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

South Metropolitan Health Service

Annual Report 2024–25

Acknowledgement of Country

South Metropolitan Health Service respectfully acknowledges the Noongar people both past and present, the traditional owners of the land on which we work. We affirm our commitment to reconciliation through strengthening partnerships and continuing to work with Aboriginal peoples.

Contents

Using the term Aboriginal

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

Statement of compliance

South Metropolitan Health Service
for the year ended 30 June 2025

Hon. Meredith Hammat 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 Annual Report of the South Metropolitan Health Service for the financial year ended 30 June 2025.

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

Adjunct Associate Professor
Robyn Collins
Board Chair
South Metropolitan Health Service
22 August 2025

Mr Liam Roche
Board member
South Metropolitan Health Service
22 August 2025

OUR YEAR

Board Chair's overview

On behalf of the South Metropolitan Health Service (SMHS) Board, it gives me great pleasure to present the 2024–25 Annual Report.

This year marks the end of our five-year strategy, one that commenced in the same year COVID-19 broke out. It is therefore timely to review the progress the organisation has made against our strategic priorities and vision of 'excellent health care, every time'.

I believe this report is a testament to the achievement and dedication of our people and their ongoing commitment to high-quality, person-centred health care.

The team remains focused on delivering clinical excellence in the care of each and every patient. This is achieved through a range of innovative, clinician-led initiatives and ongoing clinical quality improvements. We look forward to further enhancing this work through a multi-year collaboration with the Virginia Mason Institute (VMI).

Our staff continually provide compassionate care and focus on the patient experience. We have seen significant achievements in the use of digital technologies, patient education and clearer communication, ensuring patients are directly involved in their own care directions.

We are also delighted by the role consumers play across our organisation, ensuring the patient voice informs decision making. This collaborative approach is now embedded and has resulted in the successful co-design of a range of projects and operations.

While the aftershock of the pandemic is receding, there is no question the health care landscape has changed permanently as a result. The much heralded 'new normal' is one of rapid change, and continually evolving health needs.

We know our people are the lifeblood of our health service and notwithstanding the enormous pressures placed upon them in past years, they continue to provide outstanding, high-quality health care.

Our responsibility is to care for them, so they can care for others and the Board places a high premium on culture and workplace initiatives. We are delighted with the progress made to engage our people and provide career and growth opportunities. Significant leadership, coaching and development programs, a focus on wellbeing and psychological safety, and programs that foster diversity, equity and inclusion have been implemented during the past five years and will continue to shape our future.

The nature of our work and our size means we play a major role in our community. We are mindful of our responsibility to engage with community organisations, participate meaningfully in collaborations and develop mutually beneficial partnerships. During the past five years, we have forged strong relationships with schools in a bid to encourage students to explore healthcare careers. We have also engaged closely with local GPs, the industry sector and overseas hospitals to build research capability and enable collaboration across multi-disciplinary services and research prospects.

Finally, we have made great progress in our goal to be productive, innovative and environmentally and financially sustainable. Excellent work has been done to develop initiatives that reduce our carbon footprint, recognising the impact health care has on the environment.

"We don't underestimate the challenges of our healthcare system, but we are confident we have the people and the strategies to deliver excellent health care, every time."

I thank our outgoing Chief Executive Paul Forden who was a formidable force driving our five-year strategy. Paul resigned in December and we subsequently welcomed incoming Chief Executive Neil Doverty.

In July, we were also delighted to welcome Dr Stephanie Trust to the Board and I thank her and my committed fellow Board members for all their efforts.

Finally, I again thank our dedicated staff, volunteers and consumer advisers for their work and contribution to our health service.

I am pleased to endorse this report.

Adjunct Associate Professor Robyn Collins
Board Chair

Adjunct Associate Professor Robyn Collins

Chief Executive's report

I am delighted to present this report and share the achievements and challenges of South Metropolitan Health Service in 2024–25.

Health care is an intrinsic and fundamental part of the community. We are a large employer, caring for around a quarter of the Western Australian population and we have a responsibility to make South Metropolitan Health Service both an outstanding place to work and an outstanding place to receive care.

In 2024–25, our health service grew and underwent some structural changes to help us meet the ever-evolving needs of our catchment area.

In August 2024, we were pleased to welcome Peel Health Campus (PHC) back into government hands and it is now an integral part of SMHS, providing comprehensive care close to home for the residents of Mandurah and the Peel region. In the short time that PCH has been part of SMHS, we have effected significant changes, including expanding the workforce by approximately 100 extra staff; bringing a robust clinical pharmacy in-house; and opening a 3-bed, 4-chair transit lounge, a virtual acute medical unit (VAMU) and a 6-bed Nurse Special Unit take pressure off a busy emergency department and facilitate bed flow and discharges. Promisingly, this has reduced ambulance handover delays at PHC by more than 50 per cent, compared to previous years.

We also restructured our mental health services to form a standalone directorate, fostering greater consistency of services across our catchment. We continue to grow and evolve our mental health service in relation to demand and opened a 75-bed inpatient hospital for voluntary female patients in August 2024 at Cockburn. Mental health remains a complex and growing need, and our multidisciplinary teams work collaboratively to ensure care across our catchment is evidence-based, person centred, recovery-oriented and responsive to cultural and individual need.

Clinical excellence, risk management and safety are the most critical areas for a healthcare provider, and we continually strive for improvements and enhancements in this space.

We take a patient-centred approach to our clinical governance and our goal is to have a zero-harm patient safety culture. We have been making significant ongoing improvements in the quality improvement space through with our *Quality Improvement Strategy* launched in 2022, and we are now ready to take this to a new level.

In June, we commenced a three-year contract with the VMI, an internationally recognised leader in continuous quality improvement. A differentiating characteristic of the VMI program is its holistic approach, which encompasses culture, leadership and wellbeing as well as efficiency, procedures and process improvement. We look forward to working with them over the next three years to identify and embed best-practice as we strive to become a zero-harm organisation.

This focus on culture is an important one at SMHS. We work to create a culture that values excellence and teamwork, that attracts high-performing and compassionate staff. In turn, we hope to help them realise their career potential and provide them with a rewarding professional environment that allows them to balance their professional and personal lives and goals.

We also seek to foster a culture of innovation and continuous improvement and provide opportunities for clinician-led initiatives that improve health outcomes and the patient experience, increase efficiency and provide good stewardship of our resources.

A good example of this is a project to introduce a new model of care for hip and knee replacements at Fremantle Hospital (FH). Led by Dr Omar Khorshid, one of our leading orthopaedic specialists, and supported by a dedicated and hardworking multidisciplinary clinical team, the new model of care has been highly successful, with very high levels of patient satisfaction, and greater levels of confidence in patients returning home after discharge. Post-operative length of stay has been almost halved, potentially freeing up beds for more patients.

Our goal is to facilitate more of these types of projects, which we do partly through initiatives such as our Kaartdijin Innovation team and initiatives such as our pitch panels and innovation fellowships. Promoting a strong research culture is an important aspect of this and we are pleased with the progress of our multi-pronged research strategy, which has a ten-year horizon.

We also invest in traditional leadership and management programs, ensuring access to excellent training and professional development opportunities through study support, work and secondment opportunities, leadership and career development, and access to work on complex cases with some of Australia's finest clinicians and specialists.

A big focus for SMHS in 2024–25 has been investing in junior doctor recruitment and retention, as we build the medical workforce for the future. We launched our Doctor Support Unit in June 2024 and it has now been in operation for a full year, providing education, training and wellbeing support to our more than 1,500 early career medical staff. This has been highly successful as demonstrated by the significant improvement in SMHS scores in the Australian Medical Association *WA Hospital Health Check 2025* report and the increased number of interns electing to start their careers at SMHS.

We also recognise that a workplace that encourages diversity and represents our catchment area is an important for ensuring a healthy and thriving workforce and creating culturally safe spaces for our patients and visitors.

In the past year, we have continued work on our multicultural plan and our disability action and inclusion plan. We also introduced a carers network in 2025, recognising that many of our people provide significant unpaid care to family members and friends.

With more than 20,000 Aboriginal people living in our catchment area, we have a strong focus on narrowing health inequities, identifying and eliminating systemic forms of discrimination and increasing workforce opportunities for Aboriginal people. While we achieved some good outcomes in 2024–25, we acknowledge there is significant work to be done in this space, and we are committed to doing it.

Health care makes a significant impact on the environment and we are very aware of responsibility to help reduce our carbon footprint. We do this through education and though a range of practical initiatives that eliminate waste and encourage greater awareness of environmental impacts.

Finally, we were pleased to celebrate the tenth anniversary of Fiona Stanley Hospital (FSH), our major quaternary teaching hospital. This was a wonderful milestone, celebrated by many staff who have been with us since the opening, as well some of our patients, including the first baby born in FSH, and our first State Rehabilitation Service patient.

"We also seek to foster a culture of innovation and continuous improvement and provide opportunities for clinician-led initiatives that improve health outcomes and the patient experience."

My thanks to the Board for its extensive capability and oversight and to our Chair Robyn Collins for her support and guidance during a year of senior executive change.

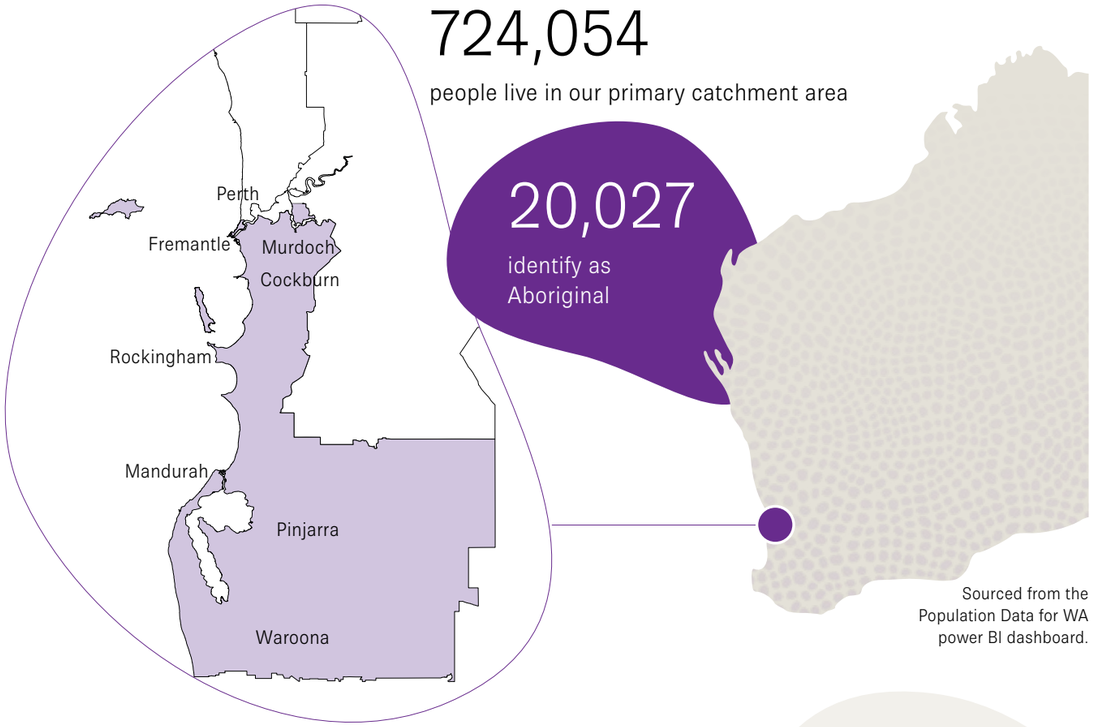
Thank you to my executive team for all their hard work and leadership, especially retiring Chief Executive Paul Forden and, Executive Directors Kath Smith, Kate Gatti and Maxine Wardrop who all served SMHS for many years.

Above all, I extend my heartfelt thanks to our hardworking and dedicated staff, volunteers and consumer partners. Your tireless commitment make this job highly rewarding.

Neil Doverty
Chief Executive

OUR COMMUNITY

Who we care for



724,054

people live in our primary catchment area

20,027

identify as Aboriginal

Sourced from the Population Data for WA power BI dashboard.

Lifestyle of our adult population

25%

drink alcohol at levels that could lead to long-term harm

41%

get the recommended amount of physical activity per week

62%

are overweight or obese

33%

eat fast food at least weekly

11%

smoke (1% less than the WA average)

Sourced from Epidemiology Directorate, Department of Health WA, Western Australia Health and Wellbeing Surveillance System.

Top countries of birth excluding Australia

India **1%**

Philippines **2%**

South Africa **2%**

New Zealand **3%**

England **8%**

The care we provided

Across our health service, our teams delivered the following care to our community

219,290

emergency department presentations

44,353 were children

18,996 – most patients seen in a month

362 – most patients seen in one day at FSH

1,016,122

outpatient appointments

294,104 delivered virtually

184,240

community-based mental health engagements

195,998 inpatients

5,832

births

100 multiple births

18 births in one day

195,998

inpatients

3,887

mental health patients

189

transplant procedures

11 heart

22 lung

1 heart and lung

46 kidney

109 bone marrow

3,990

ICU admissions

89,947

clinical home visits

Our workforce

We have **15,849** staff, working across 11,086 full-time equivalent positions.

Our workforce professions

15% Medical

45% Nursing

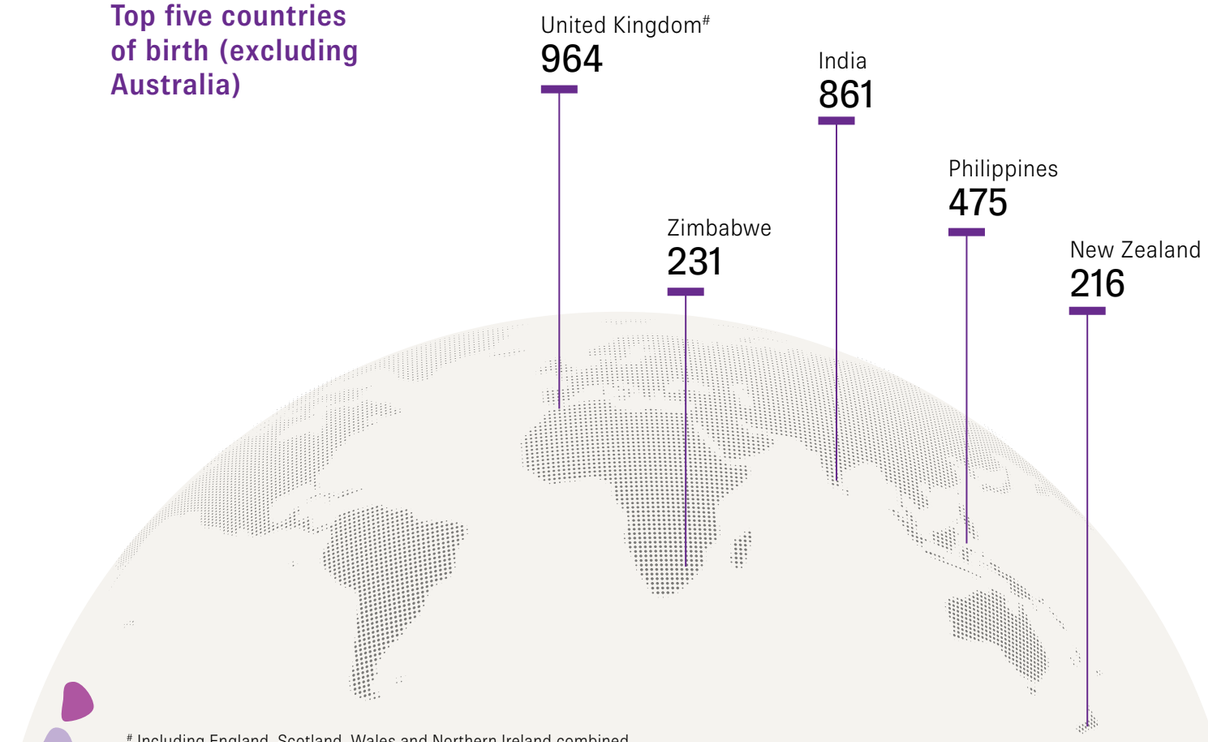
2% Midwifery

14% Allied Health

11% Hotel and hospital services (including maintenance and security)

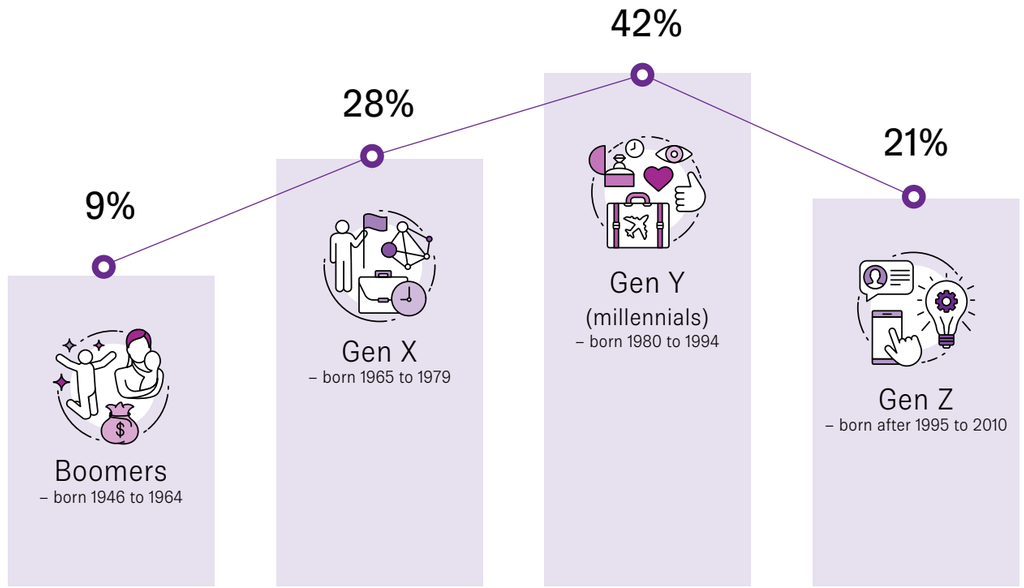
13% Administration and clerical

Top five countries of birth (excluding Australia)

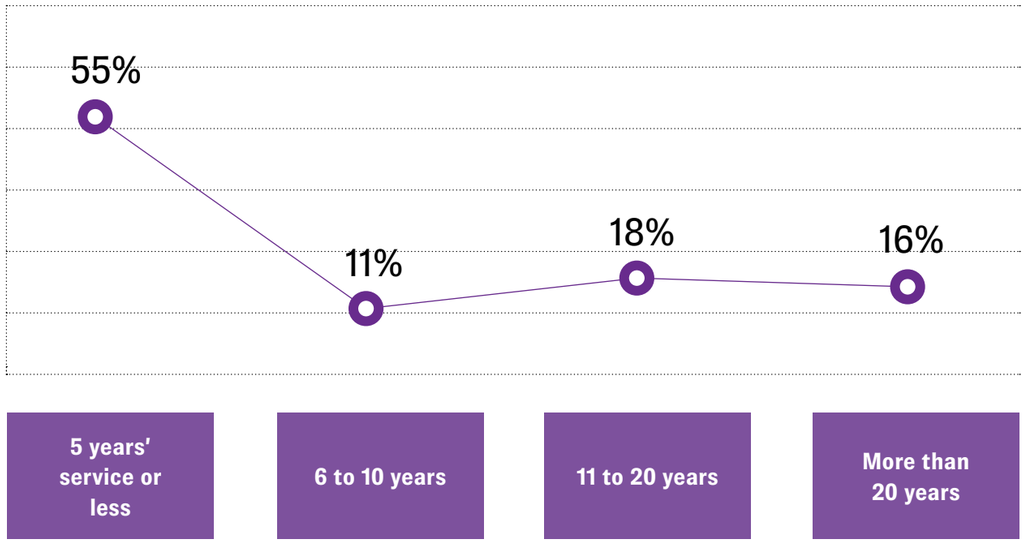


Including England, Scotland, Wales and Northern Ireland combined.

