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

East Metropolitan Health Service

Annual Report 2021-22

Statement of compliance

For year ended 30 June 2022

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

In accordance with section 63 of the *Financial Management Act 2006*, I hereby submit for your information and presentation to Parliament, the final Annual Report of the East Metropolitan Health Service for the financial year ended 30 June 2022.

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

Ian Smith PSM
Board Chair
East Metropolitan Health Service
16 September 2022

Peter Forbes
Chair, Board Finance Committee
East Metropolitan Health Service
16 September 2022

Acknowledgment of country

Nitja Noongar Boodja, Ngalak Whadjuk Moort Noongar Boodja, unna. Ngalak Noongar Bridiya, Koora — nitja — boordawaan.

East Metropolitan Health Service (EMHS) recognises the Whadjuk people of the Noongar Nation as the traditional owners of the land which we live, learn and work on today. We acknowledge that the Whadjuk people have a continuing spiritual and cultural connection to this land and pay respect to all Noongar Elders past, present and emerging. We welcome all Aboriginal and non-Aboriginal people to our services.

Acknowledgment of our Aboriginal community

The voice of the Aboriginal community is reflected in the EMHS 2021-22 Annual Report to ensure cultural appropriateness, and that the health impacts on Aboriginal people have been considered and incorporated.

Artwork by - Sarah Humphries

About East Metropolitan Health Service

The EMHS is an extensive hospital and health network that strives to maintain and improve the health and wellbeing of approximately **749,000** Western Australians within its catchment area, which covers **3647 square kilometres**. It also serves residents of regional Western Australia (WA) requiring more complex care.

Members of the network collaborate to provide tertiary, secondary and specialist healthcare services. This includes emergency and critical care, state major trauma, elective and emergency surgery, general medical, mental health, inpatient and outpatient services, aged care, palliative care, rehabilitation, and women's, children's and neonates' services.

EMHS health network – our hospitals

Royal Perth Bentley Group

Royal Perth Hospital (RPH) is an inner-city tertiary hospital, providing an extensive range of services, including adult major trauma, emergency and highly specialised services as well as community and hospital-based mental health services.

Bentley Health Service (BHS) is a specialist hospital with services including rehabilitation, elective and same-day surgery, aged care and community and hospital-based mental health services.

Armadale Kalamunda Group

Armadale Health Service (AHS) is a general hospital and health service that provides a range of health care, including emergency, maternity, intensive care and community and hospital-based mental health services.

Kalamunda Hospital (KH) provides specialist palliative care and endoscopy services.

Public/private partnerships

St John of God Midland Public Hospital (SJGMPH) is a public hospital providing a wide range of services to the Swan and Hills community, including emergency and intensive care services.

EMHS provides assessment and restorative care services for public patients through St John of God Mount Lawley (SJGML).

EMHS health network – our community services

EMHS provides an extensive range of community services and population health programs for people, both within its catchment and the wider metropolitan area. A snapshot of just a few of these services and programs is provided below.

Aboriginal community health

Aboriginal Acute Care Coordination

The **Aboriginal Acute Care Coordination** (AACC) program is a community-based follow-up service for Aboriginal people discharged from RPH with an acute condition. The program provides patient advocacy, support and education to enhance the health journey of Aboriginal patients.

Care Coordinators work with Aboriginal patients, linking them with community care providers to support access to services and assist in the management of their health conditions. The Care Coordinators provide support to attend follow-up outpatient appointments to maximise attendance and support the continuity of care.

A Remote Care Coordinator works with hospital staff and health providers to support regional patients in their health care journey.

Moorditj Djena (Strong Feet)

Moorditj Djena is a multidisciplinary podiatry and diabetes education outreach program for Aboriginal people within the Perth metropolitan area, which focuses on prevention and management of foot complications and risk factors such as diabetes, peripheral arterial disease, peripheral neuropathy and other chronic diseases.

Clients receive clinical and education services at various community clinics across the metropolitan area in a combination of community venues and the mobile clinic van. Many of the clinic locations are in partnership with other agencies and stakeholders providing services to Aboriginal people, resulting in a shared-care approach.

Services provided by Moorditj Djena include:

- podiatry for assessment, treatment and education
- Aboriginal health workers who provide health interventions for prevention, health education, support and advocacy
- a Diabetes Educator to support self-management
- a Dietitian to discuss healthy eating, including ideas for shopping on a budget, cooking healthier meals and providing recipes.

Approximately **21,300** Aboriginal people are part of the EMHS community

Health promotion

Belmont, Victoria Park, South Perth Local Drug Action Group (BVPSP LDAG)

This group has worked collaboratively with the local government areas, Cancer Council WA, Alcohol and Drug Foundation, Department of Education, WA Police and the Police and Citizens Youth Club to develop solutions for local issues, resulting in the development of the **BVPSP Youth Alcohol Action Plan 2022-25**, which was launched on 1 June 2022.

The plan represents 18 months of collaboration with youth and local service providers, reviewing contemporary evidence as to what works in minimising the impact of alcohol on young people in the community.

(see page 51 for more detail)

Moorditj Wirrin Koolangkas (Strong Spirit Kids)

Moorditj Wirrin Koolangkas focuses on prevention messages relating to alcohol, tobacco smoking, sexual health and healthy relationships targeting Aboriginal young people in the community.

Aboriginal Health Promotion Officers (AHPO) deliver interactive health education sessions in metropolitan high schools to enable informed decision-making and healthier choices for Aboriginal students aged 11-15 years. The AHPOs also engage with young people and services at community events.

The program has a key partnership with Legal Aid and the Aboriginal Legal Service to deliver content on sex, consent and the law.

Moorditj Wirrin Koolangkas

Symbol artwork by Missy Thompson

Within the red circle represents an AHPO and a student. Within this circle we exchange knowledge, and we are proud to say we learn from the children as much as they learn from us. As the circle extends out, we have the rest of the schools we meet with. We enjoy our work as we meet new students from everywhere — it reminds us how diverse Perth City is and how grateful we are to be living here.

The footsteps at the bottom are semi-filled in — walking towards the centre meeting with us. The semi-filled in footprints represent students' knowledge and spirit. As you can see, once they reach the centre — the footprints leading out of the centre are fully coloured — this is to display once meeting with our program, their spirit is empowered and recognises their spirit as having no limit in all they are to do in their journey.

Community mental health

Royal Perth Bentley Group (RPBG) delivers community mental health services covering the City East, Midland and Bentley catchment areas as well as Wungen Kartup (a Specialist Aboriginal Mental Health Service), which delivers statewide services.

Armadale Kalamunda Group (AKG) delivers community mental health services at sites covering the South East catchment area, including Armadale, Gosnells and Serpentine-Jarrahdale local government areas.

In 2021–22 the Community Mental Health Services within EMHS implemented a **Care Coordination Framework** to coordinate and improve support and service access and promote recovery to consumers of our services.

Care Coordination ensures that our clinicians:

- work alongside mental health consumers to assess, plan and review their recovery
- engage with family, carers and personal support persons to support a consumer's recovery
- collaborate with general practitioners (GPs) and other care providers to ensure consumers access the right services and supports as required.

Details of other EMHS community mental health services and programs can be found throughout this report.

During 2021-22, EMHS Community Mental Health Services:

Royal Perth Bentley Group

Cared for **2707** consumers

▲ **10% from 2020-21**

Provided services to consumers for an average length of stay of **86 days**

131 in 2020-21 ▼

Completed care with **2696 consumers**

▲ **8% from 2020-21**

Armadale Kalamunda Group

Received **3057** referrals into the Assessment and Treatment Team (ATT)

Managed an average of **430** patients per month in Community Treatment Team (CTT) programs

Consisted of:

- Clinical Treatment Team
- Assessment Treatment Team
- Early Episode Psychosis
- Transition Team (Assertive Recovery Team)
- Independent Community Living Strategy
- Older Adult Community Mental Health Service
- Jacaranda House (community residential).

Our strategic direction

EMHS strategic plan

In 2021, EMHS released the **EMHS Strategic Plan 2021-25** (Plan), which sets out the future direction and aspirations for the health service. The Plan aligns with the WA Health goal for the **delivery of safe, quality, financially sustainable and accountable healthcare for all Western Australians** and the whole-of-government goal of **strong communities, safe communities and supported families**.

The Plan was developed through extensive consultation and collaboration, which involved a series of seven focus groups with more than **80** clinical and non-clinical staff; in-person and online strategy workshops and webinars with the EMHS Executive, Board and senior leaders; and engagement with consumers. EMHS was inspired by the **Cascading Choices strategy model** and structured the development around a series of interconnected strategic choices.

Where will we play
areas to strengthen and improve

How will we do it
evolve our service delivery principles

What are our broad aspirations
our goals and strategic objectives

What capabilities must be in place
our priorities

What management systems are required
our measures of success

EMHS goals

Our people are the heart of EMHS and this goal is about providing a safe and supportive workplace that enables staff to thrive.

Consumers and community are central to everything we do, and our goal is to connect with them to understand their needs and deliver individualised, responsive care that will lead to better health outcomes.

The here and now focuses on using data and capabilities to maximise quality health care, be agile and proactive in care, and meet public sector obligations to the highest standards.

By having a future focus for **a better tomorrow**, this goal inspires us to identify, utilise and embed improvements from research, innovation and data to meet future care needs of consumers and the community.

Our vision

Healthy people, amazing care.
Koorda moort, moorditj kwabadak.

Our vision statement reflects the essence of what EMHS does and aspires to do for staff, patients and the community.

Our values

Kindness
Represented in the support that we give to one another. This is how we demonstrate genuine care and compassion to each and every person.

Excellence
The result of always striving to do better. This is represented by ongoing improvements to the way we deliver our services, creating a high-performing health service.

Respect
Demonstrated through our actions and behaviours. By showing respect to each other we, in turn, earn respect.

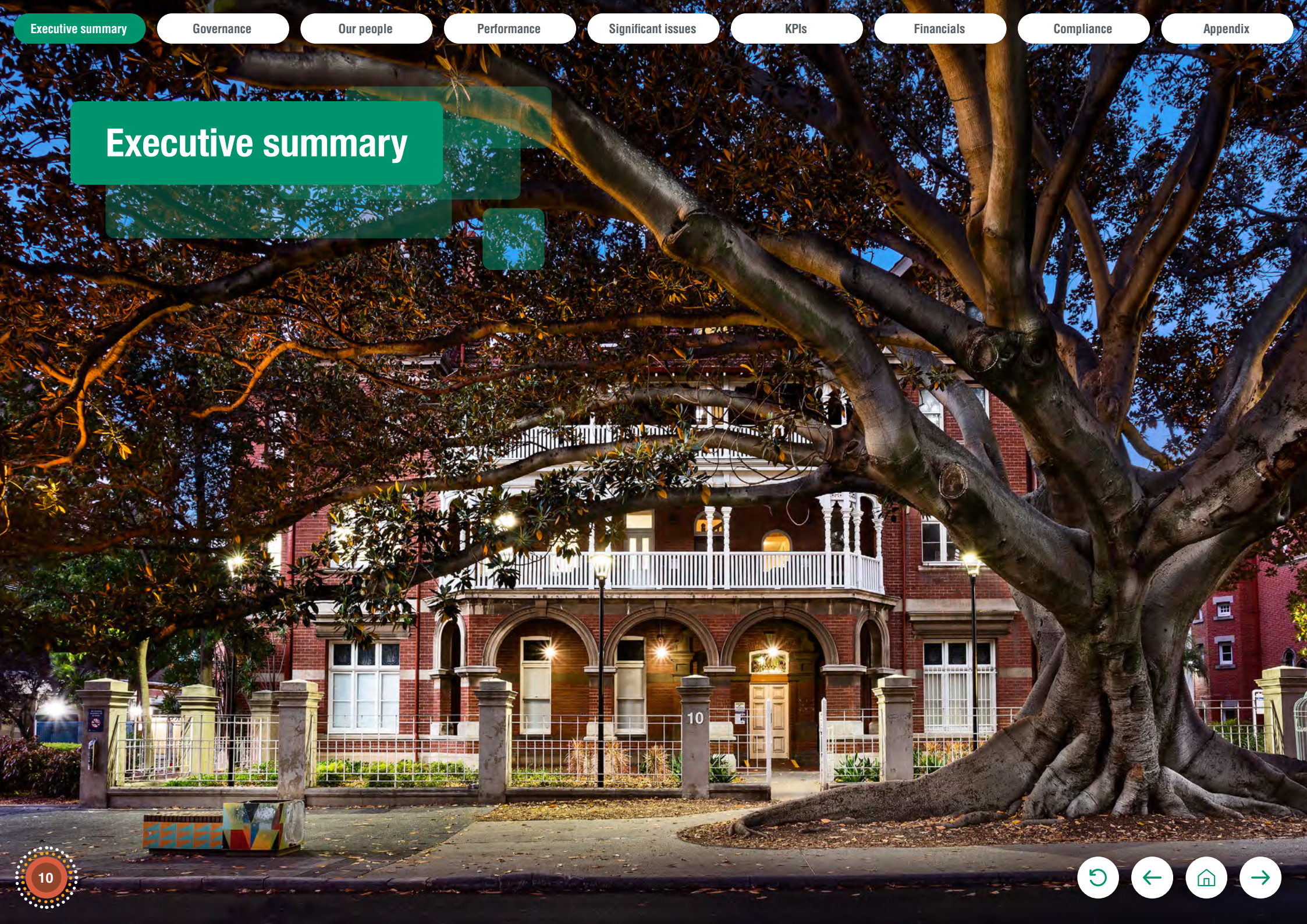
Integrity
Shown by doing the right thing, even when nobody is looking.

Collaboration
Represents working together in partnership to achieve sustainable healthcare outcomes for our community, with a shared understanding of our priorities.

Accountability
Together we have a shared responsibility to ensure the best healthcare outcomes for our community. This is a reminder that it is not only our actions — but also our inactions — for which we are accountable.

Contents

Executive summary



EMHS Board Chair and Chief Executive introduction

On behalf of the EMHS Board and Executive, we feel privileged to present the 2021-22 EMHS Annual Report.

While COVID-19 continued to test EMHS on multiple fronts during 2021–22, it did not stop us in our commitment to deliver on our vision of **healthy people, amazing care**.

This year, EMHS achieved a multitude of great things while also managing COVID, which is testament to the exceptional commitment shown by our **10,503** staff.

We attribute this success to keeping our staff healthy — physically and mentally. This was a key priority during the year, and subsequently a number of initiatives were implemented to assist in achieving that outcome, including the implementation of our **Staff Wellbeing During COVID** strategy, which helped keep staff safe so they could focus their attention on continuing to deliver the best possible care to our patients.

We also implemented a number of technology initiatives from the **EMHS Digital Strategy**, making a real difference in 2021–22. For patients, the real game changer was the ability to access free Wi-Fi — fulfilling the final milestone in the **EMHS' Digital Infrastructure Enablement** (EDIE) Wi-Fi project, which started in 2020.

Our plans to modernise the management of medications across EMHS also moved a step closer to fruition with a contract to design, build and commission EMHS' **Electronic Medication Management solution** (EMMs) awarded. This, and our multi-award winning innovative **Health in a Virtual Environment** (HIVE) expansion program, both present exciting opportunities for the future.

Our capital projects heralded a new era of care, with RPH's first involuntary **Mental Health Unit** (MHU) and new **heliport** and **Intensive Care Unit** (ICU) having opened this past year — collectively representing a significant investment in delivering superior care for the community. We also started the KH redevelopment and made great progress on modular units at BHS.

As always, EMHS has ended the year with outstanding accolades for research undertaken, with a number of our staff receiving state, national and international recognition for their progress and achievements.

Diversity has continued to be a focus for us with a range of initiatives especially designed for the Aboriginal population, including an **Aboriginal Family Garden** at RPH, which provides a supportive space for family members.

The COVID emergency reinforced what we, as the Board and Chief Executive, have known all along – that EMHS has an extraordinary team, which despite recent challenges, has remained uncompromising in its commitment to delivering amazing and compassionate care to our patients, the community and one another.

As we emerge from this pandemic, we look forward to building on the achievements of the past 12 months and to forging new frontiers to create a better tomorrow for the EMHS community in 2022–23.

Liz MacLeod
Chief Executive, EMHS

Ian Smith PSM
Board Chair, EMHS

2021-22 at a glance

141,793
Inpatients
174,760 in 2020-21 ▼

716,000
Outpatient appointments (including virtual care appointments)
675,440 in 2020-21 ▲

52,105
Operations
57,792 in 2020-21 ▼

1430
Patients experiencing homelessness
1254 in 2020-21 ▲

1441
Patients admitted with COVID-19

213,508
Emergency presentations
214,474 in 2020-21 ▼

4475
Births
4487 in 2020-21 ▼

255,075
Virtual care appointments
214,997 in 2020-21 ▲

215,434
Occasions of service for community mental health
238,209 in 2020-21 ▼

120
New research projects
100 in 2020-21 ▲

Demand for services – 2016 to 2022

EMHS was established as a health service on 1 July 2016. In comparison with EMHS' activity in 2016-17, in 2021-22:

Inpatients **increased** by
4.7%
135,477 in 2016-17 ▲

Outpatient appointments **increased** by
49%
(including virtual care appointments)
480,322 in 2016-17 ▲

Operations **increased** by
8.8%
47,904 in 2016-17 ▲

Emergency presentations **increased** by
9.6%
194,733 in 2016-17 ▲

Births **decreased*** by
10.9%
5025 in 2016-17 ▼

* Maternity services at BHS did not operate during 2021-22

Virtual care appointments **increased** by
3824%
approximately 6500 in 2016-17 ▲

EMHS 2021–22 financial summary

Total cost of services (expense limit)

Sourced from statement of comprehensive income

2021-22 target $000

$1,733,924

2021-22 actual $000

$1,865,559

Variation $000

$131,635

Net cost of services

Sourced from statement of comprehensive income

2021-22 target $000

$1,638,757

2021-22 actual $000

$1,767,617

Variation $000

$128,860

The primary reasons for the variance in the total cost of services (expense limit) and the net cost of services were due to increased expenditure on:
1) COVID-19 related employee benefits, as staffing increased (by about 25% in full time equivalent staff) and backfill costs due to staff on furlough. Also, long service leave accrued for casual staff was unfunded;
2) Patient support costs due to increased expenditure on medical, surgical and diagnostic supplies, pathology, personal protective equipment and clothing, domestic charges and drug supplies related to COVID;
3) Loss on revaluation on land;
4) Repairs, maintenance and consumables, due to equipment purchases and building alterations for COVID and non-funded capital and non-capital purchases on various capital projects;
5) Contract services due to COVID, which led to increased staffing (25% uplift) and backfill costs due to staff on furlough at SJGMPH.

Total equity

Sourced from statement of financial position

2021-22 target $000

$1,401,545

2021-22 actual $000

$1,428,715

Variation $000

$27,170

The primary reasons for the increase in total equity compared to initial estimates were:
1) EMHS drew down less capital than originally estimated, as increased construction costs placed pressure on capital budgets and project delays due to manufacturing, logistical and supply chain issues related to COVID;
2) Increase in the value of EMHS' building assets due to increases in the building indices used for valuation purposes.

Net decrease in cash held

Sourced from statement of cash flow

2021-22 target $000

$32,130

2021-22 actual $000

-$6,199

Variation $000

$38,329

The variation between actual cash balance held compared to the target was primarily due to higher employee benefits and supplies and services expenditure. While EMHS' cash inflows from State Government were higher compared to the estimate, this increase in cash inflows was less than the total payments made in operating activities.

Approved salary expense level

Sourced from statement of comprehensive income

2021-22 target $000

$955,757

2021-22 actual $000

$1,027,528

Variation $000

$71,771

The reasons for the variation in the final salary expense compared to the approved salary limit in the initial estimates were due to COVID, which led to increased expenditure on employee benefits as staffing increased (by about 25% in full time equivalent staff) and backfill costs due to staff on furlough. Also, long service leave accrued for casual staff was unfunded.

See page 109 for full financial statements

EMHS 2021–22 performance summary

Key Performance Indicators (KPIs) and KPI targets assist EMHS to assess and monitor achievement of the outcomes outlined in the **Outcome Based Management (OBM) framework** (see page 23).

Effectiveness indicators provide information on the extent to which outcomes were achieved through the funding and delivery of services to the community.

Efficiency indicators monitor the relationship between the service delivered and the resources used to produce the service (i.e. activity and cost).

Outcome one: Public hospital based services that enable effective treatment and restorative healthcare for Western Australians		
Effectiveness KPIs	**Target**	**Actual**
Unplanned hospital readmissions for patients within 28 days for selected surgical procedures (per 1000 separations)		
(a) knee replacement	≤ 23.0	**15.4**
(b) hip replacement	≤ 17.1	**20.4**
(c) tonsillectomy & adenoidectomy	≤ 81.8	**138.7**
(d) hysterectomy	≤ 42.3	**73.2**
(e) prostatectomy	≤ 36.1	**49.3**
(f) cataract surgery	≤ 1.1	**2.4**
(g) appendicectomy	≤ 25.7	**30.1**
Percentage of elective wait list patients waiting over boundary for reportable procedures		
(a) category 1 over 30 days	0%	**6.5%**
(b) category 2 over 90 days	0%	**28.3%**
(c) category 3 over 365 days	0%	**9.3%**
Healthcare-associated *staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days	≤ 1.00	**1.09**
Survival rates for sentinel conditions		
Stroke		
0-49 years	≥ 95.2%	**96.3%**
50-59 years	≥ 94.9%	**96.2%**
60-69 years	≥ 94.1%	**95.9%**
70-79 years	≥ 92.3%	**95.1%**
80+ years	≥ 86.0%	**94.4%**
Acute myocardial infarction (AMI)		
0-49 years	≥ 99.1%	**97.7%**
50-59 years	≥ 98.8%	**100%**
60-69 years	≥ 98.1%	**98.9%**
70-79 years	≥ 96.8%	**97.0%**
80+ years	≥ 92.1%	**94.6%**

Outcome one: Public hospital based services that enable effective treatment and restorative healthcare for Western Australians		
Effectiveness KPIs	**Target**	**Actual**
Fractured neck of femur (FNoF)		
70-79 years	≥ 98.9%	**97.6%**
80+ years	≥ 96.9%	**98.3%**
Percentage of admitted patients who discharged against medical advice		
a) Aboriginal patients	≤ 2.78%	**5.87%**
b) Non-Aboriginal patients	≤ 0.99%	**1.16%**
Percentage of live-born term infants with an Apgar score of less than seven at five minutes post delivery	≤ 1.80%	**1.37%**
Readmissions to acute specialised mental health inpatient services within 28 days of discharge	≤ 12.0%	**14.9%**
Percentage of post discharge community care within seven days following discharge from acute specialised mental health inpatient services	≥ 75.0%	**87.8%**
Efficiency KPIs	**Target**	**Actual**
Average admitted cost per weighted activity unit	$6907	**$7197**
Average Emergency Department cost per weighted activity unit	$6847	**$7353**
Average non-admitted cost per weighted activity unit	$6864	**$6093**
Average cost per bed-day in specialised mental health inpatient services	$1533	**$1783**
Average cost per treatment day of non-admitted care provided by mental health services	$445	**$400**

Outcome two: Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives		
Efficiency KPI	**Target**	**Actual**
Average cost per person of delivering population health programs by population health units	$32	**$113**

● Desired result ● Undesired result

See page 84 for full KPIs

Governance

Enabling legislation

EMHS, as a **Health Service Provider** (HSP), is governed by the *Health Services Act 2016* WA (HSA 2016).

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

Accountable authority

EMHS is a board-governed statutory authority, where the **EMHS Board** is directly accountable to the public through the **Minister for Health** and works with the **Director General (DG) of the Department of Health** (DoH) (System Manager).

The **System Manager** is responsible for strategic leadership, including system-wide planning, policy and performance, and enters into service agreements with HSPs for the provision of services.

The EMHS **Chief Executive** (CE) is employed by the DG as the 'chief employee' of the HSP and is accountable to the Board for coordinating and managing the daily operations of EMHS.

Shared responsibilities with other agencies

EMHS works closely with the DoH (System Manager), the Mental Health Commission (MHC), other HSPs and a large number of government and non-government agencies to deliver programs and services to achieve better health outcomes for the community of the eastern metropolitan region of WA.

Agency capability review

In 2022, EMHS commenced a management and administrative capabilities review under the WA Public Sector Commission (PSC) Agency Capability Review Program. The review will provide EMHS with an analysis of strengths and opportunities for improvement, against 21 capabilities in the areas of **leadership, culture and governance; service excellence; relationships; people;** and **resources and risk**.

Responsible Minister

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

EMHS would like to acknowledge the **Honourable Roger Cook MLA**, former Minister for Health; Medical Research; State Development, Jobs and Trade; Science (current Deputy Premier; Minister for State Development, Jobs and Trade; Tourism; Commerce; Science), as well as the **Honourable Stephen Dawson MLC**, former Minister for Mental Health; Aboriginal Affairs; Industrial Relations (current Minister for Emergency Services; Innovation and ICT; Medical Research; Volunteering).

Photo L-R: Dr Denise Glennon (EMHS Board), Melissa Parke (EMHS Board), Hon Amber-Jade Sanderson MLA (Minister for Health; Mental Health), Liz MacLeod (EMHS Chief Executive), Pia Turcinov (EMHS Board) and Dr Lesley Bennett (Executive Director RPBG)

EMHS Board

2021-22 focus and achievements

The EMHS Board is responsible for determining the strategic direction of the health service and holds overall accountability for service delivery and performance.

While the escalating COVID-19 pandemic meant all EMHS Board meetings could not be held in person, the use of technology — when required — ensured that they still went ahead and the key matters at hand could be addressed.

The EMHS COVID response, understandably, was again a primary focus of the Board. Its members were very supportive of the **Staff Wellbeing Framework** being initiated and its important role in encouraging staff to access annual leave entitlements, where possible, to reduce fatigue — which was identified as a key significant issue. Keeping staff safe — and in turn patients and the wider community — was also the Board's objective in supporting mandatory COVID vaccinations across all health services.

With safety at the forefront of all their decisions, the Board attended a presentation by Emeritus Professor Les White, former inaugural NSW Chief Paediatrician and former president of the Children's Hospitals Australasia, who led the Independent Inquiry into Perth Children's Hospital following the tragic death of Aishwarya Aswath in April 2021.

Board seizes the chance to meet the EMHS team

The EMHS Board recognises the importance of being in touch with the staff who keep the organisation running on a day-to-day basis and it remains committed to staying engaged with them.

Board Chair **Ian Smith** said it was always a pleasure to speak to "staff on the ground" and to hear their views, while providing an opportunity for the Board to express its appreciation for EMHS staff.

Ian said staff remained the backbone of any organisation and that meeting more staff was a key focus of the Board moving forward.

Following the review, EMHS reassessed its own policies and practices in keeping with the findings and recommendations from the report. Subsequently, the Board has been monitoring the priority areas of focus and implementation of actions to ensure an even safer health service, on a monthly basis.

Actions from the Office of the Auditor General — General Computing Controls Audit Findings were also monitored closely by the Board, as it resulted in 11 findings (with two deemed significant) in relation to segregation of network and unauthorised device connectivity, which is now being addressed as part of the WA Health Network Infrastructure Refresh Program.

In line with EMHS' excellence value, the Board undertook an external review which evaluated standards of governance in addition to its performance. It found that the Board generally functions well and understood the constant (and dynamic) balancing act between operational oversight, strategic foresight and immediate imperatives.

The topic of emergency access was also the basis of much discussion by the Board and given its significance, since May 2022, Chair Ian Smith, has attended the Minister for Health's Ambulance Ramping Taskforce. Concurrently, on a monthly basis, the Board monitors the **EMHS 2022 Emergency Access Program** initiatives across all its hospitals, in addition to the **HIVE**, projects within the **Emergency Department (ED) Innovation Fund** and the **Comprehensive Ambulatory Older Adult Program**.

The Board continues to fulfil its functions, roles and responsibilities as outlined in the HSP Board Governance Policy. The Board submitted the following **Attestation Statements** (for 2020-21) as part of its governance requirements:

- EMHS Governing Body Attestation Statement to the Australian Council on Healthcare Standards
- EMHS Board Annual Governing Body Attestation Statement to the Minister for Health
- EMHS Board Internal Audit Attestation Statement to the System Manager at the DoH
- quarterly EMHS Board Report to the Minister for Health, addressing the Statement of Expectations
- monthly EMHS Board Report to the Minister for Health, providing an overview of key activities for the month.

The Board took part in the Strategic Risk Workshop with AEG; EMHS Excellence Symposium; EMHS Values in Action Awards; briefing from Robyn Kruk AO — **Final Report – Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents**; and a workshop on Occupational Safety and Health — Understanding the Obligations of the New Legislation.

On 30 June 2022, EMHS farewelled three of our Board members:

Debra Zanella — an inaugural Board member, Deputy Board Chair, Chair of the Board Audit and Risk Committee and member of the Board Finance Committee.

Prof Kingsley Faulkner AM — an inaugural Board member and Chair of the Board Safety and Quality Committee and member of the Board Planning and Performance Committee.

Laura Colvin — who joined the Board in 2018 and was a member of the Board Safety and Quality Committee and Digital and Innovation Committee.

EMHS Area Executive Group

The EMHS Area Executive Group (AEG) is responsible for managing the provision of services within individual directorates and is accountable to the EMHS CE.

Absent: Diane Barr and Grant Waterer

Liz MacLeod

EMHS Chief Executive

Steve Gregory

Executive Director
People and Capability

Graeme Jones

Executive Director
Finance and Infrastructure (Chief Finance Officer)

Grant Waterer

Area Director
Clinical Services

Philip Aylward

Executive Director
Corporate Services and Contract Management

Anne-Marie Presho

Director
Office of the Chief Executive

Ben Noteboom

A/Area Director
Allied Health and Health Sciences

Sandra Miller

Executive Director
Safety, Quality and Consumer Engagement

Diane Barr

Executive Director
Armadale Kalamunda Group

Doris Lombardi

Area Director
Nursing and Midwifery

Joel Gurr

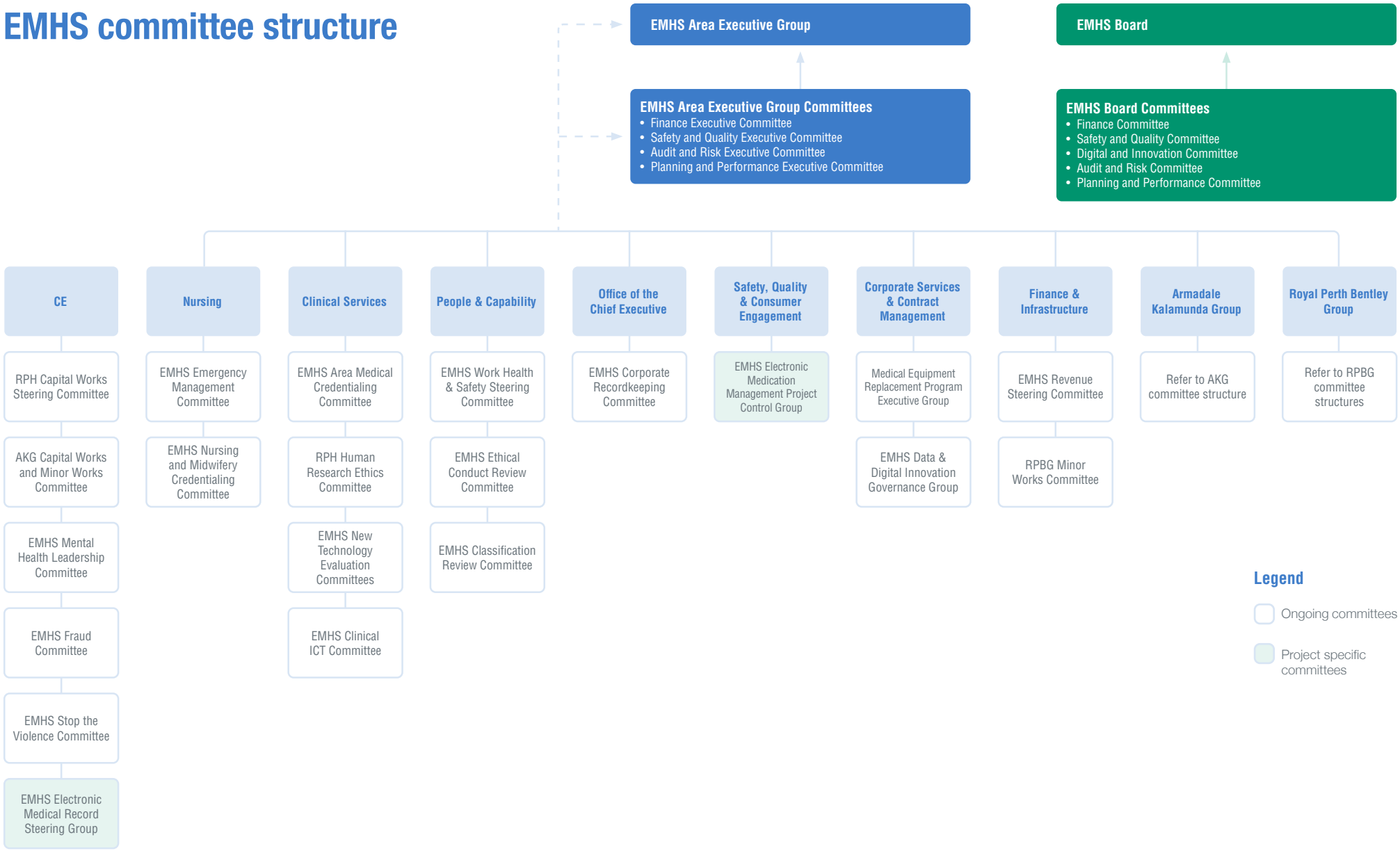
Executive Director
Clinical Services Strategy and Population Health

Lesley Bennett

Executive Director
Royal Perth Bentley Group

EMHS would like to acknowledge **John Buchanan**, who served as EMHS' inaugural Area Director of Allied Health and Health Sciences from July 2016 and retired in 2022.

EMHS committee structure



Current as at 30/06/2022 (under review)

Links to government goals and outcomes

To comply with legislative obligations as a WA Government agency, EMHS operates under the **OBM framework** determined by the DoH. This framework describes how outcomes, activities, services and KPIs are used to measure agency performance towards achieving the overarching whole-of-government and WA Health agency goals.

EMHS reports performance against KPIs for:

1. **Outcome one:** Public hospital based services that enable effective treatment and restorative healthcare for Western Australians; and
2. **Outcome two:** Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives.

WA GOVERNMENT GOAL: strong communities, safe communities and supported families

WA HEALTH AGENCY GOAL: delivery of safe, quality, financially sustainable and accountable healthcare for all Western Australians

Outcome one: 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 (per 1000 separations)	
Percentage of elective wait list 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 live-born 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 two: Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives	
Efficiency KPI	
Service 6: Public and community health services	Average cost per person of delivering population health programs by population health units

Our people

Building our team

As at 30 June 2022, EMHS employed:

Individual staff
10,503
9350 in 2020-21 ▲

Full time equivalent (FTE)
7452
6845 in 2020-21 ▲

This included: **112** Aboriginal staff members
105 in 2020-21 ▲

1081 medical
1013 in 2020-21 ▲

32 other
34 in 2020-21 ▼

1083 medical support
964 in 2020-21 ▲

1219 administration and clerical
1143 in 2020-21 ▲

2982 nursing
2681 in 2020-21 ▲

887 hotel services
848 in 2020-21 ▲

167 maintenance
162 in 2020-21 ▲

Talent team's bid to secure nurses and midwives, a winner

Nurses and midwives are the backbone of EMHS services. During 2021-22, EMHS made a concerted effort to boost its nursing and midwifery workforce.

This effort has paid off, with an additional **713*** nurses/assistants in nursing now part of the EMHS team.

This success was due to a designated **Talent Acquisition Team**, which instigated several strategic recruitment initiatives in its bid to boost numbers. These included:

- centralising and streamlining the recruitment process, a change that made applying for positions easier for both applicants and nurse managers
- targeting interstate and international applicants
- capitalising on an improved technology pilot for health, made available through the WA Government Recruitment Advertising Management System Platform. This enabled improved automation and applicant experience.

Aboriginal cadetship

EMHS values the important contributions our Aboriginal staff members make to our organisation, and recognises that the Aboriginal community will feel more comfortable accessing our healthcare services if they see more Aboriginal people delivering those services.

EMHS has a range of initiatives to encourage Aboriginal people to join our workforce, including participation in the **WA Health Aboriginal Cadetship Program**. The program offers university students the opportunity to gain paid work experience while completing their undergraduate qualifications.

EMHS has been part of this program since 2019, taking on four cadets annually. During their cadetships, EMHS cadets are given personal and professional support to help them establish a foundation for their careers.

Zyhannah, a member of EMHS' first cohort of cadets, graduated during 2021–22, receiving a Bachelor of Biomedical Science from the University of Western Australia.

During her cadetship, Zyhannah rotated through a range of placements including Respiratory Medicine, Aboriginal Community Health, Aboriginal Health Strategy and Health Promotion.

Supports Sustainable Health Review (SHR) recommendation 3a (see page 63)

*as of 30 June 2022

Leadership and staff development

EMHS is committed to developing a capable, engaged and resilient workforce by providing ongoing leadership, training and organisational development initiatives, which benefit individual staff members, managers and teams.

In March 2022, EMHS celebrated its one-year anniversary since implementing its first online learning management system (LMS) — **MyLearning**.

During 2021-22, the EMHS MyLearning team produced an extensive catalogue of courses, resources and events to support our diverse training needs. This included:

- an online corporate induction program allowing new starters to be onboarded safely and flexibly during the COVID-19 pandemic
- **22** learning bytes (short-form learning) in a Digital Leadership Academy
- **229** individual online courses and resources, including **131** eLearning modules.

The team also managed the transition from manual data entry of course completions to automatic recording, provided training solutions and support to areas that had no prior training resources, and provided MyLearning support to DoH's Public Health Operations team as part of their rapid onboarding of staff in response to the COVID pandemic.

