieved through the resourcing and delivery of services to the community.

Efficiency indicators monitor the relationship between the service delivered and the resources used to produce the service.

Table 1 to 4 provide a summary of our KPIs and variation from the 2019/20 targets. The performance notes are subject to finalisation and updating in line with the Office of Auditor General's processes, and therefore the current notes/details are subject to change.

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

Target Met | Target Not Met

Effectiveness KPI	Target	Actual	Variation
	2019 calendar year		
Unplanned hospital readmissions for patients within 28 days for selected surgical procedure			
Knee replacement	≤ 26.2	13.1	**13.1**
Hip replacement	≤ 17.1	14.7	**2.4**
Tonsillectomy and adenoidectomy	≤ 61.0	149.2	**88.2**
Hysterectomy	≤ 41.3	40.2	**1.1**
Prostatectomy	≤ 38.8	46.5	**7.7**
Cataract surgery	≤ 1.1	1.2	**0.1**
Appendicectomy	≤ 25.7	46.9	**21.2**
Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days	≤ 1.0	0.8	**0.2**
Survival rates for sentinel conditions			
Stroke			
0 to 49 years	94.4%	94.6%	**0.2%**
50 to 59 years	93.4%	91.5%	**1.9%**
60 to 69 years	93.5%	88.4%	**5.1%**
70 to 79 years	91.3%	91.3%	**0%**
80+ years	83.2%	86.7%	**3.5%**

Summary of Key Performance Indicators (cont.)

Table 2: Outcome 1 *Public hospital-based services that enable effective treatment and restorative health care for Western Australians*

Target Met | Target Not Met

Effectiveness KPI	Target	Actual	Variation
	2019 calendar year		
Survival rates for sentinel conditions			
Acute myocardial infarction			
0 to 49 years	99%	98.9%	**0.1%**
50 to 59 years	98.9%	99%	**0.1%**
60 to 69 years	98%	97.8%	**0.2%**
70 to 79 years	96.5%	97.7%	**1.2%**
80+ years	92.2%	88.4%	**3.8%**
Fractured neck of femur			
70 to 79 years	98.9%	97.7%	**1.2%**
80+ years	96.1%	96.2%	**0.1%**
Percentage of admitted patients who discharged against medical advice			
Aboriginal patients	≤ 0.77%	3.73%	**2.96%**
Non-Aboriginal patients	≤ 0.77%	0.80%	**0.03%**
Percentage of liveborn term infants with an Apgar score of less than 7 at five minutes post delivery	≤ 1.8%	1.5%	**0.3%**
Readmissions to acute specialised mental health inpatient services within 28 days of discharge	≤ 12%	15%	**3%**
Percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services	≥ 75%	72%	**3%**

Note: Actual results versus KPI results are to be read in conjunction with detailed information on each KPI found in the **Disclosures and Compliance** section of this report.
The performance notes are subject to finalisation and updating in line with the Office of Auditor General's processes, and therefore the current notes/details are subject to change.

Summary of Key Performance Indicators (cont.)

Table 3: Outcome 1 *Public hospital-based services that enable effective treatment and restorative health care for Western Australians*

Target Met | Target Not Met

Effectiveness KPI	Target	Actual	Variation
	2019/20 financial year		
Percentage of elective waitlist patients waiting over boundary for reportable procedures:			
Category 1 over 30 days	0%	8%	**8.3%**
Category 2 over 90 days	0%	13%	**12.7%**
Category 3 over 365 days	0%	8%	**7.7%**
Efficiency KPI			
Average admitted cost per weighted activity unit	$7,026	$7,475	**$449**
Average Emergency Department cost per weighted activity unit	$7,071	$6,893	**$178**
Average non-admitted cost per weighted activity unit	$6,992	$7,349	**$357**
Average cost per bed-day in specialised mental health inpatient services	$1,352	$1,538	**$186**
Average cost per treatment day of non-admitted care provided by mental health services	$417	$403	**$14**

Note: Actual results versus KPI results are to be read in conjunction with detailed information on each KPI found in the **Disclosures and Compliance** section of this report.
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Summary of Key Performance Indicators (cont.)

Table 4: Outcome 2 *Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives*

Target Met | Target Not Met

Effectiveness KPI	Target	Actual	Variation
	2018 to 19 (inclusive) calendar year		
Rate of women aged 50–69 years who participate in breast screening	≥ 70%	55%	**15%**
	2019/20 financial year		
Percentage of who have a tooth re-treated within 6 months of receiving initial restorative dental treatment			
adults	< 7.7%	5.8%	**1.9%**
children	< 2.6%	2%	**0.6%**
Percentage of eligible school children who are enrolled in the Dental Service program	≥ 69%	77%	**8%**
Percentage of eligible people who accessed Dental Health Services	≥ 15%	14%	**1%**
Efficiency KPI			
Average cost per person of delivering population health programs by population health units	$49	$69	**$20**
Average cost per breast screening	$158	$174	**$16**
Average cost per patient visit of WA Health-provided dental health programs for			
school children	$181	$237	**$56**
socioeconomically disadvantaged adults	$267	$303	**$36**
Performance indicator			
Percentage of emergency department patients seen within recommended times:			
Triage category 1 (2 minutes)	100%	100%	**0%**
Triage category 2 (10 minutes)	≥ 80%	80%	**0%**
Triage category 3 (30 minutes)	≥ 75%	51%	**24%**
Triage category 4 (60 minutes)	≥ 70%	64%	**6%**
Triage category 5 (120 minutes)	≥ 70%	87%	**17%**

Note: Actual results versus KPI results are to be read in conjunction with detailed information on each KPI found in the **Disclosures and compliance** section of this report.
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Looking Forward

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

HORIZON 1

Connected services and engaged people

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

HORIZON 2

Consistently excellent healthcare service

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

HORIZON 3

A trusted partner within health care

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

Our service network

Our hospital network

NMHS

SCGOPHCG

WNHS

MHPHDS

Joondalup Health Campus (JHC)
514 public-bed and 146 private-bed hospital

Sir Charles Gairdner Hospital (SCGH)
609-bed tertiary and teaching hospital

Osborne Park Hospital (OPH)
205-bed general hospital

King Edward Memorial Hospital (KEMH)
163-bed women's and neonatal tertiary and teaching hospital

Mental Health Services
235 beds across a range of services

- **Graylands Health Campus** – 121 beds
- **Selby Older Adult Mental Health Service** – 32 beds
- **Forensic Inpatient Services** – 30 beds
- **Sir Charles Gairdner Hospital Mental Health Services** – 52 beds
- **Hospital in the Home (HiTH)** – 24 patients

Our hospital network (cont.)

Sir Charles Gairdner Osborne Park Health Care Group (SCGOPHCG)

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

The group configuration provides the flexibility to provide the right care at the right site for each of our patients, balancing demand and service provision between the two sites. In 2019/20 the leadership teams have been working under the umbrella of the 'one service, two sites' philosophy to ensure that we operate as a single team to provide care seamlessly from the front door of the emergency and outpatient areas, through to the inpatient and specialty same day units, right to rehabilitation and on into the community.

Sir Charles Gairdner Hospital (SCGH) 609

The tertiary-quaternary campus for the group, SCGH provides a comprehensive range of clinical services to adults. With a tertiary catchment that services the NMHS population, SCGH also provides a number of State (quaternary) services. This recognises the interplay between geographical size and population demand which characterises Western Australia and which means that a single provider is the best model for some services such as liver transplantation.

SCGH opened in 1958 and currently employs 4,146 FTE staff who treated 166,896 patients this financial year. Located at the QEII Medical Centre, the collocation of SCGH with significant research facilities and university facilities provides opportunities for collaboration and a thriving research community with many active research projects underway this year.

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

Osborne Park Hospital (OPH) 205

Established in 1962, OPH is the other integral part of the group. As a specialist hospital, OPH employs 607 FTE staff with a focus on the provision of specialist aged care and rehabilitation services; elective surgery; gastroenterology and urology same day surgical activity; obstetrics and gynaecology. With a very busy medical imaging (radiology) department, OPH serves as the lower acuity site for the group. Patients at OPH are able to access suitable specialist services and receive rehabilitation services. The $24.9 million redevelopment currently underway includes a purpose-built rehabilitation unit with additional bed capacity, and a specialised 'therapy hub' which supports the delivery of multidisciplinary therapy.

The OPH Women's and Newborn Health Services delivered 1,466 babies in 2019/20, bringing a new generation into the world and allowing women to deliver closer to home. A new Neonatal Nursery and Maternal Assessment Unit is currently under construction as part of the redevelopment and will allow babies to receive care closer to their families when they need the support of a special care nursery.

Our hospital network (cont.)

Mental Health, Public Health and Dental Services (MHPHDS) 235

Mental Health, Public Health and Dental Services (MHPHDS) provide a comprehensive range of specialist mental health and public health services, including dental services.

MHPHDS Mental Health

Mental Health employs 1300 FTE staff who provides youth, adult, older adult, forensic and statewide mental health services in a variety of settings that includes inpatient units, community mental health centres, day therapy and outreach programs. Specialised care is delivered by multidisciplinary teams comprising medical, nursing and allied health professionals who provide high-quality, person-centred care.

The Inpatient Adult Mental Health Service provides acute care and rehabilitation services at Graylands Hospital, the State's only public psychiatric teaching hospital. It comprises acute beds, hospital extended-care beds and forensic services. Collocated on the Graylands Health Campus is the State Forensic Mental Health Service which includes the Frankland Centre, a maximum secured inpatient facility for people with mental illness within the judicial system. Other inpatient services are delivered at SCGH, OPH and Lower West. Other than OPH, all MHPHDS Mental Health inpatient facilities are authorised to care for involuntary patients under the *Mental Health Act 2014*.

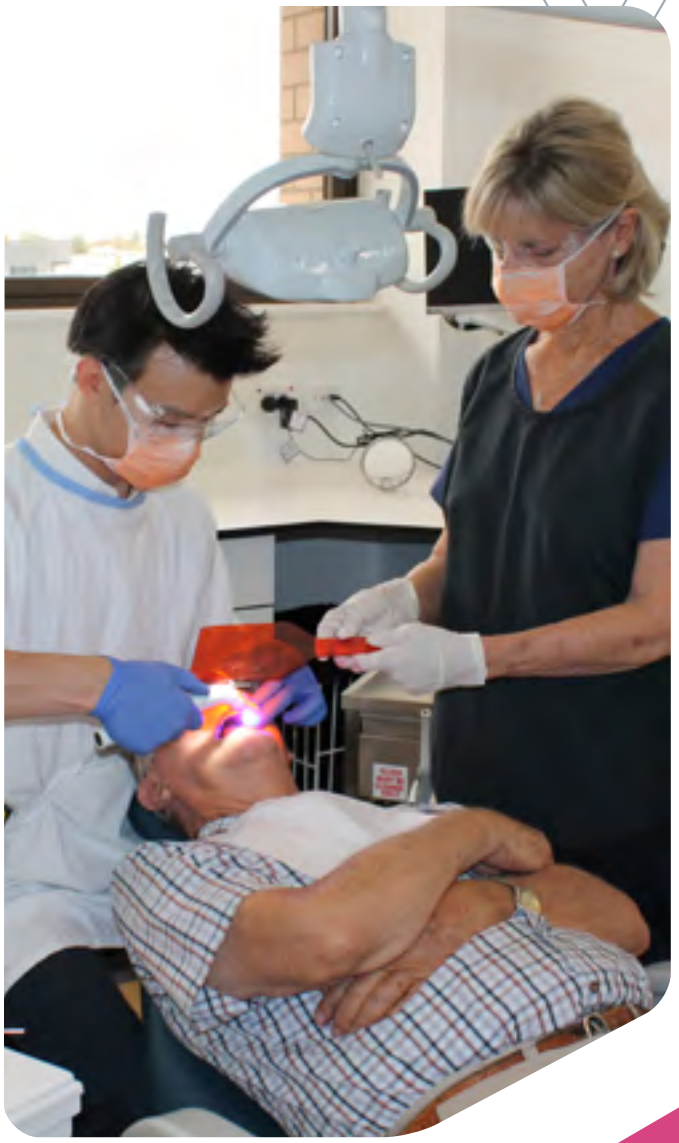
The Community Adult Mental Health Service works in partnership with service providers, consumers and carers to treat people in community clinic or home settings. Clinics are situated at Joondalup, Butler, Mirrabooka, Osborne Park and Subiaco. The Mental Health Specialties Service cares for youth and older adults as well as providing a range of specialised services.

MHPHDS Public Health

Public Health is a team of 111 FTE staff dedicated to providing a diverse range of services to protect, promote and improve the health of whole populations, with a focus on the prevention of disease and the promotion of good health. Services include Aboriginal Health, Communicable Disease Control, Infection Prevention and Control, Health Promotion, the WA Tuberculosis Control Program, DonateLife (organ and tissue donation), the State Head Injury Unit and the Humanitarian Entrant Health Service.

MHPHDS Dental Health

The Dental Health Services is the largest public dental service in WA. It consists of 726 FTE who provide oral health services to children aged 5 to 16 through the statewide School Dental Service, general and emergency dental care for eligible people through metropolitan and country general dental clinics, dental services to eligible clients of the Department of Communities and treatment to residents in metropolitan aged-care and corrective services facilities. Dental Health Services also provide dental care for mental health patients at Graylands Hospital.



Our hospital network (cont.)

Women and Newborn Health Service 163

The Women and Newborn Health Service (WNHS) incorporates King Edward Memorial Hospital and other specialist health services, providing clinical care to women and families in WA.

Established in 1916, KEMH is the State's largest maternity hospital and the only referral centre for complex, high acuity pregnancies that need more care. WNHS employs 1,440 FTE who provide care for more than 48,939 gynaecological patients each year with conditions including general gynaecology and urogynaecology.

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

There are 5,016 births at the hospital each year, with about 75–78 per cent of women needing more concentrated care and attention. Women are offered an array of birthing options, including in the hospital, in the home and in the family birth centre.

General obstetrics and maternal foetal medicine specialist services are available to women with high risk pregnancies and specialist clinics are provided in the areas of diabetes, dietetics, the Women and Newborn Drug and Alcohol Service (WANDAS), Childbirth and Mental Illness (CAMI) and Adolescent Pregnancies. Extensive postnatal care is provided including breastfeeding, physiotherapy, psychological medicine, social work, occupational therapy, physiotherapy, dietetics and pastoral care.

The Child and Adolescent Health Service Neonatal Intensive Care Unit (NICU) and KEMH Special Care Nursery (SCN) comprises 92 beds for predominantly inborn preterm or sick babies, and is located onsite at KEMH.

Our hospital network (cont.)

Joondalup Health Campus 514 (public)

NMHS provides comprehensive services to public patients at the Joondalup Health Campus (JHC) through its public–private partnership with Ramsay Health Care.

JHC is one of WA's largest hospitals, serving more than 72,027 inpatients annually, and offers a range of medical and surgical services including critical care, interventional cardiology, maternity, neonatal and paediatric services, aged care and rehabilitation.

In 2019/20 the JHC Emergency Department (ED) catered for 93,256 presentations with a dedicated paediatric area and a 10-bed Mental Health Observation Area within the ED. The JHC also contains a purpose-built Mental Health Unit that includes secure accommodation.

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

Our community

NMHS population 738,640

28% of WA's population

38% born overseas

20% culturally and linguistically diverse

40% of NMHS population **aged 45 years and above**
41% are 15–44 years

37% of adults reported doing **less than 150 minutes** of **physical activity** per week

63% of adults are considered to be **overweight or obese**

19% of adults admitted **consuming alcohol** at levels **deemed high risk**

52% of adults **do not eat two serves of fruit a day** as per recommended guidelines

18% of adults reported **mental health problems** **diagnosed by a doctor** last year

85% of adults **do not eat five serves of vegetables** as per recommended guidelines

10% of adults admit **still smoking tobacco** against medical advice

Hospitals 5 **Employees** 8943 (FTE)

Main reasons for **hospitalisation**:
- **renal dialysis** (9.5%)
- **diagnostic gastrointestinal endoscopy** (7.9%)
- **chemotherapy/radiotherapy** (7.3%)

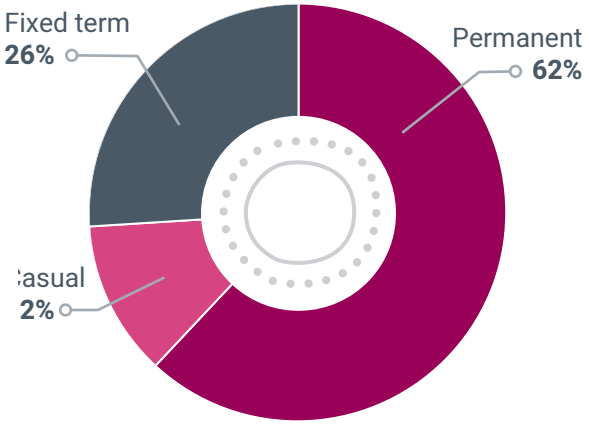
Main reasons for **deaths** between 2011 and 2015:
- **ischaemic heart disease** (13.9%)
- **dementia** (8.4%)
- **cerebrovascular diseases** (6.2%)

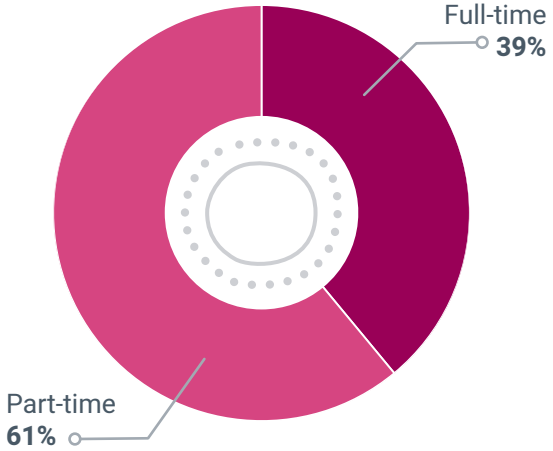
Most commonly **diagnosed cancers**:
- **prostate gland** (16.5%)
- **breast** (14%)
- **melanoma** (10.9%)

Main reasons for **outpatient services**:
- **midwifery** (10%)
- **physiotherapy** (5.5%)
- **orthopaedics** (4.5%)

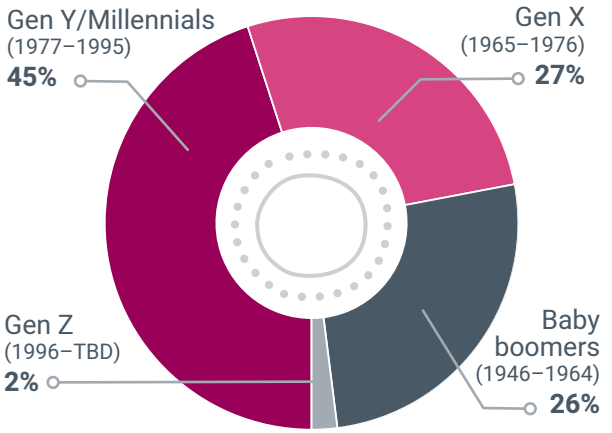
Our people

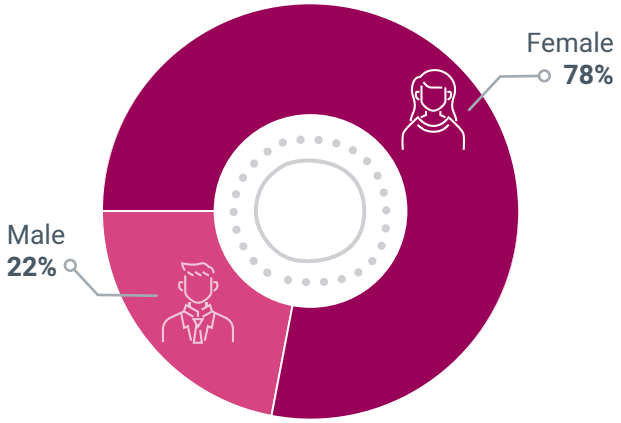
Employment status



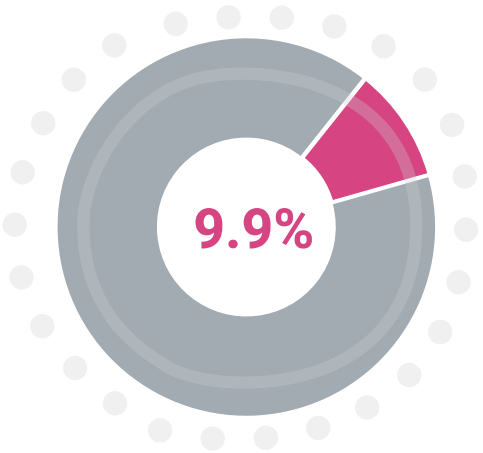


Employee profiles





Culturally and Linguistic Diverse (CaLD) employees



70 Employees with a disability

64 Aboriginal employees

Diversity

NMHS are committed to creating a workplace that reflects the diversity of our community, because a diverse workforce helps us to better understand and serve our consumers. We embrace workforce equity and diversity as a source of strength, understanding that a diverse workforce provides a broader range of skills, experience and opportunities for innovation. Among our catchment of 740,000, about 37.7 per cent of people were born overseas, 19.5 per cent are from culturally and linguistically diverse (CaLD) backgrounds and 1.3 per cent identify as Aboriginal. This proportion has remained stable, with no significant change in the past 12 months.

Our commitment to diversity and being a culturally safe workplace is demonstrated in the results of the Minister for Health 2020 'Your Voice in Health Engagement Survey' where we once again scored highly relating to the question "the people in my team behave in an accepting manner towards people from diverse backgrounds" (86 per cent, up from 83 per cent in 2019).

Our approach is to continue to provide an environment free from discrimination where people feel valued and respected and have access to equal employment opportunity (EEO). Open and inclusive employment practices and policies can help attract and retain talented staff from all groups in the community and help us to respond appropriately to changing needs and aspirations.

In addition to building an inclusive culture, we continued to progress the 'Our People' strategy, launched in December 2019, which aims to increase the diversity of our workforce by facilitating employment of under-represented groups. An EEO management plan will be launched in 2020/21. In light of the dominance of female workers in the sector, measures to increase equal opportunities (for example, through job evaluation) and to ease the reconciliation of work and family life are of paramount importance. Some work has been done in this area, but more work is needed.

Aboriginal Health and Employment

Being sensitive to cultural differences is vital for everyone who works with us. This understanding helps us create better policies and programs, particularly for Aboriginal people.

We have continued a range of healthy lifestyle and health promotion programs that meet the specific needs of Aboriginal people. These include a culturally appropriate aged-care model (palliative care and organ and tissue donation), increased immunisation rates for children aged 12–15 months, and participation in the Ironbark Project, falls prevention among older Aboriginal people. Falls are one of the leading causes of injury-related hospitalisation in older Aboriginal people in WA and contribute to a significant number of deaths each year. Other NMHS programs increase access to primary prevention and services for screening, early detection, treatment and management of chronic diseases.

NMHS is committed to building a representative, skilled Aboriginal workforce across all occupational groups and levels.

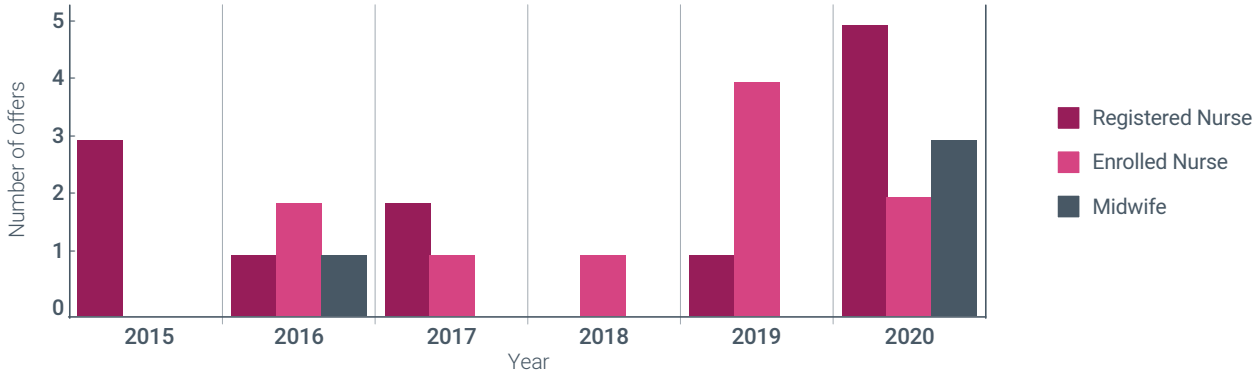
The proportion of our staff identifying as Aboriginal is currently 0.6 per cent, and we are implementing a number of strategies to increase this representation including partnering with community groups to grow our recruitment pipeline.

We aim to attract and support Aboriginal staff through:

- **affirmative measures recruitment** – applying sections 50d and 51 of the *Equal Opportunity Act 1984* to recruitment pools and targeted advertised positions
- **the WA Health Aboriginal Cadetship Program** – two undergraduates are currently employed, enabling them to work while completing a degree
- **the Aboriginal Employee Network** – representatives worked with local communities and Aboriginal coordinators at the government's Job and Skills Centres (JASCs) and Job Active Programs to promote employment opportunities.

In addition, we included an initiative of succession planning and talent management under the 'Our People' strategy and will build our leadership capacity by identifying emerging Aboriginal leaders through this process. Professional development workshops are also taking place to assist Aboriginal employees to identify their career aspirations and development needs.

NMHS offers of employment to Aboriginal nurses and midwives via GradConnect



How we made a difference

Our performance highlights

This section reports on our performance in 2019/20, outlines our achievements and demonstrates how we go about delivering our services to the community. Our purpose is to deliver safe, high-quality and timely health services to the people in the north metropolitan area and beyond.

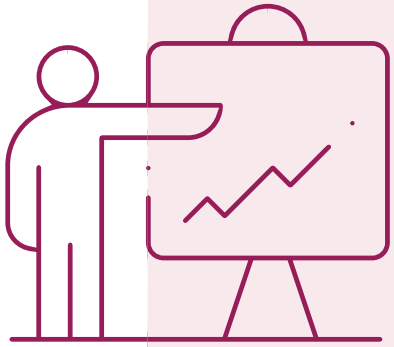
We achieve this through:

- providing the right care and support at the right time and in the right place
- taking a whole-of-system approach – working together to do the right thing for the patient, population and community
- developing seamless pathways between our hospitals and community services to improve care
- strengthening partnerships to better provide services and reach the best outcomes for patients, population and community
- aspiring and committing to creating a learning organisation through teaching, training and research.

Core Strategy 1 - Continuous improvement

Strive for better patient health outcomes by **continuously improving clinical excellence**

Improvements



1. Global Green and Healthy Hospitals

In line with our commitment to achieving greater sustainability and improved public and environmental health, SCGOPHCG and KEMH have joined the Global Green and Healthy Hospitals Network. This international network is dedicated to reducing our environmental footprint. We are committed to achieving greater sustainability and contributing to improved public and environmental health by reducing waste, implementing energy efficient practices, and promoting pedestrian, bicycle and public transport.

2. Adult Intraoperative MRI

In January, the Neville Knuckey Intraoperative Magnetic Resonance Imaging (IOMRI) suite at SCGH welcomed its first patient. A WA first, the state of the art suite is able to better identify structures within the brain than other imaging techniques. When coupled with real-time imaging during surgery, this provides for a more precise and accurate procedure. The $21 million project was funded by federal and WA governments.

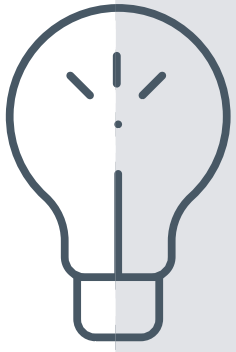
"This theatre is a dream come true and has lived up to all its expectations. It is a great asset for the health service."

Professor Stephen Honeybull
Head of Department, Neurosurgery

Core Strategy 1 - Continuous improvement

Strive for better patient health outcomes by **continuously improving clinical excellence**

Innovations



1. Smoke-free mental health

NMHS Mental Health committed to becoming totally smoke-free in August 2019. Over 100 people across MHPHDS worked to remove the smoking exemptions, by implementing policies and practices to ensure nicotine-dependent patients received appropriate support and care. Mental Health Smoking Guidelines were created to support patients to be smoke-free, and staff received training with a dedicated Smoke-Free intranet hub. Following these efforts, there has been a 33 per cent increase in Nicotine Replacement Therapy (NRT) provided to patients.

2. Sepsis pathway for safe delivery of health care for women

Jess Allan, Clinical Development Midwife in the Labour and Birth Suite of KEMH, has proactively led the Sepsis Pathway Multidisciplinary Team's changes across the WNHS to ensure safe person-centred care for all women across the service. Since the WNHS adoption of the Sepsis Pathway, there has been a significant reduction in recognising and responding to acute deterioration (RRAD) from 30 incidents in December 2018 down to 7 incidents in March 2020.

3. After hours team

A new after hours team commenced at SCGH in February, revolutionising after hours care for patients and staff. The Charlies After-hours Team (CAT) model is underpinned by a philosophy of caring for patients, their families and our staff after hours. The team provides a comprehensive, structured approach supporting existing treating teams.

Led by Dr Tim Paterson (Intensivist and CAT Head of Department), the key goals of the service are:

- provide a zero harm approach to after hours care
- bring a team approach to providing safe quality care
- create a culture of progression
- improve staff satisfaction by providing training, education and support
- make after hours an educationally and professionally rewarding term.

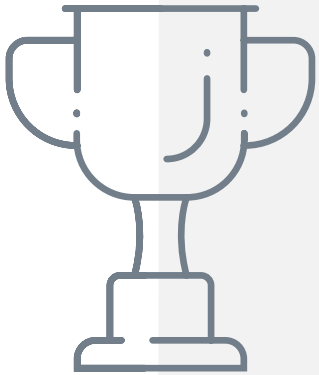
"This is a significant step forward, as more than 70% of patient care occurs after hours."

Dr Francis Lee
Medical Administration Registrar SCGH

Core Strategy 1 - Continuous improvement

Strive for better patient health outcomes by **continuously improving clinical excellence**

Awards



1. **Australian Patients Association's Awards**
   Sir Charles Gairdner Hospital was recognised as a finalist in the 2019 Australian Patients Association's Awards, in the Most Outstanding City Hospital in Australia category. The awards recognise excellence in health service delivery in a range of categories, with nominations collated via public submissions as well as through **Care Opinion Australia**.

2. **WA Nursing and Midwifery Excellence Awards 2020: Graduate of the Year (nominee)***
   Lisa Burt WNHS Family Birth Centre Midwife was nominated for her ability to adapt care to meet women's emotional, cultural and social needs with a maturity that is beyond that of a beginning level practitioner.

3. **WA Nursing and Midwifery Excellence Awards 2020: Excellence in Registered Nursing (nominee)***
   WHNS nurse Jeremy Johnson was nominated for consistently delivering highly specialised care to premature and critically ill babies and their families practising within the NICU Family Integrated Care Framework.

4. **WA Health Excellence Awards Finalist 2019: Category 6, Improving safety and quality**
   Meegan Truarn, Senior Occupational Therapist, and Kien Chan, Consultant Geriatrician, investigated the prevalence of delirium and the gross inequity in patient and hospital outcomes for people with cognitive impairment. A suite of delirium resources was rolled out at the OPH rehabilitation wards and preliminary evidence indicates a positive shift in the culture, practice and outcomes around appropriate screening and interventions for patients.

* As a result of the COVID-19 pandemic, awarding of the WA Nursing and Midwifery Excellence Awards has been postponed.

Reducing anaesthetic gas emissions at SCGH

GLOBAL GREEN and HEALTHY HOSPITALS

Anaesthetic inhalational agents are potent greenhouse gases.

The two most common inhalational agents used are desflurane and sevoflurane, and it is known that desflurane has greater negative impact on the environment compared to sevoflurane. In September 2019, SCGH anaesthetists undertook an initiative to reduce the elective usage of desflurane.

Following an education session highlighting the contribution by anaesthetic agents to the climate crisis, pharmacy data was gathered to better understand the usage of inhalational agents. This usage was then translated to the volume of anaesthetic carbon dioxide equivalents (CO_2e). Desflurane usage at SCGH contributed the overwhelming majority of CO_2e from all anaesthetics gases used.

Upon realising the significant environmental impact directly attributable to individual physician preference, a motion to reduce desflurane use was adopted by the SCGH Anaesthetic Consultants. This has been achieved by removing the desflurane vaporiser from the anaesthetic machines and storing it in the adjacent drug trolley where it is still available for use at the discretion of the attending anaesthetist.

Following this minor change in theatre set-up, over a three-month period the average CO_2e of anaesthetic gas contribution reduced from 35,000kg per month to 5,000kg per month.

Globally supporting clinical excellence in mental health

Centre for Clinical Interventions

The Centre for Clinical Interventions (CCI) is a specialised clinical psychology service that develops and provides evidence-based treatments to adults experiencing complex anxiety, mood, and eating disorders.

The CCI team conducts clinically applied research to improve existing psychological interventions, and, provides training and supervision for health practitioners in evidence-based psychological interventions.

CCI has developed evidence-based resources to support practitioners delivering psychological interventions, as well as individuals seeking self-help materials to improve their mental health, and makes these available via the internet.

During the initial stages of COVID-19, use of CCI modules videos and publications increased by 80 per cent. CCI resources are included as part of state (HealthPathways WA) and national health resources (Head2Health).

CCI were used as part of psychological support services in response to COVID-19 in health services in the UK, USA and throughout Australia. In the last 12 months, successes for the service include:

- CCI resources have been accessed from almost every country in the world
- approximately 20 million page views and 10 million downloads
- CCI clinical demonstration videos have been viewed 41,400 times.

"As a clinician, I am constantly impressed at national and international eating disorders conferences when clinical leaders and world-class services reference the role of the online West Australian CCI modules as critical components of their clinical pathways and educational opportunities for consumers, carers and clinicians of all disciplines."

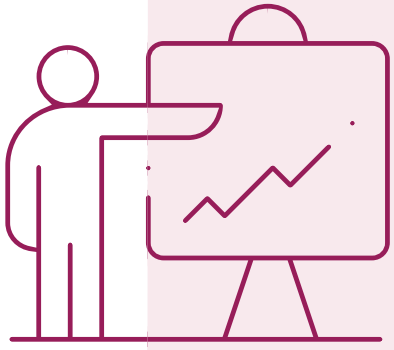
***Dr Lisa Miller** - Medical Director and Liaison Psychiatrist*
WA Eating Disorders Outreach and Consultation Service (WAEDOCS)

https://www.cci.health.wa.gov.au/

Core Strategy 2 - Teaching, training, research and innovation

Further develop centres of excellence to retain a strong **teaching, training, research and innovation** focus

Improvements



1. Sexual violence online training

In February 2020 the Sexual Assault Resource Centre (SARC) released an online learning package on sexual violence and responding to disclosures of sexual assault. As part of the WNHS, SARC provides an important service to both men and women who have been affected by sexual assault or sexual abuse. Their service consists of medical care, forensic examination, counselling, psychology and a 24-hour emergency service. The SARC education and training team comprises a group of professionals with experience and knowledge in the field of sexual violence. The team provides training opportunities related to sexual violence and trauma, to workers, volunteers and students in WA. The course covers a range of new and emerging issues such as morph porn, stealthing, technology facilitated abuse, gaslighting and recent changes to legislation.