Average age of SMHS staff by generational groupings



Length of service of our workforce



OUR STRUCTURE

Deputy Chair Kim Gibson and Board member Colin Murphy visited RGH on Allied Health day during a Board to Ward visit.

Legislation

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

Responsible Minister

SMHS is responsible to the Minister for Health, the Honourable Meredith Hammat MLA.

Governance

SMHS, as an HSP, is responsible and accountable to the Minister for Health and WA Department of Health (DoH) Director General, as the System Manager.

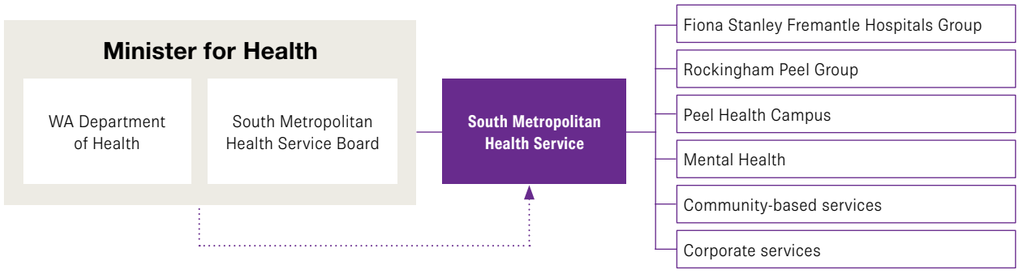
The System Manager is responsible for the overall management, performance and strategic direction of the WA public health system, ensuring the delivery of high quality, safe and timely health services.

Under section 34 of the *Health Services Act 2016*, the Board is responsible for the stewardship of the health service, including the governance of all aspects of service delivery and financial performance. It is also responsible for setting the direction within the scope of policy frameworks set by the DoH.

The Minister for Health appoints the SMHS Board and the System Manager is the employing authority of the SMHS Chief Executive.

Shared responsibilities with other agencies

SMHS works closely with DoH, Mental Health Commission (MHC), other HSPs and many government and non-government agencies to deliver programs and services to achieve better health outcomes for the community of the southern metropolitan region of WA.



Our Board

Board members are appointed for terms of up to three years. A member is eligible for reappointment but cannot hold office for more than nine consecutive years.

Members are appointed according to their expertise and experience in areas relevant to SMHS activities.

The Board is supported by an established structure of committees.

These committees monitor various aspects of SMHS performance, make decisions and recommendations, and help the health service to be responsive to emerging change.

Adjunct Associate Professor Robyn Collins | Chair
RN RM B.App. Sc FCHSM (Hon) MAICD MACM MACN

Adjunct Associate Professor Robyn Collins is a committed and highly successful health service executive and board member with an extensive career in a broad range of governance, strategic, operational and financial management environments. Adj. Assoc. Prof. Collins is currently a board member of Rosewood Aged Care and the Curtin Medical School MBBS Advisory Board. Until early June 2019, Adj. Assoc. Prof. Collins was the WA State Manager of the Australian Health Practitioner Regulation Agency (WA). Adj. Assoc. Prof. Collins was Acting Chair of the SMHS Governing Council for two years.

Ms Kim Gibson | Deputy Chair
B.App.Sci (Physio) MA Public Sector Leadership FACHSM GAICD

Ms Kim Gibson's career in health spans over 30 years across clinical practice, clinical education, health professional regulation, health reform, health service management and governance both in Australia and overseas. Former Chair of the Clinical Senate of WA, Ms Gibson is passionate about health service improvement through clinician and consumer engagement. An experienced board member, she serves on Curtin University Council and formerly chaired the Physiotherapy Board of Australia.

Dr Amanda Boudville
MBBS, FRACP

Dr Amanda Boudville is Head of Aged Care and Rehabilitation at St John of God Midland Public and Private Hospital and an experienced geriatrician and stroke physician. She has worked across various public and private health systems for more than three decades. Dr Boudville is a member of the Amana Living Board and a Federal Councillor of the Australian and New Zealand Society for Geriatric Medicine.

Ms Karen Brown
BA (English), Dip Ed, GAICD

Ms Karen Brown is Non-Executive Chair at Purple, Chair of Lotterywest and Presiding Member of Healthway. She brings experience in senior commercial, business directorship, media, strategic communications and government. Ms Brown worked at both State and Australian Government levels, serving as senior policy and media advisor to the Leader of the Opposition and Chief of Staff in the Office of the Leader of the Government in the Senate. She has extensive board experience in a range of government, commercial, health and charitable organisations. In addition to her chairing roles, Ms Brown is a board member of The Royal Flying Doctor Service Western Operations and the Pinnacle Foundation.

Mr Julian Henderson
B.Eng MBA

Mr Julian Henderson is a highly qualified senior executive with wide-ranging experience within the public and private health sector. He has a breadth of experience in diverse areas including strategic planning, policy development, project development, project management, operations and general administration.

Mr Henderson was a member of the North Metropolitan Health Service Governing Council.

Ms Sue Le Souef
BA (Hons) MA, B Juris, LLB, GAICD

Ms Sue Le Souef has extensive experience in health-related fields including nursing and health law. As a senior legal officer at the DoH, her work included medical negligence, coronial inquiries and freedom of information. She played a prominent role in the introduction of legislation for advance health directives and enduring power of attorney in WA. At the State Solicitor's Office, she worked as a senior solicitor in civil litigation including defending public hospitals in medical negligence.

Mr Colin Murphy
PSM, BCom, FCPA, FCA, FIPAA, GAICD

Mr Colin Murphy was the former and 18th Auditor General for WA. His career has included senior executive finance and administrative roles across a range of State and Australian Government departments. Mr Murphy serves on a number of boards and committees including ChemCentre WA, the Accounting Professional and Ethical Standards Board and the Winston Churchill Memorial Trust Australia. In 2021–22, he served as a Commissioner with the Perth Casino Royal Commission and has been appointed as a member of the Gaming and Wagering Commission WA. Mr Murphy was awarded a Public Service Medal in the Australia Day Honours 2010.

Ms Yvonne Parnell
GAICD, MCHSM, GradCertDis.

Ms Yvonne Parnell was a chief executive officer within the community and disability sector for over 15 years. She had previously held senior executive roles in the corporate sector. Ms Parnell has longstanding and wide-ranging involvement as a consumer leader in both health and medical research in WA and nationally since 2003. She has most recently been a member of the NHMRC Community Advisory Group and Principal Committee for Impact. She is currently the consumer member of the Australian Community Pharmacy Authority, is a Board Member of Alzheimer's Research Australia and sits on a number of other health committees, steering and reference groups.

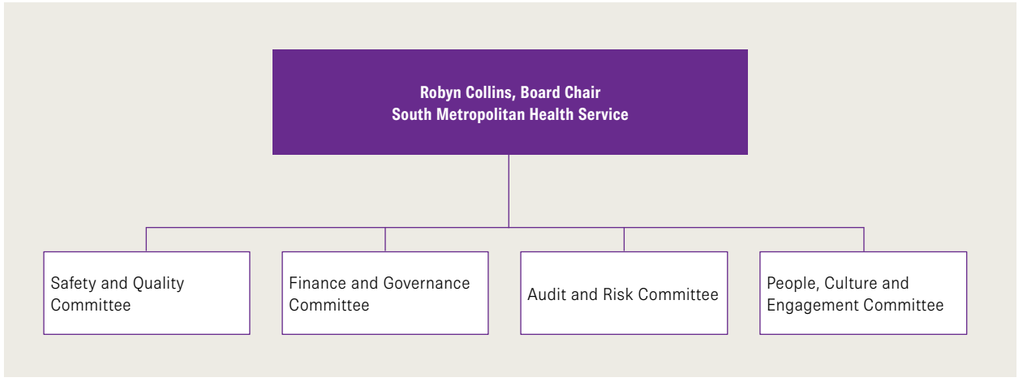
Mr Liam Roche
B.Bus

Mr Liam Roche is an experienced business leader and board member who retired from the role of Chief Operating Officer of Seven West Media (WA) following a 40-year career in the media and manufacturing industry. Mr Roche currently serves as Chair of the Perth Eye Foundation, Deputy Chair of Crime Stoppers WA, Deputy Chair of Multiple Sclerosis Society of Western Australia, a member of the Western Australia Board of the Medical Board of Australia, a non-executive director of Uniting WA and an adviser to the Murdoch University Emerging Leaders Program. Mr Roche has an extensive background in management and governance and is currently teaching the next generation of business leaders at university.

Dr Stephanie Trust

Dr Trust is a proud Gija and Walmajarri woman born and raised in the East Kimberley and is the principal General Practitioner and Clinical Director at the Wunan Health & Wellbeing Centre in Kununurra. She initially worked as an enrolled nurse and an Aboriginal health practitioner before completing her medical training in 2006. Alongside her clinical work, Dr Trust currently serves on the board of Rural Health West, an organisation committed to improving access to health care in regional communities.

Board committees



Safety and Quality Committee

Kim Gibson, Chair
Amanda Boudville
Yvonne Parnell
Stephanie Trust
Pearl Proud (external member)
Phillip Della (external member)

Purpose

Assists the SMHS Board in fostering safety and quality in patient care across the health service by monitoring and advising on matters relating to safety and quality, as well as providing assurance that the Clinical Governance, Safety and Quality Policy Framework is implemented and adhered to, and clinical systems, processes and outcomes are effective.

2024–25 key achievements

- Provided assurance and evidence to the Board of the safety and quality of care provided through in-depth review and examination of key safety and quality performance across all service areas.
- Continued to focus on safety and quality performance as services responded to mounting systemwide pressures.
- Sought assurance of safety and quality management and governance as new services came online, including Peel Health Campus, Fiona Stanley Hospital – Cockburn Health, Fiona Stanley Hospital M Block (generally referred to as the Medihotel) and Mental Health. Continued the committee's focus on matters relating to avoiding preventable patient harm through review of severity assessment code (SAC) 1 clinical incident investigation reports highlighted as of particular concern.
- Shifted the committee emphasis from compliance towards improvement through further evolution of reporting to the committee.
- Elevated consideration of Aboriginal health outcomes through regular committee discussion, development of an Aboriginal health dashboard and regular reporting of strategies to improve key indicator performance.

Finance and Governance Committee

Liam Roche, Chair
Karen Brown
Julian Henderson
Sue Le Souef
Colin Murphy
Brian Mumme (external member)

Purpose

Assists the SMHS Board by providing oversight and strategic direction in the key areas of financial management, governance, legislative compliance, contract and procurement activities and managing financial risks in the provision of health services.

2024–25 key achievements

- Oversight of the 2024–25 budget ensuring alignment with the SMHS strategic plan and systemwide priorities that meet the needs of the community.
- Ongoing monitoring of SMHS high value strategic contracts and procurement processes for all major items and services.
- Ensuring the adequacy of the SMHS financial systems, having regard to SMHS' operational requirements and its obligations under the *Financial Management Act 2006*.
- Ensured that appropriate mechanisms are in place to review and implement recommendations arising from relevant parliamentary committee reports, external reviews and evaluations of SMHS to assist in achieving best practice.

Audit and Risk Committee

Colin Murphy, Chair
Karen Brown
Julian Henderson
Sue Le Souef
Liam Roche
Brian Mumme (external member)

Purpose

Provides advice, independent assurance and assistance to the SMHS Board in respect of maintaining effective and efficient audit functions, risk, control and compliance frameworks, and ensures the implementation of, and adherence to, the Risk, Compliance and Audit Policy Framework.

2024–25 key achievements

- Strengthened SMHS procedures to minimise the potential of fraud related issues.
- Reviewed SMHS processes and controls relating to overtime, leave management and conflicts of interest to ensure best practice.
- Strengthened controls aimed at:
  - protecting SMHS from cyber security threats
  - managing integrity and ethics matters across SMHS
  - managing and ensuring that SMHS clinical incident recommendations and/or corrective actions are implemented effectively.

People, Culture and Engagement Committee

Amanda Boudville, Chair
Julian Henderson
Yvonne Parnell
Stephanie Trust
Fiona Payne (external member)

Purpose

Supports the SMHS Board in fostering a positive culture of open, appropriate and effective engagement between staff, patients, carers and the wider community, and advises on staff matters related to culture and engagement.

2024–25 key achievements

- Continued focus on medical workforce issues, including cyclical shortage of registrars as well as health and wellbeing, and training and research opportunities for staff.

Board term and meeting attendance

The SMHS Board met on 11 occasions in 2024–25.

	Position	Term	Meetings attended
Robyn Collins	Chair	1 July 2016 to 30 June 2025 (reappointed for a further 19 months on 20 November 2023)	11 of 11 meetings
Kim Gibson	Deputy Chair	1 July 2016 to 30 June 2025 (reappointed for a further three years on 1 July 2022)	10 of 11 meetings
Amanda Boudville	Board member	17 July 2017 to 30 June 2026 (reappointed for a further three years on 21 August 2023)	10 of 11 meetings
Karen Brown	Board member	1 July 2022 to 30 June 2025	11 of 11 meetings
Julian Henderson	Board member	1 July 2016 to 30 June 2025 (reappointed for a further 19 months on 20 November 2023)	11 of 11 meetings
Sue Le Souef	Board member	9 March 2020 to 30 June 2026 (reappointed for a further two and a half years on 20 November 2023)	11 of 11 meetings
Colin Murphy	Board member	9 November 2020 to 30 June 2025 (reappointed for a further three years on 1 July 2022)	9 of 11 meetings
Yvonne Parnell	Board member	1 July 2016 to 30 June 2025 (reappointed for a further two years on 21 August 2023)	9 of 11 meetings
Liam Roche	Board member	1 August 2019 to 30 June 2025 (reappointed for a further three years on 1 July 2022)	10 of 11 meetings
Stephanie Trust	Board member	15 July 2024 to 30 June 2026	6 of 11 meetings

Our executive

As at 30 June 2025


Neil Doverty


Luke Dix


Clive Mulroy


Kellie Blyth


Dr Mark Monaghan


Peta Fisher


Mark Cawthorne


Jaymie Arthurson


Hannah Whiting


Emma Davies


Tim Leen


Bryan Cook

Neil Doverty
Chief Executive
South Metropolitan Health Service (Acting)
6 January 2025 to 30 June 2025
Paul Forden (1 July 2024 to 31 January 2025)

Luke Dix
Executive Director
Fiona Stanley Fremantle Hospitals Group (Acting)

- Fiona Stanley Hospital
- Fremantle Hospital
- Rottnest Island Nursing Post

Neil Doverty (1 July 2024 to 5 January 2025)

Clive Mulroy
Executive Director
Rockingham Peel Group (Acting)

- Rockingham General Hospital
- Murray District Hospital
- Peel Community Health

Kathleen Smith (1 July 2024 to 17 April 2025)

Kellie Blyth
Executive Director
Peel Health Campus (Term contract)

- Peel Health Campus Transformation project

Dr Mark Monaghan*
Area Director
Clinical Services

- Area clinical services

Peta Fisher*
Area Director
Nursing and Midwifery

- Area nursing and midwifery services

Amanda Hannaway (1 July 2024 to 1 January 2025)

*Note: Clinical advisers to the Chief Executive and executive directors on strategic matters related to respective discipline areas.

Mark Cawthorne
Executive Director
Corporate and Finance (Term contract)

- Audit and risk
- Clinical coding
- Finance
- Legal
- Library
- Site services: infrastructure, engineering, security, telecommunications
- Soft facilities management

Jaymie Arthurson
Executive Director
Safety, Quality and Consumer Engagement (Acting)

- Clinical incident management
- Clinical governance
- Consumer and carer engagement
- Patient experience
- Patient surveys
- Policy
- Quality improvement
- Safety improvement

Dr Maxine Wardrop (1 July 2024 to 28 March 2025)

Hannah Whiting
Executive Director
Clinical Service Planning and Population Health (Acting)

- Aboriginal health
- Clinical planning
- Community subacute services (Home Hospital, RITH, CPS, CoNeCT, CoNeCT MHE)
- Health promotion
- Human resources
- Industrial relations
- Medical workforce
- Work health and safety
- Workforce planning

Kate Gatti (1 July 2024 to 27 June 2025)

Emma Davies
Executive Director
Transformation (Acting)

- Digital health
- Innovation
- Organisational development
- Research

Tim Leen
Executive Director
Mental Health (Term contract)

- Inpatient mental health services
- Cockburn Health
- Mental health liaison to emergency department and general wards
- Community and outpatient mental health services
- Mental health strategy

Bryan Cook
Executive Director
Contract Management (Term contract)

- Commercial property
- Contract management
- Environmental sustainability
- Major projects
- Procurement
- Public–private partnerships

OUR FOCUS

Our vision

Excellent health care, every time.

Our values

Care
Kaaradj

We provide compassionate care to the patient, their carer and family. Caring for patients starts with caring for our staff.

Integrity
Ngwidam

We are accountable for our actions and always act with professionalism.

Excellence
Beli-beli

We embrace opportunities to learn and continuously improve.

Respect
Kaaratj

We welcome diversity and treat each other with dignity.

Teamwork
Yaka-dandjoo

We recognise the importance of teams and together work collaboratively and in partnership.

Our values

Care

We provide compassionate care to the patient, their carer and family. Caring for patients starts with caring for our staff.

Kaaradj

Ngalak yoongi karadjiny patient-ak, baalabiny wer moort. Karadjiny patient-ak moolyak kaaradjiny ngaalang staff.

We demonstrate care when we:

- provide an environment that empowers the patient, their carer and family to openly and freely contribute to their care and treatment
- talk with, listen and respond to the patient, carer and family
- show empathy and understanding to patients, their carer and family and the situation they are dealing with in a non-judgemental manner
- focus on the patient and staff experience.

Integrity

We are accountable for our actions and always act with professionalism.

Ngwidam

Ngalak accountable ngaalang warn wer kalyakoorl yaka-l doora kartaga.