Face to face (F2F)

In January 2022, a new **MyLearning F2F function** was added to provide staff with comprehensive information on each course. This function also supports facilitators to manage their courses autonomously and electronically, disseminate training materials and capture participant feedback.

In 2021-22, staff were given access to over **400** self-bookable training sessions via F2F.

MyLearning notifications were also activated to provide staff with automatic confirmation of course details, placement in their calendar and notification to their manager, as well as the course facilitator being advised of the booking and the number of places remaining.

MyLearning help desk

A dedicated MyLearning help desk function was established in 2022 to support EMHS staff navigate the LMS, including students, graduates, volunteers and visiting medical practitioners. In addition to more than 10,000 EMHS staff, the MyLearning team also provided advice and support to:

- **3061** students on placement at EMHS
- **566** users at WA Health Public Health Operations
- **1021** users from the WA Health COVID support workforce
- **173** international medical graduates.

Photo: EMHS Learning and Development Team

Equity, Diversity and Inclusion eLearning

EMHS is proud to have collaborated with other health entities to produce a new **Equity, Diversity and Inclusion** (EDI) eLearning suite to support staff and help make our health service a vibrant, respectful and inclusive place to work. This is the first collaborative eLearning product of its kind in WA Health.

The package comprises an overview and six modules that align with identified diversity groups — women, youth, Aboriginal people, people with disability, the LGBTIQ+ community, and culturally and linguistically diverse people. It aims to educate and empower staff to respect and celebrate the diversity of our workforce and community.

Since launching the EDI suite as part of World Cultural Diversity Day celebrations (21 May 2022), **221** staff have accessed the training.

EMHS leadership, training and organisational development initiatives

- EMHS successfully piloted a new fit for purpose, in-house **Leadership and Management Program** (LAMP), with **20** participants and a modified program for **14** leaders from the RPBG's Outpatients Team
- Facilitated involvement in various leadership development activities for current and emerging leaders, including an **Aboriginal Leadership Program** and masterclass workshop series
- Implemented a range of improvements in response to the Minister for Health's **Your Voice in Health** staff survey
- Managed strategic projects to support the development of capability and culture across the organisation
- Designed and delivered new eLearning courses, onboarding programs and corporate training
- Strengthened our values-based culture through the **Above and Below the Line** behaviours program
- Encouraged participation in the organisation's **Peak Performance Program**
- Developed a new **Leading People and Performance Education Framework**

Supports Sustainable Health Review (SHR) recommendation 23 (see page 63)

Champions on mission to lift end-of-life care

In August 2021, EMHS launched an 18-month initiative to improve end-of-life care across our hospitals — the appointment of **30 Palliative Care Champions** who will use their position to champion access to high-quality and timely end-of-life care across their work areas.

The champions will take on a variety of roles to build capacity and achieve positive change at the individual, team and organisational levels.

In support of their efforts, the champions get access to professional development networking opportunities and ongoing information sharing, including a palliative care study day.

The Palliative Care Champions come from a range of disciplines (medical, nursing and allied health) and clinical areas. They were chosen from a strong field of candidates who responded to a call for expressions of interest in the new roles.

EMHS Palliative Care Champions

Simulation training helping clinicians tackle tough conversations

Talking to patients about their goals of care can be challenging for even experienced clinicians. In 2021-22, clinical staff across EMHS welcomed the roll out of free half-day simulated training sessions designed to help them have those difficult conversations.

The **Talking Together** program — guided by existing evidence-based communication frameworks and training developed by the Cancer Council WA Palliative and Supportive Care Education — uses realistic simulated scenarios to help doctors, senior nurses and allied health staff refine their skills and assist them to deliver realistic health care to patients with complex needs.

During the workshops, participants get to hone their skills with the help of professional actors who take on the roles of patients and carers in realistic scenarios. Participants also benefit from real-time feedback provided by experienced EMHS clinician facilitators.

> **"Brilliant workshop. Very valuable and teaches skills that can be used in all specialties."**

Celebrating our volunteers

Volunteers are a valued part of the EMHS team and significantly enhance the hospital experience for patients, families and carers.

Volunteer groups operate across our hospitals providing a wide range of services, including transport for patients, making cups of tea, fetching extra blankets or shopping items for patients, challenging patients to a game of cards, or simply stopping by their beds for a chat. Volunteers also run various retail outlets, provide concierge services, staff the RPH museum, and provide comfort and company to patients with dementia or at risk of delirium.

Many of the EMHS volunteers are retired and want to make a meaningful contribution to their communities.

The absence of volunteers at our hospitals for several months due to COVID-19 restrictions, gave EMHS a renewed appreciation for the difference these individuals make across our sites, and we were delighted to welcome them back following the easing of restrictions.

New group creating cultural connections for Aboriginal patients

A major development on the volunteering front during 2021-22 was the launch of EMHS' inaugural Aboriginal Volunteer Program, **Wool-lar** — a Whadjuk Noongar term meaning "celebration" or "happy times".

The main goal of Wool-lar — which began in late 2021 — is to support the overall wellbeing of Aboriginal patients who might experience isolation and cultural and family disconnection from being in hospital, hindering their recovery.

RPH Haemodialysis Unit Nurse Unit Manager, Melanie McNeice, said that for patients who faced four to five hours of dialysis, three times a week for the rest of their lives, having somebody to yarn with and provide spiritual connection was of great comfort.

> **"I'm looking forward to making unity, making connections, making sure everyone understands everyone's journey, where they've been, where they are now"**
> Noongar Elder, Athol (volunteer)

Beryl leaves legacy of warmth and kindness

In November 2021 **Friends of RPH** (RPH's volunteer service) celebrated the contribution of long-time member **Beryl**, who retired after **47 years** with the group.

During her time with Friends, Beryl crocheted **500** rugs for patients, many of which were distributed to dialysis patients. Over the 47 years, she also rounded the wards with a trolley shop, chatted and provided comfort and a listening ear to patients and served at the Friends' gift store.

Despite having led a busy life, Beryl said she enjoyed her time as a Friends volunteer and even in retirement from the group, planned to continue crocheting rugs for patients.

When **Phillip** applied to be part of the volunteer team at AHS, he mentioned gardening as a special interest. His gardening skills were quickly put to use in the rehabilitation garden, which has burst to life under his care.

Pauline knows the trauma of attending an ED when a loved one is rushed to hospital. She experienced it personally when her late daughter, Soozie, was admitted to RPH unexpectedly with what later turned out to be pancreatic cancer. Today, as a member of RPH's concierge service, Pauline tries to ease the trauma of an ED visit for other patients and their families.

Through a program called Lasting Words, volunteer **Shane** works with patients being treated palliatively at KH to tell their life stories and create an enduring legacy for their families.

Bus driver was one of five jobs self-described 'people person' **Michael** had during his working life — so he feels right at home, chatting to the patients he ferries to and from outpatient appointments, as a member of the Bentley Volunteer Drivers Group.

Saluting our champions

EMHS is made up of many amazing individuals and teams whose care, compassion and professional accomplishments shone on national and international stages during 2021-22.

EMHS Chief Executive **Liz MacLeod** was among those honoured, receiving one of the public sector's highest accolades when named **Leader of the Year Working within a Division, Team or Organisation** at the annual Institute of Public Administration Australia (IPAA) WA Achievement Awards.

Commended for her compassion, dedication and professionalism, Liz was described as somebody who led by example in encouraging individuals within EMHS to uphold the organisation's values.

She was also acknowledged for her role as Lead Chief Executive of COVID-19 Health Operations, where she worked collaboratively to ensure the preparedness of WA's health services.

Other EMHS individuals or projects nominated at the IPAA awards were AHS clinician and researcher, **Dr Sangeeta Malla-Bhat**, EMHS Aggression and Prevention Clinical Lead **Alex Knowles, Health in A Virtual Environment** (HIVE) and the **Inclusivity program,** led by nurse **Jane Armstrong**.

Another significant accolade went to RPH nephrologist and hypertension specialist and Dobney Chair in Clinical Research, **Professor Markus Schlaich**, who was awarded the **2021 Arthur C. Corcoran Memorial Lecture Award** by the American Heart Association, Council on Hypertension.

In winning this prestigious international award, Markus joins a long and illustrious list of past recipients.

EMHS' **Data and Digital Innovation (DDI) Team** won the **Innovation in Government** award at the annual INCITE Awards, WA's premier information and communications technology (ICT) awards. They were awarded the prize for developing the COVID-19 Digital Assessment App, which enabled demographic and clinical information to be collected rapidly across multiple settings, and was a vital part of the State's COVID response. The team also received national recognition for the app at the national Digital Disruptor Awards, where they won the prize for **Service Transformation for the Digital Consumer – Government**.

Photos L-R: Sharyn O'Neill (Public Sector Commissioner), Liz MacLeod, Professor Markus Schlaich and the Data and Digital Innovation Team

Also highly feted during the reporting period was RPH geriatrician **Dr Zarrin Allam**. The Postgraduate Medical Council of Western Australia named Zarrin **WA Clinical Educator of the Year** in recognition of her outstanding work as an educator. Nominations for the honour are made by peers and supervisors. Zarrin also went on to win the **Australasian Clinical Educator of the Year Award**, which is presented by the Confederation of Postgraduate Medical Education Councils.

At the Australian Institute of Management WA's 2021 Pinnacle Awards, the **HIVE** was awarded the **Pawsey Innovation Excellence** prize. The HIVE combines cutting-edge technology, artificial intelligence and highly-skilled healthcare staff to enable close and continuous monitoring of high-risk patients across multiple health sites from a command centre based at RPH.

Research led by RPH Intensive Care specialist **Dr Steve Webb** won the top accolade at the 2022 Australian Clinical Trials Alliance (ACTA) Awards, where it was named **Clinical Trial of the Year**.

Steve's Randomised, Embedded, Multi-factorial, Adaptive Platform Trial for Community-Acquired Pneumonia (REMAP-CAP) study was recognised for its "incredible contributions" to understanding how to treat COVID.

REMAP-CAP's investigation of 35 individual treatments since the pandemic was declared, is credited with having identified several treatments that are effective in treating critically ill COVID patients. Just as importantly, it identified two treatments that were widely used to treat these patients but were ineffective. Both treatments have now been withdrawn for use in those patients.

At the same awards, practice-changing research led by RPH's Director of Research in the Department of Anaesthesia and Pain Medicine, **Professor Tomás Corcoran**, won the **ACTA Award for Excellence in Trial Statistics**.

His project, Perioperative Administration of Dexamethasone and Infection (PADDI) trial was described as having demonstrated "exemplary statistical aspects" from trial design and planning, through to analysis, reporting and interpretation.

The trial set out to determine whether dexamethasone — a steroid commonly given to prevent nausea and vomiting — if given to patients undergoing surgery would increase their risk of wound-site infection. PADDI found the steroid did not increase the risk of infection and could therefore be given safely to patients undergoing surgery.

Photos L-R: Dr Zarrin Allam, Dr Steve Webb and Professor Tomás Corcoran

Valuing our people

In 2021, EMHS launched the **Values in Action** award program in response to feedback from the Your Voice in Health survey, which indicated that staff wanted more recognition for their work.

In its first year, the program received more than **50** nominations from across sites. Quarterly winners were presented with a framed certificate by the CE during a surprise visit to their place of work.

In March 2022, a gala presentation was held to announce the winner of the inaugural overall **Values in Action Award** — Orthotics and Prosthetics Technical Officer **Michael Nicolaou**, a member of EMHS' Health Technology Management Unit.

Michael was nominated for his embodiment of all six EMHS values.

In presenting Michael with his award, EMHS CE Liz MacLeod described the Values in Action award program as a chance for staff members across EMHS to celebrate individuals and teams who consistently demonstrated the organisation's values.

She said these people did amazing work and were wonderful role models.

In showcasing their achievements, Liz presented Michael and the other 2021 quarterly winners — **Roshni Mathias** (BHS), **Medical Multimedia Design Team** and **Kaylene Waring** (AKG) — with a special commemorative pin, which she hoped they would wear with pride.

Photos L-R: Kaylene Waring, Michael Nicolaou, Roshni Mathias and the Medical Multimedia Design team

Prioritising the wellbeing and safety of our people

Ensuring the safety of staff and keeping them informed during the COVID-19 emergency continued to be a priority for EMHS during 2021-22.

Hoods help keep staff COVID safe

At AKG and RPBG, innovative Australian-designed contraptions known as **medihoods** were used to enhance the protection of staff caring for patients with — or suspected of having — COVID.

The hoods prevent transmission of aerosolised droplets by enclosing the upper part of the patient's body in a transparent tent-like structure, creating a physical barrier between the patient and healthcare staff. The units also incorporate a powerful HEPA fan-filter that draws the patient's expired air out of the hood and scrubs it of more than 99% of particulate matter, further reducing transmission risk.

AKG Director of Clinical Services Dr Alison Parr described the retractable hoods as lightweight and easy to open.

"While they enhance patient and staff safety, they are also comfortable for patients," she said.

"It is a bonus that the medihoods will have a life beyond COVID, because they can also be used on patients with other transmissible illnesses."

Supporting staff in a COVID environment

During 2021-22, EMHS developed a **Staff Wellbeing During COVID** strategy to support health and wellbeing during the pandemic surge period. The strategy included a COVID vaccination program, staff wellbeing, staffing arrangements, face mask fit testing, and constant staff updates. Our Wellbeing Strategy was packed full of ideas and tools to support staff and managers during this period of uncertainty and beyond. By keeping our staff safe and informed, we were able to focus our attention on continuing to deliver amazing care to our patients.

27,422 fit tests for particulate filter respirator (PFR) masks were conducted on more than **12,000** people, including staff, volunteers, students and contractors. **99.7%** of people achieved a fit with at least one PFR, ensuring everyone in the workplace had access to suitable and appropriately fitted personal protective equipment (PPE).

HEPAs help our hospitals breathe easier

Staff were able to breathe a little easier in October 2021, when EMHS took delivery of its first consignment of high-powered HEPA air filtration units. These units had been deployed extensively in the eastern states and in WA's own state-run quarantine hotels.

AKG consultant microbiologist Dr David New said having a unit in the room of a COVID-19 patient reduced the level of virus in the room and in turn the level of virus that could escape from that room every time somebody entered or left it.

"If you think of the COVID patient as a campfire, every time you open or close the door — such as when you enter and leave the room — some of the smoke will inevitably escape into the corridors outside the room," he explained.

"So, having these filters will help us reduce the infection risk to staff and other patients."

Dr New stressed that while the filters did not replace the need for vaccination or adherence to good handhygiene and PPE practices, they did provide an added layer of protection against COVID.

The filters remove virus particles from the air and are capable of more than **25-30 air changes** an hour (depending on the size of the room). This is superior to the 10 air changes an hour, recommended by World Health Organization (WHO) guidelines.

Dr New said the filters have a life beyond COVID because they could also be used to reduce other respiratory pathogens such as the influenza virus.

During 2021-22, EMHS procured more than **300 units**, which have been in almost constant use since arriving.

Victor Powell (Clinical Nurse Specialist)

EMHS commitment to occupational safety and health and injury management

EMHS is committed to ensuring the safety, health and welfare of its staff, volunteers, contractors, patients and visitors by:

- Promoting a culture that integrates safety as a core activity into all aspects of work.
- Utilising a risk management approach to identify, investigate, assess and control physical and psychological work health and safety (WHS) issues.
- Applying a continuous improvement approach to WHS, ensuring safe systems of work are in place and are monitored and evaluated.
- Supporting workers in maintaining and improving their health and wellbeing through facilitation of wellbeing programs and strategies across EMHS.
- Providing up-to-date information to all officers, managers and supervisors, workers and safety representatives on changes to the WHS legislation.
- Ensuring all workers understand their duty of care and encouraging them to take responsibility for the health, safety and wellbeing of themselves and others at work.
- Ensuring all officers (under the *Work Health and Safety Act 2020*) are informed, understand the health and safety hazards and risks in EMHS, and provide workers with the right resources and processes to eliminate or minimise these risks, and report any issues that occur.
- Providing information, training, instruction and supervision that is necessary to protect all workers to enable and facilitate safe work practices.
- Enabling communication, consultation and collaboration with workers and other persons to ensure that all practicable measures are undertaken to improve WHS performance.
- Promoting, training and supporting elected health and safety representatives (Safety Reps), and maintaining active and engaged WHS committees.
- Undertaking proactive hazard identification activities, including quarterly workplace hazard inspections and annual aggression risk assessments, in all EMHS services and addressing issues identified through these assessments.
- Complying with relevant legislation, standards, policies, procedures and other requirements in relation to workplace health, safety and wellbeing.

Formal mechanisms for consultation with employees on occupational safety and health matters

Consultation with employees is undertaken through site WHS committees and departmental meetings, with safety as a standing agenda item. EMHS Safety Reps have access to a WHS committee, providing a mechanism for WHS issues to be escalated and for information to be shared across the service.

WHS committees are evaluated biannually to ensure they are fulfilling their purpose and the needs of the workforce and the organisation. EMHS WHS committees:

- facilitate cooperation and consultation between the business and its workers in initiating, developing and implementing measures designed to ensure workers' health and safety at work
- assist in developing safety and health standards, rules and procedures
- provide recommendations about the establishment, maintenance and monitoring of programs, measures and procedures in the workplace that are related to the safety and health of the employees
- consider and make recommendations about any changes to/at the workplace that could affect the safety or health of workers.

Compliance with injury management requirements of the *Workers' Compensation and Injury Management Act 1981*, including the development of return-to-work plans

EMHS provides a systematic approach to workplace-based injury management (IM) services for all employees following work-related injury, illness or disability. EMHS fosters an environment where it is normal practice for workers to be supported to return to productive employment as soon as medically appropriate following work-related illness, injury or disability in a safe way.

The EMHS Workers' Compensation and Injury Management System provides for:

- effective and efficient communication between all parties
- early intervention strategies and return to work processes
- clarity of policy, management practices and programs
- goals and objectives to be logically established, documented, monitored and reviewed
- regular consultation between the injured worker and employer.

EMHS actively promotes the philosophy of consultation and co-operation between the employer and employee, to ensure best practice and collaborative ways to achieve return-to-work outcomes and best practice in injury management. The early intervention approach utilised by the IM team promotes recovery at work, where this is medically appropriate and can be achieved safely. The early intervention physiotherapy program allows workers who sustain a minor musculoskeletal injury and are able to continue work in an unrestricted manner, to receive treatment in the workplace and to continue working safely while recovering.

The dedicated IM team builds and maintains positive relationships with all stakeholders, including the injured worker, their managers, treating practitioners and the Government Insurance Division (GID), with the goal to facilitate the best possible outcomes for both the injured worker and the organisation. Best practice IM strategies implemented by the team include:

- provision of return-to-work programs without delay to assist with recovery and consideration of alternative work areas where appropriate
- provision of exercise programs while on workers' compensation to facilitate recovery and return to work
- counselling through the Employee Assistance Program provider
- IM referrals to specialist doctors to facilitate diagnosis and treatment
- monitoring and review of vocational rehabilitation, ensuring it is in line with medical evidence and best practice.

Number of workers' compensation claims by occupational group

20 medical support
16 in 2020-21 ▲

106 nursing
107 in 2020-21 ▼

28 maintenance
16 in 2020-21 ▲

70 hotel services
69 in 2020-21 ▲

18 administration and clerical
19 in 2020-21 ▼

8 medical
3 in 2020-21 ▲

TOTAL 250 230 in 2020-21 ▲

Work health and safety performance indicators

Number of fatalities

YEAR	TARGET	ACTUAL
2021-22	0	0
2020-21	0	0
2019-20	0	0

LTI/D severity rate (percentage LTI/D)

YEAR	TARGET	ACTUAL
2021-22	42.72%	40.61%
2020-21	43.92%	46.41%
2019-20	40.77%	47.47%

Percentage of injured workers returned to work within 26 weeks

YEAR	TARGET	ACTUAL
2021-22	80.0%	60.6%
2020-21	80.0%	63.0%
2019-20	80.0%	62.6%

Lost Time Injury and Disease (LTI/D) incident rate (per 100)

YEAR	TARGET	ACTUAL
2021-22	3.15	3.07
2020-21	2.90	2.90
2019-20	2.90	3.50

Percentage of injured workers returned to work within 13 weeks

YEAR	TARGET	ACTUAL
2021-22	70.0%	43.3%
2020-21	70.0%	46.0%
2019-20	70.0%	48.0%

Percentage of managers and supervisors trained in occupational safety, health and injury management responsibilities

YEAR	TARGET	ACTUAL
2021-22	80.0%	72.3%
2020-21	80.0%	73.0%
2019-20	80.0%	82.6%

Performance

Safety as our priority

The provision of safe, high-quality care remains the number one priority for EMHS. We continually look for new and innovative ways of improving our performance and reducing the risk of clinical and other errors.

Emergency departments embrace triage-triggered texts

In March 2022, EMHS introduced an innovative initiative that ensures patients presenting to our busy EDs receive timely information about what they can expect from their visit.

A welcome text is sent to the patient's mobile phone once they have been triaged. The text is generated automatically upon entry of their details into our hospital system.

The message includes important information about raising concerns in the event of patient deterioration, and also provides links to the relevant hospital's website.

This safe and environmentally friendly service improvement was inspired by a similar initiative operating at SJGMPH and was prompted by the need to ensure patients, carers and family members are provided with important information and opportunities to escalate care as early as possible.

Aishwarya's CARE Call

In October 2021, EMHS changed the name and look of its existing care call system — the system that enables families and carers to escalate care in the event of a deteriorating patient.

The changes at RPH, AHS, BHS and KH were part of a WA Health system-wide collaboration involving all HSPs and were implemented in response to the tragic death of a young girl at Perth Children's Hospital.

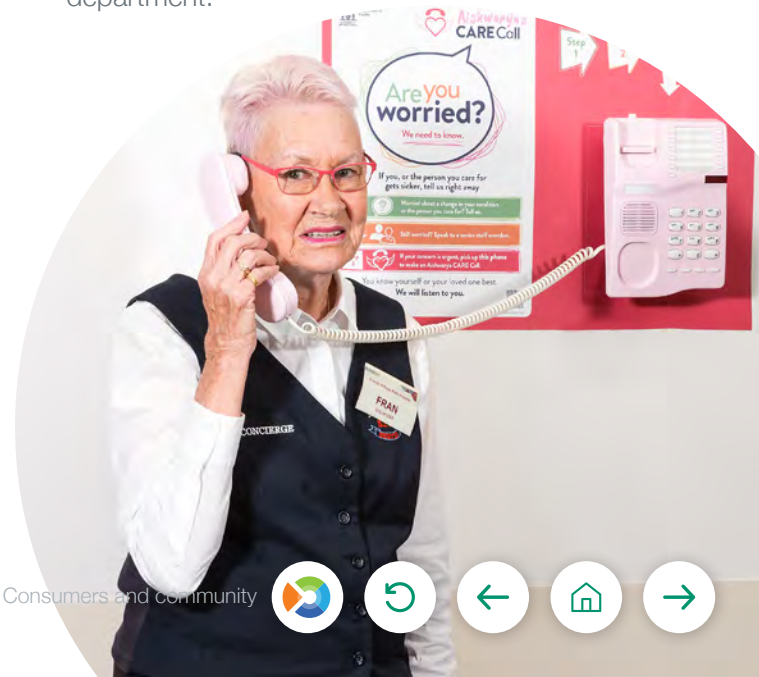
Rebranded **Aishwarya's CARE Call**, the revamped system was designed to empower families and carers to alert hospital staff to deterioration in a patient's condition, prompting an escalation in care.

In our EDs, clearly sign-posted fixed phones were installed that provide automatic connection to the Aishwarya CARE Call number, while the presence of our waiting room nurses was also bolstered.

Since the adoption and implementation of Aishwarya's CARE call, **114** calls have been made at EMHS hospitals.

Of these:

- **76** related to seeking an escalation in clinical care. Of these 76 calls:
  - **26** required clinical intervention and remained on the ward/department
  - **2** required transport to another ward/ department.



EMHS' smoke-free status

EMHS was proud to have worked towards stamping out smoking in 2021-22.

Smoking — including the use of vaping and e-cigarettes — is now prohibited across EMHS grounds, including our:

- hospitals
- community health centres
- office buildings
- car parks
- vehicles
- garden or outdoor areas.

The change was phased in gradually, with BHS becoming our first smoke-free site.

A dedicated **EMHS Smoke-free Team** was created to ensure EMHS was well prepared for the changes. It did this by:

- implementing a comprehensive communications plan and smoke-free learning pathway
- providing education and training to staff members on best-practice management of nicotine dependency
- developing a suite of new ward-based resources
- increasing access to the staff nicotine replacement therapy (NRT) program — with staff now having access to a free 12-week course per year
- developing a new suite of smoke-free signage for hospital sites to replace the outdated "no smoking" signs. The colourful new designs depict flora and fauna indigenous to our local area.

By providing a smoke-free environment for our patients, staff and visitors, we are reducing the harm from second-hand smoke exposure and supporting people who have recently stopped — or are trying to stop — smoking.

EMHS recognises that there is no safe level of exposure to tobacco smoke.

Risk management and audit

The three lines of defence model employed by EMHS clearly defines functions that are involved and responsible for effective risk management. These lines of defence are:

1) own and manage risks

2) oversee risks

3) provide independent assurance.

The EMHS Board Audit and Risk Committee forms part of the organisation's wider governance framework and provides a key oversight role for the second and third lines of defence through the risk management and audit functions.

Risk management

The 2021-22 highlights of the risk management function included the:

- assessment of risks against new WHS Legislation to ensure EMHS continues to provide a safe workplace
- improvements to the assessment of ICT risks, including patient safety impacts and cyber risks
- assessment of clinical risks and frontline risk identification, to ensure risks can be identified and escalated from the frontline and are aligned to clinical data
- review of the EMHS strategic risk profile and confirmation of key strategic risks and responsibility for control improvements.

Additionally, EMHS has undertaken a maturity assessment of the risk management function, which has assessed EMHS as having a maturity level of evolved, as well as being aligned with its industry peers. The assessment has identified a series of recommendations towards achieving its target maturity, which will be implemented over the next 12 months.

Internal audit

In 2021-22, the internal audit function undertook a quality assessment review to ensure activities performed are in accordance with the International Standards for the Professional Practice of Internal Auditing. It was found that the internal audit services conform to the auditing standards and the maturity of the function, maximising its capability to provide objective and insightful assessment for the organisation.

The risk-based Audit Plan saw major reviews conducted in high priority areas such as violence and aggression, misconduct prevention and complaints management. Recommendations from these reviews are being implemented to provide continuous improvements to processes and service delivery at EMHS.

In 2021-22, management was able to close **62%** of the internal and external recommendations logged for the year, while **38%** were in progress at the time of this report. There is a robust governance process in place headed by the Board Audit and Risk Committee, to monitor and query management and implementation of these audit recommendations.

Complaints management audit

Health consumer feedback is a valuable component of the quality improvement cycle, and the complaints process is one of the vital instruments in place at EMHS through which the organisation can obtain this feedback.

In 2021-22, EMHS commenced an internal audit of complaints management in order to determine the effectiveness of controls and systems in place for the management of feedback — including complaints from patients, families, carers and the general public.

Listening to our consumers and community

Engaging and partnering with consumers and our community remains key to achieving our vision of healthy people, amazing care.

L-R: Brenda Greenfield (Aboriginal community group member), Denese Griffin (Director Aboriginal Health Strategy) and Robert Morrison (A/Senior Development Officer Community Engagement) in the Aboriginal Family Garden

Improving the consumer experience

In 2021-22, EMHS:

- opened an **Aboriginal Family Garden** at RPH, to provide a supportive space for family members
- designed a new **Mental Health Unit** (MHU) at RPH in consultation with consumers
- returned volunteer concierges in the EDs and hospital entrances, supporting patients upon entry to our sites
- progressed KH's new **Day Hospice**, which was designed by consumers with lived experience and staff who are experts in end-of-life care
- continued to use **Care Opinion**, an online platform to enable members of the public to tell us about their experience with our services
- further implemented the Australian Commission on Safety and Quality in Health Care's **Australian Hospital Patient Experience Question Set** (AHPEQS), which has introduced the use of validated, standardised patient experience questions by way of an SMS-based survey after discharge to outpatients clinics and EDs.

AHPEQS results summary

AHPEQS question	EMHS
My views and concerns were listened to	91.0%
My individual needs were met	90.4%
I felt cared for	91.9%
I was involved as much as I wanted in making decisions about my treatment and care	88.8%
I was kept informed as much as I wanted about my treatment and care	88.7%
As far as I could tell, the staff involved in my care communicated with each other about my treatment	89.6%
I received pain relief that met my needs	91.9%
When I was in the hospital, I felt confident in the safety of my treatment and care	91.9%
Overall, the quality of the treatment and care I received was good or very good	91.9%

Consumer feedback

Consumers provide valuable feedback and contribute to improving the safety and quality of services. Feedback is also used to recognise staff and teams who go above and beyond our patients' expectations

In 2021-22, through our formal processes, EMHS received:

1480 **compliments** via formal feedback processes

90 **entirely complimentary stories** via Care Opinion

This recognises only compliments provided through a formal mechanism, but does not take into account the multitude of compliments and thanks fed back to staff informally and directly by patients, carers and their loved ones.

328 **instances of consumer feedback** received via the EMHS Ministerial Liaison Unit

EMHS also received:

1759 **complaints** via formal feedback processes

80 **complaints** via Care Opinion

EMHS manages patient feedback consistent with the **WA Health Complaints Management Policy (2019)**, with all complaints acknowledged, investigated and responded to within appropriate timeframes, and quality improvement activities initiated to address issues where appropriate.

EMHS had **15** consumer advisory groups with **165** members

Ben Horgan (Community Development Officer, RPBG Consumer Engagement)

Examples of quality improvements arising from consumer feedback

Situation #1

Feedback received via the Outpatient Survey highlighted difficulty for consumers accessing parking during periods of peak demand.

Changes implemented as a result

This feedback was tabled at the Outpatient Reform Project Control Group (ORPCG), where it was agreed that information relating to onsite parking needed to be improved. A consultation process, which involved partnering with consumers, took place and resulted in the hospital website being updated with clarity on alternative options and improved descriptions on public parking available.

Situation #2

Feedback was submitted to the AKG Consumer Liaison Office in relation to the recently opened Ambulatory Assessment Unit within the ED. The consumer providing the feedback had recently been an ED patient and was confused by their experience. Their concerns were around the patient flow and why some patients in the waiting room appeared to have been seen faster for what seemed to be a less severe injury.

Changes implemented as a result

Immediate improvements were made to the Ambulatory Assessment Unit by giving patients leaflets explaining what to expect in the ED, including patients being seen in order of their illness severity. Visual communication providing information via the television within the waiting room was also added for consumers to refer to.

Situation #3

Patient Experience received feedback from an elderly patient who, following discharge from the ED after hours, was concerned to only be provided with a telephone number for a taxi company and advised to wait at Lord Street.

Changes implemented as a result

Details of the complaint were provided to the ED for education to staff about after-hours discharge, specifically extra consideration for elderly or vulnerable patients. Furthermore, the discharge process was adapted to ensure any patient waiting for a taxi home is directed to wait in an alternative foyer, which is secure and monitored.

Feedback from Care Opinion

"I would like to give 10 stars to the maternity dept, and Liz the midwife, she has done a fantastic job. We felt she is a very, very nice lady and she helped my wife so much, we really appreciate it. I would like to give 10 stars to all the staff involved in our care. They really helped us through the whole thing and made us feel so relaxed. Liz particularly, she didn't even leave when she could have gone home, she decided to stay so she could be there to support my wife through the birth."

"My elderly grandmother was admitted to the dementia unit (7A). Her English is very limited, and she has great difficulty hearing, which in addition to her advancing dementia, I think makes her care more complicated for staff. From the nurses on the ward, I expected competence, and kindness. The care that was in fact provided was so kind and loving that it brought tears to my eyes."

"My relative had two significant falls. He presented to Armadale ED twice. The first time, he was assessed, investigated, admitted, seen by the social worker/ physio/geriatrician and sent home with a plan for follow-up.

A week later, he fell again, and we presented to Armadale ED. Again, he was assessed, investigated and a management plan enacted. I felt it was clear he could no longer manage at home on his own due to developing dementia. He was seen by a multidisciplinary team recurrently. He was admitted to the ward and transition to aged care placement was managed.

At all times I have found the staff supportive, caring and holistic in their approach. It is a particularly stressful life change for my relative and the staff supported him beautifully over this time. He spent just over four weeks in hospital and is now very happy in the same home as his wife.

A big shout out to all the staff in ED/ward involved in his care — the support staff, nursing staff, medical staff and allied health staff. What a great job you did. I really appreciate your care. Keep up the good work. Go Armadale Health Campus."

"Had an absolutely fantastic team care for me for my day surgery. From admission to discharge I cannot say thank you enough to my caregivers. I believe you are all a credit to your commitment in providing fantastic care."

"I encouraged my older son to attend to have his abdominal pain assessed. We had gone to urgent care prior, but he needed further tests. This wasn't an emergency, so we expected to wait. I watched the nurses — triage, wait room, concierge and the others that were busily coming in and out. We were both warmed by the level of care, compassion, professionalism and knowledge that we felt they demonstrated to all patients in the waiting room.

Once being brought into the main area, we were greeted by a very competent doctor and nurse that made it easy for my son to feel cared for. Thank you so much guys! Feel proud because I think you are all a truly great team and do amazing work ❤️ ❤️ "

Paraffin and pets

Occupational Therapists (OTs) are an integral part of the EMHS' allied health workforce, employed across hospital, community, and rehabilitation settings, where they provide assessment of — and help with — patients' physical, cognitive and psychosocial skills, abilities and difficulties.

At AHS, a popular OT program is the **paraffin wax treatment**, which is used in hand therapy to improve joint mobility. It involves coating the patient's hand in wax by dipping it in a bath of warm wax. The hand is then wrapped in plastic and a towel.

The treatment is used in conjunction with mobilisation exercises to improve hand function in patients with post-traumatic stiffness, arthritis, or chronic pain.

Pet therapy is another OT program that is popular with both patients and staff. It is used in the State Trauma Unit at RPH, in two of the rehabilitation wards at BHS, and at AHS.

On special visiting days at RPH, patients can request a visit from therapy dog **Zoe**, a Golden Retriever-German Shepherd Cross. At BHS, Cavoodle **Lexi** enjoys all the pampering and little **Kit** loves the attention at AHS.

Caring for our community

EMHS' catchment includes a large portion of people experiencing homelessness due to mental health issues. Two new services were progressed in 2021-22 to offer support to this particularly vulnerable consumer cohort.

Mental Health Transitional Care Unit

Work to transform a former residential aged-care facility into a contemporary mental health unit was well underway by the end of June 2022, with the first of the two-part development scheduled to open later in the year.

St James Transitional Care Unit – Bidi Wungen Kaat Centre — will provide support for up to **40** people aged 18 to 64 years, providing continuity of care as they transition from hospital back into the community, or to keep them from needing ED admission.

The unit will be made up of two 20-bed units:

- a **Prevention and Recovery Unit**, which will provide short-term care, and
- a **Rehabilitation and Recovery Unit** that will provide care for periods up to approximately six months.

The new facility will be staffed around the clock by skilled mental health clinicians and peer-support workers and will fill an important gap in support for people in the community who are experiencing a mental illness.

Individuals assessed as being ready and able to participate in a mental health rehabilitation program while living in a community setting will be accommodated in the unit, which will adopt a model of care that has been successful in the eastern states and internationally.

Medical Respite Centre

In October 2021, EMHS partnered with several community organisations to open a service that was aimed at improving the recovery prospects of newly discharged patients experiencing homelessness.

Located in the inner-city suburb of Northbridge, the 20-bed **Medical Respite Centre (MRC)** provides safe and therapeutic short-term accommodation for consumers who — while not sufficiently unwell to continue occupying a hospital bed — are too unwell to return to living on the streets.

Those whose referrals are accepted can spend up to14 days at the facility, during which time they recuperate in a stable environment supported by nurses, a GP, support workers and addiction in-reach services provided by the RPBG Consultation Liaison and Alcohol and other Drug Service.

A focus on our youth

Community support for at-risk youth

In March 2022, a new eight-bed facility opened to provide interim supported accommodation for young people with mental health issues experiencing — or at risk of — homelessness.

Known as **Momentum QP** and located in Queens Park, the service caters to people between the ages of 16 and 24 years. It provides them with safe, comfortable accommodation for up to a year during which time they can take advantage of a range of clinical and other psychosocial support services, all of which are designed to help get them back on their feet. This includes help finding work and alternative accommodation prior to leaving.

Through its provision of clinical in-reach, EMHS is one of several organisations that contribute to the service. Its in-reach is provided by a psychiatrist, psychologist and nurse, who are otherwise based at BHS.

Peer workers play a key role in the service which is led by Richmond Wellbeing and is supported by Cyrenian House and Anglicare WA.

Youth Community Assessment and Treatment Team (YCATT)

With young people disproportionately affected by mental ill-health and having the highest prevalence and incidence of mental illness across the lifespan, the launch of the **Youth Community Assessment and Treatment Team** (YCATT) filled a much-needed void in EMHS' suite of services for young people.

Opened for referrals in April 2022, YCATT provides a brief, targeted, evidence-based assessment and intervention service for young people and their carers. It will complement the work of the **East Metropolitan Youth Unit** (EMyU), which was established in 2018 to provide inpatient care for young people experiencing complex and acute mental health issues.

In particular, the new service supports people transitioning back into the community from the EMyU.

YCATT's services are offered from BHS and satellite locations across the EMHS catchment area.

Photo: Liz MacLeod (EMHS CE) and members of the EMHS mental health team

Plan to tackle youth drinking

EMHS' Health Promotion Team has played a key role in the launch of an ambitious plan to minimise alcohol-related harm among young people (12-17 years) in three local government areas (LGAs) within its catchment — the Town of Victoria Park and cities of Belmont and South Perth.

The **Youth Alcohol Action Plan (YAAP) 2022-25** — launched in June 2022 — sets out clear strategies and actions to be implemented over three years, focusing on five areas known to influence alcohol-related harm:

- underage drinking
- adult supply
- marketing
- accessibility
- community connections.

