



Government of Western Australia
North Metropolitan Health Service



Care / Respect / Innovation / Teamwork / Integrity

Kaaradjiny / Ngargal-wirrn / Milka kaaditj / Danjoo Yacker / Karnadji

Annual Report

2024-2025

Acknowledgement of Country

The North Metropolitan Health Service (NMHS) acknowledges the Whadjuk people of the Noongar nation as the traditional owners and custodians of the land on which we work and pays respect to their Elders past and present.

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

Using the term Aboriginal

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

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





Statement of compliance

Hon Meredith Hammat, MLA
Minister for Health; Mental Health

In accordance with Section 63 of the *Financial Management Act 2006*, we hereby submit for your information and presentation to Parliament, the final Annual Report of the North Metropolitan Health Service for the reporting period ended 30 June 2025.

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

Robert Toms

Chief Executive
North Metropolitan
Health Service
6 October 2025

Karen Gullick

Board Chair
North Metropolitan
Health Service
6 October 2025

Contents

Foreword	5	Performance highlights:		Disclosures and Legal Compliance	164
Significant challenges	6	Delivering on our Strategic Plan	43	Occupational health, safety	
2024-2025 at a glance	8	Strategic Plan	44	and injury management	165
Our patients	8	Driving excellence	47	Health and wellbeing snapshot	166
Summary of Key Performance Indicators	10	Partnering with our communities	52	Performance reporting	167
About NMHS	14	Advancing health equity and access	60	Injury management	168
Who we are	16	Becoming the best place to work	65	Asbestos management	168
Our values	20	Building a sustainable future	73	Multicultural Policy Framework	169
Responsible Minister	20	Embracing innovation and research	77	Workforce Inclusiveness	171
Accountable authority	20	Safety and Quality	88	Disability Access and Inclusion Plan	171
Enabling legislation	20	Key Performance Indicators	91	Complying with Public Sector Standards	
Our people	21	Certification	94	and Ethical Codes	173
Our workforce	22	KPI tables	95	Industrial Relations	174
NMHS Board	24	Governance	120	Ministerial directives	175
NMHS Executive Team	26	Board remuneration	121	Recordkeeping plans	175
Strengthening our diverse, agile		Board and committee attendance	122	Freedom of Information	175
and talented workforce	28	Financials	124	Act of Grace payments	175
Diversity and Inclusion	30	Audit opinion	125	Credit cards for personal expenditure	176
Celebrating excellence	33	Financial statements	129	Pricing policy	176
Redevelopment and capital works projects	38			Advertising expenditure	177
The New Women and Babies Hospital Project	39			Acronyms	178
Joondalup Health Campus	39			Contact details	179
Capital works	41				

Foreword

We are pleased to present the North Metropolitan Health Service 2024-25 Annual Report – our first working together as Board Chair and Chief Executive.

The past financial year has continued to see achievement and growth across our organisation, at a time of notable increasing activity, complexity, and demand for the services that we provide to the community.

Over this period, one thing that has particularly stood out is the commitment of our people across the organisation to providing safe, high quality and patient-centred services. Our people embody the purpose that underpins everything that we do at the North Metropolitan Health Service, that is to provide excellent compassionate care.

We are especially proud to share a workplace with many specialised experts and leaders in their fields, as well as teams dedicated to problem solving, innovation and continuous improvement.

Our vision is to become a transformative leader, shaping the future of healthcare. Our strategic plan is the mechanism to achieve this vision and fulfil our purpose. Within that context, we have made considerable progress and achieved many breakthrough outcomes for the State.

“The past financial year has continued to see achievement and growth across our organisation, at a time of notable increasing activity, complexity, and demand for the services that we provide to the community.”

This includes the Sir Charles Gairdner Hospital (SCGH) becoming the first hospital in Western Australia (WA) to provide robotic bronchoscopy procedures, marking a major development in lung cancer diagnosis and care in the State. The hospital also became the first location in WA to introduce phage therapy to treat multi-drug-resistant infections.

As part of our commitment to staff development, the first mental health simulation lab was opened at Graylands Hospital. In an Australian first, pregnant women at the King Edward Memorial Hospital (KEMH) can now access early pre-eclampsia screening, which is helping to reduce the risk of maternal illness and premature birth.

Improving patient flow, adopting innovative models of care, adapting our capacity to changing demand, and identifying ways to deliver care to people in their homes and in the community remains a priority focus for the organisation.

Several initiatives have been particularly effective in these areas, including early and effective discharge management, patient transfer process improvements, progress on supporting patients medically cleared for discharge, improved process, and patient flow practices and the use of data to support operational decision-making.

The expansion of our Hospital in the Home initiative and virtual health services, which now account for one-third of all outpatient

appointments, continue to improve access to care and reduce the burden of travel, particularly for people with complex needs.

To ensure focused delivery of services, we launched a Clinical Services Strategy; Consumer Engagement and Clinical Excellence Strategy; and revised Digital Health Strategy and Roadmap this year. These set out how we will achieve the six objectives in our Strategic Plan and ensure our services are meeting the needs of our community, today and into the future.

We recognise that increasing our utilisation of digital health solutions is crucial to advancing patient care and health outcomes. Our new Digital Health Strategy outlines a blueprint for work that the organisation will undertake over the coming years to fully embrace technology in the delivery of healthcare.

This blueprint includes continued support for the state-wide Electronic Medical Record, infrastructure modernisation, and Human Resource Management Information Systems programs; as well as the continued delivery of several local projects, all of which deliver considerable operational benefits.

The completion of outpatient e-prescribing across all our hospitals has delivered a transformative change, as has several pilot projects aiming using artificial intelligence to support operational excellence and decision making.

Delivering the highest standard of care requires contemporary and fit-for-purpose infrastructure. Whilst there is much work to be done, considerable investment is going into upgrading, expanding, or replacing existing facilities across our organisation.



The opening of stage one of Joondalup Health Campus's public ward block is increasing capacity in the northern corridor. This is one of the fastest growing areas in the country, and this expended capacity will help to meet growing demand.

Substantial progress has been made to the Emergency Department redevelopment and expansion of the Intensive Care Unit at SCGH, and it is pleasing to have almost completed the Radiopharmaceutical Production and Development Laboratories Cyclotron Project.

These projects are in addition to the new Women and Babies Hospital Project, which the organisation is actively supporting, and includes an expansion of services at Osborne Park Hospital.

We would like to thank all our people across the North Metropolitan Health Service for your commitment to delivering the highest standards of care as well as the support provided to the community.

Looking forward, we will continue to build on the progress that has been made over the past 12 months. We have a clear and ambitious strategic plan, underpinned by a desire for continuous improvement, that we feel stands the organisation in good stead given the complexities and challenges associated with the provision of healthcare in the 21st century.

Karen Gullick

Board Chair
North Metropolitan
Health Service

Robert Toms

Chief Executive
North Metropolitan
Health Service

Significant challenges

NMHS has faced similar challenges to other Health Service Providers (HSPs) this year with respect to increased demand on services, rising costs, and complexity of the healthcare needs of our communities.

Ageing infrastructure

Our hospitals and associated assets are integral to how we provide healthcare, and ageing infrastructure has finite capacity. As we pursue the opportunities associated with redesigning models of care it is important to assess how we use existing assets and the true long-term costs of retrofitting, rather than replacing. Infrastructure and asset risks present significant challenges and substantial investment is required to maintain and upgrade existing NMHS infrastructure and assets, to ensure fit-for-purpose and safe facilities delivery care now and meet the increased demand of the NMHS population across the next 10 years.

Demand

Increased demand and pressure on system access is a symptom of more complex challenges within the healthcare system. There is increasing demand on Emergency Departments (ED), with SCGH managing an additional 885 people presenting to ED for care compared to last year. Many patients have more complex clinical conditions that take longer to treat, and an ageing population presenting with frailty, obesity, comorbidities and poor mental health contribute to this.

Population growth

The population of WA has increased more than any other state this year, and the fastest growth has been in the Joondalup-Wanneroo corridor, which is part of the NMHS catchment. It is projected that our state's population will grow by more than 20 per cent by 2035, creating significant pressure on our hospitals and state-wide dental health, mental health and public health services. We recognise longer term planning of innovative and community-based service models and infrastructure is required to mitigate further pressure on existing services.

Ageing population

In 2023, 40 per cent of all in-patients at NMHS were aged 65 years or older. We are finding older patients have more complex needs on discharge, it has been difficult to access appropriate care in the community and aged care sectors to be able to discharge patients when they are medically stable. This has impacted the availability of beds in acute hospitals. We are implementing new models of care, such as Hospital in the Home and virtual care consultations to address this, but the positive impact of these changes will take time.

Inflation

Inflation within the healthcare industry was the third highest of any industry over the last 12 months. ABS data shows a weighted average CPI increase of 4.1 per cent from June quarter 2024 to June quarter 2025. In addition, construction market escalations in WA continue to present significant challenges for capital projects. These escalations are driven by a combination of factors, including shortages and cost increases of labour and materials, supply chain disruptions

and increased demand across the construction industry. This volatility presents challenges across the sector, particularly in forecasting and predicting market responses to tenders.

Equity in access to care

Some people in our community are experiencing complex social and economic challenges that can create barriers to accessing care. In particular, there remains an enduring disparity in access and health outcomes for Aboriginal people, resulting from the impact of multi-generational trauma. Consumers want more options to access care in a timely manner, including outside of hospital and closer to home. The evolving needs of our communities are being addressed through long-term planning, but progress can be slow. Investment and greater flexibility and agility in embracing technology will have a tangible impact.

Staff safety

NMHS is committed to keeping our staff safe while they are at work, and managing patients who present with acute, severe behavioural disturbance can put our staff at risk. We have taken steps to address this systemically with the implementation of the Behavioural Evaluation and Review Team (see page 67 for more details). Unfortunately, we have seen an increase in Code Black incidents this year, up 13 per cent from the previous year. We welcome the steps taken by the Department of Health to implement a consistent approach to address this matter and review what can be done, including policy requirements which will outline risk management training and incident management.



Healthcare workforce

Workforce shortages continue to impact health services globally and an ageing workforce will require continued focus on attracting and retaining colleagues to work at NMHS. Whilst the size of our workforce has increased this year, we have implemented talent and attraction strategies to target specific areas of current and future shortage. Activities to enable growth in the supply of workforce will need to continue over the next decade and beyond to support rising service demand and demographic changes in our current workforce.

2024–2025 at a glance

Our hospitals



187,554

**Presentations
to Emergency
Departments**

77,697 ▲

Sir Charles Gairdner

13,791 ▲

King Edward
Memorial Hospital

96,066 ▼

Joondalup



52,698

Operations

17,095 ▲

Sir Charles Gairdner

11,694 ▲

Osborne Park

6,830 ▲

King Edward
Memorial Hospital

17,079

Joondalup



9,394

Births

1,596 ▲

Osborne Park

5,475 ▼

King Edward
Memorial Hospital

2,323 ▼

Joondalup

Note: Due to variability between hospital practices, figures have been derived using the most closely aligned methodology available.

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

Our patients



29,471 ▲

Patients who received
cancer treatment



40.0% ▲

Total percentage of
in-patients aged **65+ years**



22,017 ▲

Patients cared for with
mental health illness



135,408 ▲

Elective services
accessed



100 =

Transplants
performed



845,486 ▲
Outpatient appointments
provided



231,484 ▲
Telehealth
appointments



13,565 ▲
WA Tuberculosis Control
and Program health
professional consultations



1,856 ▲
Humanitarian Entrant
Health Service
consultations



9,393 ▲
Number of Indigenous
people who accessed
inpatient services



134,868* ▼
Women screened for
breast cancer

* Decrease is due to the 2-year
screening cycle

Top 5 countries of birth (excluding Australia) for people who accessed NMHS services

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

Most common languages other than English spoken by patients

- | | |
|---------------|---------------|
| 1. Italian | 6. Polish |
| 2. Vietnamese | 7. Afrikaans |
| 3. Arabic | 8. Macedonian |
| 4. Chinese | 9. Spanish |
| 5. Persian | 10. Croatian |

Hospital in the Home 2024-2025



15,237
bed days



1,386
Total number
of unique patients

Top 5 Hospital in the Home services

1. Psychiatry
2. Psychogeriatrics
3. Gerontology
4. General/Physical Medicine
5. Emergency Medicine

Summary of Key Performance Indicators

Key Performance Indicators (KPIs) help us to assess and monitor the extent to which government outcomes are being achieved.

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

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

Table 1 provides a summary of our KPIs and variation from the 2024-2025 targets.

Table 1 Actual results versus KPI targets

OUTCOME 1: Public hospital-based services that enable effective treatment and restorative health care for Western Australians				
Effectiveness KPI	2024 calendar year			
	Target	Actual	Variation	Target met
Unplanned hospital readmissions for patients within 28 days for selected surgical procedures				
Knee replacement	≤ 21.0	19.3	1.7	✓
Hip replacement	≤ 19.4	16.0	3.4	✓
Tonsillectomy and adenoidectomy	≤ 84.4	84.9	0.5	✗
Hysterectomy	≤ 45.8	47.2	1.4	✗
Prostatectomy	≤ 40.0	46.1	6.1	✗
Cataract surgery	≤ 2.3	2.9	0.6	✗
Appendicectomy	≤ 29.7	19.8	9.9	✓
<i>Note: Expressed as a rate per 1,000 separations</i>				
Healthcare-associated <i>Staphylococcus aureus</i> bloodstream infections (HA-SABSI) per 10,000 occupied bed-days	≤ 1.0	0.8	0.2	✓

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

Effectiveness KPI	2024 calendar year			
	Target	Actual	Variation	Target met
Survival rates for sentinel conditions				
Stroke				
0 to 49 years	≥ 95.4%	95.3%	0.1%	✗
50 to 59 years	≥ 94.8%	92.1%	2.7%	✗
60 to 69 years	≥ 94.5%	90.2%	4.3%	✗
70 to 79 years	≥ 92.6%	86.9%	5.7%	✗
80+ years	≥ 87.6%	83.1%	4.5%	✗
Acute myocardial infarction				
0 to 49 years	≥ 98.9%	98.7%	0.2%	✗
50 to 59 years	≥ 98.8%	99.3%	0.5%	✓
60 to 69 years	≥ 98.2%	99.1%	0.9%	✓
70 to 79 years	≥ 97.0%	93.8%	3.2%	✗
80+ years	≥ 93.1%	90.9%	2.2%	✗
Fractured neck of femur				
70 to 79 years	≥ 98.8%	98.3%	0.5%	✗
80+ years	≥ 97.3%	96.5%	0.8%	✗
Percentage of admitted patients who discharged against medical advice				
Aboriginal patients	≤ 2.78%	3.98%	1.20%	✗
Non-Aboriginal patients	≤ 0.99%	0.82%	0.17%	✓
Percentage of liveborn term infants with an Apgar score of less than 7 at five minutes post delivery				
	≤ 1.9%	1.8%	0.1%	✓
Readmissions to acute specialised mental health inpatient services within 28 days of discharge				
	≤ 12%	9%	3%	✓
Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services				
	≥ 75%	89%	14%	✓

OUTCOME 1: Public hospital-based services that enable effective treatment and restorative health care for Western Australians				
	2024-25 financial year			
	Target	Actual	Variation	Target met
Percentage of elective waitlist patients waiting over boundary for reportable procedures:				
Category 1 over 30 days	0%	17%	17%	✗
Category 2 over 90 days	0%	28%	28%	✗
Category 3 over 365 days	0%	7%	7%	✗
Efficiency KPI	2024-25 financial year			
	Target	Actual	Variation	Target met
Average admitted cost per weighted activity unit	≤ \$7,899	\$8,348	\$449	✗
Average emergency department cost per weighted activity unit	≤ \$7,777	\$7,659	\$118	✓
Average non-admitted cost per weighted activity unit	≤ \$7,903	\$9,067	\$1,164	✗
Average cost per bed-day in specialised mental health inpatient services	≤ \$1,644	\$2,153	\$509	✗
Average cost per treatment day of non-admitted care provided by mental health services	≤ \$528	\$533	\$5	✗

OUTCOME 2: Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives				
Effectiveness KPI	2023-24 calendar years			
	Target	Actual	Variation	Target met
Rate of women aged 50–69 years who participate in breast screening	≥ 70%	49%	21%	✗
	2024-25 financial year			
	Target	Actual	Variation	Target met
Percentage of				
adults	< 6.05%	6.21%	0.16%	✗
children	< 2.11%	1.42%	0.69%	✓
who have a tooth retreated within 6 months of receiving initial restorative dental treatment				
Percentage of eligible school children who are enrolled in the School Dental Service program	≥ 78%	67%	11%	✗
Percentage of eligible people who accessed Dental Health Services	≥ 15%	13%	2%	✗
Efficiency KPI	2024-25 financial year			
	Target	Actual	Variation	Target met
Average cost per person of delivering population health programs by population health units	≤ \$53	\$65	\$12	✗
Average cost per breast screening	≤ \$160	\$183	\$23	✗
Average cost per patient visit of WA Health provided dental health programs for				
school children	≤ \$261	\$322	\$61	✗
socio-economically disadvantaged adults	≤ \$343	\$406	\$63	✗

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

About NMHS



North Metropolitan Health Service

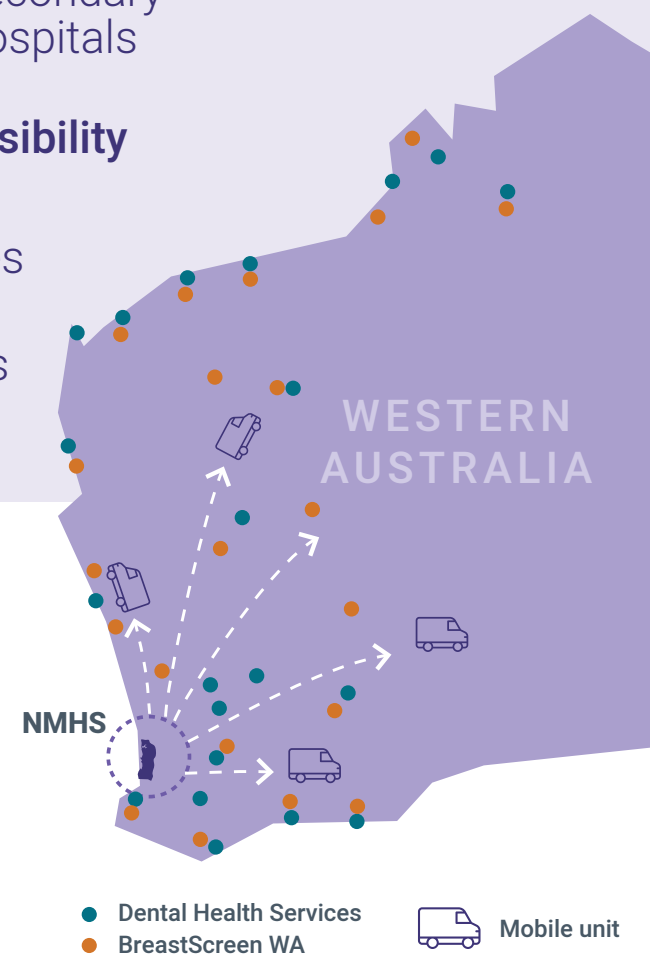
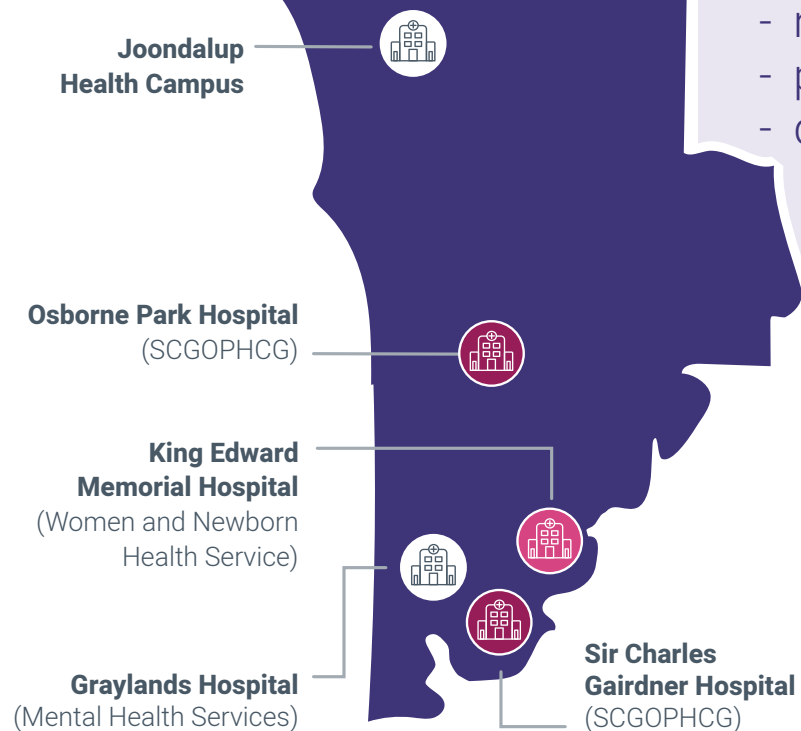
993 square kilometres **10.1** Local Government Areas **811,703** total population

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

3 tertiary hospitals | **2** secondary hospitals

plus **state-wide responsibility** for the delivery of

- mental health services
- public health
- dental health services



Who we are

Our hospitals

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

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

We also offer Hospital in the Home and virtual consultation services to enable access to care for everyone in our communities.

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

Public health services at Joondalup Health Campus are delivered by Ramsay Health Care through a public private partnership.



Learn more about
our hospitals

Service delivery beyond our catchment

NMHS has strong links with the Western Australian Country Health Service (WACHS) Goldfields and Midwest regions to ensure that rural and remote patients receive high-quality specialised care. This is supported by remote consultations, education, research and coordinated clinical pathways at SCGH and OPH.

KEMH and Graylands Hospitals provide tertiary specialist and state-wide services to regional patients across WA.

Telehealth and virtual care support is offered to clinicians and patients in regional and remote areas, as well as education and training support.



Our state-wide services

We deliver the WA Dental Health Service, Mental Health Service and Public Health services to people living across WA, providing essential screening and preventive care, treatment services and emergency care that helps to ease the burden on local hospitals.

These vital services provide access to the same high standard of healthcare for all Western Australians, and include:

- 197 dental clinics and 26 mobile dental clinics
- 243 inpatient mental health beds, 48 virtual mental health beds and 5 community mental health clinics.
- Mental health teams who support the Start Court and Links Magistrates' Court programs for adults and children at the Magistrates' Court
- 17 permanent BreastScreen WA clinics and mobile clinics that visit 10+ rural locations every year and 80+ locations every two years.
- Local and remote specialist teams delivering public health services.



Sir Charles Gairdner Osborne Park Health Care Group (SCGOPHCG)

Cancer Network WA

Centre for Clinical Interventions

Medication Dispensing Service

Neurological Intervention and Imaging Service of WA

State Sarcoma Service

Voluntary Assisted Dying

WA Liver and Kidney Transplant Service

WA Poisons Information Centre

WA Youth Cancer Service



Women and Newborn Health Service (WNHS)

Abortion and Reproductive Healthcare Service

Breastfeeding Centre WA

BreastScreen WA

Community Midwifery Program

Genetic Health WA

Maternal Fetal Medicine Service

Menopause Service

Perinatal Loss Service

Sexual Assault Resource Centre

Statewide Perinatal and Infant Mental Health Program

WA Cervical Cancer Prevention Program

WA Gynaecologic Cancer Service

WA Register of Developmental Anomalies

Women and Newborn Drug and Alcohol Service

Women's Health Strategy and Programs



Dental Health Services (DHS)

General Dental Service

School Dental Service



Mental Health Services (MHS)

Child and Adolescent Forensic Service

Neurosciences Unit

Specialist Mental Health & Neurodevelopmental Youth Detention Service

State Head Injury Unit

State Forensics Mental Health Service

Start Court and Links Magistrates' Court programs

WA Eating Disorders Outreach Consultation Service



Public Health

Boorloo Public Health Unit

Clinical Rehabilitation Service

DonateLife

Humanitarian Entrance Health Service

Metropolitan Communicable Disease Control

WA Tuberculosis Control Program



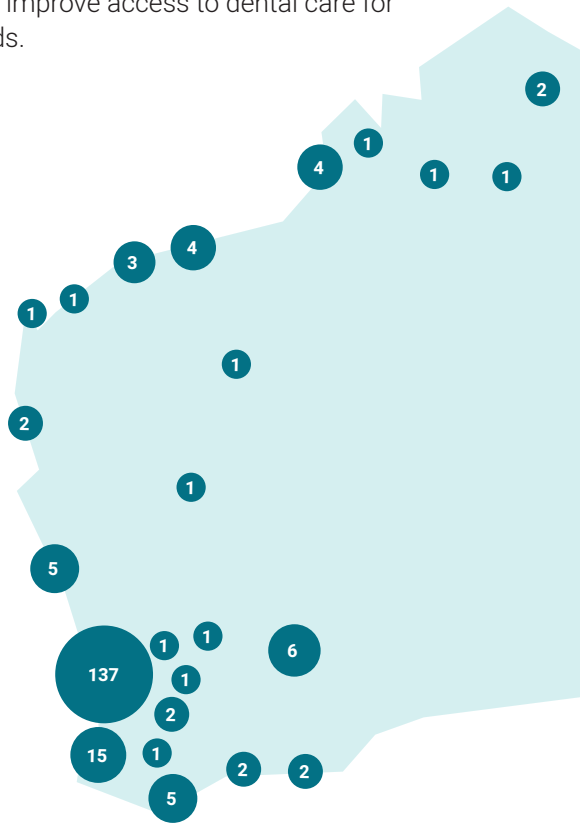
Dental Health Services

Dental Health Services provides general and emergency dental care to eligible infants and adults, and students aged 5-16 years, throughout WA.

The service operates 197 dental clinics and 26 mobile dental clinics across the state. A new Special Needs Dental Clinic located in Perth opened to patients in August 2025, providing a contemporary facility to improve access to dental care for patients with special needs.



View more information about our locations



BreastScreen WA

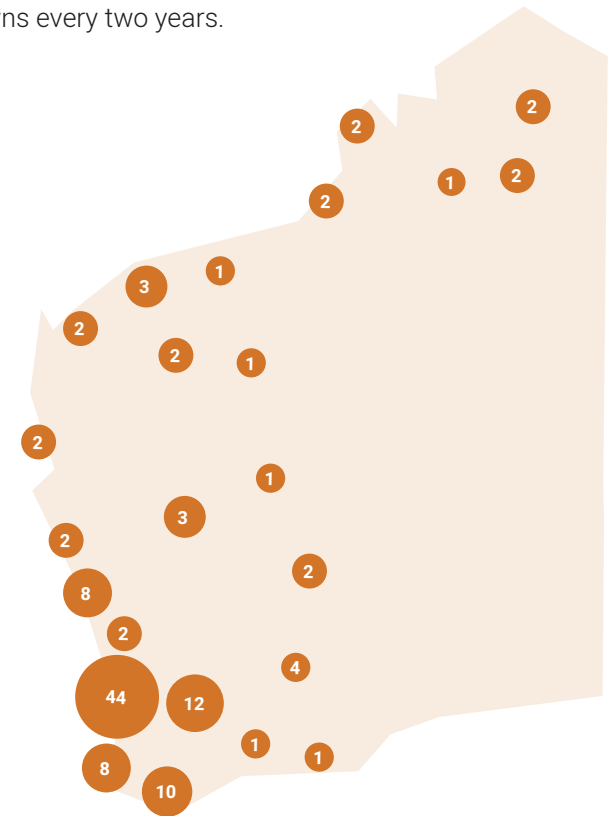
BreastScreen WA provides breast screening services at more than 100 locations in WA.

There are 12 permanent clinics located in the Perth metropolitan area, as well as Mandurah, Bunbury and Albany.

Additionally, the BreastScreen WA mobile service visits around 100 rural towns every two years.



View more information about our locations



DonateLife WA

DonateLife Western Australia (DLWA) coordinates all deceased organ and tissue donation activities across the state. The DLWA team of health professionals provide a range of donation support services and work with hospital-based donation and transplantation medical and nursing specialists, police, coronial services and tissue banks to facilitate donation and transplantation activities and encourage best practice to increase donation rates.

Participating donation hospitals in WA include:

- Armadale Health Service
- Fiona Stanley Hospital
- Joondalup Health Campus
- Rockingham General Hospital
- Royal Perth Hospital
- Sir Charles Gairdner Hospital
- Perth Children's Hospital
- St John of God Midland, Murdoch and Subiaco

In 2024, there were 46 organ donors in WA, an increase of 6.5 per cent compared to 2023. There were 232 eye donors and 10 tissue donors, a combined increase of 47 per cent from 2023.

Tuberculosis Control Program

The WA Tuberculosis Control Program provides a state-wide outpatient public health service for all cases of active and latent tuberculosis infection. The team works in partnership with WACHS under a Memorandum of Agreement to deliver care to patients outside the metropolitan area.

In 2024, the program provided clinical and case management to 233 cases of active TB disease and provided treatment and case management to 765 cases of latent TB infection, up from 161 cases managed through the service in 2023.

Humanitarian Entrant Health Service

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

In 2024, HEHS provided care to 727 people from 29 countries of origin. Less than 10 countries accounted for the majority of arrivals.

Boorloo Public Health Unit

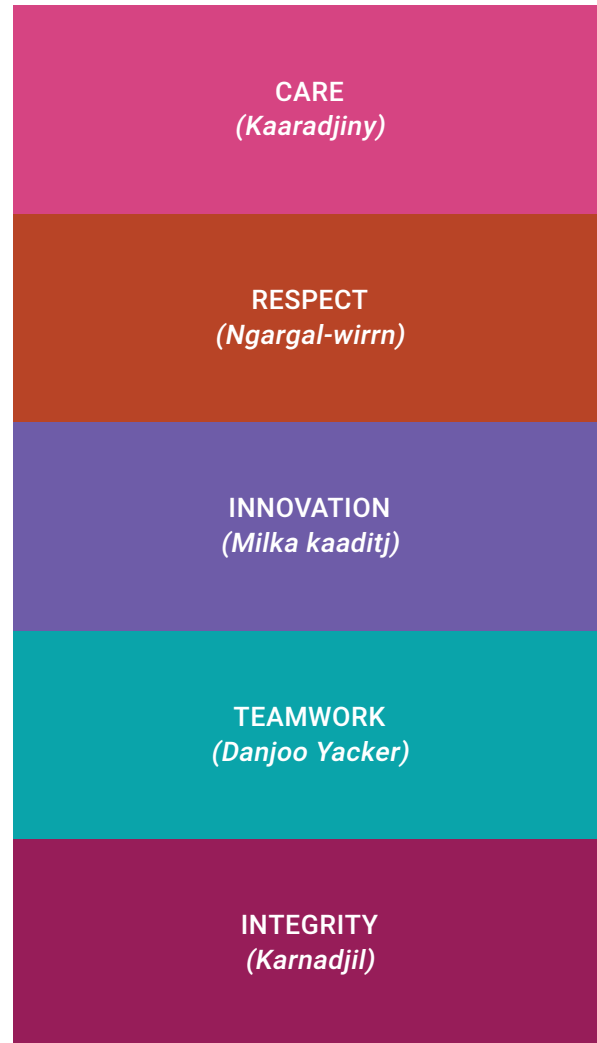
Boorloo (Perth) Public Health Unit is responsible for the management of notifiable infectious diseases, to protect the community and prevent disease outbreaks in metropolitan Perth. Boorloo PHU works collaboratively with immunisation service providers and other stakeholders to deliver WA immunisation programs and assists in preparing immunisation catch-up plans. In 2024, Boorloo PHU completed 1,511 immunisation catch-up plans.

State Head Injury Unit

The State Head Injury Unit (SHIU) is the state-wide specialist community rehabilitation service for people aged 16-65 years who have sustained an acquired brain injury (ABI). The unit works in partnership with ABI rehabilitation teams at Perth Children's Hospital (PCH) and Fiona Stanley Hospital (FSH), and Brightwater Neurological Services to improve transition pathways from paediatric to adult services in the community, where ongoing specialist medical support is needed.

The SHIU has provided 17,771 occasions of service to WA clients with ABI in 2024-25, a slight increase of 175 from 2023-2024. Hospital admissions declined from 339 in 2023-2024 to 230 this year, credited to increased staff capacity to manage cases in the community.

Our values



Responsible Minister

NMHS is responsible to the Hon. Meredith Hammat, Minister for Health and Mental Health, who has overall responsibility for the WA Department of Health. Our major projects team are also responsible to the Hon. John Carey, Minister for Health Infrastructure.

Following changes to the Health Ministry in March 2025, NMHS also has responsibility to the Hon. Sabine Winton as Minister for Preventative Health, the Hon. Simone McGurk as Minister for Aged Care and Seniors, and the Hon. Stephen Dawson as Minister for Medical Research.

Accountable authority

NMHS is a State Government board-governed statutory authority established under the *Health Services Act 2016*. The Board is directly accountable to the public and the Minister for Health, working with the Director-General of the Department of Health. Board Chair, Adjunct Associate Professor, Karen Gullick, is the reporting officer for NMHS in 2024-25.

Enabling legislation

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

Shared responsibilities

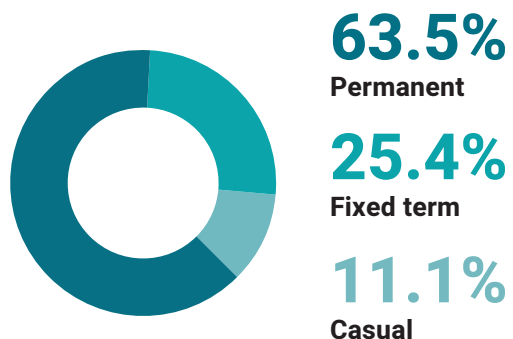
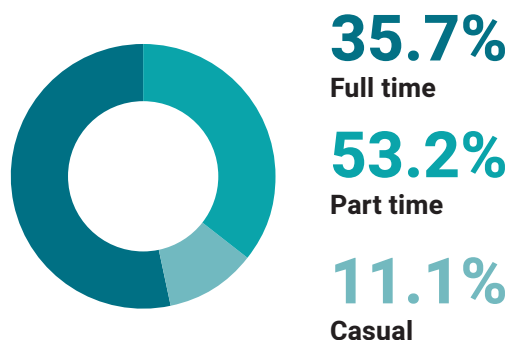
NMHS works with the WA Department of Health, the WA Mental Health Commission, Infrastructure WA, other HSPs, Department of Justice and other government and non-government agencies to deliver health services and programs to the people of Western Australia.

Our people



Our workforce

We are **14,743** people dedicated to delivering, and supporting the delivery of sustainable, quality health services to our patients and promoting and improving health outcomes in our community.



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



41.3%
Nursing & midwifery



10%
Hotel & site services



15.5%
Medical services (Doctors)

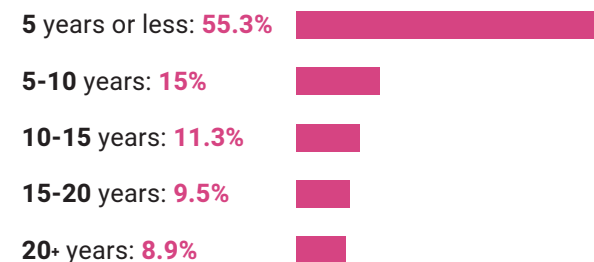


17.1%
Medical support services
(Allied health and support staff)



16%
Administration & clerical

We have **worked at NMHS** for...