We demonstrate integrity when we:

- act honestly, truthfully and transparently
- are accountable and take responsibility for our actions and decisions
- recognise when we get it wrong and disclose it as early as possible
- are consistent, fair and equitable in our interactions and decision making
- consider how our individual actions and decisions will impact on others and the health service.

Respect

We welcome diversity and treat each other with dignity.

Kaaratj

Ngalak wandjoo goordawi wer noordo yennar warma-al kaaratj.

We demonstrate respect when we:

- embrace cultural and professional diversity in our interactions and decisions
- acknowledge and appreciate the service and care being delivered
- appreciate the opinions, contribution, experience and knowledge of all staff
- communicate with honesty and openness, share information and are responsive with feedback
- listen to different points of view and incorporate when and where appropriate and provide feedback when we cannot.

Excellence

We embrace opportunities to learn and continuously improve.

Beli-beli

Ngalak barang wilyan kaadadj wer kalyakoorl kwobabiny.

We demonstrate excellence when we:

- give our absolute best as individuals and teams in everything we do
- support opportunities for teaching, training, research and innovation
- actively seek new ideas and approaches and share them across the service
- accept challenges and work proactively to deliver improvements
- consistently meet safety and quality standards
- make effective and efficient use of available resources.

Teamwork

We recognise the importance of teams and together work collaboratively and in partnership.

Yaka-dandjoo

Ngalak kaadadj yardi of teams wer dandjoo yaka banga.

We demonstrate teamwork when we:

- work across boundaries to develop relationships, partnerships and share information
- listen to the views of others to reach agreement
- are aware of our own individual behaviour and how it impacts on others
- communicate clearly and respectfully with each other
- support and encourage others to develop knowledge, skills and behaviours
- actively participate and seek information on our health service and its performance.

Our service delivery

SMHS provides hospital and community-based services to a quarter of WA's population within nine local government areas, as well as supporting WACHS patients from the Great Southern, Southern Wheatbelt and Goldfields regions. In addition, SMHS provides a range of metropolitan-wide services.

The SMHS hospital network provides quatenary, tertiary, secondary and specialist healthcare services. This includes emergency and critical care, elective and emergency surgery, general medical, mental health, inpatient and outpatient services, aged care, palliative care and women's, children's and neonates' services.

SMHS also delivers the following statewide specialist services:

- **adult burns**
- **hyperbaric**
- **rehabilitation**
- **heart, lung and renal transplants**
- **bone marrow transplants**
- **haemophilia and haemostasis.**

SMHS hospitals collaborate with SMHS community-based services to ensure patients receive positive outcomes. Community-based services are an important part of the SMHS network as they aim to keep people from returning to hospital care.

Fiona Stanley Fremantle Hospitals Group (FSFHG)

Fiona Stanley Hospital (FSH) is the major tertiary hospital in the south metropolitan area and provides comprehensive healthcare services to adults, youth and children.

Fremantle Hospital (FH) supports the tertiary services at FSH and delivers specialist hospital services including mental health, aged care and elective surgical services.

Rottnest Island Nursing Post provides accident and emergency care to Rottnest Island residents and visitors.

Ventilator Dependent Quadriplegic Community Care is a statewide service that assists and supports eligible people requiring mechanical ventilation stay in the community.

Rockingham Peel Group (RkPG)

Rockingham General Hospital (RGH) supports a range of health services including emergency, acute and general medicine, surgical, paediatrics, neonatal and obstetrics.

Murray District Hospital (MDH) provides general and geriatric medicine predominantly covering aged care services, particularly to people awaiting rehabilitation and receiving end-of-life care.

Mandurah and Kwinana community health centres both provide community health programs and clinics focused on health promotion and disease prevention management for adults and children (children's services are provided by the Child and Adolescent Health Service).

Peel Health Campus

Peel Health Campus (PHC) is a general hospital providing a range of healthcare services to the Peel region, including Mandurah, the shires of Murray and Waroona, and surrounding areas.

SMHS Mental Health

SMHS Mental Health provides care to voluntary and involuntary patients across youth, adult and older adult population groups in the south metropolitan area.

Services are delivered across all settings – including inpatient, community, outpatients and emergency departments – by multidisciplinary teams who work collaboratively to ensure care is evidence-based, person-centred, recovery-oriented and responsive to cultural and individual needs.

SMHS Mental Health was established under a single point of leadership and accountability in October 2024 to provide opportunity to introduce consistency of mental health services across sites and to grow and evolve mental health services in relation to demand.

Services are delivered through two groups:

- **Fiona Stanley Fremantle Hospital Mental Health (FSFH Mental Health)**
- **Peel and Rockingham Kwinana Mental Health Service (PaRK Mental Health).**

These groups provide services from many locations including Fremantle Hospital, Fiona Stanley Hospital, Cockburn Health, Rockingham General Hospital and Peel Health Campus, plus Rockingham and Mandurah Community Mental Health Clinics, Cockburn Integrated Health, City of Cockburn Youth Centre and Peel Health Hub.

SMHS Mental Health provides the following services for consumers with acute and complex mental health conditions.

- **Adult mental health:** services for consumers aged 18 to 64 years, including inpatient, Home Treatment/Hospital in the Home and community-based services.
- **Older adult mental health:** services specifically for consumers aged 65+ years. These services include inpatient, Home Treatment/Hospital in the Home and community-based services specifically tailored for older adults and for mental disorders in the elderly.

In addition, SMHS Mental Health provides specialist inreach to the Specialist Dementia Care program run at Villa Dalmacia by Hall and Prior.

- **Youth mental health:** services specifically for youth aged 16 to 24 years. Services include inpatient (Youth Mental Health Unit) and community (Youth Community Assessment and Treatment Team and Youth Hospital in the Home). In addition, YouthReach South provides specialist mental health for youth aged 13 to 24 years experiencing severe mental health difficulties and significant barriers to accessing care, such as homelessness.
- **Women's mental health:** Fiona Stanley Hospital–Cockburn Health (Cockburn Health) delivers inpatient services for women aged 18 to 64 years experiencing mental health disorders, eating disorders, and alcohol and other drug (AoD) behavioural and withdrawal management.
- **Specialist services:** SMHS Mental Health provides specialist programs such as the Mother and Baby Mental Health Unit at FSH and Kara Maar, the South Metropolitan Specialist Community Eating Disorder Service, which is located in a purpose-built eating disorder facility at Cockburn Integrated Health.
- **Liaison services:** mental health and AoD consultation liaison services are provided to general wards at all SMHS hospitals. Psychiatric liaison services are provided to emergency departments at FSH, RGH and PHC.
- **Other services:** other services to support crisis and long-term mental health needs across the south metropolitan area. These include Police Co-Response, Ambulance Co-Response and clinical support for public and non-government organisation (NGO) operated step-up step-down residential facilities, and an NGO operated residential rehabilitation facility in Orelia.

Health Promotion

The **Health Promotion** team works collaboratively across SMHS hospitals, community, and local governments to reduce chronic disease and injury with a focus on:

- supporting healthy eating and active living
- reducing tobacco use
- reducing harms from alcohol use
- preventing injury
- promoting mental health and wellbeing.

In the hospital setting, the team supports the implementation of *WA Health Smoke Free Policy, Healthy Options WA Food and Nutrition Policy* and promotes staff health and wellbeing.

In the community, the team supports local government with local public health planning in accordance with the *Western Australian Public Health Act 2016*. This includes providing health and wellbeing data to support local public health plans and assistance to implement best practice health promotion initiatives in the community.

Community Services

Community-delivered services provide acute and sub-acute care services which:

- allow eligible individuals to receive hospital level care at home
- help facilitate early discharge from hospital
- support individuals to remain independent at home and in the community.

Home Hospital – formerly Hospital in the Home (HITH) – is a hospital substitution program which provides in-home care comparable to a hospital. This care is generally delivered in a person's place of residence, and uses highly skilled staff, hospital-equivalent technologies, equipment and medication in line with safety and quality standards.

Rehabilitation in the Home (RITH) is a metropolitan-wide service providing hospital substitution allied health services for patients at home. Its 150 staff, specialising in physiotherapy, occupational therapy, social work, speech pathology and dietetics, service over 700 patients each day with support from medical staff and allied health assistants.

Evidence shows a prolonged hospital stay can be a risk factor for hospital acquired complications, deconditioning, loss of independence and early entry into residential care. RITH aims to reduce the burden on public hospital beds by diverting care into the community direct from emergency departments or reducing inpatient length of stay.

Complex Needs Coordination Team (CoNeCT), including CoNeCT Mental Health Expansion Team (CoNeCT MHE) provides assessment and goal-directed care coordination for patients in the community with complex health needs. The program targets patients who present more frequently to hospital and, with extra support via a care coordination approach, may be able to reduce these presentations. CoNeCT supports patients with a medical or psychosocial focus, with a separate stream to support complex National Disability Insurance Scheme patients and individuals with a primary mental health diagnosis.

Alongside the case management and care coordination approach, CoNeCT and CoNeCT MHE also have pharmacy as part of the team. This provides clinical pharmacy risk assessment, addresses poor medication management and reduces readmissions linked to medication-related factors.

Community Physiotherapy Service (CPS) provides group-based physiotherapy assessment and rehabilitation to regain and optimise function, improve quality of life and prevent hospital readmission to patients after a hospital admission. Services are provided in local community venues close to the patient's home. Patients engage in short-term classes which combine exercise and education on self-management strategies.

Western Australian Limb Service for Amputees

This statewide service provides funding for the purchase of essential prostheses to eligible WA residents.

Western Australia Voluntary Assisted Dying Statewide Care Navigator Service

Since 1 July 2021, eligible Western Australians can legally access voluntary assisted dying (VAD) as an option at the end of life.

The experienced health professionals within the SMHS Statewide Care Navigator Service provide services to patients, their families and carers, community members, health professionals and service providers who are seeking information about, or access to VAD, no matter where they live in WA.

The service also leads practitioner forums, trainings and education events which showcases shared learnings, valuable insights and real-life stories for the health community.


Thankyou For All the Love + Care

Meeting our commitments

Peel Health Campus transformation

In late 2020, the State Government announced operation of PHC would transfer to SMHS on completion of the contract with private operator Ramsay Health Care.

In August 2024, Peel Health Campus officially became part of the South Metropolitan Health Service. This transition paved the way for the hospital's redevelopment to expand services, upgrade facilities and improve access to care closer to home for the Peel community.

Since the transformation, significant progress has been made to service enhancements, safety and quality, staff and wellbeing, leadership and governance, access and equity and in the cultural and community space.

Further information is found throughout this report, but highlights include the following:

- Employing approximately 100 additional clinical and non-clinical staff to enhance onsite services, including increased medical and nursing personnel across inpatient wards.
- Bringing pharmacy services in-house, replacing the previous private subcontractor model and delivering a comprehensive medication safety and support service, aligned with practices across other public hospitals.
- Fitting a new pharmacy facility to meet regulatory compliance standards, ensuring a robust clinical pharmacy service and moving away from the community-based approach previously used at PHC.
- Implementing the digital medical record (DMR) making SMHS the first HSP in Western Australia with all sites operating under a fully integrated DMR system, enhancing clinical visibility and supporting seamless continuity of care for patients who require transfers between sites.
- Opening a six-bed Nurse Specials Unit on 3 June, requiring infrastructure enhancements and targeted staff upskilling, to support care of higher acuity patients within the wards and help reduce the time these patients spend in the emergency department.
- Opening a three-bed, four-chair Transit Lounge to support timely patient discharges and inter-hospital transfers, with consistently high utilisation since opening.
- Establishing a Virtual Acute Medical Unit within the Emergency Department to bring general medical consultants closer to the point of patient entry and support early clinical intervention and more timely discharge planning.
- Offering the first virtual spinal bracing service within PHC, enabling patients to receive care locally rather than via escorted ambulance transfers to FSH for brace fitting. This saved significant time for patients and staff and improved access to timely care.
- Reducing ambulance ramping by more than half compared to the same periods in previous years, and positioning PHC as the site with the lowest ambulance ramping rates in the state, reflecting significant improvements in patient flow and emergency department efficiency.
- Achieving full hospital accreditation in January 2025, just five months after the transition, reflecting the commitment of staff and leadership to delivering high-quality, safe, and patient-centred care..

Mental health beds at FH

Work continued over the last 12 months on the 40-bed mental health development at FH.

This increase in mental health beds and creation of a 24-hour mental health crisis care unit will significantly boost the inpatient admission capacity from 64 beds to 104 beds. It will also expand treatment and support options for mental health patients in the south metropolitan area.

Practical completion of works is expected to occur in February 2026, with a phased opening planned to commence May to June 2026.

Mental health emergency centre at RGH

The establishment of a new, short stay mental health assessment facility at RGH will improve patient and clinical outcomes. SMHS and the Department of Finance (Department of Housing and Works post- the March 2025 election) continued to work together during 2024–25. Work included collaboratively developing a detailed design for the facility. In the coming year, SMHS will work with the Department of Housing and Works to establish the project documentation required for the tender process.

Waterbirth facilities at RGH

In March 2025, the government announced a commitment of $300,000 towards a waterbirth facility at RGH to reduce the current inequity of services available to the local community. A structural engineering study was completed to confirm feasibility for converting a current birthing suite into a waterbirth facility. SMHS is continuing to work with key stakeholders to develop different design options for the birthing pool.

Electronic Medical Record Program

SMHS has taken a very active role in supporting the progression of the Electronic Medical Record (eMR) program. These contributions include completing full DMR implementation ahead of schedule, enabling SMHS to be the first HSP to have full DMR coverage.

SMHS has actively contributed to the forms harmonisation project, working with clinicians and the eMR teams to standardise clinical forms, and have provided Health Support Services (HSS) with training on how to develop eForms to progress digitisation.

SMHS continues to actively engage at various levels with the eMR program providing both technical knowledge, and clinical workflow perspectives to ensure collaborative support, alongside our newly recruited eMR Chief Medical Information Officer, and eMR Chief Nursing and Midwifery Information officer.

Establish a Women's Reproductive and Sexual Health Day Procedure Centre at Cockburn Health

Based on an election commitment, a dedicated women's reproductive health facility will be located at Cockburn Health and operated by specialist provider Sexual Health Quarters (SHQ).

The project is on track and SMHS has been working with DoH to progress the contractual arrangements with SHQ. The operating and funding model will be determined in coming months and the centre is expected to be open and operating before the end of 2025–26.

Our strategy

The *SMHS Strategic Plan 2021–2025* guides the health service in delivering its vision of excellent health care, every time.

The strategic plan supports SMHS' responsibilities under the Sustainable Health Review to prioritise the delivery of patient-centred, high-quality and financially sustainable health care.

The plan's five key strategic priorities, which have anchored the health service since 2017, further strengthen engagement with patients, families, staff and the community to design and improve the delivery of healthcare services.

Excellence in the delivery of safe, high quality clinical care

- Provide consistent high-quality care through the use of endorsed service models and by minimising variations in care.
- Consistently strive for the highest level of safe care aiming towards a zero-harm patient safety culture.
- Aim to generate a culture of continuous improvement where research, innovation and redesign are encouraged and celebrated.

Provide a great patient experience

- Place the patient and their family at the centre of the decision-making process.
- Ensure equity of access to care with a focus on minority groups and the provision of culturally sensitive care.
- Ensure patients and their families are effectively and transparently communicated with throughout their journey.
- Aim to provide exceptional customer service, which is flexible and responsive, to ensure the best possible experience for patients and our communities.

Engage, develop and provide opportunities for our workforce

- Aim to create an environment of respect and empowerment within a culture of accountability, trust and transparency.
- Focus on developing a culture that maintains a highly engaged and satisfied workforce as well as creating a safe workplace that promotes health and wellbeing.
- Identify, develop and embed Aboriginal employment opportunities and career planning at all levels.

Strengthen relationships with our community and partners

- Engage with the community to better define and deliver health services required to appropriately meet the health and wellbeing needs of the local population.
- Aim to optimise existing partnerships and explore new opportunities for innovative alliances both within and outside of health care.

Achieve a productive and innovative organisation which is environmentally and financially sustainable

- Strive to optimise the efficient use of our people and physical resources, including maintaining a sustainable financial position.
- Empower SMHS staff to improve productivity and quality, ensuring they have the required skills and tools to understand their business.

Excellence in the delivery of safe, high quality clinical care

Striving to achieve world-class best practice

SMHS has invested in significant internal and external quality improvement (QI) education, training and support in accordance with the *SMHS Quality Improvement Strategy*, the overarching roadmap for implementing an integrated organisation-wide approach to QI and embedding a culture of continuous improvement.

Setting a goal to become a world-class leader in both QI methodology and quality patient outcomes, SMHS has embarked on a large-scale transformation through a quality management program. In 2024–25, after a rigorous procurement process, it entered a three-year contact with the VMI. This will provide improvements across the organisation in the areas of quality, service design and delivery, culture and wellbeing and efficiency.

A readiness diagnostic investigation to determine SMHS' baseline commenced in June 2025 through an organisation-wide survey, focus groups, one-on-one interviews, small group interviews and walk-throughs. This will be used to formulate and co-design a SMHS-specific delivery plan for the next three years.

Safety improvement program

In 2024–25, two themed reviews of severity assessment code 1 (SAC 1) incidents were undertaken to identify opportunities for broader, systemwide improvements to patient safety and care.

A review of medication incidents affirmed that serious harm or death is rarely a direct outcome of medication incidents. Whilst there were no incidents where a patient suffered long-term harm or death as a direct result of the medication error, the review acknowledged the psychological harm to patients, families and staff, and the increased length of stay that can occur as a result of serious medication incidents. Medication safety activities are consistently undertaken across services and the review ensures common themes, contributing factors and learnings are translated into organisation wide improvements.

Sustainable improvement is the goal of SAC 1 review, and the evaluation of implemented recommendations is a critical step to reduce recurrence of incidents. The thematic review of implemented recommendations demonstrated that evidence provided largely matches what is required, but there is still opportunity to improve. As such, resources will be developed to ensure measures of improvement are robust.

Continuous quality improvement program

In 2024–25, we focused on implementing further proactive area-wide safety improvement and QI programs to build staff skills and capability, thereby reducing patient harm, variation in care, healthcare associated infections and preventable deaths.

In 2024, staff across SMHS completed the Institute for Healthcare Improvement (IHI) Basic Certificate in Quality and Safety, and Australian Council Healthcare Standards Quality Improvement Lead training in March 2025.

This year, SMHS is piloting the SMHS Applying QI course, with seven participants across SMHS sites who completed the IHI Basic Certificate Quality and Safety participating. Course participants are supported to apply their learnings to a local QI project by a QI mentor.

SMHS Mental Health transition

On 1 June 2024, SMHS Mental Health services was centralised to a single directorate under an Executive Director, Mental Health. This decision was guided by recommendations from the *2022 Independent Governance Review* and endorsed by the Minister for Health and Mental Health.

Over the past year, SMHS has undertaken a phased journey to establish SMHS Mental Health, with a focus on maintaining continuity of high-quality care while moving to a single service and maintaining strong ties with the broader SMHS environment.