The YAAP is the result of a two-year collaboration between EMHS and the LGAs, Cancer Council WA, Alcohol and Drug Foundation, Department of Education, WA Police and Police and Citizens Youth Club, as well as extensive engagement with young people, community organisations and peak bodies.

Some sobering facts

- Binge drinking at a young age carries into adulthood for **90%** of males and **70%** of females
- Under 25's make up **22%** of all alcohol-related ED admissions
- Under 25's accounted for **30%** of all deaths on WA roads where alcohol was a factor
- The later teenagers delay their first alcoholic drink, the less likely they are to become regular users of alcohol

Caring for our multicultural community

Culturally safe COVID vaccination clinic

Lifting vaccination rates among vulnerable populations was an important part of EMHS' COVID-19 response.

Our Aboriginal community was not only extremely vulnerable to COVID, but also lagged behind the overall population in its rates of vaccination.

EMHS played a key role in efforts to increase those rates by partnering with other organisations to establish a culturally safe vaccination clinic.

The clinic was set up at the Derbal Yerrigan Health Service in East Perth, with RPH providing and delivering the vaccine.

Most people jabbed were Perth locals, but some were from towns as far away as Leonora, Kalgoorlie, Roebourne and Newman. Many had learnt of the clinic through the Noongar network.

Derbal Yerrigan Chair Joslyn Eades-Tass said her organisation was grateful to EMHS and other members of the partnership for their efforts in arranging the clinic because there had been considerable vaccine hesitancy in the Aboriginal community.

Former Miss NAIDOC, **Ilona McGuire**, was among those who lined up at the clinic to get vaccinated.

Progressing care for our multicultural community

The **EMHS Multicultural Plan 2021-23** was developed to outline the key actions, desired outcomes, timeframes and responsibilities for implementation over the next three years. The Multicultural Plan focuses on three policy priorities:

1) **Harmonious and inclusive communities**
2) **Culturally responsive policies, programs and services**
3) **Economic, social, cultural, civic and political participation.**

Policy priority 1: Harmonious and inclusive communities

- The **RPH Aboriginal Family Garden** was officially opened by the then Minister for Health, Hon Roger Cook MLA, in December 2021.
- A **Wayfinding Working Group**, in collaboration with EMHS Facilities Management and Pricewaterhouse Coopers Consulting (PwC), has developed and delivered a comprehensive review of signage across the RPH site. Positive 'cleaner air' signage was installed across campus with native animal illustrations as part of the smoke-free program.

Policy priority 2: Culturally responsive policies, programs and services

- The **EMHS Strategic Plan 2021-25** was endorsed and published in August 2021. Supporting diversity and inclusion is a service delivery principle, and has specific strategic objectives and priorities aligned.
- AKG has established a **Diversity and Inclusion Committee** with the remit to explore opportunities for improvements to existing systems and processes to meet the needs of their diverse cultural and linguistic community.
- The **top 10 languages** for the RPH and BHS sites have been determined. A demographic dashboard has been drafted to capture this information live. Further, an interactive tool identifying potential diverse patients who have not been previously identified for interpreter usage is being used by language services. Priority publications have been translated into the top five languages, including consent forms and critical patient information. There are also plans to translate a welcome pack for each site.

Policy priority 3: Economic, social, cultural, civic and political participation

The EMHS COVID Vaccination Team worked closely with the WA State Vaccination Program to promote and educate, Culturally and Linguistically Diverse (CaLD) communities on COVID vaccination. This included:

- Aboriginal Liaison Officer inpatient vaccination program — educating and vaccinating Aboriginal inpatients and their visiting family members.
- Australian Islamic College — the team engaged with the school principal to understand cultural sensitivities and took advantage of a school family day to provide information around vaccination.
- Neerigen Brook Primary School — the EMHS team joined the largest local family to yarn about their vaccine concerns (the elder would decide on behalf of the entire family whether or not it got vaccinated). A pop-up vaccination clinic promoted considerable discussion within the community and resulted in members of the family receiving their first vaccine dose. The principal also assisted with ideas to further engage the community.

- St Mary's Cathedral — two pop-up clinics helped to engage homeless, and Filipino and Croatian groups.
- Door-to-door vaccinations — the team worked alongside WA Police in areas known to have heavy CaLD populations to provide vaccinations. This worked well, because many from these communities did not feel comfortable attending a local community clinic.

Posters share stories in bid to inspire

Members of EMHS' Aboriginal Health Community Advisory Group (AHCAG) turned their hands to storytelling during the year in an effort to encourage others in the community to take care of their health.

The stories of their individual health journeys were captured on **14** posters, each of which also offered a special health message and featured the individual's photo and Aboriginal artwork.

The posters have been displayed across EMHS hospitals. Each of the storytellers had a chronic illness such as diabetes, asthma or lupus and their stories chronicled the support they had received from EMHS and key Aboriginal primary healthcare services.

One of the storytellers stressed the importance of exercising regularly, of having regular check-ups and of maintaining frequent contact with family and community, while another advised people to talk to their doctor — especially if they were "not feeling right" — and of accessing health services, because they didn't need to do it alone.

As members of the AHCAG, they had gained important insights into the health system and wanted to share their health experiences to help improve the health journeys of others in their community.

EMHS excellence on display

EMHS' annual **Excellence Symposium** enables us to showcase outstanding work across our organisation, to recognise staff for fantastic achievements and to share knowledge and ideas for the benefit of all.

Our third symposium was held in November 2021, giving staff the chance to learn about the exciting work being done by colleagues across EMHS and to hear from the event's guest speaker, former AFL coach and West Coast Eagles premiership player **John Worsfold** — who, in keeping with the symposium's theme — spoke on the top topic of Striving for Excellence – Together.

Seven projects were chosen to present at the excellence event. All exemplified EMHS' vision of healthy people, amazing care, Koorda moort, moorditj Kwabadak.

RPH Theatres' Green Team

A change in the anaesthetic used in RPH operating theatres has reduced the theatres' environmental footprint to a fifth of its 2018 level despite increased theatre activity, and has reduced spending on volatiles.

Supports Sustainable Health Review (SHR) recommendation 5 (see page 63)

Health in a Virtual Environment (HIVE)

This innovative service enables clinical experts to monitor patients remotely 24/7 and to integrate data collected from medical devices to detect the earliest signs of clinical deterioration.

Medical Multimedia Design

Medical Multimedia Design, previously known as Medical Illustrations, produces patient-focused multimedia for clinical purposes, including clinical photography and graphic design, as well as a range of services to EMHS, such as patient publications and marketing material.

GoShare

Information sent via text or email helped patients follow their healthcare plans more closely at SJGMPH.

Early intervention physiotherapy program

EMHS' Early Intervention voluntary program provides employees with five sessions of in-house physiotherapy to ensure early assessment and management of injuries.

Data and Digital Innovation COVID app

The secure COVID-19 digital application has been integral to WA's COVID response, enabling rapid screening at the airport, clinics and in hotel quarantine.

Nurse-led Glaucoma Assessment Clinic

Within five months of starting, a nurse-led Glaucoma Assessment Clinic (GAC) had enabled RPH to review an extra **330 patients**.

Opened in October 2020, to reduce a backlog of patients awaiting follow-up appointments, the GAC involves a senior ophthalmology nurse assessing patients, performing eye examinations, interpreting results and providing patients with potential disease progression, and immediate referral to the consultant-led clinic to expedite care.

Photo L-R: Diane Barr (Executive Director AKG), John Worsfold and Christine Parry (Aboriginal Health Officer)

Using technology to advance our care

In line with EMHS' vision of healthy people, amazing care, EMHS continues to progress the digital strategy — **smart EMHS** — and other digital initiatives to achieve our digital future state:

> **You** connect with **us**, when and how **you** want to. **We** connect with **you**, when and how **you** need **us**.

A snapshot of just some of these initiatives is provided below:

Office of the Auditor General – General Computer Controls audit

EMHS participated in its second General Computer Controls (GCC) audit, which has resulted in a reduction from 18 open findings in 2021 to 11 open findings in 2022.

In the 12 months between audits, EMHS was able to close **nine**, and downgrade the severity of **two** of the 2021 findings — with **two** new findings identified. The qualification and significant findings relating to segregation of network and unauthorised device connectivity remain this year, and are being addressed through participation in the whole-of-health **Critical ICT Infrastructure Program**.

Registration of Rapid Antigen Test (RAT) results

EMHS has initiated a web-based application to register RAT results for patients being triaged in ED. This allows ED consultants and wards to see near real time views of the results of patients in the ED.

Transition to Microsoft (MS) Power BI

In 2021-22, EMHS progressed plans to transition to **Power BI** (business intelligence tool), which will bring innovation and integration opportunities, enabling users to perform data preparation and discovery and share insights in a single solution. The move to Power BI in early 2022-23 will improve integration with existing Microsoft products, including:

- easy sharing of content, including on MS Teams and SharePoint
- improved mobility with secure access to reporting and analytical content from inside or outside WA Health.

Staff Absence Management Process

Maintaining service delivery amid severe staff shortages has been a universal challenge for healthcare services throughout the pandemic.

An innovative dashboard, launched in February 2022, proved an invaluable tool for EMHS in maintaining oversight of staffing. The dashboard was part of a Staff Absence Management Process (SAMP) that was developed in-house by our award-winning DDI team in collaboration with our people and capability and clinical services teams. The SAMP has two components — a web-based furlough declaration form and staff absence management dashboard.

Staff unable to work due to COVID-related reasons or personal/sick leave complete a declaration form prior to the start of their shift. The dashboard extracts data from these forms to create a real-time snapshot of staff absences across EMHS by site, occupational group and area/department. Information in the dashboard is updated every 15 minutes and is used to coordinate staff and manage demand/critical services. This enables EMHS to identify and respond quickly to areas of staffing need.

RPBG Deputy Director of Clinical Services Dr Sumit Sinha-Roy said: "It enabled the RPBG medical workforce team that I manage, to pre-emptively (or really speedily), with collaboration from other clinical Heads of Departments, move junior doctors across services to supply clinical teams that were short-staffed, to maintain their services."

Valentine's Day marks the start of Wi-Fi milestone

Keeping in touch with loved ones became easier for EMHS patients who found themselves in hospital on Valentine's Day 2022.

That's because 14 February was the day patients joined staff in being able to access free **Wi-Fi**, fulfilling the final milestone in the **EMHS' Digital Infrastructure Enablement** (EDIE) Wi-Fi project.

The Wi-Fi project — that made EMHS sites Wi-Fi hotspots — was a massive undertaking and its completion was a major achievement.

Putting Wi-Fi into sites after they were built — especially ones that were built before electricity was standard — was a challenging experience.

The provision of Wi-Fi to patients enables them to stay connected to loved ones and communities, helping them feel more comfortable while in hospital.

Ambulatory video electroencephalographic monitoring

An accurate diagnosis of epilepsy and similar conditions is essential for safe and high-quality patient care. Inpatient video electroencephalographic monitoring (vEEG) is the gold standard for diagnosis, but requires hospitalisation, is expensive and is inconvenient for patients.

The pandemic prompted EMHS to consider approaches other than traditional inpatient care. Home-based **Ambulatory vEEG monitoring** (AVEM) was trialled as an alternative option because it replicates inpatient vEEG monitoring, is less expensive and is more accessible for patients.

During the reporting period, EMHS' Innovation Hub piloted an AVEM program at RPH. The pilot, led by Consultant Neurologists **Dr Jacqui-Lyn Saw**, **Dr Nicholas Lawn** and **Professor John Dunne**, has to date enrolled eight patients with unexplained paroxysmal neurological symptoms, requiring

prolonged EEG monitoring. AVEM was able to clarify symptoms and inform clinical management in six of eight patients, a proportion comparable to that obtained with vEEG.

This preliminary data indicates that home-based AVEM has the potential to transform the investigation and management of patients with paroxysmal neurological symptoms, with lower costs and improved patient convenience.

Information technology given end-user focus

As part of the **EMHS Digital Strategy**, improving the end-user computing (EUC) experience for staff and patients continued to be an important focus for EMHS during the reporting period.

As part of its EUC program, EMHS has been working on initiatives that will not only make accessing and navigating applications easier, but also possible from anywhere, at any time and from one or more devices.

Workstation on Wheels (WoW) and **Desktop Device Refresh** were two initiatives of the EUC program that made a real difference to EMHS activity in 2021-22.

WoW is a practical initiative that has enhanced the delivery of care on our wards. Doctors, for example, without having to leave the patient's bedside, are able to look up results in real time, or discuss x-ray results more easily.

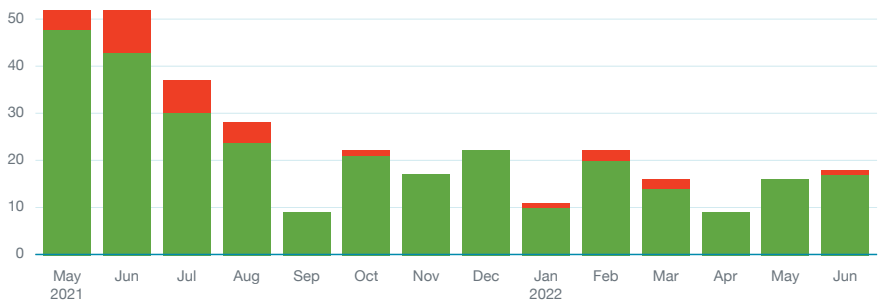
At KH, WoWs have enabled social workers and patients to attend National Disability Insurance Scheme (NDIS) meetings together from the patients' bedside.

The Desktop Device Refresh involved the replacement of more than **1000** desktop and laptop computers, most of which were more than seven years old and running outdated software.

The newer devices and applications have improved workflow and security by providing staff with access to virtual desktops (which enabled them to work from home) while products such as MS Teams enabled them to collaborate safely during the COVID-19 emergency. Enhanced authentication features also reduced the risk of non-authorised access to restricted information.

Dr Andrew Hart (Consultant Palliative Care Physician) with a WoW

Complete digital workspace failure by volume



This graph shows the downward trend in device failures, attributed to the replacement of older desktop machines.

Virtual getaways prove treat for patients

Palliative care patients at KH got the chance to escape their hospital rooms for a while — without needing to move an inch.

As part of a **virtual reality** (VR) trial exploring how VR technology could improve quality of life, the patients donned special headsets, where they had the chance to travel back to their hometowns or tick off bucket list items and final wishes.

The project's lead, Senior Occupational Therapist Karina Bowden, learnt of the technology at a conference, where the idea was promoted as an innovative way to increase patients' quality of life while in hospital.

Feedback from the patients was positive with all saying how nice it was to escape from their rooms and experience the natural world for a while.

"Globally there isn't much research about the benefit it could have for patients, but we've seen it successfully used in places like the United Kingdom during COVID as a way for patients to connect with and see their loved ones," Karina said.

Continuing to deliver safe and high-quality care

Learning from clinical incidents

EMHS is very proud of the significant improvements we continue to make in providing safe and high-quality care for our patients and consumers. This is our number one priority.

It is recognised, however, that in such a complex and challenging industry, sometimes things can go wrong. We are committed to providing an open and transparent environment that includes supporting staff to report incidents in the event that something does not go according to plan.

During 2021-22, there were **141,793** patient admissions to EMHS hospitals. In addition, **213,508** patients were seen in our EDs and another **716,000** patients were seen in an outpatient clinic or setting.

As a testament to our professional and skilled workforce, the overwhelming majority of these interactions occurred without incident. However, for a very small percentage of patients, errors did regrettably occur during their care — and in some cases, these errors resulted in unintended harm.

In the interests of transparency, we are sharing the number of serious clinical incidents that occurred in 2021-22 at our hospitals and health services.

Every incident provides a critical learning opportunity that enables us to put in place strategies to prevent others from being harmed.

During 2021-22, there were **109** clinical incidents reported with a Severity Assessment Code (SAC) rating of 1 (SAC1). A SAC1 incident is a clinical incident that has, or could have, caused serious harm or death, and which is attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.

The number of SAC1 incidents is reflective of a strong culture of reporting. The most reported types of incidents include; infection control, mental health and patient accidents/falls incidents. All SAC1 clinical incidents are subject to a rigorous investigation with the reports being reviewed by members of the EMHS Executive, as well as the EMHS Board Safety and Quality Committee.

Morbidity and mortality (M&M) review is a forum for clinicians to openly and transparently discuss the quality of care provided to patients who have died or experienced significant morbidity while under the care of a health service. The EMHS has continued to mature and strengthen its M&M review processes. M&M review is an essential component of an integrated approach to identifying clinical incidents, opportunities for quality improvement and organisational learning through peer review.

EMHS has implemented a number of other initiatives to reduce the number and severity of SAC1 incidents.

EMHS established a **Reducing Falls with Harm Improvement Group** to review and discuss patient falls in health care. EMHS sites shared current strategies in the prevention of harm from falls, including minimisation plans based on best practice and evidence to improve patient outcomes. The review of previous falls SAC1 recommendations was shared across EMHS, enabling sites to learn from past incidents.

In 2021-22, EMHS introduced **paediatric sepsis pathways** across sites with paediatric services, resulting in an evidence-based and consistent approach to the identification and management of sepsis in the paediatric setting. Further implementation of inpatient adult sepsis pathways is also occurring.

EMHS participates in healthcare associated infection (HAIs) surveillance programs including the monitoring of hospital acquired blood stream infections (HABSI), enabling review of current

practice. EMHS has created an HABSI action plan to reduce HAIs to ensure practice improvement and better patient outcomes.

EMHS has implemented the **Care Coordination in Mental Health Framework** project, which revised and implemented a mental health framework of care and pathways to support consumers in a recovery orientated approach. A key aspect of the Care Coordination Framework aims to support consumers from point of entry or re-entry to discharge, to ensure there is a seamless transition from mental health services to the next point of care during this higher-risk period.

Of the **109** serious incidents reported in 2021-22, the patient outcome[1] was noted as:

- **7** no harm
- **73** serious harm
- **2** minor harm
- **17** death
- **10** moderate harm

Learnings from a serious clinical incident

Situation

A patient with cognitive abilities was admitted for a surgical procedure following a recent fall. Upon admission multiple carers and family members were recorded within the patient demographic information system. However, the patient's official state-appointed guardian was not included as next of kin.

Following the procedure and subsequent discharge from the hospital, the patient developed an infection of the surgical site requiring further healthcare intervention.

A lack of effective and clear patient information may have led to a missed opportunity for the patient and/or their official guardian to recognise and seek earlier assistance for symptoms of a surgical site infection.

Recommendation

The service (in conjunction with the Diversity and High-Risk Working Group) will develop a patient information leaflet (or similar) which outlines the risks of infection and advises patients on what to do if signs of infection develop post-discharge. This leaflet will cater to differing levels of health literacy.

Result

The outcome will be empowerment of patients to recognise and seek earlier assistance for symptoms of a surgical site infection, which may enable earlier treatment if infection is present.

[1]The outcome does not necessarily arise as a direct cause of the incident. Factors other than healthcare-related may have contributed to the patient's outcome.

New era of medication management on horizon

Plans to modernise the management of medications across EMHS moved a step closer to fruition in 2021-22.

It comes after an international medical software solutions company, with offices in Perth, was awarded a contract to design, build and commission EMHS' **Electronic Medication Management solution** (EMMs).

The successful vendor was announced in June 2022 following a competitive tender process.

The new system will be customised to support the management of controlled substances and other high-risk medications across all EMHS sites, replacing current paper-based recordkeeping systems to enhance safety, efficiency, oversight, and accountability.

Staff across our hospitals can expect to spend less time looking for medications and performing controlled substance transactions and discrepancy investigations once the new system is in place.

L-R: Yang Lui, Sandra Miller, Bronagh Rice and Simon Scholes (EMHS Electronic Medication Management solution Team)

The system should improve patient safety by enhancing medication workflows. Other benefits of the EMMs will be automatic imprest ordering, improved inventory control and reduced wastage.

The new system is expected to be ready for implementation by late 2022.

Sustainable Health Review

Since the April 2019 release of the **Sustainable Health Review** (SHR) report, the DoH and HSPs have been progressing this ambitious reform agenda to create a modern healthcare system that includes actions to address prevention, brings care closer to home, and delivers equity in health outcomes. EMHS has prioritised seven SHR recommendations, in line with current EMHS strategic priorities.

Recommendation 2a

Halt the rise in obesity in WA by July 2024 and have the highest percentage of population with a healthy weight of all states in Australia by July 2029

Recommendation 3a

Reduce inequity in health outcomes and access to care with a focus on Aboriginal people and families in line with the WA Aboriginal Health and Wellbeing Framework 2015-30

Recommendation 5

Reduce the health system's environmental footprint and ensure mitigation and adaption strategies are in place to respond to the health impacts and risks of climate change. Set ongoing targets and measures aligned with the established national and international goals

Recommendation 11a

Improve timely access to outpatient services through moving routine, non-urgent and less complex specialist outpatient services out of hospital settings in partnership with primary care

Recommendation 11b

Improve timely access to outpatient services through requiring all metropolitan HSPs to progressively provide telehealth consultations for 65% of outpatient services for country patients by July 2022

Recommendation 13

Implement models of care in the community for groups of people who are frequent presenters to hospital

Recommendation 14

Transform the approach to caring for older people by implementing models of care to support independence at home and other appropriate settings, in partnership with consumers, providers, primary care and the Commonwealth

Recommendation 23

Build a system-wide culture of courage, innovation and accountability that builds on the existing pride, compassion and professionalism of staff to support collaboration for change

A snapshot of our work to support the SHR

Recommendation 2a

EMHS progressed **28** actions in the **EMHS Obesity Prevention Strategy 2020-25** (strategy), which included:

- advanced **Massive Open Online Courses** (MOOCs) to upskill health professionals in nutrition communication skills
- contributed to the multi-agency Fair Food WA collaboration, which was awarded the Moore Australia (WA) gold award for **Best Practice in Collaboration Between Government and Any Other Organisation** at the 2021 IPAA awards
- developed and released **Shift: A guide for media and communications professionals** — to change the way we talk about weight and reduce stigma.

Recommendation 3a

Initiatives to increase the number of Aboriginal people employed within EMHS were implemented, resulting in a workforce that is reflective of the Aboriginal population within the EMHS catchment area. This included:

- appointment to a new Equity, Diversity and Inclusion role within the EMHS People and Capability Team
- identifying tools, resources and pathways for Aboriginal people to build a support network for jobseekers and applicants
- developing resources for managers to assist and guide their understanding regarding Aboriginal employment.

Recommendation 5

In an effort to reduce our environmental footprint, EMHS' focus throughout the year has been the development of the **EMHS Sustainability Plan**, which prioritises initiatives focused on waste separation and management.

Recommendation 11a

EMHS' Outpatient Reform Program 2020-25 (OPR) is designed to transform the patient journey by making the system easier to navigate. An EMHS Outpatient 2030 forum in 2021 resulted in the development of an **Outpatient Future 2030 Roadmap** to guide EMHS priorities.

Patient experience and access, new models of care, collaboration, and workforce engagement were priorities for the OPR program in 2021-22.

Recommendation 11b

EMHS continued to implement the **EMHS Telehealth Plan 2020-22**, which aims to improve access to specialist care closer to home and improve care coordination and collaboration between health professionals and patients in WA. COVID-19 has accelerated this work and virtual care uptake increased significantly in 2021-22.

Recommendation 13

As the WA Health system-wide response lead for this recommendation, this year EMHS progressed extensive analysis and broad consultation with stakeholders — with a focus on patients with Chronic Heart Failure (CHF) or Chronic Obstructive Pulmonary Disease (COPD). This has brought together a suite of key themes and recommendations, which could help to reduce avoidable hospital presentations for people with chronic conditions.

Recommendation 14

In 2021-22, EMHS commenced implementation of several initiatives from the **EMHS Health Care of the Older Adult Service Model**, aimed at improving and optimising health pathways and integration of care for our older adult community.

Recommendation 23

Through this recommendation, EMHS aims to develop great leaders with the capability and behaviours to lead engaged and productive teams. The **EMHS Leadership Development Framework** guides a significant program of work, which prioritises coaching and supporting our leaders, including the **Leadership and Management Program**, **Leading People and Performance Education Framework** (conversation series), **Talent Management Program** and the **Change Management/ Project Management Mentoring Program**.

Innovation and research

2021-22 innovation snapshot

17 innovation events and hackathons with **325** attendees

175 EMHS staff registrations for the online **COVIDEAS** challenge in 2021-22

7 innovation projects commenced. Several ideas from the inaugural ideas challenge in 2020-21 were funded and have commenced as projects in 2021-22, including the **Plastic Surgery Virtual Hand Injury Clinic**, the **Ambulatory Video EEG Monitoring Project** (see page 57) and **virtual reality in palliative care** (see page 59).

97 students engaged in youth health innovation consultation via the **Youth Innovation Think Tank** event, **HabitHack** project and **Byford Health Hub Youth Hackathon** (see page 182), to co-design innovative solutions to real-world health challenges being addressed by EMHS

10 submissions for innovation grants. The EMHS Innovation Team supported EMHS staff to develop innovative applications for grant opportunities in 2021-22 from the **WA Health Future Health and Research Innovation Fund**

40 Innovation Champions alumni. Innovation Champions programs aim to encourage problem re-framing, human-centred design thinking and behavioural insights

2021-22 research snapshot

In 2021-22, there has been a **20%** increase in research projects, largely due to a **30%** increase in clinical trials and a **58%** increase in studies conducted with national collaborative research groups.

120 new research projects

37 investigator-initiated projects conducted by local staff and sites within WA Health

19 projects conducted in collaboration with not-for-profit organisations and institutions

47 clinical trials commenced

17 projects conducted in collaboration with WA universities

Researcher highlights need to raise bar on stillbirth data

Quality research plays a vital role in advancing patient care — and quality research relies on quality data.

In November 2021, research led by AHS Head of Obstetrics and Gynaecology **Dr Sangeeta Malla Bhat** highlighted a failure among high-income countries to pursue data on stillbirths in minority ethnic populations.

The consultant obstetrician also found that lack of a standardised approach to classifying stillbirth could be undermining efforts to better understand factors that impacted stillbirth rates.

Dr Malla Bhat had set out to investigate ethnic variation in causes of stillbirth in high-income countries through a systematic review of relevant scientific literature.

“The more we understand about the influence of ethnicity on stillbirth, the better we can care for women during pregnancy,” she explained.

But in her paper, published in the **International Journal of Gynaecology & Obstetrics**, Dr Malla Bhat concluded that even among high-income nations, there was a lack of high-quality information on the causes of stillbirth in many ethnicities.

Dr Malla Bhat’s paper also noted the wide variation in how stillbirth was defined, even between countries and reputable bodies such as the WHO and Perinatal Society of Australia and New Zealand.

She said a standardised definition would be needed to assess whether the causes of stillbirth differed across ethnic groups.

Following these findings, Dr Malla Bhat is planning to undertake a retrospective analysis of stillbirths at AHS over the past 10 years. She hoped that confining her focus to a single health service may help identify any patterns linking stillbirth to ethnicity.

EMHS getting to the heart of chest pain

Cardiology has blazed new trails during 2021-22. At RPH, the introduction of two specialised invasive investigations of coronary circulation has paved the way for enhanced diagnosis and care of patients experiencing previously unexplained chest pain.

It makes RPH the first — and currently only — hospital in WA to offer these tests, which are performed in a systematic way as an extension of the standard invasive coronary angiogram — a procedure used to detect significant coronary artery disease and restrictions in coronary arteries that carry blood to the heart muscle.

One of the new tests measures resistance within the microcirculation (the network of tiny vessels responsible for supplying oxygenated blood to the heart muscle cells, which are too small to be seen on conventional coronary angiography yet make up 90% of the overall coronary circulation), which may suggest structural microvascular disease. The other test — acetylcholine provocation — may reveal vasomotor disorders (such as coronary artery vasospasm).

The addition of these studies to the suite of tests already available through RPH, represents a significant expansion of the hospital's coronary physiology program and provides fresh hope for patients with unresolved and troublesome anginal symptoms.

It also offers exciting research opportunities, which the RPH team has capitalised on, by becoming the first in the world to recruit patients into two pioneering multicentre research studies within the field of coronary physiology.

RPH Interventional Cardiology Consultant **Dr Jon Spiro**, who has driven the establishment of this testing in WA, said many of these patients would go from doctor to doctor and incur significant expense in their quest for answers.

"In the meantime, their health, work, relationships and life in general will suffer," he said.

"To be able to provide a physiological cause for these patients' previously unexplained anginal symptoms can have profound benefits for them, including enhanced symptom management, improved lifestyle choices and better engagement in their own healthcare."

Hon Roger Cook MLA and Sandra Miller with Dr Jon Spiro and members of the RPBG Cardiology team

Pilot to test value of early warning system for brain injury

Every year about 100 Western Australians are admitted to an ICU to be treated for a traumatic brain injury (TBI). Sadly, only about half of these patients will return to a functioning or semi-functioning life.

But RPH Director of Intensive Care Research **Dr Robert McNamara** hopes he can improve the outcome for these patients.

He is leading world-first research that is trialling the use of machine learning — a form of artificial intelligence — to predict when a patient is likely to experience a rise in intracranial pressure.

This pressure is a serious complication of TBI which, if not alleviated rapidly, causes further damage, leading to worsening of the patient's injury. In severe cases, rises in intracranial pressure can reduce blood flow to the brain and cause permanent damage or death.

"The problem we face in treating these rises is that we're only putting out fires — not preventing them," Dr McNamara explains.

His project is piloting machine-learning algorithms — developed within WA Health — that can sound the alarm on these rises **up to 30 minutes before they occur**, giving ICU staff the chance to get on the front foot in treating the patient.

Significantly, the algorithms learn as they go and are adaptive to the individual patient. The algorithms being used in the project were developed by Shiv Meka, a data scientist who works with the EMHS' HIVE.

They work by looking for patterns in large volumes of real-time data, captured by monitors at the patient's bedside. The captured data includes intracranial pressure, temperature, oxygen saturation levels, blood pressure, heart rate and respiratory rate.

Dr McNamara's project will determine whether TBI patients randomly assigned to receive monitoring from these algorithms, have better outcomes than those assigned to care as usual.

The pilot will also run in other trauma ICUs across Australia in 2023.

The Pawsey Supercomputing Centre in Kensington was instrumental in the algorithms' development, providing the computing power needed to process the vast volumes of early data.

More than half of TBI patients sustain their injury in a traffic accident, about 20% on the sporting field, and between 10 and 15% during an assault.

Young people are disproportionately affected by TBIs which — in addition to the enormous human toll — cost Australian society an estimated $8-10 billion annually.

EMHS infrastructure - investing for our patients' care

Heliport heralds new era in rescues

The opening of RPH's new $10 million **heliport** in May 2022 ushered in a new era of access to care for critically injured and sick patients across WA.

As home to the State's Major Trauma Unit and Spinal Service, RPH receives about **300** patients per year by helicopter.

The heliport features a **788 square metre** elevated deck — **49m above ground** — and link-bridge connected to an inpatient reception area.

Unlike the helipad it replaces, the new landing facility can support the arrival of larger next-generation helicopters, which are expected to be in service and assisting WA communities by late 2023.

These aircraft feature enhanced technology and have greater range and speed than earlier models. They will enable patients to be airlifted faster and from more distant locations than previously possible.

The new heliport was needed to meet Civil Aviation Safety Authority regulations and is capable of accommodating aircraft such as Blackhawk and Seahawk helicopters, should they be required in a state emergency. On 26 April 2022, a Blackhawk helicopter performed a test landing on the new heliport ahead of its opening.

The landing captured the imagination of staff who were eager to catch a glimpse of the spectacular one-off event.

The new heliport was officially launched on 26 May 2022 by Health Minister Amber-Jade Sanderson (MLA) and Emergency Services Minister Stephen Dawson (MLC).

New ward helping to keep patients on the move

Ensuring patients have access to the care they need, when they need it, is a challenging goal but one for which EMHS continually strives.

The opening of Ward 1 — a slow-stream rehabilitation ward at BHS in March 2022 — was an important development that is playing a key role supporting patient flow through RPBG.

By providing appropriate rehabilitative support for patients who no longer require acute inpatient — or intensive specialist rehabilitation — care, Ward 1 helps free up beds at RPH.

While the 15-bed ward caters for patients nearing the end of their RPBG admission, it continues to support their rehabilitation, focusing on functional independence and maintaining improvements already made.

In the pipeline

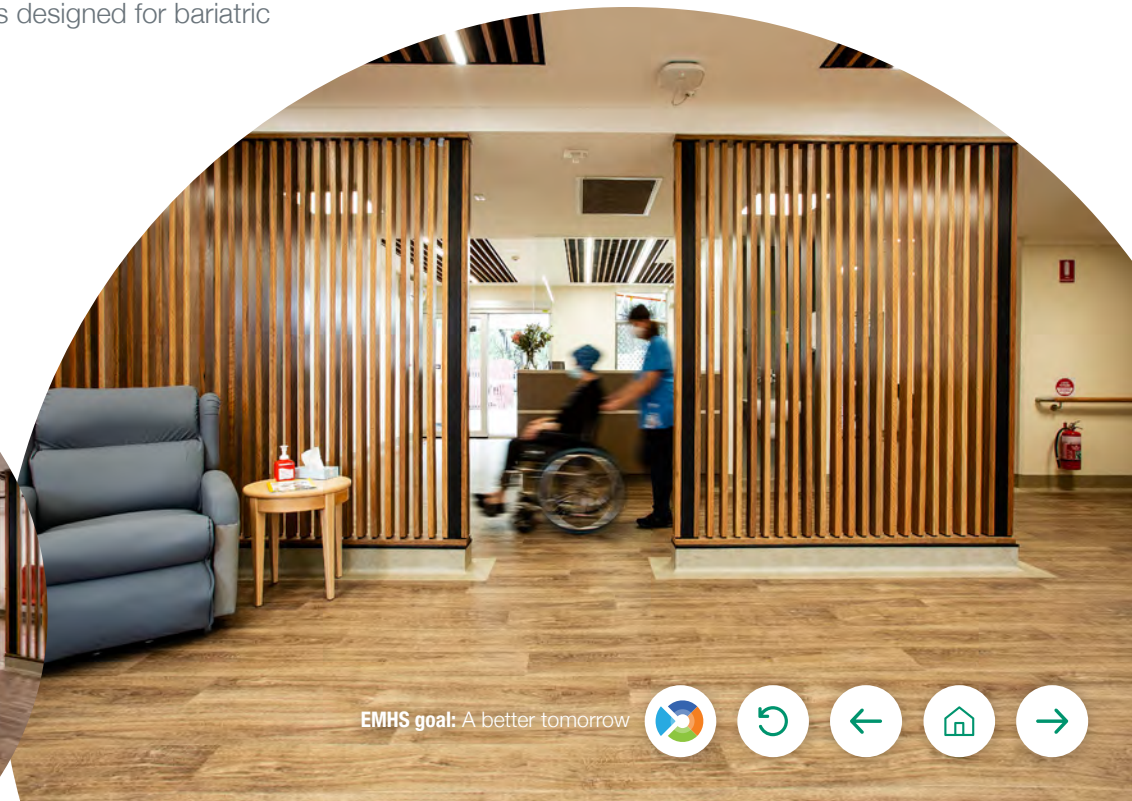
A major redevelopment of KH is set to significantly enhance the patient experience for those receiving care at the facility for life-limiting illnesses.

In May 2022, builders turned the first sod on the $9.5 million project that will transform the hospital to include:

- a refurbished wing to provide a new **Day Hospice** with fit-for-purpose therapy rooms, a dedicated entrance, waiting rooms and a social room
- upgraded rooms and ensuites in the inpatient unit
- two rooms with facilities designed for bariatric patients
- a redeveloped family room, for families to stay overnight, which also includes a hydrotherapy bath
- enhanced landscaping and improved access to outdoor spaces.

KH has been an important part of the local community since 1973 and is EMHS' specialty palliative care inpatient service.

The works will position KH as a centre of palliative care excellence, and improve the environment for both patients and their loved ones.



Kalamunda Hospital
Day Hospice

RPH's new Intensive Care Unit

In March 2022, RPH opened a new **24-bed ICU**.

The unit became the fourth ICU to be built at EMHS' tertiary hospital (its first was built in 1966) and was designed to accommodate the sickest of our patients.

The development of the new facility was a departure from the initial plan to refurbish the hospital's existing ICU.

The resultant space was more than one and a half times the size of its forerunner — **2550sqm** versus 1800sqm — and includes:

- a positive pressure room
- four negative pressure rooms
- two dedicated bariatric rooms
- a dedicated simulation training room to support the ongoing development and education of the ICU workforce
- a private room to support family and friends during some of the most difficult times.

The design also facilitated frequent air changes throughout, separate patient rooms fitted with switch glass windows, and a ventilation system that enables the safe accommodation of both COVID and non-COVID patients.

To improve clinician access to patients for procedures — and enable easy reconfiguration of rooms — ceiling-mounted pendants were installed that were both movable and equipped with power, oxygen, suction, a patient monitor, storage for airway equipment and emergency call buttons.

A circadian lighting system to assist in the management of patients at risk of experiencing delirium is another special feature of the unit. It works by mimicking natural lighting rhythms to help patients gauge the time of day.

The new unit was also wi-fi enabled and equipped with a Clinical Information System to support improved patient care through enhanced management of clinical information.

Natural light floods the unit during the day, enhancing the environment for staff and patients.

Brightly coloured artworks which depict the six seasons of the Noongar calendar adorn the unit. These were fabricated in a special glass to enable easy cleaning and compliance with strict ICU infection prevention and control standards.

EMHS puts nurses on fast-track to ICU

A critical shortage of ICU nurses and an expected surge in COVID cases forced EMHS to become creative in boosting its ICU nursing workforce.

It developed an intensive **Accelerated Training Program** (ATP) that gave registered nurses the chance to fast-track careers into ICU nursing, irrespective of their previous work experience.

The ATP launched at the end of 2021 and by the close of 2021-22, it had boosted EMHS' ICU nursing contingent by **50.32 FTE** — 44.32 at RPH and six at AHS. (At AHS, a further nine nurses from other wards and departments completed the training and were available for the ICU, as activity demand increased or permanent ICU FTE became available.)