We range in **age**:



16.9% Gen Z 1996-2015



41.6% Gen Y 1981-1996



29.5% Gen X 1965-1980



12% Baby boomers 1946-1964

Top 10 languages spoken at home other than English

Malayalam

Tagalog (Filipino)

Mandarin

Hindi

Cantonese

Nepali

Vietnamese

Arabic

Afrikaans

Shona (Bantu)

Top 5 countries of birth other than Australia



20.5%

Were **born overseas**



0.86%

Are **Aboriginal or Torres Strait Islanders**

*Information is self-reported and may be an under-representation of our full workforce.

NMHS Board

As at 30 June 2025



**Adjunct Associate Professor
Karen Gullick**
Board Chair



Rebecca Strom
Deputy Board Chair
Member, Board Audit and
Risk Committee
Member Board Finance
Committee



Jahna Cedar OAM
Chair, Board People,
Engagement and Culture
Committee
Member, Board Safety,
Quality and Consumer
Engagement Committee



**Associate Professor
Mathew Coleman**
Member, Board Safety,
Quality and Consumer
Engagement Committee
Member, Board People,
Engagement and Culture
Committee



Anthony (Tony) Evans
Chair, Board Audit and Risk
Committee
Member, Board Finance
Committee



Renae Farmer
Chair, Board Finance
Committee
Member, Board People,
Engagement and Culture
Committee



Angela Komninos
Member, Audit and Risk
Committee
Member, Board Safety,
Quality and Consumer
Engagement Committee



**Associate Professor
Lewis MacKinnon**
Chair Board Safety, Quality
and Consumer Engagement
Committee Chair
Member, Board Finance
Committee



Dr Ian Rogers
Member, People,
Engagement and Culture
Committee
Member, Board Safety,
Quality and Consumer
Engagement Committee

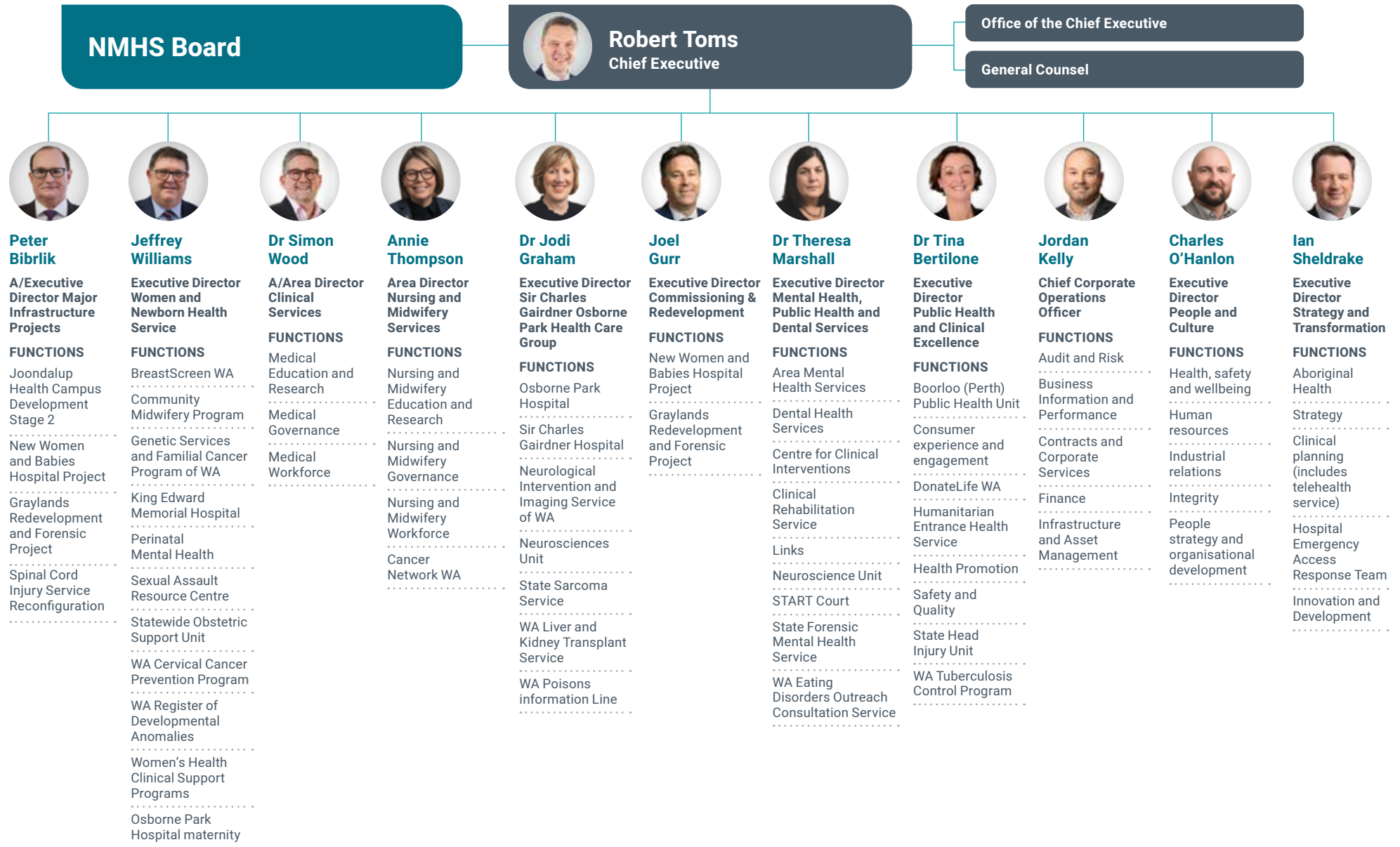


View the
biographies
of our Board
of Directors



ABOVE, L-R: Tony Evans, Mathew Coleman, Adj Assoc Prof Karen Gullick, Renae Farmer, Angela Komninos, Dr Ian Rogers and Rebecca Strom.
Absent: Jahna Cedar, Lewis MacKinnon.

NMHS Executive Team





ABOVE, L-R: Charles O'Hanlon, Joel Gurr, Ian Sheldrake, Dr Jodi Graham, Jeffrey Williams, Robert Toms, Jordan Kelly, Dr Tina Bertilone, Peter Bibrlík, Anne Thompson, Dr Simon Wood

Strengthening our diverse, agile and talented workforce

Consumers rely on the skills and expertise of our staff every hour of every day.

We continue to plan for, build and maintain a diverse and agile workforce that has the capability and capacity to meet the needs of our community and to deliver NMHS' strategic priorities. In 2024-25, new approaches to recruitment, culture and engagement, and learning and development opportunities have driven strong progress.

We are dedicated to employing and retaining a workforce as diverse as the community we support. This is embedded in our core values and is an essential pillar in our strategic goal of becoming the best place to work. Over the past year, particular focus has been on Aboriginal employment, embedding our Multicultural Plan, job security reviews and the implementation of permanency for senior practitioners.

The success of many of our teams and individuals at local, state and national awards demonstrates the exceptional talent within our services. We are proud of progress in building a culture that promotes innovation, development and accountability.

Aboriginal Employment Action Plan

In order to support our commitment to provide culturally respectful services, we are strengthening our Aboriginal workforce. An Aboriginal Employment Unit was established in July 2024 and an Aboriginal Employment Action Plan was endorsed for implementation in August 2024.

The Aboriginal Employment Action Plan addresses four key areas:

Domain	Key priorities
Attraction	- Explore and establish talent pipelines and partnerships including career fairs in partnership with TAG. - Promote career opportunities and progression pathways available to Aboriginal people.
Recruitment	- Identify and create Aboriginal specific roles. - Adapt and implement more culturally safe and appealing recruitment and selection processes.
Retention & Development	- Welcome and wrap-around services for new Aboriginal staff including mentoring. - Development and networking opportunities for Aboriginal staff. - Prioritising Aboriginal staff for development opportunities and leadership programs.
Education & Training for Cultural Security	Education and training to facilitate a culturally safe, inclusive and respectful workplace.



Key achievements in 2024-25 included:

- Updating recruitment training to include Aboriginal culturally appropriate practices and recognition of unconscious bias.
- Training Aboriginal staff in recruitment and selection to create a pool of qualified people to participate in selection processes when there are Aboriginal candidates.
- New Aboriginal cultural reflective sessions to upskill coordinators of Aboriginal services to mentor their teams.
- Upskilling staff to co-facilitate Aboriginal patient-centred care training.
- Introducing yarning circles and continuing cultural awareness training to foster cultural understanding, engagement and inclusion in the workplace.
- Developing an annual Aboriginal Employee Forum aimed at providing opportunities for Aboriginal staff to network and develop personal and professional skills. The first forum was held in July 2025. Participants said the forum offered the opportunity to bond and connect with other NMHS Aboriginal staff, and provided a sense of identity, community, belonging and connection. All participants said the forum could help retain Aboriginal staff for longer.

Diversity and Inclusion

We strive to create an inclusive, respectful and supportive workplace, acknowledging the different beliefs, culture, views and circumstances of others. As our organisation matures, our focus is on moving from unconscious bias to conscious inclusion and preventing racism and discrimination.

Some of our achievements over the past year included:

- Establishing the Aboriginal Employment Action Plan and dedicated Aboriginal Employment Unit
- Developing and launching the Multicultural Plan 2025-2027
- Developing Disability Inclusive Recruitment Practices Guideline
- NMHS Pride Network has grown to more than 400 members
- Co-designing a Beyond Bias – Embracing Cultural Diversity short course to celebrate World Day for Cultural Diversity for Dialogue and Development

Learn more about our Multicultural Plan on **p170**

Disability Access and Inclusion Plan

In 2024-25 we developed a Disability Inclusive Recruitment Practices Guide for managers to assist them to plan, attract, assess and appoint people with disability to work at NMHS.

Training and resources are provided to build a values-aligned culture and educate staff on how to work with people with disability. Managers can implement strategies under sections 66S(c) and 66R (Impairment) of the *Equal Opportunity Act 1984* to target recruitment opportunities to increase representation and progression of people with disability.

The Hidden Disabilities Sunflower initiative is being pilot tested at the OPH Stroke Unit and with two staff groups within the SCGOPHCG ED. Ninety staff have undergone training so far and now have a better understanding of invisible disabilities and what to do if they see a consumer wearing a sunflower symbol.

Our NMHS Disability Access and Inclusion Plan (DAIP) 2022-2027 further commits to ensuring that people with disability have equitable opportunity in recruitment processes and career progression.

Learn more about our DAIP on **p172**

Celebrating days of significance

We celebrate days of significance as opportunities to learn, share knowledge, and connect with our colleagues, patients and their families. In addition to days of cultural significance that were celebrated, such as Christmas, Easter, Chinese New Year, Diwali and Ramadan, the days of significance we recognised in 2024-25 included:

- NAIDOC Week (July)
- RUOK? Day (September)
- International Day of People with Disability (December)
- National Apology Day (February)
- International Women's Day (March)
- Harmony Week (March)
- National Close the Gap Day (March)
- Neurodiversity Celebration Week (March)
- International Day Against LGBTQIA+ Discrimination (IDAHOBIT) (May)
- International Day of the Midwife (May)
- International Nurses Day (May)
- Sorry Day (May)
- National Reconciliation Week (June)
- Pride Month (June)





Connecting with culture

NAIDOC Week 2024 ran from 7-14 July and offered an opportunity to honour the history, culture and achievements of Aboriginal and Torres Strait Islander peoples.

The theme “Keep the fire burning... Blak, loud and proud” honoured the enduring strength and vitality of Aboriginal and Torres Strait Islander peoples. Activities held at our sites included flag raising and smoking ceremonies, traditional bush tucker food, damper cook-off, didgeridoo and dance performances and a photo competition.

Throughout National Reconciliation Week, which ran from 27 May to 3 June 2025, various activities were organised across our sites to highlight the ongoing connection between past, present and future; and how Australians can step forward together.

Reflecting the theme ‘Bridging Now to Next’, our annual North Danjoo Yacker panel featured Professors Fiona Stanley, Shawana Andrews and Sandra Eades, who jointly authored the book “Health: Spirit, Country and Culture”. Discussion focused on how traditional and Western systems of health care can work together to support preventative and holistic care, particularly in birthing and end of life care.

Screenings of the documentary “Genocide in the Wildflower State” were also held across NMHS sites to mark National Sorry Day and National Reconciliation Week. The powerful documentary centres on truth-telling of the trauma and impact of the policies and practices on the physical and mental wellbeing of Aboriginal people.

LGBTQIA+

The NMHS Pride Network comprises approximately 400 employees who identify as LGBTQIA+ and allies.

The group meet monthly to promote and advance inclusivity, raise the profile of LGBTQIA+ needs, and promote our commitment to ensuring all people have access to safe health services and an inclusive workplace.

We participated in Pride FEST 2024 with a stall at Pride WA Fair Day and 75 employees marching in the Pride Parade, and celebrated IDAHOBIT 2025 with activities across all sites.



Celebrating excellence

Across NMHS, many of our people have stood out among their peers for excellence in leadership, expertise and patient care. We are extremely proud of the achievements of all teams and individuals.



2025 WA Nursing and Midwifery Excellence Awards

Two outstanding employees were named winners at the 2025 WA Nursing and Midwifery Excellence Awards (WANMEA).

SCGH neurosurgery and neuro-oncology nurse **Loreta Murphy** was presented the **Emerging Leader** award for her work with some of the most vulnerable patients at SCGH. Loreta spends time educating, counselling and supporting our patients and their families through the highs and lows of their journey.

SCGH Research Officer **Dr Rosemary Saunders** won the **Excellence in Research** award for her ongoing commitment to research and successfully establishing a strong research program with a focus on improving the safety and quality of older adult care in hospital settings.

WANMEA celebrate the dedication, professionalism and vital role of our nurses and midwives in delivering compassionate, safe and high-quality care to Western Australians. A further six finalists were recognised from our services:

Excellence in Leadership – Emerging

Melinda Olive, WNHS
Kathryn Boon, SCGOPHCG

Excellence in Midwifery

Jane-Anne Gardner, WNHS

Graduate of the Year

Eloise Pascoe, WNHS
Solomon Harrison, SCGOPHCG

Excellence in Research

Dr Ravani Duggan, NMHS and
Curtin University

WA Excellence in Allied Health Awards

Two winners were named from NMHS at the inaugural WA Excellence in Allied Health Awards in October 2024.

Kate Baumwol, Senior Speech Pathologist at SCGOPHCG, was named Allied Health Professional of the Year. The Centre for Clinical Interventions Team was named Allied Health Team of the Year.



Our finalists were:

Allied Health Assistant:
Jessica Warry – OPH

Allied Health Leader:
Miffy Durham – State Head Injury Unit

Allied Health Professional:
Kate Baumwol – SCGOPHCG
Valda Duffield – WNHS

Allied Health Researcher:
Erin Godecke – SCGOPHCG

Allied Health Team:
Centre for Clinical Interventions Team
– MHPHDS

Early Career Allied Health:
Leia Robinson – WNHS



Five doctors recognised in Excellence in Medical Teaching Awards

The annual SCGH and OPH Excellence in Medical Teaching Awards recognised five exemplary leaders across NMHS at a ceremony held in February 2025.

The EF Haywood Award for Best Clinical Teacher:
Dr Bridget Hogan and **Dr Holger Holldack**

The Clinical Association Award for Excellence for a Junior Doctor:
Dr Elizabeth Crostella and **Dr James Lawson**.

The **Schneider Prize** awarded to interns for demonstrating the greatest care and compassion in the practice of medicine:

Dr Aleksandra Khan from SCGH.

Dr Jenny Zhang was highly commended.



Long service awards

NMHS is extremely proud to have an incredible number of staff members who have given decades of service to our hospitals and health services. Each year we celebrate those who have worked with us for 10, 20, 30, 40 and 50 years.

In October 2024, we recognised 264 staff who had been with us for more than 20 years, and four who have been with us for 50 years.

A special mention to our 50-year recipients for their outstanding commitment:

Donna Stacey, MHPHDS

Janice Kinshela, MHPHDS

Marie Miller, MHPHDS

Eva Tomazos, SCGOPHCG

An additional 284 staff members were recognised for their 10-year service. We commend and thank each of our service award recipients for their continued commitment.

NMHS wins four Australian Institute of Public Administration Awards

NMHS teams were named winners of four categories at the Australian Institute of Public Administration Awards held in December 2024.

The awards recognise individual and organisational excellence in the public sector and acknowledge outstanding performance by both teams and individuals at all levels.



Best practice in collaboration across Government agencies

Gold Award Winner: WNHS Abortion Legislation Implementation team, for its role in the successful development and implementation of the Abortion Legislation Reform Act 2023.

Silver Award Winner:

SCGOPHCG Social Work Department, for its partnership with Legal Aid WA and other health services to deliver legal services to vulnerable patients within public hospital premises (Health Justice Partnership).

Best practice in Health and Wellbeing

Gold Winner:

North Metropolitan Health Service Junior Doctor Manifesto, which demonstrated how small investments in workplace culture and safety led to substantial improvements in cultural, economic, and service delivery outcomes for health care organisations.

Silver Winner:

Public Health Service Health Promotion Team, Smoke Free Project, for its role in helping the City of Vincent to become the first WA Local Government to implement smoke and vape-free environments within its Town Centres.

WA Health Excellence Awards

Three of our teams were recognised at the WA Health Excellence Awards in November 2024.

The **Nitrous Oxide Infrastructure Decommissioning** team received the **Excellence in Sustainability** award for their achievements in reducing the use of nitrous oxide at SCGH. A multidisciplinary team, comprising the Anaesthetics Department and Facilities Management, identified a process to test and decommission piped nitrous oxide to theatre, delivering sustainable healthcare without impacting clinical practice. The project led to a reduction in greenhouse gas emissions equivalent to 288 tonnes of carbon dioxide per year.

Our **24/7 WA Statewide Telestroke Service** received the **Excellence in Rural and Remote Healthcare** award for becoming a 24/7 oncall service to support clinicians caring for patients with acute stroke symptoms. WA-based stroke consultants assist emergency clinicians in the diagnosis, assessment and disposition of acute

stroke and Transient Ischaemic Attack patients across the State. The increased service means patients in rural and remote settings can receive timely and appropriate stroke care comparable to their metropolitan counterparts. The service includes NMHS, East Metropolitan Health Service (EMHS) and Department of Health.

The **Staff with Disability and Allies' Network** (SDAN) was awarded the **Excellence in Workplace Wellbeing and Culture** for its efforts to improve equity and increase engagement, inclusivity and diversity in the workplace. SDAN was established in 2022 to enable leadership of people with disability employed in WA Health. SDAN is run across the WA health system and includes involvement by NMHS.

A further six NMHS teams were finalists in the awards, demonstrating our collective commitment to provide outstanding health care to the WA community.

Our finalists were:

Excellence in Preventive Health: Smoke-Free Organisation Project, WNHS

Excellence in Person-Centred Care: WA Voluntary Assisted Dying, Statewide Pharmacy Service, SCGOPHCG

Excellence in Safety and Quality: Medical Oncology Symptom and Urgent Review Clinic Project, SCGOPHCG

Excellence in Workplace Wellbeing and Culture: Clinical Services Leadership Team

Excellence in Primary Health Care Integration: Introduction of non-invasive fetal Rhesus D genotyping for pregnant women in Western Australia, WNHS

Excellence in Aboriginal Health: WA Tuberculosis Outbreak Response in Aboriginal Communities, Mental Health, Public Health



Employee of the Season

Our Employee of the Season Awards celebrate outstanding employees for their efforts in making a difference to patients, staff and/or the community, and exemplifies our values: care, respect, innovation, teamwork and integrity through their behaviours and action.

The awards align to the six seasons of the Noongar calendar: Birak, Bunuru, Djeran, Makuru, Djilba and Kambarang.

The awards recognise winners at each site: **NMHS Corporate, SCGH, OPH, WNHS** and **MHPHDS**. Congratulations to each of our winners this year.

Recognising exceptional individuals



Professor Graeme Hankey, a highly regarded member of the SCGH Department of Neurology, was named an **Officer of the Order of Australia (AO)** in the 2025 Australia Day Honours List for distinguished service to medicine as a neurologist and stroke physician, to research, and as an editor and author.

Prof Hankey worked as a consultant physician at SCGH from 2013 to 2023 and remains a valued member of the Department of Neurology, attending weekly stroke clinical meetings and teaching and lecturing on stroke to junior staff.



Professor Mary Steen, Professor of Midwifery at Women and Newborn Health Service's Department of Nursing and Midwifery Education and Research, was appointed an **Officer of the Order of the British Empire (OBE)** in the 2025 King's Birthday Honours List. Prof Steen was recognised for her outstanding services to midwifery, maternal and familial health research.

She has made a significant contribution to advancing midwifery care, maternal wellbeing and perinatal health services throughout her 36 years as a registered midwife. Prof Steen's work spans service development, policy advocacy, education and research, including a patented cooling treatment for perineal trauma after childbirth. She has authored more than 200 peer-reviewed articles, written and contributed to numerous books and holds visiting professorships at several international universities.

Go the Extra Mile (GEM) awards

The NMHS 2024 Go the Extra Mile (GEM) awards form part of the NMHS staff recognition program and celebrate individuals and teams who have made significant contributions to our health service to support patients, colleagues or the community.

Driving Innovation: **Bronwyn Raykos** – MHPHDS

Excellence in Health Care Support: **Jessica Warry** – SCGOPHCG

Improving Consumer Experience: **Emma Morgan** – MHPHDS

Rising Star: **Laura Clarke** – SCGOPHCG

Researcher of the Year: **David Erceg-Hurn** – MHPHDS

Excellence in Clinical Care: **Calina Ting** – SCGOPHCG

Outstanding Leader: **Danielle Carter** – SCGOPHCG

Volunteer of the Year: **Helen Anderson** – SCGOPHCG

Strengthening Partnerships: **Aboriginal Midwifery Group Practice and Breastfeeding Centre WA** – WNHS

Green Champion of the Year: **Intensive Care Unit Team** – SCGOPHCG

Making NMHS the Best Place to Work: **Katie McLeod** – SCGOPHCG

Chief Executive Award: **Melinda Olive** – WNHS

NMHS Board Award: **Helen Anderson** – SCGOPHCG

Special Mention: **Megan Waterhouse** – WNHS; **Calina Ting** – SCGOPHCG



View the full details of
our award winners

Redevelopment and capital works projects



Strong progress has been made on the major redevelopment projects and capital works projects across our sites this year.

The New Women and Babies Hospital Project

The landmark New Women and Babies Hospital Project has continued to progress with the appointment of a managing contractor and stakeholder consultation to inform design.

Global design and infrastructure construction company Webuild was appointed by the WA Government in May 2025, and the project has now entered the design and delivery phase.

The new hospital will replace KEMH and expand services and choice for women, newborns and families across three sites. The project includes:

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

Preliminary site investigations works have commenced at OPH, where upgrades will include expanded and new labour and birthing suites, a mother and baby unit and family birth centre, as well as expanded support services including pharmacy, pathology, sterilisation, kitchen and catering.

When complete, the OPH expansion will provide capacity for double the number of births at the hospital.

More than 100 workshops were held throughout 2024-25 with stakeholders from NMHS, South Metropolitan Health Service, Child and Adolescent Health Service and consumers to develop the project documentation. This included the site functional briefs, to guide and inform the design to be undertaken and reflect the overarching project objectives. The feedback from these consultations will ensure facilities are briefed to incorporate best practice and evidence-based design and accommodate future models of care.



Joondalup Health Campus

The Joondalup Health Campus expansion is a six-year project with State and Commonwealth funding to accommodate population growth in the northern corridor and meet the changing needs of communities, now and into the future.

The project has delivered new facilities across the site, including a 102-bed mental health unit, more emergency department beds, a new discharge lounge, additional parking and supporting facilities.

Major milestones reached in 2024-25 include the opening of the first 45 beds in the new 106-bed public ward block, including a Cardiac Care Unit, and extensive theatre and procedural complex expansion.

The Cardiac Care Unit has expansive rooms to accommodate advanced monitoring equipment and floor-to-ceiling internal windows in high acuity rooms to enable close visual observation of patients from the centrally-located nurses station.



The new public ward beds are supporting a significant increase in surgeries and procedures that will be delivered in JHC's expanded theatre and procedural complex. It includes a new operating theatre, an additional interventional catheterisation laboratory (cath lab), a new anaesthetic room, five new pre-surgery holding bays, and four new post-anaesthesia care unit bed bays.

The extra operating theatre is expanding JHC's surgical capacity and the additional cath lab will double capacity to deliver image-guided cardiac and vascular procedures to around 3,000 people per year.

Looking Ahead >>>>

The final stage of the expansion will see the completion of the remaining 60 beds in the public ward block in the next year. Two additional operating theatres for shared public and private use, funded by Ramsay Health Care, will open in the public theatre complex in September 2025.

Fitted with the latest real-time 3D image generating equipment, proceduralists can now diagnose and perform interventions to treat heart attacks and other conditions with procedures like angioplasty to unblock arteries, and the implantation of pacemakers.

For the first time, patients at JHC can now receive Electrophysiological Studies, a treatment for abnormal heart rhythms, minimising their need to travel to other hospitals.

Graylands Reconfiguration and Forensics Project

Planning for stage 1 of the NMHS Graylands Reconfiguration and Forensics Project (GRAFP) has progressed, following Government support for a staged delivery.

The redevelopment concept will reconfigure the Graylands site to increase forensic mental health beds and supporting services to address the undersupply in WA.

A business case was submitted in late 2024 for Stage 1 which will comprise:

- a male adult forensic inpatient unit
- a separate child and adolescent forensic inpatient unit
- an integrated patient services and rehabilitation centre (the hub)
- a secure partial perimeter, associated road works and site works

In 2024-25, the multi-agency project team commenced project definition planning, which includes detailed planning for all new buildings and services to support Stage 1.



JHC Mental Health Unit wins global design award

The JHC Mental Health Unit was named Project of the Year - New Build International at the 2025 Design in Mental Health Awards in the UK.

The 102-bed unit, which opened in 2023, was recognised for its design complexity on a constrained site to accommodate diverse cohorts – youths, adults, older adults and patients needing psychiatric intensive care. Key design principles were to maintain safety while promoting passive observation and respect for patient privacy, and prioritise natural light. The design was led by Silver Thomas Hanley architects in conjunction with Ramsay Health Care and in consultation with consumers and the WA Office of the Chief Psychiatrist.

Critical to the Stage 1 works was a commitment by the WA Government in February 2025 to support the relocation of the Claremont Therapeutic Riding Centre.

Consultation with relevant stakeholders, including consumers/those with lived experience, is underway to inform functional briefs for the new forensic units and hub.

Capital works

In addition to the large redevelopment projects underway, there has been strong progress on capital works projects in various phases.

- The Special Needs Dental Clinic was completed in June 2025, providing a contemporary facility to improve access to dental care for patients with special needs.
- The SCGH Intensive Care Unit project construction has also commenced and will deliver an additional 10 beds by mid-2027.
- The SCGH Goods Manufacturing Project (GMP) Laboratories and Cyclotron project is preparing for practical completion and the department looks forward to commissioning the service and providing radiopharmaceuticals to support the diagnostic and therapeutic needs of the patients.
- Two operating theatres at KEMH have been refurbished to support increased demand, while work progresses on the new Women's and Babies Hospital.
- Preparations are underway to refurbish the Neurological Interventional and Imaging Service of Western Australia (NIISwa) department at SCGH, which provides in-patient care and out-patient services for vascular diseases of the brain, head, neck and spine.

SCGH Emergency Department redevelopment

The redevelopment of SCGH Emergency Department (ED) commenced this year to expand and enhance the delivery of emergency services for WA's growing population.

A new dedicated area will be established in the ED, including a Clinical Toxicology Unit, providing a separate area for alcohol and other drug-related presentations.

The tender for construction was awarded to Cooper & Oxley in January 2025. Site works commenced in February 2025 and construction commenced the following month.

The staged redevelopment will include:

- Upgraded Emergency Department entrance, waiting area and triage area.
- New Clinical Toxicology Unit
- Enhanced Observation Ward
- Enhanced ambulance triage facilities
- Fast track area
- Dedicated 'pitstop area'
- New external covered walkways and entry canopy, including a main entry canopy.

As part of the redevelopment, WA artist Emily Jackson, has been commissioned to create an



artwork to wrap around the external facade. The design will reflect the beauty and biodiversity of Western Australia's flora, ocean and geology.

Projects completed in 2024-25

- Infection Prevention and Control System
- Reconfiguring the WA Spinal Cord Injury Service
- AS4187 Sterilisations



Capital works in progress

Project Name	Estimated completion date
SCGH GMP Laboratories and Cyclotron	2025
Relocation of Special Needs Dental Clinic	Complete
QEll Medical Centre – Cladding	Ongoing
SCGH Additional CT Scanner	2027
Sir Charles Gairdner Hospital ICU	2027
SCGH Image Guided Theatre	2027
SCGH Emergency Department Upgrade and Behavioural Assessment Urgent Care Centre	2028
Replacement of Biplanar Digital Angiography Units & Refurbishment works for Biplanar Units at SCGH	2029
Automated Controlled Substance Storage	Complete
King Edward Memorial Hospital Critical Infrastructure	Ongoing
Emergency Asset Investment Program Works	Complete
SCGH Redevelopment of the Watling Retail Precinct	Complete
Electronic Medical Record rollout	Ongoing
Women and Newborn Service Relocation Project	Ongoing
Albany General Dental Clinic	2029
NMHS Anti-Ligature Remediation Project	Ongoing

Performance highlights



Delivering on our Strategic Plan



The NMHS Strategic Plan sets out the future direction of our organisation to deliver on our vision of being a transformative leader, shaping the future of healthcare.

Launched in July 2024, the Plan recognises the changing landscape of healthcare delivery and the needs of our community, and the myriad opportunities ranging from technology advances to different ways of working.

The plan outlines our enduring purpose, vision, values and six strategic objectives to guide our evolution over the next three years, to help us adapt to new environments and respond to the changing needs of our patients.

Clinical Services Strategy

Our Clinical Services Strategy 2024-2027 sits across our strategic objectives and guides the contemporary planning and delivery of all NMHS healthcare services over the next three years.

The framework identifies the clinical priorities and approaches needed to ensure we meet the current and future needs of our community. It aligns to the broader strategic goals of WA Health outlined in the Sustainable Health Review, the WA Health Clinical Services Framework addendum 2020, and other WA Health system planning priorities and strategies.

The clinical priorities identified for focused planning effort include:

Priority areas	Strategic aims
Virtual care	Further embed virtual care into in-patient and outpatient clinical services to improve efficiency and access to care, particularly for regional and remote patients accessing state-wide services.
Care in the community	To optimise care outside of the hospital setting through partnerships and care coordination between community providers and other partners, and a focus on chronic disease management and patient care at home.
Older adults	To transform care for older adults and provide high quality support to older adults in their home, or in residential care; and in doing so minimise the need to access acute hospital services.
Emergency access	Achieve minimal ambulance ramping, to optimise patient flow through our emergency departments and throughout the patient journey, and to support management of demand upon our emergency department.
Outpatient services	Achieve zero over-boundary cases on our waitlist, to expand the use of virtual care, to digitise processes and to optimise capacity in the most appropriate locations to reduce patient wait times for care.

Priority areas	Strategic aims
Prevention and screening	To ensure our preventative and screening services are contemporary and easily available to our community, with a high uptake of immunisation, breast screening, and cancer screening, and high utilisation of genetics and public Dental Health Services.
Women's health priorities	To enhance and expand priority services in response to increasing demand and considerate of the changing configuration of services in response to the new Women and Babies Hospital. Priorities for women's health will be continuously refined, with an initial focus on abortion care, improving access to care for women in rural and remote areas, gynaecology, and family and domestic violence support.
Mental health	To support the adaptation and expansion of priority services in response to rapidly increasing and evolving demand; ensuring that all mental health care across NMHS is integrated, with each other and with physical health services. Priorities will be continuously adapted, with an initial focus on eating disorders, forensics, the Youth and Older Adult Services; and enhancing the Consultation Liaison Psychiatry Service.
Cancer care	Ensure optimal care pathways and provision of care in appropriate locations, and establish delivery of the national Lung Cancer Screening Program in line with the Australian Cancer Plan.

Priority areas	Strategic aims
Renal services	To develop a contemporary, sustainable model of care for renal services, underpinned by optimal renal dialysis capacity, improved access to care in the community and compassionate end of life care for people with chronic kidney disease.
Care in the north of the north	To progress plans to enable residents in the rapidly expanding north of our catchment to be able to access care easily and equitably, including options to access services closer to home.
Planning for future sites and services	To define a target future state for clinical services in 2040 so that we can inform infrastructure and service planning needs at a local and system level. This will include assessing the local impact from major and minor capital projects and advances in technology.

Over the coming year we will continue to shape planning and delivery of new initiatives to meet the strategic aims of these priorities and ensure the best possible health outcomes for our community.

The following sections outline how we are delivering on our Strategic Plan through projects at operational and strategic levels.

Our vision is to be a transformative leader, shaping the future of healthcare.

Delivering on our Strategic Plan: Driving excellence



Driving excellence in healthcare across all NMHS hospitals and services is at the heart of everything we do.

In late 2024, the five-year Consumer Experience and Clinical Excellence Strategy 2025-2029 was launched, inclusive of three domains: safe, high-quality care, person-centred care, and clinical excellence.

This important piece of work provides a consistent and coherent approach to consumer experience and clinical excellence across all NMHS services and supports our vision of becoming a transformational leader, shaping the future of healthcare.

Produced in partnership with NMHS staff and consumers, carers and family members who use our services, the strategy focuses on delivering patient-centred care that achieves individual's healthcare goals and continuous improvement of quality of care.

The strategy emphasises the importance of a strong safety culture and the need to support learning from clinical excellence.

An action plan is now in place with key priorities, including mechanisms to support a strong safety culture across NMHS, strengthening SAC1 processes, supporting an organisational approach to quality improvement, and increasing consumer engagement in policy development, projects, committees and as part of clinical incident review panels.

NMHS Population Health Profile

The inaugural NMHS Population Health Profile is another vital piece of work that provides analysis of population trends, health status and key factors influencing the wellbeing of residents in our catchment area.

This valuable data is supporting planning and program development across our sites and services, and will help to ensure future decisions are evidence-based and specific to our communities.

The report identifies population growth and distribution, age structure, ethnic diversity and socioeconomic characteristics, and explores health indicators across the region, examining key factors, such as the health behaviours of its residents and disease prevalence.

The insights into long-term health indicators, health behaviours and disease prevalence provide a better understanding of our consumers and support strategic and data-driven decision making on our services.

This information will assist in all aspects of clinical and service planning, driving improvements and ensuring we focus on the services, cohorts and advances in models of care.

Key findings included:

- **Our catchment population is growing.** From 2018 to 2023, the average annual growth rate was 1.7%.
- **In our catchment, older people are living longer - especially women.** The population aged over 65 years is expected to grow from 16.1% of the population to 19.1% in 2033 and 21.3% in 2043. The population aged over 85 years is expected to more than double from 16,055 (2.1%) to 32,695 people (3.4%) from 2023 to 2036.
- **The NMHS population born overseas was 274,975 or 36.2% of the total population** in 2021, higher than the WA proportion of 32.2% and higher than the Australian proportion of 27.6%.

What this means for our services

Rising demand for services – planning must anticipate service pressure points to ensure timely access to care.

Ageing population – requires specialised older adult services with expanded community-based services.

High demand on Emergency Department – ongoing demand on ED requires us to explore virtual/digital strategies, so our people can be seen at appropriate locations in the community and/or closer to home.