The consolidation of mental health services under one executive leadership provides the opportunity to:

- elevate its profile within SMHS
- introduce consistency in mental health services across SMHS
- support the growth and evolution of mental health services to address increasing demand and future needs across the whole of the SMHS catchment.

This has been a year of significant transformation for mental health services across SMHS and the first step towards laying the foundation for an integrated, contemporary mental health service that deeply values and builds on the unique cultures and histories of each site.

Cockburn Health

Since opening in August 2024, Cockburn Health has emerged as a pioneering facility in women's mental health care. A statewide resource, this stand-alone, 75-bed inpatient hospital is dedicated exclusively to voluntary female patients aged 18 to 64 years. It offers specialised services in mental health, eating disorders and alcohol and AoD withdrawal management.

The phased commencement began in August 2024 with eight beds before expanding steadily to 50 beds in December 2024. It provides gender-specific, trauma-informed and recovery-focused care which integrates holistic approaches, including exercise, creative enrichment and culturally sensitive therapies to support healing and empowerment.

In May 2025, a further 10 beds were opened for AoD withdrawal management with an additional seven beds opened in June 2025. This will be fully expanded to 25 beds by December 2025. The AoD service is working with the MHC, the East Metropolitan Health Service (EMHS), Next Steps and community-based NGOs to enhance service delivery and build strong integrated pathways.

As it moves toward full operational capacity, it continues to shape new models of care for some of the most vulnerable women in our community, reaffirming the SMHS mission to deliver excellent, compassionate and evidence-based health care every time.

Therapy data management system upgrade for dialysis treatments

In 2024–25, the therapy data management system used to manage dialysis treatment data was updated, amalgamating the FSH and PHC dialysis units into a single digital clinical information system. This enables dialysis unit staff to deliver continuity of care across the dialysis units in SMHS.

This provides clinicians at all SMHS dialysis units with the same end-user experience, harmonising clinical workflows and clinical documentation. Allowing clinicians access to patient dialysis records also provides enhanced treatment safety, consistent communication and smooth patient transfer within SMHS.

WA's first fully digital medical record public health service

The implementation of a digital medical record (DMR) system at PHC in 2024–25 made SMHS the first Western Australia health service provider (HSP) to have all sites operating under a fully integrated DMR system.

This milestone enhances clinical visibility and supports seamless continuity of care for patients who require transfers between sites.

Improving identification of variation in care

SMHS is continually looking at ways to identify potential issues of unwarranted variation in care.

In 2024–25, improved reporting as a result of upgrades to a tool called 'Variation Scanner' – which utilises activity and outcome data from multiple sources – assisted clinical leaders to identify trends in clinical outcomes and identify unwarranted variation in care.

Additionally, semi-automated case review processes for hospital acquired complications (HAC) were established as a program at RGH, with a similar program for PHC HAC reviews under development.

The review processes, coordinated by site safety and quality teams, engage with specialist clinicians to:

- review flagged HACs
- confirm causation
- assess the preventability of the HAC
- examine if clinical management of the HAC was appropriate.

Clinical care standards

The Clinical Care Standards (CCS) app was expanded to support the transition of PHC to SMHS and embed SMHS systems and processes for undertaking gap analysis and action planning for CCS related quality improvement activities.

The app supports oversight of the Australian Commission on Safety and Quality in Healthcare's 18 clinical care standards and associated quality statements. Collectively, these describe the care patients should be offered by health professionals and health services for a specific clinical condition.

Work has been undertaken to address identified indicator gaps through the development of semi-automated case auditing. The CCS for acute coronary syndrome, venous thromboembolism, opioid stewardship, sepsis, and third- and fourth-degree perineal tears, have benefitted from enriched sources of information around the quality of care delivery and adherence to best practice.

Clinical workflow support

Significant work has been undertaken in collaboration with teams across SMHS to design and develop REDCap-supported processes. REDCap is a WA Health application that can be configured to safely and securely manage clinical information in formats that align closely to clinical workflows.

REDCap supported workflows for multidisciplinary team meetings (MDMs) for thoracic malignancy and interstitial lung disease were implemented this year. These meetings enable groups of senior specialist staff to discuss complex clinical cases, including new and recurring cancer diagnoses referred by treating clinicians. Recommendations and decisions resulting from these meetings facilitate the ongoing planning of timely treatment.

Clinicians and support staff benefit from the elimination of many administrative tasks, such as collating meeting agendas and generating patient summary letters. Same-day summaries are now available for referring clinicians to discuss treatment recommendations with their patients. For the first time, MDM summary letters to patients' GPs are also being automatically generated. Other HSPs are actively working to adopt these innovative tools.

The Work Based Assessment program for overseas-trained doctors at RGH and PHC is being supported with a REDCap project that automates the process of multi-source feedback (MSF) for candidates. Using the Medical Board of Australia's (MBA) forms with permission, coordinating staff, candidates, supervisors and nominated peers have been using a secure public platform to request and submit peer feedback required for the MBA.

The MSF project automatically calculates peer ratings and collates feedback comments in formats that can be used to support supervisor meetings and produce detailed candidate records. Records can also be submitted in the appropriate format to the MBA by sites.

Candidate and staff feedback has been very positive, with coordinating staff reporting a significant reduction of administrative tasks associated with MSF processes for candidates.

Perioperative patient journey audit tool designed for RGH

The implementation of a theatre auditing program at RGH resulted in a low cost, in-house, flexible auditing solution that can be updated to meet changing organisational needs by removing the time-consuming and laborious manual process which can be subject to human error.

This project incorporated an electronic bedside auditing tool that reviews compliance at the point of care through the patient journey via iPad, using both observational and documentation auditing. It has been designed to meet the current monitoring needs whilst being adaptable, supporting RkPG's requirements for auditing and aligning with national standards. Variations in care are identified by the auditor in real time, prompting immediate feedback to staff and on-the-spot improvement.

RGH clinical trial for chemotherapy-free cancer treatment

Clinical trials are essential for advancing cancer treatment and ensuring patients have access to the latest medical innovations. The RGH Haematology Clinical Trials Unit is offering hope for a future where effective, low-toxicity treatments are becoming the new standard of care.

A new clinical trial being led out of RGH is exploring a chemotherapy free approach to treating chronic lymphocytic leukaemia. The condition – one of the most common blood cancers – accounts for 30 percent of all new leukaemia cases in Australia.

The clinical trial consists solely of oral tablets, providing greater convenience and improved quality of life for patients newly diagnosed with the condition. Both medications have already been proven safe and effective when used separately. Researchers are now exploring whether using them together offers even better results while maintaining fewer side effects than chemotherapy.

Round the clock RGH theatre staffing

The roll out of 24-hour-a-day, seven-day-a-week on-site theatre staffing at RGH is leading to better patient care, improved staff wellbeing and a more efficient hospital system.

Previously, theatre, obstetrics, gynaecology and anaesthetic staff were on call after hours to provide emergency surgery, predominantly caesarean sections. This roll out has improved patient care and reduced both cancelled surgeries and staff sick days.

RGH intensive care unit expansion

With demand rising for intensive care capacity across WA, the RGH ICU was permanently expanded from eight to 10 beds in 2025. This supports patients being moved from the Emergency Department (ED) in a more timely manner, leading to safer patient care and a lower likelihood of patients being redirected to other hospitals.

As a result, the ICU team is providing additional support to critically unwell patients in the RGH wards and those presenting to the ED, as well as helping reduce the overall pressure on other SMHS hospitals. This expansion has also provided greater staff training and education opportunities.

New swallowing assessment tool for RGH

Thanks to the introduction of flexible endoscopic evaluation of swallowing at RGH, patients have access to another best practice swallowing assessment tool.

This evidence-based tool allows speech pathologists to insert a tiny camera on a flexible scope through the patients nose to see what happens in the throat as they swallow.

Intensive care patients and those who are too unwell to leave the ward can now get a high-quality swallowing assessment in a timely manner, better-informed diagnoses and greater equity in care.

The collaborative rollout involved collaboration across Speech Pathology, ICU, Moordibirdup Ward nursing staff, the policy team and ear, nose and throat colleagues at FSH.

Supporting patient discharges on weekends

Expanding the RGH Pharmacy and Allied Health teams to provide seven-day services is supporting more weekend discharges, helping more patients to get home earlier.

As part of the RkPG Winter Bed Strategy, a clinical pharmacist supports weekend discharges on medical and Moordibirdup wards, as well as general medicine outlying patients. This is also supported by a new weekend dispensary service.

Increased allied health services over the entire seven days have facilitated discharges and decreased lengths of stay for General Medicine patients.

Improving neonate care at RGH

RGH purchased eight new omnibed care incubators to keep up with the changing and complex demands of the neonatal unit. The incubators provide a consistently controlled thermal environment for preterm and sick newborns, including those admitted for hypothermia, preterm babies unable to maintaining their own temperature and babies receiving respiratory support.

The incubators quieten the external noise, offering a calmer space for babies with neuro-development issues or who need isolation. The built-in technology in the incubator monitors the baby's temperature closely and adjusts the environment to the correct comfort zone required for the baby. A built-in air curtain prevents warm air escaping if the if the lid is raised or the doors are opened, keeping the incubator at the appropriate temperature.

The incubators are popular with parents, as they also show weight trends and can be lowered for parents in wheelchairs, in particular mums recovering from caesarean section births.

Clinical audit improvement

Collaborative work has been undertaken across all SMHS sites to review and improve core clinical audit tools. Inpatient and perioperative WeCAN tools have been enhanced to capture identified process measurement gaps and to align to clinical care standards/strategic priority improvement areas.

PHC leveraged content from existing SMHS audit tools to rapidly establish core audit activities post-transition in preparation for accreditation. Dashboard reports for all SMHS sites were amended in preparation for short notice accreditations.

Short notice accreditation

In 2024–25, three of our hospitals underwent the new short notice assessment (SNA) process introduced by the Australian Commission for Safety and Quality in Healthcare. Under SNA, hospitals only receive 24 hours' notice of accreditation.

FSFHG

At initial assessment, FSFHG fully met six standards and received four recommendations across two standards where additional work for implementation was required.

The group was also assessed on a maturity scale against the implementation of the new National Clinical Trials Governance Framework. It received an outcome of 'Growing Systems' (2.66 out of a possible score of 3), an excellent result.

In May, the lead assessor returned to re-assess the four recommendations, resulting in FSFHG having fully met all required actions and being awarded full accreditation status for three years.

PHC

PHC achieved full hospital accreditation in January 2025, just five months after the transition to SMHS. This milestone reflects the commitment of staff and leadership to delivering high-quality, safe patient-centred care.

Supported research through the biobank

Launched in 2022, the SMHS Biobank has exceeded expectations. It supports 11 research projects and now houses a large number of samples, including blood, stool, urine and tissue.

A total of 9,103 samples have been managed, of which 843 have been shipped/delivered. This leaves 8,260 samples presently stored in the freezer.

The SMHS Biobank's footprint was expanded this year with the procurement of a second -80 °C freezer and a DNA extraction machine. This procurement was achieved though Future Health Research and Innovation (FHRI) Research Infrastructure Support (RIS) Grant funding.

Delivering research with purpose

SMHS is working in accordance with the *SMHS Research Strategy 2023–33*.

The strategy outlines five pillars of change and in 2024–25, we completed the following initiatives under each pillar:

Community

- The SMHS Consumer Involvement Framework was launched by the SMHS Board Chair in November 2024.
- The inaugural SMHS Research Consumer Advisory Group was established in February 2025.
- The SMHS Consumer Bank Fund was initiated, and multiple applications approved.
- The SMHS Consumer Registry was promoted, with several consumers lodging their interest.

Collaboration

- Initiated the Consultant Engagement Program to re-energise consultant engagement in research.
- Developed a draft program for junior doctors to work in research (to be progressed further in next financial year).
- Worked in partnership with WA Country Health Service (WACHS) to promote and encourage teletrials.

Culture

- Developed a draft program to buy back clinician time to focus on research (to be progressed further in next financial year).
- Embedded the inaugural Research Grants Strategy into business-as-usual.
- Worked with colleagues from the Harry Perkins Institute for Medical Research and The University of Western Australia to upgrade the safety of the consulting room clinics in the south building, located at FSH.
- Facilitated the seventh SMHS annual Research Showcase in November 2024 to celebrate our researchers' work.

Data

- Developed a flowchart to guide data approvals in research.
- Developed the ninth *Annual Research Report 2024*: 174 new research projects were approved to commence at SMHS sites in 2024.
- Formally evaluated the licence with Research Screener and secured funding for three years. This provides automation software to assist researchers when searching large literature databases.
- Formally evaluated the licence with ClinTrialRefer and secured funding for three years. This ClinTrialRefer app markets our clinical trials to the community.

Support

- Continued the Research Mentoring program to ensure novice researchers are supported by experienced researchers.
- Continued the Publication Fund to support researchers with publication costs.
- Worked with colleagues in PathWest to streamline pathology support for research projects.
- Transitioned the inaugural Research Integrity Advisors program to business-as-usual.
- Reviewed clinical trials as part of hospital accreditation for the first time and achieved a score of 2.66/3 for FSHFG.
- Worked with colleagues at Department of Health to transition Human Research Ethics Committee (HREC) to a centralised model, and as a result SMHS HREC is due to close next financial year.
- Successfully applied for the FHRI RIS Grant funding for a second year.
- Engaged at a national level for the National One Stop Shop reform.

Provide a great patient experience

Short stay arthroplasty project

A new model of care for hip and knee arthroplasty patients at FH is improving the patient experience, supporting patients to return home sooner, and significantly reducing length of stay.

Aligned to internationally recognised best practice, the project commenced in 2024 and identified the following four key focus areas:

- the introduction of a care coordination role
- an anaesthetic/analgesia protocol to minimise post operative symptoms
- patient engagement and expectation management, including a comprehensive suite of education resources
- resourcing, staff training and a model of care to support early mobilisation.

The new model of care – which included development of a clinical guideline, nursing care plans, a suite of patient information, and design of a clinical application pathway through Personify Care – commenced in May 2025.

Patient feedback has been outstanding, with 88 per cent of patients feeling very prepared for their surgery, and 82 per cent feeling very prepared for their discharge home. Multiple compliments have been received regarding the care and support provided, including, "None of my questions or doubts were left unanswered," and "The care was exceptional and very welcome".

After eight weeks of the project, and 69 patients:

- the average length of stay was 1.5 days (compared to 3.6 before the project)
- 68 per cent of patients had been discharged on day one (compared to seven per cent before the project).

The project's implementation reflects a comprehensive, patient-centred approach to clinical transformation. Supported by phased delivery, multidisciplinary governance, and a resourced project team, the project is well-positioned to transition to sustainable, best-practice arthroplasty care. Future focus will be on review of the preadmission processes to expand the care coordination role and patient optimisation.

Getting eligible patients home, sooner

Evidence shows a prolonged hospital stay can be a risk factor for HACs, deconditioning, loss of independence and early entry into residential care.

Rehabilitation in the Home (RITH) aims to address this risk and reduce the burden on public hospital beds by either diverting care into the community direct from ED or reducing an inpatient length of stay.

In 2024–25, RITH provided services to more than 12,000 patients from publicly funded hospital and emergency wards. This provided a better experience for patients in the comfort and security of their own homes and created capacity within hospitals. RITH continues to grow in demand and activity and experienced 17 per cent growth compared to 2023–24.

Maternity social work service supports Rockingham and Kwinana mothers

RGH has established a dedicated maternity social work service alongside its midwifery team, supporting maternity patients facing social challenges. The team assists pregnant mothers experiencing family violence, homelessness, mental health issues, substance use concerns or involvement in the child protection system.

Supporting patients from the start of their antenatal care through birth and into the postnatal period offers vital resources and emotional support to keep them and their children safe.

While the midwifery team supports patients through the medical and biological aspects of their care, the maternity social work team helps ensure the emotional and psychological safety of patients, often with a trauma informed lens. They offer patients a familiar face during vulnerable times and can link patients with the community services they need for the safe arrival of their baby.

New neonatal rapid access clinic for RGH

When discharged from hospital, well newborns are followed up by the RGH visiting midwifery service within the first five days of their life, or after this by the child health nurse. During this follow-up, some newborns are referred to a neonatologist or paediatricians for further review. This may be due to concerns about jaundice requiring phototherapy, poor feeding, intolerance and significant weight loss.

To prevent these babies going to the ED for care, RGH developed a neonatal rapid access clinic. Operating from the hospital's neonatal unit, expert neonatal nursing staff are available to seen the newborn immediately. This prevents long and stressful waits for families to be seen in the busy ED. Just as importantly, the clinic protects vulnerable newborns from the risk of infection.

Newborns who need to be admitted for care can be treated immediately in the unit. Neonatal nursing staff are also able to provide education and reassurance to families which allow them to be at home with further follow up at a planned time and date if required.

RGH welcomes McGrath Cancer Care nurse to better care for cancer patients

Thanks to McGrath Cancer Care, cancer patients at RGH have access to specialist nursing care and support throughout their treatment journey. Available from the moment of diagnosis, the free service is available to patients diagnosed with solid tumours without a doctor's referral.

The McGrath Cancer Care nurse supports patients and families emotionally, helping them understand their options and advocating for their needs. The nurse also links them with other RGH and community services. Patients and families are offered evidence-based information, supporting informed decision-making with the goal of achieving the best possible outcomes.

With continued collaboration and compassion, RGH's partnership with the McGrath Foundation under the Australian Cancer Nursing and Navigation Program strengthens the hospital's commitment to delivering high-quality, patient-centred care to those facing cancer.

RGH ICU family room coastal upgrade

Thanks to a donation from family members of an RGH ICU patient, a mural installed in the ICU family room has created a welcoming space for families of patients receiving critical care. The ICU team worked closely with the family to create a new space that was softer, calmer and had a more homely feel.

Some patients spend weeks on the unit, and the space is now somewhere families can relax whilst still being close to their loved ones.

New bus stop creating safe haven for MDH patients

A new bus stop art installation at MDH (pictured below) is helping patients with dementia feel more at ease during their hospital stay. Funded by donations from the Friends of Murray District Hospital Committee, the colourful bus stop and mural provide a calm, safe space where patients can sit, relax, and take a break. The bus stop offers a familiar sight that helps patients feel more secure, triggering old memories and offering comfort, and helping to reduce anxiety for patients with dementia.

The installation, completed in just two days, was designed in collaboration with a local visual artist, and each aspect of the design was carefully chosen to inspire positivity, calmness, and joy, transforming the hospital space into a peaceful retreat.

Leading the way in reducing restrictive practices within mental health

SMHS Mental Health inpatient service at RGH, Mimidi Park, has made significant strides in improving consumer care in mental health through reduction in restrictive practices.

Recognising the harm caused by restrictive practices such as restraint and seclusion, the Mimidi Park team committed to creating a safer, more compassionate environment for consumers and staff. Guided by the Safe in Care, Safe at Work Framework, Mimidi Park embedded evidence-based strategies into daily practice, prioritised education and leadership, and the involvement of lived experience to drive cultural change.