2. Guidelines for cognitive behavioural therapy by telehealth

The COVID-19 pandemic has led to a dramatically different way of working for many therapists working with eating disorders, where telehealth has become the norm. However, some clinicians may not feel equipped to deliver therapy via telehealth, while adhering to evidence-based interventions. Dr Bronwyn Raykos of the Centre for Clinical Innovations (MHPHDS) was part of a group of 22 international experts who have produced **recommendations** to better equip the clinician to provide a 'business as usual' approach to therapy with their clients. The guidelines were first published in the *International Journal of Eating Disorders* in May 2020. Dr Raykos is a senior clinical psychologist at CCI and co-director of the CCI eating disorders program.

"I just wanted to say a huge thank you for your excellent self-help modules – they make horribly complicated subjects understandable – and make a real difference!"

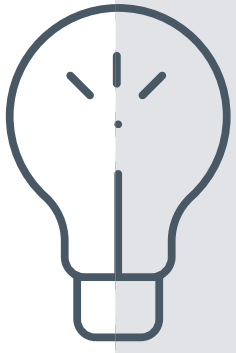
Feedback from CCI consumer

https://onlinelibrary.wiley.com/doi/full/10.1002/eat.23289

Core Strategy 2 - Teaching, training, research and innovation

Further develop centres of excellence to retain a strong **teaching, training, research and innovation** focus

Innovations



1. BreastScreen WA first on My Health Record

BreastScreen WA has delivered more than 30 years of quality care to women, and in May 2020 became the first breast screening service in Australia to connect to My Health Record. Following assessment by two consultant radiologists, consenting women will have their mammogram results uploaded to their My Health Record and the choice of receiving their results via SMS or letter, and their GP is also kept informed electronically if the patient consents.

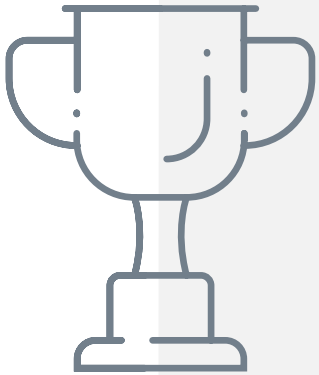
2. SCGOPHCG Research Advisory Committee (RAC) Grant winner: Improving detection of post-partum incontinence

OPH sonographer Meike Tye, in collaboration with nurse researcher Dr Vicki Patton, is researching the prevalence of pelvic floor injury after birth. The aim of the project is to investigate the number of women who injure their pelvic floor muscle after having their first child. The project includes obtaining 3D reconstructed images of their pelvic floor via ultrasound, and surveying the new mothers to enquire about symptoms of incontinence.

Core Strategy 2 - Teaching, training, research and innovation

Further develop centres of excellence to retain a strong **teaching, training, research and innovation** focus

Awards



1. **2019 Award for Excellence in Stroke Care Delivery**

   Clinical Associate Professor William 'Will' McAuliffe, Interventional Neuroradiologist and Deputy Head of Department of the Neurological Intervention and Imaging Service of WA (NIISwa), has been instrumental in developing our statewide stroke mechanical thrombectomy service and received this award for his pioneering work at the Stroke Symposium in October 2019.

2. **WA Health Excellence Awards Mental Health Commissioner's Award Winner 2019**

   This special category award recognises teams working to make a difference to the mental health and wellbeing of people in WA. The introduction of the Western Australian Eating Disorder Consultation and Outreach Service (WAEDOCS) changed the clinical environment in which patients with eating disorders receive care. WAEDOCS developed guidelines, education and mentoring models of outreach and consultation to build capacity among health professionals and services to optimise outcomes for youth and adults with eating disorders.

3. **Churchill Fellowship Award 2019 Winners**

   Churchill Fellowships, awarded in honour of Sir Winston Churchill, enable recipients to gain access to expertise from around the world in an area they are passionate about. Obstetrics and Gynaecology Consultant, Dr Jenni Pontre was recently awarded a fellowship to gain experience in the management of endometriosis, from observerships and courses in the UAE, France, Belgium, Italy and the USA. SCGH Senior Neurological Physiotherapist Mena Garcia-Vega received a Churchill Fellowship supporting her travel to South Korea to learn how some of the world's best interdisciplinary rehabilitation units meet the needs of patients with incurable brain tumours.

"This award is testament to the great team approach at Charlies and the outstanding work and commitment by my colleagues every day and at every level, that is helping Western Australians suffering severe strokes return to their families and livelihoods."

Assoc. Professor Will McAuliffe
Interventional Neuroradiologist and Deputy Head of Department of the Neurological Intervention and Imaging Service of WA (NIISwa)

Core Strategy 2 - Teaching, training, research and innovation

Further develop centres of excellence to retain a strong **teaching, training, research and innovation** focus

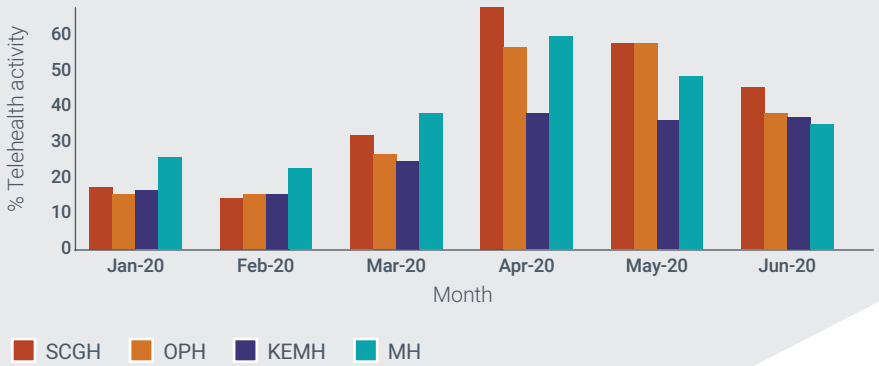
Telehealth

NMHS staff have risen to the challenges of the COVID-19 pandemic, rapidly changing our processes and embracing virtual healthcare (commonly known as telehealth) to keep staff and patients safe. In 2019/20, 99 new services across NMHS have been provisioned with telehealth technology, and usage, as a proportion of all activity, has doubled between January (18.25 per cent) and June (37.75 per cent).

The increase has been consistent across sites, with SCGH reaching a high of 66 per cent, OPH 55 per cent, KEMH 37 per cent and Mental Health 58 per cent. Furthermore, in April 2020, 67 per cent of outpatient consultations for country patients were undertaken by telehealth, surpassing the Sustainable Health Review (2019) target of 65 per cent.

Ongoing support and commitment from staff are critical as we seize this unique opportunity to build on our achievements to deliver innovative, patient-centred care. The figure below provides a snapshot of telehealth activity over the months of the COVID pandemic until 30 June 2020.

Percentage of telehealth activity of total patient activity by NMHS site, January 2020 to May 2020



Data extracted at 20 July 2020. Two data sources are in use – NMHS PAS Outpatient Collection (Attendance type filter equals 'Attended' and DoH MIND Database. Delivery mode excludes 'Home Visit', 'Multidisciplinary Case Conference' and 'Not specified', with Mental health data coming from the DoH MIND Database (Service Event Medium filter excludes 'Not applicable').

Core Strategy 2 - Teaching, training, research and innovation

Further develop centres of excellence to retain a strong **teaching, training, research and innovation** focus

Research

Research is core business at NMHS, being integral to the delivery of quality health outcomes as well as advancing safer and more effective health care. Our research is supported by our Strategic Plan that provides a roadmap to optimise the attraction and retention of high-calibre researchers and to foster growth and excellence. We achieve this through a focus on four pillars:

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

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

From left: Professor Yee Leung, and Dr Jenni Pontre WNHS

Core Strategy 2 - Teaching, training, research and innovation

Further develop centres of excellence to retain a strong **teaching, training, research and innovation** focus

SCGH Clinical Trials Pharmacy Unit

The SCGH Clinical Trials Pharmacy Unit has been involved in the conduct of hundreds of clinical trials, including single site and first-in-human trials with international collaboration. The unit is renowned for its commitment to excellence and commitment to innovation.

Clinical trials – what we do

5656 trial medications dispensed in a year

114 pharmacy clinical trials (phase 1, phase 2, phase 3)

Independently funded by investigators and **constantly alert to business opportunities**

Local, **national** and **global collaboration** with investigators

The unit is renowned for its **commitment** to **excellence** and **innovation**

Exploring **genetically modified organism** compounding

Types of trials

- Sponsored
- Collaborative
- Investigator Driven

Innovative therapies

- Vaccines
- Targeted therapies
- Immunotherapy
- RNA (ribonucleic acid) therapy
- First-in-human-exposure
- Personalised cancer treatment

Core Strategy 2 - Teaching, training, research and innovation

Coronavirus (SARS-CoV-2) and COVID-19 research

NMHS researchers collaborated on the development of vaccines and therapeutic agents to the novel coronavirus, to ensure those affected receive appropriate health care.

Four such studies were **BRACE**, **SPRINT-SARI**, **REMAP-CAP** and **ASCOT**.

Professor Michaela Lucas is leading the BRACE trial, a multicentre randomised controlled clinical trial of the BCG vaccine against COVID-19 with Professors Peter Richmond, Laurens Manning and Nigel Curtis.

BRACE

BCG vaccination to **R**educe the impact of COVID-19 in **A**ustralian healthcare workers following **C**oronavirus **E**xposure

SCGH is a participating centre for a randomised clinical trial that is investigating the use of the tuberculosis (Bacillus Calmette-Guerin – BCG) vaccine to see whether it will protect frontline healthcare workers against COVID-19 or reduce its severity until such time that a specific vaccine is developed. Researchers at Murdoch Children's Research Institute have discovered that the BCG vaccine has positive off-target effects. As well as acting as a vaccine for tuberculosis, it is able to boost the immune system and therefore may help the body fight or destroy the virus. Around 550 NMHS staff have signed up for the year-long trial, which is expected to enrol 4000 healthcare workers from hospitals across Australia.

SPRINT-SARI

Short **P**e**R**iod **I**ncide**N**ce s**T**udy of **S**evere **A**cute **R**espiratory **I**nfection

Through the Australian and New Zealand Intensive Care Society Critical Trials Group, SCGH is taking part in an international multicentre observational study of patients who become unwell with a respiratory infection and require hospitalisation within 10 days. Severe acute respiratory infection (SARI) continues to be of international concern as it has a high rate of mortality, particularly in vulnerable groups such as infants and the elderly. Data on diagnosis and treatment will be collected from all centres and used to develop capability and preparedness for a future epidemic or pandemic.

REMAP-CAP

A **R**andomised, **E**mbedded, **M**ulti-factorial, **A**daptive **P**latform trial for **C**ommunity-**A**cquired **P**neumonia

Led by Monash School of Public Health and Preventive Medicine, SCGH is one of over 200 sites taking part in a global study to simultaneously evaluate multiple treatment options for community-acquired pneumonia (CAP). Treatments include antiviral, immune modulation, steroid and macrolide antibiotics. The majority of people admitted to hospital during a respiratory pandemic are admitted as a result of CAP, which is a leading cause of death from infection worldwide and places a significant burden on our healthcare systems. Although the study has been running for a number of years, it was recently adapted to evaluate respiratory disease caused by COVID-19 through the inclusion of additional treatment interventions. The study will use clinical evidence to determine the best treatment or combination of treatments for CAP due to COVID-19 to improve patient outcomes.

ASCOT

Australa**S**ian **CO**VID-19 **T**rial

One of 50 hospitals across Australia and New Zealand, SCGH is taking part in the ASCOT clinical trial led by The Peter Doherty Institute for Infection and Immunity. This trial will test two existing treatments in patients who have been hospitalised for COVID-19. One of the drugs is an antiretroviral usually used to treat HIV infection, while the other is a drug usually used to treat rheumatoid arthritis or malaria.

The study will recruit patients who have been admitted to hospital for moderate severity disease with the aim of preventing deterioration and the need for ventilator (breathing) support in intensive care. The study will test whether each treatment, or a combination of the two, will improve outcomes for COVID-19 patients. The ASCOT uses an adaptive approach similar to REMAP-CAP so that new and emerging evidence may be used and an effective treatment found much sooner, and thus has the potential to save lives.

Organ donation under the microscope

Even after a successful transplant, organ rejection remains a significant risk for recipients, with only 50–70 per cent of donor organs functioning within five years. Many recipients experience organ rejection despite taking drugs to suppress their body's immune system. While these anti-rejection drugs are effective at preventing rejection over the short term, they suppress the entire immune system, making patients vulnerable to serious infections and even cancer over a long period of time.

Clinical immunologist Professor Michaela Lucas and her colleagues are working to improve kidney, heart and liver transplant success rates with the purchase of a new microsurgical microscope funded by the Charlies Foundation for Research. This microscope will help researchers develop and test new drugs to aid in the prevention of acute and chronic organ rejection.

The new $27,500 next-generation OPMI-7D microscope is one of only a few which allow more efficient testing of new drugs that may be approved for clinical care in the future. The microscope allows for microsurgical techniques to be practised to support pre-clinical trial modelling of organ transplanation and rejection.

The microscope has an added benefit as it is offers junior medical staff who are seeking a career in surgery with an opportunity to develop complex surgical skills, while working with a mentor as the scope has a dual head permitting two surgeons to work simultaneously.

Prof. Michaela Lucas Clinical Immunologist

"The greatest benefit of this new equipment is that it allows us to do more efficient testing of new medications which will hopefully make it into clinical care."

Professor Michaela Lucas
Clinical Immunologist

World-first research to improve outcomes for home dialysis

Assoc. Professor Dr Aron Chakera

Currently, 23 per cent of Western Australians receive their dialysis at home.

There are two different types of dialysis; peritoneal dialysis and haemodialysis. Haemodialysis relies on a machine to pump blood out of the body through an artificial filter, for four to five hours at a time, three times a week. Commonly performed at a clinic or hospital, haemodialysis, while life prolonging, can negatively impact the individual's quality of life and ability to earn an income.

Taking place daily at home, peritoneal dialysis uses the peritoneal membrane, the tough lining of the abdominal wall, to act as a filter for blood within the body when the kidneys can no longer do the task. This can be performed while the individual is asleep, reading a book, or doing their normal activities. The benefit of home dialysis is many patients are able to return to or continue in the workforce.

However, a life-threatening infection of the peritoneal cavity known as peritonitis remains a constant threat for the person undergoing peritoneal dialysis. Peritonitis is the most common complication of peritoneal dialysis. It is usually caused by bacteria or fungi and requires urgent diagnosis and treatment.

Consultant Nephrologist Dr Aron Chakera and his team are leading research into two new diagnostic tests for peritonitis that will potentially result in earlier diagnosis and targeted treatment. Dr Chakera believes the solution could lie in two tests that significantly reduce the time to identify the cause of infection, enabling earlier treatment and reduced severity of infection. One of the tests provides almost immediate confirmation of infection. The second test, which has been developed in WA by PathWest, is able to reduce the wait time to confirm antibiotic resistance profiles from days, to hours. This means the treating doctor is able to prescribe the right antibiotic up front.

"These new tests will help patients to receive the right treatments earlier leading to improved outcomes, as each hour saved in commencing appropriate treatment reduces the risk of death or inability to continue on peritoneal dialysis by almost 7%."

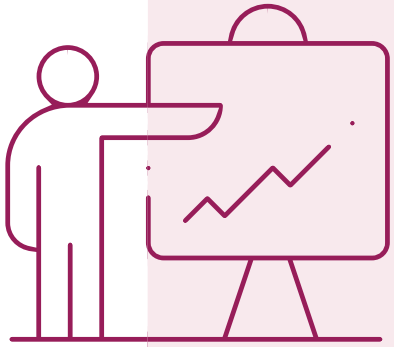
Associate Professor Dr Aron Chakera
Consultant Nephrologist

The study is one of nine projects funded by the State Government's $2.5 million Research Translation Projects program that supports the translation of research to improve patient care and outcomes.

Core Strategy 3 - Engagement

Strengthen our engagement and partnership with patients, carers, staff and our community

Improvements



1. Expansion of the inpatient Alcohol and Drug Service

The SCGOPHCG Alcohol and Drug Service (ADS) is a nurse-led consultancy service providing expert advice in the management of patients across the service who have an alcohol or other drug issue. The ADS, led by Clinical Nurse Consultant Brenda Jones, underwent significant redesign in 2019/20. The ADS experienced an increase in staff and expanded clinical services. This increase in staffing has facilitated a 63% increase in service provision. The team now provide clinical services seven days per week. Since May 2020, the service commenced on-site services to OPH one day per week and outpatient services – a SCGOPHCG first.

2. Mental Health Hospital in the Home

The new Adult Mental Health Hospital in the Home (HiTH) service commenced on 1 October 2019 and is the amalgamation of the Graylands Hospital and the SCGH Mental Health Unit (MHU) HiTH teams. Adult HiTH offers 32 beds, providing daily mental health care in home for up to 14 days as an alternative to hospital admission. The service is available for mental health consumers who are experiencing an acute episode of their condition where risks can be managed in the community. Operating from the SCGH Mental Health Unit and Joondalup Community Mental Health Service allows staff to be closer to patients, reducing travel time and providing more time for clinical care with closer links with referrers. Consumers can be referred to HiTH by their community mental health clinic, community private psychiatrist, emergency departments or public inpatient unit.

3. More oral health promotion in the WA community

The Oral Health Promotion (OHP) team has been increasingly active, participating in over 50 events across the state in October alone including health expos, university open days, school career days and toothbrushing programs in partnership with community leaders, teachers and school nurses. Relationships with community radio stations RTR and Noongar Radio, Diabetes WA, Cancer Council, WA Health Promotion in Schools Association and many others, allow OHP to deliver evidence-based training to their staff and highlighting the interconnection between many health problems and dental diseases.

Core Strategy 3 - Engagement

Strengthen our engagement and partnership with patients, carers, staff and our community

Innovations

1. Reducing blood transfusions and length of stay

Clinical Nurse Consultant Linda Campbell was the 2019 finalist in the Federal Health Minister's Award for Nursing Trailblazers, for her work in Blood Management. Linda's leadership and collaboration with patients, surgeons and General Practitioner has improved the safety and overall hospital experience for elective orthopaedic patients and contributed to the health economy. Blood transfusion rates have reduced significantly through techniques such as iron infusions and erythropoietin, saving blood for those who desperately need it, and saving $1.2 million from the State's annual health budget in transfusion costs alone.

During Research Week 2019 (Oct 21–25), Linda shared her latest study which found sarcoma patients undergoing surgery with haemoglobin (Hb) ≥130g/L and adequate iron had reduced length of stay and need for blood transfusions perioperatively (p=<0.01). The study supports greater adoption of blood management and revision of existing transfusion guidelines.

2. Online Cognitive Behavioural Therapy (CBT) strategies

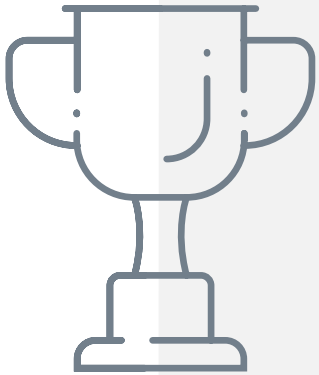
Funded by a grant from the Mental Health Commission, the Centre for Clinical Interventions has released a series of instructional **online videos** for clinicians. Topics covered include psychoeducation about depression and anxiety, as well as collaborative applications of thought diaries, behavioural experiments, and behavioural activation with clients. The videos are a useful resource suitable for mental health students, clinicians, clinical supervisors, and mental health training clinics. To date, the CCI YouTube channel has 1,350 regular subscribers and the instructional videos have been viewed more than 41,400 times.

https://www.youtube.com/channel/UCLA7ZPTJY1U6pXypCEKM8gQ/videos

Core Strategy 3 - Engagement

Strengthen our engagement and partnership with patients, carers, staff and our community

Awards



1. **2019 Parkinson's WA (PWA) Health Professional Award**

   Clinical Nurse Specialist Jo Pye and Clinical Nurse Katriona Russell from the North Metropolitan Parkinson's Service at OPH became the inaugural recipients of Parkinson's WA (PWA) Health Professional Award for their collaborative efforts in providing person-centred care.

2. **Crown Perth and *The West Australian* Healthcare Heroes**

   NMHS staff were well represented in the Healthcare Heroes Awards, with 46 of the 251 nominations for hospital and community-based healthcare workers submitted by the WA community for their efforts during COVID-19 response and preparedness.

3. **WA Nursing and Midwifery Excellence Awards 2020: Excellence in Aboriginal Health (nominee)***

   SCGH nurse Veronica 'Ronnie' Keys was nominated for her leadership role and ambassadorship in the Lighthouse Hospital Project, which aims to drive change in the acute care setting through implementation of quality activities that improve care and outcomes for Aboriginal people experiencing coronary heart disease.

4. **2019 Mental Health Awards 2019: Consumer Impact and Inspiration Award**

   This award was presented to Adult Community Mental Health Peer Coordinator Hayley Solich by Lifepath Psychology for her outstanding contribution to mental health by an individual who identifies as having a lived experience. Hayley was one of almost 150 nominations for the awards across eight categories, with the winners selected for their dedication to improving the mental health and wellbeing of Western Australians.

5. **WA Health Excellence Awards Finalist 2019: Category 4, Developing sustainable solutions for out-of-hospital healthcare**

   SCGH Hospital Pharmacy proposed to reabsorb the manufacture of antibiotic infusors by investing in a Pharmacy Technician and automated fluids transfer device. The pilot exceeded initial targets and reduced Length of Stay due to same-day manufacturing on orders. Estimates indicate at least 420 bed-days a year will be saved.

* As a result of the COVID-19 pandemic, awarding of the WA Nursing and Midwifery Excellence Awards has been postponed.

Clozapine partners

Clozapine is a psychiatric medication that works by helping to restore the balance of certain natural chemicals (neurotransmitters) in the brain.

It is used for treatment-resistant schizophrenia when other medications have not been effective. Clozapine is widely accepted to be the gold standard treatment for schizophrenia. However due to the risk of side effects clozapine requires strict prescribing and monitoring. Such effects include lowering blood cells that fight infections, cardiovascular complications like cardiomyopathy and myocarditis, seizures, low blood pressure and severe constipation.

To reduce these risks, strict monitoring of monthly blood tests and physical health is required for all patients on clozapine.

Collaboration with Clozapine consumers to improve their physical wellbeing

Patients taking Clozapine are already at risk of poor physical health outcomes due to their mental illness and the medication they are prescribed. The Clozapine Clinic focuses on health education and health promotion. Community Registered Mental Health Nurse Carey Taylor engaged with Joondalup community mental health consumers who were prescribed Clozapine, to empower them to have more control over their physical wellbeing and greater quality of life.

A Physical Health Tool was developed to monitor these patients and, combined with ongoing education sessions, enabled significant results in weight loss, smoking cessation, reduction in metabolic syndrome and improved health. Between 2017 and 2020, a combined weight loss of over 70kg was achieved. A breath carbon monoxide monitor was purchased in 2019 and this has been successful in helping some consumers in the smoking cessation program to quit smoking or greatly reduce the amount they smoke and has been instrumental in assisting many to quitting smoking completely.

Establishing a shared care model with GPs

Recent changes to the Pharmaceutical Benefits Scheme (PBS) now allow a nominated GP to prescribe and monitor clozapine as is done in community mental health clinics. A project was undertaken by Registered Mental Health Nurse Fiona Laird to engage with local GP clinics, allowing consumers to have their community-based to have their community-based care with their own GP.

Joondalup Community Mental Health consumers were screened and identified as being suitable to be managed by their GP, thus reducing the need to attend the clinic on a monthly basis.

Discharge pathways were developed and implemented, including shared appointments with the consumer, GP and Liaison Officer to provide clinical handover and education about clozapine and the monitoring requirements. As at 30 June 2020, 19 Joondalup Clozapine consumers had been successfully transferred to GP care.

Core Strategy 3 - Engagement

Strengthen our engagement and partnership with patients, carers, staff and our community

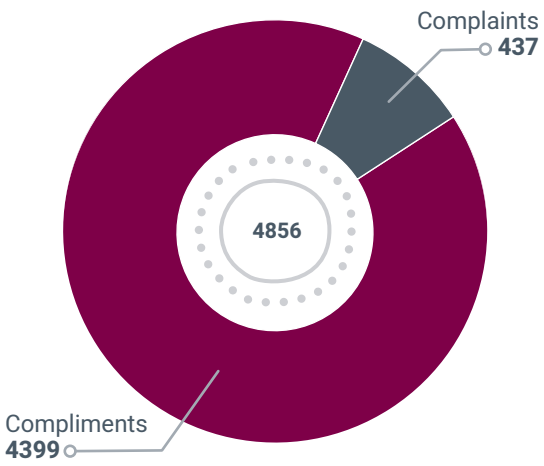
Consumer feedback

We value feedback and are constantly reviewing trends and issues that can provide us with insight into ways we can improve our services. Key data for feedback in 2019/20 are shown below.

Compliments

We are always thrilled to hear that we exceeded the expectations of our community. The number of compliments we received (4399, 91%) once again far exceeded complaints (437, 9%).

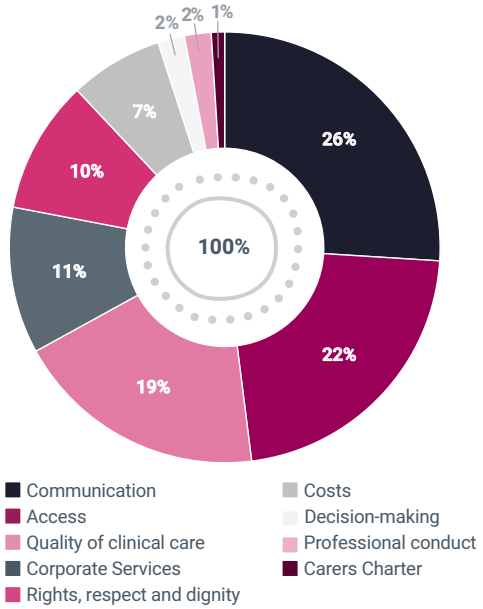
Compliments vs. complaints



Patient contacts

This year we received 1000 contacts from our consumers. The proportions of issue categories for contacts are displayed. Note that one contact may have more than one category issue type recorded for it.

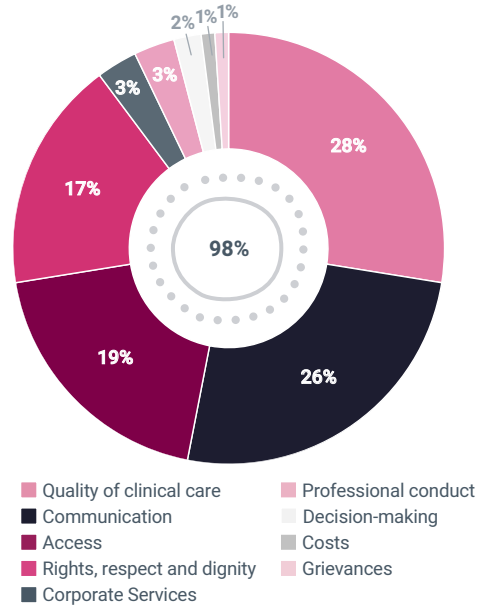
Contact issues



Patient complaints

This year we received a total of 457 complaints. Our Consumer Liaison Services aim to deal fairly and expeditiously with complaints. The proportions of issue categories for complaints are displayed. Note that one complaint may have more than one category issue type recorded for it.

Complaint issues



Core Strategy 3 - Engagement

Strengthen our engagement and partnership with patients, carers, staff and our community

"The doctor and staff there were compassionate and caring. Thank you to all staff, you made such a difference."

SCGH Mental Health Unit [Warrior, https://www.careopinion.org.au/74317]

"Be proud, Osborne Park Hospital. From Pre-Admission to going to theatre and going home, what a great job everyone did!"

OPH [pelicanjm44, https://www.careopinion.org.au/75373]

"They made me feel like I mattered, that I was part of the team and that we were partners in making sure my parent had quality input. I feel they are a shining example of how to nurse and care and how to uphold the Quality Standards."

JHC [perseusmq54, https://www.careopinion.org.au/74002]

"I feel very privileged to have had both of these services for the birth of my 3rd child, it was amazing. Child birth can go all sorts of ways and I believe the staff of both these facilities made sure it was in the best interests of mum & bub."

KEMH Community Midwifery Program [waltzqf69, https://www.careopinion.org.au/726032]

"I would like to thank all the amazing and wonderful staff at the Oral Health Centre. They were highly professional and very kind and caring and highly skilled, and very understanding. I wish them the best in their lives and in their careers and would like to thank them for the excellent care they provided for me."

WA Oral Health Centre [thubanmb44, https://www.careopinion.org.au/72603]

Core Strategy 3 - Engagement

Strengthen our engagement and partnership with patients, carers, staff and our community

Consumer engagement

When patients are engaged in their health care, measurable improvements in safety and quality can follow.

To promote stronger engagement, NMHS strives to strengthen our partnerships with patients and also with carers, staff and our community through a range of initiatives.

A variety of mechanisms are in place across NMHS for patients and carers to share their feedback.

Social media

Social media and health care are a powerful combination, especially when things are changing fast (such as when the COVID situation developed). Social media is a key way of ensuring the public is aware of the latest issues, guidelines and advisories from credible sources. NMHS is increasingly engaging with consumers and the wider community on social media platforms such as Facebook, Instagram and Twitter.

241 Facebook posts

150 Instagram posts

106 Twitter tweets

People, Engagement and Culture Advisory Council

The People, Engagement and Culture Advisory Council (PECAC) works with cultural ambassadors to provide effective positive culture change among staff, clinicians, patients and carers within NMHS. The group used workshops in July and November 2019 to develop a comprehensive work plan and established an online communication forum. This year, the number of ambassadors more than doubled to over 103 staff members.

PECAC Advisory Council members

Front row from left: Rachel Zombor, Danielle Thurlow, Linda Davies, Toni Heinemman

Back row from left: Sam Carrello, Hadley Markus, Courtney Barnes, Hilary Fine, Peter Friedland, Theresa Marshall, Lesley Barr

Core Strategy 3 - Engagement

Strengthen our engagement and partnership with patients, carers, staff and our community

Consumer engagement (cont.)

Engagement with Aboriginal people

Our Aboriginal Cultural Advisory Group (ACAG) provides culturally appropriate advice on health matters on behalf of the Aboriginal community. The ACAG meet every two months in meetings timed to align with the Noongar six seasons. This year, the ACAG have provided advice and supported program development and design in a range of areas including:

- the Statement of Intent for Aboriginal Heath, in partnership with NMHS Clinical Planning
- the Healthy Options Policy, in partnership with Health Promotion
- the Strengthening Antenatal Responses to Family and Domestic Violence project, in partnership with WNHS
- service location and design, in partnership with Dental Health Services
- and provided advice on the dual naming of rooms and public walkways.

Aboriginal Health, a statewide office within WA Health, facilitates a community forum on behalf of NMHS. The twice-yearly meetings review Aboriginal Health programs and services offered in the previous six months within the NMHS region. The meetings also seek advice on the way forward for Aboriginal Health for the upcoming six months.

NMHS Aboriginal Health peer review meetings are attended by more than 40 Aboriginal community members with presentations from the NMHS Aboriginal Health Division, BreastScreen WA, Health Consumers' Council WA, Dental Health Services, Ironbark Program Health Promotion, St John of God Subiaco and the National Disability Insurance Scheme (NDIS). These meetings provide an opportunity to engage with local Aboriginal people on providing areas for improvement. Actionable insights from these meetings include connecting the NDIS representatives with individual families, providing additional community information by direct community mail-outs, registration of community members to the Ironbark Program, providing BreastScreen appointments for community members, and providing additional information and contacts for Dental Health Services in the areas of child and adult dental services and programs.

ACAG Advisory Council members

Front row (left to right): Jennifer Bonney, Lynette Spratt, Jeanette Nettleton, Kathleen Farrell.

Back row (Left to Right): Eric Spratt, Raylene Walley, Laurel Franklin, Clive Smith, Vivienne Weir, Irene Nannup

Absent Members: Lee Bevan, Oriel Green, Barbara McGillivray, Lewis Nannup, Beverley Port-Louis and Diane Yappo

Core Strategy 3 - Engagement

Strengthen our engagement and partnership with patients, carers, staff and our community

Community Advisory Councils

Community Advisory Councils (CACs) provide support and advice to NMHS sites to improve the hospital experience for patients and hospital consumers. Some examples of CAC achievements this year include:

- input into all new build and renovation projects
- input into the relocation of KEMH to the QEIIMC site
- advocacy for accessibility features within the new rehabilitation and aged-care building and newborn services building, including coloured flooring to assist people with vision impairment
- successful lobbying of the local council to address concerns about traffic outside KEMH (a pedestrian crossing was built outside the hospital entrance to ensure the safety of all)
- improved communication with consumers
- advocacy for consumers, carers and the community
- feedback on a range of documents intended for patients, carers and their families
- a new poster welcoming visitors in seven languages.

"We are really grateful to her for 'hearing' us and also beginning to act on our concerns."

Comment from Derbarl Yerrigan staff member, regarding Clinical Nurse Manager at OPH working with CAC to update antenatal appointment letters.

Consumer Advisory Council members

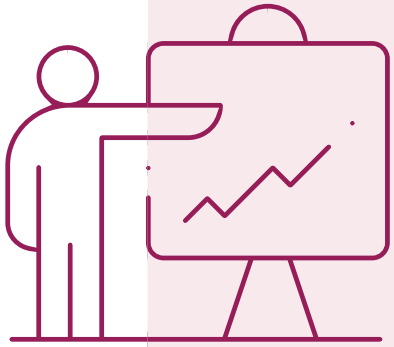
Front row from left: Howard Lance, Elizabeth Mills, Carole Kagi

Back row from left: Ryan Coltman, Tanya Basile, Judith Russell, Karen Tambree, Anne-Maree Fanning

Core Strategy 4 - Enabling our workforce

Enable, empower and **engage** our workforce

Improvements



1. Centralised education and training service

In 2020, a new centralised education and training service for Mental Health, Public Health and Dental Services was launched on the Graylands Hospital campus to provide education, training and professional development opportunities for all clinical, non-clinical and corporate staff. The service supports the learning needs of staff so they can acquire the appropriate skills, aptitude and knowledge to fulfil the requirements of their role and provide quality services to consumers within their care. The Education and Training team comprises a Coordinator, four Nurse Educators, a Senior Research Nurse and eight Staff Development Nurses.