New Women and Babies Hospital – our tertiary maternity hospital will move south of the river. Planning for birthing options in our catchment is important, with future maternity services supported by an OPH expansion and maintained JHC services.

Diversity and equity – Our region is home to a diverse, multicultural population. All services must consider planning for care that is culturally appropriate, more accessible and suited to our population's diverse needs.

Highlights across our services

Across our hospitals and services, a number of significant projects were commenced or completed in 2024-25 that will have a tangible impact on patient outcomes and continuous improvement of health service delivery.

We have established a number of improvement programs designed to improve performance across all measures, including the NMHS Hospital Emergency Access Response Team (HEART) Program, NMHS Outpatient Reform Program and WA Elective Services Target (WEST) Improvement Program. All three of these established programs have delivered some improvements in performance over the past 12 months, and continue to evolve.

HEART program

Our HEART program has continued to run innovation challenges this year to engage staff in identifying solutions for efficiency improvement.

In response to ongoing pressure on Emergency Departments at SCGH and OPH, the HEART program has focused on an assertive patient flow approach to improve discharge timeframes and patient transfers to manage incoming demand, create inpatient capacity earlier in the day and streamline patient transport requests to improve the movement of patients.

Changes to the transfer process between ICU and theatres have resulted in improved patient flow through theatres and improved collaboration and teamwork between ICU, theatre and Post Anaesthesia Care Unit (PACU) staff.

In WNHS, there has been a focus on improving patient flow targeting the induction of labour process and discharge processes.



Mental health simulation laboratory

The first dedicated mental health simulation (sim) lab has been established at Graylands Hospital, to support staff development.

The Sim Lab provides space for staff to learn or refresh mental health clinical skills and techniques. It features a life-size computerised manikin that has been programmed with a range of real-life mental health scenarios and emergencies to help teach specialised medical and mental health nursing skills in real-time.

The Mental Health Simulation Lab continues to make a meaningful impact on both staff and students, providing a safe and innovative space to engage with complex clinical scenarios. Since its introduction, the lab has been embraced with enthusiasm, with staff noting significant improvements in practice readiness and confidence among nurses and students alike.

Delivering care closer to home

SCGH's Occupational Therapy Department and WACHS have partnered to upskill allied health professionals in remote locations and enable complex lymphoedema patients to receive care closer to home.

The program connects allied health clinicians in the Kimberley with an advanced practice lymphoedema occupational therapist via telehealth. Clinicians based at Derby, Broome, and Kununurra can dial in and speak with clinicians at our cancer centre.

Results from the six-month evaluation showed significant benefits for patients and a high level of satisfaction from staff.

Our Speech Pathology team partnered with Geraldton Regional Hospital to pilot a telehealth Videofluoroscopy Swallow Study, delivering health care to patients closer to their home. Videofluoroscopy is the gold standard swallowing assessment aimed at identifying food and fluid entering the airway to reduce rates of aspiration pneumonia.

Pre-eclampsia prevention

In an Australian first, pregnant women are being offered early pre-eclampsia screening through a new program at KEMH to reduce the risk of

maternal illness and preterm birth caused by this severe complication of pregnancy.

The screening assessment is being offered to women between 11 to 14 weeks gestation to predict their risk of developing the disease. The test uses a combination of blood pressure assessment, specific laboratory blood tests and an ultrasound assessment of blood flow in the patient's uterine arteries.

"Studies have demonstrated a significant reduction in early onset pre-eclampsia if low-dose aspirin is commenced prior to 16 weeks of gestation in women recognised as at increased risk at this screening assessment," said Prof Jan Dickinson, KEMH obstetrician and Professor of Maternal Fetal Medicine at University of Western Australia.



Managing obstetric emergencies

A new interactive course has been designed to help emergency staff practise how to manage obstetric emergencies.

The course, held at the Sir Charles Gairdner Hospital Simulation Centre in March 2025, saw emergency physicians, obstetricians, midwives, anaesthetists and neonatologists run interactive workshops and simulations for emergency staff to strengthen their skills in managing pregnancy-related emergencies.

In addition to bolstering clinical capability across Western Australia, the course brought together a diverse group of clinicians to improve teamwork and collaboration across disciplines.





Nurse patient ratios

A new nurse and midwife to patient ratio staffing model was successfully implemented in nine medical and surgical wards across Sir Charles Gairdner and Osborne Park hospitals in October 2024 as part of a trial, making NMHS the first health service to roll out staff/patient ratios in multiple wards.

The model sets a minimum requirement for the number of nurses working on a particular ward in relation to the number of patients they care for across a shift, with one nurse to every four patients during the day, and one nurse to every seven patients at night.

Graeme Boardley, Nursing and Midwifery Director – Workforce Projects, said staff in the trial wards embraced ratios and new reporting requirements, and made a valuable contribution to the overall success of the new model across Western Australia.

“Our staff have done an incredible job of leading this phase one trial and demonstrating to the whole health system that nurse/midwife to patient ratios can be successfully implemented.”

Leading innovation training module

To help our leaders to create environments that support innovation across all areas of work practice, a new innovation leadership module has been introduced into the NMHS’ nationally-recognised Diploma of Leadership and Management.

The module focuses on establishing innovative work environments and was designed by our Innovation team in collaboration with our Learning and Development team.

Prostate Cancer Registry

SCGH’s Urology Department became the first site in WA to implement the Prostate Cancer Outcomes Registry for Australia and New Zealand to enhance treatment options for patients.

The registry allows doctors and researchers to identify trends in diagnosis and treatment practices, track survival rates and better understand the effects of different treatments, leading to continuous improvements in care for men diagnosed with prostate cancer.



Dental Health Service ‘best in Australia’

Dental Health Services (DHS) received very positive feedback and no recommendations in its accreditation assessment against the new National Safety and Quality Primary and Community Healthcare standards in November 2024.

Surveyors commented they believe Western Australia’s dental service is the best in the country, and called out our high staff engagement, kindness and quality of patient care. We also received positive feedback in relation to the sound policies and procedures established across all areas of the service.



Delivering on our Strategic Plan: Partnering with our communities

We partner with our communities to provide the best possible healthcare and support to patients and their families, and to drive transformational research and innovation.

We recognise the importance of working in partnership with consumers, carers and members of the community to truly understand the needs of the people who use our services. Patient feedback and consumer involvement through Consumer Advisory Councils are essential to helping us to enhance the quality of our services.

Since the launch of the Partnerships Model in 2023, work has continued to embed it more deeply across clinical and corporate areas. Efforts are ongoing to enhance the recruitment, training, and support of consumer representatives, with a focus on increasing inclusivity - particularly among Aboriginal peoples, culturally and linguistically diverse communities, and LGBTQIA+ individuals.

Consumer Advisory Councils

Our Consumer Advisory Councils (CAC) are a formal partnership between consumers and carers and NMHS Executive Committees to embed the voice and perspectives of consumers, carers and families in decisions and processes that impact their healthcare experience. There are three CACs in place across NMHS that represent WNHS, SCGOPHCG and the MHS.

In 2024-25, we reviewed our CAC model to attract new members and ensure representation reflects the diversity of our communities. Each CAC strives to include representatives from CALD backgrounds, LGBTQIA+, people with disability, Aboriginal people, and consumers with lived mental health experience.

We have also strengthened the role of CACs in providing tangible advice and advocacy and embedding the voice of consumers into service governance. New recruitment and onboarding processes were developed to support this, including Welcome Packs adapted from SMHS resources.

Other changes include the way in which meetings operate. WNHS CAC now reviews an anonymised patient complaint and the associated response each month and provides advice on how responses can be strengthened in the future. It also reviews the WNHS patient experience report and discusses actions with the service.

Some of the achievements of our CACs this year include:

- A discussion paper and recommendations to support sexual safety for mental health staff and patients in response to the Chief Psychiatrist's Guidelines.
- Advice on the consumer wayfinding experience at SCGH in light of significant redevelopment and disruption to walkways.

- The inclusion of consumer representatives on all National Safety and Quality Health Service (NSQHS) Standard Committees for WNHS.
- Recommendations to WNHS to expand the Breastfeeding Centre of WA.
- Successfully advocating for inclusion of Aboriginal representation on the WNHS Executive Committee.
- Partnering with WNHS to embed meaningful consumer representation on committees, resulting in 60% of WNHS committees now having a consumer representative.
- A review and recommendations for improvements to the KEMH creche service
- The introduction of a Ward Walking program to give consumers an opportunity to speak to CAC members and provide more diverse consumer feedback.
- The draft of a booklet to provide information to prepare individuals to transition smoothly from in-patient mental health care to independent living.
- Research on best outcomes for mental health patients in non-smoking environments, and how this can impact aggression.

Recognition and thanks

We thank the WNHS CAC members who have generously participated in workshops and consultations to inform the design of the new Women and Babies Hospital.

We also thank the outgoing Chairs of SCGOPHCG and WNHS CACs, Carole Kagi and Sonja Whimp, for their significant contribution. Carole has been an exceptional advocate for consumers over the past nine years and Chair of SCGOPHCG since 2023. Sonja has held role of WNHS Chair for four years and has consistently demonstrated her commitment to promoting the value of consumer representation. We welcome Sonja's ongoing involvement as a member of the CAC.

Committee remuneration

Members of our Consumer Advisory Committees receive participation payments in accordance with the NMHS Consumer and Carer Participation Payment Policy. Members have the right to accept or refuse remuneration for their participation.

Total committee remuneration 2024-25

	Total remuneration (\$)
SCGOPHCG Consumer Advisory Committee	\$10,200.00
Women and Newborn Community Advisory Committee	\$2,882.50

Consumer feedback

We provide opportunities for consumer feedback through a variety of methods, including providing feedback via phone, email or letter, sharing a story anonymously via Care Opinion, or completing a consumer feedback survey.

We are pleased to report positive increases in Net Promoter Score (NPS) survey responses and the number, and ranking, of our services in Care Opinion in 2024-25, which reflect the success of initiatives in place to improve the quality of care we provide.

	Number of surveys completed in 2023-2024	Number of surveys completed in 2024-2025	NPS score 2024-2025 with + or - on 2023-2024 score
MySay Inpatients	16904	17058	+76 (79)
MySay Outpatients	51950	52674	+80 (78)
MySay Emergency Department	1864	1967	+43 (53)

Care Opinion

	2023-2024	2024-2025
Number of stories	194	252
Recommendation %	78%	79%
Ranking of note	Top 5 organisation with the highest number of "staff listening, learning and making changes"	Top 3 organisation with the highest number of "staff listening, learning and making changes"

Examples of patient feedback

"My spouse recently had surgery, and we would like to say how impressed we were with the quality of care we received from all staff we saw in preadmission, recovery, G52 and G66, the surgical team, anaesthetists, nurse and support staff. Everyone we saw was friendly, caring and professional which made a very scary admission for my spouse so much easier. We felt listened to and supported all the way through."

Sir Charles Gairdner Hospital

"The entire staff were amazing. They were professional, caring and compassionate, everyone I had interaction with from when I entered the facility to when I left were friendly and extremely helpful. This is my second stay here as I was here for an operation 8 weeks ago and I had the same treatment then. I would like to say thank you to everyone. The nursing staff, theatre staff, the catering staff and the discharge lounge staff (a massive thank you)"

Joondalup Health Campus

"I had a colonoscopy at Osborne [Park] Hospital recently. The staff I saw were amazing. I felt safe and listened to. All members of the team treated me with respect and their communication skills were excellent. This included the reception staff, the porter pushing my bed to the procedure, the nurses and the consultant."

Osborne Park Hospital

"The mental health team with hospital in the home were fabulous. They were all very friendly, nonjudgmental and helpful. I found the service was crucial to helping me get through a very difficult time in my life. I looked forward to their visit every day and it helped me with the healing process. I'm so grateful I was offered this service. Thank you! Please pass on my Feedback to the team."

Mental Health Services

"An absolutely amazing experience. I felt heard and cared for. The LC [lactation consultant] made me feel like she had all the time in the world to answer my questions about breast feeding and ensure I felt empowered to keep going. She was thorough, patient, and kind. The receptionist at the Birth Centre was also warm and welcoming."

King Edward Memorial Hospital

"The dentist who saw my child did such an amazing job. My child was really nervous, and the way that she interacted with him and explained everything got him feeling relaxed and talking back with her. She was really personable and so patient and understanding. My son came away talking really positively about the dentist appointment - definitely the best experience we have had for a child dental appointment"

Dental Health Services

"It was a very pleasant experience especially as I was nervous. The reception lady was really nice and the radiographer was amazing. She was so lovely and explained everything to me and her main concern was getting the best pictures without it being painful for me - she absolutely went above and beyond to take the time to make sure I was comfortable throughout the whole process which I was extremely grateful for."

BreastScreen WA

"I would like to thank you for the invitation last Sunday to the wonderful memorial service held for Donor families and recipients, it was truly an amazing morning. Keep up the good work and we will spread the word on having the conversation, so glad my son and I had the conversation."

DonateLife WA

"The Anita Clayton Centre staff, doctors and nurses are lovely. It is a calm and organised clinic, and the staff are very kind."

WA TB Control Program

"I am grateful for all the support provided to me thank you to everyone involved from the hospital team, administrative, medical team, finance, well-being, allied health support team and specialists thank you"

State Head Injury Unit



Celebrating people with special needs

The relocation of the Special Needs Dental Clinic to the present location provided a unique opportunity to design a space that supports and celebrates people with special needs.



A feature art piece by local Perth artist, David Guhl, was selected to brighten the reception and waiting areas and honours the creativity, diversity and richness of people with special needs.

David is an award-winning artist with Down syndrome, whose work and contributions to the arts have been recognised by the Disability Services Commission and Down Syndrome WA, among others. David's practise highlights an innate connection with nature, one that inspires profound optimism and joy.

Land of Many Colours is a depiction of a West Australian landscape characterised by intense contrasts, breathtaking beauty, diversity and mesmerising vastness. It is a powerful celebration of life in all its forms, shapes, colours and uniqueness. The vibrant, fluid composition was reproduced for display utilising direct print wall graphic vinyl throughout the four treatment rooms

Metaphorically speaking, it can also be seen as a depiction of the rich tapestry of peoples that inhabit the land, the different ties and connections to the land and to one another.

Consumer feedback via Datix CFM

Priority area	FY23	FY24	FY25
Complaint	532	532	610
Contacts and concerns	1279	1039	302*
Datix CFM compliments	1097	1351	1444
SCGOPHCG* externally recorded compliments	2246	2400	2855
Total compliments	3343	3751	4299

* Compliment data provided to NMHS SQG&CE on 29 May 2025
Drop in Contacts and Concerns is due to data entry backlog

Free legal advice for vulnerable patients

Vulnerable patients at SCGH and OPH can now access free legal advice through an innovative partnership with Legal Aid WA and Northern Suburbs Legal Services.

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

This award-winning partnership aims to alleviate some of the associated pressures regarding legal matters that affect vulnerable patients, including debts, tenancy, NDIS appeals, mortgage stress, guardianship and administration, and Centrelink debts and eligibility issues.

The lawyers providing the advice have completed mandatory training to ensure they are fully equipped to provide the required services either bedside or in a designated private area, depending on the patient’s circumstances.



Connecting with our communities

Beyond our formal feedback platforms, we are continuously working with consumers and community organisations to enhance our provision of patient-centred care.

Some of the initiatives launched this year with consumers and community partners included:

- A buddy system introduced by the paediatric radiation oncology team at SCGH to provide additional support to patients and their families. Experienced radiation therapists meet patients and their family before treatment to answer questions and show them around the department, to help them feel more at ease before treatment begins.
- Sarongs for Aboriginal women having mammograms. To increase cultural safety, comfort and protection, a free sarong is given to Aboriginal women who book their mammogram with BreastScreen WA. Sarongs were designed by Pinjarup-Whadjuk artist Chloe Calyon and feature women surrounded by meeting place symbols representing communities offering support, strength and guidance.
- Free community education sessions led by the Women and Newborn Health Service on a range of topics, including migrant and refugee health and family and forced marriage, dowry and abuse.

- New traditional bush tucker meals were added to the patient catering menus at SCGH and OPH, to provide Aboriginal and Torres Strait Islander patients with additional food choices that may provide a taste of home.

Public Health Planning Partnership Agreement

Our Health Promotion Service signed the first Public Health Planning Partnership Agreement with the City of Joondalup to support the creation of the City's first local public health plan, as required by the *Public Health Act 2016*.

The NMHS Public Health Planning Development Guide was developed to outline key stages of public health planning and the support we can provide.

Partnering to increase organ donor registrations

Following the release of the Parliamentary Inquiry Report into organ and tissue donation in WA in February 2024, DonateLife WA collaborated with the Department of Transport and the Organ and Tissue Authority to reinstate and encourage Western Australians to join the Australian Organ Donor Registry when applying for or renewing a driver's licence and vehicle registration. As a result, there has been a 50% increase in registration across WA since March 2024.

Cancer Forum

More than 250 people attended the annual Cancer Forum, hosted by the Cancer Network WA and WA Clinical Oncology Group. The impressive lineup of 35 expert speakers covered topics ranging from prevention and early detection to treatment, patient support and research studies.

DonateLife Week

A number of events were held during DonateLife Week to raise awareness about organ and tissue donation and encourage more people to register as donors. More than 200 people joined the annual Gift of Life Walk, and key buildings around Perth were illuminated, including Matagarup Bridge, Perth Bell Tower, Trafalgar Bridge and Council House. Across donation hospitals, the team ran promotional campaigns, Grand Rounds, and display stalls to mark the week.



Promoting wellbeing

In partnership with Derbarl Yerrigan Health Service, we held a Mental Health Week event to promote social and emotional wellbeing to families in the northern suburbs. More than 180 people attended, and helped to launch a new community garden while learning about healthy eating for mental wellbeing.

Mini Olympics for stroke patients

Staff and volunteers at OPH hosted a mini-Olympics for stroke patients during National Stroke Week in August 2024. The event featured five sports including swimming, volleyball, shot put, basketball and javelin, with all tailored to suit the particular needs of the stroke patients. The event offered a way for patients to achieve therapy goals in a fun environment and have the opportunity to interact with other patients.



Addressing family and domestic violence

During 16 Days in WA, a full-day symposium was organised by WNHS Women's Health Strategy and Programs team to raise awareness of the signs of domestic violence and how health professionals can help. Guest speakers included Professors from Edith Cowan and Curtin Universities, WA Police, St John Ambulance

and leaders from our WNHS team and Sexual Assault Resource Centre.

NMHS is the only health service in WA with a strategic framework to identify and manage family and domestic violence as part of our commitment to women's health, safety and wellbeing.

Supporting our communities

Our teams have generously supported or donated to many causes over the year.

A \$10,000 LotteryWest grant received by the Graylands Hospital Volunteer Service provided some patients in need at Graylands Hospital, SCGH Mental Health Unit and the Frankland Centre with clothing and personal care items during their hospital stay. Funds were also put towards food vouchers, utility bills, emergency accommodation and transport after discharge, to help patients on their recovery journey.

The annual staff-led NMHS Spread the Cheer charity appeal saw more than 760 packs of personal items donated to Dandelions WA to support people experiencing homelessness or domestic violence.

Throughout the year teams organised fundraising activities for many charities, some of which include:

- Pink Ribbon
- Ovarian cancer
- Men's cancer
- National Mental Health Day
- Amputee Day
- Pregnancy and Infant Loss Remembrance Day
- DonateLife WA Jersey day
- Daffodil Day
- International Gynaecological Awareness Day
- World Prematurity Day
- Word Oral Health Day.





Delivering on our Strategic Plan: Advancing health equity and access



Advancing health equity and access is a priority given the changing demographics of our communities and growing demand for home and community services. We are strategically positioned to lead the evolution of health service delivery and build on our existing capability in delivering state-wide services from our hospitals and clinic sites.

As our catchment population continues to grow, with a projected overall increase of 16% by 2033 and even faster growth in the Joondalup-Wanneroo area, we are evolving how services are delivered to advance access and equity. Demand for virtual healthcare and home and community services is growing and is a core element to advancing health equity and access to people who are disadvantaged, vulnerable, elderly or living in remote areas.

Earlier access to screening services and preventive and holistic care will have a significant impact on overall health outcomes for all Western Australians and the sustainability of our healthcare system.

A number of significant projects were delivered in 2024-25 to expand our services and help reduce barriers to accessing health care.

These included an expansion of our telehealth services and electronic prescriptions for outpatients, additional screening services, expanded dental service clinics, a legal partnership to support vulnerable patients, and additional services to treat eating disorders.



Virtual healthcare

Across NMHS we have continued to embed virtual healthcare into our services and identify new opportunities to advance health equity and access as part of our commitment to providing the most appropriate care as close as possible to patients' homes.

Virtual care consultations continued to increase in 2024-25, with 299,975 consultations delivered by our clinicians. This represented 34.3% of all outpatient appointments.

Electronic prescribing has been a big enabler of telehealth and the rollout of e-scripts across all

NMHS hospital outpatient clinics and Emergency Departments was completed in August 2024, with SCGH, OPH and Joondalup moving to the e-script platform. The platform was first rolled out at KEMH in 2023.

More than 38,000 e-scripts were generated in 2024-25, saving hours of time for prescribers, pharmacists and patients, and reducing the risk of medication errors.

The embedding of outpatient e-prescribing has been a transformative change in the delivery of outpatient services. It has improved safety and access for patients and enabled greater uptake of telehealth, especially in rural and regional areas.

The use of electronic prescriptions has benefitted patients and prescribers, offering seamless use of telehealth with instant delivery of prescriptions to patients digitally, where appropriate. It enables timely medication access; improved visibility of prescriptions across WA Health services; automated linkages with clinical discharge information; and supports better clinical decision making.

Looking Forward >>>>

More changes are on the horizon with improvements to see e-prescribing extended to patient discharge in the coming years.

"Embedding e-prescribing across NMHS has been a transformative change in the delivery of outpatient services."

Pregnancy Choices and Abortion Care

Following the *Abortion Reform Act 2023*, our team has been instrumental in leading the development of the systems, services and resources to support women to access reproductive autonomy and compassionate abortion care across WA.

Over the last year, the Pregnancy Choices and Abortion Care (PCAC) team, along with project staff from WNHS and NMHS, has continued to drive this work, including:

- The development of state-wide guidelines for abortion care.
- A nurse practitioner-led clinic for early medical abortion at KEMH. This clinic also allows endorsed midwives to be trained in providing early medical abortion, increasing the availability of this service.
- Commencement of state-wide planning with Department of Health to ensure women can receive care closer to home.
- Training and resources to support the emotional and psychological wellbeing for people working within abortion care to foster a safe workplace.

This important work supports other HSPs and the Department, and will continue to be expanded.



Hospital in the Home

Our Hospital in the Home (HITH) service enables patients to receive acute inpatient care in the comfort of their own home, with visits by a multidisciplinary team as often as required, allowing patients to receive treatment in a familiar environment. It is also helping to enhance patient flow across the hospital.

The service was expanded in July 2024, following its launch earlier that year, and it now operates 15 beds under general medicine and geriatrics governance.

Looking Forward >>>>

Following the success of HITH in its first full year, the service will be expanded to a target of 30 beds by the end of 2025 and 50 beds by June 2026. To meet the increase, the cohort of patients accepted to HITH will expand across medical and surgical specialities with a focus on winter planning to meet increasing demand.

A patient's experience

Following a fall at home, Mr W was brought to SCGH ED and admitted for management of a head strike, skin tears, low blood pressure, delirium, and other symptoms.

The 94-year-old spent one night at SCGH and then returned home under the care of our HITH team. His multidisciplinary care included nursing, medical, physiotherapy, occupational therapy and social work. The nursing team managed his wounds, blood pressure, medication and performed screening tests. The medical team completed a comprehensive geriatric assessment, medication review and clinical information for his GP. The allied health team reviewed his home for falls prevention, progressed mobility and delivered appropriate equipment. They provided a referral to rehabilitation in the home and community physiotherapy services, and shared information about carer support and education with his family.

The patient was discharged after six days to a community care provider for ongoing care and management by his GP. The care Mr W received in his home helped him to achieve appropriate function and mobility to return to playing golf and attending bingo.



Expanded mobile breast screening

A fifth mobile breast screening unit was added to the BreastScreen WA fleet in October 2024 to enable an additional 5,000 people to access screening. The \$1.4 million mobile unit was funded by the Cook Government to increase services where demand is high.

In 2024-25, the service screened 134,868 women. Women 40 years and over with no symptoms are eligible for a free screening mammogram every two years, which significantly increases survival rates and reduces the amount of treatment required.

Over the past four years BreastScreen WA has expanded its service to several remote communities including Lombadina/Djarindjin, One Arm Point and Bidyadanga.

New early evidence kits for sexual assault

Our Sexual Assault Resource Centre (SARC) developed early forensic kits and transport processes to support people who have been sexually assaulted. The kits are available in hospitals across Western Australia and include early evidence kits, first response packs with a check list and essential information for patients, and a forensic toxicology kit for suspected drug facilitated assault. The kits provide a consistent standard of care for everyone in WA.

National Lung Cancer Screening Program

NMHS was selected to deliver the National Lung Cancer Screening Program from July 2025, as part of a system-wide program across WA Health.

The screening program is targeted at eligible people aged between 50 to 70 years old with no signs or symptoms of lung cancer.

A multidisciplinary working group was established to identify immediate strategies to address current gaps in lung cancer service delivery and prepare for an anticipated increase in demand across existing lung cancer services, including specialist services, workforce, equipment and hospital capacity.

Advancing access and equity are core pillars of this important program.

Preterm Birth Prevention Clinic

The Preterm Birth Prevention Clinic run by a specialised, multi-disciplinary team at KEMH provides access to pregnancy care for women across WA. Awareness and utilisation of this service grows every year. In 2024-2025, the clinic supported more than 225 women from remote locations, including Kununurra, Wiluna, Punmu Community (Newman), Mowanjum community (Derby), Karratha, Esperance and Christmas Island. The clinic is attracting global interest in its focus on reducing preterm births and making every day count during pregnancy.

Expanded dental services

A review of the School Dental Service (SDS) undertaken in early 2025 identified a 15% increase in the Greater Perth Metropolitan Region population since 2019. The largest growth occurred in the northern and southern ends of the metropolitan corridor and in the north-eastern Swan Valley area. To prepare for future growth and equalise enrolments at each clinic across the metropolitan region, a restructure of SDS areas will occur in July 2025.

DHS opened two dental clinics this year to meet the needs of local communities, including Jilbup and Madora Bay Dental Therapy Centres, which both opened in May 2025.

A new mobile dental clinic that will be used in Kalgoorlie and other regional locations was designed and built in 2024-25. The unit features a wheelchair lift and will be deployed later this year.



Community-based support for people with eating disorders

People living in the NMHS catchment or associated regional areas in WA who are experiencing eating disorders can now access specialist care in the community.

The North Metropolitan Eating Disorders Specialist Service (NMEDSS) opened in Subiaco in December 2024 for people aged 16 and older who are experiencing difficulties making progress in outpatient treatment, or who are being discharged from hospital-based treatment for their eating disorder and require ongoing support.

People's recovery is supported by specialists based at the same location, including peer support workers who may have lived experience of an eating disorder, exercise physiologists, physicians, dietitians, nurses and clinical psychologists and psychiatrists. Services include day program treatment, specialist outpatient clinics and intensive clinical monitoring. Virtual care is also available to people who are unable to attend the clinic.

The service offers a 'step up' from outpatient settings and a 'step-down' from inpatient settings, including hospitals and residential treatment, enabling patients to return home to continue their recovery sooner.

The service has supported 79 patients to date through an intensive day program and specialist multidisciplinary outpatient clinic,

which offers additional support. Patients attend the service 3-4 days per week for up to 12 weeks. Data from the service's first six months of operating shows:

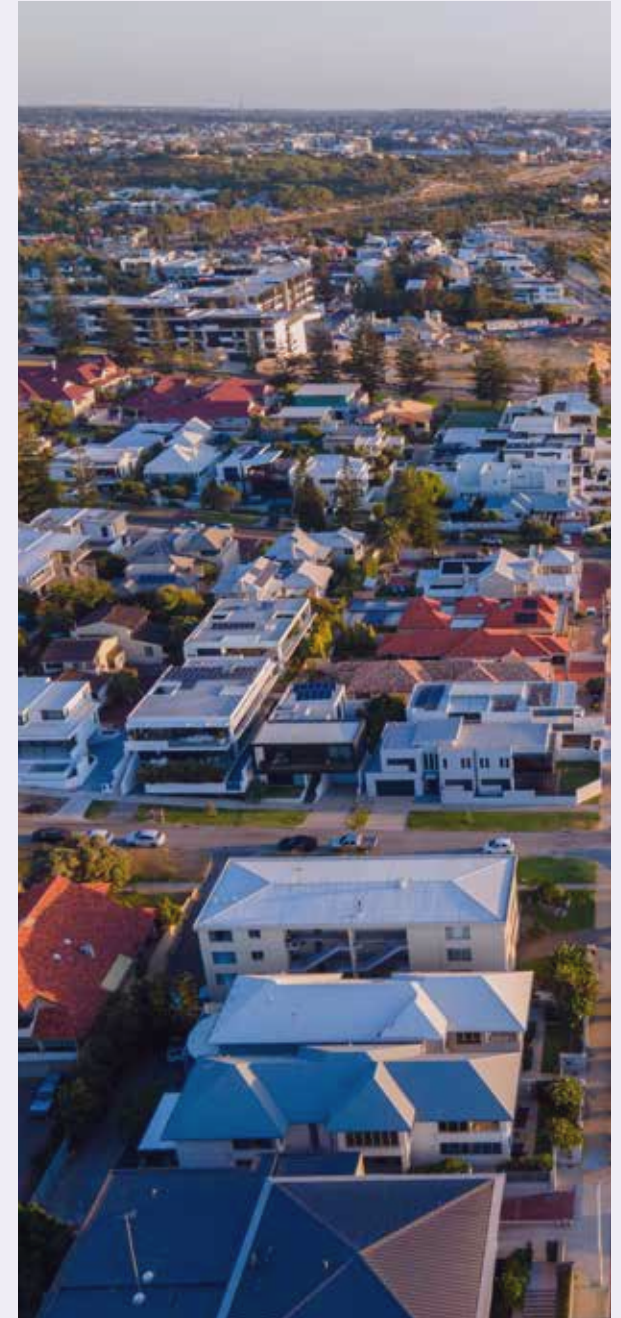
- Significant improvement in patients' physical health
- Significant improvement in psychological symptoms relating to the eating disorder, including depression and anxiety
- Significant reduction in clinical impairment from admission to discharge
- Reduction in number of hospital admissions to SCGH and reduction in lengths of stay for treatment of eating disorders since the opening of NMEDSS.

Patient feedback has been very positive, with 73 per cent of patients who responded to a recent survey rating the overall experience of the program as excellent or very good.

"The most helpful thing was the chance to challenge the eating disorder with intensive support in the community versus hospital."

"The best thing about the service is the ability to see the team virtually as I live in a remote location."

"Gave me the final push to complete a full recovery."



Delivering on our Strategic Plan: Becoming the best place to work

As part of our strategic objective to become the best place to work, we are continually looking at ways to develop our culture and engagement initiatives, enhance safety and modernise our work environments. More information about capital works and redevelopment activities is provided on page 38 of this report.

In 2024-25, areas of focus included the introduction of bi-annual engagement surveys, new initiatives to enhance safety for staff and new learning and development opportunities to build capability and drive career satisfaction.

Engagement surveys

Employee engagement is a priority across all our teams and the inaugural North Pulse survey held in September 2024 identified areas that we are doing well in and where more focus is needed.

A follow-up engagement survey in May 2025 showed meaningful positive change across all areas and saw an increase in participation to 30% of all staff. The introduction of a second survey was a valuable method to determine trends in our results, see where we have made progress and to identify areas of focus for further improvement.

The survey results showed very clearly people across our organisation are committed to providing the highest quality experience for patients, consumers and families; are confident in their roles; and have clarity around what is expected from them at work.

The top three most improved areas related to recognition, progress and wellbeing, which all showed a positive impact of the work undertaken in these areas.

Looking Forward >>>>

Priority employee engagement initiatives for the next 12 months include:

- Further focus, improvements and communication in relation to updating infrastructure, facilities and equipment
- Enhancing the skills and capacity of our line managers, to support engagement and positive work experiences for colleagues
- Materials and equipment remain areas that represent opportunities for improvement.



JMO Employer of Choice

For the third year running, NMHS proudly achieved the highest-ranking score as an Employer of Choice for Junior Medical Officers (JMOs) in the Australian Medical Association's 2025 Hospital Health Check survey.

NMHS (including SCGH, OPH and Graylands Hospital) received a top score of 94 per cent as a recommended employer. WNHS also received high scores, which were assessed separately in the survey.

The survey results showed marked improvements over six areas for WNHS, including three A+ scores. WNHS has proudly achieved an A grade for the likelihood that respondents would recommend it as an employer - a significant improvement from last year. This progress reflects the dedication of the entire WNHS team in fostering a better workplace for our JMOs and all staff.

The positive shift in our scores reinforces that we are heading in the right direction, particularly in enhancing workplace culture and staff morale for junior doctors.



Find out more

People and Culture transformation goals

Following a review of the existing People and Culture strategy and in response to feedback from our first engagement survey, we have developed transformation goals aligned under six priority areas: employee engagement; employee wellbeing; people development; attraction and recruitment; embedding flexibility; and diversity and inclusion. These priority areas form part of our strategic plan to make NMHS the best place to work. Achievements from 2024-25 are outlined to the right.

Looking Forward >>>>

Initiatives within each People and Culture domain are reviewed and reprioritised or updated annually. Over the next 12 months we will be:

- Reviewing and refreshing relevant NMHS-wide strategies, including NMHS Employee Wellbeing Strategy and NMHS Stop the Violence Strategy, to align with organisation and system level objectives
- Delivering priority L&D projects, including mandatory training and digital learning reform.

Priority area	Key achievements for 2024-25
Employee engagement	• Network for Engagement and Wellbeing (NEW) model embedded. • Delivery of new events focused on staff celebration. • Design and delivery of new engagement survey.
Employee wellbeing	• Wellbeing training and resources for managers and staff further developed. • Psychosocial risk assessment pilot implemented and evaluated.
People development	• Project Control Group established to lead Learning and Development (L&D) transformation program in line with L&D roadmap. • Expansion of leadership and development programs for managers, including a new Leadership Hub offering short courses to assist leaders.
Attraction and recruitment	• New talent acquisition model launched to deliver in-house recruitment support service. • Talent Attraction Group approved for permanent creation.
Embedding flexibility	• Supporting employees to balance their work and other life responsibilities by promoting flexible work arrangements (FWAs) across all areas of the organisation. • A new app is being developed to enable a more streamlined process for application, approval and renewal of FWAs and is in user testing.
Diversity and inclusion	• NMHS Aboriginal Employment Action Plan launched. • Workshops, education sessions and events held in relation to all diversity groups, to promote understanding, inclusivity, and respect.



Aboriginal Health Champions

Our Aboriginal Health Champions program recognises employees who go the extra mile to ensure Aboriginal people feel welcome and comfortable accessing and using our services.

The program aims to achieve cultural safety for Aboriginal patients and Aboriginal workforce, improve communication, and improve patients' health outcomes, care, hospital experience and completion of care.

After completing Aboriginal person-centred care training, participants actively participate in Aboriginal Health and Wellbeing Committees, contribute to planning and organising events of significance, and continue to promote and build cultural awareness and competence.