Staff were empowered through targeted education sessions that fostered empathy, communication and confidence in engaging with consumers. This shift in approach led to a more therapeutic ward environment, with staff spending more time with patients and less time in nursing stations. Consumers reported feeling heard and supported, and staff increasingly responded with flexibility and understanding. The introduction of a peer coordinator role and investment in sensory modulation and therapeutic activities further enhanced the quality of care.

The results have been outstanding, with an 84 per cent reduction in seclusion and a 61 per cent reduction in restraint over 12 months, both well below Western Australian averages. These achievements were recognised with a prestigious SMHS Southern Star Award at the 2024 SMHS Excellence Awards, celebrating Mimidi Park's leadership in reducing restrictive practices and improving consumer outcomes. In addition, the team presented their work to the Office of the Chief Psychiatrist's Community of Practice in March 2025.

The initiative has elevated clinical confidence and consumer satisfaction and set a benchmark for compassionate, trauma-informed mental health care across SMHS.

Access to voluntary assisted dying

The Voluntary Assisted Dying Statewide Care Navigator Service supports patients, their families and carers, community members, health professionals and service providers exploring voluntary assisted dying (VAD). Combined with the Regional Access Support Scheme, it provided assistance to more than 1,000 new patients in 2024–25, an increase of 15 per cent from the previous year.

The service also promoted increased awareness of the VAD journey through an annual service of reflection and the podcast, 'This is My Stop'.

Chemotherapy treatment activity digitised across SMHS

Building upon the successful launch of a world-class oncology information system, CHARM®, at FSH in 2023–24, the program was expanded to PHC in August 2024 and RGH in February 2025.

This system draws all vital information about a cancer patient and their journey into one single digital record, improving clinical safety and collaboration.

The project has now successfully closed out, and the system transitioned into business-as-usual support.

Think Before You Test

Think Before You Test is a new program which aims to reduce the number of unnecessary pathology tests ordered across SMHS to minimise our carbon footprint, conserve resources, optimise efficiency and limit patient exposure to unnecessary testing.

The program was launched in December 2024 at FSH ED and has since seen the average number of tests ordered decrease by almost 100 per day.

Each pathology test has a carbon cost, with CO^2 emissions from 1,000 full blood count tests estimated to be equal to driving 770 km in a car and 1,000 electrolytes, urea, creatinine tests equal to driving 650 km in a car.

On average, around 9,000 pathology tests are performed each month across SMHS.

The Think Before You Test program was recognised for innovation at the Health Roundtable 30th anniversary showcase in Sydney in April 2025.

RSVP trial

A small change in clinical practice in the FSH Intensive Care Unit (ICU) is delivering big savings in waste and expenditure, with no adverse impact on patient care.

The FSH ICU Green Team rolled out the Australian RSVP trial where infusion tubings and transducers attached to invasive lines were changed at seven days instead of three days.

After a year of the trial, and despite increased admissions to the ICU, more than $64,000 was saved in consumables without any harm to patients. This change has also significantly reduced the waste generated by the disposal of clinical consumables.

FSH ICU has an active Green Team with a focus on improving the unit's carbon footprint beyond recycling (pictured above).

Engage, develop and provide opportunities for our workforce

SMHS Carers network

At SMHS, we are strongly committed to supporting carers by creating an inclusive workplace. We value all employees who are carers, providing unpaid care to a family member or friend who may be living with:

- a disability
- mental illness
- alcohol or drug dependency
- chronic condition
- terminal illness
- frailty due to age (*Carers Recognition Act 2004*).

In February 2025, SMHS Workforce initiated steps to obtaining SMHS accreditation with the national Carers+ Employers program. Workplaces that meet the Carers + Employers Standards can be nationally recognised as Accredited Carer Friendly Employers.

There are three levels within the accreditation program. Organisations are required to start at Level 1, then may progress to level 2 and 3 or alternatively, remain at an accredited level without progressing further.

On 5 June 2025 SMHS achieved Level 1 Activate Accreditation.

SMHS is now working towards Level 2 Commit accreditation, where organisations build on their Level 1 Activate Accreditation to provide clear actions and pathways to improve and embed carer friendly workplace practices.

Aboriginal cadet helping mothers at RGH

Thanks to the Aboriginal Cadetship Program, Aboriginal women accessing antenatal care at RGH are benefitting from additional care and support.

The Aboriginal Cadetship Program provides students with real life work experience in health, supporting them to develop skills and build rapport with health professionals while studying. The program addresses healthcare disparities whilst promoting cultural competency and creating opportunities for Aboriginal people in the workforce. It also encourages representation, ensuring Aboriginal people have a voice in healthcare decisions affecting their communities.

The strong rapport built by the RGH 2024 Aboriginal Cadet with Aboriginal patients ensured they knew of all available support services they could access throughout their motherhood journey. The cadet worked with the RGH Aboriginal health practitioners to ensure the hospital is a culturally safe space for Aboriginal patients and visitors for years to come.

Midwifery research partnership at RGH

Following the successful Honorary Midwifery Research Consultant model at FSH, the program was expanded to help to create the best possible experience and outcomes for RGH mothers, babies and families. Three midwifery academic researchers from Edith Cowan University are collaborating on midwifery research with hospital midwifery staff. This new collaboration highlights the importance of midwifery-led research in achieving universal health coverage and healthier populations through the delivery of women-centred care in models that promote continuity of care.

RGH Auxiliary funds education scholarships

Thanks to profits donated by the volunteer-run RGH Auxiliary RkPG staff continue to benefit from scholarships to fund professional development opportunities.

In 2024, an additional 14 new scholarships totalling $30,000 were awarded. Nine people were supported to attend conferences (nursing, mental health and allied health staff) and the remaining five completed accredited training.

Clinical service improvement rotations

The RkPG Clinical Service Improvement program welcomed three clinicians in 2024–25. The program fosters collaboration and a collective leadership approach to empower junior clinicians from various clinical disciplines to make meaningful improvements and become strong advocates of safety, quality and service improvement.

Junior clinicians are engaged in service redesign, supporting them to design and complete improvement projects that will impact clinical workflow support to further improve an aspect of healthcare that benefits staff and patients.

The 2024–25 rotations covered topics including:

- improving patient flow as a result of refining the discharge medication process
- reducing medication administration omission errors
- development of a criteria-led arthroplasty pathway to expedite discharge.

Rockingham junior doctors complete workplace-based assessment program

In a first for RGH, five junior doctors completed the Australian Medical Council (AMC) Workplace Based Assessment program. The 12-month program, an alternative to the AMC Clinical Examination for international medical graduates, runs in line with the resident medical officer terms and rotates through six clinical areas.

Via this valid and reliable assessment program, international medical graduates (IMGs) are assessed by various senior clinicians in multiple clinical areas across a wide range of clinical domains. This ensures a robust assessment process and a variety of clinical experiences. On successful completion, candidates are awarded an AMC Certificate which allows them to apply for general registration and progress their careers.

The RGH program is an important part of the IMG Pathway to Registration Project. The project – a DoH initiative – supports IMGs currently living but not working in the Australian healthcare system in WA.

SMHS Workplace Injury Early Intervention Program

Following its successful implementation across SMHS, the Workplace Early Intervention Program (EIP) continues to provide benefits to our injured workers.

In 2024–25, SMHS completed a procurement business case for a new three-year contract, with an optional two-year extension (2026–31), reaffirming its commitment to early, proactive injury management and work-centred care. The EIP is designed to prioritise the health and recovery of injured employees by providing immediate access to clinical advice and treatment, including assessment by a general practitioner or occupational physician, and timely physiotherapy interventions.

The program's core objective is to ensure optimal injury management that supports a safe, timely and sustainable return to work following a workplace injury or illness.

To further enhance accessibility, a telehealth option was introduced, enabling employees across all SMHS sites to receive prompt medical assessments regardless of location. This innovation has enhanced response times and reduced barriers to early intervention, particularly for remote or shift-based staff.

To date, 991 cases across SMHS have been triaged into the program. Of these, 69 per cent were resolved through EIP-supported treatment, returning our injured workers back to productive work and reducing the impact of workers' compensation claims.

SMHS Wellbeing

The SMHS Chief Wellbeing Practitioner (CWP) – a role that is a WA first – continues to lead our organisational response to staff wellbeing. The *SMHS Wellbeing Framework 2022–25* guides our strategic approach to staff wellbeing with its actions grouped into four interconnected pillars.

Harnessing the collective leadership and expertise of the SMHS Wellbeing Committee, substantial progress has been made with the implementation of the framework:

SMHS Wellbeing Framework pillars	Actions	Actions completed 2024–25
Healthy culture	12	12
Healthy minds	9	8
Healthy body	9	9
Healthy places	6	5
Total	36	34

The Wellbeing Committee continues to grow, with over 180 members representing all SMHS staff regardless of discipline or location. Meeting monthly and chaired by the CWP, other key achievements include:

- increasing the visibility of staff wellbeing across SMHS and WA Health
- presentations at state, national and international conferences
- the SMHS Wellbeing Initiatives Exchange, our online central repository, highlighting some 73 locally developed wellbeing initiatives
- regular delivery of SMHS-wide events that foster community, connection and belonging
- hosting events such as Crazy Socks 4 Docs (pictured above)
- development and curation of online wellbeing hub of resources, including women's health (peri-menopause), financial health and alcohol/substance use
- organisation-wide roll-out of the People at Work (PAW) comprehensive workplace psychological risks and hazards program, a joint initiative led by SMHS Work Health and Safety with organisational development teams. Currently, PAW is being implemented within five identified areas at SMHS, all at different stages of the PAW process.

Developing our future medical workforce

Attracting and retaining junior doctors is the first step in building a strong and capable medical workforce for the future.

SMHS launched its Doctor Support Unit (DSU) at FSFHG in June 2024 to support doctors-in-training (DIT) as they navigate their early career. This includes training opportunities and wellbeing support, rosters, leave and pathways to safely raise complaints and concerns. The unit was expanded in 2024–25 to include RGH and PHC.

In 2024–25, initiatives focusing on two key areas were implemented.

Improving accessibility to education for DIT

- Created DIT Grand Round education series and funding for doctors to attend outside work hours at FSFHG, which was expanded to RGH and PHC.
- Hosted SMHS doctors career expo, including scheduled one-on-one career guidance sessions.
- Implemented the 'Refreshing practices for post leave expertise' (RIPPLE) program to support doctors returning from long leave (three months or longer) by providing workshops offering refresher skills and training (also baby friendly for those returning from parental leave).

Improving perception of SMHS as a primary medical intern employer of choices

- Improved engagement with WA medical schools and students through popular and well-attended new medical student education sessions facilitated by DSU education team.
- Continued creation of unique intern rotations, aligned with the AMC National Prevocational Framework and increased intern numbers (five each year to a max 145) in accordance with Council of Australian Government agreement to accommodate increasing WA medical graduates. Intern positions unique to single site HSP were created at FSH in neonates, paediatrics, obstetrics and gynaecology, endocrinology and palliative care. All positions received Postgraduate Medical Council WA accreditation.
- The new intern positions received very positive feedback from interns and supervising teams. In addition to continuing these positions, SMHS created new positions in hyperbaric medicine and the State Burns Centre. These positions provide future doctors a unique start to their medical career.

The result of these initiatives was a significant increase in local graduate preferencing for intern employment in 2026. In 2025, 56 students chose SMHS as their first preferred location for their internships, making SMHS ranking fifth overall out of the WA HSPs. For 2026, 109 students gave SMHS their first choice preferencing and it is now the second ranked HSP.

Capacity building

Carbon Literacy Scholarships

To build the knowledge and understanding of the impacts of climate change amongst our workforce, scholarships were provided to 27 staff from across SMHS to complete healthcare-specific carbon literacy training, facilitated by Edith Cowan University.

The course encompassed the impact human activity has on the environment, how to identify opportunities to reduce personal and workplace emissions and explored behaviour change strategies and how to advocate for environmentally sustainable change.

Projects planned and developed during the course enabled participants to achieve certification by UK's Carbon Literacy Project.

Following the success of the initial round, the scholarships will be offered again in 2025.

Organisational development

The *SMHS Organisational Development Strategy 2021–25* aims to develop team and inter-team trust, respect and effective collaboration and communication, leading to a values-based, psychologically safe organisation.

Investing in teams and staff development

Care to Manage

The Care to Manage Program continues to provide a consistent and structured approach to developing core managerial capabilities across SMHS. Designed to empower managers with the essential knowledge and skills required to lead effectively, the program reinforces a clear understanding of SMHS expectations, values, culture and strategic vision.

Now well-established and available on demand via the learning management system, Care to Manage remains a self-directed, flexible learning solution tailored to the needs of SMHS managers. The program is aligned with the *SMHS People Capability Framework* and offers interactive, bite-sized learning modules that support practical, real-world application.

As of this financial year, over 600 staff members have self-enrolled in the program, reflecting strong engagement and ongoing interest in professional development. The program continues to attract new participants and supports managers at all levels in building confidence and consistency in their leadership approach.

In 2025–26, Care to Manage will undergo a comprehensive review to ensure the content remains relevant, applicable and aligned with evolving organisational needs. This review will involve a wide range of stakeholders across SMHS, including managers, subject matter experts and learning and development professionals. The aim is to identify any gaps, enhance the learning experience and ensure the program continues to meet the expectations of current and future SMHS leaders.

Care to Lead

The Care to Lead program is an immersive leadership program that provides a bespoke development opportunity for leaders across SMHS.

The Care to Lead and Care to Lead Foundations programs remain central to SMHS's commitment to cultivating compassionate, collective leadership across our health service. These programs are designed to empower both established and emerging leaders, supporting the SMHS Strategic Plan priority to 'engage, develop and provide opportunities for our workforce,' and ultimately enhancing the quality of care for patients, families and the community.

In 2024–25, the Organisational Development team delivered seven cohorts across both programs, providing a tailored, multidisciplinary leadership development experience. Participants engaged in interactive workshops, workplace-based leadership projects and peer learning, with a strong emphasis on applying compassionate leadership principles to real-world challenges. The collaborative model continues to foster professional growth and strengthen the SMHS Leadership Alumni, who are now actively involved in ongoing mentoring and development activities.

This year's program evaluations highlighted the significant impact of compassionate leadership and self-awareness on team dynamics and leadership effectiveness. The program's structure, practical tools and interactive elements were highly valued, contributing to a positive learning experience.

Looking ahead, ongoing investment in leadership development is expected to further benefit patients, consumers, staff and the wider community by strengthening team cohesion, supporting staff wellbeing and enhancing the delivery of excellent care, every time.

SMHS Coach Training

In 2025, SMHS continued its strategic investment in leadership development through the Senior Leader as Coach Program, with 17 senior leaders successfully completing the initiative. This program is a key component of SMHS's commitment to fostering collective leadership across the organisation.

Funded in partnership with DoH's Institute of Health Leadership, the program provided 30 hours of structured training over three months. Clinical and non-clinical participants – including executive directors, service directors and medical consultants – were equipped with practical coaching tools and techniques to embed a coaching approach into their leadership practice.

Participants reported significant personal and professional growth, with recurring themes including:

- enhanced self-awareness and emotional intelligence
- increased capacity for reflection and compassion
- a structured, evidence-based approach to coaching
- strengthened cross-site collaboration and networking.

Graduates of the program joined the SMHS Coach Consultancy, an initiative that connects trained internal coaches with staff seeking professional coaching support.

With approximately 80 trained coaches volunteering their time, the initiative offers staff – supported by their managers – access to a series of individual coaching sessions.

Staff can peruse coach profiles and submit requests via an electronic form. The consultancy has become a valued resource for professional development, wellbeing and leadership growth.

This year the consultancy further expanded its services by partnering with the Care to Lead Program, providing targeted coaching to support the Care to Lead participant's leadership journey.

SMHS Human Factors Training

Launched by SMHS in early 2024, the SMHS Human Factors Training (SHFT) program supports the organisation's commitment to a culture of safety, collaboration and continuous improvement.

This face-to-face, team-based program equips staff with practical tools to apply human factors thinking in everyday work, particularly high-pressure or complex situations.

Human factors such as communication, fatigue, workload and team dynamics directly influence performance and safety. The SHFT program promotes a shared understanding of safe, effective behaviours and helps build safer, more cohesive teams across both clinical and non-clinical settings.

In early 2025, the program was strategically redesigned to increase its impact and sustainability. Shifting from one-hour sessions to a more effective half-day format improved engagement, deepened learning and reduced administrative burden. The new format has resulted in stronger uptake, growing peer interest and consistent demand from teams. The original one-hour sessions remain available upon team request, providing flexibility to meet local needs.

Delivered through nine core modules, SHFT is facilitated by trained human factors ambassadors and available to all SMHS staff.

Key achievements in 2024–25 include:

- nearly 350 staff enrolled in SHFT via the learning management system
- 26 new human factors ambassadors trained in 2025, growing the total cohort to 56
- increased uptake and demand following the streamlined half-day format
- growing informal awareness through peer conversations and team referrals.

SMHS Leadership Alumni

The SMHS Leadership Alumni initiative continues to play a pivotal role in supporting leadership development, fostering collaboration and building a culture of compassionate, collective leadership across SMHS. Established to connect leaders from all SMHS sites, the alumni provides a platform for sharing experiences, addressing leadership challenges and developing positive relationships that drive innovation and excellence in healthcare delivery.

A highlight of 2024–25 was delivery of a highly impactful event that demonstrated our commitment to ongoing professional development and engagement. In collaboration with the Australasian College of Health Service Management (ACHSM), this alumni event held in October brought together SMHS Board members, executives, Care to Lead participants and Alumni members. The event featured a panel discussion facilitated by ACHSM President Dr Neale Fong, with healthcare leaders from across the sector sharing insights on career development and the evolving landscape of healthcare leadership. This partnership also marks an important step towards the accreditation of the Care to Lead program, expanding career development opportunities for our leaders and supporting SMHS's vision of delivering excellent health care, every time.

Looking ahead, the key challenges for the alumni include:

- maintaining engagement across a growing network
- ensuring equitable access to leadership development
- supporting leaders to navigate the complexities of modern healthcare.

These challenges are identified through ongoing feedback from members, event evaluations and consultation with both internal and external stakeholders. Addressing them is essential for sustaining a vibrant, empowered leadership community that benefits patients, staff, and the wider community. By continuing to invest in our leaders and building strong partnerships, SMHS is well positioned to meet future challenges and deliver on its commitment to excellent patient care.

Some of our SMHS Care to Lead, Emerging Leaders pilot group and the Human Factors Ambassadors graduates came together to celebrate.

SMHS Leadership Mentoring Program

This program was launched in 2024 to strengthen leadership capability and foster a culture of compassionate, inclusive, and accountable leadership across SMHS. The program aims to support aspiring and emerging leaders by connecting them with experienced mentors, offering a structured pathway for professional and personal development.