2. Private practicing midwives

KEMH was the first hospital in WA to allow independent midwives to admit their own clients through the endorsed Private Practicing Midwives (EPPM) program.

EPPM enables the woman to choose their independent midwife and birthplan, while also allowing access to clinical staff and equipment if any complications arise. GP Dr Emily Slattery was the first woman in WA to capitalise on the new midwifery program, with midwife Clare Davison, for the birth of her son George.

From left: Independent midwife Clare Davison, Dr Emily Slattery with son George, and Health Minister Roger Cook (photo courtesy of ABC news)

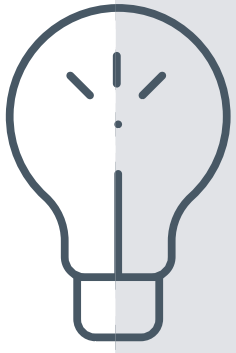
"It is so important to have this model so that women can choose where they birth. And with women that have medical risk factors, we can engage with the system so that they have got an appropriate level of care if it is necessary."

Clare Davison
Endorsed Privately Practicing Midwife

Core Strategy 4 - Enabling our workforce

Enable, empower and **engage** our workforce

Innovations



1. **Mental Health First Aid course**
   Many people lack the knowledge, skills, and confidence to support a friend, family member or co-worker experiencing a mental health problem, including how to approach someone and start a safe conversation. Mental Health First Aid (MHFA) teaches people the skills to help someone they are concerned about. It is freely accessible to all NMHS employees. Since February, 175 of our staff have completed the program.

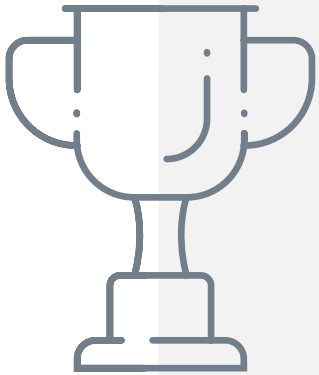
2. **Behavioural interventions in the treatment of eating disorders**
   Evidence-based treatments for eating disorders include cognitive behavioural therapy (CBT) and family-based treatment (FBT). Some examples are teaching people with eating disorders practical skills such as food preparation and food shopping, making them face their fears related to eating and/or their body using exposure (e.g. eating feared foods, looking at one's body in the mirror), and normalising their eating patterns and weight. Dr Bronwyn Raykos of the Centre for Clinical Innovations (MHPHDS) and her team sought to determine whether behavioural methods are necessary for treatments of eating disorders to be effective. **The study** found that these interventions are necessary for eating disorder recovery, but that some mental health clinicians may be reluctant to use behavioural methods partly due to anxiety about using behavioural strategies. Knowing this, supervised sessions can also be used to target clinician anxiety as well as that of the client.

https://www.sciencedirect.com/science/article/abs/pii/S0193953X19300073?via%3Dihub

Core Strategy 4 - Enabling our workforce

Enable, empower and **engage** our workforce

Awards



1. **2019 Stroke Care Champion Award**
   The Head of Stroke Rehabilitation at OPH, Dr Kien Chan, has been recognised for his extraordinary long-term dedication and commitment to stroke, becoming a finalist for the Stroke Foundation and Stroke Society of Australasia (SSA) 2019 Stroke Care Champion Award.

2. **The Australasian College of Health Service Management Stars of COVID-19**
   NMHS garnered an impressive 47 of the 220 nominations received by the WA branch of the Australasian College of Health Service Management's Stars of COVID-19 campaign.

3. **WA Nursing and Midwifery Excellence Awards 2020: Excellence in Leadership (nominee)***
   Melissa Smith was nominated for demonstrating exemplary leadership in her role as Clinical Nurse Manager for DonateLife WA, providing vital leadership and support to clinicians working to improve organ and tissue donation and transplantation outcomes in WA.

"I see it as an acknowledgement of the efforts that my team and I have put into improving stroke care outcomes, and it affirms what we are doing is resonating with the stroke community. I want all stroke patients and carers to be given the best possible chance of achieving their best possible outcome."

Dr Kien Chan
Head of Stroke Rehabilitation, Osborne Park Hospital

* As a result of the COVID-19 pandemic, awarding of the WA Nursing and Midwifery Excellence Awards has been postponed.

Caring for ourselves to better care for the WA community

Allied Health staff members run the 'What matters to you?' stall at the inaugural Festival of Wellbeing in February 2020.

WaSSAaP (Wellbeing and Staff Support Activities and Programs) is an interprofessional group with representation from all staff cohorts at SCGOPHCG.

The purpose of the WaSSAaP group is to:

- **promote, prioritise and enhance the wellbeing of all staff**
- **identify, define, and understand what factors impact staff wellbeing**
- **implement strategies to sustainably measure and improve staff wellbeing**
- **share information and outcomes pertaining to wellbeing strategies for all staff.**

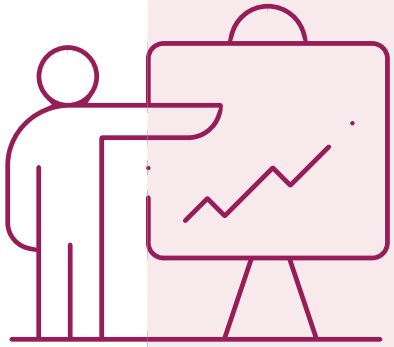
The WaSSAaP Framework recognises that a holistic approach is required to ensure all employees can be their best at work, at home, and as members of the community. The team created an 'airline safety' video welcoming staff to SCGOPHCG that included tips from the service leaders on how to access resources on personal wellbeing and self-care at work. WaSSAaP is currently undertaking research projects with industry and academic experts to examine and improve the wellbeing of healthcare workers and volunteers. They include a project to assess *'The effects of a narrative medicine programme on stress levels in hospital staff'* with The University of Western Australia, and *'Laughter yoga: planning and developing a nurse-led hospital-wide laughter wellbeing intervention for hospital staff '* with Murdoch University and the Centre for Nursing Research. In response to the COVID-19 pandemic, WaSSAaP created a dedicated COVID-19 Wellbeing resource hub for staff with information on coping with stress, anxiety and isolation, as well as tips from experts on coping mechanisms during these unprecedented times.

The Festival of Wellbeing marked the official launch of WaSSAaP on 12 February 2020. Interactive displays, food trucks, pet therapy, live music, employee support information, massages and activities such as yoga and lawn sports, encouraged staff and volunteers to focus on overall health and wellbeing. The 'What matters to you?' stall allowed staff to tell us what is important for them to maintain their wellbeing, and staff were encouraged to undertake a wellbeing self-assessment, with tips on how to improve quality of life.

Core Strategy 5 - Corporate Support

Enhance our clinical services through **professional** and **efficient corporate support**

Improvements



1. Values refresh

Our employees participated in Values Week (29 July to 4 August 2019), either filling out an online survey or attending an interactive display, to have their say on their preferred top five shared organisational values for NMHS. Following Values Week, we conducted six workshops with representatives from across the business to define the behaviours that underpinned the initial five preferred values, which will guide us as we plan for the next five years.

2. Risk management

A three-year internal audit plan has been approved by the Board, targeting areas of strategic risk to NMHS. The plan will inform staff of upcoming audits to minimise disruption to normal activity. Our staff will have an opportunity to provide feedback at the completion of audits. This will help improve future activities and add value to operational areas. Risk Management workshops were held with line management to increase the understanding and importance of risk management in NMHS. The workshops were well received and further sessions are planned.

"These five values (and behaviours) – care, respect, innovation, teamwork and integrity will now serve as a compass to guide our behaviour and decision-making. We look forward to further embedding them throughout our health service."

Dr Robyn Lawrence
Chief Executive, North Metropolitan Health Service (1 July 2019 to 3 March 2020)

Core Strategy 5 - Corporate Support

Enhance our clinical services through **professional** and **efficient corporate support**

Innovations

1. Shift Match

Made possible by the Innovative Future Program, Shift Match is being trialled at SCGOPHCG prior to consideration for an all of NMHS roll-out. The platform automatically matches suitably qualified nursing and support personnel to fill staffing shortages based upon availability, training and experience. It then communicates with staff via SMS, email or Push notification when a shift becomes available. Managing shortages usually requires the Nurse Manager to contact staff members individually to see if they can work, then wait for a reply.

2. Manage My Care app launched

Manage My Care is a patient-facing app and web portal recently rolled out across the SCGOPHCG. The app allows users to view upcoming outpatient appointments and referrals across the three metro Health Services and update their personal information, request an appointment be rescheduled or to be discharged from services. Manage My Care will be extended to KEMH and other WA Health services later in 2020/21.

Core Strategy 5 - Corporate Support

Enhance our clinical services through **professional** and **efficient corporate support**

Awards

1. WG Smith Lectureship 2019/20

The WG Smith Lectureship enables industry experts to share knowledge and experience with local clinicians and leaders. Adjunct Professor Alan Lilly came to WA to delivered an inspiring series of lectures on improving performance and the patient experience. He also met with many NMHS advisory groups including the Cancer Centre Patient Experience team, the Medical Engagement Advisory Panel (MEAP), Consumer Advisory Council, departmental heads and service executives. Winner of two Victorian Premier's Awards, Professor Lily demonstrated that it is possible to achieve organisational turn-around and performance improvement in a tangible way.

2. Queen's Birthday Honours 2020

Emeritus Professor Bryant Stokes AO AM RFD FRACS is a Neurosurgeon and former Acting Director General of the Department of Health WA, former Board Chair for NMHS, current Chair of the Neurotrauma Research Program, and Special Ministerial Advisor for the review of the clinical governance of public mental health services in WA. In his long and eminent career, he has made a substantial contribution to the WA community but it was his distinguished service to public health care governance and standards in WA through his many leadership and advisory roles that have seen him appointed an Officer in the General Division (AO) of the Order of Australia.

NMHS partners with Microsoft to streamline patient care

From left: Pammy Yeoh, John Blakey, Michael Campbell

Led by NMHS BIP Manager Michael Campbell, Coord. for Information Architecture Pammy Yeoh and Respiratory Consultant Physician Dr John Blakey, NMHS is partnering with Microsoft to better manage data for people that have tested positive to COVID-19. The app improves communication with the consumer and health service partners such as GPs or other hospitals. Developed over a period of two weeks at the height of the NMHS pandemic response, this app is now being used to gather and report patient information. Data is collected once, with NMHS staff interviewing patients and filling out a questionnaire on a mobile device.

Following review at the clinic, patient data are harvested and passed through to the application, reducing duplication of work and the amount of questions the patient must answer at each contact during isolation or treatment. That data is securely stored in WA Health's data warehouse and available for future consultations, accelerating treatment and reducing the burden on staff who now have instant access to insights that are critical to successful treatment and to monitor patient progress.

When the patient is ready to be discharged from care, the system has been designed to automatically generate a discharge letter from the hospital to the patient's GP to ensure proper continuity of care when the patient goes back into the community.

"The beauty of it is that when you open the app, you've got a short medical history of the patient that you're dealing with. Rather than weeding through reams of paper, I can have a look at this and say, 'All right, this patient's a diabetic, got heart disease, is a smoker.' I'm immensely proud to be part of this, to contribute. It's so rewarding that you're making a difference to someone's life by doing this. And that's what it boils down to at the end of the day"

Michael Campbell
Manager of Business Information and Performance

What IF we could do things better?

Innovative Future Program

Oncology patient Christine Mitchell receives her flu vaccine.

The IF Program was created to encourage staff to ask, 'what if things could be done differently' and to give employees the opportunity to explore and innovate.

Health Innovation Performance (HIP) consultant Dr Carlo Bellini challenged staff to be curious, question their everyday surrounds and be progressive in their thinking. The program seeks to help NMHS strive for innovative change as well as improve culture and moral.

In November 2019, the program launched and received 152 applications. In round one, the Area Executive Group (AEG) supported 18 applications to commence immediately and another 18 applications start immediately and another18 to be further developed. Projects that were given executive support include:

- easy access influenza vaccine program for cancer patients
- images on ceilings in procedural rooms for patients to reduce anxiety
- nurse-led Tier 2 telephone clinics
- electronic application for safe, targeted enteral nutrition in critical care
- improving end-of-life discussions with patients and their families
- recording education sessions to improve access to professional development
- instant messaging service to assist managers fill staffing shortages
- respiratory outpatient service redesign
- Aboriginal maternity care partnership
- synthetic data: realistic but not real data for open-source collaboration.

The Program Office continues to work with the AEG to streamline the application and assessment process and to trial innovative project management tools and processes. We will continue to focus on the program. With interest higher than expected, the IF team are looking forward to innovative staff submissions at the end of each application round.

"This (influenza vaccine) project focused on an area of unmet need in a vulnerable population group. COVID-19 gave us a strong impetus to get the process up and running. We realised the complexities and practicalities around launching a health promotion initiative, but the support from the IF team and collaboration with the Cancer Centre made it run smoothly. The patient feedback has been positive. It's a win-win situation for patients and the health system."

Dr Piyush Grover
Cancer Patient Flu Vaccine Project Lead, SCGH Cancer Centre

Core Strategy 5 - Corporate Support

Enhance our clinical services through **professional** and **efficient corporate support**

Learning from critical incidents

Unfortunately, despite the best efforts of our staff to provide safe, high-quality care at all times, patients may be and are unnecessarily harmed. Examples of serious clinical incidents include delays in responding to the deterioration of patients, |mental health patients who have an unexplained death (despite recent contact and assessment by our services), infections acquired in hospital, falls resulting in fractures, and a medication error resulting in the death of a patient.

We encourage staff to report these events, which we refer to as clinical incidents. By reporting clinical incidents, we are able to investigate and identify what ultimately caused its occurrence, as per the WA Clinical Incident Management Policy. By putting processes in place, we hope to prevent further incidents and harm to patients.

In 2019/20, we observed a reduction in the total number of serious clinical incidents reported by NMHS (Table 5). At 30 June 2020, there were 16 serious clinical incidents still under investigation by NMHS, and two by JHC. Where health care was found not to have been a factor in the event, the incident may be 'declassified' after receiving approval from the Department of Health. NMHS had 43 incidents that met these criteria, and JHC had eight such incidents for the year.

Health care was identified as a contributing factor in 99 of the investigations of SAC1 (serious) clinical incidents (NMHS 76; JHC 23, including those still under investigation). Death of a patient was the outcome in 28 incidents (NMHS 18; JHC 10) and serious harm was the outcome in 50 incidents (NMHS 39; JHC 11).

Table 5: SAC1 (severity assessment code) clinical incidents reported, 2019/20

SAC1 clinical incident	NMHS		JHC**	
	2018/19	2019/20	2018/19	2019/20
Total reported	129	**119**	38	**31**
Declassified*	57 (29%)	**43 (36%)**	5 (13%)	**6 (26%)**
Investigation completed	78	**60**	30	**21**
Investigation in progress	14	**16**	4	**2**
Total completed and in progress SAC1 investigations	92	**76**	34	**23**
Outcome of completed + SAC1 in progress				
Death	17 (19%)	**18 (24%)**	6 (18%)	**10 (43%)**
Serious harm	48 (52%)	**39 (51%)**	18 (53%)	**11 (48%)**
Moderate harm	9 (10%)	**9 (12%)**	8 (23%)	**1 (4%)**
Minor harm	4 (4%)	**2 (3%)**	2 (6%)	**1 (4%)**
No harm	14 (15%)	**8 (11%)**	0%	**0%**

NMHS continues to strive towards improving the safety of our services, with clinical incident reporting an essential way of achieving this goal. In the latter half of 2019 we took stock of our approach to investigations of serious clinical incidents and sought inspiration from high-performing healthcare organisations, such as Safer Care Victoria.

In August we invited Adjunct Associate Professor Bernie Harrison (right), a faculty member of the Australian Council on Healthcare Standards, to train 60 of our leaders in the best approach to root cause analysis (RCA). This helped us reset and refresh our program to be more rigorous, more accountable and more transparent. We also created a mentoring program to improve RCA report writing within the service.

Adjunct Associate Professor Bernie Harrison

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

Learning from critical incidents (cont.)

Situation

A 93-year-old woman was admitted for treatment of cellulitis (a painful skin infection) in her left leg. The patient was sent home with oral antibiotics. She returned four days later, at which time her daughter explained that she had not been taking the antibiotics. During this second admission, the patient got up from her bed to go to the toilet and fell. She sustained a fractured distal radius and ulnar of her left wrist and a minimally displaced intertrochanteric fracture of the left hip, requiring surgery.

Investigation

An expert panel comprising senior medical, nursing and allied health staff undertook a root cause analysis of the incident. The panel reviewed the patient's medical records and relevant policies. They spoke to the patient and staff members about what they remembered of the incident. A detailed timeline was established that identified potential opportunities for improvement.

Contributory factors

The panel focused on the patient's risk factors and strategies to reduce the risk of falls. On these points, the panel concluded that the patient's medications were appropriately managed but agreed there were a number of missed opportunities to formally assess cognitive impairment. There were numerous references to the patient's fluctuating confusion, including her being 'pleasantly confused'. A formal assessment would likely have provided the required triggers to implement additional fall prevention strategies.

Recommendation

Develop a plan to promote and implement the Cognitive Impairment Management Policy, which requires a cognitive screen on admission using a validated assessment tool for any patient over the age of 65.

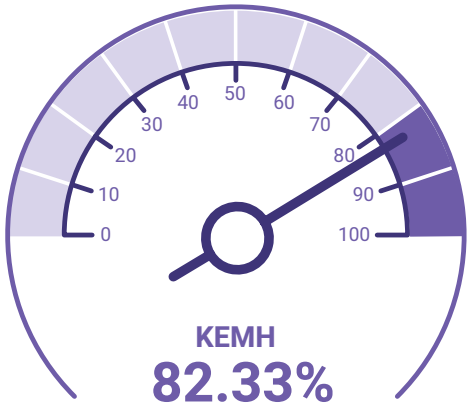
Lessons learned

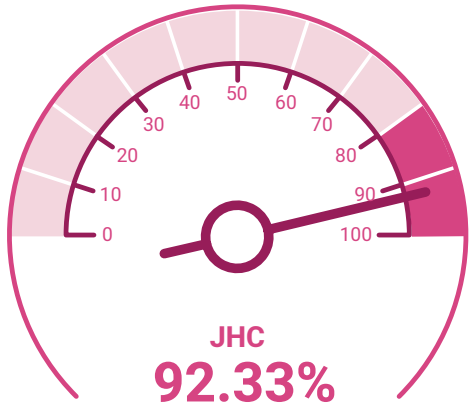
The key lesson learned related to correcting the perception of low or no risk associated with patients who are 'pleasantly confused'.

Promoting safety and quality

Hand hygiene

Hand hygiene is a priority action for the prevention of healthcare-associated infection. Washing or decontaminating hands with soap and water or an alcohol-based hand rub is an important part of quality patient care. In Australia, accredited health services must have a robust hand hygiene process. This involves a learning management system and an audit compliance monitoring program. The estimated compliance rate for a health service is a measure of how often hand hygiene is correctly performed. NMHS subscribes to the National Hand Hygiene Initiative, submitting data derived from direct observations by trained and validated observers. Data is collected on an ongoing basis and reported over three audit periods. For the auditing periods during 2019/20, mean compliance for NMHS and JHC has exceeded the national target of 80 per cent compliance with hand hygiene.





Governance

Enabling legislation

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

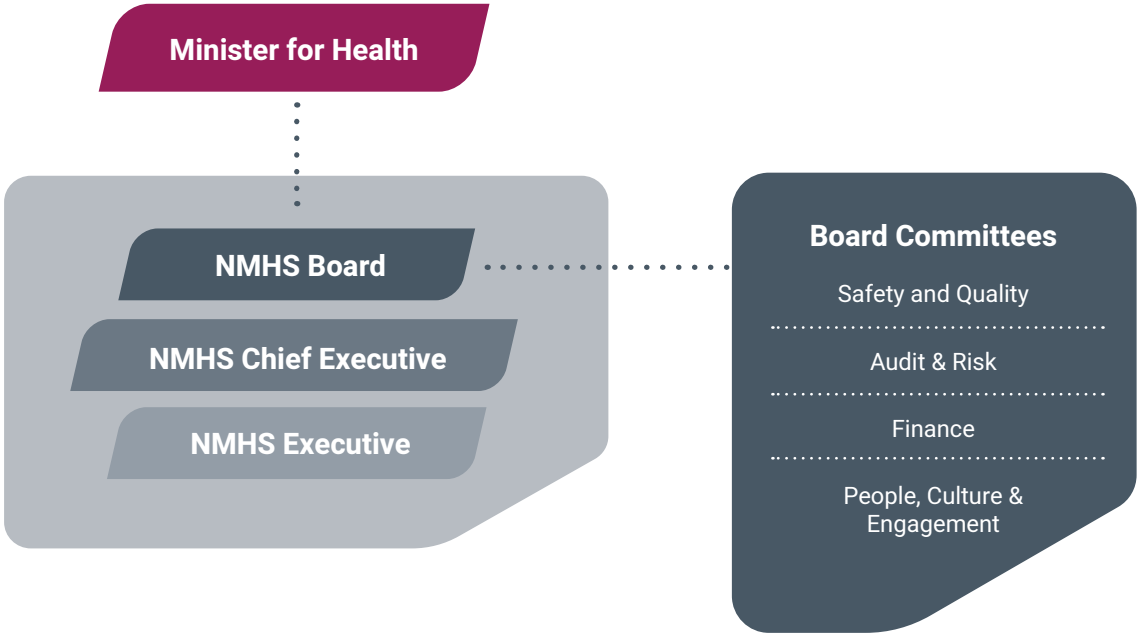
Accountable authority

NMHS is a board-governed health service provider pursuant to section 70 of the *Health Services Act 2016 (WA)*.
The NMHS Board is the accountable authority for NMHS and the Hon. Mr Jim McGinty AM is the Board Chair.

Responsible Minister

NMHS is responsible to the Hon. Roger Cook MLA – Deputy Premier; Minister for Health; Mental Health.

Our governance structure



NMHS Executive Group as of June 2020

Our Board of Authority

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

Board members are appointed for up to three years by the Minister for Health. A member is eligible for reappointment but cannot hold office for more than nine consecutive years. Members are appointed according to their expertise and experience in areas relevant to our activities.

NMHS Board members as of 30 June 2020

Our organisational structure

Dr Robyn Lawrence
Chief Executive
(1 July 2019 to 3 March 2020)

Tony Dolan
Chief Executive
(4 March 2020 to current)

Ros Elmes
Executive Director
Mental Health, Public Health and Dental Services

Responsible for:
- Aboriginal Health Strategy
- Area Mental Health Services
- Dental Health Services
- DonateLife Western Australia
- Public Health
- State Head Injury Unit

Dr Jodi Graham
Executive Director
Women and Newborn Health Service

Responsible for:
- BreastScreen WA
- Community Midwifery Program
- Genetic Services and Familial Cancer programs
- King Edward Memorial Hospital
- Newborn Emergency Transport Service Western Australia
- Perinatal Mental Health
- Sexual Assault Resource Centre
- Statewide Obstetric Support Unit
- WA Cervical Cancer Prevention Program
- WA Register of Developmental Anomalies
- Women's Health Clinical Support Programs

Janet Zagari
Executive Director
Sir Charles Gairdner Osborne Park Health Care Group

Responsible for:
- Osborne Park Hospital
- Sir Charles Gairdner Hospital

Dr Ajitha Nair
Area Executive Director
Clinical Services

Responsible for:
- Medical education and research
- Medical governance
- Medical workforce

Amanda McKnight
A/Executive Director
Nursing and Midwifery Services

Responsible for:
- Medical Equipment Replacement Program
- Nursing and Midwifery education and research
- Nursing and Midwifery governance
- Nursing and Midwifery workforce
- Patient support services

Stuart Windsor
Executive Director
Procurement, Infrastructure and Contract Management

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

Jordan Kelly
Executive Director
Business and Performance

Responsible for:
- Audit and risk
- Business information and performance
- Clinical planning (and telehealth service)
- Corporate Governance
- Finance
- Integrity and ethics workforce

Dr Theresa Marshall
Executive Director
Safety, Quality, Governance and Consumer Engagement

Responsible for:
- Community and stakeholder engagement
- Corporate governance
- Intellectual property
- Medicolegal services
- Safety and quality

Board profiles

Hon. Mr Jim McGinty AM

Board Chair

Jim was the Member for Fremantle in the State Parliament from 1990 to 2009. During that time, he held the positions of Minister for Health, Attorney General and Leader of the Opposition. Post-political life, he has served on the boards of several not-for-profit organisations including Telethon Kids Institute, Brightwater Care Group, Communicare, Access Housing Australia and Health Workforce Australia. Jim is a volunteer with Fremantle Sea Rescue.

Professor David Forbes

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

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

Professor Selma Alliex

Member, Safety and Quality Committee

Member, People, Culture and Engagement Committee

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

Board profiles (cont.)

Ms Angela Edwards

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

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

Associate Professor Christopher Etherton-Beer

Member, Audit and Risk Committee
Member, Safety and Quality Committee

Christopher is a clinical academic in geriatric medicine at The University of Western Australia and Medical Co-director at Royal Perth Hospital. He is Chair of the Western Australian Therapeutics Advisory Group and is a member of the Pharmaceutical Benefits Advisory Committee.

Dr Hilary Fine

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

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

Ms Carol Innes

Member, People, Culture and Engagement Committee (1 July 2019 to 3 July 2019)

Carol is the Manager, Aboriginal Cultural Heritage and Arts at the Metropolitan Redevelopment Authority. She is the Aboriginal Co-Chair of Reconciliation WA and a former director of the Leadership Unit at the South West Aboriginal Land and Sea Council. Carol worked in the Aboriginal and Torres Strait Islander arts sector for 11 years with experience in the government sector at both state and national levels.

Board profiles (cont.)

Mr Grant Robinson

Chair, Finance Committee
Member, Audit and Risk Committee

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

Ms Rebecca Strom

Chair, Audit and Risk Committee
Member, Finance Committee

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

Mr Steve Toutountzis

Member, Finance Committee
Member, Audit and Risk Committee

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

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 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. Performance against these activities and outcomes is summarised in Tables 1 to 4 on pages 19–22 and subsequently described in detail in the section 'Detailed information in support of KPIs' on pages 127–155.

Changes to the OBM Framework

The new OBM Framework was implemented for annual reporting from 2017/18. Changes to the Framework were made to ensure relevance to the current WA health system as part of the WA Health Reform program. There were no changes to the Framework in 2019/20.

Shared responsibilities with other agencies

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

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

Outcome 1

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

Service 1
Public hospital admitted services

Service 2
Public hospital emergency services

Service 3
Public hospital non-admitted services

Service 4
Mental health services

Outcome 2

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

Service 5
Aged and continuing care services

Service 6
Public and community health services

Service 8
Community dental health services

Service 9
Small rural hospital services

Notes: NMHS provides some aged and continuing care services (Service 5); however, most are provided by the Department of Health on our behalf. The Find Cancer Early program is an election commitment-funded program (Service 9). It aims to educate people throughout regional WA about the signs and symptoms of cancer, which will lead them to seek help from a doctor. The program is being administered by NMHS via the Cancer Council of Western Australia and the messages are being delivered through partnerships with community organisations, local media, radio and newspaper advertisements, presentations and campaign resources across seven regions (Goldfields, Wheatbelt, Great Southern, Pilbara, Kimberley, Midwest and Southwest). Resources are also focused on hard-to-reach audiences, specifically remote and Aboriginal and Torres Strait Islander people. No performance measures are reportable for services 5 and 9 as per the OBM framework.

Performance management framework (cont.)

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

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

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

Effectiveness KPIs

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

Efficiency KPIs

Service 1
Public hospital admitted services
- Average admitted cost per weighted activity unit

Service 2
Public hospital emergency services
- Average emergency department cost per weighted activity unit

Service 3
Public hospital non-admitted services
- Average non-admitted cost per weighted activity unit

Service 4
Mental health services
- Average cost per bed-day in specialised mental health inpatient services
- Average cost per treatment day of non-admitted care provided by mental health services

Performance indicator

- Percentage of Emergency Department patients seen within recommended times

Performance management framework (cont.)

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

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

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

Effectiveness KPIs

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

Efficiency KPIs

Service 6

Public and community health services:

- Average cost per person of delivering population health programs by population health units
- Average cost per breast screening

Service 8

Community dental health services:

- Average cost per patient visit of WA Health provided dental health programs for schoolchildren and socioeconomically disadvantaged adults

Key Performance Indicators

Detailed information pertaining to our performance against OBM Framework may be found in the **Disclosures and legal compliance section** of the report on the following pages:

Significant issues impacting NMHS

Pandemic preparation in action

This year, COVID-19 resulted in unprecedented pressures affecting the majority of health service providers in the State, including NMHS.

NMHS demonstrated that we are up to the task through rapid service redesign, infrastructure and site works, excellence in patient care and screening, and leadership in COVID-19 teaching, training and research.

Throughout the pandemic, we continued to remain a trusted health partner to the WA community, delivering excellent health care for our people and our communities.

Our response to COVID-19

In March, the Western Australian Government declared a state of emergency due to the pandemic resulting from COVID-19. Section 170 of the *Public Health Act* came into effect and the Department of Health took the lead in a coordinated approach to planning and readiness activities for all health service providers. Following this announcement, Dr Robyn Lawrence was seconded to the role of Deputy Chief Health Officer to provide advice and leadership on clinical service matters for the State Health Incident Coordination Centre (SHICC).

By April, the NMHS Emergency Operation Committee (EOC) had been formed under the leadership of Chief Executive Tony Dolan. The EOC established the NMHS COVID-19 clinic at SCGH as well as re-purposed a number of facilities across the organisation to accommodate a possible surge in COVID-19 cases. Surge capacity planning for the ED, intensive care unit (ICU), general beds, women and newborn services and mental health services became a priority to ensure patient flow and workforce capability and capacity.

For the safety of patients and the workforce, select services were either decreased or temporarily ceased. Elective surgery waitlist for Category 2 (Semi-urgent), and Category 3 (Non-urgent), Adult Dental Health Services and BreastScreen WA were delayed across the system. Services such as public health were expanded statewide with an increase of FTE to deliver education, testing, surveillance and tracing.

The uncertainty of COVID-19 created the need for a strong focus on maintaining staff health and wellbeing. Working from home arrangements were offered where practicable. Timely and regular updates to staff from the Chief Executive, EOC and Area Executive Group ensured patients and staff were promptly advised about changes to the work environment and the availability of staff support resources.

COVID-19 proved to be challenging for our patients, for staff and the organisation. NMHS met these challenges and continued to evolve in responding to the changing environment resulting from COVID-19.

Research suggests that in adults requiring ventilation for respiratory failure, a mode of ventilation called airway pressure release ventilation (APRV) is associated with better mortality. The WA ICU community has extensive experience with APRV, including during the H1N1 epidemic. NMHS is leading the early stages of a collaborative research effort which aims to determine which modes of ventilation afford superior benefit in ventilated patients with COVID-19. These learnings will also be shared nationally and internationally. Furthermore, all WA public hospitals' ICUs are participating, a shining example of collaboration and shared learning between the services.

"We are in the lucky situation of not having any active COVID patients at the moment, but hopefully our initial experience will still provide some useful learnings for the future."

Associate Professor Matthew Anstey
SCGH ICU Director of Research

Contact tracing

In public health, contact tracing is the process of identifying, assessing and managing people who have been exposed to a disease. This process stops infections and diseases spreading further through the community.

This year, contract tracing for COVID-19 required a big build-up of public health staff, from a team of ten to over 100. Staff came together from the Mental Health, Public Health and Dental Services (MHPHDS), the Metropolitan Centre for Communicable Diseases (MCDC), Child and Adolescent Health Service (CAHS), and the WA Country Health Service (WACHS). The public health operations team comprised physicians, doctors, nurses, epidemiologists and support staff.

Operating from 8am to 8pm, seven days a week, the team were tasked with informing people when they tested positive for COVID-19 and tracing their every move to identify who else may have been exposed.

As of June 2020, the team had contact traced 589 positive WA COVID-19 cases, which meant monitoring 1,895 people daily (including close contacts of those cases). It involved making 15,281 phone calls/texts and responding to 12,702 calls from the public requesting general information on COVID-19.

From left: Dr Ben Scalley, Clinical Lead COVID-19 Response; Jo Fagan, Director of Public Health; and Ros Elmes, Executive Director, MHPHDS.

COVID-19 site works

When the novel coronavirus was declared a pandemic, one thing seemed certain: hospitals would be taxed to meet the capacity for demand. NMHS responded quickly to convert alternative spaces ready to handle patient overflow, and an increased demand for resources.

Our Procurement, Infrastructure and Contract Management team (PICM) were tasked with urgently identifying, rapidly vacating and substantially repurposing hospital infrastructure. The multi-functional team consisting of the NMHS Property Management, Project Management, Facilities Management, Procurement and Security teams worked tirelessly for four weeks, delivering 65 projects across three major hospital sites to ensure readiness for frontline clinicians, allied health and support staff and healthcare consumers.

A daily pandemic meeting managed the critical changes, enabling progress to be constantly communicated upwards to the Emergency Operations Committee to ensure maximum response was achieved. Projects delivered included:

- establishing COVID-19 clinics at SCGH and JHC, and relocating five existing clinics
- repurposing a vacant childcare centre to house the five relocated clinics
- repurposing an entire block at SCGH to accommodate additional clinics
- constructing a new ED fast-track area, providing five additional consult rooms
- repurposing unused space as a 29-bed observation ward to ensure that a distinction between ‘clean’ and ‘dirty’ wards was maintained
- converting a cafe to house a central hospital storage area to stock COVID-19 equipment.

Procurement was a significant aspect of our COVID-19 response. In addition to sourcing adequate effective personal protective equipment for our staff, major procurement activity included:

- the purchase of additional dialysis machines, X-ray and echocardiography machines for the ICU to permit safe separation of COVID-19 patients from general ICU admissions.
- fibre-optic intubation equipment to provide for safer and more precise intubation procedures for Intensivists and Anaesthetists.

Keeping up the pace

The welcome announcement of a $32 million Minor Works Stimulus Package over three financial years enabled the commencement of works to address numerous asset replacement and upgrade works across all sites.

Early focus has been on planning and delivering works to improve staff and patient safety primarily in relation to infection control and occupational safety and health.