Increasing flexibility

A key initiative to attract and retain staff, particularly staff with carer responsibilities, is flexibility to enable career continuity without being affected by career breaks to care for family, including children or parents.

The NMHS Nursing and Midwifery Flexible Rostering Project is exploring how we can make changes to the traditional rostering system to provide greater flexibility to nurses and midwives.

The project is being trialled at OPH Ward 5 and KEMH Outpatient Services. In addition, midwives at KEMH returning from parental leave can work set shifts on set days across multiple clinical areas.

Further work is underway to review flexible work and leave arrangements options, such as flexible break times, use of leave, part time work, job sharing, utilising excess leave, compressed work patterns, working from different sites, working from home and telecommuting.

The suitability and availability of arrangements depends on the operational requirements of a work unit, type of work required and an employee's circumstance.

The aim is to align principles and practices with the NMHS Flexible Work Arrangements Policy, which focuses on an individualised approach to work arrangements, rather than the traditional standardised approach.

Feedback from nurses and midwives has been very positive, with people saying that fixed shifts enables more time between shifts for exercise, rest and being able to plan appointments.

"The flexibility of the roster has been amazing. I have been a midwife for several years but at the moment my main role in life is being a mum. Knowing I have a set shift each week that doesn't change makes things so easy, it's been wonderful. I am very appreciative of the roster and hope that it continues."

Fostering a safe work environment

Several initiatives were rolled out in 2024-25 to foster a safe work environment as part of our commitment to becoming the best place to work.

WA's first Behaviour Evaluation and Review Team

A new approach to reduce escalating behaviours, prevent Code Black incidents and support ward staff in identifying and referring patients with behaviours of concern is being trialled at SCGH.

In a WA first, a multidisciplinary Behaviour Evaluation and Review Team (BERT) is working with clinicians, patients, families and caregivers to develop individualised management plans to support patients and foster a safe environment for everyone.

The specialised approach has been designed to keep staff and patients safe, while providing comprehensive and complex care to patients exhibiting behaviours of concern to mitigate and manage further escalation.

In its first two months, BERT provided 146 consultations to assist patients experiencing behavioural responses, with the majority relating to delirium.

The team comprises a Coordinator of Nursing (BERT lead), a BERT medical lead and clinical nurse specialists, as well as specialist input from social work, occupational therapy, clinical psychology, and consultation liaison psychiatry.

The concept was developed from key learnings from working groups, past staff surveys and based on similar programs implemented in other states.

The two-year trial commenced in February 2025 and mapping is underway at OPH to determine site requirements.



Neurodiverse ED

A new peer support initiative has been launched for neurodiverse employees working in the SCGH Emergency Department.

Led by three nurses, Neurodiverse-ED gives people the opportunity to openly share supportive advice, tips and strategies on self-regulation and managing difficult situations in the workplace, as well as strategies to improve communication.

While group members have different reasons for getting involved, all share a common goal to build a community to support one another - and patients - in the Emergency Department.

The group has created a sense of inclusion and safety for many members, and empowered staff to bring their positive attributes to the workplace and wear their quirks with pride.

Beyond the Emergency Department, neurodivergent staff across NMHS meet regularly through peer support group Neurokin.

Psychological First Aid training

Psychological First Aid training for leaders has been embedded in NMHS Critical Incident Response processes to increase resilience and support mental health and wellbeing.

The new training been designed to equip leaders with essential skills to support teams effectively, especially during or after incidents in the workplace. It serves as a vital control measure by providing managers with the tools to offer

empathetic support, stabilise affected employees and connect them with additional resources if needed.

Since the program launched in February 2025, 147 staff have participated in the course.

Feedback has been positive, with attendees highlighting the importance of the training for leaders in understanding how best to support staff following potentially traumatic events.

Supporting health and wellbeing

Our Network for Engagement and Wellbeing (NEW) continues to enhance engagement and promote wellbeing across NMHS.

NEW forums were held in November 2024 and June 2025 to seek input from teams and share information on wellbeing and engagement initiatives, action planning, driving engagement, and to foster connections across the network.

A new grants program was established to fund initiatives to improve engagement and wellbeing, diversity and inclusion, and the purchase of sensory and wellness equipment for staff.

Cancer Network WA staff wellbeing plan

In response to the North Pulse staff engagement survey and an internal staff wellbeing survey in 2024, the team at Cancer Network WA (CNWA) developed a staff wellbeing plan to proactively support employees. The plan links to the NMHS Employee Wellbeing Strategy and is strongly influenced by a human-centred design philosophy, in that it was shaped and is owned by the team.

In the first six months, the CNWA wellbeing team captured specific risk factors to CNWA staff wellbeing and developed priority areas to target across mental, social, financial and physical wellbeing:

- Collated and mapped a range of implementation actions across organisational, environmental, and individual domains
- Created measurable CNWA wellbeing key performance indicators to report on
- Initiated a Wellbeing Working Group to link into the NMHS NEW group, create a CNWA

wellbeing plan and support the drive of initiatives across CNWA

- Been successful in a NMHS NEW grant to help resource initiatives
- Directly actioned staff suggestions. These included wellbeing boards across sites, digital micro-learning sessions, regular bulletin communications, sensory regulation toolkits, communal staff lunches, staff recognition initiatives, webinars, and regular workplace walks
- Ensured equity of staff access to CNWA wellbeing initiatives across multiple sites
- Created a range of continuous feedback mechanisms to monitor progress
- Created a succession plan to ensure that staff wellbeing remains a key, sustainable priority for the service.

Outcomes so far include a 50% increase in staff engagement and feedback rates, and positively moving CNWA staff overall wellbeing NPS score from -61 to 0.

Gathering of Kindness

A virtual Gathering of Kindness event was held in November 2024 to transform the culture of healthcare through compassion, connection, and communication. Industry experts, frontline healthcare workers and kindness champions delivered a series of presentations, interactive workshops, and panel discussions about how kindness can improve communication, reduce medical errors, and support wellbeing.

Wellbeing Month

Throughout June 2025, health and wellbeing activities were organised for all NMHS employees to support physical, mental health and wellness, including heart health checks to measure blood pressure and heart rate, and perceived stress levels and diabetes risk assessments.

A total of 461 staff participated in the health checks during Wellbeing Month, of which 56% were women and 44% were men. Most people (285) had not had a blood pressure check in the previous 12 months and appreciated the opportunity to check this key health risk factor.

Free bike mechanic services

Each month, NMHS employees can access free basic bike servicing and repair courtesy of the Bike Dr and the QEII Medical Centre Trust. The workplace benefit encourages people to cycle to work and have confidence their bikes are in top condition. Services include a clean, gear adjustment, brake adjustment, bearing check and test ride.





Guidance Gurus buddy system

A volunteer support program for new nursing graduates is being trialled in ward G74 at SCGH.

Created by Clinical Nurse Shannon Hewitt and supported by Clinical Nurse Specialist Ellie Tovey, Guidance Gurus pairs experienced nurses with new graduates to act as a go-to person for questions and support.

The Guidance Gurus assist in debriefing pre and post shifts, escalating concerns, building confidence in the clinical area, finding resources and providing friendship. They also send weekly messages to check in with their graduate.

Building capability through training

Our Learning and Development program continuously evolves to provide opportunities to build capability, support a high performing culture and foster career fulfilment. New training courses have been introduced to support the wellbeing of our staff, such as Psychological First Aid training and the RRR program – Recognise, Respond and Refer: Early identification and intervention on health and wellbeing issues.

As a Registered Training Organisation, we offer a nationally-accredited Diploma in Leadership and Management and various short courses to develop leadership skills and personal effectiveness such as leading teams through change, providing feedback and emotional intelligence. In 2024-25, more than 35 employees from NMHS and CAHS graduated from the Diploma in Leadership and Management program.



Leadership development

NMHS employees have the opportunity to join programs offered by the Institute for Health Leadership, such as the Aboriginal LEAD program and Executive Coaching. In 2024-25, 42 NMHS employees participated in these programs.

We have also developed bespoke leadership programs in partnership with external providers.

New programs offered in the last year are outlined below.

Program	Purpose	Attendees
Leadership Launchpad	Provide frontline leaders with the essential skills, knowledge and resources to be an effective leader and manager.	Full day – 50 Half day – 29
Medical Leadership Program	Develop leadership and management skills of existing and aspiring medical heads of department. Modules 3-6 will run in 2025-26.	Module 1 – 19 Module 2 – 21
Compassionate Leadership	Build the capability of our leaders to foster a culture of collaboration, respect, emotional intelligence and build a psychologically safe workplace.	95+ attendees
Career Conversations	Provide managers with the skills and tools to conduct effective career conversations to facilitate staff career development.	51+ attendees



Certificate II in Health Support Services for patient support services

NMHS became the first health service provider to offer a Certificate II in Health Support Services to staff employed in the Patient Support Services (PSS) team following the launch of the certification.

The new qualification reflects the essential role of PSS staff, who support the effective functioning of health services within hospitals.

Four participants completed the certification in 2024-25.

Leadership panel

Aspiring medical heads of departments gleaned leadership insights and tips from some of WA’s prominent clinical leaders joining a panel discussion about career development.

Dr Simon Wood, Dr Neale Fong, Dr Andrew Jamieson, Dr Damien Wallman, Dr Jodi Graham and Dr Smitha Bhaduri shared experiences from their leadership journeys with participants in the Medical Leadership Program. The panel covered topics ranging from challenges as a head of department, to managing former peers, building trust and credibility, and how to navigate the balance between clinical duties and leadership responsibilities.

North Space Leadership Forum

More than 180 leaders from across NMHS attended the North Space Leadership Forum 'Cultivating Empowered and Engaged Teams' in May 2025. Presenters included NMHS Board Chair Adjunct Associate Prof Karen Gullick, NMHS Chief Executive Rob Toms and consultant Daniel Murray.

Five market stalls were set up on the day to provide leaders with resources covering career growth in a changing world; giving feedback; creating a culture of care and belonging; tools to build stronger leadership; and information about new Industrial Agreements. Participants rated the event 4.8 out of 5.



Transplant Procurement Management training in Spain

Two donation specialist coordinators from DonateLife WA attended the Transplant Procurement Management Advanced International training course in Barcelona in 2024.

The Janette Hall Professional Training and Development Scholarship enabled Tanya Badenhorst and Natala Taylor to join the course and learn from experts about the advanced medical techniques used in Spain for organ transplants. Spain is considered the world leader in organ procurement and donation, and has a similar soft 'opt-out' organ donor registration system to Australia.

🌀 Delivering on our Strategic Plan: Building a sustainable future



Our commitment to making healthcare more sustainable and addressing the impacts of climate change on health, service delivery and healthcare infrastructure is unwavering. This objective in our strategic plan relates to financial and environmental management and performance, as well as proactive infrastructure planning – including buildings and ICT infrastructure – for a sustainable future.

Our inaugural Climate and Sustainability Strategy was launched in December 2024 and provides a guiding framework to deliver a reduction in our environmental impact and prepare us for the risks and impacts of climate change.

It identifies the priority areas we will focus on over the next three years to reduce our carbon footprint, operate more sustainably, and support adaptation to the impacts of climate change. These areas include:

- Climate adaptation and resilience
- Sustainable low carbon healthcare, including digital health solutions
- Asset management and utilities
- Procurement, supply chains and purchasing
- Waste reduction and increased recycling, and
- Transport and travel.

Digital health solutions

Increasing our utilisation of digital health solutions is crucial to advancing patient care and health outcomes and achieving sustainable low carbon healthcare.

Our new Digital Health Strategy 2025–2027 aligns to the WA Health Digital Strategy 2020–2030 and focuses on supporting the implementation of digital health initiatives and the delivery of the Electronic Records Management project.

The strategy identifies six key priorities to help progress the organisation's digital health journey, with a particular focus on positioning information assets at the centre of decision making.

This strategy aims to achieve:

- Optimum patient outcomes with a focus on digital enablers to support models of care
- Improved accessibility and flow of information for clinicians and consumers
- Enhanced stability and resilience of critical infrastructure and information assets
- Optimised value from our information assets, including through the use of artificial intelligence (AI) technology, to support decision-making from the Board to wards
- Investment in enabling technologies that deliver care (virtual and remote).



Green maternity ward

A ward at KEMH is being transformed into Australia's first comprehensive 'green' maternity ward.

The concept to transition Ward 3 from plastics and harmful chemicals to more sustainable alternatives was first pitched at our Streamline, Optimise and Save (SOS) innovation challenge in October 2024.

The idea was then workshopped, and additional low-investment and high-impact ideas put forward to create a sustainable ward. These included moving from single use plastic infant feeding bottles to single patient use bottles, water bottle refilling areas, reusable ice and heat packs, paper medication discharge bags, removal of plastic liners from recycling bins, reducing unnecessary wastage and recycling contamination.

In addition to these changes, a new campaign, Think Before You Glove, has helped significantly reduce the number of excess gloves going to landfill.

Looking Forward >>>>

The Green Ward pilot has the potential to be expanded across the site and in other hospitals, ultimately helping to reimagine sustainable health care in Western Australia.

Digital Medical Records

The rollout of Digital Medical Record (DMR) across our sites is nearly complete, with OPH coming online in July 2025, and SCGH on track for completion in August 2025. Implementation at KEMH and Graylands Hospital was undertaken in 2023-24.

The DMR platform changes the way patient care is documented and how clinicians access patient information, with records available in real-time across multiple locations. It securely shares electronic documents to provide accurate, up-to-date and comprehensive patient information across the WA public health system.

This significant project, delivered in partnership with Health Support Services (HSS), has included upgrades to wi-fi connectivity work and equipment, and the installation of 1668 additional monitors, 535 wall-mounted and desktop PCs, and 200 Workstations on Wheels this year.

Cyber security

We continue to work with HSS and the Office of Digital Government (Department of Premier and Cabinet) to improve cyber controls across our systems.

A focus in 2024-25 was promoting cyber awareness to employees. In addition, all employees are required to complete mandatory annual online cyber security training.

In August 2024, we participated in an executive-level cyber incident simulation exercise conducted by HSS and the Department of Health, as part of ongoing critical incident preparedness.

We meet regularly with other HSPs as part of a whole-of-health approach to meeting the WA Government Cyber Security Policy and the draft WA Health Cyber Incident Management Framework.

GEM Awards – Green Champion of the Year: SCGH ICU

A passion for sustainability led SCGH ICU's team to identify new ways to reduce plastic waste while improving patient experience, with outstanding results.

Over 12 months, the team trialled extending the time between intravenous line (IV) changes from three to seven days, in line with current evidence.

In addition to saving 948 IV lines, the trial found the risk of infection at cannula sites and patient discomfort associated with cannulation were also reduced.

The change also saved valuable staff time that was previously spent gathering equipment, washing hands, and changing lines. This time is now redirected towards more critical patient care activities.

Another initiative led by ICU, Think Before You Glove, aimed to reduce unnecessary non-sterile glove use through education and awareness. This trial is being evaluated for possible expansion across other areas.

The dedication to sustainability initiatives saw the ICU team named Green Champion of the Year in our 2024 GEM Awards.

Procurement

Under guidance from HSS and the Department of Treasury and Finance, NMHS procurement planning activities seek to identify appropriate sourcing strategies that consider opportunities for engagement with local businesses, including Aboriginal businesses and WA-based manufacturers.

Following the completion of the NMHS Strategic Forward Procurement Plan, we will target suppliers within the categories of cleaning, waste, trades and utilities that have the capability and capacity to deliver services on our behalf. We will continue to support product trials of goods manufactured locally to improve opportunities for local businesses in becoming preferred suppliers within the health supply chain.

Asset management

We have made good progress in introducing and embracing sustainable practices in asset management, utilities and transport. We were the first public health service in WA to establish an electric vehicle fleet. We have also led the way in reducing the WA health system's carbon footprint from inhaled anaesthetics, particularly desflurane. In 2024, SCGH became the first tertiary hospital in WA to decommission nitrous oxide piping to minimise waste of this potent greenhouse gas.



Other changes made to our asset management and utilities to improve sustainability included:

- Replacing more than 5000 light fittings to more energy efficient LED lights
- Undertaking replacement of damage lagging to reduce heat losses from pipework
- Upgrading 5 hot water units from old gas fired to electric hot water systems.
- Adjusting schedules of start and stop times for non-clinical building to get a saving of 30 running hours a month for HVAC systems.

Recognising the impact of travel on carbon emissions, we continue to encourage the use of virtual meetings rather than travelling to sites. At least 100 trips have been saved from within our Facilities Management team alone that would have otherwise involved the use of fleet cars.

Upskilling our workforce

We recognise that achieving our sustainability goals will require a collective effort, and we are fortunate to have a passionate, dedicated and engaged workforce who are leading the way. This includes more than 100 sustainability leaders who initiate and champion climate and sustainability initiatives across our sites and services.

Additional training opportunities were offered to NMHS staff this year to build their knowledge about climate change, decarbonisation and ways to improve sustainability in healthcare. A refreshed waste management e-learning module was also developed for staff.

A number of presentation and events were made available for staff to attend including:

- Screenings of Greening the Healthcare Sector Forum in November 2024, which showcased healthcare leaders across Australia and the Pacific who are actively working to improve health equity through decarbonisation.
- Presentations as part of Plastic Free July to educate staff about plastic as a human health issue and activities in Europe to reduce plastic exposure in wards by Minderoo Foundation and Health Care Without Harm.

Carbon Literacy Certification

Eighteen NMHS employees became certified under the UK's Carbon Literacy Project Program this year. The certification training, delivered in May 2025 and co-facilitated with Edith Cowan University, looked at ways to reduce emissions in healthcare delivery, such as sustainable procurement practices, low-carbon models of care (e.g. prescribing oral instead of intravenous medications where clinically appropriate) and waste reduction (e.g. avoid, reduce, reuse wherever possible).

Participants then developed individual and group action plans for assessment to receive their official carbon literacy certification.



Sustainable green-scaping healing gardens

A competition was held with students from UWA to design sustainable courtyard gardens at SCGH and OPH that promote healing, wellbeing, and climate resilience.

Evidence shows that increased green space on health campuses can contribute to improved wellbeing for staff and patients, faster recovery times and better clinical outcomes. Green infrastructure also helps mitigate extreme temperatures, manage flood risk and safeguard biodiversity.

The winning design, "A Home (Away from Home)" for a courtyard garden at OPH won

both the People's Choice and Judges' Choice awards. The concept has a special meaning for the student who was born at the hospital and whose family member was a patient over several months.

The design aims to transform the courtyard into a welcoming, restorative space which offers comfort, connection, and a touch of nature for all who visit.

Building is expected to begin in the first half of 2026.



Delivering on our Strategic Plan: Embracing innovation and research

We recognise that innovation and research are vital to drive transformation and enhance patients on their healthcare journey.

To help build the strong culture of research and innovation that exists across our services, work is underway to develop a strategic agenda to align research and innovation to amplify our capabilities and drive transformational change across healthcare.

Innovation

Our Innovation team is dedicated to fostering an environment where ideas thrive through creative thinking, collaborative problem solving and partnerships. The team works across the service to embed a culture of innovation, build innovation capability and maturity and support teams to embrace experimentation and new ways of thinking.

Key priority transformation areas that focus on innovation include:

- Service access and system flow
- Clinical excellence
- Digital transformation
- Workforce
- Infrastructure
- Public and preventative health.

In 2024-25, our focus was on implementing the recommendations from a functional review conducted in 2023-24. Outcomes of this work to date include:

- **A new Innovation Guide**, which sets out our shared innovation direction and a framework for delivering innovation.
- **Education materials** including an Introduction to Innovation e-learning module and video for staff to build their knowledge about why innovation matters and an innovation module for the NMHS Diploma of Leadership and Management.
- **A library of innovation tools and resources** to support staff along the innovation journey.
- **An ideas management system** to capture challenges and ideas, and empower teams to be proactive in leading innovation.

Innovative Future Program

The Innovative Future Program continues to provide support and seed funding to innovation initiatives underway across NMHS, including the following:

Automated scheduling solution

A proof of concept tested an automated scheduling solution, Skedulo, within HomeLink

and Hospital in the Home (HITH) services. Skedulo integrates a web-based app for centralised scheduling and a mobile app for community-based workforce access to streamline complex clinical workflows, reduce manual and paper-based processes, and enhance patient information security. Valuable lessons have been learnt from the trial and have been used to inform the selection of a system-wide digital solution.

Clinical role-based messaging platform

The Allied Health, Medical, Nursing and Pharmacy teams at SCGOPHCG piloted Baret, a clinical role-based messaging platform between November 2024 and January 2025. The project tested the platform's capabilities as a digital enabler to enhance patient flow. The pilot found improved real-time communication between departments and clinical teams, and enhanced policy compliance by reducing ICT security risks for information sharing. The platform complements the early success of the Emergency Care Navigation Centre at Sir Charles Gairdner Hospital, which has been instrumental in directing patients from ED to appropriate care pathways.

WA Gynaecologic Cancer Service (WAGCS) journey mapping

Program funding supported the facilitation and capability building of the WAGCS team to map their patient journeys across a large portion of their service delivery in 2024-25. This activity helped to identify challenges from both clinician and consumer perspectives. A one-day hackathon will be held with WAGCS to brainstorm these findings and improvements across the service journeys later in 2025.

Streamline, Optimise and Save (SOS) Challenge

Our inaugural Streamline, Optimise and Save (SOS) Challenge was held in September 2024 and provided an opportunity for NMHS staff to propose ideas for improving workflows, promoting financial sustainability, and minimising environmental impact.

Twenty submissions were made from various business areas, primarily targeting workflow improvements and digital solutions to streamline manual tasks. Shortlisted ideas were further refined through design workshops and presented to the NMHS Executive Team for endorsement. Some submissions that weren't shortlisted were noted as low-cost, high impact and will be progressed through other pathways.

The winning submission, put forward by the KEMH Ward 3 and Strategy and Change teams, proposed the ward transition from plastics and single-use consumables to reusable alternatives.

Other concepts approved for progression included a water refill and recycling station that uses gamification to encourage sustained use, a new clinical waste solution and increasing uptake of virtual interpreter services.

My Emergency Visit

SCGH Emergency Department was awarded a Future Health Research and Innovation (FHRI) grant to further develop an app known as My Emergency Visit, which was created to streamline patient management, communications and care for people who need to attend the Emergency Department.

The app is designed to provide a digital front door for patients to self-register, a clinical portal and tracking dashboard that provide clinicians with improved visibility of waiting room patient information. The grant will be used to develop the next part of the project, which includes the development of a digital observation chart enabling clinicians to remotely monitor waiting room patients' vital signs, supporting early intervention if a patient's condition deteriorates.

The concept was initially pitched at the 2021 NMHS Innovation Shark Tank event. After receiving Innovative Future seed funding to develop a prototype, the concept attracted further funding through the Ministerial Taskforce on Ambulance Ramping.

The \$500,000 FHRI grant announced in May 2025 will enable Phase 2 of this project - integrating MEV with the Emergency Department information system. This will transition the project from innovation to digital transformation.

Collaborating for success

NMHS partners with other HSPs, schools, universities and community organisations to enhance innovation and build capacity and capability through shared knowledge and ideas, mentoring and competitions. Some examples of partnerships in 2024-25 included:

Youth Innovation Think Tank 2024

NMHS partnered with EMHS, SMHS and WACHS to deliver this event, which sees students from years 10 to 12 work with mentors from each HSP to tackle a social problem. The NMHS Innovation team worked with students from St Hilda's Anglican School to apply human-centred design thinking to address rising suicide rates among Indigenous youth in the Karratha region. The team's proposal to reduce mental health stigma through sport won second place in the competition.



2024 WA Health Hackathon

NMHS was a key sponsor and partner of this event, organised by the WA Data Science Innovation Hub, and posed the challenge of simplifying post-stroke rehabilitation information for patients. A solution put forward by the second-place team, Torab, went on to be prototyped in collaboration with Osborne Park Hospital and our Innovation team.

2024 WA Health Innovation Showcase

This showcase, hosted by SMHS in collaboration with other HSPs, offered an opportunity to share and inspire creating sustainable healthcare solutions. We moderated a panel discussion on bridging the gap between the public health system, start-ups and industry with participants from each of the sectors. The group acknowledged the challenges faced working together and suggested closer collaboration and co-design initiatives to strengthen working relationships.



Research across NMHS



As state and national research leaders, we are involved in a number of key international research projects. In 2024-25 there were more than 390 active research projects underway across our sites, and our researchers achieved more than 800 peer reviewed publications.

Our researchers led and collaborated on a range of innovative breakthroughs that are shaping and transforming healthcare delivery and outcomes. This included new treatment approaches, robotics, new surgical approaches, the use of predictive and wearable technologies, methods to provide more care in people's homes, clinical trials, and system and process improvements. Some of these projects are described in more detail below.

"Researchers from across NMHS achieved more than 800 peer reviewed publications in 2024-25."

Research strategy

We are developing a number of activities to grow capability and attract funding to strengthen our research program.

To align with the WA Health and Medical Research Strategy 2023-2033 vision of becoming a collaborative, consumer-driven ecosystem that leads impactful research, our research strategy is focused on:

1. Capacity building, with a focus on supporting early and mid-career researchers and attracting world-leading researchers and innovators to WA
2. Knowledge generation, translation and implementation
3. Infrastructure
4. Research impact.

Investing in resources

Funding through the WA Government’s Office of Medical Research and Innovation’s new Research Infrastructure Support (RIS) program supported the provision of research facilities, equipment and services.

In line with our priority to enhance our reputation in leading research, further investment has gone into staffing resources. A new coordinator research navigation position has been created to support researchers at all stages of the research review process and to sustain research activity at SCG and OPH.

A new Research Hub was established at KEMH to support researchers with developing research questions, writing and submitting a proposal, data analysis for low/negligible risk projects and advice on governance and grant applications.

Mental health research governance responsibilities were transferred to SCGOPHCG Research Governance Office and are now aligned, providing additional expertise across the team.

Research activity

The below table shows the research activities underway across NMHS. Cancer, Imaging and Clinical Services divisions undertake the most research. At OPH, the majority of activity is undertaken by allied health researchers. In Mental Health Services, the majority of research is non clinical, non commercial projects.

	SCGOPHCG		WNHS	MHS
Commercial activities	110		11	0
Non commercial activities	246			34
	SCGH	OPH		
Clinical trials	185	4	6	6
Non clinical trials	147	20	11	28



Research at SCGOPHCG

In 2024-25, recruitment across all active studies at SCGOPHCG was expected to result in 5,057 participants. The total number of active participants in this period was 9,041.

A total of 356 projects were active in this reporting year. Of these, 205 went through a National Mutual Acceptance (NMA) Ethics process, and 151 were approved via a non-NMA Ethics process.

Improved approval timeframes

Over the past five years, time for ethical approval and site approval has markedly reduced at SCGH and OPH, attributable to changes in 2024, such as the introduction of the Research Navigation Service, and streamlined processes. The average time for ethical approval reduced from 87 days in 2023 to 37 days, before the closure of the SCGOPHCG Ethics Committee. This is compared to the nationally accepted standard of 60 days. The average time for site authorisation has reduced from 121 days in 2023 to 21 days.

“These improvements have a significant impact on the viability and appeal of NMHS as a destination for researchers and offer our patients greater opportunities to participate in potentially life-changing trials with improved approval timelines.”



Learn more about
Research Week



Research Week

The annual SCGOPHCG Research Week was held in October 2024 and featured presentations from research experts, panel discussions and a poster expo with 59 submissions, which showcased the exceptional research work underway across SCGH and OPH.

A highlight of the week was the awards evening where the winners of the Research Poster Showcase competition and Charles Foundation for Research grants were announced. The next Research Week Expo will be held in September 2025.

Looking Forward >>>>

Work will continue to strengthen our ongoing accreditation readiness against the National Clinical Trials Governance Framework in the second half of 2025. A new Research and Innovation Strategy is in development and is expected to be rolled out in late 2025.

Research and innovation grants

Our researchers were successful in a range of grant opportunities from the State Government, Charlie's Foundation for Research and other sources in 2024-25:

Lead	Activity title	Program
Dr Rajesh Thomas	Establishing the first integrated clinical, research and training program in robotic bronchoscopy in Western Australia for patients with lung cancer	FHRI Fund: Enabling Scheme - 2024-25
Ms Emma Rooney	My Emergency Visit (MEV) – Sir Charles Gairdner Hospital (SCGH) Emergency Department Pilot	FHRI Fund: Targeted Call - Health System Solutions - 2024-25
A/Prof Matthew Anstey	Predicting sepsis in the Emergency Department using AI	Innovative Solutions – Digital Health funding program (FHRI)
Dr Sanjay Ramakrishnan	DEAR-COPD: Diagnosis through Early Assessment during Respiratory Events	Charles Foundation: Bright Ideas Grant
Dr Brendan Luu	Using non-invasive OCTA imaging of the retina to detect human cancer	Charles Foundation: Bright Ideas Grant
Dr Paul Armstrong	Characterisation of liver fibrosis in patients with cystic fibrosis – a retrospective review	Charles Foundation: Bright Ideas Grant

Lead	Activity title	Program
Dr Julia Bereyne	Exploring Oncology Patients' Perceptions of Clinical Trials: A Qualitative Study	Charlies Foundation: Bright Ideas Grant
Stephanie Preen	Can augmented reality scanning technology support occupational therapy home environmental assessments? A feasibility study.	Charlies Foundation: Bright Ideas Grant
Mr Peri Mickle	Provocation threshold and severity of hypersensitivity with intravenous challenge using non-linear drug infusion	Charlies Foundation: Bright Ideas Grant
Professor Bronwyn Stuckey	Does hormone treatment of infants with undescended testes improve fertility in adult life?	Charlies Foundation: Discovery Grant
A/Prof Mahsheed Sabet	Sparing the Maximum Healthy Lung Volume during Lung Cancer Radiation Therapy by Predicting the Tumour Motion from Pre-Recorded Patient Factors	Charlies Foundation: Discovery Grant
Prof Michaela Lucas	Finding targets for new drugs to prevent rejection of transplanted organs	Charlies Foundation: Discovery Grant
Ms Alice Boyle	Can access to early hand therapy improve clinical, service and cost outcomes for patients with hand and upper limb injuries on surgical outpatient waiting lists?	Charlies Foundation: Discovery Grant

Lead	Activity title	Program
A/Prof Kun Kathy Zhu	Analysis of molecular pathways involved in osteoporosis for the development of therapies.	Charlies Foundation: Discovery Grant
Dr Bryan Ward	Examination of the regulation of a gene, CYP19A1, that is linked to osteoporosis, in the cells that are important for bone turnover	Charlies Foundation: Discovery Grant
Dr Aaron Rusnak	Identifying the location of parathyroid glands on 4DCT imaging with a diagnostic tool powered by artificial intelligence	Charlies Foundation: Discovery Grant
Dr Gemma Doleman	Developing, implementing and evaluating a co-designed support strategy for nurse managers	Charlies Foundation: Discovery Grant
Dr Elon van Dijk	Finding early signs of human cancer and its response to therapy	Charlies Foundation: Discovery Grant
A/Prof Lingjun Mou	Redefining the anatomy of liver segments in a micro-CT study of cadaveric livers	Charlies Foundation: Discovery Grant
A/Prof Matthew Anstey	Detecting changes in muscle size and function in intensive care survivors using MRI imaging	Charlies Foundation: Discovery Grant



WA's first robotic bronchoscopy service

SCGH has become the first hospital in WA to provide robotic bronchoscopy procedures, marking a major development in lung cancer diagnosis and care in the state.

The SCGH Respiratory team secured funding for the robot and integrated clinical, research and training program, which included a FHRI grant and donations from the Charlies Foundation for Research, McCusker Charitable Foundation and Institute of Respiratory Health.

The new program enables specialists to perform robotic navigational bronchoscopy, which provides minimally invasive methods to biopsy small, hard-to-reach nodules in the peripheral lung leading to earlier, more accurate diagnosis of lung cancer.

The service will play a critical role in maximising the benefit of the National Lung Cancer Screening Program, which commenced in July 2025.

Introduction of phage therapy in WA

SCGH became the first hospital in WA to use phage therapy to treat multi-drug resistant infections in late 2024.

Antimicrobial resistance has been identified by the World Health Organisation as an urgent threat to global health and is an increasing challenge for hospitals.

Phage therapy uses bacteriophages (phages), viruses found naturally in the environment that specifically target and kill bacteria. Although the concept is not new, its use in treating multi-drug resistant infections is giving clinicians and patients an alternate option to prolonged use of intravenous antibiotics or further surgeries.

Keith Loudon became the first patient in WA to receive the treatment to fight a multi-drug resistant infection he developed following heart surgery in 2021. After three years on and off IV antibiotics, a positive response to phage therapy has provided an alternative to further surgery for Keith.

Its success offers an exciting development for patients with difficult to treat, severe or drug-resistant infections. SCGH clinicians are now collaborating nationally on a clinical trial aimed at standardised treatment and monitoring of phage therapy.

LEVERAGE: new treatment options for blood cancers

Professor Chan Cheah, a Specialist Physician in Haematology and Pathology at SCGH, is leading an investigator-initiated trial into treatment options for patients with lymphoma and other blood cancers.

Known as LEVERAGE, the phase I/II clinical trial is looking into the potential of non-chemotherapy treatments for advanced stage follicular lymphoma patients, as an alternate option to chemotherapy which can have undesirable side effects.

Follicular lymphoma is the most common type of slow-growing lymphoma in the Western world, with 300 to 400 patients diagnosed a year in WA and thousands more living with it.

Interim results from the study have been positive, with 91 per cent of the 45 patients responding to the drug combination and 79 per cent achieving a complete response, with their scan at the end of the six months showing no lymphoma.

Trials like LEVERAGE are providing early opportunities for patients in WA to access promising new treatment options.

Transforming patient care in ICU with AI-assisted wearables

Researchers at SCGH's Intensive Care Unit are investigating the feasibility of using an artificial intelligence (AI) assisted smart watch over traditional methods to measure and monitor a patient's vitals.

The initial phase aims to compare and evaluate the accuracy of a wearable medical-grade bio-band in measuring a patient's heart rate, blood pressure and oxygen levels against both standard non-invasive devices and arterial lines in 30 ICU patients.

The results evaluate whether a smart watch can accurately measure vitals in unwell patients, opening the door to remote monitoring. This would free up nursing resources and reduce the need to wake patients for vital checks, and lead to new ways to detect patients deteriorating on the ward.



Revolutionary fetal monitoring device trial

A revolutionary device described as the biggest development in fetal monitoring in 50 years is being trialled at KEMH.

Developed by WA medtech company VitalTrace, along with UWA researchers, it has the potential to prevent major health issues such as birth asphyxia and cerebral palsy.

UWA Associate Professor Scott White, a Maternal Fetal Medicine Service Consultant at KEMH, has been working with inventors for seven years to get the groundbreaking wireless device to the trial stage.

The device measures lactate, the natural substance produced by cells when they use glucose for energy production when the body lacks oxygen.

“Ultimately this is about making childbirth safer, both for mothers and for babies. So, giving us a better technique to pick up the babies who are compromised, but also limiting our interventions to the mums who really need it,” A/Prof White said.

The mobile device has a small electrode sensor that is applied by an obstetrician or midwife to the baby’s scalp once the mother’s waters have broken and the baby’s head is accessible.

It transmits real time information from the sensor to a monitor using wireless technology, which means the mother can move around freely during labour while healthcare professionals monitor the wellbeing of her baby.

It is estimated the device may reduce emergency caesarean section rates by as much as half.

The next step in the development pathway of the device is an international clinical trial involving maternity hospitals globally.