The ATP is believed to be unique in Australia, in that it is designed to provide a long-term workforce solution to staff shortages, rather than a temporary short-term fix. Also novel, is that it is open to nurses with little or no experience of working in an ICU or other high acuity setting.

The program, which was developed by senior ICU staff and staff development nurses, provides two to three months of intense, supported training that includes ICU theory, simulation exercises and on-the-job training alongside experienced ICU nurses.

Nurses who complete the program emerge equipped and competent to care for ICU patients unsupervised, including being able to assist with intubation.

Intake of ICU nurses as part of the Accelerated Training Program

Unit boosts treatment options for complex mental health patients

In June 2022, EMHS opened a new **Mental Health Unit (MHU), Dabakarn**, at RPH — a major addition to EMHS' suite of mental health services.

Establishment of the unit significantly bolstered our capacity to treat patients with acute and complex mental illness, with capacity to accommodate up to 12 consumers in separate rooms.

Significantly, as RPH's first authorised ward, it can provide for the care of individuals under the *Mental Health Act 2014* requiring a locked-ward bed, as well as voluntary patients.

Dabakarn's focus on recovery-oriented care in an involuntary setting strengthens the integrated consumer recovery journey across EMHS. The unit will also play an important role in alleviating pressure on RPH's ED by assisting patient flow.

Mental Health Unit, Dabakarn

New Bentley modular ward taking shape

A new 30-bed modular ward is starting to take shape at BHS, which is part of a 2021 State Government commitment to increase bed capacity across WA's public health system.

The building is made up of three pods — administration, inpatient and therapy pods — the latter incorporating a gymnasium, dining room and group therapy area.

A lightweight construction technique has been used for the build to expedite the project, which will build capacity at BHS and help free up tertiary beds at RPH for patients requiring more acute care.

The new pods are expected to be finished by mid to late September 2022.

Significant issues

Violence and aggression

Ensuring the safety of our workforce remained a key priority for EMHS throughout 2021-22.

While COVID screening stations established at entry points to our hospitals — enabling compliance with state-wide public health measures — quelled transient antisocial behaviour along our main thoroughfares, data captured over 2021-22 showed that overall incidents of violence and aggression were trending higher than in previous years.

8235 code black/aggressive incidents
7447 in 2020-21 ▲

This placed a huge demand on security services and impacted other frontline staff across EMHS.

EMHS strategies to improve results

The **EMHS Stop the Violence Committee** and site sub-committees have multidisciplinary membership, and through monitoring and review of hazard and incident reports, aggression risk assessments, security department activity and annual staff surveys, develop action plans to help eliminate or minimise the risk to workers from harm as a result of aggression and violence in the workplace.

Actions to reduce the risk of harm include:

- increased CCTV coverage
- improvements to the security of car parks
- access and egress controls
- upgrades to duress systems
- implementation of a security officer intentional rounding program in high-risk areas
- ongoing engagement with stakeholders, both internal and external, such as WA Police, Perth Transport Authority and local councils.

In addition to the Employee Assistance Program and peer support officers, EMHS has in-house staff wellbeing programs that support both individuals and work areas to manage psychological hazards and respond to incidents in the workplace.

Future actions

Input from the staff survey and site Stop the Violence committees helped shape the **Stop the Violence Action Plan** for 2022, which was released towards the end of the current reporting period.

The plan builds on work undertaken over the previous two years and will provide tangible actions to help create a safer workplace for EMHS staff.

Patrols prove an all-round success

Hospital rounding by security personnel was rolled out across EMHS sites. The rounding provides a reassuring presence for staff and a deterrence for potential aggressors.

This intelligence-led initiative has a particular focus on wards accommodating patients with a known history of violence and aggression. The rounding also targets areas of the hospital that attract antisocial behaviour.

Staff have reacted extremely positively to the rounding and increased security presence, which aims to reduce and manage incidents of violence and aggression against staff.

Fatigue

Workforce fatigue has been a significant issue for EMHS since the start of the pandemic.

Fatigue continued to test staff during 2021–22, particularly those working in frontline clinical areas.

Absences caused by staff members contracting COVID-19, furloughing to comply with the State's strict close-contact measures or having to stay home to care for isolating family members, further stretched our depleted ranks.

Many clinical staff were deployed to COVID response programs such as the COVID clinics, vaccination clinics and fit-testing teams.

Meanwhile staff were having to devote more time to COVID infection prevention and control measures.

An increase in personal leave and COVID leave during the reporting period was a likely reflection of the increased demands on our staff during the year.

A range of resources was made available to employees across EMHS to support them during this challenging period, including free counselling sessions through the Employee Assistance Program, a range of wellness resources and — at RPBG — access to 24/7 support through the Centre for Wellbeing and Sustainable Practice.

App puts wellbeing control in hands of staff

In September 2021, all AKG staff were given access to the **Well-Being Index app** — an anonymous web-based application that gives users the ability to monitor their own levels of fatigue, as well as instantly access tools and resources that can help prevent burnout, such as helpline numbers, self-help videos and pre-loaded publications.

The app was developed in the United States, specifically for healthcare workers and has been adopted widely by healthcare organisations there and here in Australia.

AKG wanted to empower staff to take ownership of their own mental wellbeing and provide them with tools that would predict their risk of fatigue, depression, burnout, anxiety/stress, reduced mental/physical quality of life, and poor work-life balance.

The app enabled staff to compare their levels of wellbeing and fatigue with those of their peers nationally, as well as monitor changes in their personal level of wellbeing over time.

Feedback from the **125** staff members who signed up to the app had been positive, with many reporting it useful for tracking their wellbeing.

COVID-19

For much of 2021-22, EMHS' focus was on ensuring COVID readiness across our hospital sites.

Vaccinations, fit testing and PPE requirements were key priorities for staff preparations, while establishing thorough screening processes were central to EMHS' overall efforts.

In readiness for the expected influx of COVID patients, frontline preparations were made with staff uplift in identified areas of need, and COVID Navigators and Leads were initiated. Wards were also reconfigured and, at RPH, a dedicated COVID ward was created.

COVID had a significant impact on our workforce with staff absences, due not just to staff who had contracted the virus, but also those forced to furlough due to close-contact requirements or care for isolating family members, particularly children.

A surge in staff absences placed significant pressure on our workforce, most of whom were already fatigued. A **Workforce Availability Register** and dashboard of staff suitable for voluntary deployment to other areas — if and when required — assisted during the surges.

Workforce wellbeing remained a key priority for EMHS throughout the year and development of a **Staff wellbeing during COVID and beyond** toolkit for managers was one of many initiatives designed to support staff during these challenging times.

COVID-19 Public Hospital Visitor Guidelines were released in line with **WA Health's COVID-19 Framework for System Alert and Response** (SAR). All EMHS sites implemented the principles, which included the introduction of restricted access at hospital entry points.

The visitor screening process involved verifying vaccination status and ensuring no current symptoms or presence of COVID infection. In line with the SAR, the process later evolved to include RATs of all visitors and patients visiting high-risk areas.

During 2021-22, EMHS cared for:

51 COVID patients in ICU

15 COVID patients on ventilators

COVID clean helps spark joy

EMHS prepared for COVID on many fronts. At RPH, efforts were made to reduce the potential for COVID transmission in clinical areas caused by contact with contaminated surfaces.

The **COVID Lean and Clean** project involved determining what was going and what was staying — including items requiring more suitable accommodation.

The project ended up doing more than just reducing fomite and other occupational health and safety risks.

Wards were tidied, areas once used as dumping grounds for broken and damaged items were transformed into open, safe and functional spaces, and salvageable but unwanted items were distributed to grateful charities and organisations.

High-back chairs, recliners, crockery and nappies and sanitary products were among an assortment of items donated to Anglicare, while Australian Doctors for Africa accepted a consignment of surplus-to-needs stretcher beds.

Perth Zoo welcomed a big quantity of sharps bins, which could no longer be used by the hospital and the Southern Cross Men's Shed was pleased to take possession of a metal lathe and cricket equipment.

Meanwhile, a glass desiccator joined RPH's museum collection, while Curtin University re-housed an assortment of anatomical specimens.

Lesli Burns (Senior Project Officer COVID Operations)

Demand

Patients seeking hospital care have the best chance of making a good recovery if they receive the right care within clinically recommended timeframes.

Delays in care beyond these timeframes increase the patient's risk of a poor, or even harmful, outcome. That is why EMHS hospitals – like all healthcare facilities – strive to meet these targets. The WA Emergency Access Target — **WEAT** — and WA Elective Services Target — **WEST** — are two measures used to gauge the performance of our hospitals in meeting this goal.

To meet our WEAT, 90% of patients who present to our EDs must be seen and either admitted, transferred or discharged within four hours of arrival.

WEST highlights the percentage of patients on EMHS elective surgery waitlists who are over-boundary — in other words — who have not been treated within the designated clinically appropriate timeframe.

Elective surgery

Elective services patients are prioritised based on their assigned clinical urgency category:

- **Category 1** — clinically indicated within 30 days
- **Category 2** — clinically indicated within 90 days
- **Category 3** — clinically indicated within 365 days.

Restrictions imposed on elective surgery at the start of 2022 due to COVID impacted progress EMHS had made on reducing elective surgery waitlists. These pre-restriction initiatives had started to make significant inroads, including an 85% cut in over-boundary endoscopy cases between July and December 2021. Cancellation of all Category 3 procedures and less urgent Category 2 procedures set back this progress. This was compounded by patients and staff also being impacted by COVID.

Since the lifting of all restrictions towards the end of the reporting period, EMHS staff have been working hard to implement both short and long-term strategies to regain lost ground (see KPI page 88).

Emergency access

Emergency access and demand continued to stretch our services in 2021-22. This was due in part to the impact of COVID on staffing levels, not just from staff who were ill themselves, but also staff who were required to furlough or care for isolating family members. On occasions, lack of staff led to bed or ward closures, further impacting patient flow and emergency access.

Percentage of patients seen within recommended times – performance indicator

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

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

ATS category targets are outlined below:

Triage category	Treatment acuity (maximum waiting time for medical assessment and treatment)	Target (threshold)
1	Immediate (≤ 2 minutes)	100%
2	≤ 10 minutes	80%
3	≤ 30 minutes	75%
4	≤ 60 minutes	70%
5	≤ 120 minutes	70%

These recommended times and categories are used both locally by WA Health and nationally by the Department of Health and Ageing, and the Australian Institute of Health and Welfare.

2021-22 triage results

Triage category 1:

YEAR	TARGET	ACTUAL
2021-22	100%	99.6%
2020-21	100%	100%
2019-20	100%	99.8%

Triage category 2:

YEAR	TARGET	ACTUAL
2021-22	80.0%	68.0%
2020-21	80.0%	79.2%
2019-20	80.0%	84.0%

Triage category 3:

YEAR	TARGET	ACTUAL
2021-22	75.0%	18.8%
2020-21	75.0%	31.0%
2019-20	75.0%	43.0%

Triage category 4:

YEAR	TARGET	ACTUAL
2021-22	70.0%	41.5%
2020-21	70.0%	51.5%
2019-20	70.0%	63.6%

Triage category 5:

YEAR	TARGET	ACTUAL
2021-22	70.0%	78.1%
2020-21	70.0%	83.8%
2019-20	70.0%	89.8%

Period: 2019-20 to 2021-22 financial years

Contributing sites: Armadale Health Service, Royal Perth Hospital, St John of God Midland Public Hospital

Data source: Emergency Department Data Collection

EMHS performance against the ATS has declined in 2021-22 for all triage categories (with most notable decline in triage categories two, three and four).

This has been significantly impacted by a sustained increase in demand, with **213,508** ED presentations in 2021-22 compared with 204,989 in 2019-20, as well as increased complexity and acuity of patients attending across EMHS sites.

EMHS has established the **Emergency Access Program** (EAP), which aims to improve emergency access through focused initiatives across EMHS sites. It is intended to drive site-based and system-wide change, aimed at reducing pressure on EDs and improving timely access to care for patients requiring emergency services.

Midland's Geriatric ED Team

To improve performance, during 2021-22 EMHS has continued its focus on three key areas:

- **timely transfer of care** — emergency ambulance transfer of care within 30 minutes of arrival
- **discharge WEAT** — timely discharge of patients from the ED
- **ED patient flow to wards** — timely transfer of a patient from ED to the wards.

Site strategies to improve WEAT performance

Key initiatives within the EAP include the **Comprehensive Ambulatory Older Adult Program** (CAOAP), which aims to streamline access for older adult patients. The CAOAP comprises projects across sites including:

- The **Ambulatory Frailty Unit** at RPH has been established and provides a multi-purpose area for acute care and assessments, and enables pathways for direct admission. The unit has been successful in preventing multi-day admissions by providing comprehensive same-day care.
- At Midland, the multidisciplinary **Geriatric ED team's** objective is to avoid hospital admission or re-admission by providing rapid and targeted assessment and interventions based on the goals of patient care. The team provides early comprehensive multidisciplinary assessment and management of the frail older person presenting from the community and RACF.
- The **Individualised Home Support Service** (IHS) at RPH works closely with the Ambulatory Unit and provides rapid allied health and non-clinical support (personal care and home assistance services) in the home to address social and reablement needs, and facilitates timely and safe discharge from hospital. Primary focus remains on discharging patients from hospital or ED as soon as they are medically stable and assessing their ongoing needs at home through a dedicated nursing, allied health and non-clinical support team.
- The **Community Health In a Virtual Environment (Co-HIVE)** pilot has delivered remote monitoring of residents across two Residential Aged Care Facilities (RACFs) to provide proactive geriatric in-reach to consumers, either initiated by RACF nursing staff or through clinical discussion with the Co-HIVE team at RPH.
- AHS has facilitated patient flow and hospital avoidance by implementing a **Frailty Pathway** via the Older Adult Liaison Service, which optimises the patient journey in ED, inpatient and ambulatory settings.

Supports Sustainable Health Review (SHR) recommendation 14 (see page 63)

A number of infrastructure changes were also made to improve ED access and patient flow. RPH's ED was reconfigured, with the addition of two private consult rooms and three new treatment bays.

At AHS, completion of the ED upgrade incorporated a priority paediatric treatment area, waiting room, improved area for mental health patients, and enhanced spaces for ambulatory and respiratory assessments.

Mental health

The needs of people experiencing mental ill-health can vary greatly depending on their personal circumstances and the complexity and acuity of their condition.

While some may require a hospital admission, others may benefit from interventions provided by community mental healthcare services.

EMHS recognises the importance of providing a range of integrated services to meet the varying needs of patients and patient cohorts. It also understands that for consumers to gain maximum benefit from these services, the services must be well coordinated and work together for the benefit of the consumer.

EMHS mental health service provision includes:

- information, guidance and crisis response
- community-based non-admitted care
- admitted (inpatient) care
- residential and transitional care.

During 2021-22, EMHS launched several new mental health services and programs. Covering all forms of service provision — from information, guidance and crisis response, to residential and transitional care. We also catered to both general populations and specific consumer cohorts, such as young people and people experiencing — or at risk of — homelessness (see page 49-50).

In addition to these service developments, EMHS also strengthened our processes for coordinating care.

In March 2022, a proof of concept was completed for a virtual mental health service in collaboration with the EMHS Community Mental Health Services. This service, called **Co-HIVE**, seeks to remotely monitor the physiological and mental health of community-based consumers with depression, and intervene proactively to aid quicker and more complete recovery.

The service utilises wearable devices and mobile applications to support community consumers to proactively manage their mental healthcare at home, with the support of a virtual clinical workforce.

An evaluation of the proof of concept was undertaken and as a result, a larger pilot of the service will commence in 2022-23.

These developments saw EMHS continue to deliver on our commitment to recommendation 7 of the SHR, which calls for the **implementation of models of care for people to access responsive and connected mental health, alcohol and other drugs services in the most appropriate setting**.

Bidi Wungen Kaat Centre
(St James Transitional Care Unit)

Key performance indicators

Certification of Key Performance Indicators

East Metropolitan Health Service

Certification of Key Performance Indicators for the year ended 30 June 2022

We hereby certify that the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess East Metropolitan Health Service's performance and fairly represent the performance of the health service for the financial year ended 30 June 2022.

Ian Smith PSM
Board Chair
East Metropolitan Health Service
16 September 2022

Peter Forbes
Chair, Board Finance Committee
East Metropolitan Health Service
16 September 2022

Introduction

East Metropolitan Health Service (EMHS) expenditure and activity continued to be impacted by COVID-19 during the 2021-22 financial year, impacting the results related to efficiency Key Performance Indicators (KPIs) in particular.

As COVID infection rates have not abated, increased levels of expenditure continue to be experienced as EMHS must maintain staffing for the delivery of all admitted, emergency, non-admitted and mental health hospital services. Maintaining clinical safety and protocols continues to impact expenditure related to personal protective equipment (PPE) and increased costs in supply chains has flowed to increased expenditure for hospital supplies. Expenditure on staffing has increased, as EMHS addressed staff furlough and absences through agency, casual and backfill arrangements to maintain safe levels of staffing for clinical services and patient care. Population health activities for the wider EMHS catchment and community continued and increases in expenditure were primarily related to maintaining awareness of public health and hygiene standards within the wider community as it transitions into 'living with COVID'.

KPIs

Outcomes

KPIs assist EMHS to assess and monitor achievement of the following Department of Health (DoH) outcomes.

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

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

KPI data legend

Example KPI data

YEAR	TARGET	ACTUAL
2021-22	$000	$000
2020-21	$000	$000
2019-20	$000	$000

The latest available data has been used to report performance, which for some KPIs means the results are for the 2021 calendar year

Unplanned hospital readmissions for patients within 28 days for selected surgical procedures (per 1000 separations)

Rationale

Unplanned hospital readmissions may reflect less than optimal patient management and ineffective care pre-discharge, post-discharge and/or during the transition between acute and community-based care. These readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

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

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

Target

The 2021 targets for unplanned readmissions for each procedure (per 1000 separations) are outlined below. Improved or maintained performance is demonstrated by a result below or equal to target:

(a) knee replacement	≤ 23.0
(b) hip replacement	≤ 17.1
(c) tonsillectomy & adenoidectomy	≤ 81.8
(d) hysterectomy	≤ 42.3
(e) prostatectomy	≤ 36.1
(f) cataract surgery	≤ 1.1
(g) appendicectomy	≤ 25.7

Results

(a) Knee replacement:

YEAR	TARGET	ACTUAL
2021	23.0	15.4
2020	23.0	26.1
2019	26.2	28.3

(b) Hip replacement:

YEAR	TARGET	ACTUAL
2021	17.1	20.4
2020	17.1	18.1
2019	17.1	15.0

(c) Tonsillectomy & adenoidectomy:

YEAR	TARGET	ACTUAL
2021	81.8	138.7
2020	81.8	106.4
2019	61.0	120.0

(d) Hysterectomy:

YEAR	TARGET	ACTUAL
2021	**42.3**	**73.2**
2020	42.3	67.8
2019	41.3	33.9

(e) Prostatectomy:

YEAR	TARGET	ACTUAL
2021	**36.1**	**49.3**
2020	36.1	59.1
2019	38.8	14.9

(f) Cataract surgery:

YEAR	TARGET	ACTUAL
2021	**1.1**	**2.4**
2020	1.1	1.5
2019	1.1	3.0

(g) Appendicectomy:

YEAR	TARGET	ACTUAL
2021	**25.7**	**30.1**
2020	25.7	21.4
2019	25.7	28.7

Commentary

EMHS strives to provide safe, high-quality care to its patients at all times. When there is variation in care and outcomes, EMHS has established processes to ensure individual clinical case reviews are conducted. This has occurred for all unplanned hospital readmissions for system wide learnings and to identify service improvement opportunities.

Performance for unplanned readmissions following knee replacement achieved target in 2021. The result can, in part, be attributed to the implementation of several quality improvement actions within orthopaedics, such as improved clinical pathways and standard operating procedures.

Unplanned readmissions following hip replacement, hysterectomy and prostatectomy procedures have exceeded target across 2021. While these results represent very small case numbers, several quality improvement actions have been identified from individual case reviews to streamline existing care delivery. EMHS will continue to monitor performance of this indicator.

Performance for tonsillectomy and adenoidectomy is over target for the third year in a row. Peer review of all readmissions is conducted as part of the ear, nose and throat (ENT) morbidity and mortality review process and case review has demonstrated that patients are often managed conservatively, being readmitted as a precaution with minor post-operative bleeding. This is standard practice across health services.

Performance for cataract surgery is over target for the third year in a row. While rates continue to exceed the target, EMHS continues to undertake clinical case reviews to identify opportunities for improvement.

Readmissions following appendicectomy did not achieve target in 2021. The clinical case reviews of the episodes of readmissions noted a high degree of complexity with these individual cases but did not identify any significant trends or areas of clinical concern. EMHS will continue to monitor performance of this indicator.

Period:	2019 - 2021 calendar years
Contributing sites:	Armadale Health Service, Bentley Health Service, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital
Data source:	Hospital Morbidity Data Collection (HMDC); WA Data Linkage System

Percentage of elective wait list patients waiting over boundary for reportable procedures

Rationale

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

Elective surgical services delivered in the WA health system are those deemed to be clinically necessary. Excessive waiting times for these services can lead to deterioration of the patient's condition and/or quality of life, or even death. Waiting lists must be actively managed by hospitals to ensure fair and equitable access to limited services, and that all patients are treated within clinically appropriate timeframes.

Patients are prioritised based on their assigned clinical urgency category:

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

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

Target

The 2021-22 target for patients waiting over boundary for all urgency categories is 0%. A result equal to target is desired.

Results

Category 1:

YEAR	TARGET	ACTUAL
2021-22	**0%**	**6.5%**
2020-21	0%	19.6%
2019-20	0%	27.0%

Category 2:

YEAR	TARGET	ACTUAL
2021-22	**0%**	**28.3%**
2020-21	0%	27.7%
2019-20	0%	18.9%

Category 3:

YEAR	TARGET	ACTUAL
2021-22	**0%**	**9.3%**
2020-21	0%	8.6%
2019-20	0%	3.3%

Commentary

In 2021-22, EMHS endeavoured to meet the clinical waiting times recommended for the urgency categories.

The restrictions placed on hospital elective surgery waitlists during the year due to COVID-19, and together with the increasing emergency surgery demand, has greatly impacted the elective surgery waitlist over boundary initiatives across all urgency categories.

EMHS implemented several key initiatives to manage the elective surgery waitlist, that included:

- targeted activity increases to reduce the patients waiting for an endoscopy was achieved between July and December 2021. This reduced over boundary cases by 85% before the elective restrictions were put in place in the first half of 2022
- additional theatre lists across multiple specialties to reduce the over boundary waitlist
- all sites targeted patients waiting over boundary across all specialties and categories.

Managing timely access to elective surgery in 2021-22 continued as a focus across EMHS, with improved performance in timeframes for urgency category one. However, some specialties continue to have access challenges due to increases in emergency demand and workforce shortages.

To maintain a sustainable elective surgery waitlist, EMHS has implemented longer term strategies that include:

- continuation of individual specialty management plans to maintain the ongoing waitlist demand by managing the demand and over boundary cases
- recommencement of selective specialty procedures in accordance with the British Association of Day Surgery (BADS) suitable for day surgery and reduce multiday admissions
- targeting the efficiency of elective surgery theatre utilisation across sites.

Period:	2019-20 – 2021-22 financial years (average of weekly census data)
Contributing sites:	Armadale Health Service, Bentley Health Service, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital
Data source:	Elective Services Wait List Data Collection

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

Rationale

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

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

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

Target

The 2021 target for HA-SABSI is ≤1.0 per 10,000 occupied bed-days. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2021	**1.00**	**1.09**
2020	1.00	0.84
2019	1.00	0.90

Commentary

During 2021, EMHS did not achieve the target for HA-SABSI with a result equating to 37 infections from 338,112 bed-days.

EMHS participates in a state-wide surveillance program and has robust processes for the review of all cases of HA-SABSI by infection control specialists and treating clinicians, to identify the factors that contributed to the individual cases and closely monitor infection rates.

EMHS sought an independent review of HA-SABSI during 2021 to identify any contributing factors related to healthcare that may have contributed to the 2021 result. The review identified and made recommendations for improvement during 2022, which EMHS are currently implementing.

These include a stronger focus on the application of guidelines for the management of invasive devices; embracing electronic journey boards and nursing care plans to incorporate visual prompts for clinicians monitoring invasive device sites; and ongoing education, training and regular hand hygiene auditing.

The EMHS Hospital-Acquired Complications (HAC) Strategy also includes strategies to reduce bloodstream infection rates across EMHS that are based on findings and lessons arising from the clinical review of cases.

Period:	2019 – 2021 calendar years
Contributing sites:	Armadale Health Service, Bentley Health Service, Kalamunda Hospital, Royal Perth Hospital
Data source:	Healthcare Infection Surveillance Western Australia (HISWA) Data Collection

EMHS on forefront in sepsis care

Sepsis is a serious medical condition that claims the lives of almost 9000 Australians every year. It occurs when the body has an extreme immune response to an infection, leading to tissue damage and organ failure.

People who survive sepsis are often left with profound long-term health problems. Though early detection and treatment is the key to improving sepsis outcomes, it is an illness that remains difficult to diagnose.

A strong focus on sepsis research over the past decade has put EMHS at the forefront of improving the detection and care of sepsis patients in WA.

That tradition is set to continue following RPH specialist emergency doctor **Stephen MacDonald**, being awarded one of four State Government-funded Fellowships in June 2022. This will enable him to continue to pursue important sepsis research, including:

- A long-term study analysing blood samples collected from ED patients suspected of sepsis. The study is designed to gain a better understanding of the mechanisms of illness with a view to finding new diagnostic tests and treatment targets.
- Establishment of a sepsis clinical registry that will enable Dr MacDonald and his colleagues to monitor the effectiveness of new sepsis resources that are being rolled out across EMHS hospitals.

  These resources have been designed to help healthcare staff detect potential sepsis cases early, enabling prompt treatment.

  By monitoring routine clinical data collected for the registry, Dr MacDonald will be able to see whether these resources have been effective in supporting best-practice guidelines.

  The registry will also enable monitoring of patient outcomes.
- An initiative involving EMHS' HIVE program, in which sepsis patients are closely monitored remotely by specialist doctors and nurses based in the HIVE command centre.

Dr MacDonald said that as well as being difficult to diagnose, sepsis is a condition for which treatment can be fragmented because sepsis patients often have complex multisystemic problems that require the involvement of numerous different specialists.

"While about a quarter of sepsis patients get admitted to the ICU, the rest will be dispersed across other areas of the hospital," he explained.

"This makes it harder to coordinate care for these patients.

"The measures we are implementing will give us better oversight of these patients so we can ensure that all the things that need to be done are carried out in a standardised way."

Dr MacDonald believes embedding research, innovation and evaluation within routine clinical activities is the key to improving the efficiency and effectiveness of care.

Survival rates for sentinel conditions

Rationale

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

These three conditions have been chosen as they are leading causes of hospitalisation and death in Australia for which there are accepted clinical management practices and guidelines. Patient survival after being admitted for one of these sentinel conditions can be affected by many factors including the diagnosis, the treatment given, or procedure performed, age, co-morbidities at the time of the admission, and complications which may have developed while in hospital. However, survival is more likely when there is early intervention and appropriate care on presentation to an emergency department (ED) and on admission to hospital.

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

Target

Please see the target for each condition noted in the results per age group. Improved or maintained performance is demonstrated by a result equal to or exceeding target.

Stroke

Results

0 – 49 years:

YEAR	TARGET	ACTUAL
2021	95.2%	96.3%
2020	95.2%	94.7%
2019	94.4%	93.4%

50 – 59 years:

YEAR	TARGET	ACTUAL
2021	94.9%	96.2%
2020	94.9%	96.2%
2019	93.4%	95.6%

60 – 69 years:

YEAR	TARGET	ACTUAL
2021	94.1%	95.9%
2020	94.1%	99.5%
2019	93.5%	96.5%

70 - 79 years:

YEAR	TARGET	ACTUAL
2021	92.3%	95.1%
2020	92.3%	96.3%
2019	91.3%	95.9%

80+ years:

YEAR	TARGET	ACTUAL
2021	86.0%	94.4%
2020	86.0%	90.4%
2019	83.2%	93.2%

Commentary

Effective clinical engagement and coordination of care between the neurology, emergency and acute medical teams continues to result in excellent survival rates for patients experiencing this condition.

The performance of EMHS in the survival rate for stroke was met or exceeded target in all age ranges without exception. In the spirit of continuous quality improvement, all deaths are subject to a peer review as part of a morbidity and mortality review process, with actions taken to address issues and lessons learnt shared amongst clinical teams.

Acute myocardial infarction (AMI)

Results

0 – 49 years:

YEAR	TARGET	ACTUAL
2021	99.1%	97.7%
2020	99.1%	98.9%
2019	99.0%	100%

50 – 59 years:

YEAR	TARGET	ACTUAL
2021	98.8%	100%
2020	98.8%	98.9%
2019	98.9%	98.7%

60 – 69 years:

YEAR	TARGET	ACTUAL
2021	98.1%	98.9%
2020	98.1%	98.1%
2019	98.0%	98.6%

70 - 79 years:

YEAR	TARGET	ACTUAL
2021	96.8%	97.0%
2020	96.8%	98.2%
2019	96.5%	97.4%

80+ years:

YEAR	TARGET	ACTUAL
2021	92.1%	94.6%
2020	92.1%	94.4%
2019	92.2%	94.8%

Commentary

The performance of EMHS in the survival rate for acute myocardial infarction was equal to or exceeded target for all patients in the 50+ age ranges. This is largely attributed to our sustained timely access for patients to invasive coronary diagnostic and interventional procedures as well as effective inter hospital transfer arrangements of patients from Armadale Health Service (AHS) and St John of God Midland Public Hospital (SJGMPH) to Royal Perth Hospital (RPH).

The 0-49 years age group is slightly below target, representing a small number of complex cases. Monitoring will continue across 2022, with all deaths subject to a peer review as part of a morbidity and mortality review process. Actions taken to address issues and lessons learnt are shared amongst clinical teams.

Fractured neck of femur (FNoF)

Results

70 - 79 years:

YEAR	TARGET	ACTUAL
2021	98.9%	97.6%
2020	98.9%	99.2%
2019	98.9%	100%

80+ years:

YEAR	TARGET	ACTUAL
2021	96.9%	98.3%
2020	96.9%	98.2%
2019	96.1%	98.5%

Commentary

The performance of EMHS in the survival rate for fractured neck of femur patients exceeded target in the 80+ years age group. The 70-79 years age group is slightly below target, representing a small number of complex cases. Monitoring of the fractured neck of femur pathway will continue across 2022 to actively identify any opportunities for improvement. In the spirit of continuous quality improvement, all deaths are subject to a peer review as part of a morbidity and mortality review process. Actions taken to address issues and lessons learnt are shared amongst clinical teams.

Period:	2019 – 2021 calendar years
Contributing sites:	Armadale Health Service, Bentley Health Service, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital
Data source:	HMDC

Percentage of admitted patients who discharged against medical advice

Rationale

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

Between July 2015 and June 2017 Aboriginal patients (3.4%) in WA were over 11 times more likely than non-Aboriginal patients (0.3%) to discharge against medical advice, compared with 6.2 times nationally (3.1% and 0.5% respectively). This statistic indicates a need for improved responses by the health system to the needs of Aboriginal patients.

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

DAMA performance measure is also one of the key contextual indicators of Outcome 1 "Aboriginal and Torres Strait Islander people enjoy long and healthy lives" under the new National Agreement on Closing the Gap, which was agreed to by the Coalition of Aboriginal and Torres Strait Islander Peak Organisations, and all Australian Governments in July 2020.

Target

The 2021 targets for admitted patients who discharged against medical advice are:

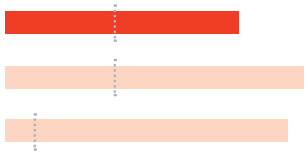
a) Aboriginal patients	**≤ 2.78%**
b) Non-Aboriginal patients	**≤ 0.99%**

Improved or maintained performance is demonstrated by a result below or equal to target.

Results

(a) Aboriginal patients:

YEAR	TARGET	ACTUAL
2021	**2.78%**	**5.87%**
2020	2.78%	7.51%
2019	0.77%	7.10%



(b) Non-Aboriginal patients:

YEAR	TARGET	ACTUAL
2021	**0.99%**	**1.16%**
2020	0.99%	1.44%
2019	0.77%	1.32%

Commentary

In 2021-22 key strategies were operationalised, with results demonstrating a reduction in DAMA rates for both Aboriginal and non-Aboriginal patients.

EMHS continues to work to improve the DAMA KPI. Key new strategies supporting DAMA performance across EMHS in 2021-22, include:

- EMHS undertook a deep review and analysis of patients with frequent or multiple DAMA, to identify targeted actions to reduce DAMAs in this cohort
- a Patient-Initiated Discharge (PID) process and form was introduced at RPH, allowing patients to be safely discharged in line with their health and social needs
- key consultation with Walk with Me and Homeless Health Care Leads to identify best practice management strategies for patients presenting with alcohol intoxication with or without homelessness.

EMHS is continuing to implement the following targeted strategies:

- improving cultural sensitivity in the organisation with Welcome to Country and DAMA videos and an Aboriginal Champion program, Kadadjiny Marr
- medical education, targeting safe discharge language and avoiding inappropriate use of the term DAMA in medical records
- sites to implement a process for safely discharging surgical patients whose surgery has been delayed or cancelled in target areas
- sites to implement a process for safely discharging the cohort of known and frequent DAMA patients admitted with alcohol intoxication.

Period:	2019 – 2021 calendar years
Contributing sites:	Armadale Health Service, Bentley Health Service, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital
Data source:	HMDC

Percentage of live-born term infants with an Apgar score of less than seven at five minutes post delivery

Rationale

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

The Apgar score is an assessment of an infant's health at birth based on breathing, heart rate, colour, muscle tone and reflex irritability. An Apgar score is applied at one, five and (if required by the protocol) ten minutes after delivery to determine how well the infant is adapting outside the mother's womb. Apgar scores range from zero to two for each condition with a maximum final total score of 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 (2020) Health, Standard 16/09/2020.

Target

The 2021 target for the percentage of live-born term infants with an Apgar score of less than seven at five minutes post delivery is ≤1.8%. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2021	**1.80%**	**1.37%**
2020	1.80%	1.54%
2019	1.80%	1.29%

Commentary

Across 2021 EMHS' performance has remained below target, which is indicative of the quality of care and skilled workforce providing maternity and neonatal services in EMHS hospitals. EMHS closely monitors performance against this and many other maternity performance and outcome measures to ensure EMHS maternity services maintain a high standard of care.

Period:	2019 – 2021 calendar years
Contributing sites:	Armadale Health Service, Bentley Health Service, St John of God Midland Public Hospital
Data source:	Midwives Notification System

Provision of information, guidance, and crisis response

EMHS furthered work on a project to strengthen our **Mental Health Emergency Response Line** and its equivalent service for consumers outside the metropolitan area, Rural Link (known collectively as MHERL).

The improvement project was established in response to recommendations from a 2019 review into the service, which provides 24-hour over-the-phone support for people experiencing a mental health crisis.

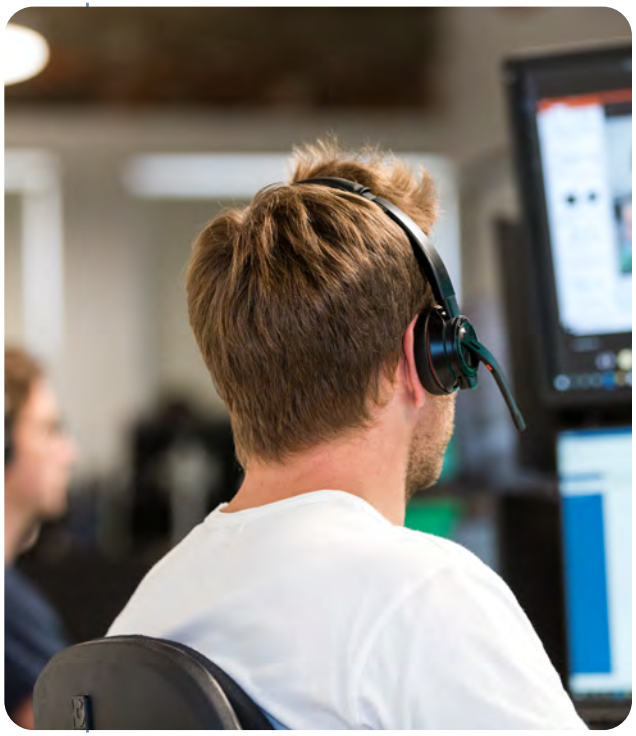
Among the project's main achievements were:

- a statewide process for escalation of care and handover of care for consumers with urgent mental health needs
- improved pathways for facilitating coordinated access for consumers to other mental health and emergency services
- an enhanced consumer feedback system
- recruitment of consumers to ensure strong consumer input into the service redesign, ongoing service provision and governance
- strengthened engagement with Aboriginal stakeholders to help MHERL become a more culturally secure service for Aboriginal consumers
- updated governance processes, as per the Public Sector Commission Good Governance Principles.

Heading into 2022-23, the project will focus on:

- developing and implementing two new roles as part of the MHERL team — a **Suicide Intervention Coordinator** and **Aboriginal Mental Health Worker**
- rebranding of the service to create a unified presence across WA that incorporates consistent messaging about what consumers can expect when contacting the service
- implementing a **Statewide Crisis Journey Board** to augment existing clinical handover processes and facilitate follow-up of referrals from MHERL
- exploring further opportunities for service provision to CaLD communities and alternative modes of provision, such as Telehealth.

Supports Sustainable Health Review (SHR) recommendation 11b (see page 63)



During 2021-22, MHERL had **17,183** contacts for mental health crisis support

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

Rationale

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

While multiple hospital admissions over a lifetime may be necessary for someone with ongoing illness, a high proportion of readmissions shortly after discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was not adequate to maintain the patient's recovery out of hospital.

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.