Planning associated with readiness for the COVID-19 pandemic resulted in a raft of infrastructure changes including the construction of a new fast-track area and a Q Class Isolation Room in the SCGH Emergency Department (ED).

These changes have been undertaken as forward works to a larger planned upgrade to the ED that will proceed in 2020/21.

Upgrades to the ED will cater for increased presentations and address safety issues relating to violence and aggression.

Health Minister Roger Cook breaking ground on the OPH expansion project, March 2020.

Photo credit, https://balcatta.walabor.org.au/news/local-news/construction-starts-on-osborne-park-hospital-expansion/

Keeping up the pace (cont.)

Infrastructure upgrades and new developments progressed during 2019/20 were as follows:

- The tender for the construction of the $24.9 million Osborne Park Rehabilitation and Neonatal Nursery Project was awarded in early 2020. Construction is well underway, with completion expected by the end of 2021.
- The Women and Newborn Relocation Project team developed an Application for Concept Approval to provide the broad strategic direction and an analysis of options to move the WNHS from the ageing King Edward Memorial Hospital to new premises at the QEII Medical Centre site. The options will be further refined in a detailed business case to be developed in 2020/21.
- The JHC Development Stage 2 Project Business Case was developed and approved, successfully securing a total project budget of $256.7 million. The project scope includes a 77-bed mental health facility, 12 ED bays, 30 medical/surgical inpatient beds, 6 new critical care beds, a theatre, a new Cardiac Catheterisation Laboratory, a specialised urgent care clinic to operate as a Behavioural Assessment Urgent Care Clinic (BAUCC), and upgrades to supporting infrastructure.
- The $15.1 million upgrade to Critical Infrastructure at KEMH has begun, with works including upgrades to electrical and mechanical infrastructure, a lift replacement program, removal of hazardous materials and repairs to the exterior façade. In addition to this, the Aluminium Composite Panel cladding to the exterior of B Block, which was identified following a statewide cladding audit, has been replaced.
- Following funding approval in early 2020, planning for the upgrades to two Cardiac Catheter Laboratories and two Interventional Radiology Rooms at SCGH is well advanced. It is anticipated these works will be completed in 2021.
- Planning has commenced for the expansion of the Radiopharmaceutical Laboratories at SCGH, including the installation of a second cyclotron. These laboratories are the sole statewide supplier of cyclotron-derived positron emission tomography (PET) radiopharmaceuticals within WA, for which demand has steadily increased over the past decade.
- Fit-out works have been completed for a new Butler Community Mental Health Service, to service clients from the northern corridor.
- Fit-out works are also underway for the BreastScreen WA Perth City Clinic, which will be relocating from Murray Street to new premises in Adelaide Terrace later in the year.

Building on sustainability and supporting innovation

Sustainable and Accountable Future Program 2018/19 to 2019/20

SAFP
Sustainable and Accountable Future program

The two-year Sustainable and Accountable Future Program (SAFP) was established in response to concerns regarding our financial performance over consecutive years. The program was designed with the intent to future-proof the delivery of sustainable quality care throughout the health service and bring the budget back to surplus. Using the evidence produced by PricewaterhouseCoopers Diagnostic Report May 2018, NMHS targeted identified areas of opportunity including: Corporate; Medical Workforce; Nursing and Midwifery workforce; Outpatients; Long stay/aged care; Emergency Departments; Revenue; Theatres, and coding.

Over the two-year life cycle, 43 projects were registered with the Program Board. Thirteen were retired by the Board due to issues with feasibility. A further 14 identified FTE or other financial savings and 16 projects identified quality improvement deliverables only. The total program target improvement figure for the two-year period was $32,070,841. The total program actual achieved savings as of April 2020 was $22,986,519, leaving a shortfall of $9,084,322. The program is closed with the remaining four open projects transitioning to business as usual to continue delivery of commitments.

Engaging our people and developing our culture

Last year, NMHS embarked on a journey with our staff to define one new set of shared organisational values. Care, Respect, Innovation, Teamwork and Integrity were identified as the core values most meaningful for NMHS staff. NMHS is striving to build a positive organisational culture based on these five values launched in November 2019, by embedding them into our behaviour, people, systems and processes.

NMHS is proud to report that a number of activities have already been completed and other integral actions are underway in response to the survey feedback. The actions identified to undertake in response to the Engagement Survey align to the four pillars of 'Our People' strategy which was developed in consultation with our staff and launched in December 2019.

The second round of the Minister for Health's Engagement Survey was conducted in March 2020 and it was pleasing to see an improvement on all questions, resulting in an increased Employee Engagement Index of NMHS by six per cent. Pride in NMHS is also increasing, with 70 per cent of our team proud to tell others where they work, and 62 per cent indicating they would recommend NMHS as a great place to work, an increase of six per cent from 2019.

Part of our cultural change program involves the establishment of a People, Engagement and Culture Advisory Council (PECAC) and People, Engagement and Culture (PEC) Ambassadors. The main role of the PECAC is to provide a forum to understand how to improve culture and engagement between our people and our community within NMHS as well as the wider community. The 103 PEC Ambassadors from across the service act as a conduit from the business into PECAC to ensure the interests of all areas of NMHS are heard and represented.

PEC Ambassadors have been involved in a number of initiatives for NMHS including the establishment of Wellness Working Groups, running a number of events aimed at improving the health and wellbeing of our people.

Initiatives completed include embedding our new values in the Staff Recognition Program comprised 'Going the Extra Mile Awards', 'Employee of the Month & Quarter Awards' and 'Long Service Awards.

Building on sustainability and supporting innovation (cont.)

Establishment of the Innovative Future Program, implemented our new induction program, rolled out Mental Health First Aid training, developed a People Manager Program on management accountabilities and developed an eLearning package to enable early identification and intervention on health and wellbeing issues.

Significant effort was exerted over the last year in promoting the health and wellbeing of NMHS staff. In addition to the initiatives already mentioned, work has progressed on a Wellbeing Implementation Plan, and Prevention and Management of Workplace Violence and Aggression Strategy to be launched in the next financial year. It was especially encouraging to see our NMHS values demonstrated in response to the COVID-19 pandemic, with our values of teamwork and innovation particularly on show as we banded together to care for our community.

Moving to a new future

Moving towards a new future has been a theme in the health service this year. The most significant aspects have been ratifying our executive leadership team, developing a new strategic plan for the health service and continuing to challenge ourselves on person-centred care and engagement with our consumers.

Recruiting and choosing the right people to form the executive leadership team to work with the Chief Executive and the Board has been critical. With all positions now filled, the team is working to deliver excellent health care while building a sustainable platform for the health service.

Gains have been made in all areas of the Board's priorities including improved financial sustainability, increased workforce integrity and advances in engagement and culture of the health service. Engaging with our people was the core tenet of designing the new vision and strategy for the health service. Hearing from over 300 staff across 35 workshops with a cumulative experience of over 4,500 years working in the health service was fundamental. This coupled with the feedback from the consumer and care forum was the groundwork that the Board and the executive leadership group used to design of a new future.

Central to the thinking and at the heart of the new plan are the elements of enabling healthy communities and person-centred care. Enabling healthy communities through co-designing, collaborating and partnering across the health system to enable people in our communities to live healthy lives will see the health service increase its action and commitment to care in the community. Important strides towards greater person-centred care have been made and continue to be built on in every part of our service, from the Consumer Advisory Councils providing input into the design of new buildings, to the changes being made as a result of consumer feedback.

To achieve a truly person-centred healthcare service we need to bring the great work that is being done in different areas together. We need to have a more integrated and unified approach across our entire service. We need to be able to learn better from the experiences of staff who advance person-centred care principles locally and extrapolate them widely.

Over the next five years, we will be working towards a vision of one team, many dreams and one integrated health service to promote and improve the health of our people and our communities.

Disclosures and legal compliance

Audit opinion

Auditor General

INDEPENDENT AUDITOR'S REPORT

To the Parliament of Western Australia

NORTH METROPOLITAN HEALTH SERVICE

Report on the financial statements

Opinion
I have audited the financial statements of the North Metropolitan Health Service which comprise the Statement of Financial Position as at 30 June 2020, the Statement of Comprehensive Income, Statement of Changes in Equity, Statement of Cash Flows, Schedule of Income and Expenses by Service, and Summary of Consolidated Account Appropriations for the year then ended, and Notes comprising a summary of significant accounting policies and other explanatory information.

In my opinion, the financial statements are based on proper accounts and present fairly, in all material respects, the operating results and cash flows of the North Metropolitan Health Service for the year ended 30 June 2020 and the financial position at the end of that period. They are 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 Responsibility for the Audit of the Financial Statements section of my report. I am independent of the Health Service in accordance with the *Auditor General Act 2006* and the relevant ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial statements. I have also fulfilled my other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Responsibility of the Board for the financial statements
The Board is responsible for keeping proper accounts, and the preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions, and for such internal control as the Board 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 and 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.

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7th Floor Albert Facey House 469 Wellington Street Perth MAIL TO: Perth BC PO Box 8489 Perth WA 6849 TEL: 08 6557 7500 FAX: 08 6557 7600

Auditor's responsibility 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.

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

Report on controls

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

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

In my opinion, in all material respects, the controls exercised by the North Metropolitan Health Service are sufficiently adequate to provide reasonable assurance that the receipt, expenditure and investment of money, the acquisition and disposal of property and the incurring of liabilities have been in accordance with legislative provisions during the year ended 30 June 2020.

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 to report on the design and implementation of controls involves performing procedures to obtain evidence about the suitability of the design of controls to achieve the overall control objectives and the implementation of those controls. The procedures selected depend on my judgement, including the 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.

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Audit opinion (cont.)

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 the controls are 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 key performance indicators

Opinion
I have undertaken a reasonable assurance engagement on the key performance indicators of the North Metropolitan Health Service for the year ended 30 June 2020. The key performance indicators are the Under Treasurer-approved key effectiveness indicators and key efficiency indicators that provide performance information about achieving outcomes and delivering services.

In my opinion, in all material respects, the key performance indicators of the North Metropolitan Health Service are relevant and appropriate to assist users to assess the agency's performance and fairly represent indicated performance for the year ended 30 June 2020.

Matter of Significance
The Under Treasurer has continued his approval to remove the following indicator as a key performance indicator (KPI):

- Percentage of emergency department patients seen within the recommended times.

The Under Treasurer's approval requires WA Health to reassess whether this indicator can be re-instated as a KPI once a new emergency department data collection system has been implemented. There is currently no set timeframe for the implementation of a new system. My opinion is not modified in respect of this matter.

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

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

Auditor General's responsibility
As required by the *Auditor General Act 2006*, my responsibility as an assurance practitioner is to express an opinion on the key performance indicators. The objectives of my engagement are to obtain reasonable assurance about whether the key performance indicators are relevant and appropriate to assist users to assess the entity's performance and whether the key performance indicators are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion.

I conducted my engagement in accordance with Standard on Assurance Engagements ASAE 3000 *Assurance Engagements Other than Audits or Reviews of Historical Financial Information* issued by the Australian Auditing and Assurance Standards Board. That standard requires that I comply with relevant ethical requirements relating to assurance engagements.

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

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

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

Matters relating to the electronic publication of the audited financial statements and key performance indicators
This auditor's report relates to the financial statements and key performance indicators of the North Metropolitan Health Service for the year ended 30 June 2020 included on the Health Service's website. The Health Service's management is responsible for the integrity of the Health Service's website. This audit does not provide assurance on the integrity of the Health Service's website. The auditor's report refers only to the financial statements and key performance indicators described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these financial statements or key performance indicators. If users of the financial statements and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to contact the entity to confirm the information contained in the website version of the financial statements and key performance indicators.

CAROLINE SPENCER
AUDITOR GENERAL
FOR WESTERN AUSTRALIA
Perth, Western Australia
/5 September 2020

Certification of Financial Statements

For year ended 30 June 2020

Government of Western Australia
North Metropolitan Health Service

Disclosures and Legal Compliance

Financial Statements

Certification of Financial Statements

For the reporting period ended 30 June 2020

The accompanying financial statements of the North Metropolitan Health Service have been prepared in compliance with the provisions of the *Financial Management Act 2006* from proper accounts and records to present fairly the financial transactions for the reporting period ended 30 June 2020 and financial position as at 30 June 2020.

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.

Name: Michael Hutchings
North Metropolitan Health Service
Chief Finance Officer

Date 11/9/2020

Name: Hon. Jim McGinty AM
North Metropolitan Health Service
Board Chair, NMHS Board

Date 11/09/2020

Name: Mr Grant Robinson
North Metropolitan Health Service
Board Member and Finance Committee Chair, NMHS Board

Date 11/9/20

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

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Financial Statements

For year ended 30 June 2020

Statement of Comprehensive Income
For the year ended 30 June 2020

	Notes	2020 $000	2019 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	3.1	1,144,530	1,183,905
Contracts for services	3.2	457,407	460,479
Patient support costs	3.3	322,379	325,396
Finance costs	7.3	603	39
Depreciation and amortisation expense	5.1, 5.2, 5.3	70,346	69,628
Asset impairment losses		-	1,861
Loss on disposal of non-current assets		180	166
Repairs, maintenance and consumable equipment	3.4	39,017	34,589
Other supplies and services	3.5	71,989	64,471
Other expenses	3.6	55,096	71,863
Total cost of services		**2,161,547**	**2,212,397**
INCOME			
Revenue			
Patient charges	4.2	71,895	74,273
Other fees for services	4.3	78,615	79,160
Commonwealth grants and contributions	4.4	665,215	635,403
Other grants and contributions	4.5	173,946	170,729
Donation revenue		654	386
Interest revenue		67	1
Other revenue	4.6	24,781	25,302
Total revenue		**1,015,173**	**985,254**
Gains			
Other gains	4.7	210	4,337
Total Gains		**210**	**4,337**
Total income other than income from State Government		**1,015,383**	**989,591**
NET COST OF SERVICES		**1,146,164**	**1,222,806**
INCOME FROM STATE GOVERNMENT			
Service appropriation	4.1	1,068,550	1,145,906
Assets assumed/(transferred)	4.1	14	45
Services received free of charge	4.1	97,038	87,830
Royalties for Regions Fund	4.1	400	371
Total income from State Government		**1,166,002**	**1,234,152**
SURPLUS/(DEFICIT) FOR THE PERIOD		**19,838**	**11,346**
OTHER COMPREHENSIVE INCOME/(LOSS)			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve		9,794	17,505
Total other comprehensive income/(loss)		**9,794**	**17,505**
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE YEAR		**29,632**	**28,851**

See also note 2.2 'Schedule of Income and Expenses by Service'.
The Statement of Comprehensive Income should be read in conjunction with the accompanying notes.

Statement of Financial Position
As at 30 June 2020

	Notes	2020 $000	2019 $000
ASSETS			
Current Assets			
Cash and cash equivalents	7.4	45,000	60,219
Restricted cash and cash equivalents	7.4	59,181	45,212
Receivables	6.1	68,417	53,236
Inventories	6.3	7,067	5,339
Other current assets	6.4	2,084	2,141
Total Current Assets		**181,749**	**166,147**
Non-Current Assets			
Restricted cash and cash equivalents	7.4	17,956	11,713
Amounts receivable for services	6.2	831,718	773,966
Infrastructure, property, plant and equipment	5.1	1,351,423	1,389,163
Right-of-use assets	5.2	22,822	-
Intangible assets	5.3	500	454
Total Non-Current Assets		**2,224,419**	**2,175,296**
TOTAL ASSETS		**2,406,168**	**2,341,443**
LIABILITIES			
Current Liabilities			
Payables	6.5	169,703	165,414
Contract liabilities	6.6	2,903	-
Borrowings	7.1	-	815
Employee related provisions	3.1	243,067	250,757
Lease liabilities	7.2	2,671	-
Other current liabilities	6.7	1,989	1,750
Total Current Liabilities		**420,333**	**418,736**
Non-Current Liabilities			
Employee related provisions	3.1	61,326	62,701
Lease liabilities	7.2	21,101	-
Total Non-Current Liabilities		**82,427**	**62,701**
TOTAL LIABILITIES		**502,760**	**481,437**
NET ASSETS		**1,903,408**	**1,860,006**
EQUITY			
Contributed equity	9.10	1,650,175	1,643,491
Reserves		173,603	163,809
Accumulated surplus/(deficit)		79,630	52,706
TOTAL EQUITY		**1,903,408**	**1,860,006**

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

Financial Statements (cont.)

For year ended 30 June 2020

Statement of Changes in Equity
For the year ended 30 June 2020

	Notes	Contributed equity $000	Reserves $000	Accumulated surplus/ (deficit) $000	Total equity $000
Balance at 1 July 2018		1,779,972	146,304	41,360	1,967,636
Surplus/(deficit)		-	-	11,346	11,346
Other comprehensive income		-	17,505	-	17,505
Total comprehensive income for the period		-	17,505	11,346	28,851
Transactions with owners in their capacity as owners:	9.10				
Capital appropriations		12,490	-	-	12,490
Other contributions by owners		1,765	-	-	1,765
Distributions to owners		(150,736)	-	-	(150,736)
Total		(136,481)	-	-	(136,481)
Balance at 30 June 2019		**1,643,491**	**163,809**	**52,706**	**1,860,006**
Balance at 1 July 2019		**1,643,491**	**163,809**	**52,706**	**1,860,006**
Initial application of new accounting standards		-	-	7,086	7,086
Restated balance at 1 July 2019		1,643,491	163,809	59,792	1,867,092
Surplus/(deficit)		-	-	19,838	19,838
Other comprehensive income		-	9,794	-	9,794
Total comprehensive income for the period		-	9,794	19,838	29,632
Transactions with owners in their capacity as owners:	9.10				
Capital appropriations		24,381	-	-	24,381
Other contributions by owners		-	-	-	-
Distributions to owners		(17,697)	-	-	(17,697)
Total		6,684	-	-	6,684
Balance at 30 June 2020		**1,650,175**	**173,603**	**79,630**	**1,903,408**

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 2020

	Notes	2020 $000 Inflows (Outflows)	2019 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriation		995,861	1,075,155
Capital appropriations		23,566	11,787
Royalties for Regions Fund		400	371
Net cash provided by State Government		**1,019,827**	**1,087,313**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(1,131,322)	(1,161,798)
Supplies and services		(850,174)	(852,419)
Finance costs		(590)	-
Receipts			
Receipts from customers		75,367	65,575
Commonwealth grants and contributions		665,214	635,403
Other grants and contributions		173,946	170,729
Donations received		432	294
Interest received		67	2
Other receipts		93,017	102,603
Net cash provided by/(used in) operating activities	7.4.2	**(974,043)**	**(1,039,611)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Payment for purchase of non-current physical and intangible assets		(21,599)	(14,030)
Receipts			
Proceeds from sale of non-current physical assets		5	29
Net cash provided by/(used in) investing activities		**(21,594)**	**(14,001)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Payments for principal element of lease		(2,989)	-
Net cash provided by/(used in) financing activities		**(2,989)**	**-**
Net increase/(decrease) in cash and cash equivalents		21,201	33,701
Cash and cash equivalents at the beginning of the period		117,144	98,330
Cash transferred to other health agencies as part of demergers		(16,208)	(14,887)
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.4	**122,137**	**117,144**

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

Financial Statements (cont.)

For year ended 30 June 2020

Summary of consolidated account appropriations
For the year ended 30 June 2020

	2020 Budget Estimate	2020 Supplementary Funding	2020 Revised Budget	2020 Actual	2020 Variance
	$000	$000	$000	$000	$000
Delivery of Services					
Item 51 Net amount appropriated to deliver services	1,062,809	5,741	1,068,550	1,068,550	-
Total appropriations provided to deliver services	**1,062,809**	**5,741**	**1,068,550**	**1,068,550**	**-**
Capital					
Item 125 Capital appropriations	45,299	3,757	49,056	24,381	24,675
GRAND TOTAL	**1,108,108**	**9,498**	**1,117,606**	**1,092,931**	**24,675**

For detail breakdown, refer to Note 2.2. See also Note 9.12 for more information on variance analysis.

Notes to the Financial Statements

For year ended 30 June 2020

1 Basis of preparation

The Health Service is a WA Government entity and is controlled by the State of Western Australia, which is the ultimate parent. The 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 principal activities have been included in the **'Overview'** which does not form part of these financial statements.

Statement of compliance

These general purpose financial statements have been prepared in accordance with:

1) The *Financial Management Act 2006* **(FMA)**
2) The Treasurer's Instructions **(the Instructions or TI)**
3) Australian Accounting Standards **(AAS)**, including applicable interpretations
4) Where appropriate, those **AAS** paragraphs applicable for not-for-profit entities have been applied.

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

Basis of preparation

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

Judgements and estimates

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

Contributed equity

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

Comparative figures

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

Notes to the Financial Statements
For the year ended 30 June 2020

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 provides the following services:

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

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

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

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

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

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

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

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

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

Notes to the Financial Statements
For the year ended 30 June 2020

2.1 Health Service objectives (continued)

5. Aged and Continuing Care Services
The provision of aged and continuing care services and community-based palliative care services.

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

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

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

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

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

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

9. Health System Management – Policy and Corporate Services
The provision of strategic leadership, policy and planning services, system performance management and purchasing linked to the statewide planning, budgeting and regulation processes.

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

Notes to the Financial Statements
For the year ended 30 June 2020

2.2 Schedule of income and expenses by service

	Public Hospital Admitted Services		Public Hospital Emergency Services		Public Hospital Non-Admitted Services		Mental Health Services		Aged and Continuing Care Services		Public and Community Health Services	
	2020 $000	2019 $000	2020 $000	2019 $000	2020 $000	2019 $000	2020 $000	2019 $000	2020 $000	2019 $000	2020 $000	2019 $000
COST OF SERVICES												
Expenses												
Employee benefits expense	596,224	643,260	56,884	54,447	149,229	146,908	199,863	198,140	11,039	10,934	49,860	47,834
Contracts for services	302,819	304,523	90,850	85,011	22,677	23,913	22,410	22,802	2,067	2,058	15,499	20,908
Patient support costs	194,124	205,272	11,722	12,251	73,516	66,743	10,269	10,157	2,434	2,376	16,639	15,367
Finance costs	18	32	1	1	6	2	445	-	3	-	115	4
Depreciation and amortisation expense	41,745	42,105	3,756	3,698	9,866	9,379	7,340	7,546	82	18	5,248	3,662
Asset impairment losses	-	1,533	-	34	-	214	-	11	-	-	-	10
Finance costs	-	-	-	-	-	-	-	-	-	-	-	-
Loss on disposal of non-current assets	68	80	-	5	8	3	-	-	-	-	108	46
Repairs, maintenance and consumable equipment	15,821	16,390	1,185	1,070	5,856	6,228	4,068	3,990	249	382	9,132	3,781
Other supplies and services	39,841	37,888	3,500	3,758	10,559	10,240	7,293	5,800	500	484	5,871	2,611
Other expenses	19,738	24,814	1,387	1,679	4,930	5,053	9,688	13,046	312	594	12,914	15,701
Total cost of services	**1,210,398**	**1,275,897**	**169,285**	**161,954**	**276,647**	**268,683**	**261,376**	**261,492**	**16,686**	**16,846**	**115,386**	**109,924**
INCOME												
Revenue												
Patient charges	54,189	55,962	1,513	1,100	10,002	10,349	461	1,138	-	1	-	1
Other fees for services	24,598	28,390	18	43	44,418	39,609	252	277	-	-	4,574	5,054
Commonwealth grants and contributions	402,020	400,976	59,507	53,547	107,028	86,273	74,488	73,289	4,435	4,322	8,050	4,698
Other grants and contributions	452	322	41	29	202	839	169,201	165,943	1,133	1,437	2,153	1,215
Donation revenue	12	5	1	-	12	8	0	3	0	-	630	370
Interest revenue	0	1	0	-	0	-	0	-	-	-	67	-
Other revenue	4,815	3,460	345	219	5,622	6,273	333	339	1	5	13,337	14,044
Total revenue	**486,086**	**489,116**	**61,425**	**54,938**	**167,284**	**143,351**	**244,735**	**240,989**	**5,569**	**5,765**	**28,811**	**25,382**
Gains												
Other gains	162	2,334	-	188	32	527	-	715	-	-	16	-
Total Gains	**162**	**2,334**	**-**	**188**	**32**	**527**	**-**	**715**	**-**	**-**	**16**	**-**
Total income other than income from State Government	**486,248**	**491,450**	**61,425**	**55,126**	**167,316**	**143,878**	**244,735**	**241,704**	**5,569**	**5,765**	**28,827**	**25,382**
NET COST OF SERVICES	**724,150**	**784,447**	**107,860**	**106,828**	**109,331**	**124,805**	**16,641**	**19,788**	**11,117**	**11,081**	**86,559**	**84,542**
INCOME FROM STATE GOVERNMENT												
Service appropriation	667,393	712,210	99,406	110,615	100,763	111,819	11,262	14,807	15,543	13,234	90,028	88,886
Assets assumed/(transferred)	-	-	-	-	-	-	-	-	-	5	-	-
Services received free of charge	60,879	57,107	5,953	5,584	15,438	14,481	5,377	4,981	439	406	4,797	1,943
Royalties for Regions Fund	-	-	-	-	-	-	-	-	-	-	-	-
Total income from State Government	**728,272**	**769,317**	**105,359**	**116,199**	**116,201**	**126,300**	**16,639**	**19,788**	**15,982**	**13,645**	**94,825**	**90,829**
SURPLUS/(DEFICIT) FOR THE PERIOD	**4,122**	**(15,130)**	**(2,501)**	**9,371**	**6,870**	**1,495**	**(2)**	**-**	**4,865**	**2,564**	**8,266**	**6,287**

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

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

Notes to the Financial Statements
For the year ended 30 June 2020

2.2 Schedule of income and expenses by service (continued)

	Community Dental Health Services		Small Rural Hospital Services		Health System Management - Policy and Corporate Services		Total	
	2020 $000	2019 $000	2020 $000	2019 $000	2020 $000	2019 $000	2020 $000	2019 $000
COST OF SERVICES								
Expenses								
Employee benefits expense	74,684	69,913	-	-	6,747	12,469	1,144,530	1,183,905
Contracts for services	688	828	396	377	-	59	457,407	460,479
Patient support costs	13,673	12,931	-	-	2	299	322,379	325,396
Finance costs	15	-	-	-	-	-	603	39
Depreciation and amortisation expense	2,308	3,219	-	-	1	1	70,346	69,628
Asset impairment losses	-	59	-	-	-	-	-	1,861
Asset revaluation decrement	-	-		-	-	-	-	-
Loss on disposal of non-current assets	(5)	32	-	-	-	-	180	166
Repairs, maintenance and consumable equipment	2,689	2,506	-	-	18	242	39,017	34,589
Other supplies and services	4,403	3,031	10	9	12	650	71,989	64,471
Other expenses	5,794	6,378	-	-	333	4,598	55,096	71,863
Total cost of services	**104,249**	**98,897**	**406**	**386**	**7,113**	**18,318**	**2,161,547**	**2,212,397**
INCOME								
Revenue								
Patient charges	5,730	5,722	-	-	-	-	71,895	74,273
Other fees for services	4,755	5,787	-	-	-	-	78,615	79,160
Commonwealth grants and contributions	9,686	12,298	-	-	-	-	665,215	635,403
Other grants and contributions	763	944	-	-	-	-	173,946	170,729
Donation revenue	-	-	-	-	-	-	654	386
Interest revenue	-	-	-	-	-	-	67	1
Other revenue	327	962	-	-	-	-	24,781	25,302
Total revenue	**21,262**	**25,713**	**-**	**-**	**-**	**-**	**1,015,173**	**985,254**
Gains								
Other gains	-	573	-	-	-	-	210	4,337
Total Gains	**-**	**573**	**-**	**-**	**-**	**-**	**210**	**4,337**
Total income other than income from State Government	**21,262**	**26,286**	**-**	**-**	**-**	**-**	**1,015,383**	**989,591**
NET COST OF SERVICES	**82,987**	**72,611**	**406**	**386**	**7,113**	**18,318**	**1,146,164**	**1,222,806**
INCOME FROM STATE GOVERNMENT								
Service appropriation	77,629	71,394	-	6	6,526	22,935	1,068,550	1,145,906
Assets assumed/(transferred)	14	45	-	-	-	(5)	14	45
Services received free of charge	4,149	2,766	6	9	-	553	97,038	87,830
Royalties for Regions Fund	-	-	400	371	-	-	400	371
Total income from State Government	**81,792**	**74,205**	**406**	**386**	**6,526**	**23,483**	**1,166,002**	**1,234,152**
SURPLUS/(DEFICIT) FOR THE PERIOD	**(1,195)**	**1,594**	**-**	**-**	**(587)**	**5,165**	**19,838**	**11,346**

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

Notes to the Financial Statements
For the year ended 30 June 2020

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	2020 $000	2019 $000
Employee benefits expense	3.1 (a)	1,144,530	1,183,905
Employee related provisions	3.1 (b)	304,393	313,458
Contracts for services	3.2	457,407	460,479
Patient support costs	3.3	322,379	325,396
Repairs, maintenance and consumable equipment	3.4	39,017	34,589
Other supplies and services	3.5	71,989	64,471
Other expenses	3.6	55,096	71,863

3.1 (a) Employee benefits expense

	2020 $000	2019 $000
Wages and salaries	1,046,514	1,083,989
Superannuation – defined contribution plans	98,016	99,916
Total employee benefits expense	**1,144,530**	**1,183,905**
Add: AASB 16 Non-monetary benefits	1,190	-
Less: Employee Contributions	(44)	-
Net employee benefits	**1,145,676**	**1,183,905**

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

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

The amount recognised in profit or loss of the Statement of Comprehensive Income comprises employer contributions paid to the Gold State Superannuation Scheme (GSS, concurrent contributions), the West State Superannuation (WSS), the Government Employees Superannuation Board Schemes (GESBs), or other superannuation funds. The employer contribution paid to the Government Employees Superannuation Board (GESB) in respect of the GSS is paid back into the Consolidated Account by the GESB.

GSS (concurrent contributions) is a defined benefit scheme for the purposes of employees and whole-of-government reporting. It is however a defined contribution plan for Health Service purposes because the concurrent contributions (defined contributions) made by the Health Service to GESB extinguishes the Health Service's obligations to the related superannuation liability.

The Health Service does not recognise any defined benefit liabilities because it has no legal or constructive obligation to pay future benefits relating to its employees. The Liabilities for the unfunded Pension Scheme and the unfunded GSS transfer benefits attributable to members who transferred from the Pension Scheme, are assumed by the Treasurer. All other GSS obligations are funded by concurrent contributions made by the Health Service to the GESB.

The GESB and other fund providers administer public sector superannuation arrangements in Western Australia in accordance with legislative requirements. Eligibility criteria for membership in particular schemes for public sector employees vary according to commencement and implementation dates.

AASB 16 Non-monetary benefits: Employee benefits in the form of non-monetary benefits, such as the provision of motor vehicles or housing, are measured at the cost.

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

3.1 (b) Employee related provisions

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

	2020 $000	2019 $000
Current		
Annual leave [a]	119,439	118,037
Time off in lieu leave [a]	28,677	31,456
Long service leave [b]	93,577	99,980
Deferred salary scheme [c]	1,374	1,284
Total current employee related provisions	**243,067**	**250,757**
Non-current		
Long service leave [b]	61,326	62,701
	61,326	**62,701**
Total employee related provisions	**304,393**	**313,458**

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

Within 12 months of the end of the reporting period	97,757	98,665
More than 12 months after the end of the reporting period	50,359	50,828
	148,116	**149,493**

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

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

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

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

Within 12 months of the end of the reporting period	15,908	16,997
More than 12 months after the end of the reporting period	138,995	145,684
	154,903	**162,681**

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

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

	2020 $000	2019 $000
Within 12 months of the end of the reporting period	824	770
More than 12 months after the end of the reporting period	550	514
	1,374	**1,284**

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.

Notes to the Financial Statements
For the year ended 30 June 2020

3.2 Contracts for services

	2020 $000	2019 $000
Public patients services [a]	425,205	404,280
Mental Health	23,016	33,706
Other aged-care services	1,256	8,965
Other contracts	7,930	13,528
Total contracts for services	**457,407**	**460,479**

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

	2020 $000	2019 $000
Medical supplies and services	227,093	226,689
Pathology services received free of charge	33,644	32,124
Domestic charges	18,077	17,712
Fees for visiting medical practitioners	13,563	14,805
Fuel, light and power	11,475	14,562
Food supplies	8,943	8,681
Patient transport costs	1,741	2,653
Research, development and other grants	7,843	8,170
Total patient support costs	**322,379**	**325,396**

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

3.4 Repairs, maintenance and consumable equipment

	2020 $000	2019 $000
Repairs and maintenance	28,983	25,386
Consumable equipment	10,034	9,203
Total repairs, maintenance and consumable equipment	**39,017**	**34,589**

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

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

3.5 Other supplies and services

	2020 $000	2019 $000
Sanitisation and waste removal services	2,762	2,817
Administration and management services	2,879	3,200
Interpreter services	2,613	2,546
Security services	331	114
Services provided by Health Support Services: [a]		
ICT services	43,565	36,490
Supply chain services	6,499	7,339
Financial services	2,994	3,176
Human resource services	10,329	8,683
Other	17	106
Total other supplies and services	**71,989**	**64,471**

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

	2020 $000	2019 $000
Communications	4,123	4,613
Computer services	2,644	2,320
Workers' compensation insurance	13,003	14,220
Operating lease expenses	-	7,321
Other insurances	11,647	12,287
Consultancy fees	2,623	3,336
Other employee-related expenses	4,869	6,212
Printing and stationeries	3,754	3,750
Expected credit losses expense	179	2,650
Freight and cartage	916	1,136
Periodical subscriptions	1,032	2,627
Write-down of assets	-	346
Motor vehicle expenses	1,419	1,462
General administration	5,749	6,728
Legal expenses	202	2,648
Rental	1,031	-
Other	1,905	207
Total other expenses	**55,096**	**71,863**

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

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

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

Notes to the Financial Statements
For the year ended 30 June 2020

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	2020 $000	2019 $000
Income from State Government	4.1		
Service appropriation	4.1.1	1,068,550	1,145,906
Assets transferred from/(to) other State Government agencies during the period	4.1.2	14	45
Services received free of charge from other State Government agencies during the period	4.1.3	97,038	87,830
Royalties for Regions Fund	4.1.4	400	371
Patient charges	4.2	71,895	74,273
Other fees for services	4.3	78,615	79,160
Commonwealth grants and contributions	4.4	665,215	635,403
Other grants and contributions	4.5	173,946	170,729
Donation revenue		654	386
Interest revenue		67	1
Other revenue	4.6	24,781	25,302
Other gains	4.7	210	4,337

4.1 Income from State Government

4.1.1 Appropriation received during the period:

	2020 $000	2019 $000
Service appropriation (funding via the Department of Health)	1,068,550	1,145,906
	1,068,550	**1,145,906**

Service appropriations are recognised as revenues at fair value in the period in which the Health Service gains control of the appropriated funds. The Health Service gains control of appropriated funds at the time those funds are deposited to the bank account or credited to the 'Amounts receivable for services' (holding account) held at Treasury.