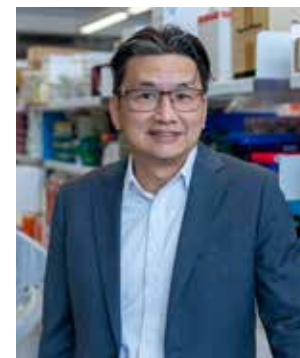
Predicting sepsis in Emergency Departments

SCGH Intensive Care Specialist Matthew Anstey is investigating how AI can be used to predict sepsis in the Emergency Department.

Using a FHRI new Innovative Solutions – Digital Health grant, the study will look at combining AI with current data sources to improve predictions of patients with sepsis. The project includes NMHS business intelligence and external AI experts.

New Collaborative Centre for Innovative Pleural Research

As part of the Government’s Collaborative Centres Program, SCGH was awarded \$1.2 million to set up a new Collaborative Centre for Innovative Pleural Research led by SCGH Director of Pleural Services Prof Gary Lee.



The Collaborative Centres Program is a new initiative to accelerate WA’s world-leading research, and develop national and international research partnerships.

Pleural effusion (abnormal buildup of fluid in the chest) affects 23 million people annually worldwide, often causing distressing breathlessness.

The funding will enable WA researchers to expand their expertise and develop new approaches for non-cancer effusions caused by heart, liver and kidney failures. This would potentially benefit five times as many patients, improving their quality of life while reducing hospital stays and invasive interventions.

The SCGH research team includes Cardiology, Hepatology and Nephrology Departments, and Edith Cowan University. Collaborative Centre Program partners include the Institute for Respiratory Health, UWA, Dartmouth Hitchcock Medical Centre and Bristol Academic Respiratory Unit.

Biobank at the forefront of endometriosis research

KEMH staff are supporting research into endometriosis, a painful condition affecting about 1 in 7 women, with hospitalisations doubling in the past decade.

Theatre staff are collecting samples from consenting patients for a biobank that researchers are using to investigate contributing factors to the condition and how to better treat it.

The researchers – two Perth students – are being supervised and supported by KEMH's Dr Pippa Robertson and Dr Krish Karthigasu.

Akaiti, who established the biobank, was inspired by a similar biobank which gathers samples from burn patients.

The biobank is a tangible step towards improving quality of life for people with endometriosis.



Watch the full story
on the ABC



Pioneering research in toddlers with The Kids Research Institute

Researchers at JHC are working with The Kids Research Institute Australia to identify why there is a high prevalence of low iron in children under three years of age in WA.

ORIGINS is the largest longitudinal birth study of its kind in Australia, using data from 10,000 babies born at JHC and conducted in partnership with The Kids Research Institute Australia. The study has found that a third of one-year-olds and up to two thirds of three-year-olds have low iron.

Work is now underway by paediatricians at JHC, through the ORIGINS sub-project IRON Child,

to find out why iron deficiency is so prevalent among toddlers and to help find solutions.

One of the areas of focus involves investigating possible links between iron deficiency and childhood anxiety and neurodevelopmental conditions, including ADHD.

While long-term outcomes from the broader ORIGINS research platform would take more time to transpire, the IRON Child project would provide some practical and affordable solutions for parents in the interim.

Partnerships

NMHS researchers are affiliated with many specialist research partners and thank our partners for their ongoing support. These include but are not limited to:

Centre for Neonatal Research and Education

Centre for Nursing Research

Charlies Foundation for Research

Curtin University

Department of Nursing and Midwifery Research

Edith Cowan University

Genetic Services of Western Australia

Harry Perkins Institute of Medical Research

Institute for Respiratory Health

Keogh Institute for Medical Research

Linea Research

Lions Eye Institute

Murdoch University

National Institutes of Health

NHMRC

PathWest

Perron Institute for Neurological and Translational Science

Perth Children's Hospital

Population Health

Queen Elizabeth II Medical Centre

The Kids Research Institute of Australia

The University of Western Australia

The Whole Nine Months – WA Preterm Birth Prevention Initiative

Western Australian Cancer Prevention Program

Western Australian Health Translation Network (WAHTN)

Women and Infants Research Foundation

Safety and Quality



We continually monitor and evaluate patient safety indicators as part of our commitment to delivering quality healthcare.

Quality Improvement

Quality Improvement (QI) is the methodical approach employed to improve the safety, effectiveness, and the experience of care. Initiatives underline our dedication to improving patient care, safety, and overall service delivery through systematic and continuous improvement. Examples of these include:

Complaints Management Improvement Project

The Complaints Management Improvement Project commenced in 2024 and comprises a range of strategies encompassing resourcing, staff training and quality assurance measures. This work is leading to a more consistent approach to complaint management across our services and improving the consumer experience for people who provide feedback.

TB control program medication charts

The WA Tuberculosis Control Program developed two new medication charts to improve the medication management process and ensure patient safety. The long stay medication chart is used for patients who are prescribed medication for more than 6 months.

It includes a section for the collection and recording of the best possible medication history. It allows the clinician to prescribe and supply medication over a longer period (i.e. 12 months) which reduces the need for multiple medication charts that can lead to errors.

Involving consumers in Serious Clinical Incident reviews

A program to include Consumer Representatives in Serious Clinical Incident reviews has been launched, with tailored inductions to support their inclusion in review panels. The presence of consumers brings valuable perspectives and promotes transparency. Their feedback has led to patient-centred solutions that improve care quality and fosters better engagement and collaboration between patients and providers. Further insights have been gathered from consumer representatives and panel members about this process, leading to development of a Consumer Representative Recruitment Procedure to support ongoing enrolment and training of consumer representatives.

Clinical Incidents via Datix CIMS

NMHS Non SAC1 Incidents

Lead	To 30/06/2024	To 30/06/25
SAC 2	761	710
SAC 3	8,322	8,522
Unconfirmed – no SAC assigned yet	250	406

Improving systems to deliver the best care possible

The overwhelming majority of interactions with our health service results in positive experiences and outcomes for patients, carers and their families. However, for a very small number of patients, regrettably, errors have occurred during their care. Any instance of avoidable harm to a patient may have tragic consequences for the patient, their family and health care staff. Open disclosure with the patient/family is essential for building trust, fostering patient-provider relationships and promoting accountability within the healthcare system.

NMHS is committed to ensuring that every clinical incident is an opportunity to learn, understand and make changes to improve care and reduce the likelihood of a similar occurrence in the future. Through ongoing training and support, staff learn about the process of identifying, reporting and investigating clinical incidents to assist with learning lessons and developing recommendations to prevent and manage the issues and risks.

Additionally, the consumer role in clinical incident investigation is increasingly being recognised as a crucial aspect of ensuring transparency, accountability and improvement in healthcare. Consumer involvement can provide valuable feedback on the patient experience and advocate for changes to complement clinical staff insight.

This year, NMHS has made good progress in better involving consumer representatives in reviews to ensure the patient is kept at the centre of the process and the consumer perspective is upheld.

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

In 2024-25, NMHS reported and reviewed 130 clinical incidents with a SAC1 rating. Of the 109 completed reviews, 25 resulted in the incident being approved for declassification by the Department of Health's Patient Safety Surveillance Unit, as it was determined that there were no healthcare factors that contributed to the adverse patient outcome.

At the time of this report, 21 SAC 1 incident reviews were still in progress. Of the 105 SAC 1 investigations that were completed or remain in progress, the patient outcome* was noted as:

No harm	7
Minor harm	3
Moderate harm	5
Serious harm	69
Death	21

*It is important to note that the patient outcome does not necessarily arise as a direct cause of the incident. There are a number of non-healthcare-related factors that may contribute to a patient's outcome. All SAC1 clinical incidents are subject to a rigorous clinical incident investigation and the reports are reviewed by members of the NMHS Executive and the NMHS Board.

Key Performance Indicators



Outcome-based management framework

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

The OBM framework describes how outcomes, services and key performance indicators (KPIs) are used to measure the performance of the WA health system towards the State Government goal of 'Strong communities, safe communities and supported families' and the WA Health agency goal of 'Delivery of safe, quality, financially

sustainable and accountable health care for all Western Australians'. The KPIs measure the effectiveness and efficiency of the services delivered against agreed government priorities and desired outcomes.

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

Outcome

1

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

Service 1

Public hospital admitted services

Service 2

Public hospital emergency services

Service 3

Public hospital non-admitted services

Service 4

Mental health services

Outcome

2

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

Service 6

Public and community health services

Service 8

Community dental health services

Performance against these activities and outcomes is summarised in the Tables on pages 10-13 and subsequently described in the following section.

Changes to OBM framework

The OBM framework was implemented for annual reporting from 2017-18. There were no material changes to the framework in 2024-25.

Shared responsibilities with other agencies

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

Key indicators related to services delivered by NMHS

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

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

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

Effectiveness KPIs

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

Efficiency KPIs

Service 1 Public hospital admitted services

- Average admitted cost per weighted activity unit

Service 2 Public hospital emergency services

- Average emergency department cost per weighted activity unit

Service 3 Public hospital non-admitted services

- Average non-admitted cost per weighted activity unit

Service 4 Mental health services

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

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

Effectiveness KPIs

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

Efficiency KPIs

Service 6 Public and community health services

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

Service 8 Community dental health services

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

Certification of key performance indicators

For the year ended 30 June 2025

We hereby certify that the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the North Metropolitan Health Service's (NMHS) performance, and fairly represent the performance of the NMHS for the financial year ended 30 June 2025.



Adj Assoc Prof Karen Gullick
Board Chair
North Metropolitan Health Service
26 September 2025



Renae Farmer
Board Finance Committee Chair
North Metropolitan Health Service
26 September 2025

Detailed information in support of Key Performance Indicators

Material changes in KPI definitions and cost allocation methodologies in accordance with the OBM framework are noted where applicable. The latest available data has been used to report performance, which in some instances means results are for the 2024 calendar year.

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

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

Rationale

The Australasian College for Emergency Medicine developed the Australasian Triage Scale (ATS) to ensure that patients presenting to Emergency Departments are medically assessed, prioritised according to their clinical urgency and treated in a timely manner¹.

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

Target

The 2024-25 targets for ED patients seen within recommended times by triage category as per the Australasian College for Emergency Medicine are as follows:

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

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

Results

In 2024-25, the percentage of ED patients seen within recommended times for triage category 1 was equal to target and all other triage categories were below target (Table 1).

Compared to 2023-24, ED presentations have increased, particularly Category 3 where it has increased by 4 per cent.

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

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

Table 1 Percentage of emergency department patients seen within recommended times, by triage category

Triage category	Financial year					Target (%)	Target met
	2020-21 (%)	2021-22 (%)	2022-23 (%)	2023-24 (%)	2024-25 (%)		
1	100	100	100	100	100	100	✓
2	78	72	71	73	72	≥ 80	✗
3	40	28	26	27	22	≥ 75	✗
4	54	41	38	39	35	≥ 70	✗
5	82	76	72	71	62	≥ 70	✗

Data source: Emergency Department Data Collection.

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 care². These readmissions necessitate patients spending additional periods of time in hospital, as well as using additional hospital resources.

Readmission reduction is a common focus of health systems worldwide as they seek to improve the quality and efficiency of healthcare delivery, in the face of rising healthcare costs and increasing prevalence of chronic disease³.

Readmission rate is considered a global performance measure, as it potentially points to deficiencies in the functioning of the overall healthcare system. Along with providing appropriate interventions, good discharge planning can help decrease the likelihood of unplanned hospital readmissions by providing patients with the care instructions they need after a hospital stay and helping patients recognise symptoms that may require medical attention.

The seven surgeries selected for this indicator are based on those in the current National Healthcare Agreement Unplanned Readmission performance indicator (NHA PI 23)⁴.

Target

Please see the 2024 targets for each surgical procedure in Table 2. Performance is achieved by a result below, or equal to, the target.

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

Results

In 2024, the rate of unplanned readmissions within 28 days achieved target for knee replacement, hip replacement and appendicectomy (Table 2). All other surgical procedure indicators did not meet target. The number of surgical procedures completed fluctuate, readmission cases for most procedures were small, and can be unrelated to the initial admission and results should be interpreted with caution.

Clinical reviews and investigations have been completed for readmissions and no trends or systemic issues have been identified.

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

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

Of the 22 tonsillectomy and adenoidectomy patients who were readmitted, most had post-operative bleeding and were conservatively managed with medication and monitoring without the need for further intervention.

There has been improved pre-operative patient education on expected bleed volumes and when to return to hospital due to a bleed. Post-operative bleeds cannot be predicted and occur for a variety of reasons, such as patient risk factors, co-morbidities, and compliance with post-operative advice.

It should be noted that some NMHS sites have a differing patient cohort and case-mix where tonsillectomies and adenoidectomies are exclusively undertaken on adults where post operative complication rates are higher than those observed in children. Adult tonsillectomies are sometimes undertaken as part of more complex ENT surgeries (e.g., for malignancy), leading to increased bleeding, pain and or complications and therefore increasing the rate of readmissions compared to children.

Hysterectomy had 27 readmissions which were often related to bleeding, infection or pain and only required conservative management.

There were 13 readmissions for prostatectomy procedures across sites; the most common reason was due to haematuria and required bladder washout and/or antibiotics.

There were seven cataract surgery patients who readmitted. Patients are provided instructions and follow up eye clinic appointment upon discharge.

Appendicectomy had 16 readmissions and performance has greatly improved compared to prior year.

2. Australian Institute of Health and Welfare (2009). Towards national indicators of safety and quality in health care. Cat. no. HSE 75. Canberra: AIHW. Available at: <https://www.aihw.gov.au/reports/health-care-quality-performance/towards-national-indicators-of-safety-and-quality/summary>

3. Australian Commission on Safety and Quality in Health Care. Avoidable Hospital Readmissions: Report on Australian and International indicators, their use and the efficacy of interventions to reduce readmissions. Sydney: ACSQHC; 2019. Available at: <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/avoidable-hospital-readmission-literature-review-australian-and-international-indicators>

4. <https://meteor.aihw.gov.au/content/index.phtml/itemId/742756>

Table 2 Unplanned hospital readmissions for patients within 28 days for selected surgical procedures (per 1,000 separations)

Surgical procedure	Calendar year						Target met
	2020 (per 1,000)	2021 (per 1,000)	2022 (per 1,000)	2023 (per 1,000)	2024 (per 1,000)	Target (per 1,000)	
Knee replacement	34.9	23.4	20.2	25.8	19.3	≤ 21.0	✓
Hip replacement	7.2	14.2	17.7	8.9	16.0	≤ 19.4	✓
Tonsillectomy and adenoidectomy	157.2	150.0	92.4	120.0	84.9	≤ 84.4	✗
Hysterectomy	38.3	54.6	47.7	48.5	47.2	≤ 45.8	✗
Prostatectomy	25.4	42.8	30.0	33.8	46.1	≤ 40.0	✗
Cataract surgery	1.6	2.1	0.0	3.0	2.9	≤ 2.3	✗
Appendicectomy	33.6	27.3	28.4	30.3	19.8	≤ 29.7	✓

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

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 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 death⁵. Waiting lists must be actively managed by hospitals to ensure fair and equitable access to limited services, and that all patients are treated within clinically appropriate timeframes.

Patients are prioritised based on their assigned clinical urgency category:

- Category 1 – procedures that are clinically indicated within 30 days
- Category 2 – procedures that are clinically indicated within 90 days
- Category 3 – procedures that are clinically indicated within 365 days.

On 1 April 2016, the WA health system introduced a new statewide performance target for the provision of elective services. For reportable procedures, the target requires that no patients (0%) on the elective waiting lists wait longer than the clinically recommended time for their procedure, according to their urgency category.

Reportable cases are defined as:

All waiting list cases that are not listed on the Elective Services Wait List Data Collection (ESWLDC) Commonwealth Non-Reportable Procedures list. This list is consistent with the Australian Institute of Health and Welfare (AIHW) list of Code 2 (other) procedures that do not meet the definition of elective surgery. It also includes additional procedure codes that are intended to better reflect the procedures identified in the AIHW Code 2 list.

Target

The 2024-25 target is 0%. Performance is achieved by a result equal to the target.

Results

In 2024-25, all urgency categories for elective surgery waitlist patients waiting over boundary did not meet target (Table 3) and is reflective of system-wide pressures on demand, capacity and patient flow.

Compared to 2020-21, demand for elective surgery has increased, particularly Category 1 where it has increased by 44%.

NMHS have a range of strategies underway to reduce waitlist pressures and increase admissions to address the growing demand. These include referral redirection, improving theatre efficiencies, expanding areas and additional recruitment. These strategies and performance continue to be closely monitored.

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

Table 3 Percentage of elective waitlist patients waiting over boundary for reportable procedures

	Financial year						
Urgency category	2020-2021 (%)	2021-2022 (%)	2022-2023 (%)	2023-2024 (%)	2024-2025 (%)	Target (%)	Target met
Category 1 over 30 days	11	15	17	17	17	0	✗
Category 2 over 90 days	14	26	31	29	28	0	✗
Category 3 over 365 days	5	10	20	9	7	0	✗

Data source: Elective Services Waitlist Data Collection.

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. 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%⁶).

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.

Target

The 2024 target is 1.0 per 10 000 occupied bed-days. Performance is achieved by a result below, or equal to, the target.

A low or decreasing HA-SABSI rate is desirable and the WA target reflects the nationally agreed benchmark.

Results

In 2024, HA-SABSI per 10,000 occupied bed-days in public hospitals achieved target (Table 4).

Staff education, case investigation and monitoring are in place as part of infection prevention and management.

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

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

	Calendar year						Target met
	2020 (per 10,000)	2021 (per 10,000)	2022 (per 10,000)	2023 (per 10,000)	2024 (per 10,000)	Target (per 10,000)	
HA-SABSI	0.6	0.5	0.5	0.8	0.8	≤ 1.0	✓

Data source: Healthcare Infection Surveillance WA Data Collection.

Survival rates for sentinel conditions

Rationale

This indicator measures performance in relation to the survival of people who have suffered a sentinel condition – specifically a stroke, acute myocardial infarction (AMI), or fractured neck of femur (FNOF).

These three conditions have been chosen as they are leading causes of hospitalisation and death in Australia for which there are accepted clinical management practices and guidelines. Patient survival after being admitted for one of these sentinel conditions can be affected by many factors, including the diagnosis, the treatment given, or procedure performed, age, co-morbidities at the time of the admission, and complications

that may have developed while in hospital. However, survival is more likely when there is early intervention and appropriate care on presentation to an emergency department and on admission to hospital.

By reviewing survival rates and conducting case-level analysis, targeted strategies can be developed that aim to increase patient survival after being admitted for a sentinel condition.

Target

Please see the 2024 targets for each condition in Table 5, Table 6 and Table 7. Performance is achieved by a result above, or equal to, the target.

Results

Survival rates for stroke

In 2024, the survival rates for patients with stroke did not meet target for all age groups (Table 5) and are impacted by severity of disease on admission and patients with multiple comorbidities. It should be noted that NMHS provides the Statewide Neurological Intervention and Imaging Service.

There is continued coordinated care across departments, rehabilitation at home and outpatient care and audits of key performance parameters. Cases are reviewed and discussed, and monitoring is ongoing.

Table 5 Survival rate for stroke

	Calendar year						
Age group (years)	2020 (%)	2021 (%)	2022 (%)	2023 (%)	2024 (%)	Target (%)	Target met
0 to 49	94.4	93.7	93.1	92.7	95.3	≥ 95.4	✗
50 to 59	92.6	91.3	89.1	95.5	92.1	≥ 94.8	✗
60 to 69	89.9	91.6	91.0	91.7	90.2	≥ 94.5	✗
70 to 79	87.6	89.2	89.6	88.2	86.9	≥ 92.6	✗
80+	85.8	85.3	84.1	81.8	83.1	≥ 87.6	✗

Data source: Hospital Morbidity Data Collection.

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

Survival rates for sentinel conditions (continued)

Survival rates for acute myocardial infarction (AMI)

The survival rates for patients with AMI achieved target for age groups 50 to 59 and 60 to 69 (Table 6). Survival rates for all other age groups did not meet target and are impacted by severity of disease on admission and patients with multiple comorbidities. Cases are reviewed and monitoring is ongoing to identify opportunities for further improvement.

Table 6 Survival rate for acute myocardial infarction

	Calendar year						
Age group (years)	2020 (%)	2021 (%)	2022 (%)	2023 (%)	2024 (%)	Target (%)	Target met
0 to 49	98.6	100.0	97.8	100.0	98.7	≥ 98.9	✖
50 to 59	99.4	98.8	97.5	99.3	99.3	≥ 98.8	✔
60 to 69	99.1	98.6	98.6	98.1	99.1	≥ 98.2	✔
70 to 79	97.1	94.0	96.3	97.1	93.8	≥ 97.0	✖
80+	90.5	90.9	93.4	92.5	90.9	≥ 93.1	✖

Data source: Hospital Morbidity Data Collection.

Survival rates for fractured neck of femur (FNOF)

Survival rates for patients with FNOF did not meet target for both age groups (Table 7). Patients are impacted by severity of disease on admission and patients with multiple comorbidities. Processes are in place and cases are reviewed and discussed to identify opportunities to further improve patient outcomes.

Table 7 Survival rate for fractured neck of femur

	Calendar year						
Age group (years)	2020 (%)	2021 (%)	2022 (%)	2023(%)	2024 (%)	Target (%)	Target met
70 to 79	98.0	96.9	100.0	99.0	98.3	≥ 98.8	✗
80+	97.1	95.5	92.6	94.8	96.5	≥ 97.3	✗

Data source: Hospital Morbidity Data Collection.

Percentage of admitted patients who discharged against medical advice

Rationale

Discharge against medical advice (DAMA) refers to patients leaving hospital against the advice of their treating medical team or without advising hospital staff (e.g. take own leave, left without notice, missing and not found, or discharge at own risk). Patients who do so have a higher risk of readmission and mortality⁷ and have been found to cost the health system 50% more than patients who are discharged by their physician.⁸

The national Aboriginal and Torres Strait Islander Health Performance Framework reports discharge at own risk under the heading 'Self-discharge from hospital'. Between July 2019 and June 2021 Aboriginal patients (4.4%) in WA were 7.5 times more likely than non-Aboriginal patients (0.6%) to discharge at own risk, compared with 5.2 times nationally (3.8% and 0.7% respectively)⁹. This statistic indicates

a need for improved responses by the health system to the needs of Aboriginal patients. This indicator is also being reported in the Report on Government Services 2024 under the performance of governments in providing acute care services in public hospitals¹⁰.

This indicator provides a measure of the safety and quality of inpatient care. Reporting the results by Aboriginal status measures the effectiveness of initiatives within the WA health system to deliver culturally secure services to Aboriginal people. While the aim is to achieve equitable treatment outcomes, the targets reflect the need for a long-term approach to progressively closing the gap between Aboriginal and non-Aboriginal patient cohorts.

Discharge against medical advice performance measure is also one of the key contextual indicators of Outcome 1 "Aboriginal and Torres Strait Islander people enjoy long and healthy lives" under the new National Agreement on Closing the Gap, which was agreed to by the Coalition of Aboriginal and Torres Strait Islander Peak Organisations, and all Australian Governments in July 2020¹¹.

Target

Please see the 2024 targets for Aboriginal and non-Aboriginal patients in Table 8. Performance is achieved by a result below, or equal to, the target.

Results

In 2024, the percentage of admitted patients who discharged against medical advice achieved target for non-Aboriginal patients while Aboriginal patients did not meet target (Table 8).

Family/community responsibilities were the most common reason for why Aboriginal patients DAMA. Aboriginal Health Liaison Officer services are available at NMHS hospitals; however, patients may choose to not use this service. Patients who DAMA are contacted, and follow-up plans are organised where appropriate.

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

7. Yong et al. Characteristics and outcomes of discharges against medical advice among hospitalised patients. *Internal medicine journal* 2013;43(7):798-802.
8. Aliyu ZY. Discharge against medical advice: sociodemographic, clinical and financial perspectives. *International journal of clinical practice* 2002;56(5):325-27.
9. See Table D3.09.3 <https://www.indigenoushpf.gov.au/measures/3-09-self-discharge-from-hospital/data#DataTablesAndResources>
10. For more information see 12 Public hospitals - Report on Government Services 2024 - Productivity Commission (pc.gov.au)
11. <https://www.closingthegap.gov.au/national-agreement>

Table 8 Percentage of admitted patients who discharged against medical advice

	Calendar year						
	2020 (%)	2021(%)	2022 (%)	2023 (%)	2024 (%)	Target (%)	Target met
Aboriginal	3.92	3.46	3.81	3.17	3.98	≤ 2.78	✗
Non-Aboriginal	0.76	0.74	0.71	0.80	0.82	≤ 0.99	✓

Data source: Hospital Morbidity Data Collection.

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

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

Rationale

This indicator measures the condition of newborn infants immediately after birth and provides an outcome measure of intrapartum care and newborn resuscitation.

The Apgar score is an assessment of an infant’s health at birth based on breathing, heart rate, colour, muscle tone and reflex irritability. An Apgar score is applied at one, five and (if required by the protocol) ten minutes after birth to determine how well the infant is adapting outside the mother’s womb. Apgar scores range from zero to two for each condition with a maximum final total score of ten. The higher the Apgar score the better the health of the newborn infant.

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

Target

The 2024 target for liveborn term infants with an Apgar score of less than 7 at five minutes post-delivery is 1.9 per cent. Performance is achieved by a result below, or equal to, the target.

Results

In 2024, the percentage of liveborn infants with an Apgar score of less than seven at five minutes post-delivery achieved target (Table 9). Cases are reviewed and performance continues to be monitored.

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

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

	Calendar year						
Live births	2020 (%)	2021 (%)	2022 (%)	2023 (%)	2024 (%)	Target (%)	Target met
Apgar Score < 7	1.7	1.7	1.8	1.7	1.8	≤ 1.9	✔

Data source: Midwives Notification System.

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

Rationale

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

While multiple hospital admissions over a lifetime may be necessary for someone with ongoing illness, a high proportion of readmissions shortly after discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was not adequate to maintain the patient’s recovery out of hospital¹². Rapid readmissions place pressure on finite beds and may reduce access to care for other consumers in need.

These readmissions mean that patients spend additional time in hospital and utilise additional

resources. A low readmission rate suggests that good clinical practice is in operation. Readmissions are attributed to the facility at which the initial separation (discharge) occurred, rather than the facility to which the patient was readmitted.

By monitoring this indicator, key areas for improvement can be identified. This can facilitate the development and delivery of targeted care pathways and interventions aimed at improving the mental health and quality of life of Western Australians.

Target

The 2024 target is 12% readmissions within 28 days to an acute specialised mental health inpatient service. Performance is achieved by a result below, or equal to, the target.

Results

In 2024, the rate of readmissions to acute specialised mental health inpatient services within 28 days of discharged achieved target (Table 10). This indicator looks at total readmissions and it should be noted that some readmission cases are warranted as part of accepted best practice protocols.

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

12. Australian Health Ministers Advisory Council Mental Health Standing Committee (2011). Fourth National Mental Health Plan Measurement Strategy. Available at: <https://www.aihw.gov.au/getmedia/d8e52c84-a53f-4eef-a7e6-f81a5af94764/Fourth-national-mental-health-plan-measurement-strategy-2011.pdf.aspx>

Table 10 Readmissions to acute specialised mental health inpatient services within 28 days of discharge

	Calendar year						Target	Target met
	2020 (%)	2021 (%)	2022 (%)	2023 (%)	2024 (%)			
Readmission rate	15	15	12	10	9	≤ 12	✓	

Data source: Hospital Morbidity Data Collection.

Outcome

1

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

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

Rationale

In 2022, one in four (6.6 million) Australians reported having a mental or behavioural condition¹³. Therefore, it is crucial to ensure effective and appropriate care is provided not only in a hospital setting but also in the community.

Discharge from hospital is a critical transition point in the delivery of mental health care. People leaving hospital after an admission for an episode of mental illness have increased vulnerability and, without adequate follow up, may relapse or be readmitted.

The standard underlying the measure is that continuity of care requires prompt community follow-up in the period following discharge from hospital. A responsive community support system for persons who have experienced a psychiatric episode requiring hospitalisation is essential to maintain their clinical and functional stability and to minimise the need for hospital readmissions. Patients leaving hospital after a psychiatric admission with a formal discharge plan that includes links with public community based services and support are less likely to need avoidable hospital readmissions.

Target

The 2024 target is 75%. Performance is achieved by a result above, or equal to, the target.

Results

In 2024, the percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services achieved target (Table 11).

Patients receive either telephone follow up or are managed through other programs. Non-compliant records continue to be reviewed, and performance continues to be monitored.

13. National Health Survey, 2022

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

	Calendar year						Target	Target met
	2020 (%)	2021 (%)	2022 (%)	2023 (%)	2024 (%)			
Post-discharge community care	84	86	85	88	89	≥ 75	✓	

Average admitted cost per weighted activity unit (WAU)

Rationale

This indicator is a measure of the cost per WAU compared with the State target, as approved by the Department of Treasury and published in the 2024-25 Budget Paper No. 2, Volume 1.

The measure ensures a consistent methodology is applied to calculating and reporting the cost of delivering inpatient activity against the state's funding allocation. As admitted services received nearly half of the overall 2024-25 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

Target

The 2024-25 target is \$7,899 per WAU. Performance is achieved by a result below, or equal to, the target.

Results

In 2024-25, the average admitted cost per weighted activity did not meet target (Table 12). During 2024-25 supplementary funding was provided from the State Government to support the costs of providing additional activity, increases in award rates associated with new Enterprise Bargaining Agreements (EBAs) and cost pressures associated with service delivery.

Activity levels delivered during the year were unable to address the full impact of resource growth, resulting in a higher unit cost to target and 2023-24 actuals.

Table 12 Average admitted cost per weighted activity unit

	Financial year						Target met
	2020-2021 (\$)	2021-2022 (\$)	2022-2023 (\$)	2023-2024 (\$)	2024-2025 (\$)	Target (\$)	
Average cost	7,080	7,715	8,014	8,168	8,348	≤ 7,899	✗

Data sources: OBM Allocation application; Oracle 11i financial system; Hospital Morbidity Data Collection; The Open Patient Administration System (TOPAS); Web-Based Patient Administration System (webPAS); Contracted Health Entities (CHEs) discharge extracts.

Outcome

1

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

Average emergency department cost per weighted activity unit

Rationale

This indicator is a measure of the cost per WAU compared with the State target as approved by the Department of Treasury, which is published in the 2024-25 Budget Paper No. 2, Volume 1.

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

Target

The 2024-25 target is \$7,777 per WAU. Performance is achieved by a result below, or equal to, the target.

Results

In 2024-25, the average emergency department cost per weighted activity unit achieved target (Table 13) and has improved compared to 2023-24.

During the year, the WA Government provided supplementary funding for additional activity and cost pressures associated with service delivery. In addition, NMHS increased service delivery to meet emergency services demand.

Table 13 Average emergency department cost per weighted activity unit

	Financial year						Target	Target met
	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025			
	(\$)	(\$)	(\$)	(\$)	(\$)	(\$)		
Average cost	6,646	7,129	7,242	7,988	7,659	≤ 7,777		✓

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

Average non-admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per WAU compared with the State (aggregated) target, as approved by the Department of Treasury, which is published in the 2024-25 Budget Paper No. 2, Volume 1.

The measure ensures that a consistent methodology is applied to calculating and reporting the cost of delivering non-admitted activity against the State’s funding allocation.

Non-admitted services play a pivotal role within the spectrum of care provided to the WA public. Therefore, it is important that non-admitted service provision is monitored to ensure the efficient delivery of safe and high-quality care.

Target

The 2024-25 target is \$7,903 per WAU. Performance is achieved by a result below, or equal to, the target.

Results

In 2024-25, the average admitted cost per weighted activity did not meet target (Table 14). During the year WA Government provided additional funding for activity, costs associated with new EBAs and cost pressures. Additional activity was unable to meet the increased costs to meet service delivery requirements, resulting in a higher average cost per unit to target and 2023-24 actuals.

Table 14 Average non-admitted cost per weighted activity unit

	Financial year						Target	Target met
	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025			
	(\$)	(\$)	(\$)	(\$)	(\$)	(\$)		
Average cost	6,785	7,258	8,827	8,669	9,067	≤ 7,903		✗

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

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

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

Rationale

Specialised mental health inpatient services provide patient care in authorised hospitals. To ensure quality of care and cost-effectiveness, it is important to monitor the unit cost of admitted patient care in specialised mental health inpatient services. The efficient use of hospital resources can help minimise the overall costs of providing mental health care and enable the reallocation of funds to appropriate alternative non-admitted care.

Target

The 2024-25 target is \$1,644 per bed-day in specialised mental health inpatient services. Performance is achieved by a result below, or equal to, the target.

Results

In 2024-25, the average cost per bed-day in specialised mental health inpatient did not meet

target (Table 15). During the year, the Mental Health Commission provided additional funding for increases in new EBAs. In addition, higher inpatient acuity levels resulted in additional resourcing requirements to ensure safe service delivery. The number of bed days has remained relatively consistent with target and as a result higher costs have increased the average cost per day to target and 2023-24 actuals.

Table 15 Average cost per bed-day in specialised mental health inpatient services

	Financial year						Target	Target met
	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025			
	(\$)	(\$)	(\$)	(\$)	(\$)	(\$)		
Average cost	1,439	1,595	1,730	1,973	2,153	≤ 1,644		✗

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

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

Rationale

Public community mental health services consist of a range of community-based services, such as emergency assessment and treatment, case management, day programs, rehabilitation, psychosocial, residential services and continuing care. The aim of these services is to provide the best health outcomes for the individual through the provision of accessible and appropriate community mental health care.

Public community-based mental health services are generally targeted towards people in the acute phase of a mental illness who are receiving post-acute care.

Efficient functioning of public community mental health services is essential to ensure that finite funds are used effectively to deliver maximum community benefit. This indicator provides a measure of the cost-effectiveness of treatment for public psychiatric patients under public community mental health care (non-admitted/ambulatory patients).

Target

The 2024-25 target is \$528 per treatment day of non-admitted care provided by mental health services. Performance is achieved by a result below, or equal to, the target.

Results

In 2024-25, the average cost per treatment day of non-admitted care provided by mental health services did not meet target (Table 16). A slight increase in costs is attributable to a rise in services aimed at addressing demand to ensure 2024-25 objectives are met.

Table 16 Average cost per treatment day of non-admitted care provided by mental health services

	Financial year						Target	Target met
	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025			
	(\$)	(\$)	(\$)	(\$)	(\$)	(\$)		
Average cost	372	412	496	522	533	≤ 528		✗

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

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

Rate of women aged 50–69 years who participate in breast screening

Rationale

BreastScreen Australia aims to reduce illness and death resulting from breast cancer through organised screening to detect cases of unsuspected breast cancer in women, thus enabling early intervention which leads to increased treatment options and improved survival. It has been estimated that breast cancer detected early is considerably less expensive to treat than when the tumour is discovered at a later stage. Mass screening using mammography can improve early detection by as much as 15-35%.¹⁴

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 2023–24 target is $\geq 70\%$ of women aged 50-69 years who participate in breast screening. Performance is achieved by a result above, or equal to, the target.

Results

From 2023 to 2024, the rate of women aged 50-69 years who participated in breast screening did not meet target (Table 17).

Compared to 2022-2023, BreastScreen WA has screened over 1000 additional women, but the number of women aged 50-69 years residing in WA has increased.

Efforts to increase screening capacity have been adversely impacted by national workforce shortages and infrastructure limitations. BreastScreen WA has been working to overcome these challenges and has been able to procure and launch an additional screening mobile van for 2025.