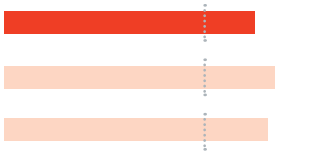
By monitoring this indicator, key areas for improvement can be identified. This can facilitate the development and delivery of targeted care pathways and interventions aimed at improving the mental health and quality of life of Western Australians.

Target

The 2021 target for readmissions to acute specialised mental health inpatient services within 28 days of discharge is ≤12.0%. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2021	**12.0%**	**14.9%**
2020	12.0%	16.1%
2019	12.0%	15.7%



Commentary

With demand for services and patient acuity high, readmission rates have remained relatively steady when compared year on year. The result this year is a positive reflection of the strategies that have been implemented with a focus on reducing the level of unplanned readmissions to mental health inpatient services.

These strategies include:

- Commencement of the Youth Community Assessment Treatment Team, which provides early intervention and timely support to young adults experiencing mental health concerns. Benefits include, and are not limited to, admission diversion, prevention of readmission and facilitation of early discharge.
- Continuation of the Hostel Inreach Initiative. This project aims to increase mental health and physical health treatments and supports to an at risk/vulnerable cohort, as well as reduce ED presentations and admissions.

- Continuation of the Project Air / Dialectical Behaviour Therapy Program for Adult Community Royal Perth Bentley Group (RPBG). Project Air is a Personality Disorders Strategy that aims to enhance treatment options for people with Personality Disorders and their families and carers. A key component of Project Air is the Gold Card Clinics, which provide brief psychological interventions to frequent presenters to EDs, in the context of psychosocial crisis with emotion dysregulation, suicidal ideation or self-harming behaviour, supporting admission diversion, readmission and treatment.
- Continuation of the Active Response Team (ART) service at both RPBG and Armadale Kalamunda Group (AKG), in partnership with various Non-Government Organisation (NGO) providers of mental health services, in order to maximise the care planning and support opportunities to keep patients well in the community.
- Commencement of Momentum QP (Youth Mental Health and Alcohol and Drug Homelessness Service). EMHS' partnership with Richmond fellowship, Anglicare and Cyrenian House, provides residents with a 12-month recovery-focused program with referrals, including from ED and mental health inpatient units. Aims include, but are not limited to, providing treatment and reducing hospital presentations, admissions and readmissions.
- St John of God Midland Head to Health offers assessment and short to medium term treatment to adults experiencing mild to moderate mental health concerns, immediate care to access information and assistance navigating to other appropriate services.

EMHS continues to strive to reduce the number of readmissions to acute specialised mental health inpatient services within 28 days of discharge.

Period:	2019 – 2021 calendar years
Contributing sites:	Armadale Health Service, Bentley Health Service, Royal Perth Hospital, St John of God Midland Public Hospital
Data source:	HMDC (inpatient separations)

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

Rationale

In 2017-18, one in five (4.8 million) Australians reported having a mental or behavioural condition. Therefore, it is crucial to ensure effective and appropriate care is provided not only in a hospital setting but also in the community.

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

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

Target

The 2021 target percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services is ≥75.0%. Improved or maintained performance is demonstrated by a result equal to or above target.

Results

YEAR	TARGET	ACTUAL
2021	**75.0%**	**87.8%**
2020	75.0%	87.1%
2019	75.0%	85.5%

Commentary

Over the past three years EMHS has consistently exceeded the 75% target. This result demonstrates our commitment to connecting with our public mental health acute inpatients within a week of being discharged from hospital to assist our consumers through a key transition of care.

Period:	2019 – 2021 calendar years
Contributing sites:	Armadale Health Service, Bentley Health Service, Royal Perth Hospital, St John of God Midland Public Hospital
Data source:	Mental Health Information Data Collection (MIND) (ambulatory mental health service contacts); HMDC (inpatient separations)

Average admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per weighted activity unit (WAU) compared with the state target, as approved by the Department of Treasury and published in the 2021-22 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 2021-22 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

Target

The 2021-22 target for average admitted cost per WAU is $6907. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2021-22	$6907	$7197
2020-21	$7073	$6733
2019-20	$7026	$6501

Please note: 2019-20 and 2020-21 actuals have been restated in accordance with the 2021-22 Outcome Based Management Key Performance Indicator Data Definition Manual

Commentary

The target for 2021-22 was developed by WA Health for all Health Service Providers (HSPs). EMHS has not performed favourably against the 2021-22 target with an average admitted cost per WAU of $7197, which is $290 above the target of $6907. The 2021-22 result is also $464 above the actual average admitted cost per WAU in 2020-21.

EMHS' performance in 2021-22 was impacted in the first part of the reporting year by the residual effects of changes in elective surgery schedules, which resulted in lower than anticipated inpatient activity. Performance in the latter part of the year was also impacted by increased staffing costs associated with preparing for a 'surge' in expected COVID patients attending hospitals and covering staff furloughing as a result of COVID protocols.

Period:	2019-20 – 2021-22 financial years
Contributing sites:	Armadale Health Service, Bentley Health Service, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital, St John of God Mount Lawley (contracted services)
Data source:	OBM allocation application; Oracle 11i financial system; HMDC extracts; TOPAS; webPAS; Contracted Health Entity's (CHE) discharge extracts

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 2021-22 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 2021-22 target for average ED cost per WAU is $6847. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2021-22	$6847	$7353
2020-21	$6853	$7098
2019-20	$7071	$7039

Please note: 2019-20 and 2020-21 actuals have been restated in accordance with the 2021-22 Outcome Based Management Key Performance Indicator Data Definition Manual

Commentary

The target for 2021-22 was developed by WA Health for all HSPs. The actual average ED cost per WAU is $506 above the 2021-22 target of $6847. It is also $255 higher than the actual average cost of $7098 in 2020-21 when compared to the performance in that year.

EMHS EDs remain open and fully prepared for all emergencies on a 24/7 x 365 basis to ensure staff and patients always remain safe and protected irrespective of other environmental factors. In 2021-22, ED costs have increased, due primarily to the additional safeguards implemented to address recommendations from health reports into ED waiting room practices and processes for maintaining patient safety.

Period:	2019-20 – 2021-22 financial years
Contributing sites:	Armadale Health Service, Royal Perth Hospital, St John of God Midland Public Hospital
Data source:	OBM allocation application; Oracle 11i financial system; Emergency Department Data Collection (EDDC)

Marquees a triage triumph for EMHS

To prevent COVID-19 spreading through our hospitals, EMHS had to ensure non-COVID patients were kept apart from those known to have — or suspected of having — the virus.

Large marquees, erected outside the EDs of RPH, AHS and SJGMPH were central to EMHS' efforts to achieve this separation.

The structures were designed to serve as temporary triage stations for patients seeking emergency care — including those arriving by ambulance.

Arrangements were introduced that required patients to present to the marquees where staff would assess their COVID status and direct them appropriately. Known cases were automatically streamed into the ED's 'red zones'. Those assessed as being at low risk of COVID were given the green light to enter the ED, while anyone suspected of having COVID was given a RAT.

The marquees project was a major logistical exercise and a significant accomplishment for EMHS. At RPH alone, to accommodate the new structure, extensive road and site works were needed, including the closure of a portion of Victoria Square to traffic, the removal of parking bays, adjustment of the main hospital entrance and removal of a concrete island to enable the re-routing of access to ambulance bays.

AHS was similarly challenged and worked closely with outside agencies to create an entirely new traffic flow for ambulances, ambulatory visitors and carers.

The marquees themselves were carefully planned and configured to include patient waiting zones, designated swabbing stations, screening and triage spaces, and discrete donning and doffing areas.

On top of this, the new structures had to be waterproof, connected to hospital power supplies and fitted with reverse cycle air-conditioning and duress alarms.

In a race against time to ensure our hospitals were ready for the anticipated rise in COVID cases following the opening of the WA border, the marquees were erected and up and running within a matter of weeks, an accomplishment that highlighted the commitment of EMHS staff to ensuring the health and safety of our community.

Royal Perth and Armadale Hospital COVID Triage marquees

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 2021-22 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 2021-22 target for average non-admitted cost per WAU is $6864. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2021-22	$6864	$6093
2020-21	$7025	$6004
2019-20	$6992	$7569

Please note: 2019-20 and 2020-21 actuals have been restated in accordance with the 2021-22 Outcome Based Management Key Performance Indicator Data Definition Manual

Commentary

The target for 2021-22 was developed by WA Health for all HSPs. EMHS has performed positively against the 2021-22 target of $6864 by $771. Although EMHS has performed positively against the target in both 2020-21 and 2021-22, the actual average cost of $6093 is $89 more when compared to the actual average cost of $6004 in the previous year.

Non-admitted activity is related to inpatient activity, as patients who are discharged from hospital are generally referred to non-admitted services for follow-up consultations and medication. Non-admitted activity can include 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.

Although EMHS experienced a decline in inpatient activity as a result of some residual effects of COVID protocols, the health service has been able to maintain the previous year's positive performance with respect to the ratio of expenditure to activity for non-admitted services.

Period:	2019-20 – 2021-22 financial years
Contributing sites:	Armadale Health Service, Bentley Health Service, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital, St John of God Mount Lawley (contracted services)
Data source:	OBM allocation application; Oracle 11i financial system; Non Admitted Patient Data Collection (NAP DC)

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 2021-22 target for average cost per bed-day in specialised mental health inpatient services is $1533. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2021-22	**$1533**	**$1783**
2020-21	$1622	$1724
2019-20	$1492	$1694

Please note: 2019-20 and 2020-21 actuals have been restated in accordance with the 2021-22 Outcome Based Management Key Performance Indicator Data Definition Manual

Commentary

EMHS' actual average cost of $1783 is $250 above the 2021-22 target of $1533, and it is also $59 above the actual performance of $1724 in 2020-21.

The EMHS' average cost has only marginally increased against the actual 2020-21 average cost of $1724. Although the actual performance in 2021-22 is relatively close to the actual average re-stated cost for 2019-20, the costs associated with treatment of complex mental health cases has increased over the reported timeframes and is reflective of the increasing complexities associated with supporting and treating mental health in the community.

Period:	2019-20 – 2021-22 financial years
Contributing sites:	Armadale Health Service, Bentley Health Service, Royal Perth Hospital, St John of God Midland Public Hospital
Data source:	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. Efficient functioning of public community mental health services is essential to ensure that finite funds are used effectively to deliver maximum community benefit.

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

Target

The 2021-22 target for average cost per treatment day of non-admitted care provided by mental health services is $445. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2021-22	**$445**	**$400**
2020-21	$415	$346
2019-20	$420	$383

Please note: 2019-20 and 2020-21 actuals have been restated in accordance with the 2021-22 Outcome Based Management Key Performance Indicator Data Definition Manual

Commentary

EMHS has performed marginally better (by $45) against the 2021-22 target of $445 for the average cost per treatment day of non-admitted care provided by mental health services.

The increase in costs in 2021-22 relates primarily to the increased level of care services provided within a community setting, particularly as the community required higher levels of support outside of hospital settings to cope with the effects of COVID protocols. Providing increased care and care-based community services can impact a health service's ability to perform efficiently, particularly if cost increases associated with higher levels of community care are related to general environmental cost pressures outside the health service's immediate control.

Period:	2019-20 – 2021-22 financial years
Contributing sites:	Armadale Mental Health Service, Bentley Mental Health Service, Royal Perth Hospital (psychiatry), Specialised Aboriginal Mental Health Service, Midland Mental Health Service
Data source:	OBM allocation application; Oracle 11i financial system; Mental Health Information Data Collection (MIND)

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

Rationale

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

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

Target

The 2021-22 target for average cost per person of delivering population health programs by population health units is $32. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2021-22	$32	$113
2020-21	$19	$66
2019-20	$17	$13

Please note:

- 2019-20 was based on 2014-18 population estimates
- 2020-21 was based on 2015-19 population estimates
- 2021-22 is based on the 2016-20 population estimates
- 2019-20 and 2020-21 actuals have been restated in accordance with the 2021-22 Outcome Based Management Key Performance Indicator Data Definition Manual

Commentary

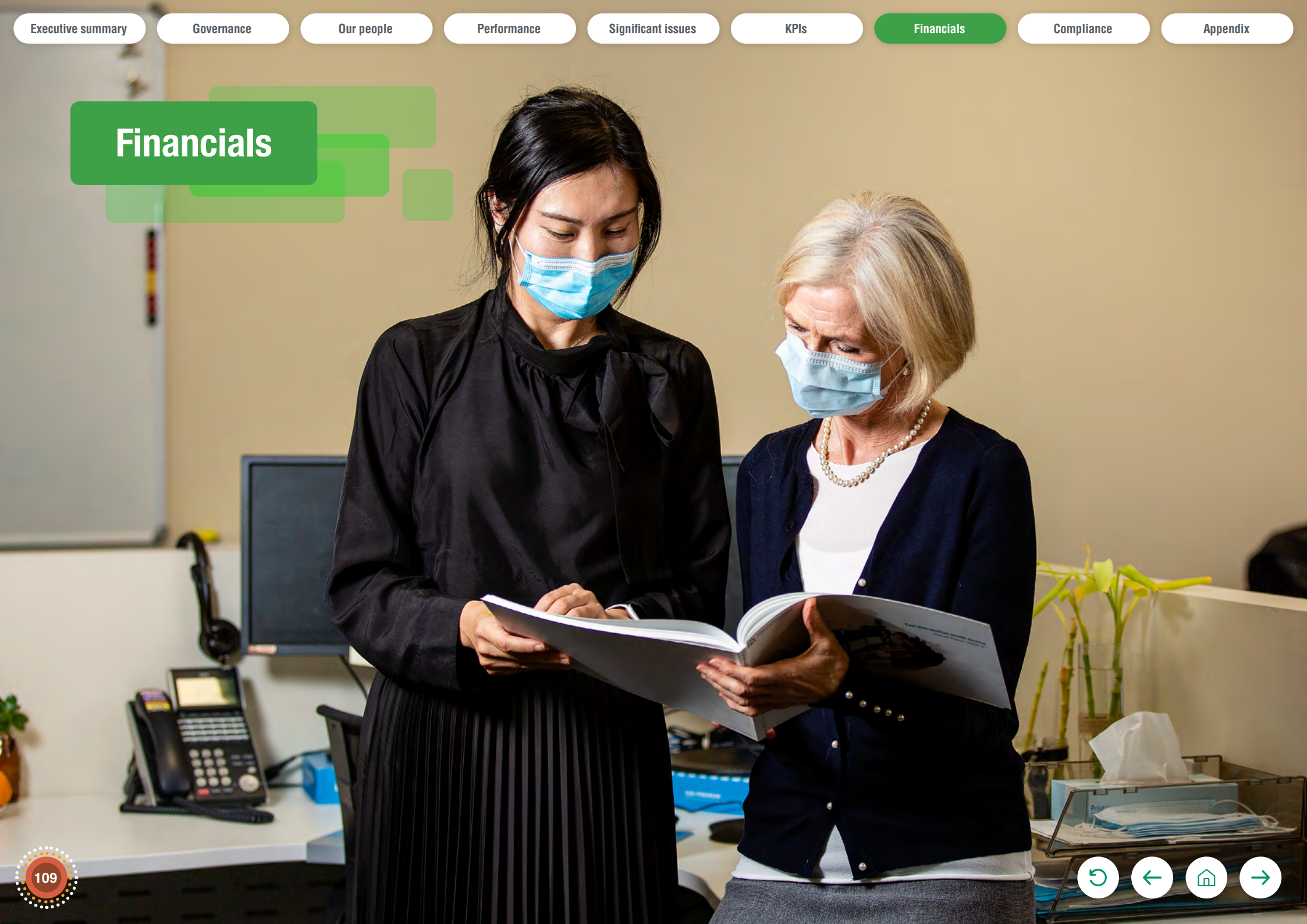
The target for 2021-22 was developed at a WA Health level for all HSPs. EMHS' average cost per person of delivering population health programs was $113, which is $81 above the target of $32.

The 2021-22 target increased by $13 when compared to the 2020-21 target, however both targets were not adjusted for COVID-19 expenditure pressures that related to the preparation for, and response to, the pandemic. These expenditure pressures included servicing quarantine hotels, supporting mobile testing in the community, establishing and maintaining COVID-19 vaccination clinics and responding to other public health protection measures.

If COVID-19 related expenditure was excluded from the calculation of the indicator, the EMHS performance results in 2021-22 are favourable against the 2021-22 target and comparable in dollar value to pre-COVID average cost for delivering population health programs within EMHS' catchment area.

Period:	2019-20 – 2021-22 financial years
Contributing sites:	East Metropolitan Health Service health region
Data source:	OBM allocation application; Oracle 11i financial system; Estimated Resident Populations for 2016-20 and 2021 population projection provided by the Epidemiology Directorate, Public and Aboriginal Health Division, WA Department of Health

Financials



Certification of financial statements

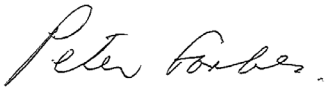
For the reporting period ended 30 June 2022

The accompanying financial statements of the East 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 2022 and financial position as at 30 June 2022.

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.

Ian Smith PSM
Chair, EMHS Board
East Metropolitan Health Service
16 September 2022

Graeme Jones
Chief Finance Officer
East Metropolitan Health Service
16 September 2022



Peter Forbes
Chair, EMHS Board Finance Committee
East Metropolitan Health Service
16 September 2022

Auditor General

INDEPENDENT AUDITOR'S REPORT
2022
East Metropolitan Health Service

To the Parliament of Western Australia

Report on the audit of the financial statements

I have audited the financial statements of the East Metropolitan Health Service (Health Service) which comprise:

- the Statement of Financial Position at 30 June 2022, and the Statement of Comprehensive Income, Statement of Changes in Equity and Statement of Cash Flows for the year then ended
- Notes comprising a summary of significant accounting policies and other explanatory information.

In my opinion, the financial statements are:

- based on proper accounts and present fairly, in all material respects, the operating results and cash flows of the East Metropolitan Health Service for the year ended 30 June 2022 and the financial position at the end of that period
- in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions.

Basis for opinion

I conducted my audit in accordance with the Australian Auditing Standards. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my report.

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

Responsibilities of the Board for the financial statements

The Board is responsible for:

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

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

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

Auditor's responsibilities for the audit of the financial statements

As required by the *Auditor General Act 2006*, my responsibility is to express an opinion on the financial statements. The objectives of my audit are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Australian Auditing Standards will always detect a material misstatement when it exists.

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

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

Report on the audit of controls

Basis for Qualified Opinion

I identified significant weaknesses in network security controls and controls over unauthorised connection of devices at the East Metropolitan Health Service. These weaknesses could result in a potential security exposure to the network and increased vulnerabilities which could undermine the integrity of data across all systems, including the financial system.

Qualified Opinion

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

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

In my opinion, except for the possible effects of the matters described in the Basis for Qualified Opinion paragraph, in all material respects, the controls exercised by the East Metropolitan Health Service are sufficiently adequate to provide reasonable assurance that the receipt, expenditure and investment of money, the acquisition and disposal of property and the incurring of liabilities have been in accordance with legislative provisions during the year ended 30 June 2022.

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 East Metropolitan Health Service for the year ended 30 June 2022. The key performance indicators are the Under Treasurer-approved key effectiveness indicators and key efficiency indicators that provide performance information about achieving outcomes and delivering services.

In my opinion, in all material respects, the key performance indicators of the East Metropolitan Health Service are relevant and appropriate to assist users to assess the Health Service's performance and fairly represent indicated performance for the year ended 30 June 2022.

The Health Service'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 control as the Board determines necessary to enable the

preparation of key performance indicators that are free from material misstatement, whether due to fraud or error.

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

Auditor General's responsibilities

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

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

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

My independence and quality control relating to the reports on controls and key performance indicators

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

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 2022, 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 our 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 our 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 East Metropolitan Health Service for the year ended 30 June 2022 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.

Grant Robinson
Assistant Auditor General Financial Audit
Delegate of the Auditor General for Western Australia
Perth, Western Australia
19 September 2022

East Metropolitan Health Service
Statement of comprehensive income
For the year ended 30 June 2022

	Note	2022 $000	2021 $000
Cost of services			
Expenses			
Employee benefits expense	3.1.1	1,027,528	942,742
Contracts for services	3.2	341,212	328,494
Patient support costs	3.3	259,016	240,812
Fees for visiting medical practitioners	3.4	25,971	28,879
Finance costs	7.2	52	58
Depreciation and amortisation expense	5.5	44,471	43,445
Repairs, maintenance and consumable equipment	3.5	36,445	28,661
Other supplies and services	3.6	10,472	8,389
Cost of sales	4.7	3,496	3,348
Other expenses	3.7	116,896	99,217
Total cost of services		1,865,559	1,724,045
Income			
Patient charges	4.4	45,943	44,133
Other fees for services	4.5	490	763
Commonwealth grants and contributions	4.2	240	476
Other grants and contributions	4.3	1,087	1,483
Donation income	4.6	98	266
Sale of goods	4.7	3,402	3,177
Other income and recoveries	4.8	46,682	46,666
Total income other than income from State Government		97,942	96,964
Net cost of services		1,767,617	1,627,081
Income from State Government			
Department of Health - Service Agreement:			
- State component	4.1	880,558	826,326
- Commonwealth component	4.1	526,449	487,385
Mental Health Commission - Service Agreement	4.1	210,998	193,229
Income from other state government agencies	4.1	44,633	45,861
Resources received	4.1	89,904	70,023
Total income from State Government		1,752,542	1,622,824
Deficit for the period		(15,075)	(4,257)
Other comprehensive income			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.10	53,902	6,870
Total other comprehensive income		53,902	6,870
Total comprehensive income for the period		38,827	2,613

The statement of comprehensive income should be read in conjunction with the accompanying notes.

See also note 2.2 'Schedule of income and expenses by service'.

East Metropolitan Health Service
Statement of financial position
As at 30 June 2022

	Note	2022 $000	2021 $000
Assets			
Current assets			
Cash and cash equivalents	7.3	112,886	128,130
Restricted cash and cash equivalents	7.3	41,892	37,057
Receivables	6.1	26,819	27,609
Inventories	6.3	5,374	4,672
Other current assets	6.4	29,784	26,616
Total current assets		216,755	224,084
Non-current assets			
Restricted cash and cash equivalents	7.3	20,889	16,679
Amounts receivable for services	6.2	613,846	570,045
Property, plant and equipment	5.1	625,896	578,090
Intangible assets	5.2	139	35
Right-of-use assets	5.3	1,795	1,640
Service concession assets	5.4	309,562	294,546
Total non-current assets		1,572,127	1,461,035
Total assets		1,788,882	1,685,119
Liabilities			
Current liabilities			
Payables	6.5	97,351	101,322
Grant liabilities	6.6	955	1,255
Lease liabilities	7.1	609	552
Employee benefits provisions	3.1.2	212,860	196,704
Other current liabilities	6.7	1,090	744
Total current liabilities		312,865	300,577
Non-current liabilities			
Employee benefits provisions	3.1.2	46,073	46,296
Lease liabilities	7.1	1,229	1,112
Total non-current liabilities		47,302	47,408
Total liabilities		360,167	347,985
Net assets		1,428,715	1,337,134
Equity			
Contributed equity	9.10	1,234,101	1,181,347
Reserves	9.10	148,065	94,163
Accumulated surplus		46,549	61,624
Total equity		1,428,715	1,337,134

The statement of financial position should be read in conjunction with the accompanying notes.

East Metropolitan Health Service
Statement of changes in equity
For the year ended 30 June 2022

	Note	2022 $000	2021 $000
Contributed equity	9.10		
Balance at start of period		1,181,347	1,146,450
Transactions with owners in their capacity as owners:			
Contribution by Owners – Capital appropriations administered by Department of Health		52,754	34,897
Balance at end of period		1,234,101	1,181,347
Reserves	9.10		
Asset revaluation reserve			
Balance at start of period		94,163	87,293
Other comprehensive income for the period		53,902	6,870
Balance at end of period		148,065	94,163
Accumulated surplus			
Balance at start of period		61,624	65,881
Deficit for the period		(15,075)	(4,257)
Balance at end of period		46,549	61,624
Total equity			
Balance at start of period		1,337,134	1,299,624
Total comprehensive income for the period		38,827	2,613
Transactions with owners in their capacity as owners		52,754	34,897
Balance at end of period		1,428,715	1,337,134

The statement of changes in equity should be read in conjunction with the accompanying notes.

East Metropolitan Health Service
Statement of cash flows
For the year ended 30 June 2022

	Note	2022 $000 Inflows/(Outflows)	2021 $000 Inflows/(Outflows)
Cash flows from State Government			
Contribution by Owners – Capital Appropriations administered by Department of Health		52,753	34,867
Service agreement - Department of Health		1,363,206	1,271,284
Service agreement - Mental Health Commission		210,998	193,229
Funds received from other state government agencies		44,633	45,861
Net cash provided by State Government		1,671,590	1,545,241
Utilised as follows:			
Cash flows from operating activities			
Payments			
Employee benefits		(1,010,483)	(919,345)
Supplies and services		(712,421)	(685,573)
Finance costs		(52)	(58)
Receipts			
Receipts from customers		45,661	40,493
Commonwealth grants and contributions		240	476
Other grants and contributions		1,087	1,484
Donations received		53	131
Other receipts		51,106	47,356
Net cash used in operating activities	7.3.2	(1,624,809)	(1,515,036)
Cash flows from investing activities			
Payments			
Purchase of non-current assets		(52,542)	(45,899)
Receipts			
Proceeds from sale of non-current assets		250	10
Net cash used in investing activities		(52,292)	(45,889)
Cash flows from financing activities			
Payments			
Principal elements of lease payments		(688)	(444)
Receipts			
Net cash used in financing activities		(688)	(444)
Net decrease in cash and cash equivalents		(6,199)	(16,128)
Cash and cash equivalents at the beginning of the period		181,866	197,994
Total cash and cash equivalents at the end of the period		175,667	181,866

The statement of cash flows should be read in conjunction with the accompanying notes.

East Metropolitan Health Service
Notes to the financial statements
As at 30 June 2022

Note 1 Basis of preparation

East Metropolitan Health Service (the Health Service) is a Western Australian Government entity, controlled by the State of Western Australia which is the ultimate parent. The Health Service is a not-for-profit entity (as profit is not its principal objective).
A description of the nature of its operations and its principal activities have been included in the 'Governance/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 16 September 2022.

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 modified.

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 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.

East Metropolitan Health Service
Notes to the financial statements
As at 30 June 2022

Note 1 Basis of preparation (continued)

Contributed equity

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

Note 2 Health Service outputs

How the Health Service operates

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

2.1 Health Service objectives

Services

To comply with its legislative obligation as a WA Government agency, 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 agency performance towards achieving the relevant overarching whole of government goal of strong communities, safe communities and supported families and the WA health system agency goal of delivery of safe, quality, financially sustainable and accountable healthcare for all Western Australians. The Health Service is predominantly funded by Parliamentary appropriations.

The Health Service provides the following services:

Public hospital admitted services

The provision of healthcare services to patients in metropolitan 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 WA Health. Admission to hospital and the treatment provided may include access to acute and/or sub-acute inpatient services, as well as hospital in the home services. Public hospital admitted services include 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'.

East Metropolitan Health Service
Notes to the financial statements
As at 30 June 2022

2.1 Health Service objectives (continued)

Public hospital emergency services

The provision of services for the treatment of patients in emergency departments of metropolitan hospitals, inclusive of public patients treated in private facilities under contract to WA Health. 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 include 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 hospital services to patients who do not undergo a formal admission process, inclusive of public patients treated by private facilities under contract to WA Health. 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 include 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'.

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 and community bed based services. This service includes the provision of state-wide mental health services such 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 include 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 WA Health.

Aged and continuing care services

The provision of aged and continuing 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.

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 include 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 and services to assist rural based patients travel to receive care.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

2.2 Schedule of income and expenses by service

	Public hospital admitted	Public hospital emergency	Public hospital non-admitted	Mental health	Aged and continuing care	Public and community health	Total
	2022 $000	2022 $000	2022 $000	2022 $000	2022 $000	2022 $000	2022 $000
Cost of services							
Expenses							
Employee benefits expense	589,173	115,402	118,703	152,929	8,594	42,727	1,027,528
Contracts for services	188,648	62,164	28,328	34,746	466	26,860	341,212
Patient support costs	168,819	22,652	37,537	10,738	2,020	17,250	259,016
Fees for visiting medical practitioners	23,497	955	1,408	111	-	-	25,971
Finance costs	6	1	2	28	5	10	52
Depreciation and amortisation expense	27,299	5,170	5,482	5,520	369	631	44,471
Repairs, maintenance and consumable equipment	22,194	2,850	4,470	3,898	201	2,832	36,445
Other supplies and services	3,047	1,418	1,591	2,343	23	2,050	10,472
Cost of sales	-	-	2,432	1,064	-	-	3,496
Other expenses	69,405	11,793	12,716	6,318	564	16,100	116,896
Total cost of services	1,092,088	222,405	212,669	217,695	12,242	108,460	1,865,559
Income							
Patient charges	37,860	1,976	5,017	1,090	-	-	45,943
Other fees for services	-	-	-	321	-	169	490
Commonwealth grants and contributions	-	240	-	-	-	-	240
Other grants and contributions	126	21	22	2	-	916	1,087
Donation income	31	5	8	7	-	47	98
Sale of goods	-	-	2,366	1,036	-	-	3,402
Other income and recoveries	25,446	672	13,478	355	11	6,720	46,682
Total income other than income from State Government	63,463	2,914	20,891	2,811	11	7,852	97,942
Net cost of services	1,028,625	219,491	191,778	214,884	12,231	100,608	1,767,617
Income from State Government							
Department of Health - Service Agreement:							
- State component	579,658	126,541	110,167	5,548	6,893	51,751	880,558
- Commonwealth component	348,751	74,418	65,021	-	4,147	34,112	526,449
Mental Health Commission - Service Agreement	-	-	-	210,998	-	-	210,998
Income from other state government agencies	40,130	1,762	1,539	-	470	732	44,633
Resources received	54,991	9,085	9,400	1,729	10	14,689	89,904
Total income from State Government	1,023,530	211,806	186,127	218,275	11,520	101,284	1,752,542
Surplus/(deficit) for the period	(5,095)	(7,685)	(5,651)	3,391	(711)	676	(15,075)

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

2.2 Schedule of income and expenses by service (continued)

	Public hospital admitted	Public hospital emergency	Public hospital non-admitted	Mental health	Aged and continuing care	Public and community health	Total
	2021 $000	2021 $000	2021 $000	2021 $000	2021 $000	2021 $000	2021 $000
Cost of services							
Expenses							
Employee benefits expense	547,226	105,057	110,318	141,863	8,177	30,101	942,742
Fees for visiting medical practitioners	23,000	1,019	4,738	122	-	-	28,879
Contracts for services	199,432	70,223	26,040	32,174	596	29	328,494
Patient support costs	159,169	21,332	35,243	10,387	2,140	12,541	240,812
Finance costs	9	2	3	36	6	2	58
Depreciation and amortisation expense	26,800	4,855	5,364	5,564	360	502	43,445
Repairs, maintenance and consumable equipment	18,552	1,852	4,090	3,238	167	762	28,661
Other supplies and services	3,404	1,257	1,555	1,799	64	310	8,389
Cost of sales	-	-	2,329	1,019	-	-	3,348
Other expenses	63,886	9,574	12,169	5,771	593	7,224	99,217
Total cost of services	1,041,478	215,171	201,849	201,973	12,103	51,471	1,724,045
Income							
Patient charges	36,439	1,915	4,742	1,037	-	-	44,133
Other fees for services	39	6	9	508	-	201	763
Commonwealth grants and contributions	-	476	-	-	-	-	476
Other grants and contributions	230	-	34	10	-	1,209	1,483
Donation income	85	15	20	21	-	125	266
Sale of goods	-	-	2,210	967	-	-	3,177
Other income and recoveries	25,207	704	12,487	637	3,560	4,071	46,666
Total income other than income from State Government	62,000	3,116	19,502	3,180	3,560	5,606	96,964
Net cost of services	979,478	212,055	182,347	198,793	8,543	45,865	1,627,081
Income from State Government							
Department of Health - Service Agreement:							
- State component	562,829	121,851	104,783	5,599	4,909	26,355	826,326
- Commonwealth component	334,234	72,360	62,225	-	2,915	15,651	487,385
Mental Health Commission - Service Agreement	-	-	-	193,229	-	-	193,229
Income from other state government agencies	31,380	6,483	6,082	-	365	1,551	45,861
Resources received	47,156	8,558	8,882	1,562	9	3,856	70,023
Total income from State Government	975,599	209,252	181,972	200,390	8,198	47,413	1,622,824
Surplus/(deficit) for the period	(3,879)	(2,803)	(375)	1,597	(345)	1,548	(4,257)

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

		2022 $000	2021 $000
Note 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:

	Note
Employee benefits expense	3.1.1
Employee benefits provisions	3.1.2
Contracts for services	3.2
Patient support costs	3.3
Fees for visiting medical practitioners	3.4
Repairs, maintenance and consumable equipment	3.5
Other supplies and services	3.6
Other expenses	3.7

3.1.1 Employee benefits expense

Employee benefits	937,490	863,408
Termination benefits	192	118
Superannuation - defined contribution plans (a)	89,817	79,179
Total employee benefits expense	1,027,499	942,705
Add: AASB 16 Non-monetary benefits (b)	29	37
Net employee benefits	1,027,528	942,742

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

(b) Non-monetary employee benefits that are predominantly relating to the provision of vehicle benefits recognised under AASB 16.

Employee benefits include salaries and wages, fringe benefits plus the fringe benefits tax component and leave entitlements including superannuation contribution components.

Workers' compensation insurance expense is excluded here but included in note 3.7 'Other expenses'.

Termination benefits are payable when employment is terminated before normal retirement date, or when an employee accepts an offer of benefits in exchange for the termination of employment. Termination benefits are recognised when the Health Service is demonstrably committed to terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy. Benefits falling due more than 12 months after the end of the reporting period are discounted to present value.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000

3.1.1 Employee benefits expense (continued)

Superannuation is the amount recognised in profit or loss of the statement of comprehensive income comprises employer contributions paid to the GSS (concurrent contributions), the WSS, other GESB schemes or other superannuation funds. The employer contribution paid to the Government Employees Superannuation Board (GESB) in respect of the GSS is paid back into the Consolidated Account by the GESB.

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

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

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

3.1.2 Employee benefits provisions

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

Current		
Annual leave (a)	108,706	99,314
Time off in lieu leave (a)	30,449	27,255
Long service leave (b)	73,086	69,531
Deferred salary scheme (c)	619	604
	212,860	196,704
Non-current		
Long service leave (b)	46,073	46,296
Total employee benefits provisions	258,933	243,000

(a) Annual leave and time off in lieu leave liabilities are classified as current as there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000
3.1.2 Employee benefits provisions (continued)		

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

Within 12 months of the end of the reporting period	79,725	75,409
More than 12 months after the end of the reporting period	59,430	51,160
	139,155	126,569

Annual leave and time off in lieu leave are not expected to be settled wholly within 12 months after the end of the reporting period and therefore considered to be 'other long-term employee benefits'. The leave liability is recognised and measured at the present value of amounts expected to be paid when the liabilities are settled using the remuneration rate expected to apply at the time of settlement.

(b) Long service leave liabilities are classified as current where there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Pre-conditional and conditional long service leave provisions are classified as non-current liabilities because the Health Service has an unconditional right to defer the settlement of the liability until the employee has completed the requisite years of service.

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

Within 12 months of the end of the reporting period	27,609	17,863
More than 12 months after the end of the reporting period	91,550	97,964
	119,159	115,827

The provision 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. When assessing expected future payments, consideration is given to expected future wage and salary levels including non-salary components such as employer superannuation contributions, as well as the experience of employee departures and periods of service. The expected future payments are discounted using market yields on national government bonds at the end of the reporting period with terms to maturity that match, as closely as possible, the estimated future cash outflows.

Under the advice of Government Sector Labour Relations (GSLR), casual employees of the Health Service are entitled to long service leave even if the applicable awards provide casual loading in lieu of long service leave. The provision for casual employees who are currently employed by the Health Service has been included in the long service leave balance: $9.07 million. The amount of obligation for the casual employees who are no longer employed by the Health Service has been included in the Payables (note 6.5): $1.09 million.

(c) The deferred salary scheme liabilities relate to Health Service employees who have entered into an agreement to self-fund an additional twelve months leave in the fifth year of the agreement. The provision recognises the value of salary set aside for employees to be used in the fifth year. The liability is measured on the same basis as annual leave. It is classified as a current provision as employees can leave the scheme at their discretion at any time.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000
3.1.2 Employee benefits provisions (continued)		

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

Within 12 months of the end of the reporting period	408	300
More than 12 months after the end of the reporting period	211	304
	619	604

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 turnover rates and usage rates of leave in service or at termination. 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.

Sick Leave
Liabilities for sick leave are recognised when it is probable that sick leave paid in the future will be greater than the entitlement that will accrue in the future. Past history indicates that on average, sick leave taken each reporting period is less than the entitlement accrued. This is expected to continue in future periods. Accordingly, it is unlikely that existing accumulated entitlements will be used by employees and no liability for unused sick leave entitlements is recognised. As sick leave is non-vesting, an expense is recognised in the statement of comprehensive income for this leave as it is taken.

3.2 Contracts for services

Public patient services (a)	307,321	294,726
Mental health services (a)	31,747	31,934
Home and community care (a)	468	646
Other contracts	1,676	1,188
Total contracts for services	341,212	328,494

(a) Private hospitals and non-government organisations are contracted to provide various services to public patients and the community.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000
3.3 Patient support costs		
Drug supplies	61,318	58,176
Pathology	52,191	45,067
Prosthesis	26,168	25,731
Other medical supplies and services	77,922	72,346
Domestic charges	21,917	20,223
Fuel, light and power	7,735	7,914
Food supplies	7,553	7,095
Patient transport costs	3,512	3,662
Research, development and other grants	700	598
Total patient support costs	259,016	240,812
3.4 Fees for visiting medical practitioners		
Fees for visiting medical practitioners (VMPs)		
Clinical	19,251	21,816
Radiology	6,720	7,063
Total fees for visiting medical practitioners	25,971	28,879

VMPs, both general practitioners and specialists, are contracted to provide medical services to a hospital via a Medical Services Agreement. VMPs are independent contractors operating medical businesses and are not Health Service employees.