Service appropriations fund the net cost of services delivered (as set out in note 2.2). Appropriation revenue comprises the following:

- Cash component; and
- A receivable (asset).

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

Notes to the Financial Statements
For the year ended 30 June 2020

4.1 Income from State Government (continued)

4.1.2 Assets assumed/(transferred) from/(to) other State government agencies during the period:

	2020 $000	2019 $000
Transfers from/(to) WA Country Health Service (WACHS)	14	45
	14	**45**

Liabilities assumed by other parties are recognised as income at fair value when the liabilities are assumed.
Asset transferred from other parties are recognised as income at fair value when the assets are transferred.

4.1.3 Services received free of charge from other State government agencies during the period:

	2020 $000	2019 $000
Department of Finance – government leased accommodation	6	18
PathWest – pathology services	33,644	32,124
Services received from Health Support Services (HSS)		
ICT services	43,566	36,490
Supply chain services	6,499	7,339
Financial services	2,994	3,176
Human resource services	10,329	8,683
	97,038	**87,830**

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

4.1.4 Royalties for Regions Fund

	2020 $000	2019 $000
Regional Community Services Account	400	371
Total Royalties for Regions Fund	**400**	**371**

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.

TOTAL INCOME FROM STATE GOVERNMENT	**1,166,002**	**1,234,152**

Notes to the Financial Statements
For the year ended 30 June 2020

4.2 Patient charges

	2020 $000	2019 $000
Inpatient bed charges	47,508	50,559
Inpatient other charges	7,149	6,559
Outpatient charges	17,238	17,155
	71,895	**74,273**

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

	2020 $000	2019 $000
Recoveries from Commonwealth Government	73,632	74,300
Clinical services to other health organisations	3,165	3,272
Non-clinical services to other health organisations	1,671	1,588
Pathology services to other Health Services and other government agencies	147	-
	78,615	**79,160**

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

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

4.4 Commonwealth grants and contributions

	2020 $000	2019 $000
Capital Grants		
King Edward Memorial Hospital Critical Infrastructure upgrade	297	-
Intra Operative MRI Project	441	2,117
Fremantle General Dental Clinic upgrade	80	2,612
Other	2	25
Recurrent Grants		
National Health Reform Agreement (funding via Department of Health)	556,520	524,642
National Health Reform Agreement (funding via Mental Health Commission)	74,488	73,289
Other	33,387	32,718
	665,215	**635,403**

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

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

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

Under previous accounting policy for 30 June 2019, income from Commonwealth grants is recognised at fair value when the grant is received.

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

4.5 Other grants and contributions

	2020 $000	2019 $000
Mental Health Commission – service delivery agreement	167,355	164,300
Mental Health Commission – other	1,836	1,639
Disability Services Commission – community aids and equipment program	1,133	1,416
Other	3,622	3,374
	173,946	**170,729**

The accounting policy for other grants and contributions are similar to that of Commonwealth grants and contributions. Please refer to Note 4.4.

4.6 Other revenue

	2020 $000	2019 $000
Use of hospital facilities	6,252	8,412
Rent from commercial properties	288	214
Rent from residential properties	293	335
Boarders' accommodation	1,904	1,839
RiskCover insurance premium rebate	5,739	5,304
Sale of radiopharmacies	2,613	1,949
Parking	4,583	4,420
Other	3,109	2,829
	24,781	**25,302**

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

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

4.7 Other gains

	2020 $000	2019 $000
Reversal of impairment losses in prior year	210	-
Revaluation increments (offsetting decrements)	-	4,337
	210	**4,337**

Notes to the Financial Statements
For the year ended 30 June 2020

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	2020 $000	2019 $000
Property, plant and equipment	5.1	1,351,423	1,389,163
Depreciation	5.1.1	66,258	69,504
Right-of-use assets	5.2	22,822	-
Depreciation	5.2.1	3,931	-
Intangible assets	5.3	500	454
Amortisation	5.3.1	157	124

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

Notes to the Financial Statements
For the year ended 30 June 2020

5.1 Infrastructure, property, plant and equipment

Year ended 30 June 2019	Land	Buildings	Buildings under construction	Site infrastructure	Leasehold improvements	Computer equipment	Furniture & fittings	Motor vehicles	Medical equipment	Other plant & equipment	Work In progress	Artworks	Total
	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
1 July 2018													
Gross carrying amount	224,383	1,038,733	14,402	136,810	2,265	938	7,215	210	120,681	75,158	313	332	1,621,440
Accumulated depreciation	-	(51,193)	-	(9,213)	(1,052)	(391)	(1,331)	(84)	(33,340)	(7,822)	-	-	(104,426)
Accumulated impairment loss	-	-	-	-	-	-	-	-	-	-	-	-	-
Carrying amount at start of period prior to demerger	**224,383**	**987,540**	**14,402**	**127,597**	**1,213**	**547**	**5,884**	**126**	**87,341**	**67,336**	**313**	**332**	**1,517,014**
Demerger of PathWest	-	**(72,352)**	**(12)**	-	-	**(258)**	**(76)**	-	**(18,941)**	**(809)**	**(144)**	-	**(92,592)**
Carrying amount at start of period	**224,383**	**915,188**	**14,390**	**127,597**	**1,213**	**289**	**5,808**	**126**	**68,400**	**66,527**	**169**	**332**	**1,424,422**
Additions	-	525	2,463	3	2,333	79	131	-	7,089	346	-	13	12,982
Disposal	-	-	-	-	-	-	(14)	-	(161)	(20)	-	-	(195)
Transfers to other reporting entities	-	-	-	1,765	-	-	-	-	45	-	-	-	1,810
Transfers from work in progress	-	7,335	(11,336)	438	-	160	25	-	3,496	-	(118)	-	-
Revaluation increments/(decrements)	5,405	16,437	-	-	-	-	-	-	-	-	-	-	21,842
Impairment losses	-	-	-	-	-	-	(115)	-	(1,615)	(83)	-	(35)	(1,848)
Depreciation	-	(44,721)	-	(5,538)	(464)	(148)	(677)	(29)	(14,179)	(3,748)	-	-	(69,504)
Write-off assets	-	-	(300)	-	-	-	-	-	-	-	(46)	-	(346)
Carrying amount at 30 June 2019	**229,788**	**894,764**	**5,217**	**124,265**	**3,082**	**380**	**5,158**	**97**	**63,075**	**63,022**	**5**	**310**	**1,389,163**

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

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

5.1 Infrastructure, property, plant and equipment (continued)

Year ended 30 June 2020	Land $000	Buildings $000	Buildings under construction $000	Site infrastructure $000	Leasehold improvements $000	Computer equipment $000	Furniture & fittings $000	Motor vehicles $000	Medical equipment $000	Other plant & equipment $000	Work In progress $000	Artworks $000	Total $000
1 July 2019													
Gross carrying amount	229,788	990,678	5,517	139,016	4,598	919	7,281	210	112,209	74,675	51	345	1,565,287
Accumulated depreciation	-	(95,914)	-	(14,751)	(1,516)	(539)	(2,008)	(113)	(47,519)	(11,570)	-	-	(173,930)
Accumulated impairment loss	-	-	(300)	-	-	-	(115)	-	(1,615)	(83)	(46)	(35)	(2,194)
Carrying amount at start of period	**229,788**	**894,764**	**5,217**	**124,265**	**3,082**	**380**	**5,158**	**97**	**63,075**	**63,022**	**5**	**310**	**1,389,163**
Additions	-	294	5,243	-	-	2,312	870	-	12,153	723	-	-	21,595
Disposal	-	-	-	-	-	-	(4)	-	(173)	(7)	-	-	(184)
Transfers from Work in Progress	-	747	(747)	-	-	-	-	-	-	-	-	-	-
Transfers from/(to) other reporting entities	-	-	-	-	-	-	(31)	-	(2,810)	(56)	-	-	(2,897)
Transfers from /(to) other asset classes	-	(493)	493	-	-	-	5	-	(5)	-	-	-	-
Revaluation increments/(decrements)	(172)	9,966	-	-	-	-	-	-	-	-	-	-	9,794
Impairment losses	-	-	-	-	-	-	-	-	-	-	-	-	-
Impairment losses reversed	-	-	-	-	-	-	-	-	210	-	-	-	210
Depreciation	-	(42,712)	-	(4,824)	(639)	(382)	(668)	(27)	(13,307)	(3,699)	-	-	(66,258)
Carrying amount at 30 June 2020	**229,616**	**862,566**	**10,206**	**119,441**	**2,443**	**2,310**	**5,330**	**70**	**59,143**	**59,983**	**5**	**310**	**1,351,423**
Gross carrying amount	229,616	1,001,192	10,506	139,016	4,598	3,231	8,121	210	121,374	75,335	51	345	1,593,595
Accumulated depreciation	-	(138,626)	-	(19,575)	(2,155)	(921)	(2,676)	(140)	(60,826)	(15,269)	-	-	(240,188)
Accumulated impairment loss	-	-	(300)	-	-	-	(115)	-	(1,405)	(83)	(46)	(35)	(1,984)
Carrying amount at 30 June 2020	229,616	862,566	10,206	119,441	2,443	2,310	5,330	70	59,143	59,983	5	310	1,351,423

Notes to the Financial Statements
For the year ended 30 June 2020

5.1 Infrastructure, property, plant and equipment (continued)

Initial recognition

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

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

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

Subsequent measurement

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

- land
- buildings

Land is carried at fair value.

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

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

Revaluation model:

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

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

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

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

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

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

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

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

Land and buildings were revalued as at 1 July 2019 by the Western Australian Land Information Authority (Valuations and Property Analytics). The valuations were performed during the year ended 30 June 2020 and recognised at 30 June 2020. In undertaking the revaluation, fair value was determined by reference to market values for land: $4.07 million (2019: $4.512 million) and buildings: $0.32 million (2019: $0.53 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 (cont.)

For year ended 30 June 2020

5.1 Infrastructure, property, plant and equipment (continued)

	2020 $000	2019 $000
5.1.1 Depreciation and impairment		
Depreciation		
Buildings	42,712	44,721
Site infrastructure	4,824	5,538
Leasehold improvements	639	464
Computer equipment	382	148
Furniture and fittings	668	677
Motor vehicles	27	29
Medical equipment	13,307	14,179
Other plant and equipment	3,699	3,748
Total depreciation for the period	**66,258**	**69,504**

All surplus assets at 30 June 2020 have either been classified as assets held for sale or have been written-off.

Please refer to note 5.3 for guidance in relation to the impairment assessment that has been performed for intangible assets.

Finite useful lives

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

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

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

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

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

Impairment

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

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

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

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

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

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.

Notes to the Financial Statements
For the year ended 30 June 2020

5.2 Right-of-use assets

Year ended 30 June 2020	Land $000	Buildings $000	Plant, equipment and vehicles $000	Total $000
As at 30 June 2019				
Opening net carrying amount	-	-	-	-
Recognition of right-of-use assets on initial application of AASB 16	677	15,916	3,082	19,675
Restated opening carrying amount	677	15,916	3,082	19,675
1 July 2019				
Gross carrying amount	677	15,916	3,082	19,675
Accumulated depreciation	-	-	-	-
Carrying amount at start of period	**677**	**15,916**	**3,082**	**19,675**
Additions	-	8,309	-	8,309
Transfers from/(to) other reporting entities	-	-	(20)	(20)
Derecognition	-	(1,211)	-	(1,211)
Depreciation	(115)	(2,683)	(1,133)	(3,931)
Carrying amount at 30 June 2020	**562**	**20,331**	**1,929**	**22,822**
Gross carrying amount	677	23,014	3,062	26,753
Accumulated depreciation	(115)	(2,683)	(1,133)	(3,931)
Carrying amount at 30 June 2020	**562**	**20,331**	**1,929**	**22,822**

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

5.2 Right-of-use assets

Initial recognition

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

The Health Service assesses whether:
a) The contract involves the use of an identified asset. The asset may be explicitly or implicitly specified in the contract.
b) The customer has the right to obtain substantially all of the economic benefits from the use of the asset throughout the period of use.
c) The customer has the right to direct the use of the asset throughout the period of use. The customer is considered to have the right to direct the use of the asset only if either:
i. The customer has the right to direct how and for what purpose the identified asset is used throughout the period of use; or
ii. The relevant decisions about how and for what purposes the asset is used is predetermined and the customer has the right to operate the asset, or the customer designed the asset in a way that predetermines how and for what purpose the asset will be used throughout the period of use.

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

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

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

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

Subsequent Measurement

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

Depreciation and impairment of right-of-use assets

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

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

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

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

	2020 $000	2019 $000
Depreciation expense of right-of-use assets	3,931	-
Lease interest expense	586	-
Expenses relating to variable lease payments not included in lease liabilities	17	-
Short-term leases	78	-
Low-value leases	1	-
Total amount recognised in the statement of comprehensive income	**4,613**	**-**

The total cash outflow for leases in 2020 was $3,671,000.

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

Up to 30 June 2019, the Health Service classified lease as either finance leases or operating leases. From 1 July 2019, the Health Service recognises leases as right-of-use assets and associated lease liabilities in the Statement of Financial Position.

The corresponding lease liabilities in relation to these right-of-use assets have been disclosed in note 7.2.

Notes to the Financial Statements
For the year ended 30 June 2020

5.3 Intangible assets

Year ended 30 June 2019	Computer software $000	Works in progress $000	Total $000
1 July 2018			
Gross carrying amount	355	12,095	12,450
Accumulated amortisation	(212)	-	(212)
Carrying amount at start of period prior to demerger	**143**	**12,095**	**12,238**
Demerger of PathWest	(5)	(12,095)	(12,100)
Carrying amount at start of period	**138**	**-**	**138**
Additions	453	-	453
Impairment losses	(13)	-	(13)
Amortisation expense	(124)	-	(124)
Carrying amount at 30 June 2019	**454**	**-**	**454**

Year ended 30 June 2020	Computer software $000	Works in progress $000	Total $000
1 July 2019			
Gross carrying amount	785	-	785
Accumulated amortisation	(331)	-	(331)
Carrying amount at start of period	**454**	**-**	**454**
Additions	203	-	203
Amortisation expense	(157)	-	(157)
Carrying amount at 30 June 2020	**500**	**-**	**500**
Gross carrying amount	988	-	988
Accumulated amortisation	(488)	-	(488)

Initial recognition

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

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

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

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

(a) the technical feasibility of completing the intangible asset so that it will be available for use or sale;
(b) an intention to complete the intangible asset and use or sell it;
(c) the ability to use or sell the intangible asset;
(d) the intangible asset will generate probable future economic benefit;
(e) the availability of adequate technical, financial and other resources to complete the development and to use or sell the intangible asset; and
(f) the ability to measure reliably the expenditure attributable to the intangible asset during its development.

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

Subsequent measurement

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

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

5.3 Intangible assets (continued)

5.3.1 Amortisation and impairment

Charge for the period	2020 $000	2019 $000
Computer software	157	124
Total amortisation for the period	**157**	**124**

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

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

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

Computer software[a]	5 years

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

Impairment of intangible assets

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

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

Notes to the Financial Statements
For the year ended 30 June 2020

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	2020 $000	2019 $000
Receivables	6.1	68,417	53,236
Amounts receivable for services	6.2	831,718	773,966
Inventories	6.3	7,067	5,339
Other current assets	6.4	2,084	2,141
Payables	6.5	169,703	165,414
Contract liabilities	6.6	2,903	-
Other current liabilities	6.7	1,989	1,750

6.1 Receivables

	2020 $000	2019 $000
Current		
Trade Receivables	56,591	60,582
Other receivables	516	-
Allowance for impairment of trade receivables	(29,944)	(37,200)
Accrued revenue	32,649	21,475
GST Receivables	8,605	8,379
Total current receivables	**68,417**	**53,236**

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

6.1.1 Movement in the allowance for impairment of trade receivables

	2020 $000	2019 $000
Reconciliation of changes in the allowance for impairment of trade receivables:		
Balance at start of period	37,200	37,729
Demerger of PathWest	-	(1,135)
Restated balance at start of period	**37,200**	**36,594**
Transfers to another Health Service	(255)	-
Expected credit losses expense	179	2,650
Net Write-back adjustment	-	(1,913)
Amounts written-off during the period	(7,180)	(131)
Balance at end of period	**29,944**	**37,200**

The maximum exposure to credit risk at the end of the reporting period for trade 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 (Holding Account)

	2020 $000	2019 $000
Non-current	831,718	773,966
Balance at end of period	**831,718**	**773,966**

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

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

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

6.3 Inventories

	2020 $000	2019 $000
Current		
Pharmaceutical stores – at cost	6,557	4,891
Engineering stores – at cost	510	448
Total inventories	**7,067**	**5,339**

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

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

6.4 Other current assets

	2020 $000	2019 $000
Current		
Prepayments	2,084	2,127
Paid parental leave scheme	-	-
Other	-	14
Total other current assets	**2,084**	**2,141**

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

	2020 $000	2019 $000
Current		
Trade payables	20,251	16,482
Other payables	16,489	11,713
Accrued expenses	107,302	116,542
Accrued salaries	25,661	20,675
Accrued interest	-	2
Total current payables	**169,703**	**165,414**

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

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

6.6 Contract liabilities

	2020 $000	2019 $000
Current	2,903	-
Non-current	-	-
Total contract liabilities	**2,903**	**-**

The Health Service's contract liabilities relate to capital grants received for critical infrastructure upgrade. Refer to Note 4.4 for more information.

6.7 Other current liabilities

	2020 $000	2019 $000
Income received in advance	-	14
Refundable deposits	1,113	1,089
Paid parental leave scheme	244	-
Other	632	661
Total other current liabilities	**1,989**	**1,750**

Notes to the Financial Statements
For the year ended 30 June 2020

7 Financing

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

	Notes	2020 $000	2019 $000
Borrowings	7.1		
Department of Treasury loans	7.1.1	-	815
Lease liabilities	7.2	23,772	-
Finance costs	7.3	603	39
Cash and cash equivalents	7.4		
Cash and cash equivalents	7.4.1	45,000	60,219
Restricted cash and cash equivalents	7.4.1	77,137	56,925
Reconciliation of net cost of services to net cash used in operating activities	7.4.2	(974,043)	(1,039,611)
Commitments	7.5		
Operating lease commitments	7.5.1	-	24,480
Capital commitments	7.5.2	19,860	8,457

7.1 Borrowings

7.1.1 Department of Treasury loans	2020 $000	2019 $000
Current	-	815
Balance at end of period	**-**	**815**

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

Notes to the Financial Statements
For the year ended 30 June 2020

7.2 Lease liabilities

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

	2020 $000	2019 $000
Lease liabilities		
Current	2,671	-
Non-current	21,101	-
Total lease liabilities	**23,772**	**-**

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

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

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

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

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

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

This section should be read in conjunction with note 5.2.

Subsequent Measurement

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

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

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

7.3 Finance costs

	2020 $000	2019 $000
Lease interest expense	586	-
Other interest expense	17	39
	603	**39**

Notes to the Financial Statements
For the year ended 30 June 2020

7.4 Cash and cash equivalents

7.4.1 Reconciliation of cash	2020 $000	2019 $000
Cash and cash equivalents	45,000	60,219
Restricted cash and cash equivalents	77,137	56,925
Balance at end of period	**122,137**	**117,144**
Restricted cash and cash equivalents		
Current		
Grant from State and Commonwealth Governments	11,391	2,865
Other specific purposes [a]	47,423	41,980
Mental Health Commission funding [b]	367	367
Total current	**59,181**	**45,212**
Non-Current		
Accrued salaries suspense account [c]	17,956	11,713
Total Non-Current	**17,956**	**11,713**
Balance at end of period	**77,137**	**56,925**

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

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

[b] See note 9.8 Special purpose accounts.

[c] Funds held in the suspense account for the purpose of meeting the 27th pay in a reporting period that occurs every 11th year. This account is classified as non current for 10 out of 11 years.

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

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

	Notes	2020 $000	2019 $000
Net cost of services		(1,146,164)	(1,222,806)
Non-cash items			
Expected credit losses expenses	3.6	179	2,650
Write-down of assets	3.6	-	346
Depreciation and amortisation expense	5.1, 5.2, 5.3	70,346	69,628
Asset impairment losses / (reversal)		(210)	1,861
Net loss from disposal of non-current assets		180	166
Finance costs		-	40
Net donation of non-current assets		(222)	(92)
Adjustment for expenses related to transfer of PathWest		788	-
Asset revaluation decrement / (increment)		-	(4,337)
Services received free of charge	4.1.3	97,038	87,830
(Increase)/decrease in assets			
GST receivable		(226)	(986)
Receivables		(8,820)	(10,532)
Inventories		(1,728)	(1,014)
Other current assets		57	(2,139)
Increase/(decrease)in liabilities			
Payables		4,289	21,758
Contract liabilities		2,903	-
Current employee related provisions		8,683	8,533
Non-current employee related provisions		(1,375)	8,779
Other current liabilities		239	705
Net cash used in operating activities		**(974,043)**	**(1,039,611)**

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

7.5 Commitments

The totals presented for commitments are GST inclusive.

7.5.1 Non-cancellable operating lease commitments	2020 $000	2019 $000
Commitments for minimum lease payments are payable as follows:		
Within 1 year	-	4,660
Later than 1 year and not later than 5 years	-	11,885
Later than 5 years	-	7,935
	-	24,480

Operating leases are expensed on a straight line basis over the lease term as this represents the pattern of benefits derived from the leased properties.

Operating lease commitments predominantly consist of contractual agreements for office accommodation and residential accommodation. The basis on which contingent operating leases payments are determined is the value for each lease agreement under the contract terms and conditions at current values.

From 1 July 2019, the Health Service has applied AASB 16. Refer to note 5.2, note 7.2 and note 9.2 for more information regarding the recognition of right of use assets and lease liabilities.

7.5.2 Capital commitments

Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows:

	2020 $000	2019 $000
Within 1 year	10,504	8,457
Later than 1 year and not later than 5 years	9,356	-
	19,860	8,457

Notes to the Financial Statements
For the year ended 30 June 2020

8 Risks and contingencies

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

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

8.1 Financial risk management

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

(a) Summary of risks and risk management

Credit risk

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

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

Liquidity risk

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

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

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

Market risk

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

Other than as detailed in the interest rate sensitivity analysis table at Note 8.1(e), 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 in current year, 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:

	2020 $000	2019 $000
Financial assets		
Cash and cash equivalents	122,137	117,144
Financial assets at amortised cost	891,529	818,823
Total financial assets	**1,013,667**	**935,967**
Financial liabilities		
Financial liabilities at amortised cost	193,475	166,229
Total financial liability	**193,475**	**166,229**

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

Notes to the Financial Statements
For the year ended 30 June 2020

8.1 Financial risk management (continued)

(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	Current	< 30 days	31 - 60 days	61 - 90 days	> 91 days
	$000	$000	$000	$000	$000	$000
30 June 2020						
Expected credit loss rate		4.28%	10.60%	15.44%	13.27%	83.46%
Estimated total gross carrying amount at default	57,345	19,114	2,098	863	949	34,322
Expected credit losses	(29,944)	(818)	(222)	(133)	(126)	(28,645)
30 June 2019						
Expected credit loss rate		8.65%	13.04%	21.99%	29.69%	85.54%
Estimated total gross carrying amount at default	60,582	9,900	5,326	2,827	2,417	40,112
Expected credit losses	(37,200)	(856)	(694)	(622)	(718)	(34,310)

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

Notes to the Financial Statements
For the year ended 30 June 2020

8.1 Financial risk management (continued)

(d) Liquidity risk and interest rate exposure

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

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

		Interest rate exposure				Maturity dates					
	Weighted average effective interest rate %	Carrying amount $000	Fixed interest rate $000	Variable interest rate $000	Non-interest bearing $000	Nominal Amount $000	Up to 1 month $000	1–3 months $000	3 months to 1 year $000	1–5 years $000	More than 5 years $000
2020											
Financial assets											
Cash and cash equivalents	-	122,137	-	-	122,137	122,137	122,137	-	-	-	-
Receivables [a]	-	59,812	-	-	59,812	59,812	59,812	-	-	-	-
Amounts receivable for services	-	831,718	-	-	831,718	831,718	-	-	-	-	831,718
		1,013,667	**-**	**-**	**1,013,667**	**1,013,667**	**181,949**	**-**	**-**	**-**	**831,718**
Financial liabilities											
Payables	-	169,703	-	-	169,703	169,703	169,703	-	-	-	-
Lease liabilities	2.79	23,772	23,772	-	-	24,542	233	459	1,979	7,404	14,467
		193,475	**23,772**	**-**	**169,703**	**194,245**	**169,936**	**459**	**1,979**	**7,404**	**14,467**

[a] *The amount of receivables excludes GST recoverable from ATO (statutory receivable).*

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

Notes to the Financial Statements
For the year ended 30 June 2020

8.1 Financial risk management (continued)

(d) Liquidity risk and interest rate exposure (continued)

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	1–3 months $000	3 months to 1 year $000	1–5 years $000	More than 5 years $000
2019											
Financial assets											
Cash and cash equivalents	-	117,144	-	-	117,144	117,144	105,431	-	-	-	11,713
Receivables [a]	-	44,857	-	-	44,857	44,857	44,857	-	-	-	-
Amounts receivable for services	-	773,966	-	-	773,966	773,966	-	-	-	-	773,966
		935,967	**-**	**-**	**935,967**	**935,967**	**150,288**	**-**	**-**	**-**	**785,679**
Financial liabilities											
Payables	-	165,414	-	-	165,414	165,414	165,414	-	-	-	-
Department of Treasury loans	3.15	815	-	815	-	841	70	140	631	-	-
		166,229	**-**	**815**	**165,414**	**166,255**	**165,484**	**140**	**631**	**-**	**-**

[a] *The amount of receivables excludes GST recoverable from ATO (statutory receivable).*

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

Notes to the Financial Statements
For the year ended 30 June 2020

8.1 Financial risk management (continued)

(e) Interest rate sensitivity analysis

The following table represents a summary of the interest rate sensitivity of the Health Service's financial assets and liabilities at the end of the reporting period on the surplus for the period and equity for a 1% change in interest rates. It is assumed that the change in interest rates is held constant throughout the reporting period.

		-100 basis points		+100 basis points	
	Carrying amount $000	Surplus $000	Equity $000	Surplus $000	Equity $000
2019					
Financial liabilities					
Department of Treasury loans	815	8	8	(8)	(8)
Total Increase/(Decrease)		**8**	**8**	**(8)**	**(8)**

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

8.2 Contingent assets and liabilities

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

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

8.2.1 Contingent assets

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

Litigation in progress	2020 $000	2019 $000
Pending litigation that may be recoverable on settlement of claims from former employee	1,000	-
Number of claims	1	-

8.2.2 Contingent liabilities

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

Litigation in progress	2020 $000	2019 $000
Pending litigation that is not recoverable from RiskCover insurance and may affect the financial position of the Health Service	385	99
Number of claims	2	1

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 Act, 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.

Sites with external flammable cladding

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

The undernoted NMHS buildings have been identified as having an element of Aluminium Composite Panelling (ACP) façade
•B Block – Neonatal – KEMH. Works completed. Defects and liability period commenced
•RR Block - Sarich Building, QEII MC
•DD Block – Cancer Centre, QEII MC
•UU Block – Adult Mental Health, QEII MC
•WW Block – Engineering Workshops, QEII MC
•YY Block – Engineering Workshops, QEII MC
•HH Block – Central Energy Plant, QEII MC

Full risk assessments have been undertaken for each building and, while not considered a high risk, all ACP's will be removed. At the time of reporting, NMHS is unable to estimate the potential financial effect arising as a result of this assessment.

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

Notes to the Financial Statements
For the year ended 30 June 2020

8.3 Fair value measurements

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).

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

Assets measured at fair value: 2019	Level 1 $000	Level 2 $000	Level 3 $000	Fair value at end $000
Land				
Residential	-	22	-	22
Specialised	-	4,490	225,276	229,766
Buildings				
Residential and commercial car park	-	130	9,157	9,287
Specialised	-	400	885,077	885,477
	-	**5,042**	**1,119,510**	**1,124,552**

Valuation techniques used 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)

2020	Land $000	Buildings $000
Fair value at start of period	225,276	894,234
Additions and transfers from work in progress	-	548
Revaluation increments/(decrements)	271	10,165
Depreciation	-	(42,701)
Fair value at end of period	**225,547**	**862,246**

2019	Land $000	Buildings $000
Fair value at start of period	221,212	986,659
Fair value of balance transferred from abolished Health Service	-	(72,352)
Additions and transfers from work in progress	-	8,273
Revaluation increments/(decrements)	5,044	16,449
Transfers from/(to) other asset class	(980)	(479)
Depreciation	-	(44,316)
Fair value at end of period	**225,276**	**894,234**

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

8.3 Fair value measurements (Continued)

Valuation processes

There were no changes in valuation techniques during the period.

Land (Level 3 fair values)

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

Buildings and Infrastructure (Level 3 fair values)

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

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

Basis of valuation

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

Notes to the Financial Statements
For the year ended 30 June 2020

9 Other disclosures

9.1 Events occurring after the end of the reporting period

There have been no events after the end of the reporting period which have a material impact on the Health Service.

9.2 Initial application of Australian Accounting Standards

(a) AASB 15 Revenue from Contract with Customers and AASB 1058 Income of Not-for-Profit Entities

AASB 15 Revenue from Contracts with Customers replaces AASB 118 Revenue for annual reporting periods on or after 1 January 2019. Under the new model, an entity shall recognise revenue when (or as) the entity satisfies a performance obligation by transferring a promised good or service to a customer and is based upon the transfer of control rather than transfer of risks and rewards.

AASB 15 focuses on providing sufficient information to the users of financial statements about the nature, amount, timing and uncertainty of revenue and cash flows arising from the contracts with customers. Revenue is recognised by applying the following five steps:

- Identifying contracts with customers
- Identifying separate performance obligations
- Determining the transaction price of the contract
- Allocating the transaction price to each of the performance obligations
- Recognising revenue as each performance obligation is satisfied.

Revenue is recognised either over time or at a point in time. Any distinct goods or services are separately identified and any discounts or rebates in the contract price are allocated to the separate elements.

In addition, incomes other than from contracts with customers are subject to AASB 1058 Income of Not-for-Profit Entities. Income recognition under AASB 1058 depends on whether such a transaction gives rise to liabilities or a contribution by owners related to an asset (such as cash or another asset) recognised by the Health Service.

The Health Service adopts the modified retrospective approach on transition to AASB 15 and AASB 1058. No comparative information is restated under this approach, and the Health Service recognises the cumulative effect of initially applying the Standard as an adjustment to the opening balance of accumulated surplus at the date of initial application (1 July 2019).

The nature and effect of the changes as a result of adoption of AASB 15 and AASB 1058 are described as follows:

	1 July 2019 $'000
Assets	
Receivables	7,086
Equity	
Adjustment to accummulated surplus	(7,086)

In addition, the Health Service has applied the practical expedient and elected to apply these standards retrospectively only to contracts and transactions that were not completed contracts at the date of initial application, i.e. as at 1 July 2019.

Set out below are the amounts by which revenue items are affected for the year ended 30 June 2020 as a result of the adoption of AASB 15 and AASB 1058.

	Under AASB 15 / AASB 1058 $'000	(Increase) / decrease $'000	Under AASB 118 and AASB 1004 $'000
Commonwealth grants and contributions	665,215	2,903	668,118
Other revenue	24,781	941	25,722
Net result	**689,996**	**3,844**	**693,840**

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

9.2 Initial application of Australian Accounting Standards (continued)

(b) AASB 16 Leases

AASB 16 Leases supersedes AASB 117 Leases and related Interpretations. AASB 16 primarily affects lessee accounting and provides a comprehensive model for the identification of lease arrangements and their treatment in the financial statements of both lessees and lessors.

The Health Service applies AASB 16 Leases from 1 July 2019 using the modified retrospective approach. As permitted under the specific transition provisions, comparatives are not restated. The cumulative effect of initially applying this Standard is recognised as an adjustment to the opening balance of accumulated surplus.

The main changes introduced by this Standard include identification of leases within a contract and a new lease accounting model for lessees that require lessees to recognise all leases (operating and finance leases) on the Statement of Financial Position as right-of-use assets and lease liabilities, except for short term leases (lease terms of 12 months or less at commencement date) and low-value assets (where the underlying asset is valued less than $5,000). The operating lease and finance lease distinction for lessees no longer exists.

Under AASB 16, the Health Service takes into consideration all operating leases that were off balance sheet under AASB 117 and recognises:

a) right of use assets and lease liabilities in the Statement of Financial Position, initially measured at the present value of future lease payments, discounted using the incremental borrowing rate (2.79%) on 1 July 2019;

b) depreciation of right-of-use assets and interest on lease liabilities in the Statement of Comprehensive Income; and

c) the total amount of cash paid as principal amount, which is presented in the cash flows from financing activities, and interest paid, which is presented in the cash flows from operating activities, in the Statement of Cash Flows.

The Health Service measures concessionary leases that are of low value terms and conditions at cost at inception.

The right-of-use assets are assessed for impairment at the date of transition and no impairment has been identified.

On transition, the Health Service has elected to apply the following practical expedients in the assessment of their leases that were previously classified as operating leases under AASB 117:

(a) A single discount rate has been applied to a portfolio of leases with reasonably similar characteristics;

(b) The Health Service has relied on its assessment of whether existing leases were onerous in applying AASB 137 Provisions, Contingent Liabilities and Contingent Assets immediately before the date of initial application as an alternative to performing an impairment review. The Health Service has adjusted the right-of-use assets at 1 July 2019 by the amount of any provisions included for onerous leases recognised in the statement of financial position at 30 June 2019;

(c) Where the lease term at initial application ended within 12 months, the Health Service has accounted for these as short-term leases;

(d) Initial direct costs have been excluded from the measurement of the right-of-use asset;

(e) Hindsight has been used to determine if the contracts contained options to extend or terminate the lease.

Measurement of lease liabilities

Operating lease commitments disclosed as at 30 June 2019	24,480
Less : Goods and Services Tax	(2,225)
Less : Short term leases not recognised as liability	(161)
Less : Leases payment not qualified under AASB 16 as at 1st July 2019	(7,018)
Add : Leases qualified under AASB 16, not previously identified as commitments	5,148
Lease qualified under AASB 16	**20,224**
Discounted using incremental borrowing rate at date of initial application [1]	(549)
Lease liability recognised at 1 July 2019	**19,675**

[1] The WATC incremental borrowing rate was used for the purposes of calculating the lease transition opening balance.