In the 2024–25 financial year, the program opened its first, post-pilot round of applications and received strong interest from staff across a range of disciplines and sites. Applicants were guided through a clear eligibility process, which included the completion of prerequisite leadership development courses including Care to Manage and Care to Lead. To maximise participation, the program provided flexible timelines for meeting these requirements.

A key highlight was the return of several mentors who had participated in the earlier pilot program. Their continued involvement has brought valuable experience, continuity and enthusiasm to the new cohort, further strengthening the program's foundation. The program also demonstrated responsiveness to participant needs by postponing masterclass sessions, allowing more time for prerequisite completion and ensuring all participants could fully engage in the mentoring experience.

Looking ahead, the program will commence masterclasses and mentoring sessions in the next financial year. Ongoing priorities include supporting participants to complete their prerequisites and preparing for the next cohort intake. By investing in leadership development, SMHS is building a resilient pipeline of leaders who are equipped to drive positive change and deliver compassionate, high-quality care to patients, staff and the community.

SMHS MyLearning project

As SMHS expands in size and digital maturity, we require a contemporary learning management framework and system to be effective in delivering and supporting the training needs of SMHS. This project aims to enhance the usage, reliability, administration and efficiency of the SMHS learning management system (MyLearning) and associated reports across SMHS.

By enhancing how training is accessed and tracked, SMHS and the health services can empower staff to easily locate and complete necessary training, while enabling managers to gain clear insights into their teams' skills and achievements – ultimately supporting safe and high-quality patient care.

In 2025, the project team initiated multiple initiatives to improve consistency, access and accuracy of training resources within the MyLearning system. This included using approved course naming conventions and imagery, course catalogue simplification, archiving historic content and re-designing course and system features.

The team has several key project initiatives planned and underway to develop responsive and accurate reporting for staff and managers such as:

- course template redesign and management
- user friendly course and skill reporting – staff and manager report suite.

Strengthen relationships with our community and partners

Put it to the People

Put it to the People is an online community engagement platform, supporting consumers, carers and the wider community to be involved in the planning and delivery of health services across SMHS.

The platform includes a translation tool that offers information and engagement activities in multiple languages, improving opportunities for collaboration with diverse communities. This ability is integral to the wide community engagement that will be undertaken in the development of the SMHS Multicultural Action Plan, in the upcoming year.

In 2024–25, the platform received 10,972 visits from 7,986 visitors, leading to 437 contributions to activities and consultations across SMHS.

Through this platform, SMHS engaged with the community in a range of projects, including name suggestions for a new SMHS foundation, selecting new smoke and vape free messaging for our hospitals and providing input into our next SMHS Consumer and Carer Engagement strategy.

The platform was also used to allow staff and consumers to nominate SMHS staff for a compassionate care award, recognising staff who provide compassionate, person-centred care as part of Patient Experience Week celebrations.

Engaging with GPs

The GP Engage program is designed to strengthen relationships and develop communication pathways between SMHS and our local GPs, with the overall aim of improving patient care within our communities. The program has been developed and delivered in partnership with WA Primary Health Alliance (WAPHA).

The initial phase of the program, launched in the prior financial year, focused on primary health care providers within the FSFHG catchment. Key activities included educational and face-to-face networking events. The second phase, launched in 2025, expanded the program to the RkPG catchment area, with the first event hosted at PHC in June.

The program also looks to introduce a broader range of initiatives aimed at further strengthening relationships.

Supporting older Western Australians to stay at home

In 2024–25, Community Physiotherapy Service (CPS) partnered with WAPHA to deliver a linkage program aimed at supporting clients over 65 years of age to remain at home by preventing avoidable ED presentations and hospital admissions.

CPS expanded its model of care to accept GP referrals to address the needs of primary care patients at high risk of ED presentation where this risk may be managed by receiving physiotherapy in the community. Social work is embedded into the CPS model of care to address unmet social needs of its patients, enabling the service to address social complexity impacting the physical health of clients and carers.

This financial year, CPS also partnered with Curtin University to implement a university-funded student-supported model of service delivery to offer additional pulmonary rehabilitation programs in SMHS. The intent is to develop innovative, sustainable and scalable solutions to improve the utilisation of these programs.

Advocating for consumers

Across SMHS, our community advisory councils (CACs) continued to ensure the consumer voice is heard, acknowledged and valued.

The FSFHG CAC's Teach-back project – which supports patients, families and carers to make healthcare plans and decisions – was taken to the WA Clinical Senate and selected for roll-out across all HSPs. This outstanding achievement recognises not only the excellent resources created, but the structured teaching and training delivered to multidisciplinary staff. Four FSFHG consumer groups also provided more focused, local consumer representation to support ED, mental health and maternity services.

A SMHS research consumer advisory group was formed and is strengthening connections and understandings between researchers and consumers, including in the area of clinical trials.

With the transition of PHC, we welcomed members to the hospital's first CAC as a SMHS hospital. This structured partnership between consumer and carer representatives and PHC will support the shared goal of improving the consumer services and experiences.

At RkPG, CAC members visited wards with a staff member to conduct short face-to-face snapshot surveys. These 'consumer buzz surveys' focused on the information consumers received on topics including staying safe in hospital, patient rights and the Aishwarya's CARE Call process. It also identified whether this information was communicated personally by their treating team or through onsite publications such as flyers and posters.

Consumers were invited to shape the RGH maternity service now and into the future by sharing their knowledge and experiences as part of the newly formed Maternity Advisory Group.

Blood cancer research puts RGH on the map

Three RGH clinicians were invited to present their research on blood cancer at the Society of Australia and New Zealand 2024 annual Blood Conference, recognising excellence in their research fields. The clinicians enjoyed sharing their research activities at a national level and showcasing RGH, not only as a leader in clinical research in Australia but as a preferred site for academic and industry collaborations.

Positive delegate feedback on the RGH presentations noted that the hospital has pioneered a model of treatment to improve access to life-saving cancer treatments to outer metropolitan areas. RGH was also commended for encouraging junior doctors, nurses and allied health staff to participate in research opportunities, allowing significant career progression.

Staff attending had the opportunity to upskill in the latest cancer treatments and network with medical staff from across the nation, vital for continuing to provide exceptional healthcare closer to home.

Improving consumer engagement skills

In 2024, a new education session was designed to upskill staff in engaging consumers in recognition of the importance of their role in quality improvement projects. The session was delivered across all SMHS sites in 2025, with staff reporting it provided helpful information that will assist developing quality improvement projects at a ward level.

Collaborating with schools

The SMHS School Work Experience Program continued to grow in 2024–25, providing local high school students with valuable exposure to healthcare careers. This year, the program expanded its reach by partnering with three additional schools, enabling a wider range of students to participate and benefit from real-world experience in a hospital setting.

A significant highlight was the expansion of placement opportunities to seven additional hospital departments. In addition to Patient Support Services, students were able to gain hands-on experience in a broader array of clinical and non-clinical areas. Year 11 and 12 students from non-ATAR pathways spent one day per week over the course of a term in supervised placements across diverse work streams, broadening their understanding of healthcare operations and career options.

Key achievements included the successful placement of highly motivated students and the strengthening of school-community partnerships. The expansion to more schools and departments was well received, offering students a richer and more varied experience.

Despite these successes, several challenges remain. The program continues to face difficulties aligning placements with workforce needs and recruitment outcomes, and the resource-intensive nature of delivery without a dedicated budget raises concerns about long-term sustainability. While the current structured model is on hold, opportunities for ad hoc work experience placements continue under existing workforce policies, ensuring ongoing support for student engagement in healthcare careers.

Addressing mental health challenges across the Peel region

Led by SMHS, the multi-agency Peel Mental Health Taskforce was established to provide coordination to improve mental health service delivery across the Peel health district region (Mandurah, Waroona and Murray local governments).

The taskforce enables and supports the prioritisation, development and implementation of identified mental health, AOD and psychosocial projects to prevent crisis and improve mental health outcomes.

The taskforce comprises high level representation from organisations, including:

- SMHS
- MHC
- WAPHA
- Department of Communities
- Department of Education
- Child and Adolescent Mental Health Services
- Peel Development Commission
- PHC
- WA Police
- local mental health and Aboriginal service providers
- consumers and carers with lived experience.

The taskforce is informed by local representative sub-groups. Overall, the partnership approach engages representatives from over 50 government and NGOs, with communications shared regularly and input on various initiatives sought.

Over 2024–25 several major initiatives progressed in partnership.

- The **Wandjoo Gateway 'no wrong door'** approach resulted in 10 public and private Peel high-schools signing on to deliver streamlined mental health support for their students through a series of best-practice processes and engagement tools, including the innovative 'story capture sheet' which acts as a universal referral form.
- Through the **Peel Collaborative Commissioning Project**, comprehensive service mapping of the Peel mental health and AOD sector was completed, with the major commissioning bodies for these services forming a working group to move towards more aligned commissioning of services in the region.
- Established in 2025 with staff attendance from approximately 33 government and NGOs, the **Peel Mental Health Community of Practice** was formed to create new knowledge, and to share it accordingly with members to advance the mental health area of professional practice. Quarterly meeting topics have included eating disorders and non-suicidal self-injury.

- The **Youth Innovation Think Tank** was initiated by the EMHS in 2024. This year marks the second collaboration between SMHS, EMHS and WACHS. The program engages Year 11 and 12 students from across the state, who work with a diverse group of DoH employees as mentors. Together, they develop innovative solutions to real-world health problems using human-centered design methodology. The students then present their solutions in a shark tank-style pitch to a panel of WA Health representatives. The preliminary round will be held at the end of July 2025, followed by the grand final in September 2025.

SingHealth nursing and midwifery collaboration

SMHS continued its successful twinning partnership with Singapore Health Services (SingHealth) to explore opportunities for collaboration in nursing education, training and research.

In 2024–25, SMHS submitted 22 abstracts for consideration at the SingHealth 2025 Nursing Conference, held in July 2025, all of which were accepted for presentation.

Post the conference, SMHS will reflect on the experience and look at how we can translate these learnings locally to improve both patient care and staff experiences.

SMHS twining partnership in India

SMHS has been in a partnership with Indian hospital Sarojini Naidu Medical College (SNMC) since July 2023.

The purpose is to collaborate across multidisciplinary services and research and provide better understanding of clinical outcomes for patients and staff across both organisations.

In 2024, the partnership successfully established bilateral clinical ownership in haematology, cardiology and emergency medicine, and saw the operationalising of SNMC Cathlab and Cardiac Coronary Care Unit besides exchanges leading to procurement of flow cytometry for SNMC haematological services.

In early 2025, FSFHG Head of Geriatric Medicine Dr Bhaskar Mandal visited SNMC to deliver a continuing professional development seminar. More than 120 medicine faculty members, trainee doctors, twinning hospital leads and physicians from surrounding Indian hospitals attended. Dr Bhaskar was also invited to be a keynote speaker at the Annual Indian Geriatric Association Conference in Varanasi, India.

As a result of Dr Bhaskar's talks, more metropolitan Indian hospitals and community care centres have reached out, keen to explore collaboration in developing India's aged care services for its 100+ million population over the age of 65.

This provides an opportunity for SMHS to leverage our world class geriatric expertise and ongoing interactions to build bilateral exchanges and comprehensive framework of care and geriatric medicine with partner hospitals towards equitable geriatric care.

Achieve a productive and innovative organisation which is environmentally and financially sustainable

Sustainability

SMHS is committed to being an environmentally sustainable and climate resilient organisation, which is integral to our vision of excellent health care, every time. The *SMHS Environmental Sustainability Strategy 2023–26* sets out the pathway for us to achieve our net zero ambitions by 2040 for the health of this and future generations.

Reducing single-use plastics

Aprons and gloves

In 2025, SMHS transitioned from plastic to biodegradable non-sterile gloves. SMHS uses more than 16 million single-use gloves every year which go to landfill and take decades to break down and become dangerous micro-plastics.

The new biodegradable nitrile disposable gloves are made to break down in landfill in one to five years, without releasing micro-plastics. SMHS has also introduced compostable aprons to replace more than 500,000 plastic aprons used each year.

While these items are now more environmentally friendly, the focus remains on using resources wisely and avoiding unnecessary use and waste.

Blood bags

More than 30,000 plastic blood delivery bags have been replaced with a more environmentally sustainable option in a staff-initiated collaboration between Pathwest and the FSH Transfusion Medicine Unit.

A trial of plant-based biodegradable bags in November 2024 found they were as good if not better than the plastic version, with porters, nurses and laboratory staff all providing positive feedback.

As well as saving thousands of plastic bags from going to landfill, the biodegradable item is cheaper and will save around $1,100 a year.

Measuring our carbon emissions

In 2024, SMHS began the process of onboarding to a whole-of-government Emission Reporting System which will enable it to collate, analyse and report sustainability data, including greenhouse gas emissions.

The process is being coordinated by the Department of Water and the Environment Government Net Zero project team with SMHS one of approximately 100 government organisations and Government Trading Enterprises being onboarded to the platform.

The project supports agencies to prepare an emissions profile and develop an emissions reduction plan and aligns with the state's commitment to reduce Government greenhouse gas emissions by 80 per cent below 2020 levels by 2030 and to reach net-zero by 2050.

FSH achieves national environmental performance rating

FSH has become the first hospital in Western Australia to successfully achieve a National Australian Built Environment Rating System (NABERS) rating — a nationally recognised benchmark for environmental performance in buildings.

This government-backed program assesses how efficiently buildings use energy and water, manage waste and maintain indoor environmental quality, and provides a comparison against other equivalent sized hospitals.

SMHS has identified a range of initiatives to enhance building efficiency and performance.

Digital prescribing rolled out at RGH

Since 2023, electronic prescribing (ePrescribing) via the Clinical Workbench app has enabled WA health prescribers to provide electronic prescriptions to outpatients. In 2025, RGH rolled out the application to improve accessibility for outpatients to receive their medication from community pharmacies. Patients can choose to receive a QR code via SMS, email or their active script list if they are registered.

This provides greater convenience for patients and helps streamline prescribing in telehealth settings, removing the need for paper prescriptions. E-prescribing also helps reduce errors and assist prescribers in navigating PBS restrictions, reducing workload and administrative burden.

MET transformation at RGH

Changes were made to the Medical Emergency Team (MET) call system at RGH in November 2024, to reduce the incidence of false alarms. A common cause of false alarms was patients mistakenly pressing the emergency button instead of the light, resulting in unnecessary use of clinicians' time and significant disruption to workflow and therefore overall patient safety.

Separate medical emergency teams were established to ensure specialised, timely emergency assistance. Team members now receive clear and reliable alerts, such as a confirmed code blue, ensuring their response is both timely and appropriate.

Immediate results highlighted a substantial reduction in false alarms, from 41 per cent in November to 9 per cent in December 2024. This shift saved approximately 1,540 minutes of clinicians' time in a single month. This number is likely an under-representation, as it likely takes a lot longer to get back into a task once momentum has been lost following a distraction. False alarms have consistently reduced since then, with one month as low as 3 per cent.

The true value of this project is in creating sustainable and safe services, with senior clinicians no longer distracted unnecessarily from their duties which results in safer care for RGH patients and reduced costs.

Innovation in action

Dream big – Innovation pitch panels

These panel events enable SMHS Kaartdijin Innovation to collect and develop innovative ideas for improving the way we work. Ideas are presented by SMHS staff and assessed based on the issue description, vision, value, feasibility, strategic alignment and transformational impact.

Four ideas from the November 2024 Pitch Panel were approved to progress through the pipeline. Two ideas were awarded SMHS Innovation Fellowships, enabling successful applicants to work in the innovation team for a dedicated period to develop and test their idea:

- an AI application developed by a FSH senior speech pathologist that uses lip-reading to facilitate communication among intensive care patients
- a digital application that enables the delivery of speech therapy to patients, developed by the FSH Coordinator of Speech Pathology in collaboration with researchers at Murdoch University.

Another idea, presented by an external startup on developing a digital language translation app for healthcare, was accepted in the newly established SMHS Health Ready program.

2024 WA HSP Innovation Showcase

On 8 October 2024, SMHS hosted the WA Health Service Provider Innovation Showcase at Fiona Stanley Hospital, expanding upon the 2023 inaugural event by WACHS. The 2024 showcase was a hybrid event, connecting WA health service professionals with innovative local start-ups and celebrating the creative efforts of teams across WA HSPs and their partners.

The event offered an inclusive forum for HSPs to connect and share best practices and reinforced the significance of partnerships in driving sustainable healthcare excellence. For those in rural and regional areas, limited access to knowledge-sharing events presents additional challenges. This showcase addressed those needs directly, ensuring WA Health staff across locations could engage with the latest advancements and collaborations.

Attendees engaged with innovative models in patient-centred care, digital health, sustainability and commercialisation of healthcare solutions.

In nurturing these cross-sector connections, the innovation showcase aimed to bring transformative impacts to WA Health's patients, staff and communities. The event underscored the value of collaboration across health services, academia and industry, creating a foundation for sustained healthcare improvement with various meaningful sessions throughout the day.

HealthReady

The launch of the HealthReady program on 8 October 2024, led by SMHS Kaartdijin Innovation, marked a pivotal step in advancing health innovation across Western Australia. Anchored in WA Health's strategic priorities and aligned with the state's broader economic and research and innovation strategy, HealthReady is designed to accelerate the development, validation, and implementation of high-impact health solutions. There are currently 12 innovators in the pipeline.

HealthReady Pitch Panel

The first activation of the HealthReady pipeline occurred in August 2024 with the HealthReady Pitch Panel, a structured forum for sourcing and evaluating early-stage innovations. Held pre-launch, the panel showcased three promising ideas – two from external innovators and one from an SMHS staff member– targeting neonatal care, organ and tissue transport, and patient health literacy.

Select concepts were invited to progress further within the pipeline, initiating co-design and pathway-to-implementation planning. The panel also reinforced the role of SMHS as a catalyst for collaboration between clinicians, researchers and industry innovators.

HealthReady Strategy Workshop

Building on the momentum, the HealthReady Strategy Workshop, held in February 2025, convened over 30 stakeholders from WA Health, academia, industry and the startup ecosystem to co-design the strategic framework for HealthReady.

This in-person, interactive session focused on ensuring the pipeline delivers sustained value to WA innovators and health services.

Key outcomes through a series of collaborative exercises included:

- validating the HealthReady framework
- refinement of the program scope
- streamlined research, governance and ethics process
- insights for a strategy document, which underpinned a major grant submission.

SMHS recently received $1.2 million from FHRI to strengthen our current capability, enhance patient-centred care and service delivery by supporting WA-based innovations.

With additional panels and workshops scheduled through 2025–26, HealthReady continues to build a robust pipeline of innovation, ensuring WA remains at the forefront of health system transformation.

LifeFit SurgFit

SMHS Kaartdijin Innovation continues to deliver the virtual SurgFit School – a key component of the LifeFit SurgFit program – while actively exploring new opportunities to enhance digital healthcare services for patients across SMHS.