3.5 Repairs, maintenance and consumable equipment		
Repairs, maintenance and consumable equipment		
Repairs and maintenance	23,461	21,469
Consumable equipment	12,984	7,192
Total repairs, maintenance and consumable equipment	36,445	28,661

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 'Property, plant and equipment').

3.6 Other supplies and services		
Other supplies and services (recognised as an expense as incurred)		
Sanitisation and waste removal services	1,796	1,660
Administration and management services	3,058	2,466
Interpreter services	1,509	1,525
Security services	3,433	1,683
Contract management	147	133
Outsourced health promotion	140	98
Outsourced engineering	130	106
Employee assistance	86	100
Other	173	618
Total other supplies and services	10,472	8,389

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000
3.7 Other expenses		
Other expenses		
Services provided by Health Support Services: (a)		
ICT services	41,925	39,681
Supply chain services	11,495	5,302
Financial services	2,016	2,048
Human resources services	8,069	6,831
Workers compensation insurance	20,373	17,929
Lease expenses (b)	128	45
Other insurances	8,311	6,547
Legal services (c)	1,259	87
Audit fees (c)	959	711
Consultancy fees	3,438	4,446
Printing and stationery	3,139	2,841
Library subscription	1,495	1,464
Expected credit losses expense (d)	514	342
Communications	2,412	2,174
Freight, cartage and manual handling fees (c)	593	472
Other employee related expenses	2,292	1,452
Write-down of assets (e)	-	469
Loss on disposal of non-current assets (f)	26	67
Asset revaluation decrement (c)	1,764	-
Motor vehicle expenses	507	494
Computer services	2,694	4,242
Accommodation (c)	438	497
Other	3,049	1,076
Total other expenses	116,896	99,217

(a) Services received free of charge. (See note 4.1 'Income from State Government').
(b) See note 5.3 'Right-of-use assets' and 7.1 'Lease liabilities'. Included within lease expenses are short-term leases with lease terms of up to 12 months and low-value leases with identified assets of up to $5,000 both of these exclude leases with another wholly-owned public sector lessor agency. The lease expenses also include variable lease payments and maintenance expenses related to the leased assets.
(c) These expenses have been reclassified for comparative purposes
(d) Expected credit losses expense is recognised as the movement in the allowance for expected credit losses. The allowance for expected credit losses of trade receivables is measured at the lifetime expected credit losses at each reporting date. The Health Service has established a provision matrix that is based on its historical credit loss experience. (See note 6.1.1 'Movement of the allowance for impairment of receivables').
(e) See note 5.1 'Property, plant and equipment'.
(f) Loss on disposal of non-current assets is now included as part of other expenses.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000

Note 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 income received by the Health Service and the relevant notes are:

	Note
Income from State Government	4.1
Commonwealth grants and contributions	4.2
Other grants and contributions	4.3
Patient charges	4.4
Other fees for services	4.5
Donation income	4.6
Commercial activities	4.7
Other income and recoveries	4.8

4.1 Income from State Government

	2022 $000	2021 $000
Service Agreement received (a):		
Department of Health - Service Agreement - State component (b)	880,558	826,326
Department of Health - Service Agreement - Commonwealth component	526,449	487,385
Total service agreement received from Department of Health	1,407,007	1,313,711
Mental Health Commission - Service Agreement	210,998	193,229
Income from other state government agencies (c):		
Disability Services Commission - community aids and equipment program	339	536
Insurance Commission of Western Australia - patient fees MVIT (motor injuries)	33,205	34,384
Insurance Commission of Western Australia - RiskCover insurance rebate	14	84
Road Trauma Program - Injury Prevention	605	621
Health Technology Management Services	5,645	5,478
Business Intelligence Services	4,284	4,251
Other Health Service Providers	541	507
Total income from other state government agencies	44,633	45,861

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000
4.1 Income from State Government (continued)		
Resources received from other state government agencies during the year (e):		
Services received free of charge:		
Health Support Services - shared services		
ICT services	41,925	39,682
Supply chain services	11,495	5,302
Financial services	2,016	2,048
Human resources services	8,069	6,831
Rapid Antigen Test Kits	3,299	-
PathWest - indirect costs	17,917	15,629
Department of Justice - legal services	388	-
Department of Finance - rental lease management	12	12
Assets transferred in (out):	4,783	519
Total resources received	89,904	70,023
Total income from State Government	1,752,542	1,622,824

(a) Service agreement income is recognised at fair value in the period in which the Health Service gains control of the funds. The Health Service gains control of the funds at the time those funds are deposited in the bank account. If the service agreement specifies specific performance obligation(s), the income is recognised when the Health Service has satisfied its performance obligation(s).

(b) Service agreement from Department of Health comprises a cash component and a receivable (asset) component. The receivable which is the Holding Account (see note 6.2 'Amounts receivable for services (Holding Account)') comprises the budgeted depreciation expense for the year and any agreed increase in leave liabilities.

(c) Income from other state government agencies include amounts paid by other government agencies on a charge out basis (fee for service model).

(d) Resources received from other state government agencies are recognised as income (and assets or expenses) equivalent to the fair value of the assets, or the fair value of those services that can be reliably determined and which would have been purchased if not donated.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000
4.2 Commonwealth grants and contributions		
Recurrent grants	240	476
Total Commonwealth grants and contributions	240	476

Following update in the Treasury Instruction 1102, income is recognised based on the immediate funding source. Where the Commonwealth funding is received via a Service Agreement with Department of Health who has control of the funding, this is recognised as Income from State Government. Refer to Note 4.1 Income from State Government.

4.3 Other grants and contributions		
Research and other grants	1,087	1,483
Total other grants and contributions	1,087	1,483
4.4 Patient charges		
Inpatient bed charges	34,453	33,008
Inpatient other charges	4,497	4,469
Outpatient charges	6,993	6,656
Total patient charges	45,943	44,133
4.5 Other fees for services		
Non-clinical services to other health organisations	490	763
Total other fees for services	490	763
4.6 Donation income		
General public donations	98	266
Total donations	98	266
4.7 Commercial Activities - Sale of Goods		
Sales:		
Cafeteria sales income	3,402	3,177
Cost of sales	(3,496)	(3,348)
Gross loss	(94)	(171)

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

4.8 Other income and recoveries

	2022 $000	2021 $000
Abatements	391	322
Royalty income	1,277	1,014
Rent from commercial properties	888	809
Parking	568	741
Commissions	168	123
Sponsorship	494	501
Training and education	32	59
Clinical trial income	2,675	2,509
Medical reports and certificates	109	104
Use of hospital facilities	-	10
Pharmaceutical Benefits Scheme (PBS)	39,500	39,168
Reversal asset revaluation decrement	-	980
Other	580	326
Total other income and recoveries	46,682	46,666

Income recognition
Until 30 June 2019, income was recognised and measured at the fair value of consideration received or receivable. From 1 July 2019, income is recognised at the transaction price when the Health Service transfers control of the services to customers. Income is recognised for the major activities as follows:

Sale of goods
Income is recognised at the transaction price when the Health Service transfers control of the goods to customers.

Provision of services
Income is recognised on delivery of the service to the customer.

Grants, donations, gifts and other non-reciprocal contributions
Income is recognised at fair value when the Health Service obtains control over the assets comprising the contributions, usually when cash is received. Other non-reciprocal contributions that are not contributions by owners are recognised at their fair value. Contributions of services are only recognised when a fair value can be reliably determined and the services would be purchased if not donated.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000

Note 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.

	Note
Property, plant and equipment	5.1
Intangible assets	5.2
Right-of-use assets	5.3
Service concession assets (SCA)	5.4
Depreciation and amortisation expense	5.5

5.1 Property, plant and equipment

Land

Carrying amount	77,004	78,868
Reconciliation:		
Carrying amount at start of period	78,868	77,858
Transfers from/(to) other reporting entities	-	30
Revaluation increments/(decrements)	(1,864)	980
Carrying amount at end of period	77,004	78,868

Buildings

Carrying amount	445,864	399,875
Reconciliation:		
Carrying amount at start of period	399,875	404,756
Additions	30,623	8,805
Transfers from works in progress	7,975	2,314
Revaluation increments/(decrements)	30,287	6,746
Write-down of assets	-	(23)
Depreciation	(22,896)	(22,723)
Carrying amount at end of period	445,864	399,875

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000
5.1 Property, plant and equipment (continued)		
Site infrastructure		
Gross carrying amount	27,459	27,459
Accumulated depreciation	(9,217)	(7,680)
Carrying amount	18,242	19,779
Reconciliation:		
Gross carrying amount at start of period	27,459	28,956
Accumulated depreciation	(7,680)	(7,642)
Carrying amount at start of period	19,779	21,314
Depreciation	(1,537)	(1,535)
Carrying amount at end of period	18,242	19,779
Leasehold improvements		
Gross carrying amount	3,227	3,221
Accumulated depreciation	(1,854)	(1,512)
Carrying amount	1,373	1,709
Reconciliation:		
Gross carrying amount at start of period	3,221	2,993
Accumulated depreciation	(1,512)	(1,162)
Carrying amount at start of period	1,709	1,831
Additions	6	228
Depreciation	(342)	(350)
Carrying amount at end of period	1,373	1,709
Computer equipment		
Gross carrying amount	6,464	5,087
Accumulated depreciation	(1,541)	(550)
Carrying amount	4,923	4,537
Reconciliation:		
Gross carrying amount at start of period	5,087	2,126
Accumulated depreciation	(550)	(2,124)
Carrying amount at start of period	4,537	2
Additions	1,500	4,589
Transfers from works in progress	5	351
Transfers between asset classes	(11)	-
Depreciation	(1,108)	(405)
Carrying amount at end of period	4,923	4,537

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000
5.1 Property, plant and equipment (continued)		
Furniture and fittings		
Gross carrying amount	2,404	2,325
Accumulated depreciation	(1,522)	(1,375)
Carrying amount	882	950
Reconciliation:		
Gross carrying amount at start of period	2,325	2,905
Accumulated depreciation	(1,375)	(1,686)
Carrying amount at start of period	950	1,219
Additions	113	3
Transfers from works in progress	-	(39)
Disposals	(5)	-
Transfers between asset classes	(6)	-
Depreciation	(170)	(233)
Carrying amount at end of period	882	950
Motor vehicles		
Gross carrying amount	75	75
Accumulated depreciation	(38)	(32)
Carrying amount	37	43
Reconciliation:		
Gross carrying amount at start of period	75	75
Accumulated depreciation	(32)	(25)
Carrying amount at start of period	43	50
Depreciation	(6)	(7)
Carrying amount at end of period	37	43

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000
5.1 Property, plant and equipment (continued)		
Medical equipment		
Gross carrying amount	77,228	65,107
Accumulated depreciation	(40,441)	(33,258)
Carrying amount	36,787	31,849
Reconciliation:		
Gross carrying amount at start of period	65,107	61,085
Accumulated depreciation	(33,258)	(31,552)
Carrying amount at start of period	31,849	29,533
Additions	8,616	8,978
Transfers from/(to) other reporting entities	4,040	496
Transfers from works in progress	43	14
Disposals	(39)	(77)
Transfers between asset classes	6	-
Write-down of assets (a)	-	(9)
Depreciation	(7,728)	(7,086)
Carrying amount at end of period	36,787	31,849
Other plant and equipment		
Gross carrying amount	14,465	13,062
Accumulated depreciation	(5,140)	(4,080)
Carrying amount	9,325	8,982
Reconciliation:		
Gross carrying amount at start of period	13,062	16,334
Accumulated depreciation	(4,080)	(7,229)
Carrying amount at start of period	8,982	9,105
Additions	1,303	937
Transfers from works in progress	559	-
Disposals	(232)	-
Transfers between asset classes	11	-
Depreciation	(1,298)	(1,060)
Carrying amount at end of period	9,325	8,982
Artworks		
Carrying amount	1,062	1,062
Reconciliation:		
Carrying amount at start of period	1,062	1,062
Additions	-	-
Carrying amount at end of period	1,062	1,062

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000
5.1 Property, plant and equipment (continued)		
Works in progress		
Carrying amount	30,397	30,436
Reconciliation:		
Carrying amount at start of period	30,436	10,158
Additions	8,564	23,016
Capitalised to asset classes	(8,582)	(2,640)
Transfers between asset classes	-	339
Write-down of assets (a)	(21)	(437)
Carrying amount at end of period	30,397	30,436
Total property, plant and equipment		
Gross carrying amount	685,649	626,577
Accumulated depreciation	(59,753)	(48,487)
Carrying amount	625,896	578,090
Reconciliation:		
Gross carrying amount at start of period	626,575	608,309
Accumulated depreciation	(48,487)	(51,421)
Carrying amount at start of period	578,088	556,888
Additions	50,726	46,556
Transfers from/(to) other reporting entities	4,040	526
Disposals	(276)	(77)
Revaluation increments/(decrements)	28,423	7,726
Transfers between asset classes	0	339
Write-down of assets (a)	(21)	(469)
Depreciation	(35,085)	(33,399)
Carrying amount at end of period	625,896	578,090

(a) Expenses capitalised in the previous financial year, expensed in the current financial year. See note 3.7 'Other expenses'.

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 significantly less than fair value, 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).

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.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000

5.1 Property, plant and equipment (continued)

Subsequent measurement
Subsequent to initial recognition as an asset, the revaluation model is used for the measurement of land and buildings and historical cost for all other property, plant and equipment. Land and buildings are carried at fair value less accumulated depreciation (buildings) and accumulated impairment losses. All other items of property, plant and equipment are carried at historical cost less accumulated depreciation and accumulated impairment losses.

Where market-based evidence is available, the fair value of land and buildings (non-clinical sites) is determined on the basis of current market values by reference to recent market transactions.

In the absence of market-based evidence, fair value of land and buildings (clinical sites) is determined on the basis of existing use. This normally applies where buildings are specialised or where land use is restricted. Fair value for existing use 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. Fair value for restricted use land 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).

When buildings are revalued, the accumulated depreciation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount.

Land and buildings are independently valued annually by the Western Australian Land Information Authority (Valuation Services) 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 2021 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2022 and recognised at 30 June 2022. In undertaking the revaluation, fair value was determined by reference to market values for land: $20.5 million (2021: $19.1 million) and buildings: $2.0 million (2021: $1.7 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).

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

5.1 Property, plant and equipment (continued)

Revaluation model
Where market-based evidence is available, the fair value of land and buildings (non-clinical sites) is determined on the basis of current market values by reference to recent market transactions.

In the absence of market-based evidence, fair value of land and buildings (clinical sites) is determined on the basis of existing use. This normally applies where buildings are specialised or where land use is restricted. Fair value for existing use 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. Fair value for restricted use land 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).

When buildings are revalued, the accumulated depreciation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount.

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. In order to estimate fair value on the basis of existing use, the current replacement costs are determined on the assumption that the buildings will be used for the same functions in the future. A major change in utilisation of the buildings may result in material adjustment to the carrying amounts.

Derecognition
Upon disposal or derecognition of an item of property, plant and equipment, any revaluation surplus relating to that asset is retained in the asset revaluation reserve.

Impairment of assets
Property, plant and equipment and intangible assets are tested for any indication of impairment at the end of each reporting period. 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 recoverable amount, an impairment loss is recognised in profit or loss. Where a previously revalued asset is written down to recoverable amount, the loss is recognised as a revaluation decrement in other comprehensive income. As the Health Service is a not-for-profit entity, unless a specialised asset has been identified as a surplus asset, the recoverable amount is the higher of an asset's fair value less costs to sell and depreciated replacement cost.

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.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000

5.1 Property, plant and equipment (continued)

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.

The recoverable amount of assets identified as surplus assets is the higher of fair value less costs to sell and the present value of future cash flows expected to be derived from the asset. Surplus assets carried at fair value have no risk of material impairment where fair value is determined by reference to market-based evidence. Where fair value is determined by reference to depreciated replacement cost, surplus assets are at risk of impairment and the recoverable amount is measured. Surplus assets at cost are tested for indications of impairment at the end of each reporting period.

As at 30 June 2022 there were no indications of impairment to property, plant and equipment and intangible assets.

5.2 Intangible assets

Computer software		
Gross carrying amount	481	345
Accumulated amortisation	(342)	(310)
Carrying amount	139	35
Reconciliation:		
Gross carrying amount at start of the period	345	2,749
Accumulated amortisation	(310)	(2,663)
Carrying amount at start of the period	35	86
Additions	136	-
Amortisation	(32)	(51)
Carrying amount at end of the period	139	35
Works in progress		
Carrying amount	-	-
Reconciliation:		
Carrying amount at start of period	-	339
Additions	-	-
Transfers between asset classes	-	(339)
Carrying amount at end of period	-	-

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000
5.2 Intangible assets (continued)		
Total intangible assets		
Gross carrying amount	481	345
Accumulated amortisation	(342)	(310)
Carrying amount	139	35
Reconciliation:		
Gross carrying amount at start of period	345	3,088
Accumulated amortisation	(310)	(2,663)
Carrying amount at start of period	35	425
Additions	136	-
Transfers between asset classes	-	(339)
Amortisation	(32)	(51)
Carrying amount at end of period	139	35

Computer software
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.

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.

Acquisitions of intangible assets costing $5,000 or more and internally generated intangible assets costing $50,000 or more are capitalised and measured at cost. Costs incurred below these thresholds are immediately expensed directly to the statement of comprehensive income.

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

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

See note 5.1 'Property, plant and equipment' for testing assets for impairment.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000
5.3 Right-of-use assets		
Buildings		
Gross carrying amount	994	527
Accumulated depreciation	(289)	(365)
Carrying amount	705	162
Reconciliation:		
Opening net carrying amount	162	48
Additions	769	297
Depreciation	(226)	(183)
Carrying amount at end of the period	705	162
Vehicles		
Gross carrying amount	2,293	2,402
Accumulated depreciation	(1,203)	(924)
Carrying amount	1,090	1,478
Reconciliation:		
Opening net carrying amount	1,478	1,941
Additions	69	88
Disposals (leases expired)	(1)	(16)
Depreciation	(456)	(535)
Carrying amount at end of the period	1,090	1,478
Total Right-of-use assets		
Gross carrying amount	3,287	2,929
Accumulated depreciation	(1,492)	(1,289)
Carrying amount	1,795	1,640
Reconciliation:		
Opening carrying amount	1,640	1,989
Additions	838	385
Disposals (leases expired)	(1)	(16)
Depreciation	(682)	(718)
Carrying amount at end of the period	1,795	1,640

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000

5.3 Right-of-use assets (continued)

Initial Recognition

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

- the net present value of the future minimum payments
- 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 (make good provision)

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). Lease payments associated with these leases are expensed as incurred.

Subsequent Measurement

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

Depreciation and impairment of right-of-use assets

Right-of-use assets are depreciated on a straight-line basis over the lease term as the Health Service generally expect to fully consume the useful life of the assets over the lease term. The lease term includes option to extend the lease if it is stated in the contract and the Health Service is reasonably certain to exercise the option.

Right-of-use assets are tested for impairment when an indication of impairment is identified.

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

Depreciation expense of right-of-use assets		
Buildings	226	183
Vehicles	456	535
Total right-of-use asset depreciation	682	718
Lease interest expense (included in Finance cost)	10	2
Short-term leases (included in Other Expenses)	18	-

The statement of cash flows shows the following amounts relating to leases:

Finance costs	52	58
Principal elements of lease payments	688	444

The Health Service has leases for vehicles and office accommodation (buildings).

The Health Service has secured the right-of-use assets against the related lease liabilities for the vehicles. In the event of default, the rights to the leased motor vehicles will revert to the lessor.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000

5.3 Right-of-use assets (continued)

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 at note 7.1 Lease liabilities.

Key judgements have been made in determining whether there is reasonable certainty around exercising contract 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. In addition, uncertainty may arise from the estimation of the lease term, determination of the appropriate discount rate to discount the lease payments and assessing whether right-of-use assets may require impairment.

5.4 Service concession assets (SCA)

Land SCA		
Carrying amount	11,100	11,000
Reconciliation:		
Carrying amount at start of period	11,000	11,000
Revaluation increments/(decrements)	100	-
Carrying amount at end of period	11,100	11,000
Buildings SCA		
Carrying amount	269,192	251,286
Reconciliation:		
Carrying amount at start of period	251,286	256,870
Revaluation increments/(decrements)	23,617	124
Depreciation	(5,711)	(5,708)
Carrying amount at end of period	269,192	251,286

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000
5.4 Service concession assets (SCA) (continued)		
Site infrastructure SCA		
Gross carrying amount	16,831	16,831
Accumulated depreciation	(1,098)	(732)
Carrying amount	15,733	16,099
Reconciliation:		
Gross carrying amount at start of period	16,831	16,831
Accumulated depreciation	(732)	(366)
Carrying amount at start of period	16,099	16,465
Depreciation	(366)	(366)
Carrying amount at end of period	15,733	16,099
Computer equipment SCA		
Gross carrying amount	215	215
Accumulated depreciation	(215)	(215)
Carrying amount	-	-
Reconciliation:		
Gross carrying amount at start of period	215	215
Accumulated depreciation	(215)	(215)
Carrying amount at end of period	-	-
Furniture and fittings SCA		
Gross carrying amount	776	776
Accumulated depreciation	(534)	(356)
Carrying amount	242	420
Reconciliation:		
Gross carrying amount at start of period	776	776
Accumulated depreciation	(356)	(178)
Carrying amount at start of period	420	598
Depreciation	(178)	(178)
Carrying amount at end of period	242	420
Medical equipment SCA		
Gross carrying amount	7,443	7,443
Accumulated depreciation	(4,203)	(2,856)
Carrying amount	3,240	4,587
Reconciliation:		
Gross carrying amount at start of period	7,443	7,443
Accumulated depreciation	(2,856)	(1,439)
Carrying amount at start of period	4,587	6,004
Depreciation	(1,347)	(1,417)
Carrying amount at end of period	3,240	4,587

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000
5.4 Service concession assets (SCA) (continued)		
Other plant and equipment SCA		
Gross carrying amount	12,909	12,909
Accumulated depreciation	(3,854)	(2,755)
Carrying amount	9,055	10,154
Reconciliation:		
Gross carrying amount at start of period	12,909	12,909
Accumulated depreciation	(2,755)	(1,377)
Carrying amount at start of period	10,154	11,532
Depreciation	(1,099)	(1,377)
Carrying amount at end of period	9,055	10,154
Artworks SCA		
Carrying amount	1,000	1,000
Reconciliation:		
Carrying amount at start of period	1,000	1,000
Carrying amount at end of period	1,000	1,000
Computer software SCA		
Gross carrying amount	1,068	1,068
Accumulated amortisation	(1,068)	(1,068)
Carrying amount	-	-
Reconciliation:		
Gross carrying amount at start of the period	1,068	1,068
Accumulated amortisation	(1,068)	(801)
Carrying amount at start of the period	-	267
Amortisation	-	(267)
Carrying amount at end of the period	-	-
Total service concession assets		
Gross carrying amount	320,534	302,528
Accumulated depreciation	(10,972)	(7,982)
Carrying amount	309,562	294,546
Reconciliation:		
Gross carrying amount at start of period	302,528	308,112
Accumulated depreciation	(7,982)	(4,376)
Carrying amount at start of period	294,546	303,736
Revaluation increments/(decrements)	23,717	124
Depreciation	(8,701)	(9,312)
Carrying amount at end of period	309,562	294,546

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000

5.4 Service concession assets (SCA) (continued)

AASB 1059 'Service Concession Arrangements: Grantor' defines a service concession arrangement as 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 at its own discretion rather than at the direction of the grantor.

The Health Service manages a contract in relation to a 20-year public-private partnership agreement between St John of God Health Care and the State of Western Australia that was signed in 2012, to operate a hospital for public patients in Midland - St John of God Midland Public Hospital (SJOGMPH).

Where the Health Service identified existing assets which meet the conditions as set under AASB 1059, these assets have been reclassified as service concession assets and measured initially at current replacement cost in accordance with the cost approach to fair value in AASB 13 Fair Value Measurement.

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.

5.5 Depreciation and amortisation expense

Depreciation and amortisation charge for the period:		
Buildings	22,896	22,723
Medical equipment	7,728	7,086
Site infrastructure	1,537	1,536
Leasehold improvements	342	350
Computer equipment	1,108	405
Furniture and fittings	170	233
Motor vehicles	6	6
Other plant and equipment	1,298	1,060
Right-of-use asset	653	683
Service concession asset	8,701	9,312
Total depreciation for the period	44,439	43,394
Total amortisation for the period - Computer software	32	51
Total depreciation and amortisation for the period	44,471	43,445

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

5.5 Depreciation and amortisation expense (continued)

Useful lives
All 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 works of art. 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 for each class of depreciable asset (including intangibles) are:

Buildings	50 years
Site infrastructure	50 years
Leasehold improvements	Term of the lease
Computer equipment	3 to 10 years
Furniture and fittings	2 to 20 years
Motor vehicles	3 to 10 years
Medical equipment	2 to 25 years
Other plant and equipment	3 to 50 years
Computer software	5 to15 years

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

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

The Health Service's policy is to depreciate all items of property, plant and equipment on a straight-line basis. The exception to this are land and works of art, which are considered to have an indefinite life. 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.

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.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000

Note 6 Other assets and liabilities

This section sets out the Health Service's other assets utilised for economic benefits and liabilities incurred during normal operations.

Assets	Note
Receivables	6.1
Amounts receivable for services (Holding Account)	6.2
Inventories	6.3
Other current assets	6.4
Liabilities	
Payables	6.5
Grant liabilities	6.6
Other current liabilities	6.7

6.1 Receivables

Current		
Patient fee debtors (a)	25,316	24,821
Other receivables	2,597	2,755
Less: Allowance for impairment of receivables	(14,506)	(15,164)
Accrued income	9,228	10,948
GST receivable	4,184	4,249
Total current	26,819	27,609

The Health Service does not hold any collateral or other credit enhancements as security for receivables.

(a) Under the Private Patient Scheme approved by the State Government, the Department of Health provides ex-gratia payments towards private patient fees not paid in full by health insurance funds. The Health Service has received $0.8 million in ex-gratia payments for the 2021-22 period (2020-21: $1.4 million). Receipt of ex-gratia payments from the Department have been applied by the Health Service against the patient fee invoices reducing the debtors balance.

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000

6.1 Receivables (continued)

Accounting procedure for Goods and Services Tax
Rights to collect amounts receivable from the Australian Taxation Office (ATO) and responsibilities to make payments for Goods and Services Tax (GST) have been assigned to the Department of Health. This accounting procedure was a result of application of the grouping provisions of *A New Tax System (Goods and Services Tax) Act 1999* whereby the Department of Health became the Nominated Group Representative (NGR) for the GST Group as from 1 July 2012. The entities in the GST group include the Department of Health, Mental Health Commission, South Metropolitan Health Service, North Metropolitan Health Service, East Metropolitan Health Service, Child and Adolescent Health Service, Health Support Services, WA Country Health Service, PathWest Laboratory Medicine WA, QE II Medical Centre Trust, and Health and Disability Services Complaints Office.

GST receivables on accrued expenses are recognised by the Health Service. Upon the receipt of tax invoices, GST receivables for the GST group are recorded in the accounts of the Department of Health.

6.1.1 Movement of the allowance for impairment of receivables

Balance at start of period	15,164	18,778
Expected credit losses (note 3.7 'Other expenses')	514	342
Amounts written off during the period	(728)	(2,591)
Amount recovered during the period	27	-
Debt waivers during the period (a)	(471)	(1,365)
Balance at end of period	14,506	15,164

(a) Debt waivers are discretionary in nature and under justifiable and reasonable circumstances, can be used by the Accountable Authority to permanently forgive a debt.

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.

Key sources of estimation uncertainty - Provision for doubtful debt
Historical debt collection trends are used to estimate impairment of receivables. Changes in the economic, political and legislative environment can affect debt collection rates. These changes may impact the carrying amount of receivables.

6.2 Amounts receivable for services (Holding Account)

Non-current	613,846	570,045
Total amounts receivable for services	613,846	570,045

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).

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000
6.3 Inventories		
Current		
Pharmaceutical stores - at cost	4,615	4,066
Engineering stores - at cost	759	606
Total inventories	5,374	4,672

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		
Current		
Prepayments	29,784	26,616
Total other assets	29,784	26,616

Other non-financial assets include prepayments which represent payments in advance of receipt of goods or services or that part of expenditure made in one accounting period covering a term extending beyond that period.

6.5 Payables		
Current		
Accrued expenses	61,796	60,986
Trade creditors	5,428	12,398
Accrued salaries	30,105	27,916
Other creditors	22	22
Total current	97,351	101,322

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 7-30 days.

TI 323 Timely Payment of Accounts require payments for goods, services and constructions of less than $1 million and not subject to an exemption, to be paid within 20 calendar days. Payments over $1 million are required to be settled within 30 calendar days of the sooner of the receipt of a correctly rendered invoice, or, provision of goods or services.

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000
6.6 Grant liabilities		
Current	955	1,255
Non-current	-	-
	955	1,255
Reconciliation of changes in grant liabilities		
Balance at start of period	1,255	-
Additions	-	1,731
Income recognised in the reporting period	(300)	(476)
Balance at end of period	955	1,255
Expected satisfaction of grant liabilities		
Within 1 year	500	1,255
Later than 1 year, and not later than 5 years	455	-
Later than 5 years	-	-
Balance at end of period	955	1,255

The Health Service received funding from the Community Health and Hospital Program for the construction of Mental Health Emergency Centre at the St John of God Midland Public Hospital. The grant liabilities represent the amount unspent at the reporting date.

	2022 $000	2021 $000
6.7 Other current liabilities		
Current		
Refundable deposits	225	209
Paid parental leave scheme	94	99
Unearned income	635	321
Other	136	115
Total current	1,090	744

Note 7 Financing

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

	Note
Lease liabilities	7.1
Finance costs	7.2
Cash and cash equivalents	7.3
Reconciliation of cash	7.3.1
Reconciliation of net cost of services to net cash flows used in operating activities	7.3.2
Commitments	7.4

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000
7.1 Lease liabilities		
Current	609	552
Non-current	1,229	1,112
	1,838	1,664

Initial measurement
At the commencement date of the lease, the Health Service recognises lease liabilities measured at the present value of lease payments to be made over the lease term. 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 dependant on sales are recognised by the Health Service in profit or loss in the period in which the condition that triggers those payment occurs.

This section should be read in conjunction with note 5.3.

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.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000
7.2 Finance costs		
Finance costs		
Finance lease charges	52	58
Total finance costs	52	58

Finance costs include the interest component of lease liability repayments.

7.3 Cash and cash equivalents

7.3.1 Reconciliation of cash

Current		
Cash and cash equivalents	112,886	128,130
Restricted cash and cash equivalents (a)	41,892	37,057
	154,778	165,187
Non-current		
Accrued salaries suspense account (b)	20,889	16,679
Total cash and cash equivalents at end of period	175,667	181,866

(a) Restricted cash and cash equivalents are assets, the uses of which are restricted by specific legal or other externally imposed requirements. These include medical research grants, donations for the benefits of patients, medical education, scholarships, capital projects, employee contributions and staff benevolent funds.

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

For the purpose of the statement of cash flows, cash and cash equivalent (and restricted cash and cash equivalent) assets comprise of cash on hand and cash at bank.

The accrued salaries suspense account (see note 7.3.1 'Reconciliation of cash') consists of amounts paid, from Health Service appropriations for salaries expense, into a Treasury suspense account to meet 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.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

		2022 $000	2021 $000
7.3.2 Reconciliation of net cost of services to net cash flows used in operating activities			
Net cost of services (statement of comprehensive income)		(1,767,617)	(1,627,081)
Non-cash items	Note		
Depreciation and amortisation expense	5.5	44,471	43,445
Expected credit loss expense	3.7	514	342
Services received free of charge	4.1	85,120	69,508
Net (gain)/loss on disposal of non-current assets	3.7	26	67
Donation of non-current assets		(45)	(135)
Write down of property, plant and equipment	3.7	-	469
Asset revaluation decrement	3.7	1,764	-
Reversal asset revaluation decrement	4.8	-	(980)
Write-off of receivables	6.1.1	(1,199)	(3,956)
Adjustment for other non-cash items		(276)	785
(Increase)/decrease in assets			
GST receivable	6.1	65	(898)
Other current receivables	6.1	1,383	53
Inventories	6.3	(702)	(175)
Prepayments and other current assets	6.4	(3,168)	(25,540)
Increase/(decrease) in liabilities			
Current payables	6.5	(1,424)	5,874
Current employee benefits provisions	3.1.2	16,156	18,442
Other current liabilities	6.7	346	217
Non-current employee benefits provisions	3.1.2	(223)	4,527
Net cash used in operating activities (statement of cash flows)		(1,624,809)	(1,515,036)

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

		2022 $000	2021 $000
7.4	**Commitments**		
7.4.1	**Capital commitments**		

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

Within 1 year	18,690	17,629
Balance at end of period	18,690	17,629

The totals presented for capital commitments are inclusive of GST.

7.4.2 Private sector contracts for the provision of health services commitments

Expenditure commitments in relation to private sector organisations contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:

Within 1 year	395,728	370,202
Later than 1 year, and not later than 5 years	1,916,197	1,499,315
Later than 5 years, and not later than 10 years	2,043,157	1,925,599
Later than 10 years	863,404	2,084,786
Balance at end of period	5,218,486	5,879,902

The totals presented for private sector contracts for the provision of health services commitments are inclusive of GST.

7.4.3 Other commitments

Other expenditure commitments contracted for at the reporting period but not recognised as liabilities, are payable as follows:

Within 1 year	93,316	41,691
Later than 1 year, and not later than 5 years	4,781	3,136
Balance at end of period	98,097	44,827

The totals presented for other commitments are inclusive of GST.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

Note 8 Risks and contingencies

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

	Note
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, borrowings, finance leases, receivables and payables. The Health Service has limited exposure to financial risks. The Health Service's overall risk management program focuses on managing the risks identified below.

All financial assets and liabilities recognised in the statement of financial position, whether they are carried at cost or fair value, are recognised at amounts that represent a reasonable approximation of fair value unless otherwise stated in the applicable notes.

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 generally confined to patient fee debtors (see note 6.1 'Receivables'). The main receivable of the Health Service is the amounts receivable for services (holding account). For receivables other than government agencies and patient fee debtors, 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.

In circumstances where a third party is responsible for payment, or there are legal considerations, payment of accounts can be delayed considerably. Unpaid debts are referred to an external debt collection service on a case by case basis, considering financial election and reasons for non-payment.

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 normal course of operations.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000
8.1 Financial risk management (continued)		

The Health Service has appropriate procedures to manage cash flows including drawdowns 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. The Health Service's exposure to market risk for changes in interest rates relates primarily to the long-term debt obligations. The Health Service's borrowings are limited to the Department of Treasury loans. The interest rate risk for the loans is managed by the Department of Treasury through portfolio diversification and variation in maturity dates.

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:

Financial assets		
Cash and cash equivalents	112,886	128,130
Restricted cash and cash equivalents	62,781	53,736
Financial assets at amortised cost (1)	22,635	23,360
Amounts receivable for services	613,846	570,045
Total financial assets	812,148	775,271
Financial liabilities		
Financial liabilities measured at amortised cost	100,144	104,241
Total financial liabilities	100,144	104,241

(1) The amount of receivables and financial assets at amortised cost excludes GST recoverable from ATO (statutory receivable).

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

8.1 Financial risk management (continued)

c) Credit risk exposure

		Days past due				
	Total	Current	< 30 days	31-60 days	61-90 days	>91 days*
	$000	$000	$000	$000	$000	$000
30 June 2022						
Expected credit loss rate		4%	9%	21%	29%	77%
Estimated total gross carrying amount at default	37,141	12,536	4,893	1,875	1,216	16,621
Expected credit losses	(14,506)	(558)	(425)	(392)	(354)	(12,777)
30 June 2021						
Expected credit loss rate		4%	14%	30%	35%	82%
Estimated total gross carrying amount at default	38,524	16,640	2,947	1,471	1,552	15,914
Expected credit losses	(15,164)	(724)	(423)	(446)	(539)	(13,032)

*Includes receivables with maturity dates greater than 2 years.

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.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

8.1 Financial risk management (continued)

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

		Interest rate exposure				Maturity dates			
	Weighted average effective interest rate	Carrying amount	Fixed interest rate	Variable interest rate	Non-interest bearing	Nominal amount	Up to 3 months	3 months to 1 year	1 - 5 years	More than 5 years
	%	$000	$000	$000	$000	$000	$000	$000	$000	$000
2022										
Financial Assets										
Cash and cash equivalents		112,886	-	-	112,886	112,886	112,886	-	-	-
Restricted cash and cash equivalents		62,781	-	-	62,781	62,781	62,781	-	-	-
Receivables - non-interest bearing (1)		22,635	-	-	22,635	22,635	22,635	-	-	-
Amounts receivable for services		613,846	-	-	613,846	613,846	-	-	-	613,846
		812,148	-	-	812,148	812,148	198,302	-	-	613,846
Financial Liabilities										
Payables	-	97,351	-	-	97,351	97,351	97,351	-	-	-
Lease liabilities	3.09%	1,838	1,838	-	-	1,838	-	609	1,224	5
		99,189	1,838	-	97,351	99,189	97,351	609	1,224	5
2021										
Financial Assets										
Cash and cash equivalents		128,130	-	-	128,130	128,130	128,130	-	-	-
Restricted cash and cash equivalents		53,736	-	-	53,736	53,736	53,736	-	-	-
Receivables - non-interest bearing (1)		23,360	-	-	23,360	23,360	23,360	-	-	-
Amounts receivable for services		570,045	-	-	570,045	570,045	-	-	-	570,045
		775,271	-	-	775,271	775,271	205,226	-	-	570,045
Financial Liabilities										
Payables	-	101,322	-	-	101,322	101,322	101,322	-	-	-
Department of Treasury Loans	3.16%	1,664	1,664	-	-	1,664	-	553	1,106	5
		102,986	1,664	-	101,322	102,986	101,322	553	1,106	5

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

e) Interest rate sensitivity analysis

The Health Service does not have exposure on changes to the interest rate environment as it does not have financial instrument which depends on variable interest rates.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

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, are measured at the best estimate.