Notes to the Financial Statements
For the year ended 30 June 2020

9.3 Future impact of Australian Standards issued not yet operative

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

		Operative for reporting periods beginning on/after
AASB 1059	*Service Concession Arrangements: Grantors* This Standard addresses the accounting for a service concession arrangement (a type of public private partnership) by a grantor that is a public sector agency by prescribing the accounting for the arrangement from the grantor's perspective. Timing and measurement for the recognition of a specific asset class occurs on commencement of the arrangement and the accounting for associated liabilities is determined by whether the grantee is paid by the grantor or users of the public service provided. *The Health Service is still assessing the financial impact of this standard.*	1 Jan 2020
AASB 2018-6	*Amendments to Australian Accounting Standards – Definition of a Business* The Standard amends AASB 3 to clarify the definition of a business, assisting entities to determine whether a transaction should be accounted for as a business combination or as an asset acquisition. *There is no financial impact.*	1 Jan 2020
AASB 2018-7	*Amendments to Australian Accounting Standards – Definition of Material* The Standard principally amends AASB 101 and AASB 108. The amendments refine the definition of material in AASB 101. The amendments clarify the definition of material and its application by improving the wording and aligning the definition across AASB Standards and other publications. The amendment also includes some supporting requirements in AASB 101 in the definition to give it more prominence and clarifies the explanation accompanying the definition of material *There is no financial impact.*	1 Jan 2020
AASB 2019-1	*Amendments to Australian Accounting Standards – References to the Conceptual Framework* This Standard sets out amendments to Australian Accounting Standards, Interpretations and other pronouncements to reflect the issuance of the Conceptual Framework for Financial Reporting (Conceptual Framework) by the AASB. *There is no financial impact.*	1 Jan 2020

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

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

		Operative for reporting periods beginning on/after
AASB 2019-2	*Amendments to Australian Accounting Standards – Implementation of AASB 1059* This Standard makes amendments to AASB 16 and AASB 1059 to: (a) amend the modified retrospective method set out in paragraph C4 of AASB 1059; (b) modify AASB 16 to provide a practical expedient to grantors of service concession arrangements so that AASB 16 would not need to be applied to assets that would be recognised as service concession assets under AASB 1059; and (c) include editorial amendments to the application guidance and implementation guidance accompanying AASB 1059. *The Health Service is still assessing the financial impact of this standard.*	1 Jan 2020
AASB 2020-1	*Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-current* This Standard amends AASB 101 to clarify requirements for the presentation of liabilities in the statement of financial position as current or non current. *There is no financial impact.*	1 Jan 2022

Notes to the Financial Statements
For the year ended 30 June 2020

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	**2020**	**2019**
$0 – $10,000	1	1
$20,001 – $30,000	-	2
$30,001 – $40,000	-	1
$40,001 – $50,000	7	5
$70,001 – $80,000	-	1
$80,001 – $90,000	1	-
	9	**10**

	2020	**2019**
	$000	**$000**
Short-term employee benefits	368	329
Post-employment benefits	35	33
Total compensation of members of the accountable authority	**403**	**362**

Compensation band of senior officers

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

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

	2020	**2019**
$60,001 – $70,000	-	1
$110,001 – $120,000	-	1
$120,001 – $130,000	-	1
$130,001 – $140,000	1	-
$140,001 – $150,000	-	1
$150,001 – $160,000	-	1
$180,001 – $190,000	-	1
$200,001 – $210,000	1	1
$210,001 – $220,000	1	2
$220,001 – $230,000	2	1
$250,001 – $260,000	1	-
$260,001 – $270,000	-	1
$270,001 – $280,000	1	-
$350,001 – $360,000	-	1
$390,001 – $400,000	1	-
$420,001 – $430,000	1	-
$510,001 – $520,000	-	1
$570,001 – $580,000	2	-
	11	**13**

	2020	**2019**
	$000	**$000**
Short-term employee benefits	2,824	2,281
Post employment benefits	313	228
Other long-term benefits	363	271
Termination benefits	-	-
Total compensation of senior officers	**3,500**	**2,780**

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

9.5 Related party transactions

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

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

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

Significant Transactions with Government-related entities

In conducting its activities, the Health Service is required to transact with the State and entities related to the State. These transactions are generally based on the standard terms and conditions that apply to all agencies. Such transactions include:
- income from State Government;
- equity contributions;
- services received free of charge from Health Support Services, PathWest and Department of Finance;
- lease rentals payments to Department of Finance (Government Office Accommodation and State Fleet);
- insurance payments to the Insurance Commission and RiskCover fund;
- lease rentals payments to Department of Housing (Government Regional Officer Housing);
- remuneration for services provided by the Auditor General.

Material transactions with other related parties

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

Significant transactions with other related parties

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

9.6 Related bodies

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

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

9.7 Affiliated bodies

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

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

Notes to the Financial Statements
For the year ended 30 June 2020

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.

	2020 $000	2019 $000
Balance at the start of period	367	124
Add Receipts		
Service delivery agreement:		
Commonwealth contributions	74,488	73,289
State contributions	167,354	164,299
Other	1,836	1,639
	243,678	239,227
Less Payments	(243,678)	(238,984)
Balance at the end of period	**367**	**367**

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

9.9 Remuneration of auditors

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

	2020 $000	2019 $000
Auditing the accounts, financial statements, controls, and key performance indicators	**292**	**292**

9.10 Equity

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

	2020 $000	2019 $000
Contributed equity		
Balance at start of period	1,643,491	1,779,972
Contributions by owners		
Capital appropriation	24,381	12,490
Transfer of infrastructure from Health Ministerial Body (HMB)	-	1,765
Total contributions by owners	**1,667,872**	**1,794,227**
Distributions to owners		
Transfer of Neonatal Services to Child and Adolescent Health Service	(18,485)	-
Demerger of PathWest	788	(150,736)
Total distributions to owners	**(17,697)**	**(150,736)**
Balance at end of period	**1,650,175**	**1,643,491**

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

Notes to the Financial Statements
For the year ended 30 June 2020

9.11 Supplementary financial information

(a) Write-offs

	2020 $000	2019 $000
Revenue and debts written-off under the authority of the Accountable Authority	7,180	131
Public and other property written off under the authority of the Accountable Authority	509	-
	7,689	**131**

(b) Losses through theft, defaults and other causes

Losses of public money, and public and other property through theft or default	170	102
Amounts recovered	(5)	(78)
	165	**24**

(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:

	2020 $000	2019 $000
Department of Corrective Services – dental treatment	1,552	1,949
Disability Services Commission – dental treatment	1,469	1,568
	3,021	**3,517**

Notes to the Financial Statements
For the year ended 30 June 2020

9.12 Explanatory statement (Controlled Operations)

For the year ended 30 June 2020

All variances between estimates (original budget) and actual results for 2020, and between the actual results for 2019 and 2020 are shown below. Narratives are provided for key major variances, which are generally greater than 10% and $1 million.

9.12.1 Statement of Comprehensive Income Variances

	Variance note	2020 Estimate $000	2020 Actual $000	2019 Actual $000	Variance between estimate and actual $000	Variance between actual 2020 and 2019 $000
COST OF SERVICES						
Expenses						
Employee benefits expense		1,138,117	1,144,530	1,183,905	6,413	(39,375)
Contracts for services		460,383	457,407	460,479	(2,976)	(3,072)
Patient support costs	1	273,592	322,379	325,396	48,787	(3,017)
Finance costs	2	2,224	603	39	(1,621)	564
Depreciation and amortisation expense		71,977	70,346	69,628	(1,631)	718
Asset impairment losses	a	-	-	1,861	-	(1,861)
Loss on disposal of non-current assets		-	180	166	180	14
Repairs, maintenance and consumable equipment	b	37,027	39,017	34,589	1,990	4,428
Other supplies and services	1, c	98,850	71,989	64,471	(26,861)	7,518
Other expenses	3, d	46,776	55,096	71,863	8,320	(16,767)
Total cost of services		**2,128,946**	**2,161,547**	**2,212,397**	**32,601**	**(50,850)**
INCOME						
Revenue						
Patient charges		68,361	71,895	74,273	3,534	(2,378)
Other fees for services	4	70,134	78,615	79,160	8,481	(545)
Commonwealth grants and contributions		645,382	665,215	635,403	19,833	29,812
Other grants and contributions		170,829	173,946	170,729	3,117	3,217
Donation revenue		13	654	386	641	268
Interest revenue		-	67	1	67	66
Other revenue	5	21,795	24,781	25,302	2,986	(521)
Total Revenue		**976,514**	**1,015,173**	**985,254**	**38,659**	**29,919**
Gains						
Other gains	e	-	210	4,337	210	(4,127)
Total Gains		**-**	**210**	**4,337**	**210**	**(4,127)**
Total income other than income from State Government		**976,514**	**1,015,383**	**989,591**	**38,869**	**25,792**
NET COST OF SERVICES		**1,152,432**	**1,146,164**	**1,222,806**	**(6,268)**	**(76,642)**
INCOME FROM STATE GOVERNMENT						
Service appropriation		1,062,809	1,068,550	1,145,906	5,741	(77,356)
Assets assumed/(transferred)		-	14	45	14	(31)
Services received free of charge	f	89,223	97,038	87,830	7,815	9,208
Royalties for Regions Fund		400	400	371	-	29
Total income from State Government		**1,152,432**	**1,166,002**	**1,234,152**	**13,570**	**(68,150)**
SURPLUS/(DEFICIT) FOR THE PERIOD		**-**	**19,838**	**11,346**	**19,838**	**8,492**
OTHER COMPREHENSIVE INCOME/(LOSS)						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve		3,083	9,794	17,505	6,711	(7,711)
Total other comprehensive income/(loss)		**3,083**	**9,794**	**17,505**	**6,711**	**(7,711)**
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR PERIOD		**3,083**	**29,632**	**28,851**	**26,549**	**781**

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

Notes to the Financial Statements
For the year ended 30 June 2020

9.12 Explanatory statement (Controlled Operations) (continued)

9.12.2 Statement of Financial Position Variances

	Variance note	2020 Estimate $000	2020 Actual $000	2019 Actual $000	Variance between estimate and actual $000	Variance between actual 2020 and 2019 $000
ASSETS						
Current Assets						
Cash and cash equivalents		62,847	45,000	60,219	(17,847)	(15,219)
Restricted cash and cash equivalents		41,800	59,181	45,212	17,381	13,969
Receivables		46,070	68,417	53,236	22,347	15,181
Inventories	6	5,339	7,067	5,339	1,728	1,728
Other current assets		1,764	2,084	2,141	320	(57)
Total Current Assets		**157,820**	**181,749**	**166,147**	**23,929**	**15,602**
Non-Current Assets						
Restricted cash and cash equivalents		18,546	17,956	11,713	(590)	6,243
Amounts receivable for services		845,943	831,718	773,966	(14,225)	57,752
Infrastructure, property, plant and equipment		1,364,333	1,351,423	1,389,163	(12,910)	(37,740)
Right-of-use assets	7	49,526	22,822	-	(26,704)	22,822
Intangible assets		467	500	454	33	46
Total Non-Current Assets		**2,278,815**	**2,224,419**	**2,175,296**	**(54,396)**	**49,123**
TOTAL ASSETS		**2,436,635**	**2,406,168**	**2,341,443**	**(30,467)**	**64,725**
LIABILITIES						
Current Liabilities						
Payables		148,329	169,703	165,414	21,374	4,289
Contract liabilities	8	-	2,903	-	2,903	2,903
Borrowings		815	-	815	(815)	(815)
Employee related provisions		243,635	243,067	250,757	(568)	(7,690)
Lease liabilities	7	-	2,671	-	2,671	2,671
Other current liabilities	9	17,145	1,989	1,750	(15,156)	239
Total Current Liabilities		**409,924**	**420,333**	**418,736**	**10,409**	**1,597**
Non-Current Liabilities						
Employee related provisions		55,967	61,326	62,701	5,359	(1,375)
Lease liabilities	7	46,443	21,101	-	(25,342)	21,101
Total Non-Current Liabilities		**102,410**	**82,427**	**62,701**	**(19,983)**	**19,726**
TOTAL LIABILITIES		**512,334**	**502,760**	**481,437**	**(9,574)**	**21,323**
NET ASSETS		**1,924,301**	**1,903,408**	**1,860,006**	**(20,893)**	**43,402**
EQUITY						
Contributed equity		1,768,977	1,650,175	1,643,491	(118,802)	6,684
Reserves		152,241	173,603	163,809	21,362	9,794
Accumulated surplus /(deficit)		3,083	79,630	52,706	76,547	26,924
TOTAL EQUITY		**1,924,301**	**1,903,408**	**1,860,006**	**(20,893)**	**43,402**

Notes to the Financial Statements
For the year ended 30 June 2020

9.12 Explanatory statement (Controlled Operations) (continued)

9.12.3 Statement of Cash Flows Variances

	Variance note	2020 Estimate $000	2020 Actual $000 Inflows (Outflows)	2019 Actual $000 Inflows (Outflows)	Variance between estimate and actual $000	Variance between actual 2020 and 2019 $000
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriation		990,814	995,861	1,075,155	5,047	(79,294)
Capital appropriations	10, g	45,299	19,261	11,787	(26,038)	7,474
Equity contribution	11	3,083	4,304	-	1,221	4,304
Royalties for Regions Fund		400	400	371	-	29
Net cash provided by State Government		**1,039,596**	**1,019,826**	**1,087,313**	**(19,770)**	**(67,487)**
Utilised as follows:						
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits		(1,131,284)	(1,131,322)	(1,161,798)	(38)	30,476
Supplies and services		(827,404)	(850,174)	(852,419)	(22,770)	2,245
Finance costs	2	(2,208)	(590)	-	1,618	(590)
Receipts						
Receipts from customers	h	74,361	75,367	65,575	1,006	9,792
Commonwealth grants and contributions		645,382	665,214	635,403	19,832	29,811
Other grants and contributions		170,829	173,946	170,729	3,117	3,217
Donations received		13	432	294	419	138
Interest received		-	67	2	67	65
Other receipts		91,930	93,017	102,603	1,087	(9,586)
Net cash provided by/(used in) operating activities		**(978,381)**	**(974,043)**	**(1,039,611)**	**4,338**	**65,568**
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Payment for purchase of non-current physical and intangible assets	10, g	(45,299)	(21,599)	(14,030)	23,700	(7,569)
Receipts						
Proceeds from sale of non-current physical assets		-	5	29	5	(24)
Net cash provided by/(used) in investing activities		**(45,299)**	**(21,594)**	**(14,001)**	**23,705**	**(7,593)**
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Payments for principal element of lease	i	(3,083)	(2,989)	-	94	(2,989)
Net cash provided by/(used) in financing activities		**(3,083)**	**(2,989)**	**-**	**94**	**(2,989)**
Net increase/(decrease) in cash and cash equivalents		12,833	21,200	33,701	8,367	(12,501)
Cash and cash equivalents at the beginning of the period		117,193	117,144	98,330	(49)	18,814
Cash transferred to other health agencies as part of demergers		(6,833)	(16,208)	(14,887)	(9,375)	(1,321)
CASH AND CASH EQUIVALENTS AT END OF THE PERIOD		**123,193**	**122,136**	**117,144**	**(1,057)**	**4,992**

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

9.12 Explanatory statement (Controlled Operations) (continued)

Major Estimate and Actual (2020) Variance Narratives

1 **Patient support costs and other supplies and services**
The actual for patient support costs and other supplies and services in aggregate are higher than the estimate due to increased spending on medical supplies and services during the COVID-19 period.

2 **Finance costs**
The estimate for finance costs are higher than actuals due to interest expense for GOA and GROH leases. These leases are subsequently not considered to be within the scope of AASB 16.

3 **Other expenses**
Actual is higher than estimate due to additional $4.1M spending for Marie Stopes family planning organisation and additional $4.8M for items that cannot be capitalised in accordance with accounting standards (original budget forms part of capital appropriations estimate).

4 **Other fees for services**
The variance predominantly reflects additional Pharmaceutical Benefits Scheme recoveries from the Commonwealth ($7.4M) and funds received for Poisons Information Centre services provided to others ($0.7M).

5 **Other revenue**
This represents revenue for parking facilities ($4M) which was not budgeted in the Estimates.

6 **Inventories**
Inventories are higher than Estimates due to higher pharmaceutical stocks, in preparation for the increased demand anticipated for COVID 19 cases.

7 **Right-of-use assets and lease liabilities**
The Estimates for right-of-use assets and lease liabilities are higher than Actuals as it include GOA and GROH leases. These leases are not within the scope of AASB 16.

8 **Contract liabilities**
The Actuals for contract liabilities is due to the application of AASB 15 which was not budgeted in the Estimates.

9 **Other current liabilities**
The estimate for other current liabilities include the accruals for superannuation and PAYG taxes. These accruals have been recognised as payables in the actual figures.

10 **Capital appropriations and payments for purchase of non-current physical and intangible assets**
Capital appropriations are lower than Estimates due to lower spending on physical and intangible assets as a result of delays in capital projects due to COVID 19.

11 **Equity contribution**
The actual amount received for equity contribution related to AASB 16 leases has been captured under capital appropriations.

Major Actual (2020) and Comparative (2019) Variance Narratives

a **Asset impairment losses**
There are no asset impairment losses during the year.

b **Repairs, maintenance and consumable equipment**
The Actuals are higher this year due to higher spending on consumables (by $0.5M) and on building maintenance (by $1.8M) as well as the costs related to lease maintenance expense ($1.0M).

c **Other supplies and services**
The Actuals are higher this year due to higher resources received free of charge (RRFOC) from Health Support Services for provision of additional services in response to COVID-19 ($2.7M).

Notes to the Financial Statements
For the year ended 30 June 2020

9.12 Explanatory statement (Controlled Operations) (continued)

d **Other expenses**
The Actuals are lower this year due to reduction in doubtful debts expense (by $2.5M), reduction in premium for worker's compensation (by $1.2M) and the effect of application of AASB 16 where operating lease expenses (previously $7.0M) are now recognised as depreciation of right-of-use assets.

e **Other gains**
Other gains for the current financial year refers to reversal of impairment losses whereas the previous year refers to increment in asset revaluation.

f **Services received free of charge**
Increase in funding and expenses for Resources Received Free of Charge including funding for additional services provided by Health Support Services in response to Covid-19.

g **Capital appropriations and payments for purchase of non-current physical and intangible assets**
The increase in capital appropriations compared with last year is due to higher spending for the acquisition of property, plant and equipment related to a number of new capital projects which commenced in 2019-20.

h **Receipts from customers**
Receipts from customers increased as a result of repayments by patients and non-patients as a result of ongoing improvements to collection practices and record keeping.

i **Payments for principal element of lease**
Payments for principal element of lease incurred due to application of AASB 16.

Notes to the Financial Statements (cont.)

For year ended 30 June 2020

Notes to the Financial Statements
For the year ended 30 June 2020

10 Trust Accounts

	Notes
Disclosure of Trust Accounts	10.1

10.1 Disclosure of Trust Accounts

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

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

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

	2020 $000	2019 $000
Balance at the start of period	180	157
Add Receipts	936	1,154
Less Payments	(921)	(1,131)
Balance at the end of period	**195**	**180**

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

RF Shaw Foundation	1,166	1,166
King Edward Memorial Clinical Staff Association	59	45
	1,225	**1,211**
Balance at the start of period	1,211	1,279
Add Receipts	80	17
Less Payments	(66)	(85)
Balance at the end of period	**1,225**	**1,211**

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

Certification Key Performance Indicators

For year ended 30 June 2020

Government of Western Australia
North Metropolitan Health Service

Disclosures and Legal Compliance

Financial Statements

Certification of Key Performance Indicators

For the reporting period ended 30 June 2020

We hereby certify the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the North Metropolitan Health Service's (NMHS) performance, and fairly represent the performance of the NMHS for the financial year ended 30 June 2020.

Name: Hon. Jim McGinty AM
North Metropolitan Health Service
Board Chair, NMHS Board

Date 11/09/2020

Name: Mr Grant Robinson
North Metropolitan Health Service
Board Member and Finance Committee Chair, NMHS Board

Date

Detailed information in support of Key Performance Indicators

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

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

Rationale

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

The 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 Health Agreement Unplanned Readmission performance indicator (NHA PI 23).

Target

Please see the 2019 targets for each surgical procedure in Table 6. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2019, the rate of unplanned readmissions within 28 days for knee replacement, hip replacement and hysterectomy was below target (Table 6). All other surgical procedure indicators for unplanned hospital readmissions within 28 days were above target. The number of readmission cases for all procedures were small and results should be interpreted with caution. Clinical reviews and investigations have been completed for all readmissions and no trends or systemic issues have been identified.

Compared to the prior year (2018), performance for knee replacement has improved due to ongoing clinical changes to surgical wound closure technique in theatre (i.e. derma-bond and strata-fix closure technique) and a change to the wound dressing from a daily change to a single dressing that remains intact throughout the patients' recovery.

Of the 27 tonsillectomy and adenoidectomy patients that readmitted, some had minor bleeding and were admitted for overnight observation only and did not require further surgical intervention. Strategies such as patient education on post-discharge management may assist with prevention and have been implemented.

The readmission rate for hysterectomy has improved due to factors such as the proactive review of antimicrobial stewardship and improved clinical pathways.

There were 10 readmissions for prostatectomy procedures across four sites; some readmissions were expected due to case complexities and known complications.

Appendicectomy had 44 readmissions of which some were for infection, pain control and overnight observation and were resolved without further surgical intervention. The practice of appendectomy surgery closure is being reviewed to determine if this contributed to readmissions.

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

Detailed information in support of Key Performance Indicators (cont.)

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

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

Table 6: Unplanned hospital readmissions for patients within 28 days for selected surgical procedures (per 1000 separations), 2016–19

Target Met | Target Not Met

Surgical procedure	Calendar year				
	2016 (per 1000)	2017 (per 1000)	2018 (per 1000)	Target (per 1000)	2019 (per 1000)
Knee replacement	21.9	36.1	27	≤ 26.2	**13.1**
Hip replacement	16.5	21.3	14.4	≤ 17.1	**14.7**
Tonsillectomy and adenoidectomy	142.9	112.4	102.7	≤ 61	**149.2**
Hysterectomy	34.9	45.5	51.9	≤ 41.3	**40.2**
Prostatectomy	48.1	45.5	48.9	≤ 38.8	**46.5**
Cataract surgery	3.6	2.0	1.1	≤ 1.1	**1.2**
Appendicectomy	28	18.4	33.5	≤ 25.7	**46.9**

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

Detailed information in support of Key Performance Indicators (cont.)

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

Percentage of elective waitlist patients waiting over boundary for reportable procedures

Rationale

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

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

Patients are prioritised based on their assigned clinical urgency category:

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

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

Reportable cases are defined as:

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

Target

The 2019/20 target is zero per cent. Performance is demonstrated by a result equal to the target.

Results

In 2019/20, all urgency categories for elective surgery wait list patients waiting over boundary were above target (Table 7). During the year, NMHS experienced challenges associated with demand and health system restrictions.

Elective surgery was scaled back across the public health system to prepare hospital capacity for COVID-19 between 23 March 2020 and 27 April 2020. WA Health hospitals were permitted to continue Category 1 elective procedures while reviewing

Category 2 elective surgeries and proceeding with cases deemed urgent. All

Category 3 elective surgeries were postponed. Restrictions on elective surgery were eased starting from 28 April 2020.

Category 1 was impacted by the reduction in available lists due to limited capacity related to aging infrastructure and resource availability. Planned refurbishment is in progress.

The backlog in Category 1 has led to a delay in Category 2 and 3 patients being undertaken. NMHS sites and services have developed and commenced a plan to clear backlog of elective surgeries. Performance and strategies are being monitored.

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

Detailed information in support of Key Performance Indicators (cont.)

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

Percentage of elective waitlist patients waiting over boundary for reportable procedures

Table 7: Percentage of elective waitlist patients waiting over boundary for reportable procedures, 2016/17–2019/20

Target Met | Target Not Met

	Financial Year				
Urgency category	2016/17 (%)	2017/18 (%)	2018/19 (%)	Target (%)	2019/20 (%)
Category 1 over 30 days	5	6	8	0	**8**
Category 2 over 90 days	7	7	8	0	**13**
Category 3 over 365 days	2	3	5	0	**8**

Data source: Elective Services Waitlist Data Collection.

Detailed information in support of Key Performance Indicators (cont.)

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

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

Rationale

Staphylococcus aureus bloodstream infection is a serious infection that may be associated with the provision of health care. Also called golden staph, it is a common bacterium that lives on the skin or in the nose. *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 per cent[3]).

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.

A low or decreasing HA-SABSI rate is desirable and the WA target was developed based on historical results.

Target

The 2019 target is ≤1.0 per 10,000 occupied bed-days. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2019, HA-SABSI per 10,000 occupied bed-days in public hospitals was below target (Table 8). The target was met due to the implementation of strategies such as staff education, implementation of general principles of Surgical Prophylaxis for administration for antibiotics and continual monitoring of HA-SABI incidences using a multidisciplinary approach.

These initiatives have contributed to enhanced outcomes. Ongoing reviews are undertaken to identify systemic trends across specialties.

Target Met Target Not Met

Table 8: Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days, 2017–19

	Calendar year			
	2017 (per 10,000)	2018 (per 10,000)	Target (%)	2019 (per 10,000)
HA-SABSI per 10,000 occupied bed-days	0.7	1.0	≤ 1.0	**0.8**

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

Detailed information in support of Key Performance Indicators (cont.)

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

Survival rates for sentinel conditions

Rationale

This indicator measures performance in relation to the survival of people who have suffered a sentinel condition – specifically a stroke, acute myocardial infarction (AMI) or fractured neck of femur (FNOF).

These 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 three sentinel conditions can be affected by many factors, including the diagnosis, the treatment given or procedure performed, age, comorbidities at the time of the admission and complications that may have developed while in hospital. However, survival is more likely when there is early intervention and appropriate care on presentation to an ED and on admission to hospital.

By reviewing survival rates and conducting case-level analysis, targeted strategies can be developed that aim to increase patient survival after being admitted for a sentinel condition.

Target

Please see the targets for each condition in Table 9, Table 10 and Table 11. Maintained performance is demonstrated by a result above, or equal to, the target.

Results

In 2019, the survival rates for stroke were above target for patients in age groups cohort of 0 to 49 and 80+ and equal to target for age group 70 to 79 years (Table 9); however, the survival rates were below target for patients in all other age groups. Survival rates are impacted by severity of disease on admission and patients with multiple comorbidities. Process improvements have been implemented around timeliness of reviews and involvement of senior clinicians and work has commenced to identify gaps in service and areas for improvement such as stroke pathways and standardised care guidelines.

Target Met Target Not Met

Table 9: Survival rate for stroke, 2016–19

	Calendar year				
Age group (years)	2016 (%)	2017 (%)	2018 (%)	Target (%)	2019 (%)
0 to 49	87.7	93.5	92.8	94.4	**94.6**
50 to 59	87.5	91.8	92.2	93.4	**91.5**
60 to 69	92.4	92	93.1	93.5	**88.4**
70 to 79	90.6	91.2	88.7	91.3	**91.3**
80+	84.4	86.1	84.6	83.2	**86.7**

Detailed information in support of Key Performance Indicators (cont.)

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

Survival rates for sentinel conditions

Target Met Target Not Met

The survival rates for patients with acute myocardial infarction were above target for age groups 50 to 59 and 70 to 79 (Table 10). Survival rates were below target for all other age groups and are impacted by severity of disease on admission and patients with multiple comorbidities.

Table 10: Survival rate for acute myocardial infarction, 2016–19

	Calendar year				
Age group (years)	2016 (%)	2017 (%)	2018 (%)	Target (%)	2019 (%)
0 to 49	100	99.1	96.9	99	**98.9**
50 to 59	99.2	98.9	97.9	98.9	**99.0**
60 to 69	97.9	96.9	97.7	98	**97.8**
70 to 79	93.3	96.6	96.3	96.5	**97.7**
80+	90.1	91.6	91.2	92.2	**88.4**

Survival rates for patients with fractured neck of femur were above target for age group 80+ and below target for age group 70 to 79 (Table 11).
Survival rates are impacted by severity of disease on admission and patients with multiple comorbidities. Compliance with Clinical Care Standard has been reviewed and identified an area for improvement and guidelines are being developed to support clinical pathway and care.

Table 11: Survival rate for fractured neck of femur, 2016–19

	Calendar year				
Age group (years)	2016 (%)	2017 (%)	2018 (%)	Target (%)	2019 (%)
70 to 79	93.8	100	95.9	98.9	**97.7**
80+	97.4	96.6	95.2	96.1	**96.2**

Data source: Hospital Morbidity Data Collection.

Detailed information in support of Key Performance Indicators (cont.)

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

Percentage of admitted patients who discharged against medical advice

Rationale

Discharge against medical advice (DAMA) refers to patients leaving hospital against the advice of their treating medical team or without advising hospital staff (e.g. absconding or missing and not found). Patients who do so have a higher risk of readmission and mortality and have been found to cost the health system 50 per cent more than patients who are discharged by their physician.

Between July 2013 and June 2015, Aboriginal patients in WA were almost 12.7 times more likely than non-Aboriginal patients to discharge against medical advice, compared with seven times nationally. This statistic indicates a need for improved responses by the health system to the needs of Aboriginal patients.

This indicator provides a measure of the safety and quality of inpatient care. Reporting the results by Aboriginality measures the effectiveness of initiatives within the WA health system to deliver culturally secure services to Aboriginal people and achieve equitable treatment outcomes for Aboriginal patients.

Target

The 2019 target is ≤ 0.77 per cent. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2019, the percentage of admitted patients who DAMA were above target for all groups (Table 12). Outcomes of reviews indicates that Aboriginal patients may DAMA due to family/community responsibilities, not wanting to remain in hospital any longer, or discharge following an improvement in their condition despite not completing treatment.

Aboriginal Hospital Liaison Officers (AHLO) are available; however it should be noted that not all patients choose to use the AHLO service. As part of outcomes from an audit, revisions to processes have also been implemented and performance continues to be monitored.

Review of non-Aboriginal DAMA cases identified that patients commonly DAMA due to social issues surrounding family and accommodation. Recommendations from an audit have been implemented and revisions to processes have been made. No trends have been identified and monitoring of performance continues.

[4] Yong et al. Characteristics and outcomes of discharges against medical advice among hospitalised patients. Internal medicine journal 2013:43(7):798-802.
[5] Aliyu ZY. Discharge against medical advice: sociodemographic, clinical and financial perspectives. International journal of clinical practice 2002;56(5):325-27.
[6] Commonwealth of Australia. (2017). Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report, Commonwealth of Australia, Canberra.

Detailed information in support of Key Performance Indicators (cont.)

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

Percentage of admitted patients who discharged against medical advice

Target Met Target Not Met

Table 12: Percentage of admitted patients who discharged against medical advice, 2017–19

	Calendar year			
Patients discharged against medical advice (percentage)	2017 (%)	2018 (%)	2019 (%)	Target (%)
Aboriginal	3.36	3.81	≤ 0.77	**3.73**
Non-Aboriginal	0.76	0.75	≤ 0.77	**0.80**

Data source: Hospital Morbidity Data Collection.

Detailed information in support of Key Performance Indicators (cont.)

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

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

Rationale

This indicator of the condition of newborn infants immediately after birth provides an outcome measure of intrapartum care and newborn resuscitation.

The Apgar score is an assessment of an infant's health at birth based on breathing, heart rate, colour, muscle tone and reflex irritability. An Apgar score is applied at one, five and (if required by the protocol) 10 minutes after delivery to determine how well the infant is adapting outside the mother's womb. Apgar scores range from zero to two for each condition with a maximum final total score of 10. The higher the Apgar score, the better the health of the newborn infant.

This outcome measure can lead to the development and delivery of improved care pathways and interventions to improve the health outcomes of infants and aligns to the National Core Maternity Indicators (2019) Health, Standard 19 June 2019.

Target

The 2019 target for liveborn term infants with an Apgar score of less than 7 at five minutes post-delivery is ≤ 1.8 per cent. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2019, the percentage of liveborn infants with an Apgar score of less than 7 at five minutes post-delivery was below target (Table 13). Audits conducted throughout the year have not identified any unfavourable trends.

Work processes have been reviewed and initiatives to enhance outcomes have resulted in a 0.5% decrease compared to the prior year (2018).

Table 13: Percentage of liveborn term infants with an Apgar score of less than 7 at five minutes post-delivery, 2016–19

Target Met | Target Not Met

	Calendar year				
Live births	2016 (%)	2017 (%)	2018 (%)	Target (%)	2019 (%)
Apgar Score < 7	1.6	1.6	2	≤ 1.8	**1.5**

Data source: Midwives Notification System.

Detailed information in support of Key Performance Indicators (cont.)

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

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

Rationale

Readmission rate is considered to be a global performance measure as it potentially points to deficiencies in the functioning of the overall mental 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.[7] These readmissions mean that patients spend additional time in hospital and use 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 2019 target is ≤ 12 per cent readmissions within 28 days to an acute specialised mental health inpatient service. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2019, the rate of readmissions to acute specialised mental health inpatient service within 28 days of discharge was above target (Table 14). This indicator looks at total readmissions and it should be noted that some readmission cases are warranted as part of accepted best practice protocols.

During 2019, strategies were implemented to improve performance and have resulted in a 1% decrease compared to the prior year (2018). Clinical reviews on readmissions have been undertaken and no systemic issues have been identified. Strategies are in place to prevent readmissions and are being monitored.

Target Met Target Not Met

Table 14: Readmissions to acute specialised mental health inpatient services within 28 days of discharge, 2017–19

	Calendar year			
	2017 (%)	2018 (%)	Target (%)	2019 (%)
Readmission rate	18	16	≤ 12	**15**

[7]Australian Health Ministers Advisory Council Mental Health Standing Committee (2011). Fourth National Mental Health Plan Measurement Strategy. Available at: https://www.aihw.gov.au/getmedia/d8e52c84-a53f-4eef-a7e6-f81a5af94764/Fourth-national-mental-health-plan-measurement-strategy-2011.pdf.aspx

Detailed information in support of Key Performance Indicators (cont.)

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

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

Rationale

In 2017–18, one in five (4.8 million) Australians reported having a mental or behavioural condition.[8] It is crucial therefore to ensure effective and appropriate care is provided not only in a hospital setting but also in the community.

Discharge from hospital is a critical transition point in the delivery of mental health care. People leaving hospital after an admission for an episode of mental illness have increased vulnerability and, without adequate follow-up, may relapse or be readmitted.