The LifeFit SurgFit program helps patients prepare for surgery and supports their recovery. Over the past year, the program expanded to encompass a broader range of surgical specialties and successfully implemented the use of a digital companion platform. This platform serves as a centralised hub for patients, enabling streamlined and early access to appointments, personalised healthcare guidance and secure sharing of clinical information. With an impressive registration rate of 85 per cent, the digital companion is performing on par with other mature outpatient services.

The SurgFit program also extended its reach to RGH, optimising general surgery patients. Notably, the SurgFit School has exceeded key performance indicators for five consecutive months and achieved financial sustainability. As a result, the service is now poised to transition into a business-as-usual model, ensuring continued integration and long-term impact within SMHS.

Neonatal Intensive Care Unit mobile app

The concept for a Neonatal Intensive Care Unit (NICU) parent support app was initially presented to the Innovation Pitch Panel to assist FSH families whose babies were discharged early under the gastric enteric tube feeding early discharge (GET FED) program.

Designed to deliver tailored educational content and collect clinical data, the app enables healthcare providers to monitor infant growth and feeding progress, supporting healthy development post-discharge.

In 2024–25, the project broadened its scope to include all NICU parents. A proof-of-concept version of the app was developed on the WeGuide platform and piloted with 20 parents, including those with babies still in the ward and those discharged early. The pilot's benefit realisation demonstrated:

- 87.5 per cent of participants reported feeling more supported through the app
- 75 per cent indicated that the resources and information provided helped reduce their stress or anxiety
- that parents showed a 15 per cent average increase in understanding of their baby's condition and a 20 per cent boost in confidence when performing caregiving tasks.

The app has now successfully transitioned into a business-as-usual model, with close to 90 parents signed up. Feedback continues to be collected to guide ongoing improvements, with plans to explore statewide expansion to other NICUs.

Innovation grants 2024–25

In 2024–25, SMHS secured seven competitive innovation grants totalling $3.3 million through the FHRI Fund of Western Australia. These grants reflect SMHS's commitment to advancing healthcare innovation that improves patient outcomes and service delivery.

Five grants were led by SMHS clinicians with the support of Kaartdijin Innovation, which provided critical assistance in information and communications technology (ICT), financial, project management, procurement and governance. The remaining two grants fund internal innovation projects, overseen by a steering committee to ensure alignment with strategic objectives.

These grants were awarded following rigorous competitive processes, reflecting SMHS's capacity to identify and develop solutions aligned with both local and statewide health priorities. By supporting clinician-led innovation and integrating multidisciplinary expertise, SMHS ensures these initiatives directly benefit patients, staff and the broader community.

As these innovations progress, they will contribute to SMHS's strategic vision of embedding transformative, patient-centred technologies and models of care within the WA health system.

The seven successful grants are:

HealthReady Program ($1,197,175) to strengthen SMHS capability to foster collaboration between clinicians, innovators and industry, accelerating the translation of innovations into practice
Virtual Auditory Rehabilitation for Older Cochlear Implant Users ($450,000) for a patient-centred, accessible digital health solution for older cochlear implant users, improving rehabilitation outcomes through remote support.
Orva: AI Health Companion Platform ($483,411) to empower patients to better understand and manage their health information, enhancing health literacy and reducing preventable hospital visits.
Blockchain-Based Clinical Trial Recruitment Solution ($98,909) for digital technology for secure, patient-controlled data sharing in clinical trials.
Digital Cannulation Management Tool ($98,925) for a digital tool to improve intravenous catheter safety and monitoring.
Virtual Immunology Clinic Expansion for Infants and Young Children ($496,599) towards a project which aims to expand specialist immunology support via a virtual clinic, improving access for infants and young children at risk of allergies, especially in regional and remote areas.
Enhancement and Validation of SMHS Digital Companion for Surgical Patients ($498,920) focused on improving surgical patient care through a digital companion to enhance patient engagement, reduce complications, and integrate AI-powered support within clinical workflows.

Digital health

Digital health has been evidenced to be one of the most significant drivers of health outcomes and productivity gains in healthcare.

Modern health care services require contemporary platforms, operating models and services designed around patient centred care. SMHS has a dedicated digital health team, working in partnership with clinical and other areas to support the delivery of safe, high quality health care and more efficient operating models.

Enhancing digital health capability

An 18-month program, titled 'Planning, architecture, compliance and engagement' (PACE) designed to transform the current environment into a contemporary, digitally mature health service was launched in 2024–25.

More than 180 staff and 50 consumers were consulted to develop a five-year digital health strategy, due to be launched in early 2025–26. This strategy, which will direct clinical change and transformation supported by technology, is aligned to the *SMHS Strategic Plan 2021–25* and the *WA Health Digital Strategy 2020–30*.

A framework has been developed to ensure we measure and track the success of the strategy, alongside a roadmap that dictates when initiatives will be delivered.

Initiatives to consolidate and streamline governance within the ICT landscape also commenced, including a digital tool to streamline the ICT governance and approvals process. More than 140 digital requests have been submitted since its launch in October 2024.

We also consolidated our governance committees and invited consumers to join as members on these to strengthen their voice within digital health.

Work commenced to formalise a digital health operating model, aligned to an assurance framework, to help manage how we manage, govern and grow digital health capabilities within the organisation.

Managing our SMHS digital products

The use of SMHS digital health platforms has seen a significant rise of application development at various levels, with approximately 300 new apps built every year since 2023.

For better management, these were grouped into 'product families' of related applications and data which share common characteristics and functionalities and are served by product teams.

The five product families are:

- clinical
- research
- performance
- finance
- workforce.

Digital Health Products currently supports, administers and manages over 250 SMHS applications, and is enhancing governance, assurance and support to over 900.

The product teams receive and facilitates more than 100 technical support requests weekly, and more than 60 new digital initiatives.

This new way of working has already helped and will continue to help address several enterprise risks and deliver on the SMHS 2025 strategic action plan.

Key highlights for 2024–25 highlights	
Empowered consumers	Outpatient appoint Bladder diary app MySay expansion
Informed clinicians	Outpatient clinic availability Doctor Support Unit pilot
Optimised performance	SMHS Intranet modernisation Clinical forms catalogue consolidation
Supported workforce	Pyxis Users Access Audit tool to support OAG Full SMHS digital medical records Implementation of SMHS HATS customer support pilot
Embedded research and innovation	Health Code Collective co-creation with Doctor Support Unit, Integrity and Ethics

Cloud Rise

A program to establish a multi-vendor public cloud architecture and modernise the SMHS digital operating environment started at the beginning of 2025.

Called Cloud Rise, it is essential to ensuring patient safety and continuity of care, operational continuity and enhancing cybersecurity, and is aligned with the SMHS goal to operate a fully digital hospital by 2030.

It will introduce clinical orientated digital platform, seamless data management, modern AI toolsets and work towards eliminating significant risks. A long-term strategy has been approved with the potential to expand to other health service providers and partners.

Achievements in 2024–25 include:

- implementation of a Digital Health Platforms team to apply a standardised approach across all SMHS sites
- signing an agreement to implement Amazon Web Services Public Cloud
- a strategic direction that will save SMHS ~$15 million in enterprise compute costs over the next five years.

Code Focus

Code Focus – a clinical coding auditing and workflow management platform that seamlessly integrates with the patient administration system (webPAS) – was implemented in May 2025.

Designed to enhance operational efficiency, Code Focus delivers a range of benefits including increased revenue, reduced clinical queries, shortened discharge-to-coding timeframes and a significant decrease in coding errors. These improvements contribute to more accurate and timely data capture, essential for both patient care and funding outcomes.

The implementation of Code Focus addresses the limited availability of skilled clinical coding professionals, a critical challenge. As demand for experienced coders continues to outpace supply, the platform provides essential support by streamlining complex coding processes.

This enables the clinical coding team to work more effectively and maintain high standards of accuracy, despite resource constraints.

Cyber Shield

This program was established to support safe and secure ways of providing modern care and protect staff and patient data in the face of rising and persistent digital attacks.

Cyber Shield is designed to support the complexity of SMHS's digital environment, where cybersecurity responsibilities are shared across multiple stakeholders. The program has improved visibility and control across all sites, strengthened compliance with government policy and provided assurance to organisational leadership and stakeholders.

These initiatives have substantially enhanced SMHS's cybersecurity, reinforcing our commitment to patient privacy and the integrity of our healthcare services and a comprehensive awareness program was implemented in 2024–25.

Health Application Training and Support pilot

A multi-year program of work to standardise the health application training and support (HATS) model across SMHS commenced in 2024–25. The overall goal is to make it easier for clinicians to raise queries for different clinical applications and where appropriate self-serve, through the creation of a 'single digital front door', while allowing SMHS to retain control over key KPIs such as resolution time, satisfaction and first-time fix rates.

Achievements in 2024–25 included a new ticketing portal and implementation and adoption of a more efficient workflow.

Transition of the SMHS intranet to SharePoint

In 2024–25, the SMHS intranet transitioned to SharePoint Online, consolidating more than 1,800 sites and over 10,000 documents. This major digital upgrade spanned all six main SMHS hospital sites and community services, aiming to streamline information access, improve collaboration and support the 'One SMHS' cultural initiative.

The project was completed within budget and on schedule, engaging more than 400 document custodians and delivering a comprehensive suite of tutorials, roadshows and educational workshops. The new intranet platform enhances security, simplifies access to system updates and eliminates duplication.

Our issues

Access to emergency care

Public hospital EDs are accessible 24 hours a day, seven-days-a-week to provide acute and emergency care to patients arriving either by ambulances or other means. While some people require immediate attention for life-threatening conditions or trauma, most require less urgent care.

This financial year, more than 219,200 people attended a SMHS ED, which is an average of 600 presentations per day. Of these presentations, 51 per cent were seen at FSH, making it one of the busiest EDs in Australia.

There were 3.5 per cent more ambulances this year and a 4.2 per cent decline in average daily ramping hours across SMHS when compared to 2023–24.

FSH saw 111,851 emergency patients in 2024–25, received an average of 99 ambulances per day (which is a 4 per cent increase in ambulance attendances) and a 13 per cent increase in ambulance ramping (image 1). Of note, the number of Australasian Triage Scale (ATS) 1 to 3 presenting to FSH ED increased by 2.5 per cent when compared to 2023–24. These are patients whose conditions are classed as immediately life-threatening, potentially life-threatening or imminently life-threatening and/or in very severe pain or requiring time-critical treatment. This group represents the most acutely unwell patients who present to ED.

RGH saw 61,464 emergency patients in 2024–25. PHC had 45,975 total emergency department presentations, averaging 852 ambulances a month in 2024–25.

Table 1. ED presentations by triage category

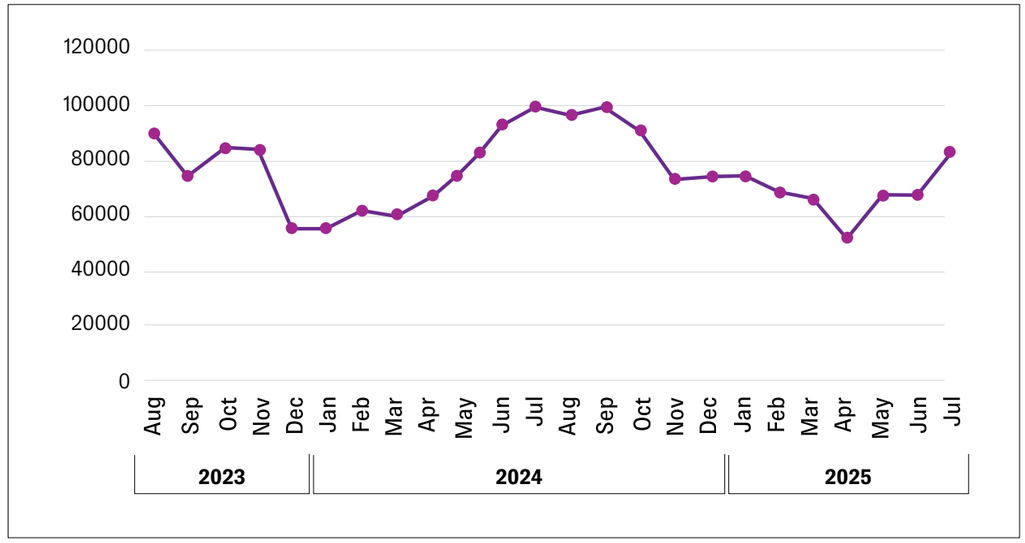
Hospital	1	2	3	4	5	TOTAL
FSH	2,049	25,089	47,247	34,898	2,568	111,851
	2%	22%	42%	31%	2%	
RGH	531	10,517	25,823	21,983	2,610	61,464
	1%	17%	42%	36%	4%	
PHC	348	6,051	17,590	19,832	2,154	45,975
	1%	13%	38%	43%	5%	
Total	2,928	41,657	90,660	76,713	7,332	219,290
	1%	19%	41%	35%	3%	

2024–25 initiatives

During the year, a number of initiatives were implemented across SMHS to improve access to emergency care. This included strong collaborations across the various SMHS sites and services to enhance strategic oversight and coordinate activities as part of the Winter Strategy with initiatives such as:

- expansion of 7-day services, particularly focused on allied health staffing at the weekend to support the discharge of patients and overall hospital flow
- introduction of transit lounges, targeted staffing and other site specific activities aimed to increase morning discharge rates.

Image 1. Total ramped hours trend for FSH, PHC and RGH



Fiona Stanley Hospital Emergency Department

Despite the high volume of patients presenting with urgent and complex needs each day, FSH continues to make improvements within ED to manage flow and access. Several initiatives have been implemented with the aim to improve patient flow and reduce delays. In 2024–25, the number of treatment bays was increased to support more timely assessment, commencement of treatment and disposition planning for patients presenting to the ED. This was achieved by the relocation of the adult Emergency Short Stay Unit to an area outside of the existing footprint.

A dedicated discharge stream, established in 2020 to address COVID-19 challenges and later dissolved, was reinstated. This helps with patient assessment and adds capacity to ED to accommodate patients waiting extended periods of time for inpatient beds.

A dedicated zone within the department to manage lower acuity patients who are unlikely to require inpatient admission was also established.

Medihotel opening and commissioning

On 29 July 2024, the Premier of Western Australia entered into an eight-year agreement with Aegis Health to lease four floors of the Medihotel, delivering a boost to SMHS and WA Health bed availability.

Based adjacent to FSH, the Medihotel offers a range of nursing and medical led services to patients aged 18 years and older, including support for patients who no longer require tertiary level care.

It provides additional hospital capacity and was opened to improve timely access to care, with an innovative service delivery 24 hours a day, seven days a week.

While it is embedded into the FSFHG governance structure, there are also dedicated wards for adult patients over the age of 65, or over the age of 45 for Aboriginal people, from other HSPs.

All 80 beds are now open with full operations in place since January 2025. Bed occupancy is consistently over 90 per cent, with high levels of patient satisfaction.

RGH Emergency Department

In 2024–25, the Emergency Department Musculoskeletal Diversion Project at RGH operated as a mature, seven-day service, providing timely outpatient care for musculoskeletal injuries and easing ED congestion.

The project's success was reinforced by a comprehensive economic analysis showing cost-effectiveness and scalability, and by the implementation of an after-hours referral pathway that expanded patient access.

These achievements culminated in the project receiving the 2024 WA Health Excellence Award for Patient Centred Care and laid the foundation for its expansion to other hospitals.

The Acute Ambulatory Care Unit at RGH also continued to develop as an ED diversion and admission avoidance pathway for adults to provide safe and quality care. In addition, a new general medicine model of care was developed to improve patient flow, which has had a positive impact on emergency access.

Peel Health Campus Emergency Department

PHC implemented numerous initiatives that assisted with emergency access and patient flow, leading to a sustained trend of reduced ramping hours during the year. This was despite increasing patient volumes and higher acuity presentations, particularly over winter.

PHC implemented daily executive and multidisciplinary team leadership huddles to identify and action opportunities and solutions to access challenges in real time, achieving consistently reduced total monthly ramping hours since transitioning from Ramsay Health Care to SMHS with a reduction in ramping hours of 19.2 per cent at a total of 2,680.2 hours, compared with the previous year total of 3,317.1 hours (image 2). The monthly average ramping hours was more than halved from December 2024–June 2025 (120 hours), compared with the six months prior between June-November 2024 (363 hours) (image 3).

During the year, opportunities were identified that would require longer term planning to commission and implement strategies for the future. In May 2025, a new 3-bed, 4-chair transit lounge was opened, which is showing close to 40 per cent of all multi-day discharge throughput. In June PHC commissioned a 6 bedded Nurse Specials Unit to create flow for ED patients requiring monitoring or increased nursing care and reduce the requirement for MET call patients on the ward to return to ED.