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

Table 17 Rate of women aged 50-69 years who participate in breast screening

	2019-2020 (%)	2020-2021 (%)	2021-2022 (%)	2022-2023 (%)	2023-2024 (%)	Target (%)	Target met
Participation rate	50	50	53	50	49	≥ 70	✗

Note: This measure counts the women screened within a 24-month period (1 January 2023 to 31 December 2024) as it is recommended that women in the cohort attend the free screening every two years.

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

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

Rationale

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

A low unplanned 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, resource utilisation, future treatment options and patient satisfaction.

By measuring and monitoring this KPI, the level of potentially avoidable unplanned returns can be assessed in order to identify key areas for improvement (i.e. cost-effectiveness and efficiency, initial treatment and patient satisfaction). This KPI is nationally reported in the Australian Council on Healthcare Standards Oral Health Indicators¹⁵. Its inclusion provides opportunity for benchmarking across jurisdictions.

Target

Please see the 2024-25 targets for adults and children in Table 18. Performance is achieved by a result below the target.

Results

In 2024-25, the percentage of children who have a tooth re-treated within 6 months of receiving initial restorative dental treatment achieved target (Table 18) while adults did not meet target.

Dental Health Services continue to monitor clinic/clinician re-treatment rates through the Clinical Oral Health Advisory Committee.

15. Australian Clinical Indicator Report 2015-2022, 24th Edition
<https://www.achs.org.au/news/acir2015-22>

Table 18 Percentage of adults and children who have a tooth re-treated within six months of receiving initial restorative dental treatment

	Financial year					Target (%)	Target met
	2020-2021 (%)	2021-2022 (%)	2022-2023 (%)	2023-2024 (%)	2024-2025 (%)		
Adults	5.59	5.86	5.14	5.88	6.21	< 6.05	✗
Children	1.93	1.91	1.68	1.43	1.42	< 2.11	✓

Note: Prior financial year data is used to ensure results are aligned to the reports provided to the Australian Council on Healthcare Standards.

Data source: Dental Information Management Patient Management System (DenIM PMS).

Outcome

2

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

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

Rationale

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

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

Target

The 2024-25 target is ≥ 78%. Performance is achieved by a result above, or equal to, the target.

Results

In 2024-25, the percentage of eligible children who are enrolled in the School Dental Service program did not meet target (Table 19).

School enrolment continues to be impacted by the challenges of dental therapist recruitment and has resulted in less available appointments at various school clinics, as well as less promotion and visibility of the service.

Table 19 Percentage of eligible school children who are enrolled in the School Dental Service program

	Financial year						
	2020-2021 (%)	2021-2022 (%)	2022-2023 (%)	2023-2024 (%)	2024-2025 (%)	Target (%)	Target met
Eligible school children who are enrolled in the School Dental program	77	75	73	69	67	≥ 78	✗

Note: Eligible school children are all school children aged 5 to 16 or until the end of year 11 (whichever comes first) who attend a Western Australian Department of Education recognised school. A parent/guardian is required to consent to dental examination and screening of their child in the School Dental Service program.

Data sources: Dental Information Management Patient Management System (DenIM PMS); Department of Education WA.

Percentage of eligible people who accessed Dental Health Services

Rationale

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

To facilitate equity of access to dental health care for all Western Australians, dental treatment services (including both emergency care and non-emergency care) are provided through subsidised dental programs to eligible people in need.

This indicator measures the level of access to these subsidised dental health services by monitoring the proportion of all eligible people receiving the services.

Measuring the use of dental health services provided to eligible people can help identify areas that require more focused intervention and prevention and health promotion strategies to help ensure the improved dental health and wellbeing of Western Australians with the greatest need.

Target

The 2024-25 target is $\geq 15\%$. Performance is achieved by a result above, or equal to, the target.

Results

In 2024-25, the percentage of eligible people who accessed Dental Health Services did not meet target (Table 20).

Compared to 2023-24, the number of eligible people residing in WA has increased by 4.4 per cent. The ability to meet target continues to be impacted by workforce shortages due to dental recruitment challenges that have resulted in fewer available appointments at various school clinics. Workforce recruitment strategies are currently being reviewed.

Table 20 Percentage of eligible people who accessed Dental Health Services

	Financial year						Target	Target met
	2020-2021 (%)	2021-2022 (%)	2022-2023 (%)	2023-2024 (%)	2024-2025 (%)			
Eligible people who accessed Dental Health Services	14	13	14	14	13	≥ 15		✗

Note: Eligible people are defined as those who hold a current Pension Concession Card (Centrelink) or Health Care Card. Eligible people who access a public dental service or receive treatment through a participating private dental practitioner.

Australian Government funded dental health services provided through the National Partnership Agreement is not included.

Data sources: Dental Information Management (DenIM) database; Commonwealth Department of Social Services (DSS) Payment Demographic data.

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

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

Rationale

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

Population health aims to improve health by integrating all activities of the health sector and linking them with broader social and economic services and resources as described in the WA Health Promotion Strategic Framework 2022-2026.¹⁶ This is based on the growing understanding of the social, cultural and economic factors that contribute to a person’s health status.

Target

The 2024-25 target is \$53. Performance is achieved by a result below, or equal to, the target.

Results

In 2024-25, the average cost per person of delivering population health programs did not meet target (Table 21). Delivery and approval of a commonwealth funded program during 2024-25 and, higher costs to provide Tuberculosis programs, particularly in country areas, resulted in an increased average cost per person compared to target. Population growth and a reclassification of

services from health programs to hospital services resulted in lower average cost this year compared to 2023-24.

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

Table 21 Average cost per person of delivering population health programs by population health units

	Financial year						Target	Target met
	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025			
	(\$)	(\$)	(\$)	(\$)	(\$)	(\$)		
Average cost	64	97	84	69	65	≤ 53		✗

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

Average cost per breast screening

Rationale	Target	Results
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.	The 2024-25 target is \$160 per breast screening. Performance is achieved by a result below, or equal to, the target.	In 2024-25, the average cost per breast screening did not meet target (Table 22). Wage growth, additional post screening assessments, cost pressures and increased activity in screening minority populations in regional areas have contributed to the higher unit costs.

Table 22 Average cost per breast screening

	Financial year					Target (\$)	Target met
	2020-2021 (\$)	2021-2022 (\$)	2022-2023 (\$)	2023-2024 (\$)	2024-2025 (\$)		
Average cost	154	153	159	177	183	≤ 160	✗

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

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

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

Rationale

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

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

Target

Please see the 2024-25 targets for patient groups in Table 23. Performance is achieved by a result below, or equal to, the target.

Results

In 2024-25, the average cost per patient visit of WA Health-provided dental health programs did not meet target for school children and socio-economically disadvantaged adults (Table 23).

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

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

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

Table 23 Average cost per patient visit of WA Health-provided dental health programs for school children and socio-economically disadvantaged adults

	Financial year						Target met
	2020-2021 (%)	2021-2022 (%)	2022-2023 (%)	2023-2024 (%)	2024-2025 (%)	Target (%)	
School children	219	302	315	305	322	≤ 261	✗
Socio-economically disadvantaged adults	284	365	370	379	406	≤ 343	✗

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

Governance



Board remuneration

Position title	Member name	Type of remuneration	Period of membership in 2024-25 (months)	Current term of appointment/tenure	Base salary/sitting fees	Gross/actual remuneration for 2024-25
Chair/Deputy Chair	Karen Gullick	Annual	12	1 August 2022 - 30 June 2025	\$53,629	\$59,796
Deputy Chair/Chair	Rebecca Strom	Annual	12	1 July 2023 - 30 June 2025	\$62,835	\$70,061
Member	Jahna Cedar	Annual	12	10 October 2022 - 30 June 2025	\$41,792	\$46,598
Member	Matthew Coleman	Annual	12	1 January 2024 – 30 June 2026	\$41,792	\$46,598
Member	Anthony Evans	Annual	12	1 July 2024 – 30 June 2027	\$41,792	\$46,598
Member	Renae Farmer	Annual	12	1 July 2024 – 30 June 2027	\$40,185	\$44,806
Member	Angela Komninos	Annual	12	8 April 2024 – 7 April 2027	\$0	\$0
Member	Lewis MacKinnon	Annual	12	1 July 2023 – 30 June 2026	\$41,792	\$46,598
Member	Ian Rogers	Annual	12	1 July 2024 – 30 June 2027	\$40,185	\$44,806
Member	Angela Edwards	Annual	8	1 July 2022 – 28 February 2025	\$29,736	\$33,156

* If applicable, include sessional payment, per meeting, half day or annual

** Refers to board members' membership during the reporting period, not their entire tenure on the board or committee.
Period of membership should correlate with the respective remuneration received.

*** Refers to term of appointment/tenure (if relevant) or appointment type (e.g. sessional/full-time)

Board and committee attendance and eligibility

		Board		Audit and Risk Committee		Finance Committee		People, Engagement and Culture Committee		Safety, Quality and Consumer Engagement Committee	
Number of meetings held		11		5		11		6		11	
Position title	Member name	Eligibility to attend	Attended	Eligibility to attend	Attended	Eligibility to attend	Attended	Eligibility to attend	Attended	Eligibility to attend	Attended
Chair	Karen Gullick	11	11			6	5			6	6
Deputy Chair	Rebecca Strom	11	11	2	2	5	5				
Member	Jahna Cedar OAM	11	5					6	6	11	9
Member	Matthew Coleman	11	9					6	5	11	10
Member	Angela Edwards	7	6	3	1			4	4		
Member	Tony Evans	11	8	5	4	11	10				
Member	Renee Farmer	11	11			11	10	6	6		
Member	Angela Komninos	11	10	5	4					11	9
Member	Lewis MacKinnon	11	9	3	3	5	5			11	11
Member	Ian Rogers	11	8					6	6	11	9



Financials



Audit opinion



Auditor General

INDEPENDENT AUDITOR'S REPORT

2025

North Metropolitan Health Service

To the Parliament of Western Australia

Report on the audit of the financial statements

Opinion

I have audited the financial statements of the North Metropolitan Health Service (Health Service) which comprise:

- the statement of financial position as at 30 June 2025, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended
- notes comprising a summary of material accounting policies and other explanatory information.

In my opinion, the financial statements are:

- based on proper accounts and present fairly, in all material respects, the operating results and cash flows of the Health Service for the year ended 30 June 2025 and the financial position as at the end of that period
- in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions.

Basis for opinion

I conducted my audit in accordance with the Australian Auditing Standards. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my report.

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

Responsibilities of the Board for the financial statements

The Board is responsible for:

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

Audit opinion continued

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

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

Auditor's responsibilities for the audit of the financial statements

As required by the *Auditor General Act 2006*, my responsibility is to express an opinion on the financial statements. The objectives of my audit are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Australian Auditing Standards will always detect a material misstatement when it exists.

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

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

Report on the audit of controls

Opinion

I have undertaken a reasonable assurance engagement on the design and implementation of controls exercised by the Health Service. The controls exercised by the Health Service are those policies and procedures established to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with the State's financial reporting framework (the overall control objectives).

In my opinion, in all material respects, the controls exercised by the Health Service are sufficiently adequate to provide reasonable assurance that the controls within the system were suitably designed to achieve the overall control objectives identified as at 30 June 2025, and the controls were implemented as designed as at 30 June 2025.

Other Matter

The Health Service has made payments using the direct payments to third parties pathway throughout the year. The Department of Health has approved this pathway to be used in limited circumstances as expenditure is not subject to levels of approval required under Treasurer's Instruction 5 Expenditure and Payments.

While this is not a primary pathway for expenditure for the Health Service, we have identified weaknesses in how this pathway is used and the types of transactions processed using this pathway, which increases the risk of fraud.

To allow for more detailed reporting of these concerns, the Auditor General has decided to report these matters separately as a performance audit to be tabled in Parliament.

My opinion is not modified in respect of this matter.

The Board's responsibilities

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

Auditor General's responsibilities

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

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

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

Limitations of controls

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

Report on the audit of the key performance indicators

Opinion

I have undertaken a reasonable assurance engagement on the key performance indicators of the Health Service for the year ended 30 June 2025 reported in accordance with the *Financial Management Act 2006* and the Treasurer's Instructions (legislative requirements). The key performance indicators are the Under Treasurer-approved key effectiveness indicators and key efficiency indicators that provide performance information about achieving outcomes and delivering services.

Audit opinion continued

In my opinion, in all material respects, the key performance indicators report of the Health Service for the year ended 30 June 2025 is in accordance with the legislative requirements, and the key performance indicators are relevant and appropriate to assist users to assess the Health Service's performance and fairly represent indicated performance for the year ended 30 June 2025.

The Board's responsibilities for the key performance indicators

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

In preparing the key performance indicators, the Board is responsible for identifying key performance indicators that are relevant and appropriate, having regard to their purpose in accordance with Treasurer's Instruction 3 Financial Sustainability – Requirement 5: Key Performance Indicators.

Auditor General's responsibilities

As required by the *Auditor General Act 2006*, my responsibility as an assurance practitioner is to express an opinion on the key performance indicators. The objectives of my engagement are to obtain reasonable assurance about whether the key performance indicators are relevant and appropriate to assist users to assess the 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 3 - Requirement 5 for measuring the extent of outcome achievement and the efficiency of service delivery. The procedures selected depend on my judgement, including the assessment of the risks of material misstatement of the key performance indicators. In making these risk assessments, I obtain an understanding of internal control relevant to the engagement in order to design procedures that are appropriate in the circumstances.

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

My independence and quality management relating to the report on financial statements, controls and key performance indicators

I have complied with the independence requirements of the *Auditor General Act 2006* and the relevant ethical requirements relating to assurance engagements. In accordance with ASQM 1 *Quality Management for Firms that Perform Audits or Reviews of Financial Reports and Other Financial Information, or Other Assurance or Related Services Engagements*, the Office of the Auditor General maintains a comprehensive system of quality management including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Other information

Those charged with governance are responsible for the other information. The other information is the information in the entity's annual report for the year ended 30 June 2025, but not the financial statements, key performance indicators and my auditor's report.

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

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

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

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

This auditor's report relates to the financial statements and key performance indicators of the North Metropolitan Health Service for the year ended 30 June 2025 included in the annual report on the Health Service's website. The Health Service's management is responsible for the integrity of the Health Service's website. This audit does not provide assurance on the integrity of the Health Service's website. The auditor's report refers only to the financial statements, controls and key performance indicators described above. It does not provide an opinion on any other information which may have been hyperlinked to/from the annual report. If users of the financial statements and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to contact the entity to confirm the information contained in the website version.



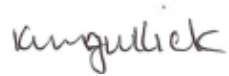
Sandra Labuschagne
Deputy Auditor General
Delegate of the Auditor General for Western Australia
Perth, Western Australia
30 September 2025

Certification of financial statements

For the year ended 30 June 2025

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 2025 and financial position as at 30 June 2025.

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



Adj Assoc Prof Karen Gullick
Board Chair
North Metropolitan Health Service
26 September 2025



Renae Farmer
Board Finance Committee Chair
North Metropolitan Health Service
26 September 2025



Lorraine Williamson
Chief Finance Officer
North Metropolitan Health Service
26 September 2025

Statement of comprehensive income

For the year ended 30 June 2025

	Notes	2025 \$'000	2024 \$'000
COST OF SERVICES			
Expenses			
Employee benefits expense	3.1	1,660,203	1,504,628
Contracts for services	3.2	608,018	559,149
Patient support costs	3.3	477,689	436,826
Finance costs	7.2	1,774	1,563
Depreciation and amortisation expense	5.1, 5.2, 5.3, 5.4	90,622	83,015
Repairs, maintenance and consumable equipment	3.4	60,280	52,110
Other supplies and services	3.5	102,905	95,104
Other expenses	3.6	102,960	92,060
Total cost of services		3,104,451	2,824,455
INCOME			
Revenue			
Patient charges	4.2	84,075	79,371
Other fees for services	4.3	122,872	103,646
Other grants and contributions	4.4	6,639	5,633
Donation revenue		973	431
Other revenue	4.5	29,918	26,517
Total revenue		244,477	215,598
Total income other than income from State Government		244,477	215,598
NET COST OF SERVICES		2,859,974	2,608,857
Income from State Government			
Department of Health - Service Agreement - State Component	4.1	1,644,559	1,440,160
Department of Health - Service Agreement - Commonwealth Component	4.1	684,982	700,754
Mental Health Commission - Service Agreement	4.1	350,166	313,092
Income from other state government agencies	4.1	5,149	3,036
Assets assumed/(transferred)	4.1	973	68
Services received free of charge	4.1	136,885	125,045
Royalties for Regions Fund	4.1	411	411
Total income from State Government		2,823,125	2,582,566
SURPLUS/(DEFICIT) FOR THE PERIOD		(36,849)	(26,291)
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.10	338,608	76,121
Total other comprehensive income		338,608	76,121
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		301,759	49,830

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

Statement of financial position

As at 30 June 2025

	Notes	2025 \$'000	2024 \$'000
ASSETS			
Current Assets			
Cash and cash equivalents	7.3	40,426	33,577
Restricted cash and cash equivalents	7.3	75,164	76,846
Receivables	6.1	73,835	61,802
Inventories	6.3	13,714	12,158
Other current assets	6.4	4,391	3,849
Total Current Assets		207,530	188,232
Non-Current Assets			
Receivables	6.1	44,974	34,849
Amounts receivable for services	6.2	1,222,852	1,133,798
Infrastructure, property, plant and equipment	5.1	1,635,118	1,373,538
Right-of-use assets	5.4	29,374	30,565
Service concession assets	5.2	539,906	421,560
Intangible assets		2,122	929
Total Non-Current Assets		3,474,346	2,995,239
TOTAL ASSETS		3,681,876	3,183,471
LIABILITIES			
Current Liabilities			
Payables	6.5	230,059	206,991
Lease liabilities	7.1	4,023	3,489
Employee related provisions	3.1	365,615	314,651
Other current liabilities	6.7	1,217	1,352
Total Current Liabilities		600,914	526,483
Non-Current Liabilities			
Lease liabilities	7.1	30,500	31,415
Employee related provisions	3.1	55,963	66,570
Total Non-Current Liabilities		86,463	97,985
TOTAL LIABILITIES		687,377	624,468
NET ASSETS		2,994,499	2,559,003
EQUITY			
Contributed equity	9.10	2,203,454	2,069,717
Reserves	9.10	842,614	504,006
Accumulated deficit		(51,569)	(14,720)
TOTAL EQUITY		2,994,499	2,559,003

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

Statement of changes in equity

For the year ended 30 June 2025

	Contributed equity \$'000	Reserves \$'000	Accumulated surplus/ (deficit) \$'000	Total equity \$'000
Notes				
Balance at 1 July 2023	1,962,833	427,885	11,571	2,402,289
Surplus/(deficit)	-	-	(26,291)	(26,291)
Other comprehensive income	-	76,121	-	76,121
Total comprehensive income for the year	-	76,121	(26,291)	49,830
Transactions with owners in their capacity as owners: 9.10				
Capital appropriations administered by Department of Health	106,884	-	-	106,884
Other contributions by owners	-	-	-	-
Distributions to owners	-	-	-	-
Total	106,884	-	-	106,884
Balance at 30 June 2024	2,069,717	504,006	(14,720)	2,559,003
Balance at 1 July 2024	2,069,717	504,006	(14,720)	2,559,003
Surplus/(deficit)	-	-	(36,849)	(36,849)
Other comprehensive income	-	338,608	-	338,608
Total comprehensive income for the year	-	338,608	(36,849)	301,759
Transactions with owners in their capacity as owners: 9.10				
Capital appropriations administered by Department of Health	133,737	-	-	133,737
Other contributions by owners	-	-	-	-
Distributions to owners	-	-	-	-
Total	133,737	-	-	133,737
Balance at 30 June 2025	2,203,454	842,614	(51,569)	2,994,499

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 2025

	Notes	2025 \$'000	2024 \$'000
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriation		2,595,802	2,377,238
Capital appropriations administered by Department of Health		133,742	106,883
Royalties for Regions fund		411	411
Net cash provided by State Government		2,729,955	2,484,532
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(1,610,835)	(1,464,358)
Supplies and services		(1,199,618)	(1,094,016)
Finance costs		(1,774)	(1,563)
Receipts			
Receipts from customers		79,350	80,991
Other grants and contributions		6,639	5,633
Donations received		511	394
Other receipts		143,460	120,610
Net cash used in operating activities	7.3.2	(2,582,267)	(2,352,309)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Payment for purchase of non-current physical and intangible assets		(128,478)	(110,130)
Receipts			
Proceeds from sale of non-current physical assets		121	9
Net cash used in investing activities		(128,357)	(110,121)
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Payments for principal element of lease		(4,039)	(3,699)
Payments to accrued salaries account		(10,125)	(6,387)
Net cash used in financing activities		(14,164)	(10,086)
Net increase/(decrease) in cash and cash equivalents		5,167	12,016
Cash and cash equivalents at the beginning of the year		110,423	98,407
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.3.1	115,590	110,423

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

Notes to the financial statements

For the year ended 30 June 2025

1 Basis of Preparation

North Metropolitan Health Service (The Health Service) is a Western Australian Government entity and is controlled by the State of Western Australia, which is the ultimate parent. The Health Service is a not-for-profit entity (as profit is not its principal objective).

A description of the nature of its operations and its principle activities have been included in the **Overview** which does not form part of these financial statements.

These annual financial statements were authorised for issue by the accountable authority of the Health Service on 26 September 2025.

Statement of compliance

These general purpose financial statements are prepared in accordance with:

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

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

Basis of preparation

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

Judgements and estimates

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

Contributed equity

AASB Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities* requires transfers in the nature of equity contributions, other than as a result of a restructure of administrative arrangements, to be designated as contributions by owners (at the time of, or prior to, transfer) before such transfers can be recognised as equity contributions. Capital appropriations have been designated as contributions by owners by TI 8 – Requirement 8.1(i) and will be credited directly to Contributed Equity.

2 Health Service outputs

How the Health Service operates

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

	Notes
Health Service objectives	2.1
Schedule of Income and Expenses by Service	2.2

2.1 Health Service objectives

Mission

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

Services

The Health Service operates under an Outcome Based Management framework (OBM). The OBM framework is determined by WA Health and replaces the former activity based costing framework for annual reporting from 2017/18 and beyond. This framework describes how outcomes, activities, services and key performance indicators (KPIs) are used to measure the Health Service's performance towards achieving its mission.

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

Public Hospital Admitted Services

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

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

Public Hospital Emergency Services

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

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

Public Hospital Non-Admitted Services

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

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

Notes to the financial statements continued

For the year ended 30 June 2025

2.1 Health Service objectives (continued)

Mental Health Services

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

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

Aged and Continuing Care Services

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

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

Public and Community Health Services

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

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

Community Dental Health Services

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

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

Small Rural Hospital Services

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

Health System Management – Policy and Corporate Services

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

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

Notes to the financial statements continued

For the year ended 30 June 2025

2.2 Schedule of Income and Expenses by Service

	Public Hospital Admitted Patient		Public Hospital Emergency Services		Public Hospital Non- Admitted Services		Mental Health Services		Aged Continuing Care Services	
	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
COST OF SERVICES										
Expenses										
Employee benefits expense	859,736	778,093	91,973	83,286	244,825	214,491	278,482	256,230	20,099	16,296
Contracts for services	401,209	362,987	98,391	102,452	25,835	22,466	50,687	41,805	9,328	6,899
Patient support costs	268,520	252,168	20,243	18,032	115,973	103,853	20,625	14,686	3,038	3,134
Finance costs	97	92	2	1	189	167	963	933	25	12
Depreciation and amortisation expense	54,671	49,768	4,979	4,563	12,361	11,606	10,996	10,207	85	83
Repairs, maintenance and consumable equipment	31,368	28,852	2,794	2,056	10,084	7,613	6,644	6,115	579	252
Other supplies and services	54,058	50,030	8,401	7,746	14,048	12,361	14,239	13,741	2,011	1,144
Other expenses	41,198	35,486	3,625	3,007	13,092	11,405	14,569	13,291	1,001	462
Total cost of services	1,710,857	1,557,476	230,408	221,143	436,407	383,962	397,205	357,008	36,166	28,282
INCOME										
Revenue										
Patient charges	69,901	65,285	2,241	2,020	6,427	6,943	853	602	-	-
Other fees for services	35,696	30,140	-	-	74,017	62,412	80	121	-	-
Other grants and contributions	223	1,783	-	6	42	59	-	-	3	2
Donation revenue	40	4	1	-	3	1	8	5	-	-
Other revenue	3,085	2,704	62	59	7,345	5,656	510	392	3	-
Total revenue	108,945	99,916	2,304	2,085	87,834	75,071	1,451	1,120	6	2
Total income other than income from State Government	108,945	99,916	2,304	2,085	87,834	75,071	1,451	1,120	6	2
NET COST OF SERVICES	1,601,912	1,457,560	228,104	219,058	348,573	308,891	395,754	355,888	36,160	28,280

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

Notes to the financial statements continued

For the year ended 30 June 2025

2.2 Schedule of Income and Expenses by Service (continued)

	Public Hospital Admitted Patient		Public Hospital Emergency Services		Public Hospital Non- Admitted Services		Mental Health Services		Aged Continuing Care Services	
	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
INCOME FROM STATE GOVERNMENT										
Department of Health - Service Agreement - State Component	998,951	871,803	149,626	133,435	221,246	171,422	9,786	29,860	24,319	22,008
Department of Health - Service Agreement - Commonwealth Component	479,181	504,630	67,231	71,939	119,222	102,286	-	-	5,889	4,735
Mental Health Commission - Service Agreement	-	-	-	-	-	-	350,166	313,092	-	-
Income from other state government agencies	1,610	-	-	-	1	-	-	-	-	157
Assets assumed/(transferred)	854	-	40	-	79	-	-	-	-	-
Services received free of charge	74,183	73,123	12,019	10,065	17,313	17,691	19,490	12,391	1,433	932
Royalties for regions fund	-	-	-	-	-	-	-	-	411	-
Total income from State Government	1,554,779	1,449,556	228,916	215,439	357,861	291,399	379,442	355,343	32,052	27,832
SURPLUS/(DEFICIT) FOR THE PERIOD	(47,133)	(8,004)	812	(3,619)	9,288	(17,492)	(16,312)	(545)	(4,108)	(448)

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

Notes to the financial statements continued

For the year ended 30 June 2025

2.2 Schedule of Income and Expenses by Service (continued)

	Public and Community Health Services		Community Dental Services		Small Rural Hospital Services		Health System Management - Policy and Corporate Services		Total	
	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
COST OF SERVICES										
Expenses										
Employee benefits expense	88,536	83,679	76,185	71,732	-	-	367	821	1,660,203	1,504,628
Contracts for services	21,771	21,290	797	854	-	396	-	-	608,018	559,149
Patient support costs	24,069	21,320	25,221	23,633	-	-	-	-	477,689	436,826
Finance costs	391	303	107	55	-	-	-	-	1,774	1,563
Depreciation and amortisation expense	4,007	3,736	3,523	3,052	-	-	-	-	90,622	83,015
Repairs, maintenance and consumable equipment	4,899	4,175	3,912	3,047	-	-	-	-	60,280	52,110
Other supplies and services	4,075	4,430	6,073	5,577	-	-	-	75	102,905	95,104
Other expenses	19,655	19,229	9,689	8,943	-	-	131	237	102,960	92,060
Total cost of services	167,403	158,162	125,507	116,893	-	396	498	1,133	3,104,451	2,824,455
INCOME										
Revenue										
Patient charges	-	-	4,653	4,521	-	-	-	-	84,075	79,371
Other fees for services	8,877	7,158	4,202	3,815	-	-	-	-	122,872	103,646
Other grants and contributions	6,371	3,783	-	-	-	-	-	-	6,639	5,633
Donation revenue	838	421	83	-	-	-	-	-	973	431
Other revenue	18,835	17,287	78	417	-	-	-	2	29,918	26,517
Total revenue	34,921	28,649	9,016	8,753	-	-	-	2	244,477	215,598
Total income other than income from State Government	34,921	28,649	9,016	8,753	-	-	-	2	244,477	215,598
NET COST OF SERVICES	132,482	129,513	116,491	108,140	-	396	498	1,131	2,859,974	2,608,857

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

Notes to the financial statements continued

For the year ended 30 June 2025

2.2 Schedule of Income and Expenses by Service (continued)

	Public and Community Health Services		Community Dental Services		Small Rural Hospital Services		Health System Management - Policy and Corporate Services		Total	
	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
INCOME FROM STATE GOVERNMENT										
Department of Health - Service Agreement - State Component	139,983	118,140	100,068	92,133	-	-	580	1,359	1,644,559	1,440,160
Department of Health - Service Agreement - Commonwealth Component	3,773	7,478	9,686	9,686	-	-	-	-	684,982	700,754
Mental Health Commission - Service Agreement	-	-	-	-	-	-	-	-	350,166	313,092
Income from other state government agencies	3,534	2,873	4	6	-	-	-	-	5,149	3,036
Assets assumed/(transferred)	-	68	-	-	-	-	-	-	973	68
Services received free of charge	5,566	4,517	6,881	6,326	-	-	-	-	136,885	125,045
Royalties for regions fund	-	-	-	-	-	411	-	-	411	411
Total income from State Government	152,856	133,076	116,639	108,151	-	411	580	1,359	2,823,125	2,582,566
SURPLUS/(DEFICIT) FOR THE PERIOD	20,374	3,563	148	11	-	15	82	228	(36,849)	(26,291)

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

Notes to the financial statements continued

For the year ended 30 June 2025

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	2025 \$'000	2024 \$'000
Employee benefits expenses	3.1(a)	1,660,203	1,504,628
Employee related provisions	3.1(b)	421,578	381,221
Contracts for services	3.2	608,018	559,149
Patient support costs	3.3	477,689	436,826
Repairs, maintenance and consumable equipment	3.4	60,280	52,110
Other supplies and services	3.5	102,905	95,104
Other expenses	3.6	102,960	92,060

3.1(a) Employee benefits expenses

	2025 \$'000	2024 \$'000
Wages and salaries	1,498,027	1,363,449
Superannuation - defined contributions plans	162,176	141,179
Total employee benefits expenses	1,660,203	1,504,628
Add: AASB 16 Non-monetary benefits	1,793	1,631
Less: Employee Contribution	(25)	(26)
Net employee benefits	1,661,971	1,506,233

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

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

The amount recognised in profit or loss of the Statement of Comprehensive Income comprises employer contributions paid to the GSS (concurrent contributions), the WSS, the GESBs, or other superannuation funds.

AASB 16 Non-monetary benefits: Non-monetary employee benefits, that are employee benefits expenses, predominantly relate to the provision of vehicle and housing benefits are measured at the cost incurred by the Health Service.

Employee Contributions: Contributions made to the Health Service by employees towards employee benefits that have been provided by the Health Service. This includes both AASB 16 and non-AASB 16 employee contributions.

3.1(b) Employee related provisions

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

	2025 \$'000	2024 \$'000
Current		
Annual leave	171,779	156,816
Time off in lieu	42,989	39,476
Long service leave	148,783	116,664
Deferred salary scheme	2,064	1,695
	365,615	314,651
Non-Current		
Long service leave	55,963	66,570
	55,963	66,570
Total employee related provisions	421,578	381,221

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

	2025 \$'000	2024 \$'000
Within 12 months of the end of the reporting period	117,259	105,581
More than 12 months after the end of the reporting period	97,509	90,711
	214,768	196,292

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

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

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

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

	2025 \$'000	2024 \$'000
Within 12 months of the end of the reporting period	38,684	27,999
More than 12 months after the end of the reporting period	166,062	155,235
	204,746	183,234

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

Notes to the financial statements continued

For the year ended 30 June 2025

3.1(b) Employee related provisions (continued)

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

	2025	2024
	\$'000	\$'000
Within 12 months of the end of the reporting period	413	373
More than 12 months after the end of the reporting period	1,651	1,322
Carrying amount at end of period	2,064	1,695

Key sources of estimation uncertainty – long service leave

Key estimates and assumptions concerning the future are based on historical experience and various other factors that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year.

Several estimates and assumptions are used in calculating the Health Service's long service leave provision. These include:

- Expected future salary rates
- Discount rates
- Employee retention rates
- Expected future payments

Changes in these estimations and assumptions may impact on the carrying amount of the long service leave provision.

Any gain or loss following revaluation of the present value of long service leave liabilities is recognised as employee benefits expense.

3.2 Contracts for services

	2025	2024
	\$'000	\$'000
Public patients services ^(a)	523,019	488,355
Mental Health	50,653	41,816
Other aged-care services	15,647	14,847
Other contracts	18,699	14,131
Total contracts for services	608,018	559,149

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

	2025	2024
	\$'000	\$'000
Medical supplies and services	340,129	307,176
Pathology services received free of charge	45,594	40,893
Domestic charges	25,273	23,278
Fees for visiting medical practitioners	19,033	17,914
Fuel, light and power	17,172	16,376
Food supplies	14,001	13,663
Patient transport costs	4,571	4,206
Research, development and other grants	11,916	13,320
Total patient support costs	477,689	436,826

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

3.4 Repairs, maintenance and consumable equipment

	2025	2024
	\$'000	\$'000
Repairs and maintenance	38,425	33,245
Consumable equipment	21,855	18,865
Total repairs, maintenance and consumable equipment	60,280	52,110

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

3.5 Other supplies and services

	2025	2024
	\$'000	\$'000
Sanitation and waste removal services	3,561	3,438
Administration and management services	4,073	4,199
Interpreter services	3,109	3,163
Security services	803	1,743
Services provided by Health Support Services: ^(a)		
ICT services	61,117	54,918
Supply chain services	11,308	10,659
Financial services	3,192	2,894
Human resource services	14,372	13,784
Other	1,370	306
Total other supplies and services	102,905	95,104

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

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

Notes to the financial statements continued

For the year ended 30 June 2025

3.6 Other expenses

	2025	2024
	\$'000	\$'000
Communications	3,848	4,530
Computer services	4,935	5,620
Workers' compensation insurance	30,458	22,833
Other insurances	23,026	22,257
Consultancy fees	7,152	3,111
Other employee related expenses	7,096	5,658
Printing and stationery	4,603	4,457
Expected credit losses expense	2,830	3,629
Freight and cartage	2,167	2,005
Periodical subscriptions	1,155	881
Motor vehicle expenses	1,422	1,607
General administration	7,444	9,792
Legal expenses	86	538
Rental	3,067	2,675
Assets impairment	1,605	-
Loss on disposal of non-current assets	-	152
Other	2,066	2,315
Total other expenses	102,960	92,060

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

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

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

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

4 Our funding sources

How we obtain our funding

This section provides additional information about how the Health Service obtains its funding and the relevant accounting policy notes that govern the recognition and measurement of this funding. The primary incomes received by the Health Service and the relevant notes are:

	Notes	2025	2024
		\$'000	\$'000
Income from State Government	4.1	2,823,125	2,582,566
Patient charges	4.2	84,075	79,371
Other fees for services	4.3	122,872	103,646
Other grants and contributions	4.4	6,639	5,633
Other revenue	4.5	29,918	26,517

4.1 Income from State Government

	2025	2024
	\$'000	\$'000
Appropriation received for the period:		
Department of Health - Service Agreement - State Component	1,644,559	1,440,160
Department of Health - Service Agreement - Commonwealth Component	-	222
- Capital grants	684,982	700,532
- Recurrent grants	350,166	313,092
Mental Health Commission - Service Agreement	350,166	313,092
Total appropriation received	2,679,707	2,454,006

Grants and income from other state government agencies:

Disability Services Commission	-	-
Recoveries for Insurance Claims from State Government Insurers	665	900
Pathology services to other Health Services	30	31
Insurance Commission of Western Australia - patient fees (motor vehicle injuries)	1,607	-
Graduate Transition to Practice Program funding from Chief Nursing and Midwifery Office WA	1,132	1,080
Other specific grants	1,715	1,025
Total grants and subsidies	5,149	3,036

Assets assumed/(transferred)	973	68
Total assets assumed/(transferred)	973	68

Resources received from other public sector entities during the period:

Department of Finance - government leased accommodation	66	39
Department of Education - Dental therapy units rental expense	1,236	1,182
State Solicitor's Office - legal service	-	370
PathWest - pathology services	45,594	40,893
Services received from Health Support Services (HSS)		
ICT services	61,117	54,918
Supply chain services	11,308	10,659
Financial services	3,192	2,894
Human resources services	14,372	13,784
COVID testing kits	-	306
Total received	136,885	125,045

Regional Community Services Account	411	411
Total Royalties for Regions Fund	411	411

Total income from State Government	2,823,125	2,582,566
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Notes to the financial statements continued

For the year ended 30 June 2025

4.1 Income from State Government (continued)

Service Appropriation is recognised at fair value in the period in which the Health Service gains control of the appropriated funds. The Health Service gains control of appropriated funds at the time those funds are deposited to the bank account or credited to the holding account held at Treasury.