The standard underlying this measure is that continuity of care requires prompt community follow-up in the period following discharge from hospital. A responsive community support system for persons who have experienced a psychiatric episode requiring hospitalisation is essential to maintain their clinical and functional stability and to minimise the need for hospital readmissions. Patients leaving hospital after a psychiatric admission with a formal discharge plan that includes links with public community-based services and support are less likely to need avoidable hospital readmissions.

Target

The 2019 target is ≥ 75 per cent. Maintained performance is demonstrated by a result above, or equal to, the target.

Results

In 2019, the percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services was below target (Table 15).

During 2019, strategies such as service education and training and processes to standardise procedures were implemented to improve performance. This has resulted in a 1% increase compared to the prior year (2018).

To ensure compliancy, ongoing monitoring and review of performance is conducted to facilitate continuity of care.

Target Met Target Not Met

Table 15: Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services, 2016–19

	Calendar year				
	2016 (%)	2017 (%)	2018 (%)	Target (%)	2019 (%)
Post-discharge community care	53	66	71	≥ 75	**72**

[8]National Health Survey 2017-18 - https://www.abs.gov.au/ausstats/abs@.nsf/mf/4364.0.55.001

Note: The 2019 definition is aligned to the national definition and is inclusive of community contacts with patients' carers/next of kin.
Data source: Mental Health Information Data Collection; Hospital Morbidity Data Collection.

Detailed information in support of Key Performance Indicators (cont.)

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

Service 1 *Public hospital admitted services*

Average admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per weighted activity unit (WAU) compared with the State target, as approved by the Department of Treasury and published in the 2019/20 Budget Paper no. 2, vol.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 2019/20 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

Target

The 2019/20 target is $7,026 for admitted services per weighted activity unit. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2019/20, the average cost per weighted activity unit was above target (Table 16). The relative increase compared to the prior year (2018/19), was due to the reallocation of resources towards the COVID-19 pandemic response and the substantial reduction in activity in the last quarter of the year.

Target Met Target Not Met

Table 16: Average admitted cost per weighted activity unit, 2017/18–2019/20

	Financial year			
	2017/18 ($)	2018/19 ($)	Target ($)	2019/20 ($)
Average cost	7,087	7,137	7,026	**7,475**

Data sources: OBM Allocation application; Oracle 11i financial system; Hospital Morbidity Data Collection; The Open Patient Administration System (TOPAS); Web-Based Patient Administration System (webPAS); Contracted Health Entities (CHEs) discharge extracts.

Detailed information in support of Key Performance Indicators (cont.)

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

Service 2 *Public hospital emergency services*

Average emergency department (ED) cost per weighted activity unit

Rationale

This indicator is a measure of the cost per WAU compared with the State target as approved by the Department of Treasury, which is published in the 2019/20 Budget Paper no. 2, vol.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 2019/20 target is $7,071 for emergency department services per weighted activity unit. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2019/20, the average emergency department cost per weighted activity unit was below target (Table 17). The increase in cost compared to the prior year (2018/19) was due to the reduction in activity in 2019/20.

Target Met Target Not Met

Table 17: Average emergency department cost per weighted activity unit, 2017/18–2019/20

	Financial year			
	2017/18 ($)	2018/19 ($)	Target ($)	2019/20 ($)
Average cost	6,095	6,212	7,071	**6,893**

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

Detailed information in support of Key Performance Indicators (cont.)

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

Service 3 *Public hospital non-admitted services*

Average non-admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per WAU compared with the State (aggregated) target, as approved by the Department of Treasury, which is published in the 2019/20 Budget Paper no. 2, vol. 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 2019/20 target is $6,992 for non-admitted services per weighted activity unit. Maintained performance is demonstrated by a result below, or equal to, the target

Results

In 2019/20, the average non-admitted cost per weighted activity unit was above target (Table 18).

Target Met | Target Not Met

Table 18: Average non-admitted cost per weighted activity unit, 2017/18–2019/20

	Financial year			
	2017/18 ($)	2018/19 ($)	Target ($)	2019/20 ($)
Average cost	7,224	7,018	6,992	**7,347**

Data sources: OBM Allocation application; Oracle 11i financial system; Non-Admitted Patient Activity and Waitlist (NAPAAWL) Data Collection; Interim Collection of Aggregate Data (ICAD).

Detailed information in support of Key Performance Indicators (cont.)

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

Service 4 *Mental Health Services*

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

Rationale

Specialised mental health inpatient services provide patient care in authorised hospitals and designated mental health units located within hospitals. To ensure quality of care and cost-effectiveness, it is important to monitor the unit cost of admitted patient care in specialised 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 2019/20 target is $1,352 per bed-day in specialised mental health inpatient services. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2019/20, the average cost per bed-day in specialised mental health inpatient services was above target (Table 19). This was in part due to reduced activity following a temporary drop in acute beds demand for mental health services during COVID-19 as well as due to the quarantining of some beds to allocate resources to support the COVID-19 effort. The costs allocations have also been refined to better reflect cost of inpatient service provision, resulting in a marginal higher cost per bed-day.

Target Met Target Not Met

Table 19: Average cost per bed-day in specialised mental health inpatient services, 2016/17–2019/20

	Financial year				
	2016/17 ($)	2017/18 ($)	2018/19 ($)	Target ($)	2019/20 ($)
Average cost	1,501	1,482	1,500	1,352	**1,538**

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

Detailed information in support of Key Performance Indicators (cont.)

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

Service 4 *Mental Health Services*

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

Rationale

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

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

Target

The 2019/20 target is $417 per treatment day of non-admitted care provided by mental health services. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2019/20, the average cost per treatment day of non-admitted care provided by mental health services was below target (Table 20).

Target Met Target Not Met

Table 20: Average cost per treatment day of non-admitted care provided by mental health services, 2017/18–2019/20

	Financial year			
	2017/18 ($)	2018/19 ($)	Target ($)	2019/20 ($)
Average cost	465	432	417	**403**

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

Detailed information in support of Key Performance Indicators (cont.)

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

Rate of women aged 50–69 years who participate in breast screening

Rationale

BreastScreen Australia aims to reduce illness and death resulting from breast cancer through organised screening to detect cases of unsuspected breast cancer in women, thus enabling early intervention, which leads to increased treatment options and improved survival. It has been estimated that breast cancer detected early is considerably less expensive to treat than when the tumour is discovered at a later stage. Mass screening using mammography can improve early detection by as much as 15 to 35 per cent.[9]

High rates reported against this KPI will reflect the efficient use of the physical infrastructure and specialist staff resources required for the population-based breast cancer screening program. High rates will also be an indication of a sustainable health system as early detection reduces the cost to hospital services at the later stages of a patient's journey.

Target

The 2018 to 2019 target is ≥ 70 per cent of women aged 50–69 years who participate in breast screening. Maintained performance is demonstrated by a result above, or equal to, the target.

Results

From 2018 to 2019, the rate of women aged 50–69 years who participate in breast screening was below target (Table 21). Population growth increased the demand on resources and participation is limited by the assessment capacity for women with screening abnormalities.

BreastScreen WA is establishing a new northern suburb's Breast Assessment Centre and a fixed clinic in the Great Southern region. These initiatives are due in 2021 and will expand the breast assessment capacity and allow reallocating mobile screening units to service the rapidly growing population of outer metropolitan Perth once operational.

Target Met | Target Not Met

Table 21: Rate of women aged 50 to 69 years who participate in breast screening, 2016 to 2019

	Calendar years			
	2016 to 17 (%)	2017 to 18 (%)	Target (%)	2018 to 19 (%)
Participation rate	56	56	≥ 70	**55**

Note: This measure counts the women screened within a 24-month period (1 January 2018 to 31 December 2019) 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. [9]Elixhauser A, Costs of breast cancer and the cost-effectiveness of breast cancer screening, Int J Technol Assess Health Care. 1991; 7(4):604-15. Review.

Detailed information in support of Key Performance Indicators (cont.)

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

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

Rationale

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

A low unplanned re-treatment 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, use of resources, future treatment options and patient satisfaction.

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

Target

Please see the targets for adults and children in Table 22. Maintained performance is demonstrated by a result below the target.

Results

In 2019/20, the percentage of adults and children who have a tooth re-treated within six months of receiving initial restorative dental treatment was below target (Table 22).

Performance was attributable to training, regular monitoring of clinic/clinician re-treatment rates, improving clinical techniques and procedures where issues are identified and quality assurance of equipment and materials used statewide.

Target Met | Target Not Met

Table 22: Percentage of adults and children who have a tooth re-treated within six months of receiving initial restorative dental treatment, 2017/18–2019/20

	Financial year			
	2017/18 (%)	2018/19 (%)	Target (%)	2019/20 (%)
Adults	6	6.1	< 7.7	**5.8**
Children	2.2	2.1	< 2.6	**2.0**

Note: Prior year data is used to ensure results aligned to the reports provided to the Australian Council on Healthcare Standards. **Data sources:** Dental Information Management Patient Management System (DenIM PMS).

Detailed information in support of Key Performance Indicators (cont.)

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

Percentage of eligible schoolchildren 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 ensure the improved dental health and wellbeing of children.

Target

The 2019/20 target is ≥ 69 per cent. Maintained performance is demonstrated by a result above, or equal to, the target.

Results

In 2019/20, the percentage of eligible children who are enrolled in the School Dental Service program was above target (Table 23). Performance for this indicator remains above target as the Dental Health Service continues to actively enrol children into the service.

Target Met Target Not Met

Table 23: Percentage of eligible schoolchildren enrolled in the School Dental Service program, 2016/17–2019/20

	Financial year				
	2016/17 (%)	2017/18 (%)	2018/19 (%)	Target (%)	2019/20 (%)
Eligible school children enrolled in the School Dental Service program	80	79	79	≥ 69	77

Note: Eligible schoolchildren are all schoolchildren aged 5 to 16 or until the end of Year 11 (whichever comes first) who attend a WA Department of Education recognised school. A parent/guardian is required to consent to dental examination and screening of their child in the School Dental Service program. **Data sources:** Dental Information Management Patient Management System (DenIM PMS); Department of Education WA.

Detailed information in support of Key Performance Indicators (cont.)

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 and diagnosis with 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 Western Australians in need. This indicator measures the level of access to these subsidised dental health services by monitoring the proportion of all eligible people receiving the services.

Through measuring the use and amount of dental health services provided to eligible people, the percentage of eligible people proactively involved in publicly funded dental care can be determined. This in turn 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 2019/20 target is ≥ 15 per cent. Maintained performance is demonstrated by a result above, or equal to, the target.

Results

In 2019/20, the percentage of eligible people who accessed Dental Health Services was below target (Table 24). Performance was impacted by COVID-19 restrictions on the delivery of dental services from March to May 2020.

Target Met Target Not Met

Table 24: Percentage of eligible people who accessed Dental Health Services, 2017/18–2019/20

	Financial year			
	2017/18 (%)	2018/19 (%)	Target (%)	2019/20 (%)
Eligible people who accessed Dental Health Services	15	14	≥ 15	**14**

Note: Eligible people are defined as those who hold a current Pension Concession Card (Centrelink) or Health Care Card.
Data sources: Dental Information Management System (DenIM) database; Commonwealth Department of Social Services (DSS) Payment Demographic data.

Oral health snapshot

Oral health means people can eat, speak and socialise without discomfort or embarrassment, and without active disease in their mouth that affects their overall wellbeing. Through our Dental Health Services (DHS), the State Government provides priority populations (such as the homeless and Aboriginal groups) who may be vulnerable to poor oral health, a 'safety net' to access urgent and routine dental services and subsidised care.

The Commonwealth National Partnership Agreement (NPA) provides additional funding to Dental Health Services to alleviate pressure on adult public dental waiting lists, which at 30 April 2019 had an average wait time for non-urgent general care of more than eight months. The aim of the NPA is to improve the oral health of adult patients who are eligible for public dental services, with a focus on patients at high risk of major oral health problems such as Aboriginal persons and those from rural and regional areas.

Activity under the NPA is measured in terms of Dental Weighted Activity Units (DWAUs). NPA funding is based on states achieving benchmark activity at 65% and 100% above baseline activity from 2013/14. Cumulative, from 1 January 2017 to 31 March 2020, WA exceeded the NPA target 3 months ahead of schedule, recording 211,885 DWAUs against the benchmark of 158,375 DWAUs.

To achieve this, the NPA project team developed four approaches to provide additional public dental services for eligible adults in WA:

- increased use of the private sector through established DHS metropolitan and country dental subsidy schemes
- increased capacity at existing public dental facilities
- increased funding for NGOs that provide dental care in areas of unmet need
- innovative models of dental service delivery to provide targeted care to Aboriginal people with chronic health conditions, people at risk of homelessness, and remote communities.

While the NPA funding positively impacted patients, the majority of public dental health care in WA continued to be provided through existing DHS clinics and contracted private clinics. Services are provided to eligible patients as determined by Healthcare Card or Pension Card status.
The NPA funding supported the employment of additional dental teams to improve capacity at metropolitan and country public dental clinics.

Under the NPA, DHS had provided oral health care to over 11 000 patients. Partnership with NGOs has facilitated access to dental services for 1400 Aboriginal and homeless persons.

Dental research

In addition to clinical services, the DHS continues to progress research in the following areas to improve oral health outcomes for rural and remote children, and those children with special needs:

- the Kimberley Kids Project is an NHMRC supported $1.4m study to determine if an Atraumatic Restorative Treatment approach (hand instruments only) can be incorporated within primary dental care in remote Aboriginal communities
- alternate Care Pathway is exploring the use of Atraumatic Restorative Treatments as an alternative to general anaesthesia for those children who would normally require sedation to receive dental care.

Partnering with Non-Government Organisations

Developing partnerships with five NGOs enabled us to provide dental services to people who otherwise lack access to timely and preventive care due to structural, cultural and/or financial barriers.

Moordijt Koort

Through the Moordijt Koort Aboriginal Wellness Centre in Kwinana, NPA funding allowed Aboriginal clients with chronic health conditions to receive oral health care close to home and in a culturally safe manner. Aboriginal liaison officers offered support to make and attend appointments with the patient, complete paperwork, and provide transport and translation services where needed. As a result, 26 clients who had not sought dental care for three or more years received much-needed care.

Derbarl Yerrigan Dental Clinic

NPA funding allowed Derbarl Yerrigan to employ an additional dentist. The employment of a female Aboriginal dentist ensured that Aboriginal clients felt culturally safe and supported for urgent and ongoing care.

Kimberley Dental Team

NPA grant funding supported volunteer dentists and final-year dental students to provide services and oral health education throughout the Kimberley region as well as targeted services within residential mental health and transitional housing hostels in the Perth Metropolitan area.

Spinifex Health Service

The NPA grant agreement provided funding and support for a visiting dentist to provide onsite services to the remote Tjuntjuntjara Community, reducing the need for residents to travel 700 kilometres to Kalgoorlie for dental care.

St Patrick's Community Support Centre

An onsite dental clinic at St Patrick's in Fremantle ensures vulnerable clients at risk of homelessness can obtain urgent and routine dental services in a safe, secure and supportive environment. Dental services are provided by a team of volunteer dentists, with NPA grant funding for support staff and consumables to ensure high standards of care. In total, all the above services provided oral health care to about 1400 Aboriginal and homeless patients seeking dental care in 2019/20.

Dental Health Services

While the NPA funding positively impacted patients, the majority of public dental care in WA continued to be provided through existing DHS clinics and contracted private clinics. The NPA funding supported the employment of additional dental teams to improve capacity at metropolitan and country public dental clinics. Services are provided to eligible patients as determined by healthcare card or pension card status. As of 31 March 2020, the DHS had provided oral health care to over 11,000 extra patients under the NPA.

Impact of oral health services

“It has given me confidence to go to my Granddaughter's school and read books to her class.”

“No pain and I don't cover my mouth anymore when I talk.”

“I can now feel proud to smile.”

“I can eat better food.”

“At first, I was scared of the dentist, but he helped me relax. The chair was scary when it moved at first. Now I don't mind the dentist.”

Detailed information in support of Key Performance Indicators (cont.)

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

Service 6 *Public and community health services*

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

Rationale

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

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

Target

The 2019/20 target is $49 per person of delivering population health programs by population health units. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2019/20, the average cost per person of delivering population health programs by population health units was above target (Table 25). The relative increase compared to the prior year (2018/19), was due to the allocation of resources from March to June 2020 for public health screening and related services associated with the COVID-19 pandemic response.

Target Met Target Not Met

Table 25: Average cost per person of delivering population health programs by population health units, 2017/18–2019/20

	Financial year			
	2017/18 ($)	2018/19 ($)	Target ($)	2019/20 ($)
Average cost	50	50	49	**69**

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

Detailed information in support of Key Performance Indicators (cont.)

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

Service 6 *Public and community health services*

Average cost per breast screening

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

Target
The 2019/20 target is $158 per breast screening. Maintained performance is demonstrated by a result below, or equal to, the target.

Results
In 2019/20, the average cost per breast screening was above target (Table 26). Performance was impacted by the temporary suspension of breast cancer screening in March 2020 due to COVID-19 restrictions.

Services returned to full capacity from 3 June 2020.

Target Met | Target Not Met

Table 26: Average cost per breast screening 2017/18–2019/20

	Financial year			
	2017/18 ($)	2018/19 ($)	Target ($)	2019/20 ($)
Average cost per breast screening	165	158	158	**174**

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

Detailed information in support of Key Performance Indicators (cont.)

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

Service 8 *Community dental health services*

Average cost per patient visit of WA Health-provided dental health programs for schoolchildren and socioeconomically disadvantaged adults

Rationale

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

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

Target

Please see the targets for patient groups in Table 27. Maintained performance is demonstrated by a result below, or equal to, the target.

Results

In 2019/20, the average cost per patient visit of WA Health-provided dental health programs was above target for school children and socioeconomically disadvantaged adults (Table 27).

Performance for both programs was impacted by COVID-19 restrictions in delivering services as patient visits for school children and socioeconomically disadvantaged adults decreased during the COVID-19 restricted period.

Target Met Target Not Met

Table 27: Average cost per patient visit of WA Health-provided dental health programs for schoolchildren and socioeconomically disadvantaged adults, 2017/18–2019/20

	Financial year			
	2017/18 ($)	2018/19 ($)	Target ($)	2019/20 ($)
Schoolchildren	198	193	181	**237**
Socioeconomically disadvantaged adults	272	281	267	**303**

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

Detailed information in support of Key Performance Indicators (cont.)

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

Percentage of emergency department (ED) 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 EDs 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 time frames. This provides an overall indication of the effectiveness of WA's emergency departments which can assist in driving improvements in patient access to emergency care.

Table 28: 2019/20 targets for ED patients seen within recommended times by triage category as per the Australasian College for Emergency Medicine

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 important time critical treatment or severe pain	≤ 30	≥ **75**
4	Potentially serious or situational urgency or significant complexity or severity	≤ 60	≥ **70**
5	Less urgent or clinico-administrative problems	≤ 120	≥ **70**

Maintained performance is demonstrated by a result above, or equal to, the target.

[10]Australasian College for Emergency Medicine. (2013) Policy on the Australasian Triage Scale, Australasian College for Emergency Medicine, Melbourne. Available from: https://acem.org.au/getmedia/484b39f1-7c99-427b-b46e-005b0cd6ac64/P06-Policy-on-the-ATS-Jul-13-v04.aspx

Detailed information in support of Key Performance Indicators (cont.)

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

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

Results

In 2019/20, the percentage of ED patients seen within recommended times for triage category 2 was equal to target; category 5 was above target and all other triage categories were below target (Table 29).

The results were impacted by the commencement of COVID-19 Clinics at SCGH and JHC on 10 and 25 March 2020 respectively to stream patients away from ED where they would normally present with Influenza-like symptoms. Performance has improved for triage category 2 to 5 compared to the prior year (2018/19).

Review of cases have been completed via the clinical incident management system and strategies such as improvements to models of care, patient journey, discharge planning and staff education and training are underway to improve outcomes.

Table 28: Percentage of emergency department (ED) patients seen within recommended times (unaudited performance indicator)

	Financial year				
Triage category	2016/17 (%)	2017/18 (%)	2018/19 (%)	Target (%)	2019/20 (%)
1	100	100	100	100	**100**
2	77	80	76	≥ 80	**80**
3	40	43	45	≥ 75	**51**
4	57	59	57	≥70	**64**
5	93	92	85	≥70	**87**

Data sources: Emergency Department Data Collection.

Ministerial Directives

Treasurer's Instruction (TI) 902 (12) requires the disclosure of information about ministerial directives relevant to the setting of desired outcomes or operational objectives, the achievement of desired outcomes or operational objectives, investment activities and financing activities.

As per the definition of a ministerial direction in Part 7, section 60 of the *Health Services Act 2016*, NMHS has not received any ministerial directives related to this requirement. However, the Minister for Health provided a Statement of Expectation that set out the Minister's expectations for the roles and responsibilities of the NMHS Board, as well as its accountabilities and priorities. The Board responded with a Statement of Intent.

Statement of Expectation

http://www.nmahs.health.wa.gov.au/AboutUs/pdf/StatementofExpectations.pdf

Statement of Intent

http://www.nmahs.health.wa.gov.au/AboutUs/pdf/StatementofIntent.pdf

Financial disclosures

Pricing policy

The National Health Reform Agreement sets the policy framework for public hospital fees and charges. Under the agreement, an eligible person who receives public hospital services as a public patient in a public hospital or a publicly contracted bed in a private hospital is treated at no charge to the patient. This arrangement is consistent with the Medicare principles that are embedded in the *Health Services Act 2016*.

The majority of hospital fees and charges for public hospitals are set under Schedule 1 of the Health Services (Fees and Charges) Order 2016 and are reviewed annually. The following informs fees and charges at WA public hospitals for a range of patients.

Nursing Home Type Patients

The State charges public patients who require nursing care and/or accommodation after the 35th day of their stay in hospital, providing they no longer need acute care and they are deemed to be Nursing Home Type Patients. The total daily amount charged is no greater than 87.5 per cent of the current daily rate of the single aged pension and the maximum daily rate of rental assistance.

Compensable or Medicare ineligible patients

Patients who are either 'private' or 'compensable' and Medicare ineligible (overseas residents) may be charged an amount for public hospital services as determined by the State. The setting of compensable and Medicare ineligible hospital accommodation fees is set close to, or at, full cost recovery.

Private patients (Medicare eligible Australian residents)

The Commonwealth Department of Health regulates the Minimum Benefit payable by health funds to privately insured patients for private shared ward and same day accommodation. The Commonwealth also regulates the Nursing Home Type Patient 'contribution' based on March and September pension increases. To achieve consistency with the *Commonwealth Private Health Insurance Act 2007*, the State sets these fees at a level equivalent to the Commonwealth Minimum Benefit.

Veterans

Hospital charges of eligible war service veterans are determined under a separate Commonwealth–State agreement with the Department of Veterans' Affairs. Under this agreement, the Department of Health does not charge medical treatment to eligible war service veteran patients; instead, medical charges are fully recouped from the Department of Veterans' Affairs.

Further fees and charges

The Pharmaceutical Benefits Scheme regulates and sets the price of pharmaceuticals supplied to eligible outpatients, eligible patients on discharge and eligible day-admitted chemotherapy patients. Inpatient medications are supplied free to all eligible patients. Medicare ineligible patients are charged at the rates set by the WA Department of Health within the *Fees and Charges Manual*.

Other categories of fees are specified under health regulations through 'determinations', such as the supply of surgically implanted prostheses, magnetic resonance imaging services and pathology services. The pricing for these hospital services is determined according to their cost of service.

The Dental Health Services' charges to eligible patients for dental treatment are based on the Department of Veterans' Affairs fee schedule of dental services for dentists and dental specialists.

Eligible patients are charged the following co-payment rates:

- 50 per cent of the treatment fee if the patient holds a current Healthcare Card or Pensioner Concession Card
- 25 per cent of the treatment fee if the patient is the current holder of one of the above cards and receives a near full pension or an allowance from Centrelink or the Department of Veterans' Affairs.

Financial disclosures (cont.)

Capital works

We have a substantial Asset Investment Program that facilitates remodelling and development of health infrastructure. Program initiatives include the continuation of major projects to reconfigure infrastructure and investment in metropolitan general and tertiary hospitals (Table 30 and Table 31).

Table 30: Major Asset Investment Program works completed, 2019/20

Initiative	Estimated Total Cost in 2019/20 $000
Joondalup Mental Health Observation Area	4,563
KEMH Redevelopment Holding Funds	1,263
NMHS Critical Infrastructure Project	1,742
KEMH Dishwasher	117
Graylands Hospital Redevelopment *– High Priority Ligature Risk Remediation*	96
Total	**7,781**

Note: The information above is based upon the 2019/20 published budget papers.

Table 31: Major capital works in progress, 2019/20

Initiative	Estimated total cost 2019/20 (a) $000	Estimated Expenditure to 2018/19 (b) $000	Estimated total to Completion (=b-a) $000	Expected completion date
Joondalup Health Campus Development stage 2[1,2,4]	158,744	117	158,627	Ongoing
Osborne Park Hospital[1,2,4]	24,806	1,120	23,686	Ongoing
Osborne Park Hospital reconfiguration stage[1]	273	261	12	N/A
WA Spinal Cord Injury Service reconfiguration[1,2]	35,738	163	35,575	Ongoing
Sarich Neuroscience[1,2,3]	35,479	35,395	84	Completed
SCGH – redevelopment stage 1[1]	7,565	3,565	4,000	N/A
Infection prevention and control system[1,2]	2,382	886	1,496	Ongoing
Fremantle Dental Clinic[1,2,3]	2,584	2,542	42	Completed
Automated Controlled Substance Storage[4]	800	-	800	Ongoing
KEMH Critical Infrastructure[4]	15,184	-	15,184	Ongoing

Notes:

1. The information above is based upon the:
   i) 2019/20 published budget papers.
   ii) 2018/19 published budget papers.
2. Completion timeframes are based upon a combination of known dates at the time of reporting.
3. Projects listed above as 'completed' may still be in the defects period.
4. Includes new works project published in 2019/20 budget papers.

Financial disclosures (cont.)

Employment profile

Government agencies are required to report the number of employees, by category. Table 32 shows the year-to-date (June 2020) number of NMHS full-time equivalent (FTE) employees for 2019/20.

Table 32: NMHS total full-time equivalent employees by category

Category	Definition	2019/20	%
Nursing and midwifery	All nursing and midwifery occupations, excluding agency nurses and midwives	3,351	**37.5%**
Executive, corporate, administration and clerical	All clerical-based occupations including patient-facing (ward) clerical support employees (83 FTE from Department of Health's Health Services Union in specific cost centres)	1,489	**16.6%**
Medical support	All allied health and scientific/technical related occupations	1,370	**15.3%**
Medical salaried and sessional	All medical occupations including junior medical officers, registrars and specialist medical practitioners	1,279	**14.3%**
Patient support services	Includes catering, cleaning, hospital service assistants, stores/supply laundry and transport occupations	760	**8.5%**
Dental clinic assistants	Dental clinic assistants	311	**3.5%**
Site services	Engineering, garden and security-based occupations	187	**2.1%**
Agency	Includes the following occupational categories: administration and clerical, medical support, patient support services, site services, medical salaried (excludes visiting medical practitioners) and medical sessional	73	**0.8%**
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care	81	**0.9%**
Agency nursing and midwifery	Workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest	33	**0.4%**
Other occupations	Including, but not limited to, Aboriginal Health Workers	8	**0.1%**
Total FTE employees		8,943	**100%**

Note: Total FTE, excluding Department of Health is 8943. For comparison with 2018/19 with an FTE of 9073, on 15 July 2019, indicating a reduction of 131 FTE 2019/20.
Data source: Human Resource (HR) Data Warehouse via Pulse Enterprise Data Warehouse, data extracted 9 July 2020.

Employee disclosures

Recognition and awards

NMHS Staff Recognition Program

Employee recognition has long been a cornerstone of effective management. Employees want to know how they are doing, and recognising employees demonstrates what success looks like. In July 2019, NMHS implemented a new staff recognition program (SRP) to recognise and reward dedicated individuals, teams and volunteers who help make our service one to be proud of.

The SRP forms one of the initiatives designed to engage and enable employees and enhance productivity and organisational performance. They are part of the Organisational Development Strategy endorsed by the NMHS Area Executive Group.

The SRP is delivered through three streams:

- NMHS Gem Awards
- Employee of the Month and Quarter Awards
- Long Service Awards.

NMHS Gem Awards

The NMHS Going the Extra Mile (Gem) Awards provide an opportunity to celebrate and reward high achieving staff (individuals and teams) who exemplify our values of **Care**, **Respect**, **Innovation**, **Teamwork** and **Integrity** in their daily service.

Our hospital and health service network provides highly specialised, multidisciplinary health care to 738,640 Western Australians, and we each have a role to play in delivering our vision of **excellence in health care for our community**.

The 11 Gem Award categories align with our strategic priorities and recognise our ongoing commitment to delivering the best outcomes and highest levels of care for our patients and community. This includes a focus on improving clinical excellence, developing centres of excellence, establishing strong partnerships and engagement, and functioning as an empowered workforce – and all supported by robust corporate systems.

The Gem Awards provide a valuable opportunity to showcase the great work being done throughout our service and celebrate our exceptional staff. The inaugural GEM finalists were announced on 1 May 2020, with a total of 53 finalists.

The breadth and spread of nominations throughout our hospital and health service network was truly amazing. These are the individuals and teams that continually go the extra mile and demonstrate our values to make a difference to the lives of their patients, colleagues and community. Congratulations to all of our 2020 finalists.

NMHS Employee of the Month and Quarter Awards

The Employee of the Month and Quarter Awards aim to showcase and celebrate employees who have shown exceptional effort, gone beyond the scope of their usual duties, and whose contributions have led to improved outcomes for patients, staff or the community.

We recognise that all employees play an important role in achieving the NMHS vision of excellence in health care for our community and in demonstrating our values in everything we do. These awards give our people the opportunity to be recognised by their peers.

NMHS Long Service Awards

The Long Service Awards recognise staff members who have completed continuous service at any of the NMHS sites or services in 10, 20, 30 and 40-year increments. We recognised 1,097 employees in 2019/2020.

10 years	740 people	20 years	238 people	30 years	104 people	40 years	15 people

WA Senior Australian of the Year

From left: Prof. John Newnham, The Hon. Scott Morrison, MP, Prime Minister of Australia.

Professor John Newnham, consultant obstetrician and gynaecologist at KEMH, was named WA Australian Senior of the Year in November 2019.

Professor Newnham is one of the world's leading authorities in the prevention of preterm birth – the single greatest cause of death and disability in children aged up to five. A professor of obstetrics, he has been instrumental in making WA an international hot spot for research and clinical excellence in pregnancy and life before birth.

In 1989, he founded and led the pioneering Raine Study, the world's first and most enduring pregnancy-focused lifetime cohort project. Professor Newnham developed a program for preventing preterm birth – a pioneering initiative that resulted in an 8 per cent reduction in premature births across WA. After a successful national rollout in 2018, he founded the Australian Preterm Birth Prevention Alliance – the world's first national program of its kind.

In accepting the honour, Professor Newnham called for more support for a new program to reduce the rate of preterm births. "It is now time for prevention of preterm birth to become a national priority for Australia," he said.

Professor Newnham said that for many years he has had the privilege to care for women with complicated pregnancies and sick babies before they are born.

"As a young medical student, I became fascinated by life before birth, and how little was known about the events before birth and how they may impact on our health and our disease throughout the rest of our lives," he said.

"I believe I have found an undiscovered continent, and I have spent the rest of my life exploring it."

WA Young Australian of the Year

NMHS employee and Medical student Yarlalu Thomas was honoured as the 2020 WA Young Australian of the Year.

Mr Thomas, a precision public health fellow in genetic and rare diseases at KEMH, is a Nyangumarta Pitjikarli man, originally from Warralong, south-east of Port Hedland. He was the first in his community to complete a high-school certificate and enrolled in a Bachelor of Medical Science and Doctor of Medicine (MD) at the University of Sydney. Between his bachelor's degree and MD, Mr Thomas was awarded the inaugural Roy Hill Community Foundation Fellowship.

He currently works with the WA Register of Developmental Anomalies, Genetic Services WA and Cliniface to transform genetic healthcare services for remote Indigenous people. Mr Thomas also works with Pilbara Faces, which aims to understand 3D facial variation of Indigenous people to provide more accessible, quicker and non-invasive diagnoses for children with rare and genetic diseases, and Foetal Alcohol Spectrum Disorder.

Mr Thomas launched the UNESCO-endorsed Life Languages project to translate medical terminology into Indigenous languages internationally, combining the newest scientific and medical knowledge with old and ancient wisdom.

Mr Yarlalu Nanmurr Thomas

Minister for Health Award

Dr Gareth Baynam, a clinical geneticist with a long-standing commitment to improved Indigenous health care, was recognised with the Minister's Award for Health Excellence in November 2019. Dr Baynam, a paediatrician and researcher at KEMH, heads WA's groundbreaking Undiagnosed Diseases Program, which aims to achieve diagnoses for young people with rare, complex and undiagnosed medical conditions.

Without a diagnosis, such patients can spend many years undergoing unnecessary medical tests and miss out on opportunities for treatment. The program, established in 2016, has a 55 per cent diagnostic rate – more than double its initial target rate.

Dr Baynam was also instrumental in establishing the Rare and Undiagnosed Diseases Diagnostic Service (better known as RUDDS), a service that uses gene panel technology for patient diagnoses.

He guided the development and international use of the information management platform called Patient Archive, which allows patient data to be shared securely between countries, a transformative initiative that enables the diagnoses of rare diseases.

In 2015, Dr Baynam made medical history by discovering a new genetic disease caused by a mutation in the MTOR gene, which regulates how cells grow, divide and function. His discovery explained why three young siblings from a remote Aboriginal community were born with severe medical problems. The diagnosis helped these children get the treatment they needed.

From left: The Hon. Mr Roger Cook, Minister for Health, Dr Gareth Baynam

Employee disclosures (cont.)

Industrial relations

Hospital personnel have difficulties in meeting the needs of their patients if their own needs are not met. This is where our Industrial Relations (IR) team excels. The team provides a bridge between our internal and external environment, fostering productive relationships between NMHS and our employees, unions and other key stakeholders.

In 2019/20, the IR team provided representation and advocacy on workplace issues before the WA Industrial Relations Commission, Fair Work Commission, Public Service Arbitrator, Public Service Appeal Board, Australian Human Rights Commission, Equal Opportunity Commission and the Industrial Magistrates Court.

The IR team are contributing to the development, review and implementation of workforce-related policies, strategies, systems and processes, including providing industrial advice on workplace change and general workforce issues in response to COVID-19.