Contingent assets and 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

The Health Service has no 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 Act, DWER classifies these sites on the basis of the risk to human health, the environment and environmental values. Where sites are classified as *contaminated – remediation required* or *possibly contaminated – investigation required*, the Health Service may have a liability in respect of investigation or remediation expenses.

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

8.3 Fair value measurements

Assets measured at fair value **2022**	**Level 1** **$000**	**Level 2** **$000**	**Level 3** **$000**	**Total** **$000**
Land (note 5.1 'Property, plant and equipment')				
Vacant land	-	890	-	890
Specialised land	-	19,650	67,564	87,214
Buildings (note 5.1 'Property, plant and equipment')				
Residential and commercial carpark	-	2,000	-	2,000
Specialised buildings	-	-	713,056	713,056
	-	22,540	780,620	803,160

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

8.3 Fair value measurements (continued)

Assets measured at fair value **2021**	**Level 1 $000**	**Level 2 $000**	**Level 3 $000**	**Total $000**
Land (note 5.1 'Property, plant and equipment')				
Vacant land	-	810	-	810
Specialised land	-	18,300	70,758	89,058
Buildings (note 5.1 'Property, plant and equipment')				
Residential and commercial carpark	-	1,740	-	1,740
Specialised buildings	-	-	649,421	649,421
	-	20,850	720,179	741,029

AASB 13 requires disclosure of fair value measurements by level of the following fair value measurement hierarchy:

Level 1 inputs - quoted prices (unadjusted) in active markets for identical assets.

Level 2 inputs - input other than quoted prices included within level 1 that are observable for the asset, either directly or indirectly.

Level 3 inputs - input not based on observable market data.

There were no transfers between levels 1, 2 or 3 during the current and previous periods.

Valuation techniques to derive level 2 and level 3 fair values

The Health Service obtains independent valuations of land and buildings from the Western Australian Land Information Authority (Valuations and Property Analytics) annually. Two principal valuation techniques are applied to the measurement of fair values:

Market approach (comparable sales)
The Health Service's commercial car park and vacant land are valued under the market approach. This approach provides an indication of value by comparing the asset with identical or similar properties for which price information is available. Analysis of comparable sales information and market data provides the basis for fair value measurement.

The best evidence of fair value is current prices in an active market for similar properties. Where such information is not available, Western Australian Land Information Authority (Valuations and Property Analytics) considers current prices in an active market for properties of different nature or recent prices of similar properties in less active markets and adjusts the valuation for differences in property characteristics and market conditions.

For properties with buildings and other improvements, the land value is measured by comparison and analysis of open market transactions on the assumption that the land is in a vacant and marketable condition. The amount determined is deducted from the total property value and the residual amount represents the building value.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

8.3 Fair value measurements (continued)

Cost approach
Properties of a specialised nature that are rarely sold in an active market or are held to deliver public services are referred to as non-market or current use type assets. These properties do not normally have a feasible alternative use due to restrictions or limitations on their use and disposal. The existing use is their highest and best use.

For current use land assets, fair value is measured firstly by establishing the opportunity cost of public purpose land, which is termed the hypothetical alternate land use value. This approach assumes unencumbered land use based upon potential highest and best alternative use as represented by surrounding land uses and market analysis.

Fair value of the land is then determined on the assumption that the site is rehabilitated to a vacant marketable condition. This requires costs associated with rehabilitation to be deducted from the hypothetical alternate land use value of the land. Costs may include building demolition, clearing, planning approvals and time allowances associated with realising that potential.

In some instances the legal, physical, economic and socio-political restrictions on land results in a minimal or negative current use land value. In this situation the land value adopted is the higher of the calculated rehabilitation amount or the amount determined on the basis of comparison to market corroborated evidence of land with low level utility. Land of low-level utility is considered to be grazing land on the urban fringe of the metropolitan area with no economic farming potential or foreseeable development or redevelopment potential at the measurement date.

The Health Service's hospitals and community centres are specialised buildings and their fair value is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset (i.e. current replacement cost). Current replacement cost is generally determined by estimating the current cost of reproduction or replacement of the building, on its current site, adjusted for physical deterioration and all relevant forms of obsolescence and optimisation. Obsolescence encompasses physical deterioration, functional (technological) obsolescence and economic (external) obsolescence. Current replacement cost is unlikely to be materially different from depreciated replacement cost as a measure of value in use of specialised assets that are rarely sold.

The techniques involved in the determination of the current replacement costs include:

a) Review and updating of the 'as-constructed' drawing documentation.
b) Categorisation of the drawings using the Building Utilisation Categories (BUC's) which designate the functional areas typically provided by the following types of clinical facilities. Each BUC has different cost rates which are calculated from the historical construction costs of similar clinical facilities and are adjusted for the year-to-year change in building costs using building cost index.
   - Nursing Posts and Medical Centres
   - Metropolitan Secondary, Specialist and General Hospitals
   - Tertiary Hospitals
c) Measurement of the general floor areas.
d) Application of the BUC cost rates per square metre of general floor areas.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

8.3 Fair value measurements (continued)

The maximum effective age used in the valuation of specialised buildings is 50 years. The effective age of buildings is initially calculated from the commissioning date and is reviewed after the buildings have undergone substantial renewal, upgrade or expansion.

The straight-line method of depreciation is applied and assumes a uniform pattern of consumption over the initial 37.5 years of asset life (up to 75% of current replacement costs). All specialised buildings are assumed to have a residual value of 25% of their current replacement costs.

The valuations are prepared on a going concern basis until the year in which the current use is discontinued. Buildings with definite demolition plan are not subject to annual revaluation. The current replacement costs at the last valuation dates for these buildings are written down to the statement of comprehensive income as depreciation expenses over their remaining useful life.

Fair value measurements using significant unobservable inputs (Level 3)

	Land $000	Buildings $000
2022		
Fair value at beginning of period	70,758	649,422
Additions	-	38,599
Revaluation increments/(decrements) recognised in profit or loss	-	-
Revaluation increments/(decrements) recognised in other comprehensive income	(3,194)	53,608
Depreciation	-	(28,573)
Fair value at end of period	67,564	713,056

	Land $000	Buildings $000
2021		
Fair value at beginning of period	70,728	658,906
Additions	30	11,097
Revaluation increments/(decrements) recognised in profit or loss	-	-
Revaluation increments/(decrements) recognised in other comprehensive income	-	7,796
Depreciation	-	(28,377)
Fair value at end of period	70,758	649,422

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

8.3 Fair value measurements (continued)

Valuation processes

Western Australian Land Information Authority (Valuation and Property Analytics) determines the fair values of the Health Service's land and buildings. A quantity surveyor is engaged by the Health Service to provide an update of the current construction costs for specialised buildings. Western Australian Land Information Authority (Valuation and Property Analytics) may endorse the current construction costs calculated by the quantity surveyor for specialised buildings and calculates the current replacement costs.

Note 9 Other disclosures

This section includes additional material disclosures required by accounting standards or other pronouncements, for the understanding of this financial report.

9.1 Events occurring after the end of the reporting period

The Health Service is unaware of any event occurring after the reporting date that would materially affect the financial statements.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

9.2 Changes in accounting policies

After assessment of the new and amended standards that have been issued but not yet effective, the Health Service has determined that none of those standards has material impact on the financial statements.

9.3 Future impact of Australian Accounting Standards not yet operative

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

Title	Operative for reporting periods beginning on/after
AASB 2020-1 Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-current This Standard amends AASB 101 to clarify requirements for the presentation of liabilities in the statement of financial position as current or non-current. There is no financial impact.	1 Jan 2023
AASB 2020-3 - Amendments to Australian Accounting Standards – Annual Improvements 2018–2020 and Other Amendments This Standard amends: (a) AASB 1 to simplify the application of AASB 1; (b) AASB 3 to update a reference to the Conceptual Framework for Financial Reporting; (c) AASB 9 to clarify the fees an entity includes when assessing whether the terms of a new or modified financial liability are substantially different from the terms of the original financial liability; (d) AASB 116 to require an entity to recognise the sales proceeds from selling items produced while preparing property, plant and equipment for its intended use and the related cost in profit or loss, instead of deducting the amounts received from the cost of the asset; (e) AASB 137 to specify the costs that an entity includes when assessing whether a contract will be loss-making; and (f) AASB 141 to remove the requirement to exclude cash flows from taxation when measuring fair value. There is no financial impact.	1 Jan 2022

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

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

Title	Operative for reporting periods beginning on/after
AASB 2020-6 - Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-current – Deferral of Effective Date	1 Jan 2022
This Standard amends AASB 101 to defer requirements for the presentation of liabilities in the statement of financial position as current or non-current that were added to AASB 101 in AASB 2020-1. There is no financial impact.	
AASB 2021-2 - Amendments to Australian Accounting Standards – Disclosure of Accounting Policies and Definition of Accounting Estimates	1 Jan 2023
This Standard amends: (a) AASB 7, to clarify that information about measurement bases for financial instruments is expected to be material to an entity's financial statements; (b) AASB 101, to require entities to disclose their material accounting policy information rather than their significant accounting policies; (c) AASB 108, to clarify how entities should distinguish changes in accounting policies and changes in accounting estimates; (d) AASB 134, to identify material accounting policy information as a component of a complete set of financial statements; and (e) AASB Practice Statement 2, to provide guidance on how to apply the concept of materiality to accounting policy disclosures. There is no financial impact.	

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

9.4 Key management personnel

The Health Service has determined that key management personnel include cabinet ministers, board members and senior officers of the Health Service. However, the Health Service is not obligated to compensate ministers and therefore disclosures in relation to ministers' compensation may be found in the *Annual Report on State Finances.*

The Board of East Metropolitan Health Service is the Accountable Authority for the Health Service.

Total compensation (includes the superannuation expense incurred by the Health Service) for key management personnel, comprising members and senior officers of the Accountable Authority for the period are presented within the following bands:

	2022	2021
Compensation of members of the Accountable Authority		
Compensation band		
$0 - $10,000	-	1
$ 20,001 - $ 30,000	-	1
$ 40,001 - $ 50,000	9	8
$ 80,001 - $ 90,000	-	1
$ 90,001 - $ 100,000	1	-
Total:	10	11

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

		2022	2021
9.4	Key management personnel (continued)		
Compensation of senior officers			
	Compensation band		
	$ 70,001 - $ 80,000	1	-
	$140,001 - $150,000	1	-
	$170,001 - $180,000	1	1
	$180,001 - $190,000	-	1
	$200,001 - $210,000	-	1
	$210,001 - $220,000	-	1
	$220,001 - $230,000	-	2
	$230,001 - $240,000	4	1
	$240,001 - $250,000	2	1
	$250,001 - $260,000	1	1
	$430,001 - $440,000	1	-
	$440,001 - $450,000	-	1
	$490,001 - $500,000	-	1
	$510,001 - $520,000	1	-
	$550,001 - $560,000	1	1
	Total:	13	12
	Short-term employee benefits (a)	3,614	3,520
	Post-employment benefits	387	352
	Other long-term benefits	92	78
Total compensation of key management personnel		4,093	3,950

(a) The short-term employee benefits include salary, motor vehicle benefits, district and travel allowances incurred by the Health Service in respect of senior officers.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

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 senior officers and their close family members, and their controlled or jointly controlled entities
- all members of the Accountable Authority, and their close family members, and their controlled or jointly controlled entities
- all cabinet ministers 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)
- the Government Employees Superannuation Board (GESB)

9.5 Related party transactions (continued)

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

	Note
Income from State Government	4.1
Capital appropriations administered by Department of Health	9.10
Superannuation payments to GESB	3.1.1
Remuneration for services provided by Office of the Auditor General	9.9
Lease payments to the Department of Finance (Government Office Accommodation and State Fleet motor vehicles)	3.7, 7.1

Material transactions with other related parties
Outside of normal citizen type transactions with the Health Service, there were no other 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 that receives more than half of its funding and resources from an agency and is subject to operational control by that agency.

The Health Service had no related bodies during the reporting period.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000

9.7 Affiliated bodies

An affiliated body is a body that receives more than half its funding and resources from an agency but is not subject to operational control by that agency.

The Health Service had no affiliated bodies during the reporting period.

9.8 Special purpose accounts

Mental Health Commission Fund (East Metropolitan Health Service) 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 the East Metropolitan Health Service, in accordance with the annual Service Agreement and subsequent agreements.

Balance at start of period	1,186	624
Receipts		
Commonwealth contributions (note 4.1)	79,014	65,258
State contributions (note 4.1)	131,854	126,021
Other (note 4.1)	130	1,950
	212,184	193,853
Payments	(211,734)	(192,667)
Balance at end of period	450	1,186

The special purpose accounts are established under section 16(1)(d) of the *Financial Management Act 2006*.

9.9 Remuneration of auditors

Remuneration paid or payable to the Auditor General in respect of the audit for the current financial year is as follows:

Auditing the accounts, financial statements, controls, and key performance indicators	335	305

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

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. The asset revaluation reserve represents that portion of equity resulting from the revaluation of non-current assets.

	2022 $000	2021 $000
Contributed equity		
Balance at start of the period	1,181,347	1,146,450
Contributions by owners (a)		
Contribution by Owners – Capital Appropriations administered by Department of Health (b)	52,753	34,897
Total contributions by owners	1,234,100	1,181,347
Total contributed equity at end of period	1,234,100	1,181,347

(a) *AASB 1004 'Contributions'* requires transfers of net assets as a result of a restructure of administrative arrangements to be accounted for as contributions by owners and distributions to owners.

TI 955 designates non-discretionary and non-reciprocal transfers of net assets between State government agencies as contributions by owners in accordance with *AASB Interpretation 1038*. Where the transferee agency accounts for a non-discretionary and non-reciprocal transfer of net assets as a contribution by owners, the transferor agency accounts for the transfer as a distribution to owners.

(b) *TI 955 'Contributions by Owners Made to Wholly Owned Public Sector Entities'* designates capital appropriations as contributions by owners in accordance with *AASB Interpretation 1038 'Contributions by Owners Made to Wholly-Owned Public Sector Entities'*.

Asset revaluation reserve		
Balance at start of the period	94,163	87,293
Net revaluation increments/(decrements):		
Buildings	53,902	6,870
Total asset revaluation reserve at end of period	148,065	94,163

The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets on a class of assets basis. Any increment is credited directly to the asset revaluation reserve, except to the extent that the increment reverses a revaluation decrement previously recognised as an expense (see note 5.1 'Property, plant and equipment').

For land revaluation decrement recognised as an expense, see note 3.7 'Other expenses'.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

	2022 $000	2021 $000
9.11 Supplementary financial information		
a) Write-offs		
Debts written off under the authority of the Accountable Authority	728	2,473
Public and other property written off under the authority of the Accountable Authority	-	-
Debts written off under the authority of the Minister	-	118
	728	2,591
b) Debt waivers		
Debts waived under the authority of the Accountable Authority	471	1,365
	471	1,365

9.11 Supplementary financial information (continued)

Debt waivers are discretionary in nature and under justifiable and reasonable circumstances, can be used by the Accountable Authority to permanently forgive a debt.

c) Losses through theft, defaults and other causes

Losses of public money, and public and other property through theft or default	23	187
Amounts recovered	(10)	(105)
	13	82

9.12 Administered trust accounts

Funds held in these trust accounts are not controlled by the Health Service and are therefore not recognised in the financial statements.

The Health Service administers trust accounts for the purpose of holding patients' private moneys.

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

Balance at start of period	22	19
Add receipts	64	72
	86	91
Less payments	(69)	(69)
Balance at end of period	17	22

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

Note 10 Explanatory statement

All variances between actual results for 2022 and estimates (original budget) are shown below. Narratives are provided for key major variances, which are greater than 10% and $17 million for the statement of comprehensive income, statement of cash flows and statement of financial position.

Statement of comprehensive income	Note	Estimates 2022 $000	Actuals 2022 $000	Variance between actual and estimate $000
Expenses				
Employee benefits expense		955,757	1,027,528	71,771
Contracts for services		333,280	341,212	7,932
Patient support costs	1	233,686	259,016	25,330
Fees for visiting medical practitioners		26,364	25,971	(393)
Finance costs		64	52	(12)
Depreciation and amortisation expense		46,489	44,471	(2,018)
Repairs, maintenance and consumable equipment		24,580	36,445	11,865
Other supplies and services		9,228	10,472	1,244
Cost of sales		3,609	3,496	(113)
Other expenses		100,867	116,896	16,029
Total cost of services		1,733,924	1,865,559	131,635
Income				
Patient charges		42,779	45,943	3,164
Other fees for services		478	490	12
Commonwealth grants and contributions		-	240	240
Other grants and contributions		26	1,087	1,061
Donation income		70	98	28
Sale of goods		3,609	3,402	(207)
Other income and recoveries		48,205	46,682	(1,523)
Total income other than income from State Government		95,167	97,942	2,775
Net cost of services		1,638,757	1,767,617	128,861
Income from State Government				
Department of Health - Service Agreement:				
- State component	2	790,760	880,558	89,798
- Commonwealth component		524,653	526,449	1,796
Mental Health Commission - Service Agreement		220,968	210,998	(9,970)
Income from other state government agencies		36,912	44,633	7,721
Resources received	3	57,706	89,904	32,198
Total income from State Government		1,630,999	1,752,542	121,543
Surplus / (deficit) for the period		(7,758)	(15,076)	(7,318)
Other comprehensive income				
Items not reclassified subsequently to profit or loss				
Changes in asset revaluation reserve		-	53,902	53,902
Total other comprehensive income		-	53,902	53,902
Total comprehensive income for the period		(7,758)	38,827	46,585

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

Note 10 Explanatory statement (continued)

Statement of financial position	Note	Estimates 2022 $000	Actuals 2022 $000	Variance between actual and estimate $000
Assets				
Current assets				
Cash and cash equivalents		156,051	112,886	(43,165)
Restricted cash and cash equivalents		37,057	41,892	4,835
Receivables		28,207	26,819	(1,388)
Inventories		4,672	5,374	702
Other current assets	4	1,403	29,784	28,381
Total current assets		227,390	216,755	(10,635)
Non-current assets				
Restricted cash and cash equivalents		20,888	20,889	1
Amounts receivable for services		616,535	613,846	(2,689)
Property, plant and equipment		613,534	625,896	12,362
Intangible assets		35	139	104
Right-of-use assets		9,130	1,795	(7,335)
Service concession assets		285,538	309,562	24,024
Total non-current assets		1,545,660	1,572,127	26,467
Total assets		1,773,050	1,788,882	15,832
Liabilities				
Current liabilities				
Payables		109,507	97,351	(12,156)
Grant liabilities		-	955	955
Lease liabilities		3,230	609	(2,621)
Employee benefits provisions		203,662	212,860	9,198
Other current liabilities		744	1,090	346
Total current liabilities		317,143	312,865	(4,278)
Non-current liabilities				
Employee benefits provisions		47,813	46,073	(1,740)
Lease liabilities		6,549	1,229	(5,320)
Total non-current liabilities		54,362	47,302	(7,060)
Total liabilities		371,505	360,167	(11,338)
Net assets		1,401,545	1,428,715	27,170
Equity				
Contributed equity		1,253,516	1,234,101	(19,415)
Reserves		94,163	148,065	53,902
Accumulated surplus		53,866	46,549	(7,317)
Total equity		1,401,545	1,428,715	27,170

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

Note 10 Explanatory statement (continued)

Statement of cash flows	Note	Estimates 2022 $000	Actuals 2022 $000	Variance between actual and estimate $000
Cash flows from State Government				
Contribution by Owners – Capital Appropriations administered by Department of Health	5	72,169	52,753	(19,416)
Service agreement - Department of Health		1,268,924	1,363,206	94,282
Service agreement - Mental Health Commission		220,968	210,998	(9,970)
Funds received from other state government agencies		36,912	44,633	7,721
Net cash provided by State Government		1,598,973	1,671,590	72,617
Utilised as follows:				
Cash flows from operating activities				
Payments				
Employee benefits		(947,282)	(1,010,483)	(63,201)
Supplies and services	6	(638,609)	(712,421)	(73,812)
Finance costs		(64)	(52)	12
Receipts				
Receipts from customers		39,025	45,661	6,636
Commonwealth grants and contributions		-	240	240
Other grants and contributions		26	1,087	1,061
Donations received		70	53	(17)
Other receipts		52,292	51,106	(1,186)
Net cash used in operating activities		(1,494,542)	(1,624,809)	(130,267)
Cash flows from investing activities				
Payments				
Purchase of non-current assets	5	(70,318)	(52,542)	17,776
Receipts				
Proceeds from sale of non-current assets		-	250	250
Net cash used in investing activities		(70,318)	(52,292)	18,026
Cash flows from financing activities				
Payments				
Principal elements of lease payments		(1,983)	(688)	1,295
Net cash used in financing activities		(1,983)	(688)	1,295
Net increase (decrease) in cash and cash equivalents		32,130	(6,199)	(38,329)
Cash and cash equivalents at the beginning of the period		181,866	181,866	-
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD			112,886	112,886
RESTRICTED CASH AT THE END OF PERIOD			62,781	62,781
Total cash and cash equivalents at the end of the period		213,996	175,667	(38,329)

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

Note 10 Explanatory statement (continued)

Explanation of significant variances between actuals and estimates

Statement of comprehensive income

1. The variance in Patient support costs is primarily due to increased expenditure on medical, surgical, diagnostic and drug supplies, pathology costs from PathWest, domestic cleaning charges and personal protective equipment (PPE) related to Covid-19 ($23.73M). There were additional costs related to medical support for the Medical Respite Centre to improve the health and wellbeing of people with complex conditions experiencing homelessness ($1.6M).

2. In addition to the receipt of increased funding for Covid-19 ($52.3M), new funding was provided for additional programs (e.g. the Emergency Department Innovation Fund; Newly Qualified Nurses and Midwives program) and the establishment of the Mental Health Transition Unit ($11.3M). Additional funding was provided to pay for casual employees eligible to cash out long service leave entitlements ($3.8M) and for asset replacement (life cycle fee) at the St. John of God Public hospital ($1.6M) and there was a realignment of funding from the Commonwealth to the State Government ($20.8M).

3. The variance represents the increased services and support for Covid-19 received by the EMHS from Health Support Services, PathWest and legal services from the Department of Justice ($28M). It also includes medical equipment received from the Department of Health to set up the new Intensive Care Unit at Royal Perth Hospital ($4.3M).

Statement of financial position

4. The actual result for "Other current assets" is greater than originally estimated, as the EMHS prepaid its insurance premium for the financial year 2022-23 ($28.5M).

Statement of cash flows

5. The EMHS drew down less capital than originally estimated as increased construction costs placed pressure on capital budgets, and this flowed through to delays in the release of tender documentation for large projects such as the Midland Mental Health Emergency Centre and Royal Perth Hospital Aseptic Unit ($8.1M). Other projects such as the Mental Health Anti-Ligature at Bentley Hospital were delayed because of manufacturing and logistical delays and supply chain disruption related to Covid-19 ($8.5M).

6. The increase in the Payment of Supplies and services reflects the prepayment of the health services' insurance premium for the financial year 2022-23 ($28.5M), as well as increased costs of medical, surgical, diagnostic and drug supplies, increased pathology costs from PathWest, additional domestic cleaning charges and personal protective equipment (PPE) costs related to Covid-19 ($27.1M). There was also additional expenditure for the maintenance of medical and surgical equipment and diagnostic supplies ($18.2M).

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

Note 10 Explanatory statement (continued)

All variances between actual results for 2022 and 2021 are shown below. Narratives are provided for key major variances, which are greater than 10% and $17 million for the statement of comprehensive income, statement of cash flows and statement of financial position.

Statement of comprehensive income	Note	Actuals 2022 $000	Actuals 2021 $000	Variance between 2022 and 2021 results $000
Expenses				
Employee benefits expense		1,027,528	942,742	84,786
Contracts for services		341,212	328,494	12,718
Patient support costs		259,016	240,812	18,204
Fees for visiting medical practitioners		25,971	28,879	(2,908)
Finance costs		52	58	(6)
Depreciation and amortisation expense		44,471	43,445	1,026
Repairs, maintenance and consumable equipment		36,445	28,661	7,784
Other supplies and services		10,472	8,389	2,083
Cost of sales		3,496	3,348	148
Other expenses	7	116,896	99,217	17,679
Total cost of services		1,865,559	1,724,045	141,515
Income				
Patient charges		45,943	44,133	1,810
Other fees for services		490	763	(273)
Commonwealth grants and contributions		240	476	(236)
Other grants and contributions		1,087	1,483	(396)
Donation income		98	266	(168)
Sale of goods		3,402	3,177	225
Other income and recoveries		46,682	46,666	16
Total income other than income from State Government		97,942	96,964	978
Net cost of services		1,767,617	1,627,081	140,537
Income from State Government				
- State component		880,558	826,326	54,232
- Commonwealth component		526,449	487,385	39,064
Mental Health Commission - Service Agreement		210,998	193,229	17,769
Income from other state government agencies		44,633	45,861	(1,228)
Resources received	8	89,904	70,023	19,881
Total income from State Government		1,752,542	1,622,824	129,718
Surplus / (deficit) for the period		(15,075)	(4,257)	(10,818)
Other comprehensive income				
Changes in asset revaluation reserve		53,902	6,870	47,032
Total other comprehensive income		53,902	6,870	47,032
Total comprehensive income for the period		38,827	2,613	36,214

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

Note 10 Explanatory statement (continued)

Statement of financial position	Actuals 2022 $000	Actuals 2021 $000	Variance between 2022 and 2021 results $000
Assets			
Current assets			
Cash and cash equivalents	112,886	128,130	(15,244)
Restricted cash and cash equivalents	41,892	37,057	4,835
Receivables	26,819	27,609	(790)
Inventories	5,374	4,672	702
Other current assets	29,784	26,616	3,168
Total current assets	216,755	224,084	(7,329)
Non-current assets			
Restricted cash and cash equivalents	20,889	16,679	4,210
Amounts receivable for services	613,846	570,045	43,801
Property, plant and equipment	625,896	578,090	47,806
Intangible assets	139	35	104
Right-of-use assets	1,795	1,640	155
Service concession assets	309,562	294,546	15,016
Total non-current assets	1,572,127	1,461,035	111,092
Total assets	1,788,882	1,685,119	103,763
Liabilities			
Current liabilities			
Payables	97,351	101,322	(3,971)
Grant liabilities	955	1,255	(300)
Lease liabilities	609	552	57
Employee benefits provisions	212,860	196,704	16,156
Other current liabilities	1,090	744	346
Total current liabilities	312,865	300,577	12,288
Non-current liabilities			
Employee benefits provisions	46,073	46,296	(223)
Lease liabilities	1,229	1,112	117
Total non-current liabilities	47,302	47,408	(106)
Total liabilities	360,167	347,985	12,182
Net assets	1,428,715	1,337,134	91,581
Equity			
Contributed equity	1,234,101	1,181,347	52,754
Reserves	148,065	94,163	53,902
Accumulated surplus	46,549	61,624	(15,075)
Total equity	1,428,715	1,337,134	91,581

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

Note 10 Explanatory statement (continued)

Statement of cash flows	Note	Actuals 2022 $000	Actuals 2021 $000	Variance between 2022 and 2021 results $000
Cash flows from State Government				
Contribution by Owners – Capital Appropriations administered by Department of Health	9	52,753	34,867	17,886
Service agreement - Department of Health		1,363,206	1,271,284	91,922
Service agreement - Mental Health Commission		210,998	193,229	17,769
Funds received from other state government agencies		44,633	45,861	(1,228)
Net cash provided by State Government		1,671,590	1,545,241	126,349
Utilised as follows:				
Cash flows from operating activities				
Payments				
Employee benefits		(1,010,483)	(919,345)	(91,138)
Supplies and services		(712,421)	(685,573)	(26,848)
Finance costs		(52)	(58)	6
Receipts				
Receipts from customers		45,661	40,493	5,168
Commonwealth grants and contributions		240	476	(236)
Other grants and contributions		1,087	1,484	(397)
Donations received		53	131	(78)
Other receipts		51,106	47,356	3,750
Net cash used in operating activities		(1,624,809)	(1,515,036)	(109,773)
Cash flows from investing activities				
Payments				
Purchase of non-current assets		(52,542)	(45,899)	(6,643)
Receipts				
Proceeds from sale of non-current assets		250	10	240
Net cash used in investing activities		(52,292)	(45,889)	(6,403)
Cash flows from financing activities				
Payments				
Principal elements of lease payments		(688)	(444)	(244)
Net cash used in financing activities		(688)	(444)	(244)
Net decrease in cash and cash equivalents		(6,199)	(16,128)	9,929
Cash and cash equivalents at the beginning of the period		181,866	197,994	(16,128)
Total cash and cash equivalents at the end of the period		175,667	181,866	(6,199)

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2022

Note 10 Explanatory statement (continued)

Explanation of significant variances between 2022 and 2021 results

Statement of comprehensive income

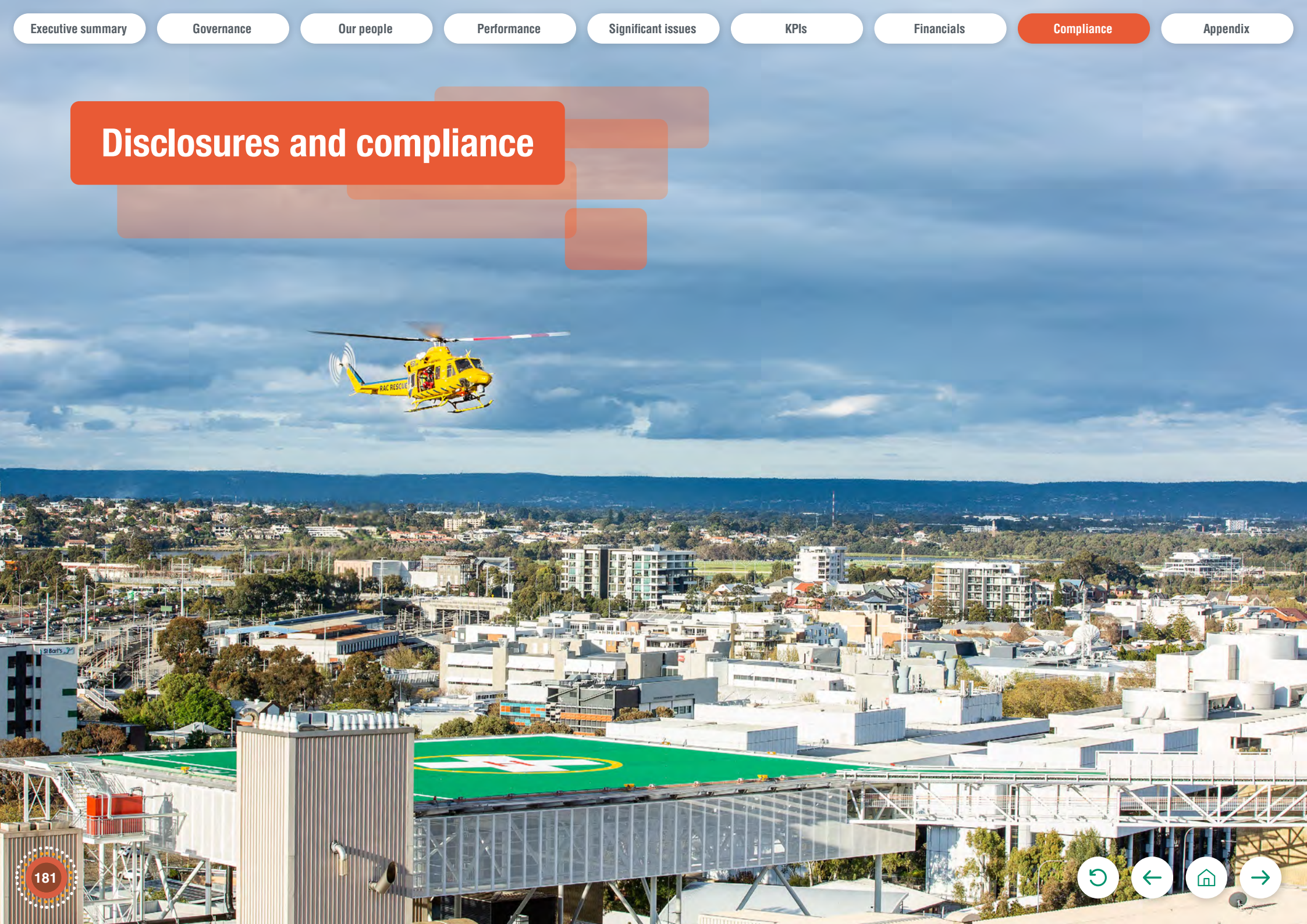
7. Increase in Other expenses reflects the increases in Health Support Services Resources Received ($9.6M), workers compensation insurance premiums and legal expenses ($5.4M), the loss on revaluation of land ($1.8M) and the hire of non-medical equipment ($0.7M).

8. The increase in Resources Received Free of Charge relates primarily to the increased services and support provided to the EMHS for Covid-19 activities, from Health Support Services and PathWest ($16.3M). It also recognises the value of medical equipment received from the Department of Health to set up the new Intensive Care Unit at Royal Perth Hospital ($4.3M).

Statement of cash flows

9. The increased spending on the acquisition of non-current assets resulted in higher cash drawdown from the capital appropriation. This included an additional cash outlay for the Royal Perth Hospital Intensive Care Unit project ($13M) and on the Medical Equipment Replacement Program ($3.5M).

Disclosures and compliance



Ministerial directives

Treasurer's Instructions 903(12) require disclosure of information on any ministerial directives relevant to the setting or achievement of desired outcomes or operational objectives, investment activities and financing activities.

Although no ministerial directives were issued for EMHS in 2021-22, the EMHS Board released a **Statement of Intent** in July 2021 in response to the Minister for Health's **Statement of Expectations** regarding the priorities and accountabilities of the EMHS Board.

Both of these documents are publicly available on the EMHS website www.emhs.health.wa.gov.au/About-Us/Health-Service-Board.

The Board's Statement of Intent outlines a commitment in preparedness and management of the COVID-19 pandemic response; an ongoing focus on safety and quality; mental health; workforce safety, wellbeing and engagement; commitment to permanent employment; implementation of the recommendations of the SHR; research and innovation; implementation of the Government's election commitments; key EMHS workstreams; hospital performance targets; Care Opinion; and financial performance.

EMHS continued to progress key election commitments during 2021-22, which include the **Armadale Mental Health Emergency Centre** (MHEC), **RPH Innovation Hub** and **Byford Health Hub**.

Youth share vision of health hub ideal

EMHS is responsible for planning and delivering the **Byford Health Hub** — a 2021 State Government election commitment to help meet the health and social needs of the rapidly growing Serpentine Jarrahdale Shire.

The concept for the Byford Health Hub is to bring a mix of health and social services under the one roof.

At a special hackathon in April 2022, a group of final-year high school students from Byford Secondary College were asked to consider how the health hub might ensure youth-friendly access for younger members of the community.

Students were given pre-reading material and a journey-mapping activity, which involved dividing into teams and workshopping ideas which they presented to a group of invited guests and judges.

The students' vision included:

- a mix of health and wellbeing services, conveniently located in a bright and welcoming environment
- a setting that incorporated green spaces and that integrated with recreational and other amenities
- services with digital functionality that provided flexible appointment times and affordable care
- provision for consumers to choose their clinicians
- services staffed with relatable clinicians who provided care that was free of judgement.

The health hub is in line with the recommendations of the SHR, which sets direction to drive a cultural shift away from acute hospital-based care to prevention and seamless access to services at home and in the community.

Government policy requirements

Summary of board and committee remuneration

The total 2021-22 remuneration for each EMHS State Government board or committee (i.e. EMHS boards and committees where members may receive a sitting fee) is listed in the following table. For full EMHS board or committee details, please see page 196.

EMHS board / committee	Total remuneration ($)
EMHS Board	497,324
RPH Human Research Ethics Committee	10,960
RPH Animal Ethics Committee	6434
Cultural Security Working Group	656
Aboriginal Health Community Advisory Group – Aboriginal Men Health Support Network Working Group	225
Aboriginal Workforce Working Group	290
Aboriginal Health Community Advisory Group Aboriginal community forum working group	2250
Aboriginal Youth Health Working Group	1808
Armadale and Kalamunda Aboriginal Health Community Advisory Group	2218
Swan, Hills and Midland Aboriginal Health Community Advisory Group	2619
Bentley Aboriginal Health Community Advisory Group	3178
RPH and Inner City Aboriginal Health Community Advisory Group	3133
Aboriginal Health Advisory Council	4694
RPBG Consumer Advisory Committee	3797
RPBG Integrated Lived Experience Advisory Group (LEAG)	2978
AKG Consumer Advisory Committee	840

Occupational safety, health and injury management

See pages 37-39

WA multicultural policy framework

See pages 52-53

Other financial and governance disclosures

Pricing policy

EMHS charges for goods and services rendered on a partial or full cost recovery basis and complies with the *Health Insurance Act 1973*, the Addendum to National Health Reform Agreement (NHRA) 20-25, the HSA 2016, and the **WA Health Funding and Purchasing Guideline 2016-17**. These fees and charges are determined though the WA Health costing and pricing authorities and approved by the Minister for Health.

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

Indemnity insurance

In 2021-22, the amount of the insurance premium paid to indemnify directors of the EMHS Board [with 'director' defined as per Part 3 of the *Statutory Corporations (Liability of Directors) Act 1996*] against a liability incurred under sections 13 or 14 of that Act was **$83,891.50** (including GST).

Capital works

EMHS has made a substantial investment in the improvement and development of its infrastructure during 2021-22.