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

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

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

Assets transferred from other parties are recognised as income at fair value when the assets are transferred.

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

The Regional Community Services Account is a sub-fund within the overarching 'Royalties for Regions Fund'. The recurrent funds are committed to projects and programs in WA regional areas and are recognised as revenue when the Health Service receives the funds. The Health Service has assessed Royalties for Regions agreements and concludes that they are not within the scope of AASB 15 as they do not meet the 'sufficiently specific' criterion.

4.2 Patient charges

	2025 \$'000	2024 \$'000
Inpatient bed charges	65,939	60,567
Inpatient other charges	4,828	5,312
Outpatient charges	13,308	13,492
Total patient charges	84,075	79,371

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

	2025 \$'000	2024 \$'000
Recoveries from the Pharmaceutical Benefits Scheme (PBS)	114,273	96,772
Clinical services to other health organisations	7,485	5,767
Non-clinical services to other health organisations	1,114	1,107
Total other fees for services	122,872	103,646

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

4.4 Other grants and contributions

	2025 \$'000	2024 \$'000
Research grants	1,351	3,322
Other grants	5,288	2,311
	6,639	5,633

4.5 Other revenue

	2025 \$'000	2024 \$'000
Use of hospital facilities	10,890	9,011
Rent from commercial properties	532	421
Rent from residential properties	111	120
Boarders' accommodation	2,593	2,532
Sale of radiopharmaceuticals	6,932	5,800
Parking	5,589	5,386
Other	3,271	3,247
Total other revenue	29,918	26,517

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	2025 \$'000	2024 \$'000
Property, plant and equipment	1,635,118	1,373,538
Depreciation	76,562	70,200
Right-of-use assets	29,374	30,565
Depreciation	4,847	4,577
Service concession assets	539,906	421,560
Depreciation	8,852	8,005
Intangible assets	2,122	929
Amortisation	361	233

Notes to the financial statements continued

For the year ended 30 June 2025

5.1 Infrastructure, property, plant and equipment

	Land \$'000	Buildings \$'000	Buildings under construction \$'000	Site infrastructure \$'000	Leasehold improvements \$'000	Computer equipment \$'000	Furniture and fittings \$'000	Motor vehicles \$'000	Medical equipment \$'000	Other plant and equipment \$'000	Work in progress \$'000	Artworks \$'000	Total \$'000
1 July 2023													
Gross carrying amount	240,729	799,489	55,482	92,920	9,460	3,189	6,150	230	138,677	74,812	3,635	315	1,425,088
Accumulated depreciation	-	-	-	(26,373)	(3,652)	(1,690)	(2,975)	(214)	(73,413)	(25,128)	-	-	(133,445)
Accumulated impairment loss	-	-	-	-	-	-	(73)	-	(179)	(51)	-	-	(303)
Carrying amount at start of year	240,729	799,489	55,482	66,547	5,808	1,499	3,102	16	65,085	49,633	3,635	315	1,291,340
Additions	-	-	33,765	-	-	25	411	-	19,716	721	1,928	-	56,566
Disposals	-	-	-	-	-	61	-	-	61	(20)	-	-	102
Transfers from work in progress	-	26,084	(26,084)	-	-	-	-	-	(94)	(67)	-	-	(161)
Transfers of assets from owner	-	64	-	-	-	-	-	-	-	-	-	-	64
Revaluation increments/(decrements)	13,687	82,140	-	-	-	-	-	-	-	-	-	-	95,827
Depreciation	-	(45,825)	-	(3,808)	(727)	(368)	(643)	(8)	(15,187)	(3,634)	-	-	(70,200)
Carrying amount at 30 June 2024	254,416	861,952	63,163	62,739	5,081	1,217	2,870	8	69,581	46,633	5,563	315	1,373,538
Gross carrying amount	254,416	861,952	63,163	92,920	9,460	3,275	6,564	229	156,101	75,350	5,563	315	1,529,308
Accumulated depreciation	-	-	-	(30,181)	(4,379)	(2,058)	(3,621)	(221)	(86,341)	(28,666)	-	-	(155,467)
Accumulated impairment loss	-	-	-	-	-	-	(73)	-	(179)	(51)	-	-	(303)

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

Notes to the financial statements continued

For the year ended 30 June 2025

5.1 Infrastructure, property, plant and equipment (continued)

	Land	Buildings	Buildings under construction	Site infrastructure	Leasehold improvements	Computer equipment	Furniture and fittings	Motor vehicles	Medical equipment	Other plant and equipment	Work in progress	Artworks	Total
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
1 July 2024													
Gross carrying amount	254,416	861,952	63,163	92,920	9,460	3,275	6,564	229	156,101	75,350	5,563	315	1,529,308
Accumulated depreciation	-	-	-	(30,181)	(4,379)	(2,058)	(3,621)	(221)	(86,341)	(28,666)	-	-	(155,467)
Accumulated impairment loss	-	-	-	-	-	-	(73)	-	(179)	(51)	-	-	(303)
Carrying amount at start of year	254,416	861,952	63,163	62,739	5,081	1,217	2,870	8	69,581	46,633	5,563	315	1,373,538
Additions	-	-	54,838	-	-	1,489	398	-	15,738	1,150	6,247	-	79,860
Disposals	-	-	-	-	-	-	-	-	(37)	-	-	-	(37)
Transfers from work in progress	-	2,664	(4,137)	1	1,471	-	-	1	1	-	(1)	-	-
Revaluation increments/(decrements)	10,130	251,520	-	-	-	-	-	-	-	-	-	-	261,650
Impairment losses	-	(1,508)	-	(218)	-	(88)	(126)	-	(1,288)	(103)	-	-	(3,331)
Depreciation	-	(51,656)	-	(3,808)	(952)	(512)	(659)	(9)	(15,476)	(3,490)	-	-	(76,562)
Carrying amount at 30 June 2025	264,546	1,062,972	113,864	58,714	5,600	2,106	2,483	-	68,519	44,190	11,809	315	1,635,118
Gross carrying amount	264,546	1,062,972	113,864	92,703	10,931	4,666	6,896	230	161,376	75,970	11,809	315	1,806,278
Accumulated depreciation	-	-	-	(33,989)	(5,331)	(2,557)	(4,217)	(230)	(91,839)	(31,652)	-	-	(169,815)
Accumulated impairment loss	-	-	-	-	-	(3)	(196)	-	(1,018)	(128)	-	-	(1,345)

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

Notes to the financial statements continued

For the year ended 30 June 2025

5.1 Infrastructure, property, plant and equipment (continued)

Initial recognition

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

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

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

Subsequent measurement

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

- land
- buildings

Land is carried at fair value. Buildings are carried at fair value less accumulated depreciation and accumulated impairment losses. All other property, plant and equipment are stated at historical cost less accumulated depreciation and accumulated impairment losses.

Revaluation model:

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

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

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

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

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

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

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

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

Land and buildings were revalued as at 1 July 2024 by the Western Australian Land Information Authority (Valuations and Property Analytics). The valuations were performed during the year ended 30 June 2025 and recognised at 30 June 2025. In undertaking the revaluation, fair value was determined by reference to market values for land: \$6.4 million (2024: \$5.6 million) and buildings: \$0.6 million (2024: \$0.4 million). For the remaining balance, fair value of buildings was determined on the basis of current replacement cost and fair value of land was determined on the basis of comparison with market evidence for land with low level utility (high restricted use land).

Notes to the financial statements continued

For the year ended 30 June 2025

5.1.1 Depreciation and impairment

	2025 \$'000	2024 \$'000
Depreciation		
Buildings	51,656	45,825
Site infrastructure	3,808	3,808
Leasehold improvement	952	727
Computer equipment	512	368
Furniture and fittings	659	643
Motor vehicles	9	8
Medical equipment	15,476	15,187
Other plant and equipment	3,490	3,634
Total depreciation for the period	76,562	70,200

All surplus assets at 30 June 2025 have either been classified as assets held for sale or have been written-off.

Please refer to note 5.4 for guidance in relation to the impairment assessment that has been performed for intangible assets.

Finite useful lives

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

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

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

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

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

Impairment

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

Where an asset measured at cost is written down to its recoverable amount, an impairment loss is recognised through profit or loss. Where a previously revalued asset is written down to its recoverable amount, the loss is recognised as a revaluation decrement through other comprehensive income.

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

5.1.1 Depreciation and impairment (continued)

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

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

5.2 Right-of-use assets

	Land \$'000	Buildings \$'000	Plant equipment and vehicles \$'000	Total \$'000
1 July 2023				
Gross carrying amount	728	34,174	5,403	40,305
Accumulated depreciation	(478)	(8,006)	(2,854)	(11,338)
Carrying amount at start of period	250	26,168	2,549	28,967
Additions	-	3,361	2,761	6,122
Cost Adjustment	-	(350)	421	71
Disposals	-	-	(18)	(18)
Depreciation	(130)	(3,042)	(1,405)	(4,577)
Carrying amount at 30 June 2024	120	26,137	4,308	30,565
Gross carrying amount	728	36,320	7,040	44,088
Accumulated depreciation	(608)	(10,183)	(2,732)	(13,523)
1 July 2024				
Gross carrying amount	728	36,320	7,040	44,088
Accumulated depreciation	(608)	(10,183)	(2,732)	(13,523)
Carrying amount at start of period	120	26,137	4,308	30,565
Additions	-	1,696	1,522	3,218
Cost Adjustment	-	589	164	753
Disposals	-	(281)	(34)	(315)
Depreciation	(120)	(3,272)	(1,455)	(4,847)
Carrying amount at 30 June 2025	-	24,869	4,505	29,374
Gross carrying amount	-	37,761	7,504	45,265
Accumulated depreciation	-	(12,892)	(2,999)	(15,891)

Notes to the financial statements continued

For the year ended 30 June 2025

5.2 Right-of-use assets (continued)

Initial recognition

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

The Health Service assesses whether:

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

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

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

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

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

Subsequent Measurement

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

5.2.1 Depreciation and impairment of right-of-use assets

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

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

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

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

	2025 \$'000	2024 \$'000
Depreciation expense of right-of-use assets	4,847	4,577
Lease interest expense	1,774	1,563
Expenses relating to variable lease payments not included in lease liabilities	-	14
Short-term leases	-	-
Low-value leases	-	-
Total amount recognised in the statement of comprehensive income	6,621	6,154

The total cash outflow for leases in 2025 was \$5,813,000 (2024: \$5,276,000).

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

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

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

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

Notes to the financial statements continued

For the year ended 30 June 2025

5.3 Service concession assets

	Land \$'000	Buildings \$'000	Buildings under construction \$'000	Site infrastructure \$'000	Computer equipment \$'000	Furniture & fittings \$'000	Medical equipment	Other plant & equipment \$'000	Total \$'000
1 July 2023									
Gross carrying amount	31,500	237,744	113,207	14,120	128	1,952	5,105	66	403,822
Accumulated depreciation	-	-	-	(1,823)	(128)	(1,335)	(4,715)	(49)	(8,050)
Carrying amount at start of period	31,500	237,744	113,207	12,297	-	617	390	17	395,772
Additions	-	-	52,703	-	263	29	91	414	53,500
Disposals	-	(9,817)	-	-	-	-	-	-	(9,817)
Transfers from Work in Progress	-	94,940	(94,940)	-	-	-	-	-	-
Revaluation increments/(decrements)	-	(9,890)	-	-	-	-	-	-	(9,890)
Depreciation	-	(7,289)	-	(334)	(37)	(209)	(79)	(57)	(8,005)
Carrying amount at 30 June 2024	31,500	305,688	70,970	11,963	226	437	402	374	421,560
Gross carrying amount	31,500	305,688	70,970	14,120	391	1,983	5,196	481	430,329
Accumulated depreciation	-	-	-	(2,158)	(165)	(1,545)	(4,794)	(107)	(8,769)
1 July 2024									
Gross carrying amount	31,500	305,688	70,970	14,120	391	1,983	5,196	481	430,329
Accumulated depreciation	-	-	-	(2,158)	(165)	(1,545)	(4,794)	(107)	(8,769)
Carrying amount at start of period	31,500	305,688	70,970	11,962	226	438	402	374	421,560
Additions	-	-	48,092	-	-	-	422	-	48,514
Disposals	-	-	-	-	-	-	-	-	-
Transfers from Work in Progress	-	95,267	(95,268)	-	-	1	-	-	-
Revaluation increments/(decrements)	4,100	74,584	-	-	-	-	-	-	78,684
Depreciation	-	(8,122)	-	(334)	(40)	(210)	(84)	(62)	(8,852)
Carrying amount at 30 June 2025	35,600	467,417	23,794	11,628	186	229	740	312	539,906
Gross carrying amount	35,600	467,417	23,794	14,120	391	1,984	5,618	481	549,405
Accumulated depreciation	-	-	-	(2,492)	(205)	(1,755)	(4,878)	(169)	(9,499)

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

Notes to the financial statements continued

For the year ended 30 June 2025

5.3 Service concession assets (continued)

Initial recognition

A service concession arrangement is an arrangement which involves an operator:

- that is contractually obliged to provide public services related to a service concession asset on behalf of the grantor; and
- managing at least some of those services under its own discretion, rather than at the direction of the grantor.

The Health Service as the grantor has identified one service concession arrangement in operation.

Ramsay Health Care (Ramsay) holds a 20-year contract to provide a range of services to public patients at Joondalup Health Campus. The contract, which is managed by the North Metropolitan Health Service (NMHS), specifies an annual maximum operating budget for required levels of activity and the services to be provided to public patients.

Where the Health Service has existing assets which meet the conditions specified in the policy, these assets have been reclassified as service concession assets and have been measured based on the current replacement cost in accordance with the cost approach to fair value in AASB 13 as at the date of reclassification.

Subsequent to initial recognition or reclassification, a service concession asset is depreciated or amortised in accordance with AASB 116 Property, Plant and Equipment with any impairment recognised in accordance with AASB 136.

Subsequent measurement

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

- land
- buildings

The policy in connection with the revaluation model is outlined in note 5.1.

5.3.1 Depreciation and impairment of service concession assets

	2025	2024
	\$'000	\$'000
Charge for the period		
Buildings	8,122	7,289
Site infrastructure	334	334
Computer equipment	40	37
Furniture and fittings	210	209
Medical equipment	84	79
Other plant and equipment	62	57
Total depreciation for the period	8,852	8,005

5.3.1 Depreciation and impairment of service concession assets (continued)

Finite useful lives

Service concession assets are systematically depreciated over their estimated useful lives in a manner that reflects the consumption of their future economic benefits.

Depreciation is calculated on a straight-line basis, at rates that allocate the asset's value, less any estimated residual value, over its estimated useful life.

Estimated useful lives for the different asset classes for current and prior years are included in the table below:

Asset	Useful life:
Buildings	50 years
Site infrastructure	50 years
Computer equipment	4 to 10 years
Furniture and fittings	5 to 20 years
Medical equipment	3 to 25 years
Other plant and equipment	3 to 50 years

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

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

Impairment

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

As at 30 June 2025 there were no indications of impairment to service concession assets.

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

Notes to the financial statements continued

For the year ended 30 June 2025

5.4 Intangible assets

	Computer software \$'000	Works in progress \$'000	Total \$'000
Year ended 30 June 2024			
1 July 2023			
Gross carrying amount	2,205	-	2,205
Accumulated amortisation	(1,043)	-	(1,043)
Carrying amount at start of year	1,162	-	1,162
Cost Adjustment	-	-	-
Transfers from/(to) other agency	-	-	-
Amortisation expense	(233)	-	(233)
Carrying amount at 30 June 2024	929	-	929
Gross carrying amount	2,205	-	2,205
Accumulated amortisation	(1,276)	-	(1,276)
Year ended 30 June 2025			
1 July 2024			
Gross carrying amount	2,205	-	2,205
Accumulated amortisation	(1,276)	-	(1,276)
Carrying amount at start of period	929	-	929
Cost Adjustment	1,551	3	1,554
Transfers from/(to) other agency	-	-	-
Amortisation expense	(361)	-	(361)
Carrying amount at 30 June 2025	2,119	3	2,122
Gross carrying amount	3,756	-	3,756
Accumulated amortisation	(1,637)	-	(1,637)

Initial recognition

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

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

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

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

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

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

5.4 Intangible assets (continued)

Subsequent measurement

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

5.4.1 Amortisation and impairment

	2025 \$'000	2024 \$'000
Computer software	361	233
Total amortisation for the period	361	233

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

Impairment of intangible assets

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

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

Notes to the financial statements continued

For the year ended 30 June 2025

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	2025 \$'000	2024 \$'000
Receivables	6.1	118,809	96,651
Amounts receivable for services	6.2	1,222,852	1,133,798
Inventories	6.3	13,714	12,158
Other current assets	6.4	4,391	3,849
Payables	6.5	230,059	206,991
Capital grant liabilities	6.6	-	-
Other liabilities	6.7	1,217	1,352

6.1 Receivables

	2025 \$'000	2024 \$'000
<u>Current</u>		
Trade receivables	35,046	28,442
Other receivables	1,425	795
Allowance for impairment of trade receivables	(13,111)	(12,399)
Accrued revenue	39,052	34,774
GST receivable	11,423	10,190
Total current receivables	73,835	61,802
<u>Non-current</u>		
Accrued salaries account ^(a)	44,974	34,849
Total non-current receivables	44,974	34,849
Total receivables	118,809	96,651

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

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

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

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

6.1.1 Movement in the allowance for impairment of trade receivables

	2025 \$'000	2024 \$'000
Reconciliation of changes in the allowance for impairment of trade receivables		
Balance at start of period	12,399	9,386
Expected credit losses expense	2,830	3,629
Net write-back adjustment	4	667
Amounts written off during the period	(2,122)	(1,283)
Balance at end of period	13,111	12,399

The maximum exposure to credit risk at the end of the reporting period for receivables is the carrying amount of the asset inclusive of any allowance for impairment as shown in the table at Note 8.1(c) 'Credit risk exposure'

The Health Service does not hold any collateral as security or other credit enhancements for receivables.

6.2 Amounts receivable for services

	2025 \$'000	2024 \$'000
Current	-	-
Non-current	1,222,852	1,133,798
Balances at end of period	1,222,852	1,133,798

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

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

6.3 Inventories

	2025 \$'000	2024 \$'000
Current		
Pharmaceutical stores - at cost	12,565	10,847
Engineering stores - at cost	1,149	1,311
Total inventories	13,714	12,158

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

	2025 \$'000	2024 \$'000
Current		
Prepayments	4,391	3,849
Total other current assets	4,391	3,849

Other non-financial assets include prepayments which represent payments in advance of receipt of goods or services or that part of expenditure made in one accounting period covering a term extending beyond that period.

Notes to the financial statements continued

For the year ended 30 June 2025

6.5 Payables

	2025 \$'000	2024 \$'000
Current		
Trade payables	17,919	11,221
Other payables	725	2,725
Accrued expenses	150,205	141,467
Accrued salaries	61,210	51,578
Total current payables	230,059	206,991

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

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

6.6 Capital grant liabilities

	2025 \$'000	2024 \$'000
Reconciliation of changes in capital grant liabilities		
Opening balance at the beginning of the period	-	311
Additions / (Reversals)	-	(89)
Income recognised in the reporting period	-	(222)
Total capital grant liabilities	-	-
Current	-	-
Non-current	-	-
Total capital grant liabilities	-	-

The Health Service's capital grant liabilities relate to capital grants received for critical infrastructure upgrade.

6.7 Other current liabilities

	2025 \$'000	2024 \$'000
Refundable deposits	1,226	1,222
Paid parental leave scheme	278	279
Other	(287)	(149)
Total other current liabilities	1,217	1,352

7 Financing

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

	Notes	2025 \$'000	2024 \$'000
Lease liabilities	7.1	34,523	34,904
Finance costs	7.2	1,774	1,563
Cash and cash equivalents	7.3		
Cash and cash equivalents	7.3.1	40,426	33,577
Restricted cash and cash equivalents	7.3.1	75,164	76,846
Reconciliation of net cost of services to net cash used in operating activities	7.3.2	(2,582,267)	(2,352,309)
Capital commitments	7.4	264,765	269,713

7.1 Lease liabilities

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

	2025 \$'000	2024 \$'000
Lease liabilities		
Current	4,023	3,489
Non-current	30,500	31,415
Total lease liabilities	34,523	34,904

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

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

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

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

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

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

This section should be read in conjunction with Note 5.2.

Subsequent measurement

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

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

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

Notes to the financial statements continued

For the year ended 30 June 2025

7.2 Finance costs

	2025 \$'000	2024 \$'000
Lease interest expense	1,774	1,563
Finance costs expensed	1,774	1,563

7.3 Cash and cash equivalents

7.3.1 Reconciliation of cash

	2025 \$'000	2024 \$'000
Cash and cash equivalents	40,426	33,577
Restricted cash and cash equivalents	75,164	76,846
Balance at end of period	115,590	110,423

Restricted cash and cash equivalents

Current

Grants from State and Commonwealth Governments	11,056	10,346
Other specific purposes ^(a)	54,842	56,234
Mental Health Commission funding ^(b)	9,266	10,266
Total current	75,164	76,846

Total restricted cash and cash equivalents

75,164	76,846
---------------	---------------

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

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

(b) See note 9.8 Special purpose accounts.

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

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

	Notes	2025 \$'000	2024 \$'000
Net cost of services		(2,859,974)	(2,608,857)
Non-cash items:			
Expected credit losses expense	3.6	2,830	3,629
Depreciation and amortisation expense	5.0	90,622	83,015
Net loss from disposal of non-current assets	3.6	(95)	152
Write-off of receivables	6.1.1	(2,118)	(616)
Write down of inventories		313	322
Donation of non-current assets		(462)	(36)
Assets impairment		1,605	-
Services received free of charge	4.1	136,886	125,045
(Increase)/decrease in assets:			
GST receivable		(1,233)	(1,154)
Receivables		(11,512)	(7,131)
Inventories		(1,878)	(1,045)
Other current assets		(542)	(299)
Increase/(decrease) in liabilities:			
Payables		23,069	27,643
Capital grant liabilities		-	(311)
Current employee related provisions		50,966	25,108
Non-current employee related provisions		(10,608)	2,410
Other current liabilities		(136)	(184)
Net cash used in operating activities		(2,582,267)	(2,352,309)

7.4 Capital commitments

The commitments below are inclusive of GST where relevant.

	2025	2024
	\$'000	\$'000
Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows:		
Within 1 year	238,744	263,975
Later than 1 year and not later than 5 years	26,021	5,361
Later than 5 years	-	377
	<u>264,765</u>	<u>269,713</u>

Notes to the financial statements continued

For the year ended 30 June 2025

8 Risks and Contingencies

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

	Notes
Financial risk management	8.1
Contingent assets and liabilities	8.2
Fair value measurements	8.3

8.1 Financial risk management

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

(a) Summary of risks and risk management

Credit risk

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

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

Liquidity risk

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

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

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

Market risk

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

The Health Service is not exposed to interest rate risk because the majority of cash and cash equivalents and restricted cash are non-interest bearing and it has no other borrowings other than lease liabilities.

8.1 Financial risk management (continued)

(b) Categories of financial instruments

The carrying amounts of each of the following categories of financial assets and financial liabilities at the end of the reporting period are:

	2025 \$'000	2024 \$'000
Financial assets		
Cash and cash equivalents	115,590	110,423
Financial assets at amortised cost ^(a)	1,330,238	1,220,259
Total financial assets	1,445,828	1,330,682
Financial liabilities		
Financial liabilities measured at amortised cost	264,582	241,895
Total financial liabilities	264,582	241,895

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

(c) Credit risk exposure

The following table details the credit risk exposure on the Health Service's trade receivables using a provision matrix.

	Total \$'000	Current \$'000	<30 days \$'000	Days past due 31-60 days \$'000	61-90 days \$'000	>91 days \$'000
30 June 2025						
Expected credit loss rate		2.46%	5.23%	16.16%	26.31%	73.29%
Estimated total gross carrying amount at default	35,045	10,844	4,625	1,299	2,136	16,141
Expected credit losses	(13,111)	(267)	(242)	(210)	(562)	(11,830)
30 June 2024						
Expected credit loss rate		3.01%	4.05%	10.54%	23.21%	75.29%
Estimated total gross carrying amount at default	28,442	6,742	3,134	1,195	2,180	15,191
Expected credit losses	(12,399)	(203)	(127)	(126)	(506)	(11,437)

Notes to the financial statements continued

For the year ended 30 June 2025

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

	Weighted average effective interest rate %	Interest rate exposure					Maturity dates				
		Carrying amount \$'000	Fixed interest rate \$'000	Variable interest rate \$'000	Non- interest bearing \$'000	Nominal amount \$'000	Up to 1 month \$'000	1 to 3 months \$'000	3 months to 1 year \$'000	1 to 5 years \$'000	More than 5 years \$'000
2025											
<u>Financial assets</u>											
Cash and cash equivalents	-	115,590	-	-	115,590	115,590	115,590	-	-	-	-
Receivables ^(a)	-	107,386	-	-	107,386	107,386	107,386	-	-	-	-
Amounts receivable for services	-	1,222,852	-	-	1,222,852	1,222,852	-	-	-	-	1,222,852
		1,445,828	-	-	1,445,828	1,445,828	222,976	-	-	-	1,222,852
<u>Financial liabilities</u>											
Payables	-	230,059	-	-	230,059	230,059	230,059	-	-	-	-
Lease liabilities ^(b)	5.01	34,523	34,523	-	-	46,143	493	1,322	3,850	16,542	23,936
		264,582	34,523	-	230,059	276,202	230,552	1,322	3,850	16,542	23,936
2024											
<u>Financial assets</u>											
Cash and cash equivalents	-	110,423	-	-	110,423	110,423	110,423	-	-	-	-
Receivables ^(a)	-	86,461	-	-	86,461	86,461	86,461	-	-	-	-
Amounts receivable for services	-	1,133,798	-	-	1,133,798	1,133,798	-	-	-	-	1,133,798
		1,330,682	-	-	1,330,682	1,330,682	196,884	-	-	-	1,133,798
<u>Financial liabilities</u>											
Payables	-	206,991	-	-	206,991	206,991	206,991	-	-	-	-
Lease liabilities ^(b)	4.80	34,904	34,904	-	-	47,349	435	893	3,793	16,729	25,499
		241,895	34,904	-	206,991	254,340	207,426	893	3,793	16,729	25,499

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

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

Notes to the financial statements continued

For the year ended 30 June 2025

8.2 Contingent assets and liabilities

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

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

8.2.1 Contingent assets

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

8.2.2 Contingent liabilities

Contaminated sites

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

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

8.3 Fair value measurements

Fair value hierarchy

AASB 13 requires disclosure of fair value measurements by level of the following fair value measurement hierarchy:

- 1) quoted prices (unadjusted) in active markets for identical assets (level 1)
- 2) input other than quoted prices included within level 1 that are observable for the asset either directly or indirectly (level 2); and
- 3) inputs for the asset that are not based on observable market data (unobservable input) (level 3).

	Level 1 \$'000	Level 2 \$'000	Level 3 \$'000	Total \$'000
2025				
Assets measured and recognised at fair value:				
Land				
Residential	-	45	-	45
Specialised	-	6,360	293,741	300,101
Buildings				
Residential and commercial car park	-	49	55,387	55,436
Specialised	-	400	1,474,553	1,474,953
	-	6,854	1,823,681	1,830,535
2024				
Assets measured and recognised at fair value:				
Land				
Residential	-	44	-	44
Specialised	-	5,520	280,352	285,872
Buildings				
Residential and commercial car park	-	190	45,396	45,586
Specialised	-	230	1,121,824	1,122,054
	-	5,984	1,447,572	1,453,556

Valuation techniques to derive Level 2 fair values

The level 2 fair values of residential properties, commercial car park and land are derived using the market approach. Market evidence of sales prices of comparable land and buildings (office accommodation) in close proximity is used to determine price per square metre.

Notes to the financial statements continued

For the year ended 30 June 2025

8.3 Fair value measurements (continued)

Fair value measurements using significant unobservable inputs (Level 3)

	Land \$'000	Buildings \$'000	Total \$'000
2025			
Fair value at start of period	280,352	1,167,220	1,447,572
Additions and transfers from work in progress	-	97,931	97,931
Revaluation increments/(decrements)	13,389	325,881	339,270
Impairment	-	(1,322)	(1,322)
Depreciation	-	(59,770)	(59,770)
Fair value at end of period	293,741	1,529,940	1,823,681
2024			
Fair value at start of period	267,176	1,036,789	1,303,965
Additions and transfers from work in progress	-	121,024	121,024
Revaluation increments/(decrements)	13,176	72,222	85,398
Transfers of assets to other agency	-	64	64
Disposals	-	(9,817)	(9,817)
Depreciation	-	(53,062)	(53,062)
Fair value at end of period	280,352	1,167,220	1,447,572

Valuation processes

There were no changes in valuation techniques during the period.

Land (Level 3 fair values)

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

Buildings (Level 3 fair values)

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

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

Basis of valuation

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

9 Other disclosures

This section includes additional material disclosures required by accounting standards or other pronouncements, for the understanding of this financial report.

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

9.1 Events occurring after the end of the reporting period

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

9.2 Changes in accounting policy

The following standards are first applied for the reporting period ended on 30 June 2025:

- AASB 2020-1 - Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-current
- AASB 2022-10 - Amendments to Australian Accounting Standards – Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities

Notes to the financial statements continued

For the year ended 30 June 2025

9.3 Future impact of Australian Accounting Standards not yet operative

The Health Service cannot early adopt an Australian Accounting Standard unless specifically permitted by TI 9 – Requirement 4 *Application of Australian Accounting Standards and Other Pronouncements* or by an exemption from TI 9. Where applicable, the Health Service plans to apply the following Australian Accounting Standards from their application date.

		Operative for reporting periods beginning on/after
Operative for reporting periods beginning on/after 1 Jan 2026		
AASB 2024-2	<i>Amendments to Australian Accounting Standards – Classification and Measurement of Financial Instruments</i>	
	This Standard amends AASB 7 and AASB 9 as a consequence of the issuance of Amendments to the Classification and Measurement of Financial Instruments (Amendments to IFRS 9 and IFRS 7) by the International Accounting Standards Board in May 2024.	1 Jan 2026
	The Health Service has not assessed the impact of the Standard.	
AASB 2024-3	<i>Amendments to Australian Accounting Standards – Annual Improvements Volume 11</i>	
	This Standard amends AASB 1, AASB 7, AASB 9, AASB 10 and AASB 107 as a consequence of the issuance of Annual Improvements to IFRS Standards – Volume 11 by the International Accounting Standards Board in July 2024.	1 Jan 2026
	The Health Service has not assessed the impact of the Standard.	
Operative for reporting periods beginning on/after 1 Jan 2028		
AASB 18(NFP /super)	<i>Presentation and Disclosure in Financial Statements (Appendix D) [for not-for-profit and superannuation entities]</i>	
	This Standard replaces AASB 101 with respect to the presentation and disclosure requirements in financial statements applicable to not-for-profit and superannuation entities. This Standard is a consequence of the issuance of IFRS 18 Presentation and Disclosure in financial Statements by the International Accounting Standards Board in April 2024.	1 Jan 2028
	This Standard also makes amendments to other Australian Accounting Standards set out in Appendix D of this Standard.	
	The Health Service has not assessed the impact of the Standard.	

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

	2025	2024
Compensation band (\$)		
\$20,001 – \$30,000	-	2
\$30,001 – \$40,000	1	-
\$40,001 – \$50,000	6	6
\$50,001 – \$60,000	1	1
\$70,001 – \$80,000	1	-
\$80,001 – \$90,000	-	1
	9	10
	2025	2024
	\$'000	\$'000
Short-term employee benefits	394	414
Post-employment benefits	45	45
	439	459

Compensation band of senior officers

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

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

	2025	2024
Compensation band (\$)		
\$50,001 – \$100,000	1	1
\$150,001 – \$200,000	1	1
\$200,001 – \$250,000	-	3
\$250,001 – \$300,000	7	5
\$300,001 – \$350,000	4	1
\$400,001 – \$450,000	-	1
\$500,001 – \$550,000	1	2
\$550,001 – \$600,000	1	1
\$600,001 – \$650,000	1	1
	16	16
	2025	2024
	\$'000	\$'000
Short-term employee benefits	4,205	4,227
Post-employment benefits	474	471
Other long-term benefits	430	350
Termination benefits	-	216
Total compensation of senior officers	5,109	5,264

Notes to the financial statements continued

For the year ended 30 June 2025

9.5 Related party transactions

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

Related parties of the Health Service include:

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

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

Significant Transactions with Government-related entities

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

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

Material transactions with other related parties

Outside of normal citizen type transactions with the Health Service, there were no related party transactions that involved key management personnel and/or their close family members and/or their controlled (or jointly controlled) entities.

9.6 Related bodies

A related body is a body which receives more than half its funding and resources from the Health Service, and is subject to operational control by the Health Service.

The Health Service had no related bodies during the financial year.

9.7 Affiliated bodies

An affiliated body is a body that receives more than half its funding and resources from the Health Service, but is not subject to operational control by the Health Service.

The Health Service had no affiliated bodies during the financial year.

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.

	2025 \$'000	2024 \$'000
Balance at start of period	10,266	15,749
Add receipts		
Service delivery arrangement:		
Commonwealth contributions	119,177	104,040
State contributions	230,711	209,052
	349,888	313,092
Less Payments	(350,887)	(318,575)
Balance at end of period	9,267	10,266

The special purpose accounts are established under section 16(1)(d) of the FMA.

9.9 Remuneration of auditors

Remuneration paid or payable to the Auditor General in respect of the audit is as follows:

	2025 \$'000	2024 \$'000
Auditing the accounts, controls, financial statements and key performance indicators	532	488
	532	488

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.