The IR team provide advice on interpreting industrial agreements and awards and contribute to WA Health workshops. Assurance that we are meeting our obligations in industrial relations is provided by the team's advice in the following areas:

- large-scale workforce initiatives and change management programs
- management of claims and disputes related to investigations, disciplinary matters and contractual/agreement claims (e.g. pay, rosters and conditions)
- implementation of Commissioner's Instruction no. 23 (CI23), conversion and appointment of fixed-term contract and casual employees to permanency resulted in 321 employees converted to permanency under CI23 and 408 employees converted to permanency via non-CI23 mechanisms.

Employee development

Organisational learning practices in healthcare organisations can help to improve existing skills and knowledge, and provide opportunities to discover better ways of working together. We are committed to promoting organisational learning and development with a strong focus on support services and employee career development.

All employees undertake mandatory training to address modifiable risks to both patients and staff, to better provide safe and sustainable health care. Mandatory training at NMHS includes modules in accountable and ethical decision making, Aboriginal cultural awareness, emergency procedures, manual tasks, clinical deterioration and basic life support, My Health Record and management of aggression.

Each NMHS site provides in-house training and education to ensure staff have the appropriate skills and knowledge to fulfill their clinical and non-clinical roles. Training can be conducted either internal or external to sites and through online eLearning resources.

Additional programs support our 2,000 managerial and supervisory staff as well as frontline managers. This training focuses on equipping managers with the leadership skills required to recruit, manage and develop their staff, including communication, coaching, feedback, conflict management and motivation. We have recently completed development of an eLearning package on People Manager Accountabilities – understanding your role and responsibilities.

NMHS provides a wide range of undergraduate, graduate training and leadership development programs to employees. As a Registered Training Organisation, NMHS offers nationally recognised post-graduate nursing programs such as Intensive Care Nursing, Emergency, and Infection Control, and the Diploma of Leadership and Management which currently has 100 current enrolments. Mandatory training continued through the COVID-19 response to ensure the ongoing provision of safe, high-quality care. Wherever practicable, training was converted to eLearning programs; other modified training respected social distancing rules.

During 2020, thousands of our staff took the opportunity to upskill in the use of personal protective equipment (PPE). The COVID-19 pandemic also provided the impetus to increase Mental Health First Aid training. To date, 175 of our staff have completed the program.

Employee disclosures (cont.)

Workers' compensation

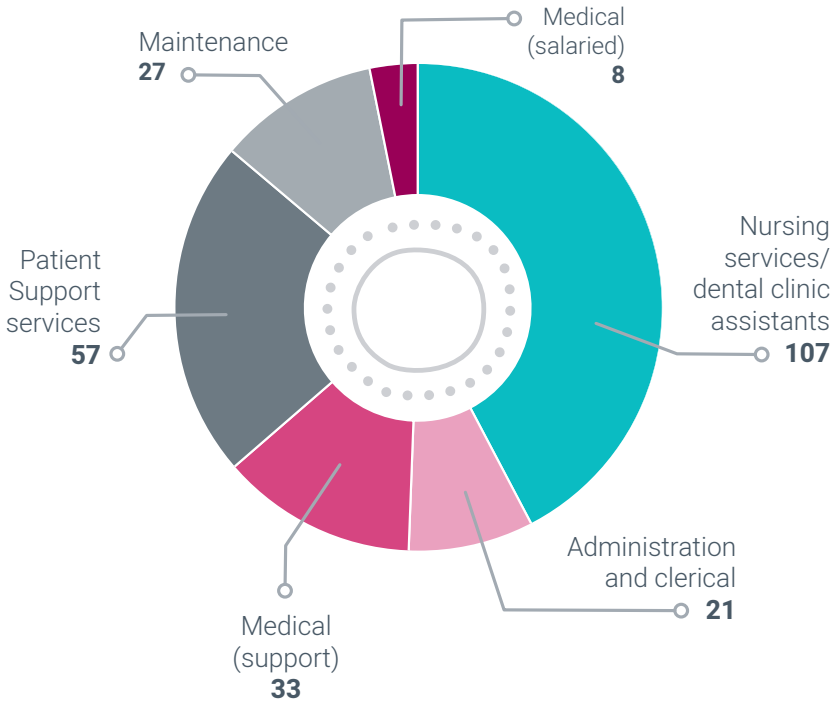
NMHS has a an injury management system in place which governs the standardised management of workers compensation claims, and the provision of injury management services that are administered in accordance with the *Workers' Compensation and Injury Management Act 1981* and *Workers' Compensation Code of Practice (Injury Management) 2005.*

Injury Management Consultants in collaboration with Occupational Health Physicians are accessible to all staff and managers to ensure high levels of specialist support are provided for staff with work-related injuries or illnesses. These consultants provide expert advice and services to ensure best practice case management strategies, including timely opportunities for staff to return to productive duties when it is medically appropriate.

NMHS adopts a multidisciplinary case management approach to facilitate the early and safe return to work of injured workers which involves the injury management consultant, line managers, injured workers and their treating physicians. This approach ensures the programs are appropriate to the employees' capacity and workplace.

Employee rehabilitation programs also extend to non-compensable injuries where there is a risk of exacerbating factors and/or a requirement to provide expert advice to facilitate the employee's safe return to work. This is facilitated by occupational health physicians who provide expert advice.

In 2019/20 a total of **253** workers compensation claims were made:



Note: The workers compensation total claims made and employee categories were obtained from RiskCover all claims monthly spreadsheet as at 30 June 2020 and filtered by FY 2019/20.

Board and committee remuneration

Board and committee remuneration

The total annual remuneration for each board or committee is listed in Table 33.
For details of individual board or committee members, please refer to Appendix B.

Table 33: Summary of State Government boards and committees within NMHS, 2019/20

Board/Committee name	Total remuneration ($)
NMHS Board	403,016.00
WNHS Community Advisory Council (formerly KEMH Community Advisory Committee)	10,972.50
OPH Community Advisory Council	7,360.50
Sir Charles Gairdner Hospital Community Advisory Council	4,155.00
Mental Health Community Advisory Council	21,435.00

Other legal requirements

Act of grace payments

No Act of Grace payments pursuant to authorisations given under Section 80(1) of the *Financial Management Act* were made in the 2019/20 financial year.

Unauthorised use of credit cards

NMHS officers are issued with corporate credit cards (Purchasing Cards) when their functions require this facility. The credit cards provide a clear audit trail for the purchase of goods and services and are not to be used for personal (unauthorised) purposes. If a cardholder makes a personal purchase, they must give written notice to NMHS within five working days and refund the total amount of expenditure.

Fourteen NMHS cardholders recorded personal purchases on their Purchasing Card. All of these cardholders declared a personal expenditure and all monies were refunded in full (Table 34). No referrals for disciplinary action were instigated during the reporting period.

Table 34: Personal use credit card expenditure by NMHS cardholders 2019/2020

Credit card personal use expenditure	Aggregate amount ($)
Reporting period	1,701.96
Settled by the due date (within 5 working days)	1,689.26
Settled after the period (after 5 working days)	12.70
Outstanding at balance date	0

Advertising and sponsorship

In accordance with section 175Z of the *Electoral Act 1907*, Health Service Providers are required to report total advertising expenditure. In 2019/20 the total expenditure was $92,936, which is a significant reduction from $328,620 in 2018/19. The organisations from which advertising services were procured and the amount paid to each organisation are shown in Table 35.

Table 35: Summary of NMHS advertising expenditure by provider 2019/20

Category	Provider	$
Advertising agencies	Australian Diabetes Educator's Association Ltd	150
	Complete Office Supplies Pty Ltd	1,750
	Delta Print	231
	Discus on Demand Pty Ltd	289
	Dynamic Gift International	4,572
	Luckshaw Consulting	14,000
	Midland Trophies	173
	Picton Press	8,276
	Sensis Pty Ltd	52
	SurveyMonkey	262
	Telstra Corporation Limited	1,122
	The Australasian College for Emergency Medicine	550
	The Thoracic Society of Australia and New Zealand Incorporated	236
	The Trustee for Branded Products	2,825
	Subtotal	34,488
Market research organisations	Nil	0
Media advertising organisations	Carat Australia Media Services	58,448
	Subtotal	**58,448**
	Total	**92,936**

Other legal requirements (cont.)

Freedom of Information

The Freedom of Information (FOI) Act 1992 gives the public a general right of access to documents and records held by NMHS.

NMHS comprises a mix of tertiary-quaternary, specialist and general hospitals including:

- Sir Charles Gairdner Hospital
- Osborne Park Hospital
- King Edward Memorial Hospital
- Graylands Hospital
- Joondalup Health Campus (Public/Private).

The types of information held by NMHS include:

- clinical records
- correspondence
- test results
- genetic information
- photographs
- medication charts
- demographic information
- CCTV footage
- clinical incident reports and findings
- invoices for hospital-related care
- CDs of radiological images
- occupational health and safety reports
- financial records
- human resource records.

The FOI Act recognises two kinds of requests for access to information, personal information and non-personal information. Personal information is defined as 'information or an opinion, whether true or not, and whether recorded in a material form or not, about an individual, whether living or dead' (Clause 3, Schedule 1 of the FOI Act).This includes, but is not limited to, information from which the identity of an individual is apparent or can reasonably be ascertained. Non-personal information is defined as information concerning people other than the FOI access applicant. This also includes, but is not limited to, information, opinions, contact details or genetic information.

Members of the public can request access to documents held by NMHS via an FOI application. Applications for patient records are received and managed at individual hospital sites and forms can be accessed via each hospital's website.

Applications for corporate and non-clinical information are managed by NMHS and applications can be made to the NMHS FOI Coordinator via **nmhs.foi@health.wa.gov.au**.

The number and type of new applications received by NMHS under FOI legislation are shown in Table 36.

Table 36: Summary of NMHS Freedom of Information applications, 2019/20

Service name	Personal	Non-personal
Women and Newborn Health Service	212	0
Sir Charles Gairdner Osborne Park Health Care Group	659	165
Mental Health, Public Health and Dental Services	400	21
NMHS Corporate	6	14
Total	**1,277**	**200**

Other legal requirements (cont.)

Compliance with Public Sector Standards and ethical codes

All NMHS employees are required to comply with the Western Australian Public Sector Standards in Human Resource Management and Commissioner's Instructions. To assist employees to understand and comply with the principles of workplace behaviour and conduct, a comprehensive set of WA Health and NMHS policies and guidelines are made available to all employees. NMHS employees may access these information resources via the NMHS intranet, which includes external links to the Department of Health and Public Sector Commission websites. Onsite human resource managers and human resource partners provide information and support to line managers in the implementation of the Public Sector Standards.

Recruitment and selection

In 2019/20, 14 breach of standard claims were lodged regarding the recruitment, selection and appointment process, or the management process of an employee's performance. Of these, six claims were finalised internally and eight were sent to the Public Sector Commission for review. Of these, five have subsequently been dismissed and three claims are ongoing. NMHS uses a central recruitment and selection process through Health Support Services to assist with a consistent approach and capacity for monitoring the compliance of the Standards in respect to human resource management. As part of the recruitment, selection and appointment process, applicants are notified of the breach claim process through a standardised letter.

Grievance resolution

The WA Health Grievance Resolution Policy complies with the Public Sector Standards in Human Resource Management - Grievance Resolution Standard, the Public Sector Code of Ethics and the WA Health Code of Conduct. All NMHS employees involved in grievances receive the WA Health Grievance Resolution policy and the NMHS Guidelines for Resolving Employee Grievances.

Code of Conduct

All NMHS employees are responsible for ensuring their behaviour reflects the standards of conduct embodied in the WA Health Code of Conduct. A significant review of the Code was finalised and published in October 2019. The revised Code was incorporated into all relevant NMHS policies, training packages and intranet pages. The updates were communicated to all employees. The Code defines the standards for ethical and professional conduct and outlines the behaviours expected of employees throughout the WA health system. Accountable and Ethical Decision Making, Aboriginal Cultural eLearning, Recordkeeping Awareness, Management of Aggression, Code of Conduct, and Prevention of Bullying, Harassment and Discrimination in the Workplace.

These training packages are designed to communicate the expectations of workplace conduct and the process for managing breaches of conduct. Employee compliance with the Code of Conduct is monitored through the breach of discipline internal reporting process. Under the WA Health Discipline Policy, NMHS are required to review, assess and investigate all complaints alleging breaches of the Code of Conduct. All alleged breaches of the code are considered breaches of discipline under the *Health Services Act 2016*. In 2019/20, a total of 198 matters were lodged and investigated internally as an allegation of a breach of discipline.

Recordkeeping plans

In a positive recordkeeping culture, all employees understand the value of record management and are actively engaged with it. NMHS are committed to the continuous improvement of our recordkeeping culture, tools and practices to ensure compliance with the *State Records Act* 2000. A record revitalisation program is scheduled for late 2020 in support of this commitment.

We continued to progress with the NMHS Record Keeping Plan (RKP) which details our recordkeeping programs and systems, disposal arrangements, policies and procedures. Our RKP was endorsed by the State Records Commission in 2015 with a review scheduled for submission by August 2020.

Record Management training sessions continue to be offered to all staff. Feedback from these sessions is used to gauge the effectiveness of delivery and enhance future development of training. Training is supported by our intranet site where resources are available for all staff.

Annual estimates

Pursuant to advice from the Under Treasurer, granting all entities in WA Health a partial exemption from TI 953(4) and allowing the submission of annual estimates to the Minister for Health by 17 December 2020 (for FY 2020/21), NMHS annual operational budget estimates for the following financial year will be provided at a later date.

Disability Access and Inclusion Plan

We comply with the legislative requirements of the *Western Australian Disability Services Act 1993* (as amended in 2004) through a commitment to achieve the seven desired outcomes listed in Schedule 3 of the *WA Disability Services Regulations 2004* (as amended in June 2013). NMHS continues its commitment to the implementation of our Disability Access and Inclusion Plan (DAIP) 2017–2022.

General services and events

We ensure that people with disability have the same opportunities as other people to access services and events. We provide opportunities for all service users to provide feedback about NMHS facilities and services, and support our staff to improve accessibility for people with disability. A 'Visiting Assistance Animals' guide was developed to help those coming to hospital with an assistance animal. The guide was launched on 29 April 2020 to coincide with International Guide Dog Day and supports the existing NMHS 'Visiting Assistance Animals' policy.

Buildings and facilities

We ensure all building and facilities are physically accessible to people with disability. At OPH, work was completed to make the occupational therapy area more accessible with improved pathways, pathway railings and new toilet door handles. Planning for disability access is also included in new builds, such as the rehabilitation and aged-care building and newborn services building at Osborne Park Hospital.

Quality of service

The National Disability Insurance Scheme (NDIS) is Australia's first national scheme for people with disability. This year, we have provided ongoing education to staff regarding NDIS access and planning, with a focus on ensuring multidisciplinary team collaboration. Workspaces have been created to facilitate collaboration on NDIS-related documents, such as access request forms and pre-planning tools. Relationships have also been strengthened with local area coordinators and NDIS partner agencies, such as Mission Australia. We continue to be represented on the NDIS Health Reference Group, which has assisted with escalation of any NDIS-related discharge delays with special considerations during COVID-19.

Complaints and safeguarding

NMHS values all feedback received by patients, carers and stakeholders. A range of feedback mechanisms are available to enable patients to submit a complaint, compliment or feedback. People with disability are provided with the same access to this process and can lodge a complaint in person, in writing or over the phone. We also subscribe to Care Opinion, an independent site where people can anonymously share their stories about their experience of care.

Consultation and engagement

Community Advisory Councils at our hospitals and services provide advice and support to improve the experience for patients, their relatives and carers, and other health service consumers. At a Diversity Dialogue event held in August 2019 at SCGH, staff were invited to a panel discussion with health consumers to learn more about how having disability impacts their care. The event was run in partnership with the Health Consumers' Council and People with Disability WA.

Employment, people and culture

People with disability have the same opportunities as other people to obtain and maintain employment within NMHS. We comply with the WA health system Recruitment, Selection and Appointment Policy and associated procedures to ensure recruitment and selection is undertaken in a consistent, inclusive, open and transparent manner.

Information and communication

BreastScreen WA developed the *Guide to Breast Health* booklet, which helps carers to educate clients with intellectual disability about the process of having a screening mammogram and ensure their informed consent. A pictorial resource has been developed to assist staff during the clinic appointment.

The Special Needs Dental Clinic have developed **Maggie goes to the dentist**, a 'Social Story' tool for patients with Autism Spectrum Disorder (ASD) to reduce their anxiety as they learn how they should behave in social settings such as being a patient in a dental clinic, willingly sitting in the dental chair and having an examination or scale and clean. These details help those with ASD pick up on cues they normally wouldn't notice.

https://www.dental.wa.gov.au/publications/maggie-goes-dentist

Government policy

Substantive equality

Substantive equality is a fundamental human right which goes beyond recognising the equality of everyone. Instead, it identifies differences among groups, to ensure that policies and practices within the organisation are capable of meeting the specific needs of certain groups of people. By addressing factors associated with systemic discrimination, we are better equipped to provide equitable access to services and improve health outcomes.

Within the NMHS context, our initiatives in substantive equality align with the State Government's Policy Framework for Substantive Equality. They improve service delivery for disadvantaged Western Australians in our catchment with access to culturally appropriate information and services. These include:

- supporting the development of a National Cervical Screening Program
- developing resources on Huntington's disease for Aboriginal people, particularly kinship groups in the Kimberley where there is a significant genealogy of Huntington's disease
- developing a counselling and intervention trial clinic called 'Come as you Can', with the Babbingur Mia Aboriginal Health Service
- strengthening health promotion partnerships and collaboration with local Aboriginal communities to provide safe, healthy, inclusive and welcoming spaces at NMHS
- improving discharge communication with community Aboriginal Health Services following an Aboriginal person's hospital stay
- partnering with the Heart Foundation for the Lighthouse Hospital Project to improve outcomes for Aboriginal persons with coronary disease
- partnering with 10 Aboriginal Medical Services in regional locations to provide oral health care, reducing barriers for Aboriginal people accessing dental services.

As at 30 June 2020, NMHS employed eight Aboriginal Hospital Liaison Officers, who act as a cultural link between health professionals and Aboriginal patients and their families. These officers play an important role in breaking down any perceived barriers of communication so patients and their families have a better understanding of their health care journey and treatment.

To ensure continued Aboriginal community engagement, we facilitate the Aboriginal Cultural Advisory Group (ACAG), which has a diverse membership and provides advice on matters and issues that are relevant to Aboriginal people.

We established the Aboriginal Health Working Group to oversee the effectiveness of the NMHS Action Plan, in alignment with the WA Health Aboriginal Health and Wellbeing Framework 2015–2030. Cross-cultural communication training workshops are available for staff to build an understanding of Aboriginal cultural groups and how, as individuals, we all have the capacity to better identify the needs of Aboriginal people. Sustained initiatives this year reflect our continued investment in substantive equality for other disadvantaged Western Australians including:

- culturally and linguistically diverse (CaLD) people
- people with disability
- refugees
- female prisoners
- rural women.

In partnership with other CaLD services, we piloted a WA Cervical Cancer Prevention Program (WACCPP) to improve access to tailored information on cervical screening. Fifteen sessions were successfully delivered between June and November 2019, with evaluation findings showing increased knowledge and intention to participate in cervical screening among CaLD participants.

NMHS has increased the provision of interpreting services to non-English speaking patients attending outpatient clinics or being seen in the community, ensuring that a lack of English vocabulary or comprehension does not impact the provision or understanding of access to services.

Government policy (cont.)

Through our Disability Access and Inclusion Plan, we improved access to information, services and events for people with disability, who make up about five per cent of the State's population. We facilitated patient access to the NDIS by providing staff education, strengthening working relationships with Local Area Coordinators and partner agencies. By creating workspaces that allow multidisciplinary team input into documents such as the Access Request Form and pre-planning tools, NMHS improved processes thereby ensuring escalation of NDIS-related discharge delays.

The 2019/20 financial year was the first full year of operation for the relocated Fremantle General Dental Clinic to the Fremantle Hospital site. The relocated clinic is more accessible to people with disability or limited mobility with the addition of a bigger treatment room. This project capitalised on existing public transport and increased accessible parking for patients and staff.

We have partnered with the Humanitarian Entrant Health Service (HEHS) to introduce an appointment with refugee clients as an opportunity to complete vaccination schedules and identify whether further support is required. Through established referral pathways, clients from the HEHS are also able to access dental care through any one of our Dental Health Services clinics. NMHS is training lecturers in the Adult Migrant English Program at the North Metropolitan TAFE to integrate healthy lifestyle education into English lessons for new migrants.

Other initiatives focused on increasing substantive equality include supporting WA prisons to overcome barriers to accessing complete and current cervical screening histories, necessary for cervical screening and clinical management among female prisoners. This ongoing work is supported by the WACCPP through establishing processes with the National Cancer Screening Register (NCSR) aimed at improving the identification of women on the NCSR who have limited personally identifiable information.

Another initiative includes providing an equitable and culturally appropriate breast cancer screening service for eligible women in rural WA. BreastScreen WA commenced community health days in towns where the mobile screening unit was located to enable women to 'walk in' for a breast screen, reaching women who may otherwise have missed out on diagnosis and treatment. BreastScreen WA was also the fist screening service of its kind to record patient cancer screening results on My Health Record.

Priority Start Policy

Priority Start policy replaced the Government Building Training policy on 1 April 2019. The Policy applies to building constructions, civil construction, and maintenance contracts, with a total value (inclusive of GST) over $5 million. The policy also applies to individual contracts over $5 million awarded under a State Government panel arrangement. As at 30 June 2020, none of the building, maintenance or construction contracts awarded by NMHS have a labour value greater than $5 million over the life of the contract.

Occupational safety and health, and injury management

NMHS is committed to providing a safe workplace and achieving high standards in safety and health for our employees, contractors, volunteers and visitors. To achieve this, an integrated risk management approach to occupational safety and health (OSH) is in place, which is underpinned by policies and procedures in accordance with the *Occupational Safety and Health Act 1984*, the *Occupational Safety and Health Regulations 1996* and the *Code of Practice on Occupational Safety and Health in the Western Australian Public Sector.*

The establishment of clear OSH policies, goals and strategies, the articulation of employee responsibilities and the development of preventive programs enables a proactive approach to OSH to achieve best practice outcomes. Hazard and risk management processes include the use of incident/hazard report forms, workplace hazard inspections, risk assessments and job safety analyses. A consultative approach to the resolution of safety risks is adopted in order to ensure that hazards are addressed and incidents are investigated, thereby promoting a positive safety culture.

NMHS regularly provides information about safety and health and promote activities to ensure that all staff have access to current and relevant information, particularly when it applies to their roles and the healthcare environment. Safety and health policies, procedures, guidelines and other related information are available to all staff through HealthPoint and intranet pages.

All NMHS sites facilitate OSH management and consultation through:

- the election of OSH representatives
- the establishment of OSH committees and working groups
- hazard/incident reporting and investigation
- routine workplace inspections
- resolution of issues process
- implementation of regular audits, risk assessments and control measures to prevent incidents occurring.

Government policy (cont.)

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

Occupational Safety, Health and Injury Management Training for Managers and Supervisors was cancelled in response to prioritisation of COVID-19 clinical activities and personal protective equipment (PPE) awareness training. This resulted in a reduction in manager training percentage from the base year. Training has recommenced targeting non-compliant managers and supervisors to increase compliance. Numbers of lost time injuries are reducing; however, the number of severe claims remained stable from the base year (Table 37). Due to the calculation methodology, this has resulted in a higher severity percentage despite the positive lost time result. Further information regarding training for managers and claim severity is detailed below (refer note 2).

Table 37: Occupational safety and health assessment and performance indicators, 2019/20

Measures	Results 2017/18 (1) Base Year	Results 2018/19	Results 2019/20 Current reporting year
Number of fatalities	0	0	**0**
Lost time injury and disease incidence rate(2)	2.6 (3)	2.3 (3)	**2.3**
Lost time injury and severity rate(2)	32.50 (3)	35.41 (3)	**37.56**
Percentage of injured workers returned to work (i) within 13 weeks(5)	60% (3)	61% (3)	**59%**
Percentage of injured workers returned to work (ii) within 26 weeks(5)	69% (3)	69% (3)	**70%**
Percentage of managers trained in occupational safety, health and injury management responsibilities, including refresher training within 3 years(6)	71%	69%	**51%**

Notes:

1. Target is 10% improvement on base year 2017/18. The performance reporting examines a three-year trend and, as such, the comparison base year is two years prior to the current reporting year.
2. LTIs and Severe Claims lodged during the financial year as provided by RiskCover (excludes declined and withdrawn claims). Severity Rate for prior financial years is as extracted at the relevant reporting period.
3. 2017/18 and 2018/19 data may be different to previous annual report data. The data reported above has been recalculated in line with current methodologies by using RiskCover data only, in alignment with other HSPs.
4. Claim severity. The reducing LTI rate indicates that minor injuries are well managed and staff are supported to return to work within a reasonable timeframe. However, it is important to note that there may be numerous factors impacting on injured staff and their ability to return to productive work. Return to work can be complicated by real or perceived workplace stress and conflict, personal issues, underlying health concerns, performance issues, mental health disorders and other factors.
5. Calculated from RiskCover All Claims Report. Includes lost time claims with an accident date within the last calendar year. Return to Work is calculated by using days lost/days normally worked where the worker has a level of fitness of 'Fit for Pre-injury duties on Pre-injury Hours'.
6. Managers and supervisors requiring training are determined from our HR records by flagging management position numbers.

Appendices

Contact Information

North Metropolitan Health Service

Street address: **QEII Medical Centre, 2 Verdun Street, Nedlands WA 6009**
Postal address: **Locked Bag 2012, Nedlands WA 6009**
Telephone: **(08) 6457 3496**
Email: **nmhs.corporatecommunications@health.wa.gov.au**
Web: **www.nmahs.health.wa.gov.au**

Joondalup Health Campus (Public)*
Street and postal address: **Shenton Avenue, Joondalup WA 6027**
Telephone: **(08) 9400 9400**
Web: **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
Street address: **374 Bagot Road, Subiaco WA 6008**
Postal address: **PO Box 134, Subiaco WA 6904**
Telephone: **(08) 6458 2222**
Web: **www.kemh.health.wa.gov.au**

Sir Charles Gairdner Osborne Park Health Care Group

Sir Charles Gairdner Hospital
Street address: **QEII Medical Centre, Hospital Avenue, Nedlands WA 6009**
Postal address: **Locked Bag 2012, Nedlands WA 6009**
Telephone: **(08) 6457 3333**
Web: **www.scgh.health.wa.gov.au**

Osborne Park Hospital
Street and postal address: **36 Osborne Park Place, Stirling WA 6021**
Telephone: **(08) 6457 8000**
Web: **www.oph.health.wa.gov.au**

Mental Health, Public Health and Dental Services

Mental Health
Street and postal address: **54 Salvado Road, Wembley WA 6014**
Telephone: **(08) 9242 9642**
Web: **www.nmahsmh.health.wa.gov.au**

Dental Health Services
Street address: **43 Mount Henry Road, Como WA 6152**
Postal address: **Locked Bag 15, Bentley Delivery Centre, WA 6983**
Telephone: **(08) 9313 0555**
Web: **www.dental.wa.gov.au**

Graylands Hospital Campus
Street address: **Brockway Road, Mount Claremont WA 6010**
Postal address: **PO Private Bag No. 1, Claremont WA 6910**
Telephone: **(08) 6159 6600**
Web: **www.nmahsmh.health.wa.gov.au**

Board and committee remuneration 2019/20

Table 38: NMHS Board remuneration

Position title	Member name	Type of remuneration	Period of membership (months)	Term of appointment / tenure	Base salary / Sitting fees ($)	Gross/actual remuneration ($)
Chair	**Hon. Jim McGinty AM**	Per annum	12	3 years	75,796	82,997.00
Deputy Chair	**David Forbes**	Per annum	12	3 years	41,751	45,717.00
Member	**Selma Alliex**	Per annum	12	3 years	41,751	45,717.00
Member	**Angela Edwards**	Per annum	12	3 years	41,751	45,717.00
Member	**Christopher Etherton-Beer**	Per annum	12	3 years	-	-
Member	**Hilary Fine**	Per annum	12	3 years	41,751	45,717.00
Member	**Carol Innes***	Per annum	<1	3 years	-	-
Member	**Grant Robinson**	Per annum	12	3 years	41,751	45,717.00
Member	**Rebecca Strom**	Per annum	12	3 years	41,751	45,717.00
Member	**Steve Toutountzis**	Per annum	12	3 years	41,751	45,717.00
					Total	**403,016.00**

***Note:** Ms Carol Innes resigned effective 4 July 2019 and therefore was ineligible to attend any board or committee meetings.

Board and committee remuneration 2019/20 (cont.)

Table 39: WNHS Community Advisory Council remuneration
(formerly known as the KEMH Community Advisory Committee)

Position title	Member name	Type of remuneration	Period of membership (months)	Term of appointment / tenure	Base salary / Sitting fees ($)	Gross/actual remuneration ($)
Chair	Jody Blake	Per hour	12	sessional	35	2,380.00
Vice Chair	Sonja Whimp	Per hour	12	sessional	35	2,310.00
Member	Alison Vaughan	Per hour	12	sessional	-	-
Member	Amanda Hocking	Per hour	12	sessional	35	840.00
Member	Ann McRae	Per hour	12	sessional	35	630.00
Member	Caitlin Kameron	Per hour	12	sessional	35	735.00
Member	Gail Yarran	Per hour	12	sessional	35	560.00
Member	Gemma Cadby	Per hour	12	sessional	35	490.00
Member	Jane Jones	Per hour	12	sessional	35	525.00
Member	Joanne Beedie	Per hour	12	sessional	35	525.00
Member	Maryam Aghamohammadi	Per hour	12	sessional	35	560.00
Member	Nicole Woods	Per hour	12	sessional	35	875.00
Member	Sirad Elmi	Per hour	12	sessional	35	315.00
Member (Carer)	Jenny Bedford	Per hour	4	sessional	35	122.50
Member	Sharon Kenny	Per Hour	3	sessional	35	70.00
Member	Alaine Haddon-Casey	Per Hour	1	sessional	35	35.00
					Total	**10,972.50**

Board and committee remuneration 2019/20 (cont.)

Table 40: SCGH Community Advisory Council remuneration

Position title	Member name	Type of remuneration	Period of membership (months)	Term of appointment / tenure	Base salary / Sitting fees ($)	Gross/actual remuneration ($)
Chair	**Carolyn Boyd**	Per hour	12	sessional	35	410.00
Deputy Chair	**Elizabeth Mills**	Per hour	12	sessional	35	630.00
Member	**Tanya Basile**	Nil	12	sessional	-	-
Member	**Anne-Marie Fanning**	Nil	12	sessional	-	-
Member	**Jay Jay Jegathesan**	Per hour	12	sessional	35	630.00
Member	**Carole Kagi**	Per hour	12	sessional	35	705.00
Member	**Howard Lance**	Per hour	12	sessional	35	705.00
Member	**Judy Russell**	Per hour	5	sessional	35	70.00
Member	**Karen Tambree**	Per hour	12	sessional	35	555.00
Member	**Cheryl Bridge**	Per hour	2	sessional	35	150.00
Member	**Sergio Cooper**	Per hour	6	sessional	35	300.00
					Total	**4155.00**

Board and committee remuneration 2019/20 (cont.)

Table 41: OPH Community Advisory Council remuneration

Position title	Member name	Type of remuneration	Period of membership (months)	Term of appointment / tenure	Base salary / Sitting fees ($)	Gross/actual remuneration ($)
Chair	**Joan Varian**	Per hour	12	sessional	35	1,473.50
Deputy Chair	**Tom Benson**	Per hour	6	sessional	35	262.50
Member	**Pam Van Omme**	Per hour	12	sessional	35	595.00
Member	**Joey McAuley**	Per hour	12	sessional	35	227.50
Member	**Beverley Port-Louis**	Per hour	12	sessional	35	280.00
Member	**Dianne Glenister**	Per hour	12	sessional	35	770.00
Member	**Sue Haydon**	Per hour	12	sessional	35	735.00
Member	**Diane Yappo**	Per hour	12	sessional	35	245.00
Member	**Merrianne Soloway**	Per hour	12	sessional	35	1,214.50
Member	**Margaret Erneste**	Per hour	12	sessional	35	420.00
Member	**Oluseywen Bakare**	Per hour	12	sessional	35	560.00
Member	**Peter Wilson**	Per hour	12	sessional	35	577.50
					Total	**7,360.50**

Board and committee remuneration 2019/20 (cont.)

Table 42: Mental Health Community Advisory Council remuneration

Position title	Member name	Type of remuneration	Period of membership (months)	Term of appointment / tenure	Base salary / Sitting fees ($)	Gross/actual remuneration ($)
Chair	**Alan Alford**	Per hour	10 years	2 years	$35	4,725.00
Deputy Chair	**Phoebe Kingston**	Per hour	3 years	2 years	$35	2,380.00
Member	**Seamus Murphy**	Per hour	4 years	2 years	$35	1,155.00
Member	**Virginia Catterall**	Per hour	1 year	2 years	$35	8,520.00
Member	**Sonja Whimp**	Per hour	1 year	2 years	$35	1,260.00
Member	**Ron Deng**	Per hour	2 years	2 years	$35	350.00
Member	**Lyn Murphy**	Per hour	1 year	2 years	$35	770.00
Member	**Nathan Issel**	Per hour	2 years	2 years	$35	350.00
Member	**Shauna Gaebler**	No Payment	4 years	2 years	$35	-
Member	**Mei Huang**	No Payment	3 years	2 years	$35	-
Member	**Mish Gerovich**	Per hour	-	2 years	$35	1,925.00
					Total	**21,435.00**

Board and committee remuneration 2019/20 (cont.)

Table 44: Board and committee attendance and eligibility 2019/20 (the number of board and board committee meetings, and the number of meetings attended by each board member during the 12 months ending 30 June 2020).

	Board		Audit and Risk		Safety and Quality		Finance		People, Culture and Engagement	
No. of meetings held	11		6		11		12		12	
	Attended	Eligible to attend	Attended	Eligible to attend	Attended	Eligible to attend	Attended	Eligible to attend	Attended	Eligible to attend
Hon. Jim McGinty AM	**10**	11								
David Forbes (Deputy Chair)	**11**	11			**11**	11	**12**	12		
Selma Alliex	**8**	11			**9**	11			**10**	12
Angela Edwards	**8**	11	**6**	6					**11**	12
Christopher Etherton-Beer	**8**	11	**5**	6	**9**	11				
Hilary Fine	**11**	11			**11**	11			**12**	12
Grant Robinson	**10**	11	**6**	6			**11**	12		
Rebecca Strom	**11**	11	**6**	6			**12**	12		
Steve Toutountzis	**11**	11	**6**	6			**12**	12		
Pip Brennan*									**11**	12

* Executive Director, Consumer Advisory Council. Specialist advisor to the NMHS Board

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