Incomplete capital works (as at 30 June 2022)					
Capital works	**Expected period of completion**	**Estimated cost to complete ($000)**	**Estimated total cost in 2020-21 ($000)**	**Estimated total cost in 2021-22 ($000)**	**Estimated total cost variation ($000)**
EMHS fire safety upgrades	30/06/2024	7,000	7,000	7,000	0
RPH Aseptic Unit	30/06/2023	7,290	4,760	7,290	2,530
KH palliative care services	30/06/2023	9,500	9,500	9,500	0
RPH fire risk	30/06/2025	9,962	9,962	9,962	0
SJGMPH Mental Health Emergency Centre (MHEC)	30/06/2024	6,021	6,021	6,021	0
BHS redevelopment	30/06/2023	7,254	7,254	7,254	0
Byford Health Hub	30/06/2024	5,892	0	5,892	5,892
COVID-19 EMHS 50 beds	30/06/2023	1,600	0	1,600	1,600
COVID-19 RPH 28 ICU beds	30/06/2023	800	0	800	800
RPH Intensive Care Unit	30/06/2023	28,864	30,243	28,864	-1,379
RPH Mental Health Observation Area	30/06/2023	12,985	11,785	12,985	1,200
Emergency capital works	30/06/2023	6,806	1,769	6,806	5,037
EMHS Anti-Ligature Remediation Program	30/06/2024	5,000	0	5,000	5,000
Four x 30-bed modular	30/06/2023	170	0	170	170
Mental Health Emergency Centre (MHEC): Armadale	30/06/2025	15,766	0	15,766	15,766
BHS Secure Extended Care Unit	30/06/2025	24,460	0	24,460	24,460
Mental Health Transition Unit	30/06/2023	670	4,670	670	-4,000
RPH Helipad	30/06/2023	10,075	10,075	10,075	0
RPH Innovation Hub	30/06/2024	10,640	10,640	10,640	0
RPH redevelopment stage 1	30/06/2023	20,289	20,289	20,289	0
SJGMPH cladding	30/06/2023	1,838	1,838	1,838	0
Urgent Mental Health anti-ligature work at BHS	30/06/2024	3,898	0	3,898	3,898
EMHS HIVE	30/06/2026	22,892	0	22,892	22,892
EMHS Wi-Fi rollout	30/06/2023	11,128	0	11,128	11,128

Capital works completed in 2021-22			
Capital works	**Total cost ($000)**	**Estimated total cost in 2020-21 ($000)**	**Total cost variation ($000)**
COVID-19 medical equipment	341	341	0

Employment and staff development

See pages 25-29

Workers' compensation

See page 38

Industrial relations

From September 2021 through to June 2022, EMHS Industrial Relations focused on COVID-19 vaccination compliance consistent with the COVID-19 Mandatory Vaccination and Vaccination Program Policy and the Chief Health Officer's Directions issued under the *Public Health Act 2016*.

Other legal disclosures

Expenditure on advertising

In 2021-22, EMHS did not incur any expenditure on advertising in accordance with section 175Z of the *Electoral Act 1907*.

Unauthorised use of credit cards

WA Government purchasing cards can be issued by EMHS to employees where their functions warrant usage of this facility.

These credit cards are not to be used for personal (unauthorised) purposes (i.e. a purpose that is not directly related to performing functions for the agency). All credit card purchases are reviewed by someone other than the cardholder to monitor compliance. If during a review it is determined that the credit card was used for unauthorised purchases, written notice must be given to the cardholder and the EMHS Board.

EMHS had seven instances (total amount of $439) where a purchasing card was used for personal purposes in 2021-22. A review of these transactions confirmed they were immaterial and the result of genuine and honest mistakes, and no further action was deemed necessary as prompt notification and full restitution was made by the individuals concerned. These were not referred for disciplinary action. Within the period of 1 July 2021 to 30 June 2022:

Organisation	Total
Instances of use for personal purposes	7
Aggregate amount of personal use expenditure	$439
Aggregate amount of personal use expenditure settled by a due date	5
Aggregate amount of personal use expenditure settled after the due date	2
Aggregate amount of personal use expenditure remaining unpaid at end of financial year	0
Number of referrals for disciplinary action instigated by the notifiable authority	0

Compliance with public sector standards and ethical codes

Public Sector Standards

The Public Sector Standards in Human Resource Management (the standards) set out the minimum standards of merit, equity and probity to be complied with by WA public sector bodies and their employees.

WA Health and EMHS maintain Human Resource (HR) policies and guidelines that are consistent with the standards. These are available to all employees on the EMHS intranet and/or the WA Health policy frameworks internet pages. This includes:

- WA Health Grievance Resolution Policy and EMHS Employee Grievance Resolution Guidelines (revised March 2021), fact sheets and flow charts (new March 2021)
- WA Health Recruitment, Selection and Appointment Policy
- WA Health Discipline Policy and EMHS Discipline Guide
- EMHS Peak Performance Policy, guidelines, fact sheets and automated performance planning tool
- EMHS Employee Separation Policy
- EMHS Expression of Interest Guidelines and template.

HR Business Partners are available to provide information, guidance and support to line managers in application of these policies and procedures and for the management of any claims of breach of standards.

EMHS maintains and supports a network of trained **Employee Support Officers**. These employees provide a voluntary point of contact for employees with a workplace concern or query, which may include queries about the public sector standards or related processes.

EMHS utilises WA Health's shared service centre Health Support Services (HSS) for transactional employment services. This enables consistent application of the employment standard and breach claim process to our recruitment and selection practices and provides an external mechanism for review.

Awareness of the public sector standards is communicated via:

- notification of the breach claim rights, processes and period within relevant employment and grievances processes
- provision of information on the EMHS intranet
- recruitment, selection and appointment training for recruiting managers and panel members; and
- peak performance training for line managers.

During 2021-22, there were:

7 breach of standard claims were lodged against the employment standard

- **1** was resolved internally and was withdrawn
- **1** is currently being managed by HR
- **5** were referred to the PSC (four dismissed, one ongoing)

0 claims against the grievance resolution, performance management, termination or redeployment standards

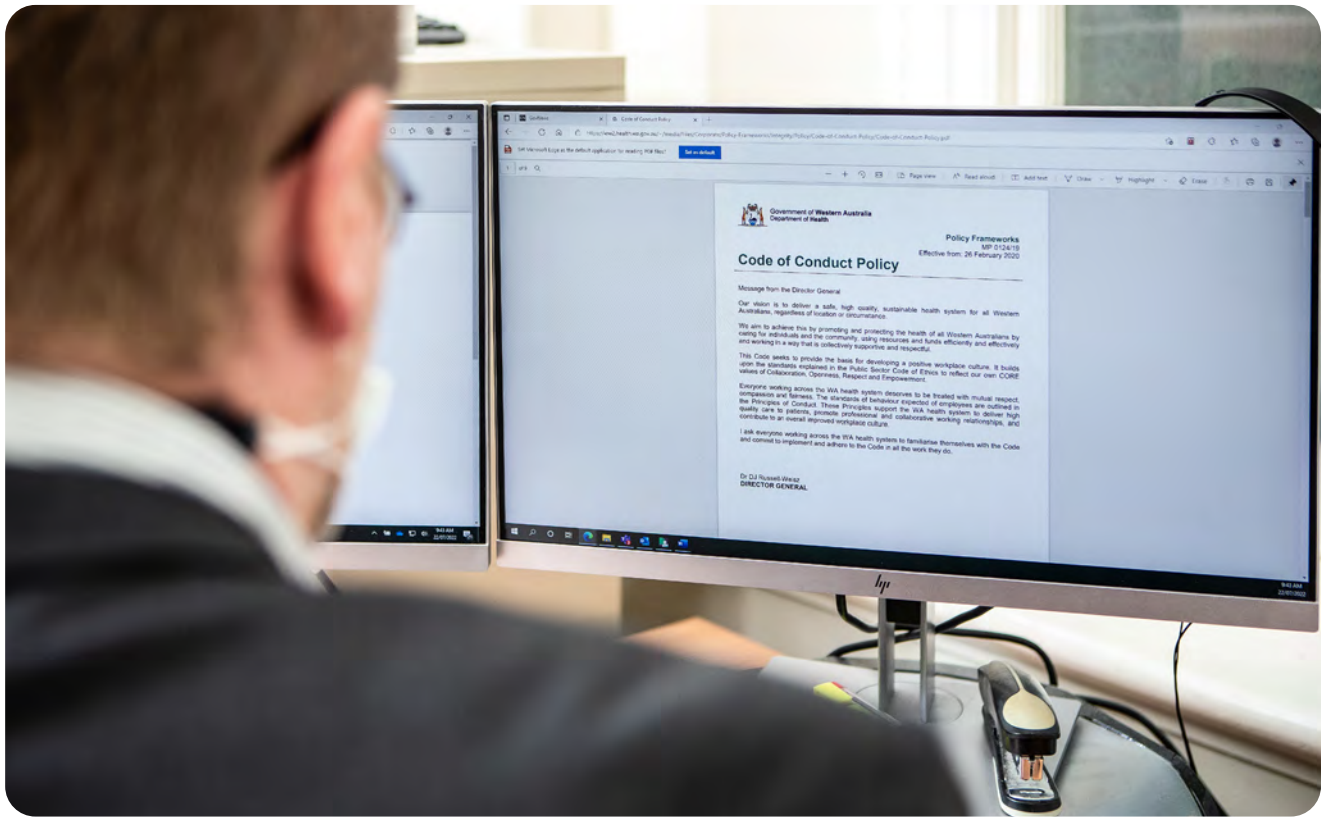
Code of Conduct

Integrity and ethical behaviour are integral to EMHS' core business. EMHS is committed to:

- putting the public interest first and fulfilling our public duty
- making the right decisions in accordance with agreed policy and procedures, in line with organisational objectives and job requirements
- making decisions and taking actions that can be explained and justified.

WA Health and EMHS maintain integrity-related policies and guidelines that support the implementation of the **WA Public Sector Code of Ethics** and the **WA Health Code of Conduct Policy**. This includes policies that address the management of breaches of discipline; gifts, benefits and hospitality; additional employment; conflicts of interest; pre-employment integrity checks; record keeping; discrimination and harassment; workplace bullying; and use of official information. These policies are available to all employees on the EMHS intranet and/or WA Health policy frameworks page.

During 2021-22, EMHS has reviewed and updated two significant integrity-related policies. These are the **EMHS Additional Employment Policy**, which outlines the conditions under which EMHS employees may be permitted to undertake additional employment, and the **Employee Interests Procedure – Management of Gifts, Benefits and Hospitality, Travel, Additional Employment and Conflicts of Interest**. This procedure outlines EMHS processes for disclosing, documenting and managing these interests.



All EMHS employees are responsible for ensuring that their behaviour reflects the standards of conduct embodied in the WA Health Code of Conduct Policy.

To support awareness of their responsibilities, new staff receive and acknowledge the Code of Conduct as a part of their offer of employment to work with EMHS. Responsibility for workplace behaviours

and conduct is reinforced at formal induction, and through completion of mandatory training, including Accountable and Ethical Decision-Making, Recordkeeping Awareness, and Prevention of Bullying.

In addition, EMHS has an **Online Managers Induction eLearning Program**. This program provides new and existing managers with the skills and knowledge they need to excel in their roles and provides a useful resource to refer to when needed, including modules on integrity, governance, decision-making and risk and compliance. Staff with direct reports and/or level G10 or above are required to complete this module within six weeks of commencement of employment.

EMHS regularly encourages staff to reflect on the EMHS values (including accountability, integrity and respect), and to incorporate these into their work. This occurs formally at recruitment and within the ongoing **Peak Performance Program**. Additionally, regular reminders about conduct-related topics are distributed across EMHS via electronic newsletters and on the EMHS intranet.

All staff are required to report suspected breaches of the Code of Conduct. Several pathways are available for staff to report concerns, including speaking with their line manager, a member of HR or the Manager of Integrity and Ethics, or by making contact with the EMHS Fraud Hotline, an EMHS Public Interest Disclosure (PID) Officer, the Corruption and Crime Commission (CCC), or the PSC. These options are communicated on the EMHS intranet, as well as at induction, on displayed posters and via Board and CE global messages and newsletter reminders.

The requirement to report suspected breaches of the Code of Conduct is also reinforced to nursing and pharmacy staff during Medicine Discrepancy Investigations training sessions, which are delivered regularly throughout the year by Integrity and Ethics staff.

The **EMHS Ethical Conduct Review Committee** (ECRC) meets bi-monthly. This committee was established to support EMHS to take a proactive approach to integrity and ethical conduct. The ECRC reports to the EMHS AEG and provides oversight in regard to:

- EMHS governance protocols and related documents for staff awareness and education
- the timely management of integrity and ethical governance issues to ensure compliance with relevant policy and statutory obligations
- the timely reporting of all misconduct matters in accordance with relevant policy and statutory obligations
- integrity and ethics activity data, in particular misconduct reports and related data, to monitor trends and issues across EMHS.

During 2021-22:

83 reports of potential breaches of the Code of Conduct (breaches of discipline) were received

All suspected breaches of discipline, including reportable misconduct were managed in accordance with the requirements of the WA Health Discipline policy and, where appropriate, were reported to the PSC or the CCC as required under the *Corruption, Crime and Misconduct Act 2003*. Where appropriate, breaches of discipline are also reported to the WA Police and/or to the Australian Health Practitioner Regulation Agency (AHPRA).

Disability access and inclusion

EMHS is committed to ensuring that people with a disability, as well as their families and carers, have the same opportunities as others to access the EMHS services, facilities and information.

The EMHS **Disability Access and Inclusion Plan 2017-22** (DAIP) outlines the EMHS strategies for meeting seven desired disability outcome areas that were identified in the *Disability Service Act 1993*. Throughout 2021-22, a range of developments helped improve outcomes for consumers with a disability.

General services and events

Outcome one: People with disability have the same opportunities as other people to access the services of, and any events organised by a public authority.

In 2021-22, EMHS put a number of measures in place to improve access to our services, particularly with restrictions imposed due to COVID-19. These measures included:

- expanded use of volunteers at site entrances to assist with visitor enquiries and wayfinding
- purchase of additional wheelchairs for consumer transit, given reduction in access points to sites
- created and sign-posted additional rest stations in access walkways and rostered additional staff to assist people with disabilities to navigate to different areas
- increased use of WoWs and devices (e.g. tablets). to increase access to family meetings held in clinical areas and allow consumers to participate in external events, including funerals
- consideration given to accessibility of services and community events e.g. NAIDOC Week celebrations and Close the Gap events
- supporting overnight boarders for vulnerable patients.

Buildings and facilities

Outcome two: People with disability have the same opportunities as other people to access the buildings and other facilities of a public authority.

Regular and ongoing maintenance of EMHS buildings, grounds, car parks and facilities ensures we continue to meet compliance with relevant disability and access requirements.

EMHS has increased senior car parking and ACROD bays, with numbers above minimum requirements. Access to buildings was improved with better signage and the installation of ‘touchless’ entry and free-call phones at sites, as well as ramps to EDs, COVID ED marquees and COVID clinics.

At KH, the refurbishment and new day hospice facility incorporated disability access into designs, including refreshing of accessible toilet areas and additional ramp access to garden areas, enabling both wheelchair and bed access.

Information and communication

Outcome three: 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 are able to access it.

EMHS' Communications Team continually monitors EMHS publications and ensures that our consumers and community have the ability to obtain information in different formats and languages if required.

Initiatives to improve information and communication have included:

- progression of a signage and wayfinding review, with additional visual aids provided at key locations, including for directions to amenities
- increased variety and access to alternative 'call buttons' or communications with nursing staff on inpatient wards
- audit of hearing loop utilisation and accessibility of EDI internal resources
- utilisation of digital solutions to assist with communication.

For communication with our CaLD community, EMHS:

- provides ongoing access to a variety of interpreter services, including in-person, by phone and by Telehealth
- ensures Caring for Carers resources are available for CaLD groups
- makes various Aboriginal-specific services available across sites, including augmentation of resources to support weekend and after-hours accessibility.

Quality of service

Outcome four: People with disability receive the same level and quality of service from the staff of a public authority as other people receive from the staff of that public authority.

During 2021-22, EMHS has focused on accessibility as part of its organisation values.

This has included the expansion of the volunteer Forget Me Not program, which enables more time to create meaningful connections to support people with dementia and cognitive impairment through their hospital journey.

EMHS is also embracing technology to improve access, with the expansion of Telehealth (virtual care) access and training for outpatient services, and the trial use of virtual reality technology for palliative care patients to engage in experiences otherwise inaccessible due to loss of physical function (see page 59).

Complaints and safeguarding

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

EMHS provides a variety of methods for providing feedback and lodging complaints, including paper based, web/email, verbal and the Care Opinion platform, as well as feedback provided directly to staff and volunteers. Patient feedback and complaints are constantly monitored via EMHS' consumer advisory committees/groups, as well as quarterly reviews at Disability Access and Inclusion committee meetings.

EMHS also installed visual aids and equipment regarding **Aishwarya's CARE call** and other consumer-initiated care escalation pathways across hospitals, especially in EDs (see page 41).

Consultation and engagement

Outcome six: People with disability have the same opportunities as other people to participate in any public consultation by a public authority.

Consultation and engagement activities with stakeholders was unfortunately limited in 2021-22 due to COVID. Where possible, however, EMHS has continued to involve consumers in service design and delivery.

In 2021-22 this included various site-level consumer engagement activities seeking input on design of new models of care (e.g. ED geriatrics team, COVID screening and COVID clinics), consumer representation on Disability Access and Inclusion Committees and diverse representation on site consumer advisory committees/groups.

EMHS also engaged with the community, including local high-school students, in planning for the new Shire of Serpentine Jarrahdale Byford Health Hub (see page 182).

Employment people and culture

Outcome seven: People with a disability have the same opportunities as other people to obtain and maintain employment with a public authority.

In 2021-22, EMHS implemented a new Talent Acquisition Team to assist in recruitment strategies, incorporating equity and diversity principles (see page 26). In addition, a new EMHS EDI role was created.

Recordkeeping

EMHS continues to implement an Electronic Document Records Management System (EDRMS) across its sites in accordance with the **EMHS Recordkeeping Plan**. There have been **120,901** records saved since implementation to 30 June 2022, with **371** active users within the system. All users have received EDRMS [HPE Records Manager (HPE RM)] training, either in face-to-face or group format.

Regular compliance audits are conducted, ensuring the HPE RM EMHS dataset is being maintained and corporate records are captured appropriately.

The **EMHS Corporate Recordkeeping Strategy** was approved by the AEG in March 2022, with objectives and key deliverables being scheduled across the remainder of 2022 and 2023. The Strategy reconfirms EMHS' commitment to manage records in an effective and efficient manner and in accordance with the *State Records Act 2000* (the Act).

A corporate recordkeeping project relating to hard-copy records across EMHS was undertaken in 2021-22. A review of archived records held at on-site locations was commenced in order to classify records in accordance with the relevant Retention and Disposal Schedules.

EMHS has a number of training programs in place to provide guidance to staff on good recordkeeping practices. This commences with the mandatory DoH Records Awareness Training and the EMHS EDRMS training. The EMHS corporate recordkeeping intranet page provides staff with training resources, quick help guides, policies and supporting information to enable staff to comply with the Act.

For the remainder of 2022, the Corporate Recordkeeping area will be focusing on developing standardised online training sessions and online video help sessions in a bid to streamline the training process across EMHS.

Freedom of information

The *WA Freedom of Information Act 1992* (FOI 1992) gives all Western Australians a right of access to information held by EMHS. Access to information can be made through a Freedom of Information (FOI) application, which should be addressed to the FOI Office at the appropriate EMHS site.

FOI applications can be granted full access, partial access or access may be refused in accordance with the *FOI 1992*.

In 2021-22, EMHS received **3569** new applications under FOI legislation.

AHS

Non-personal	Personal
37	537

KH

Non-personal	Personal
0	8

EMHS

Non-personal	Personal
11	4

Swan Districts Hospital (SDH)

Non-personal	Personal
0	96

SDH records — general (applications via AHS)

RPH

Non-personal	Personal
339	2116

BHS

Non-personal	Personal
18	403

(includes SDH records — mental health)

FOI information

For information about FOI at EMHS, please refer to the **EMHS FOI brochure** at www.emhs.health.wa.gov.au/~/media/HSPs/EMHS/Hospitals/RPH/Documents/Patients/FOI/emhs-freedom-of-information-brochure.pdf, or visit the FOI page at the relevant EMHS site:

AKG (includes applications for SDH – general)
www.ahs.health.wa.gov.au/Patients-and-Visitors/Accessing-Health-Records/Freedom-of-Information

RPH
www.rph.health.wa.gov.au/Patients-and-Visitors/Accessing-Health-Records/Accessing-Records-via-Freedom-of-Information

BHS (includes applications for SDH – mental health)
www.bhs.health.wa.gov.au/Patients-and-Visitors/Accessing-Health-Records/Accessing-Records-via-Freedom-of-Information

EMHS
www.emhs.health.wa.gov.au/About-Us/Accessing-Records/Accessing-Records-via-Freedom-of-Information

SJGMPH
www.sjog.org.au/patients-and-visitors/privacy

Appendix

Site contact details

Royal Perth Bentley Group

Royal Perth Hospital

Address
197 Wellington Street
Perth WA 6000

Postal address
GPO Box X2213
Perth WA 6847

Telephone (08) 9224 2244
Fax (08) 9224 3511
rph.health.wa.gov.au

Bentley Health Service

Address
18 – 56 Mills Street
Bentley WA 6102

Postal address
PO Box 158
Bentley WA 6982

Telephone (08) 9416 3666
Fax (08) 9416 3711
bhs.health.wa.gov.au

Armadale Kalamunda Group

Armadale Health Service

Address
3056 Albany Highway
Mount Nasura WA 6112

Postal address
PO Box 460
Armadale WA 6992

Telephone (08) 9391 2000
Fax (08) 9391 2149
ahs.health.wa.gov.au

Kalamunda Hospital

Address
Elizabeth Street
Kalamunda WA 6076

Postal address
PO Box 243
Kalamunda WA 6926

Telephone (08) 9257 8100
Fax (08) 9293 2488

St John of God Health Care (SJGHC)

St John of God Midland Public Hospital

Address
1 Clayton Street
Midland WA 6056

Postal address
GPO Box 1254
Midland WA 6936

Telephone (08) 9462 4000
Fax (08) 9462 4050
Email info.midland@sjog.org.au
sjog.org.au/midland

Acronyms index

Acronym	In full
AHCAG	Aboriginal Health Community Advisory Group
AHS	Armadale Health Service
AKG	Armadale Kalamunda Group
ATS	Australasian Triage Scale
BHS	Bentley Health Service
CaLD	Culturally and linguistically diverse
CE	Chief Executive
Co-HIVE	Community Health In a Virtual Environment
DDI	Data and Digital Innovation
DG	Director General
DoH	Department of Health
ED	Emergency Department
EDI	Equity, diversity and inclusion
EMHS	East Metropolitan Health Service
EMMs	Electronic Medication Management solution
GP	General Practitioner
HABSI	Hospital acquired blood stream infection
HAI	Healthcare associated infection
HIVE	Health In a Virtual Environment
HR	Human resources

Acronym	In full
HSP	Health Service Provider
ICT	Information and communication technology
ICU	Intensive Care Unit
IPAA	Institute of Public Administration Australia
KH	Kalamunda Hospital
KPI	Key Performance Indicator
MHU	Mental Health Unit
OBM	Outcome Based Management
PPE	Personal protective equipment
PSC	Public Sector Commission
RAT	Rapid Antigen Test
RPBG	Royal Perth Bentley Group
RPH	Royal Perth Hospital
SJGMPH	St John of God Midland Public Hospital
WA	Western Australia
WAU	Weighted activity unit
WEAT	WA Emergency Access Target
WEST	WA Elective Services Target
WHS	Work health and safety
WoW	Workstation on wheels

Board and committee remuneration

EMHS Board				
Position	**Name**	**Type of remuneration**	**Period of membership in 2021-22**	**Total remuneration in 2021-22 ($)***
Chair	Ian Smith	Sessional	12 months	83,585
Deputy Chair	Debra Zanella	Sessional	12 months	45,971
Member	Ross Keesing	Sessional	12 months	45,971
Member	Kingsley Faulkner	Sessional	12 months	45,971
Member	Denise Glennon	Sessional	12 months	45,971
Member	Amanda Gadsdon	Sessional	12 months	45,971
Member	Laura Colvin	Sessional	12 months	45,971
Member	Peter Forbes	Sessional	12 months	45,971
Member	Pia Turcinov	Sessional	12 months	45,971
Member	Melissa Parke	Sessional	12 months	45,971
TOTAL				**497,324**

*includes superannuation

Human Research Ethics Committee (HREC)

Position	Name	Type of remuneration*	Period of membership in 2021-22	Total remuneration in 2021-22 ($)
Chair (until 30 January 2022)	Frank van Bockxmeer	Sessional	7 months	10,960
Chair (from 31 January 2022)	Stephen MacDonald	n/a**	5 months	0
Medical research	Stephen MacDonald	n/a	7 months	0
Lay person (M)	Hamish Milne	n/a	12 months	0
Lay person (M)	Paul Hansen	n/a	10 months	0
Lay person (F)	Helen Walsh	n/a	12 months	0
Lay person (F)	Grace Moro	n/a	12 months	0
Professional care member	Wayne Epton	n/a	12 months	0
Professional care member	Jonathon Burcham	n/a	12 months	0
Pastoral care	Michael Hertz	n/a	12 months	0
Lawyer	Stephen Sparkes	n/a	12 months	0
Lawyer	Elizabeth Maynard	n/a	12 months	0
Medical research	Ramin Gharbi	n/a	12 months	0
Medical research	Dieter Weber	n/a	12 months	0
Medical research	Janice Fogarty	n/a	12 months	0
Medical research	Xavier Fiorilla	n/a	12 months	0
TOTAL				**10,960**

*n/a = aside from the Chair, HREC members do not receive payment
**n/a = WA Health employee, not eligible for payment

RPH Animal Ethics Committee

Position	Name*	Type of remuneration**	Period of membership in 2021-22	Total remuneration in 2021-22 ($)
Chair	Member 1	Annual	12 months	5234
Category A (vet)	Member 2	Per meeting	12 months	0
Category B (animal-based research)	Member 3	n/a	12 months	0
Category B Deputy	Member 4	Per meeting	12 months	600
Category C (animal welfare)	Member 5	Per meeting	12 months	0
Category C Deputy	Member 6	Per meeting	12 months	600
Category D (community)	Member 7	Per meeting	12 months	0
Executive officer	Member 8	n/a	12 months	0
TOTAL				**6434**

*personal details suppressed with permission from the Minister for Health
**n/a = WA Health employee, not eligible for payment

Cultural Security Working Group

Position	Name	Type of remuneration*	Period of membership in 2021-22	Total remuneration in 2021-22 ($)
Chair	Denese Griffin	n/a	12 months	0
Member	Kerry Thorne	Per meeting	12 months	105
Member	Delson Stokes	Per meeting	12 months	164
Member	Fred Penny	Per meeting	12 months	105
Member	Raelene Hayward	Per meeting	12 months	94
Member	Leon Hayward	Per meeting	12 months	94
Member	Jim Morrison	Per meeting	12 months	94
TOTAL				656

*n/a = WA Health employee, not eligible for payment

AHCAG – Aboriginal men health support network working group

Position	Name	Type of remuneration	Period of membership in 2021-22	Total remuneration in 2021-22 ($)
Member	Bernard Riley	Per meeting	2 months	75
Member	Athol Michael	Per meeting	2 months	75
Member	Rex Wright	Per meeting	2 months	75
Member	Lester Morrison	Per meeting	2 months	0
Member	Leon Hayward	Per meeting	2 months	0
Member	Robert Johns	Per meeting	2 months	0
TOTAL				225

Aboriginal workforce working group

Position	Name	Type of remuneration	Period of membership in 2021-22	Total remuneration in 2021-22 ($)
Chair	Barbara McGillivray	Per meeting	12 months	220
Vice Chair	Kerry Thorne	Per meeting	12 months	70
Member	Tammy Bennell-Yarran	Per meeting	12 months	0
Member	Gail Wynne	Per meeting	12 months	0
Member	Delson Stokes	Per meeting	12 months	0
TOTAL				290

AHCAG Aboriginal community forum working group

Position	Name	Type of remuneration	Period of membership in 2021-22	Total remuneration in 2021-22 ($)
Chair	Valerina Dorizzi	Per meeting	3 months	600
Vice Chair	Kevin Fitzgerald	Per meeting	3 months	75
Member	Donelle Merritt	Per meeting	3 months	150
Member	Charmaine Pell	Per meeting	3 months	225
Member	Rex Wright	Per meeting	3 months	300
Member	Gail Wynne	Per meeting	3 months	150
Member	Tammy Yarran	Per meeting	3 months	150
Member	Delson Stokes	Per meeting	3 months	150
Member	Brenda Greenfield	Per meeting	3 months	150
Member	Athol Michael	Per meeting	3 months	75
Member	Bernard Riley	Per meeting	3 months	150
Member	Kerry Thorne	Per meeting	3 months	75
TOTAL				**2250**

Aboriginal youth health working group

Position	Name	Type of remuneration	Period of membership in 2021-22	Total remuneration in 2021-22 ($)
Chair	Jennifer Bonney	Per meeting	12 months	262
Vice Chair	Barbara McGillivray	Per meeting	12 months	182
Member	Rex Wright	Per meeting	12 months	257
Member	Brenda Greenfield	Per meeting	12 months	187
Member	Dorothy Winmar	Per meeting	12 months	257
Member	Athol Michael	Per meeting	12 months	75
Member	Member*	Per meeting	12 months	182
Member	Shirley Thorne	Per meeting	12 months	182
Member	Victor Ronan	Per meeting	12 months	112
Member	Valerina Dorizzi	Per meeting	12 months	112
TOTAL				**1808**

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Armadale and Kalamunda AHCAG

Position	Name	Type of remuneration	Period of membership in 2021-22	Total remuneration in 2021-22 ($)
Chair	Clive Hayden	Per meeting	12 months	150
Vice Chair	Lester Morrison	Per meeting	12 months	462
Member	Leon Hayward	Per meeting	12 months	304
Member	Raelene Hayward	Per meeting	12 months	304
Member	Tammy Yarran	Per meeting	12 months	156
Member	Dennis Johns	Per meeting	12 months	150
Member	Wendy Hayden	Per meeting	12 months	150
Member	Robert Johns	Per meeting	12 months	150
Member	Mort Hansen	Per meeting	12 months	0
Member	Vivienne Hansen	Per meeting	12 months	0
Member	Charmaine Pell	Per meeting	11 months	191
Member	Lorna McGibbon	Per meeting	9 months	112
Member	Susan Woods	Per meeting	5 months	19
Member	Rex Bellotti	Per meeting	6 months	35
Member	Elizabeth Bellotti	Per meeting	6 months	35
TOTAL				2218

Swan, Hills and Midland AHCAG

Position	Name	Type of remuneration	Period of membership in 2021-22	Total remuneration in 2021-22 ($)
Chair	Keegan Morrison	Per meeting	9 months	370
Vice Chair	Tiffany Bennell	Per meeting	9 months	150
Member	Darryl Indich	Per meeting	12 months	300
Member	Donelle Merritt	Per meeting	9 months	300
Member	Doreen Creed	Per meeting	12 months	0
Member	Lisa Morrison	Per meeting	9 months	370
Member	Brittney Kelly	Per meeting	9 months	370
Member	Darren Kelly	Per meeting	9 months	295
Member	Reid Ryder	Per meeting	9 months	70
Member	Tannika Simpson	Per meeting	9 months	70
Member	Amanda Tomlinson	Per meeting	9 months	230
Member	Tomisha Ware	Per meeting	9 months	94
TOTAL				2619

Bentley AHCAG

Position	Name	Type of remuneration	Period of membership in 2021-22	Total remuneration in 2021-22 ($)
Chair	Joanne Hayward	Per meeting	12 months	319
Vice Chair	Kerry Thorne	Per meeting	12 months	344
Member	Brenda Greenfield	Per meeting	12 months	609
Member	Dorothy Winmar	Per meeting	12 months	459
Member	Shirley Voss	Per meeting	12 months	150
Member	Delson Stokes	Per meeting	10 months	194
Member	Kevin Fitzgerald	Per meeting	10 months	344
Member	Victor Ronan	Per meeting	12 months	459
Member	Erica Stewart	Per meeting	9 months	150
Member	Marie Bartlett	Per meeting	9 months	150
TOTAL				3178

RPH and Inner City AHCAG

Position	Name	Type of remuneration	Period of membership in 2021-22	Total remuneration in 2021-22 ($)
Chair	Jennifer Bonney	Per meeting	12 months	469
Vice Chair	Barbara McGillivray	Per meeting	12 months	169
Member	Valerina Dorizzi	Per meeting	12 months	319
Member	Shirley Thorne	Per meeting	12 months	319
Member	Rex Wright	Per meeting	12 months	469
Member	Tania Harris	Per meeting	12 months	0
Member	Gail Wynne	Per meeting	12 months	319
Member	Bernard Riley	Per meeting	5 months	300
Member	Athol Michael	Per meeting	5 months	450
Member	Amanda Barber	Per meeting	12 months	0
Member	Member*	Per meeting	12 months	319
TOTAL				3133

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Aboriginal Health Advisory Council

Position	Name	Type of remuneration	Period of membership in 2021-22	Total remuneration in 2021-22 ($)
Chair	Barbara McGillivray	Per meeting	12 months	659
Vice Chair	Jennifer Bonney	Per meeting	12 months	631
Member	Clive Hayden	Per meeting	12 months	341
Member	Lester Morrison	Per meeting	12 months	191
Member	Joanne Hayward	Per meeting	12 months	191
Member	Kerry Thorne	Per meeting	12 months	341
Member	Keegan Morrison	Per meeting	8 months	150
Member	Tiffany Bennell	Per meeting	6 months	0
Interim member	Leon Hayward	Per meeting	One meeting	140
Interim member	Raelene Hayward	Per meeting	One meeting	140
Interim member	Wendy Johns	Per meeting	One meeting	140
Interim member	Robert Johns	Per meeting	One meeting	140
Interim member	Charmaine Pell	Per meeting	One meeting	140
Interim member	Brenda Greenfield	Per meeting	One meeting	140
Interim member	Victor Ronan	Per meeting	One meeting	140
Interim member	Member*	Per meeting	One meeting	140
Interim member	Valerina Dorizzi	Per meeting	One meeting	140

Aboriginal Health Advisory Council (continued)

Position	Name	Type of remuneration	Period of membership in 2021-22	Total remuneration in 2021-22 ($)
Interim member	Shirley Thorne	Per meeting	One meeting	140
Interim member	Darryl Indich	Per meeting	One meeting	140
Interim member	Lisa Morrison	Per meeting	One meeting	140
Interim member	Brittney Kelly	Per meeting	One meeting	140
Interim member	Roseanne Michael	Per meeting	One meeting	140
Interim member	Darren Kelly	Per meeting	One meeting	140
Interim member	Gail Wynne	Per meeting	One meeting	90
TOTAL				**4694**

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RPBG Consumer Advisory Committee (CAC)

Position	Name	Type of remuneration	Period of membership in 2021-22	Total remuneration in 2021-22 ($)
Chair	Warren Lance	Per meeting	12 months	457
Deputy Chair	Robert McCormack	Per meeting	12 months	327
Deputy Chair	Judy Fetzer	Per meeting	12 months	145
Member	Cynthia Keith	Per meeting	12 months	177
Member	Barbara Hislop	Per meeting	12 months	317
Member	Greg Swenson	Per meeting	12 months	215
Member	Gail Wynne	Per meeting	6 months	75
Member	Jason D'Silva	Per meeting	12 months	290
Member	Jo Treacy	Per meeting	12 months	430
Member	Karen Tambree	Per meeting	12 months	317
Member	Kelly Minson	Per meeting	12 months	252
Member	Nartasha Bianchi	Per meeting	6 months	215
Member	Peter Grocott	Per meeting	6 months	140
Member	Sandra Thorne	Per meeting	12 months	370
Member	Zaida Messier	Per meeting	6 months	70
TOTAL				**3797**

RPBG Integrated Lived Experience Advisory Group (LEAG)

Position	Name	Type of remuneration	Period of membership in 2021-22	Total remuneration in 2021-22 ($)
Member	Louise Wilson	Per meeting	12 months	228
Member	Janine Mans	Per meeting	12 months	237
Member	Bruce Forster	Per meeting	6 months	295
Member	Lorenzo Martinez	Per meeting	6 months	297
Member	Member*	Per meeting	12 months	56
Member	Robert Wood	Per meeting	6 months	466
Member	Cristina Sorbilli-Negovetic	Per meeting	6 months	486
Member	Lauren Cole	Per meeting	6 months	75
Member	Ron Deng	Per meeting	12 months	182
Member	Timothy Fay	Per meeting	12 months	450
Member	Emily Winterburn	Per meeting	6 months	75
Member	Phillip Moncrieff	Per meeting	6 months	131
TOTAL				**2978**

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Armadale Kalamunda CAC				
Position	**Name**	**Type of remuneration**	**Period of membership in 2021-22**	**Total remuneration in 2021-22 ($)**
Chair	Dorothy Harrison	Per meeting	12 months	770
Deputy Chair	Julie Hoey	Per meeting	12 months	70
Carer representative	Sherly Little	Per meeting	12 months	0
TOTAL				**840**

Please note: Community members are paid in accordance with the Health Consumers' Council Consumer Participation Policy. Total remuneration may include payments for participation other than committee meetings.

Our Aboriginal community

Within WA, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of WA. No disrespect is intended to our Torres Strait Islander colleagues and community.

Feedback and accessibility

Thank you for reading our EMHS Annual Report 2021-22. We invite you to contact us to provide feedback on the report, or if you would like additional information about EMHS. For accessibility, this document is available in other formats upon request.

EMHS would like to acknowledge all of the staff who have contributed to the compilation of this report.

Please note: Photos without masks were either taken when masks were not mandatory, or in an appropriate setting.

Cover photos (left-to-right)

- Robert Morrison, A/Senior Development Officer Community Engagement, EMHS Aboriginal Health Strategy
- Moreica Pabbruwe, Biomedical Engineer – Biomaterials, Medical Engineering & Physics
- Natasha Lionetto-Civa, Occupational Therapist, SJGMPH
- Sara Beaman, Graduate Registered Midwife, AHS
- Michelle Janssan, Clinical Nurse, BHS
- Sione Ashworth, Registered Nurse, AHS

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