	2025 \$'000	2024 \$'000
Balance at start of period	2,069,717	1,962,833
Contribution by owners		
Capital Appropriations administered by Department of Health	133,737	106,884
Transfer of property, plant and equipment from Department of Health	-	-
	2,203,454	2,069,717
Distributions to owners		
Transfer of property, plant and equipment to HSS	-	-
Total contribution by owners	-	-
Balance at end of period	2,203,454	2,069,717
	2025 \$'000	2024 \$'000
Asset revaluation reserve		
Balance at the start of period	504,006	427,885
Net revaluation increments/(decrements):		
Land	14,230	13,688
Buildings	324,378	62,433
Balance at end of period	842,614	504,006

Notes to the financial statements continued

For the year ended 30 June 2025

9.11 Supplementary financial information

(a) Write-offs

	2025 \$'000	2024 \$'000
Revenue and debts written off under the authority of:		
The Accountable Authority	1,468	1,284
The Minister	654	-
The Treasurer	-	-
	<u>2,122</u>	<u>1,284</u>

(b) Losses through theft, defaults and other causes

	2025 \$'000	2024 \$'000
Losses of public monies and public or other property through theft or default	131	10
Less amount recovered	(131)	(7)
Net losses	<u>-</u>	<u>3</u>

(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:

	2025 \$'000	2024 \$'000
Department of Justice - dental treatment	804	843
Disability Services Commission - dental treatment	959	412
	<u>1,763</u>	<u>1,255</u>

9.12 Disclosure of Trust Accounts

Funds held in these trust accounts are not controlled by the Health Service and are therefore not recognised in the financial statements:

(a) The Health Service administers trust accounts for the purpose of holding patients' private monies.

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

	2025 \$'000	2024 \$'000
Balance at the start of period	153	166
Add Receipts	529	739
Less Payments	(545)	(752)
Balance at the end of period	<u>137</u>	<u>153</u>

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

	2025 \$'000	2024 \$'000
RF Shaw Foundation		
Balance at start of period	6	6
Less Payments	-	-
Balance at the end of period	<u>6</u>	<u>6</u>

Trust Accounts are used by the Health Service to account for funds that the Health Service may be holding on behalf of another party, such as patients' cash. The Health Service does not have control of the use of these funds, and cannot deploy them to meet its objectives. Trust accounts do not form part of the resources available to the Health Service, and are not reported as assets in the financial statements.

10 Explanatory statements

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

	Notes
Explanatory statement for controlled operations	10.1

10.1 Explanatory statement for controlled operations

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

All variances between annual estimates (original budget) and actual results for 2025, and between the actual results for 2025 and 2024 are shown below. Narratives are provided for key major variances which vary more than 10% from their comparative and which are also more than 1% of the following (as appropriate):

- Estimate and actual results for the current year:
 - Total Cost of Services of the annual estimates for the Statement of comprehensive income and Statement of cash flows (1% of \$2,772,606,000), and
 - Total Assets of the annual estimates for the Statement of financial position (1% of \$3,395,080,000).
- Actual results between the current year and the previous year:
 - Total Cost of Services of the previous year for the Statements of comprehensive income and Statement of cash flows (1% of \$2,824,455,000), and
 - Total Assets for the previous year for the Statement of financial position (1% of \$3,183,471,000).

Notes to the financial statements continued

For the year ended 30 June 2025

10.1.1 Statement of comprehensive income variances

	Variance Notes	Estimate 2025 \$'000	Actual 2025 \$'000	Actual 2024 \$'000	Variance between actual and estimate \$'000	Variance between actual results for 2025 and 2024 \$'000
COST OF SERVICES						
Expenses						
Employee benefits expense	1,a	1,424,655	1,660,203	1,504,628	235,548	155,575
Contracts for services		581,756	608,018	559,149	26,262	48,869
Patient support costs		443,805	477,689	436,826	33,884	40,863
Finance costs		654	1,774	1,563	1,120	211
Depreciation and amortisation expense		89,053	90,622	83,015	1,569	7,607
Repairs, maintenance and consumable equipment		45,105	60,280	52,110	15,175	8,170
Other supplies and services		92,553	102,905	95,104	10,352	7,801
Other expenses		95,025	102,960	92,060	7,935	10,900
Total cost of services		2,772,606	3,104,451	2,824,455	331,845	279,996
INCOME						
Revenue						
Patient charges		77,767	84,075	79,371	6,308	4,704
Other fees for services		110,706	122,872	103,646	12,166	19,226
Other grants and contributions		14,220	6,639	5,633	(7,581)	1,006
Donation revenue		-	973	431	973	542
Other revenue		27,053	29,918	26,517	2,865	3,401
Total revenue		229,746	244,477	215,598	14,731	28,879
Total income other than income from State Government		229,746	244,477	215,598	14,731	28,879
NET COST OF SERVICES		2,542,860	2,859,974	2,608,857	317,114	251,117
INCOME FROM STATE GOVERNMENT						
Department of Health - Service Agreement - State Component	2,b	1,397,978	1,644,559	1,440,160	246,581	204,399
Department of Health - Service Agreement - Commonwealth Component		670,419	684,982	700,754	14,563	(15,772)
Mental Health Commission - Service Agreement	c	337,126	350,166	313,092	13,040	37,074
Income from other state government agencies		-	5,149	3,036	5,149	2,113
Assets assumed/(transferred)		-	973	68	973	905
Services received free of charge		136,926	136,885	125,045	(41)	11,840
Royalties for Regions Fund		411	411	411	-	-
Total income from State Government		2,542,860	2,823,125	2,582,566	280,265	240,559
Surplus/(deficit) for the period		-	(36,849)	(26,291)	(36,849)	(10,558)
Other comprehensive income items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve		-	338,608	76,121	338,608	262,487
Total other comprehensive income		-	338,608	76,121	338,608	262,487
Total comprehensive income for the period		-	301,759	49,830	301,759	251,929

10.1.1 Statement of comprehensive income variances (continued)

Major estimate and actual (2025) variance narratives:

- 1) Employee benefits expense
The variance between estimate and actual of \$235.5 million (16.5%) is due to higher number of employees to meet higher activity levels, increased employment costs arising from new Award Agreements, leave liabilities valuation adjustments, higher Riskcover Workers Compensation premiums and legislated superannuation increment.
- 2) Department of Health – Service Agreement – State Component
The variance between estimate and actual of \$246.6 million (17.6%) is due to supplementation funding received to support the higher cost of service provision, expansion of patient services and increased activity levels.

Major actual (2025) and comparative (2024) variance narratives:

- a) Employee benefits expense
The employee benefits expense has increased by \$155.6 million (10.3%) in line with the increase in activity levels as well as higher employment costs arising from new Award Agreements, increased FTE, leave liabilities valuation adjustments and legislated superannuation increment.
- b) Department of Health – Service Agreement – State Component
The State Component appropriations for the Service Agreement has increased by \$204.4 million (14.2%) to support the higher cost of providing services, expansion of patient services and increased activity levels.
- c) Mental Health Commission – Service Agreement
The Mental Health Commission funding under the Service Agreement has increased by \$37.1 million (11.8%) due to increased activity levels and higher cost of providing services.

Notes to the financial statements continued

For the year ended 30 June 2025

10.1.2 Statement of financial position variances

Variance Notes	Estimate 2025 \$'000	Actual 2025 \$'000	Actual 2024 \$'000	Variance between actual and estimate \$'000	Variance between actual results for 2025 and 2024 \$'000
ASSETS					
Current assets					
Cash and cash equivalents	20,382	40,426	33,577	20,044	6,849
Restricted cash and cash equivalents	68,326	75,164	76,846	6,838	(1,682)
Receivables	61,802	73,835	61,802	12,033	12,033
Inventories	12,158	13,714	12,158	1,556	1,556
Other current assets	4,336	4,391	3,849	55	542
Total current assets	167,004	207,530	188,232	40,526	19,298
Non-current assets					
Receivables	54,224	44,974	34,849	(9,250)	10,125
Amounts receivable for services	1,222,851	1,222,852	1,133,798	1	89,054
Infrastructure, property, plant and equipment	1,509,765	1,635,118	1,373,538	125,353	261,580
Right-of-use assets	27,790	29,374	30,565	1,584	(1,191)
Service concession assets	3,d 412,516	539,906	421,560	127,390	118,346
Intangible assets	930	2,122	929	1,192	1,193
Total non-current assets	3,228,076	3,474,346	2,995,239	246,270	479,107
Total assets	3,395,080	3,681,876	3,183,471	286,796	498,405
LIABILITIES					
Current liabilities					
Payables	206,991	230,059	206,991	23,068	23,068
Capital grant liabilities	-	-	-	-	-
Lease liabilities	3,458	4,023	3,489	565	534
Employee related provisions	4,e 314,651	365,615	314,651	50,964	50,964
Other current liabilities	1,839	1,217	1,352	(622)	(135)
Total current liabilities	526,939	600,914	526,483	73,975	74,431
Non-current liabilities					
Lease liabilities	29,328	30,500	31,415	1,172	(915)
Employee related provisions	66,570	55,963	66,570	(10,607)	(10,607)
Total non-current liabilities	95,898	86,463	97,985	(9,435)	(11,522)
Total liabilities	622,837	687,377	624,468	64,540	62,909
NET ASSETS	2,772,243	2,994,499	2,559,003	222,256	435,496
EQUITY					
Contributed equity	2,258,355	2,203,454	2,069,717	(54,901)	133,737
Reserves	513,888	842,614	504,006	328,726	338,608
Accumulated surplus/(deficit)	-	(51,569)	(14,720)	(51,569)	(36,849)
Total equity	2,772,243	2,994,499	2,559,003	222,256	435,496

10.1.2 Statement of financial position variances (continued)

Major estimate and actual (2025) variance narratives:

- 3) Service concession assets
- The variance between estimate and actual of \$99.8 million (24.2%) is due to the increase in building construction work as part of the Joondalup Health Campus redevelopment.
- 4) Employee related provisions
- The variance between estimate and actual of \$51.0 million (16.2%) is largely due to the impact of higher effective rates of pay arising from new Award Agreements on the leave balances calculations and the leave liabilities valuation adjustments.

Major actual (2025) and comparative (2024) variance narratives:

- d) Service concession assets
- Service concession assets have increased by \$90.8 million (22.9%) due to the increase in building construction work as part of the Joondalup Health Campus redevelopment.
- e) Employee related provisions
- Employee related provisions have increased by \$51.0 million (16.2%) due to the impact of higher effective rates of pay arising from new Award Agreements on the leave balances calculations as well as leave liabilities valuation adjustments.

Notes to the financial statements continued

For the year ended 30 June 2025

10.1.3 Statement of cash flows variances

	Variance Notes	Estimate 2025 \$'000	Actual 2025 \$'000	Actual 2024 \$'000	Variance between actual and estimate \$'000	Variance between actual results for 2025 and 2024 \$'000
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriation	5	2,330,690	2,595,802	2,377,238	265,112	218,564
Capital appropriations administered by Department of Health	6	192,009	133,742	106,883	(58,267)	26,859
Royalties for Regions Fund		411	411	411	-	-
Net cash provided by State Government		2,523,110	2,729,955	2,484,532	206,845	245,423
Utilised as follows:						
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits	7,f	(1,405,280)	(1,610,835)	(1,464,358)	(205,555)	(146,477)
Supplies and services		(1,121,540)	(1,199,618)	(1,094,016)	(78,078)	(105,602)
Finance costs		(654)	(1,774)	(1,563)	(1,120)	(211)
Receipts						
Receipts from customers		77,767	79,350	80,991	1,583	(1,641)
Other grants and contributions		-	6,639	5,633	6,639	1,006
Donations received		-	511	394	511	117
Other receipts		137,759	143,460	120,610	5,701	22,850
Net cash used in operating activities		(2,311,948)	(2,582,267)	(2,352,309)	(270,319)	(229,958)
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Payment for purchase of non-current physical and intangible assets	8	(192,009)	(128,478)	(110,130)	63,531	(18,348)
Receipts						
Proceeds from sale of non-current physical assets		-	121	9	121	112
Net cash used in investing activities		(192,009)	(128,357)	(110,121)	63,652	(18,236)
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Payments for principal element of lease		(2,118)	(4,039)	(3,699)	(1,921)	(340)
Payments to accrued salaries account		-	(10,125)	(6,387)	(10,125)	(3,738)
Net cash used in financing activities		(2,118)	(14,164)	(10,086)	(12,046)	(4,078)
Net increase/(decrease) in cash and cash equivalents		17,035	5,167	12,016	(11,868)	(6,849)
Cash and cash equivalents at the beginning of the year		125,897	110,423	98,407	(15,474)	12,016
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		142,932	115,590	110,423	(27,342)	5,167

10.1.3 Statement of cash flows variances (continued)

Major estimate and actual (2025) variance narratives:

- 5) Service appropriation
The variance between estimate and actual of \$265.1 million (11.4%) is due to supplementation funding received to support the higher cost of providing services, expansion of patient services and increased activity levels.
- 6) Capital appropriations administered by Department of Health
The variance between estimate and actual of \$58.3 million (30.3%) is largely due to changes in the capital project deliverables and outlays that have occurred since the estimate were developed.
- 7) Employee benefits
The variance between estimate and actual of \$205.6 million (14.6%) is due to higher number of employees to meet higher activity levels, increased employment costs arising from new Award Agreements, higher Riskcover Workers Compensation premiums and legislated superannuation increment.
- 8) Payment for purchase of non-current physical and intangible assets
The variance between estimate and actual of \$63.5 million (33.1%) is due to changes in the capital project deliverables and outlays that have occurred since the estimate were developed. These changes stemmed from changes in project timelines and complications in tendering processes delaying the commencement of some projects.

Major actual (2025) and comparative (2024) variance narratives:

- f) Employee benefits
Expenditure on employee benefits has increased by \$146.5 million (10.0%) due to the increase in employee numbers in line with higher activity levels as well as higher employment costs arising from new Award Agreements, higher Workers Compensation premium and legislated superannuation increment.

Disclosures and Legal Compliance



Occupational health, safety and injury management

We are committed to the health, safety and wellbeing of our staff, patients and visitors at all sites. This is achieved through preventive measures and ongoing management, monitoring and evaluation of potential hazards and risks.

The new *Workers Compensation and Injury Management Act 2023* came into effect on 1 July 2024. We successfully implemented changes to return to work programs and payroll processes to comply with the new Act. This included commencing provisional payments where liability decisions have been deferred and notifying employees when income compensation is being reduced or discontinued.

Other priorities in 2024-25 included:

- A review of our psychosocial risk assessment tools and process. The psychosocial risk assessment process is a legislative requirement under the *Work Health and Safety Act 2020* (WA) and Work Health and Safety Regulations 2022. The updated process will be rolled out across our sites later in 2025.
- An internal audit of the organisation's practices and compliance with the Work Health and Safety Act, ensuring adherence to legislative requirements and continuous improvement in workplace safety.
- Reviews of our Employee Wellbeing Strategy and the Stop the Violence Strategy, both of which conclude in 2025.

- The rollout of the Converge International Wellbeing App. The app provides all employees free access to 24/7 counselling support, fun behaviour-change challenges, a health dashboard, and wellbeing insights.
- Enhanced training and onboarding for health and safety representatives (HSRs). A safety culture perception survey of HSRs showed an overall improvement and opportunities to strengthen training and onboarding. New representatives now receive one-on-one sessions and additional resources are provided to all representatives, such as monthly toolbox talk presentations. Our WHS for Managers training has been converted into a self-enrolling, self-paced eLearning package.

We received one Workplace Violence and Aggression notice in March 2025 which is due in September 2025.

Health and wellbeing snapshot



375

Fit for work referrals undertaken



3,378

Pre-employment health assessments performed



75

Peer support officers trained in psychological first aid, to support staff experiencing challenges with work, relationships, or other life stressors



238

Hazards reported / potential incidents averted.



314

Safety reps trained across NMHS sites. Reps attend bi-monthly committee meetings.



6,764

Reported Code Black incidents



Preventing hearing loss at work

A pilot is underway in our Facilities Management team to provide audiometric assessments and hearing protection fit-testing to identify hearing loss.

The Work Health Safety Act 2020 and Workers Compensation & Injury Management Act 2023 require noise-related hazards to be managed in the workplace and testing for workers whose exposure exceeds the permissible limits.

The assessments and fit-testing enable employees to receive further investigation and, where required, injury management intervention. Additional training in hearing conservation is also being offered to raise awareness of exposure risks.

Performance reporting

Measures	Results 2022-2023	Results 2023-2024	Results 2024-2025	Targets ⁽¹⁾	Comments
	Prior year	Prior year	Current reporting year		
Number of fatalities	0	0	0	0	Target met
Lost time injury and disease incidence rate ⁽²⁾	2.5	2.9	2.4	0 or 10% reduction (2.07)	Target met
Lost time injury severity rate ⁽²⁾	47	35	43.67	0 or 10% reduction (41.4)	Target not met
Claim severity rate ⁽³⁾	44.7	32	43.42	0 or 10% reduction (36.2)	Target not met
Percentage of injured workers returned to work (i) within 13 weeks ⁽⁴⁾	47.8%	56%	60.0%	N/A	N/A
Percentage of injured workers returned to work (ii) within 26 weeks ⁽⁴⁾	65.9%	67%	76.4%	Greater than or equal to 80%	Target not met
Percentage of managers trained in occupational safety, health and injury management responsibilities, including refresher training within 3 years ⁽⁵⁾	57%	45%	54%	Greater than or equal to 80%	Target not met Compliance has increased, training model has been simplified to enable higher engagement levels.

Injury management

Our injury management (IM) and early intervention (EI) programs for workplace injuries continue to deliver positive outcomes for injured staff and the health service.

The IM system ensures injured employees are offered timely support through the EI or workers' compensation pathways to optimise their recovery and return to work. The EI program provides funding and early access to treatment for physical and psychological injuries with preferred treatment providers. If ongoing treatment or medical intervention is required, the employee is supported through the workers' compensation pathway.

The IM consultants work across NMHS sites to deliver these programs, partnering with WHS, Wellbeing and site HR business partners to assist staff to remain at work or return to work following a workplace injury. They also engage regularly with management to address barriers to return to work and facilitate alternative pathways if return to work within the health service is not feasible.

We received 254 workers compensation claims with a date of injury in the reporting period and finalised 340 claims with either a return to work or settlement, resulting in a reduction in the number of active claims. There was a significant increase in the number of claims settled in 2024-25 compared to the previous five years. NMHS has achieved record return-to-work rates in the reporting period, with 72% of claimants who ceased work in 2024 returning to work within 26 weeks.

Number of workers compensation claims 2024-2025		
	2023-24	2024-25
Nursing and midwifery services	174	125
Dental clinic assistants	14	3
Administration and clerical	15	20
Medical (support)	21	24
Hotel services	54	56
Maintenance	26	18
Medical (salaried)	13	8
Total	317	254

Asbestos management

Over 1,000sqm of asbestos was removed from NMHS sites in 2024-25 through major infrastructure and capital works projects.

Systems are in place to identify, assess and manage the risks associated with asbestos-containing materials on sites/buildings under our remit and comply with the Work Health and Safety (General) Regulations 2022.

Management registers and plans define the risk of each identified or assumed asbestos material. These are reviewed and updated annually by an external environmental service provider, and include recommendations on how to manage or maintain material in its current state to avoid disturbance. Identification stickers are used to

alert staff and the public where confirmed or assumed asbestos material is present.

Annual area-specific training is in place for employees who are at higher risk of exposure due to their tasks potentially disturbing asbestos.

In line with NMHS risk management plans, asbestos is only removed when demolition, refurbishment or tasks that may disturb the material are to occur. Where capital works are to occur, reviews of registers and management plans are undertaken in advance and further testing is conducted. All asbestos must be removed prior to works commencing.

When removal does occur, air monitoring is conducted during the process and removal notices are displayed.

NMHS received one WorkSafe improvement notice to maintain a safe system of work for the management of asbestos, including the review of supervision and information provided to workers. NMHS accepted and implemented the recommendations within the period set by WorkSafe.

WA Multicultural Policy Framework

The NMHS Multicultural Plan 2025-2027 was developed by internal and external stakeholders to deliver on the three policy priority areas of the WA Multicultural Policy Framework:

1. Harmonious and inclusive communities
2. Culturally responsive policies, programs and services
3. Economic, social, cultural, civic and political participation.

Launched in March 2025, our Plan links to the following policies and strategic documents:

- NMHS Strategic Plan 2024-2027
- NMHS Workforce Diversity and Inclusion Strategy 2022-2025
- NMHS Consumer Experience & Clinical Excellence Strategy 2025-2029
- NMHS Partnership Model
- National Safety and Quality Health Service Standards
- National Safety and Quality Primary and Community Healthcare Standards
- Policy Framework for Substantive Equality
- Western Australian Multicultural Policy Framework
- Workforce Diversification and Inclusion Strategy for WA Public Sector Employment 2020-2025

Following are some of the achievements over the past year, outlined under our priorities.

Priority 1: Harmonious and inclusive communities

NMHS sites celebrate at least four cultural days of significance each year, including Harmony Day, Ramadan, Diwali and Chinese New Year. Days of significance and annual events are published in a calendar and promoted to all employees.

The CaLD Equity Diversity and Inclusion eLearning package has now also been included in the new onboarding checklist for NMHS employees. Over 330 NMHS staff completed the module this year, more than six times the previous year.

The NMHS CaLD Diversity intranet page is regularly updated with relevant information to share with staff. This includes promoting education and training, resources and events for cultural days of significance.

Multiple events were held across NMHS sites and services to celebrate Harmony Week, including the launch of the NMHS Multicultural Plan 2025-2027.

Priority 2: Culturally responsive policies, programs and services

The new NMHS Policy Governance Framework provides the structure and tools to ensure a consistent approach to policy development and governance across NMHS and requires staff to consider the interests of diverse groups, such as CaLD groups, during policy development and review.

The NMHS Population Health Profile 2025-2026 was released in June 2025. The profile provides staff with information about the NMHS population, including demographics, cultural diversity and language spoken, to support data-driven decision making across our services.



A patient experience tool for newly arrived refugees accessing health services through the Humanitarian Entrant Health Service was developed and pilot tested.

The severity assessment code (SAC)1 investigation report template now includes a prompt for family and cultural perspective.

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

NMHS employee CaLD data is monitored and included in our quarterly workforce profile dashboard report presented to Executive and Board.

The Public Health team hosted a Settlement Language Pathways to Employment and Training TAFE student at Anita Clayton Centre in June 2025.

In conjunction with the Future Institute of Australia, we have co-designed two short courses to help employees further develop cultural sensitivity, respect diverse perspectives and values, and increase understanding of different cultures.

The one-hour virtual course *Beyond Bias – Embracing Cultural Diversity*, and half day in-person course *From Unconscious Bias to Conscious Inclusion* were promoted as part of World Day for Cultural Diversity for Dialogue and Development.

The Multicultural Plan includes a number of measures of success which will be monitored to track progress and initiate new actions as required.

A detailed progress report will be submitted to the Department of Local Government, Sport and Cultural Industries - Office of Multicultural Interests (OMI) annually.



View our Multicultural Plan
2025-2027

Workforce inclusiveness

We are committed to a diverse and inclusive workplace, to reflect the communities we serve. Our focus is to create an inclusive, respectful and supportive workplace, acknowledging the different beliefs, culture, views and circumstances of others, moving from unconscious bias to conscious inclusion, and preventing racism and discrimination.

As part of the most recent WA Public Sector Census, our staff were asked about their diversity, whether they had shared this with our agency and, if not, the reason for not sharing.

Our results showed that employees who responded to the Census showed a willingness and openness to share personal information.

- Aboriginal and Torres Strait Islander staff were most likely to share (80%).
- For people with disability, 66.7% of survey respondents shared they have a disability; however, the most cited reason for not sharing was that no workplace adjustments were required to undertake their role.

We have identified actions to improve diversity and inclusion in the year ahead including:

- Implementation of our Aboriginal Employment Action Plan, which includes initiatives covering attraction and recruitment, retention and development, and education and training for cultural security
- Development of a Culturally and Linguistically Diverse Recruitment Guide, and
- Trialling implementation of the Sunflower Initiative to offer support and care for people with hidden disabilities.

Our NMHS Workforce Diversity and Inclusion Strategy 2022-2025 has provided a roadmap to strengthening and further embedding initiatives to support diversity and inclusion across our services. We are on track to complete all remaining action items within 2025 timeframes.

Read more about our achievements in Our People chapter on page 21.

Looking Ahead >>>>>

Diversity and Inclusion initiatives will be incorporated into a new integrated NMHS People Strategy for 2026 onwards and are actions in our Multicultural Plan 2025-2027.

Disability Access and Inclusion Plan

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

The NMHS Disability Access and Inclusion Plan (DAIP) 2022-2027 guides our efforts across all NMHS sites and services. Below are highlights of the year for each of the seven outcome areas of the DAIP.

General services and events

Outcome 1: People with disability have the same opportunities as other people to access the services of, and any events organised by, a public authority

- The NMHS Policy Governance Framework was published in April 2025 and incorporates principles to ensure the needs of people with disability are considered during policy development and review.
- The new Special Needs Dental Clinic underwent construction and opened to patients in August 2025.

Buildings and facilities

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

- Multiple works were undertaken to improve accessibility at SCGH, OPH and office space in Subiaco. An accessibility map for KEMH was also updated.

Information and communications

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

- The Sexual Assault Resources Centre developed two Easy Read consumer resources and published two short videos about their service on their website.
- A number of staff at WNHS attended training to assist them to develop Easy Read consumer resources.

Quality of service

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

- Communication Partner training was provided to staff and volunteers throughout OPH to build skills and confidence in having conversations with people who have a communication disability.
- The National Disability Insurance Scheme (NDIS) Coordination Team at SCGH introduced new e-referrals and online resources to aid clinicians seeking support with navigating the NDIS.

Complaints and safeguarding

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

- As part of International Day of People with Disability celebrations, consumers and staff at SCGH and OPH were invited to participate in an interactive display to provide feedback on disability access.
- Biannual reports on consumer feedback relating to disability access and inclusion assist in identifying potential areas for improvement.

Consultation and engagement

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

- Proactive efforts have been made to increase participation of people with disability across all consumer advisory groups. In 2024-25, new appointees were made on the Project Consumer Advisory Groups as part of the New Women and Babies Hospital development, and to the newly established Diversity and Inclusion Committee at WNHS.

Employment, people and culture

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

- A guide outlining disability-inclusive recruitment practices was developed for all NMHS hiring managers.
- Work has commenced on a workplace guide aiming to improve the knowledge and capacity of medical staff supervisors and colleagues to support disabled or neurodivergent junior medical doctors.

Complying with Public Sector Standards and Ethical Codes

Recruitment training to ensure recruitment processes and employment decisions complied with the Public Sector Commissioner's Instructions: Employment Standard and Filling a Public Sector Vacancy, as well as onsite support, information, consultancy and advisory services in all areas covered by the Public Sector standards in human resource management.

NMHS has a dedicated Integrity Directorate, supported by the broader People and Culture team. It actively promotes and works to embed the NMHS values and expected standards of conduct among the workforce, including the expectation to speak up about suspected breaches of the Code of Conduct. The directorate also investigates suspected breaches of the Code.

In 2024-25, the Integrity Directorate:

- continued to provide advice to staff in relation to ethical dilemmas and potential breaches of the Code
- conducted discipline investigations in accordance with the *Health Services Act 2016* and Public Sector Commissioner's Instructions

- coordinated corruption prevention and maturity assessments to inform improvements to the NMHS Integrity Framework
- developed and delivered new integrity education programs including: *Preventing sexual harassment in the workplace*, and *Ensuring integrity standards in your team*
- delivered 53 face-to-face integrity education sessions to 1,117 employees.

As at 30 June 2025, 96% of staff had completed Accountable and Ethical Decision Making (AEDM) training, and 85% had completed triennial AEDM-Refresher training. AEDM and AEDM-R represent mandatory training for all staff and ensure compliance with Commissioner's Instruction 40: Ethical Foundations.

In 2024-25, the Integrity Directorate received 154 new reports of potential misconduct and/or breaches of the Code. Suspected breaches of the Code/ behaviour not consistent with the Code were objectively assessed by the Integrity Directorate and, where appropriate, further triaged through the NMHS Multi-Disciplinary Assessment Committee to determine the most appropriate action to be taken, ensuring all relevant considerations were appropriately tested in a timely and technically robust manner.

One Grievance Standard Claim was referred to the Public Sector Commission (PSC) and was still being addressed in July 2025. Five claims were referred to PSC for the Employment Standard and all were dismissed.

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

Industrial Relations

Our Industrial Relations (IR) consultants maintain close links with professional groups including all WA system unions, Department of Health, and the WA health system IR network, ensuring contemporary IR practices and approaches are applied. Major IR activities in 2024-25 are outlined below.

WA Health system Industrial Agreements bargaining consultation

In 2024-25, IR delivered consultation presentations to HR and leadership networks for the following industrial agreements:

- WA Health System - HSUWA – PACTS Industrial Agreement 2024
- WA Health System – United Workers Union (WA) – Enrolled Nurses, Assistants in Nursing, Aboriginal Health Workers, Ethnic Health Workers, and Aboriginal Health Practitioners Industrial Agreement 2022
- WA Health System – United Workers Union (WA) – Hospital Support Workers Industrial Agreement 2024
- WA Health System - Medical Practitioners – AMA Industrial Agreement 2024
- WA Health System – Australian Nursing Federation – Registered Nurses, Midwives, Enrolled (Mental Health) and Enrolled (Mothercraft) Nurses Industrial Agreement 2024.

A range of education presentations and resources were provided to assist teams with understanding changes to the *Industrial Relations Act 1979*, *Minimum Conditions of Employment Act 1993* and amendments to the *Public Sector Management Act 1994* and the *Health Services Act 2016*.

Job security reviews

The IR team continued to monitor and review fixed term and casual contract usage in accordance with agreement provisions, with 100% of reviews completed within the 90-day timeframe.

A total of 1200 were completed in 2024-25 with 119 recommended for conversion. A further 1647 have been identified for review in 2025-26.

Ongoing reporting and monitoring of average casual and agency usage for Health Service Union (HSU) cohorts across all areas of NMHS is trending at 4.84%, above 4 per cent agreement target. For Health Service Worker (HSW) cohorts is trending at 16.48 per cent, which is 6.48 per cent over the industrial agreement target of 10 per cent.

Efforts to reduce insecure employment arrangements include the NMHS Job Security Action Plan, which is overseen by an Executive sub-committee. Key strategies are to increase scrutiny on casual and agency appointments in high-volume operational areas and identify areas of long-term temporarily funded positions for review and potential to convert to permanency.

Implementation of Permanency for WA Health Senior Practitioners

Following industrial commitments to introduce permanency provisions for senior medical practitioners in the replacement WA Health System – Medical Practitioner – AMA Industrial agreement 2022, permanency as a mode of employment was introduced in March 2024.

Over 850 reviews have been completed and 450 permanent contracts had been issued as at 8 July 2025. The review period was extended to September 2025.

Industrial Relations has provided expert representation and advocacy for a range of industrial matters before the Western Australian Industrial Relations Commission (WAIRC), its constituent authorities the Public Sector Appeal Board (PSAB) and the Industrial Magistrate's Court (IMC), and for discrimination-related complaints before the Equal Opportunity Commission (EOC).

Agency capability review requirements

NMHS is not under an agency capability review and did not receive any Ministerial Directives during the 2024-25 financial year.

Recordkeeping plans

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

Healthcare records management systems within NMHS are well established, with robust processes, policy, and procedures. To further support the recordkeeping practices of healthcare records, NMHS is implementing a Digital Medical Record (DMR) project across hospital sites.

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

All new staff must undertake the mandatory online Recordkeeping Awareness Training course. Face-to-face and online TRIM training sessions have been developed and are available to all staff.

Freedom of Information

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

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

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

Act of Grace payments

No Act of Grace payments pursuant to authorisations under Section 80(1) of the *Financial Management Act* were made in the 2024-25 financial year.

Use of credit cards for personal expenditure

NMHS officers are issued with corporate credit cards (purchasing cards) when their functions require this facility. Purchasing cards provide a clear audit trail and are not to be used for personal (unauthorised) purposes. If a cardholder makes a personal purchase, they must give written notice to NMHS within five working days and refund the total amount of expenditure.

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

Personal use credit card expenditure by NMHS cardholders 2024-25	
	Aggregate amount (\$)
Reporting period	2,122
Settled by the due date (within 5 working days)	1,577
Settled after the period (after 5 working days)	545
Outstanding at balance date	-

Pricing policy

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

Guidelines for rules in relation to fees and charges are outlined in the WA Health Fees and Charges Manual. This is a mandatory document in the WA Health Financial Management Policy Framework and binding to all HSPs under the HSA 2016. The Health Services (Fees and Charges) Amendment Order (No.4) 2024 was published on 17 June 2024, giving effect to the fees and charges published in the WA Health Fees and Charges Manual on 1 July 2024.

Advertising, market research, polling and direct mail expenditure

In accordance with section 174Z of the *Electoral Act 1907*, HSPs are required to report total advertising expenditure. In 2024-25, the total expenditure was \$163,857 compared with \$74,512 in 2023-24. The organisations from which advertising services were procured and the amount paid to each organisation are shown in the below table.

We did not incur any expenditure on polling organisations, market research organisations or direct mail organisations.

Category	Provider	\$
Advertising agencies		
	Brandconnect (WA)	31,755
	Creative ADM	1,225
	Gatecrasher Advertising Pty Ltd	22,725
	Initiative Media Australia Pty Ltd	49,086
	JCDECAUX Australia Trading Pty Ltd	9,757
	Subtotal	114,548
Media advertising organisations		
	Carat Australia Media Services Pty Ltd	31,765
	Facebook	4,183
	LinkedIn	156
	Speirins Media Pty Ltd	13,205
	Subtotal	49,309
Total		163,857

Acronyms

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

Contact details

North Metropolitan Health Service

QEII Medical Centre, 2 Verdun Street,
Nedlands WA 6009
Locked Bag 2012, Nedlands WA 6009
(08) 6457 3333
www.nmhs.health.wa.gov.au

Joondalup Public Hospital*

Shenton Avenue, Joondalup WA 6027
(08) 9400 9400
www.joondaluphealthcampus.com.au

*Operated on behalf of the State Government by Joondalup Hospital Pty Ltd, a subsidiary of Ramsay Health Care.

Women and Newborn Health Service

374 Bagot Road, Subiaco WA 6008
PO Box 134, Subiaco WA 6904
(08) 6458 2222
www.kemh.health.wa.gov.au

Sir Charles Gairdner Osborne Park Health Care Group

Sir Charles Gairdner Hospital
Hospital Avenue, Nedlands WA 6009
Locked Bag 2012, Nedlands WA 6009
(08) 6457 3333
www.scgh.health.wa.gov.au

Osborne Park Hospital
36 Osborne Park Place, Stirling WA 6021
(08) 6457 8000
www.oph.health.wa.gov.au

Mental Health, Public Health and Dental Health Services

Mental Health
54 Salvado Road, Wembley WA 6014
(08) 9380 7700
www.nmhs.health.wa.gov.au/Hospitals-and-Services/Mental-Health

Graylands Hospital Campus

Brockway Road, Mount Claremont WA 6010
PO Private Bag No.1, Claremont WA 6910
(08) 6159 6600
www.nmhs.health.wa.gov.au/Hospitals-and-Services/Hospitals/Graylands

Public Health

Anita Clayton Centre Suite 1,
311 Wellington Street, Perth WA 6000
(08) 9222 8500
www.nmhs.health.wa.gov.au/Hospitals-and-Services/Public-Health

Dental Health Services

43 Mount Henry Road, Como WA 6152
Locked Bag 15, Bentley Delivery Centre, WA 6983
(08) 9313 0555
www.dental.wa.gov.au



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

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

Locked Bag 2012, Nedlands WA 6009

(08) 6457 3333

nmhs.health.wa.gov.au