Image 2. Total ramping hours per month (source: St John WA dashboard)

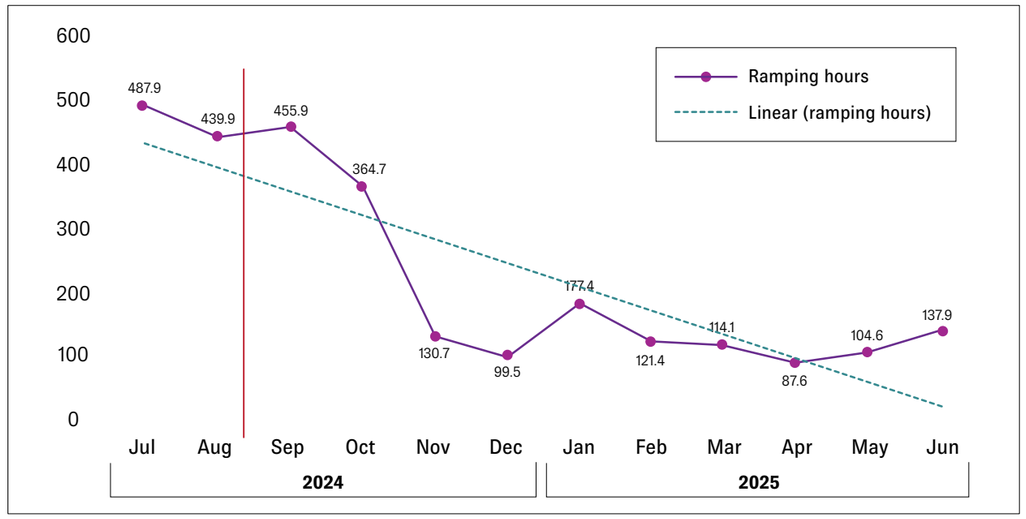
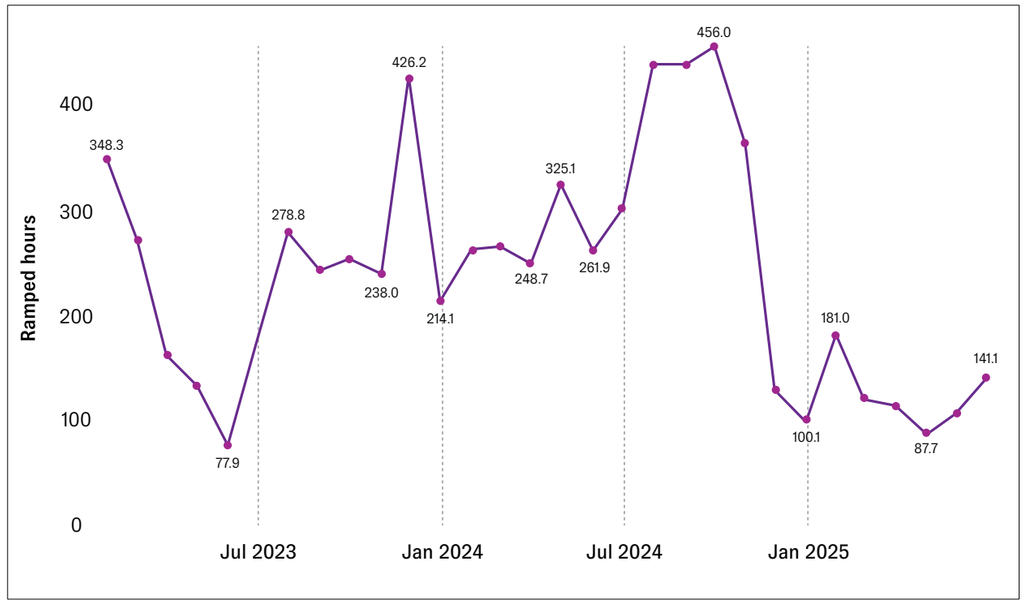
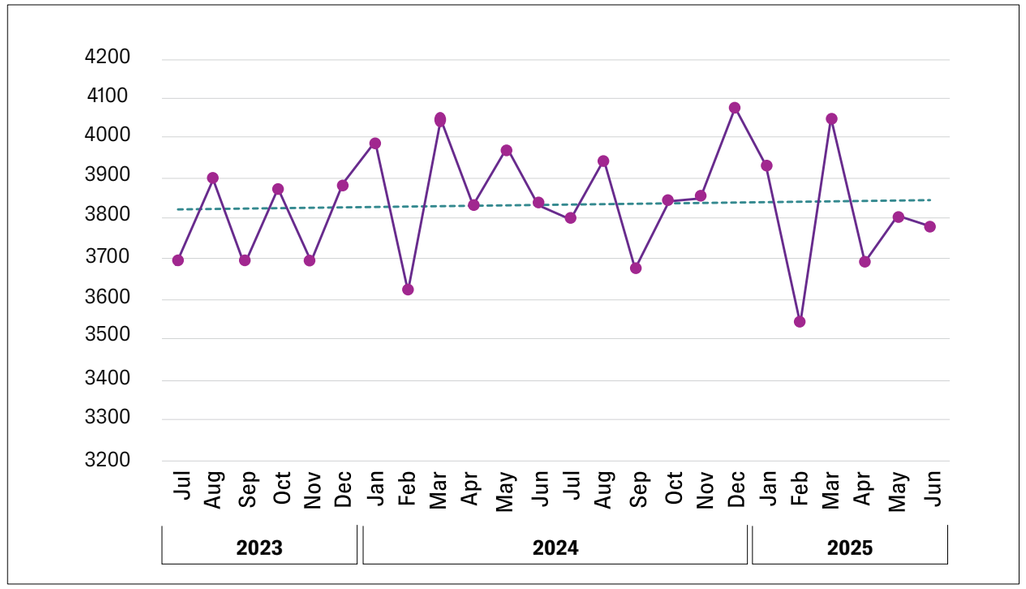


Image 3. Total ramped hours trend at PHC



Total presentations to the PHC ED have remained stable throughout 2024–25 with total annual presentations (approx. 46,000 annual total, 3,830 monthly average) and overall annual trend remaining similar to 2023–24 (image 4).

Image 4. Total PHC ED presentations 2023–24 and 2024–25 financial years (source: SMHS Dashboard)



Access to elective surgery

Hospitals across Australia actively manage waitlists to provide patients with timely and appropriate access to elective surgery. A person requiring elective surgery is prioritised based on their assigned clinical urgency category:

Category 1 – urgent: procedures that are clinically indicated within 30 days.

Category 2 – semi-urgent: procedures that are clinically indicated within 90 days.

Category 3 – non-urgent: procedures that are clinically indicated within 365 days.

SMHS endeavours to meet the clinically recommended times for elective surgery as it understands and acknowledges that delays have the potential to impact a patient's quality of life and surgical outcomes.

A patient who has been waiting longer than the recommended timeframe in one of the three clinical urgency categories is defined as over boundary (OB).

During 2024–25, SMHS continued to work actively to improve the timeliness of treatment for elective waitlisted patients. SMHS' priority is to treat patients in turn; the waitlist reduction strategies have focused on how the longest wait patients can be prioritised, particularly for the more clinically urgent categories 1 and 2.

The primary focus has been on reducing the OB numbers for the nine specialties that account for more than 80 per cent of OB cases via internal and external strategies. Cardiothoracic surgery, gastroenterology, general surgery paediatric surgery, and ophthalmology have been the key success stories.

SMHS will continue to manage wait lists and implement the necessary strategies to reduce over boundary case numbers across all elective surgery categories.

Access to outpatient services

Outpatient services link primary and acute care, providing specialist treatment and clinical assessment for SMHS patients and allow them to receive a diagnosis, procedure, assessment, treatment or education without admission to hospital. They also perform an important function in managing inpatient hospital demand through admission prevention, hospital avoidance and hospital substitution. We continue to work on improving the accessibility, quality, and experience of outpatient services for our patients.

SMHS remains committed to:

- providing timely access to appropriate care in an appropriate setting
- providing patients with greater choice in how they attend appointments, including by phone and video where possible
- reducing wait times and improving access to our services
- improving data quality, analytics and access to service information
- improving the value of each appointment for our patients and clinicians
- collaborating with primary care providers to build their capabilities and capacity in providing better patient care within the community
- improving outpatient access to all groups.

SMHS strategic achievements in 2024–25 included:

- completion of the Aboriginal and Torres Strait Islander (ATSI) outpatients project to develop recommendations to improve attendance rates
- progressing a did not attend (DNA) appointments project to develop recommendations to improve timely access to outpatient services
- continued enhancement of the Virtual Immunology Clinic GP
- ongoing promotion of virtual care delivery and streamlining video appointments to make it easier for our patients to receive care and for our clinicians to deliver care remotely. This includes:
  - — expanding existing platforms and exploring new specialty specific virtual care service delivery models
  - — strengthening virtual care support structures across sites
- ongoing primary care engagement to explore opportunities for co-designing shared models of care with specialist outpatient services.
- strengthening virtual care support structures across sites
- participating in systemwide outpatient reform initiatives, with SMHS sites chosen to pilot the new WA Health-wide electronic referral system (currently under development) – Smart Referral WA – planned for statewide rollout in 2026
- preparation and planning for Smart Referral WA pilot phase
- participating in systemwide outpatient reform initiatives
  - — Accessing Specialist Hospital Knowledge
  - — Manage My Care
  - — Clinician Assist.

SMHS outpatient data 2024–25

315,153 referrals for specialist advice.

259,011 new patients were seen in outpatient clinics.

1,021,329 outpatient appointments, 4 per cent increase in activity compared to the last financial year.

Of these, **312,699** (or 30.6 per cent) were delivered using telephone and video.

Supporting and growing the workforce

Over the course of 2024–25 three significant expansions occurred in SMHS.

- On 13 August 2024 SMHS welcomed PHC with almost 1,100 new employees from Ramsay Health Care as well as gap recruited staff. Significant work occurred contracting, inducting and preparing staff to join the SMHS team. The new staff and managers were supported by a SMHS Transition team.
- Cockburn Health, a 75-bed inpatient facility, commenced its phased opening on 5 August 2024 as a speciality service providing women-centred, holistic, trauma-informed, and recovery-focused inpatient care. Positions were created to operationalise the facility with focussed recruitment continuing to occur to fill workforce requirements. Recruitment continued to enable further expansion of services offered. On 12 May 2025, the phased commissioning of level began by expanding our care to include AoD behavioural and withdrawal management for women.
- The Medihotel opened on 24 September 2024 providing a 24/7 service for low-acuity patients who no longer require tertiary level care but still need to be near FSH. An additional 80.66 full time equivalent (FTE) positions were recruited between August and December 2024.

Across SMHS additional recruitment activities have continued to occur:

- Sharing employee stories through targeted internal and external communication campaigns to support recruitment and retention.
- Attending career expos eg: Perth Skill West Careers and Employment Expo and Recruit WA – Job Ready Expo with NMHS working collaboratively to share costs – June 2025.
- Attending local expos run by City of Rockingham and City of Mandurah to promote opportunities at RKPG and PHC
- Commencing work in late 2024 regarding apprenticeship maximisation at sites to future proof trade recruitment

SMHS has also implemented strategies to strengthen the nursing and midwifery workforce:

- Increased attendance at university and TAFE Expos – ten in total.
- Employed 79 visa-sponsored nurses into the nursing workforce.
- Implemented the nurse unit manager work-life balance project aimed at increasing job satisfaction and improve recruitment into these roles.
- Expanded the SMHS/WACHS partnership program to all areas of WACHS, providing opportunities for our nurses.
- Strengthened pathways for the nurse practitioner (NP) role and provided opportunities for staff to commence their NP Masters training.
- Continued ongoing recruitment for the nursing and midwifery workforce through carefully managed recruitment pools for midwives, registered and enrolled nurses, and assistants in nursing.
- Conducted an enrolled nursing workforce review to increase the number of enrolled nurse jobs and positions available.
- Credentialled 348 assistant in nursing staff across FSFHG and created a database.
- Continued growth of the nursing refresher and supervised practice programs.
- Recruited 15 Aboriginal staff and worked with Aboriginal workforce team to further improve the recruitment of Aboriginal staff to nursing positions.
- Continued support of Qualification Allowance (QA) with 241 QA applications being processed in 2024, and 135 processed in 2025.

- Increased graduate nurse positions with 292 positions offered and planning underway for 308 positions in 2025–26.
- Approved and processed five advanced skilled enrolled nurse applications.
- Used general leave relief EOI pool for senior registered nurse (SRN) 1-6 positions to reduce the burden of applying for SRN positions.
- Preparation for commencement of nurse-to-patient ratios across SMHS in 2025–26 was completed.
- Continued development of senior clinical leader development program Voyager to help develop prepared leaders and ensure SRN succession planning.
- Created 'Boss Bytes' podcast as a resource for managers to access information on common HR queries and issues.
- Developed new nursing and midwifery video to be included with all recruitment adverts.

To support our staff, HR training has been offered around recruitment and how to apply for a job, including specialist education for consultants preparing for job applications.

OUR PERFORMANCE

Performance management framework

To comply with its legislative obligation as a WA Government agency, SMHS operates under the Outcome Based Management (OBM) Framework determined by DoH. This framework describes how outcomes, services and key performance indicators (KPIs) are used to measure agency performance towards achieving the relevant overarching wholeof-government goals.

This framework is underpinned by key principles of:

The 2024–25 KPIs measured the effectiveness and efficiency of SMHS in achieving the health outcomes of:

Outcome one

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

SMHS services that support outcome one:

- public hospital admitted services
- public hospital emergency services
- public hospital non-admitted services
- mental health services.

Outcome two

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

SMHS services that support outcome two:

- public and community health services.

Table 2 aligns the SMHS KPIs to the WA Health system outcomes and State Government goals.

Performance against these activities and outcomes is summarised on page 95 and described in detail within the compliance section of this report.

Table 2. Services delivered by SMHS to achieve outcomes

WA Government Goal: Safe Strong and Fair Communities: supporting our local and regional communities to thrive

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

Outcome 1: Public hospital based services that enable effective treatment and restorative health care for Western Australians		**Outcome 2:** Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives
Key effectiveness indicators contributing to Outcome 1	**Key efficiency indicators within Outcome 1**	**Key efficiency indicators within Outcome 2**
Unplanned hospital readmissions for patients within 28 days for selected surgical procedures: (a) knee replacement; (b) hip replacement; (c) tonsillectomy and adenoidectomy; (d) hysterectomy; (e) prostatectomy; (f) cataract surgery; (g) appendicectomy	Average admitted cost per weighted activity unit (WAU)	Average cost per person of delivering population health programs by population health units
Percentage of elective wait list patients waiting over boundary for reportable procedures (a) % Category 1 over 30 days (b) % Category 2 over 90 days (c) % Category 3 over 365 days	Average Emergency Department cost per WAU	
Healthcare-associated Staphylococcus aureus bloodstream infections (HA-SABSI) per 10,000 occupied bed-days	Average non-admitted cost per WAU	
Survival rates for sentinel conditions: (a) Stroke; (b) Acute Myocardial Infarction; (c) Fractured Neck of Femur	Average cost per bed-day in specialised mental health inpatient services	
Percentage of admitted patients who discharged against medical advice: a) Aboriginal patients; and b) Non-Aboriginal patients	Average cost per treatment day of non-admitted care provided by mental health services	
Percentage of live-born term infants with an Apgar score of less than 7 at 5 minutes post delivery		
Readmissions to acute specialised mental health inpatient services within 28 days of discharge		
Percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services		

Source: Extracted from Outcome Based Management (OBM) Framework and Policy (MP 011519),2024–25 OBM KPI Data Definition Manual v1.0

Summary of Key Performance Indicators

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

Key Performance indicator (KPI)	Calendar year 2024 Target	2024 Actual	Variation
Key Effectiveness Indicators			
Unplanned hospital readmissions of patients within 28 days for selected surgical procedures (represented as per 1,000 separations)			
(a) Knee replacement	≤ 21.0	23.1	- 2.1
(b) Hip replacement	≤ 19.4	8.9	10.5
(c) Tonsillectomy and adenoidectomy	≤ 84.4	99.4	- 15.0
(d) Hysterectomy	≤ 45.8	20.7	25.1
(e) Prostatectomy	≤ 40.0	25.9	14.1
(f) Cataract surgery	≤ 2.3	0.6	1.7
(g) Appendicectomy	≤ 29.7	17.0	12.7
Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days	≤ 1.0	0.8	0.2
Survival rates for sentinel conditions			
(a) Survival rate for stroke, by age group			
0–49	≥ 95.4%	99.3%	3.9%
50–59	≥ 94.8%	98.6%	3.8%
60–69	≥ 94.5%	96.2%	1.7%
70–79	≥ 92.6%	93.8%	1.2%
80 and above	≥ 87.6%	87.7%	0.1%
(b) Survival rate for acute myocardial infarction, by age group			
0–49	≥ 98.9%	99.1%	0.2%
50–59	≥ 98.8%	98.7%	-0.1%
60–69	≥ 98.2%	97.0%	-1.2%
70–79	≥ 97.0%	97.4%	0.4%
80 and above	≥ 93.1%	92.2%	-0.9%
(c) Survival rate for fractured neck of femur, by age group			
70–79	≥ 98.8%	100.0%	1.2%
80 and above	≥ 97.3%	94.6%	-2.7%
Percentage of admitted patients who discharged against medical advice			
(a) Aboriginal	≤ 2.78%	3.80%	-1.02%
(b) Non-Aboriginal	≤ 0.99%	0.70%	0.29%
Percentage of live-born term infants with an Apgar score of less than 7 at 5 minutes post delivery	≤ 1.9%	1.0%	0.90%
Readmissions to acute specialised mental health inpatient services within 28 days of discharge	≤ 12%	14%	-2.00%
Percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services	≥ 75%	88%	13.0%

Summary of Key Performance Indicators continued

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

Key Performance Indicator (KPI)	Financial Year 2024–25 Target	2024–25 Actual	Variation
Key Effectiveness Indicators			
Percentage of elective wait list patients waiting over boundary for reportable procedures			
(a) Category 1 over 30 days	0.0%	33.6%	-33.6%
(b) Category 2 over 90 days	0.0%	34.7%	-34.7%
(c) Category 3 over 365 days	0.0%	19.0%	-19.0%
Key Efficiency Indicators			
Average admitted cost per weighted activity unit	≤ $7,899	$8,219	-$320
Average Emergency Department cost per weighted activity unit	≤ $7,777	$8,284	-$507
Average non-admitted cost per weighted activity unit	≤ $7,903	$7,227	$676
Average cost per bed-day in specialised mental health inpatient services	≤ $1,975	$2,170	-$195
Average cost per treatment day of non-admitted care provided by mental health services	≤ $604	$642	-$38

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

Key Efficiency Indicators			
Average cost per person of delivering population health programs by population health units	≤ $18	$28	-$10

Financial targets

Table 3. Financial results

	2024–25 target ($'000)	2024–25 actual ($'000)	Variation (+/-) ($'000)
Total cost of services	2,615,755	2,893,595	277,840
Net cost of services	2,367,182	2,630,556	263,374
Total equity	3,320,356	3,665,268	344,912
Net increase/decrease in cash held	32,119	(10,700)	(42,819)
Approved full time equivalent staff level (salary associated with FTE)	1,632,302	1,809,385	177,083

Explanation of variance

Total cost of services variation

In the 2024–25 financial year, the total cost of healthcare services exceeded original estimates by $278 million, an 11 per cent increase. This variance was primarily driven by the following factors which were not fully accounted for in the original budget targets: negotiated wage increases, bed expansions at Cockburn Health and the Medihotel, the transition of PHC to SMHS operational responsibility, and overall growth in service delivery.

Whilst the initial targets included some escalation, the impact of renegotiated industrial agreements was greater than anticipated. These agreements introduced higher base pay rates plus increases to allowances and penalty rates, significantly increasing the employee expenses. The outstanding leave balances were also revalued by the wage changes, compounding the employee costs.

Bed capacity was expanded with the commissioning of 75 beds at the Cockburn Health, and 80 beds at the Medihotel. These expansions required new lease agreements, recruitment of additional clinical and support staff, increased shared services costs to support the operational scale-up and enabled increased throughput in service delivery.

On 13 August 2024, operational responsibility for PHC transitioned from Ramsay Health Care to SMHS, resulting in nearly 1,100 staff joining the WA Health system. This transition incurred higher costs due to site integration efforts, including alignment with WA Health systems and processes, plus retention strategies to encourage staff to remain at PHC under SMHS management.

Net cost of services variation

The $263 million variance aligns with the earlier explanation, tempered with a small increase in revenue.

Total equity variation

The increase in the total equity balance of $345 million is primarily from the revaluation of land and buildings at $142 million, a change in accounting standards resulting in an uplift of $262 million to capture professional and project management fees not included in the revaluation, and the take-up of PHC assets. This gain was partially offset by the deficit reported for the financial year.

Net increase/decrease in cash held variation

The cash position decreased by $43 million. Although government funding played a significant role in supporting overall operational costs, there remained a gap that required the use of cash reserves.

Approved salary expense level variation

As described in the total cost of services variation section, the $177 million increase in salary expenses can be attributed to bed expansion with opening of facilities at Cockburn Health and the Medihotel, the transition of PHC staff to SMHS, and growth in patient activity which was supported by additional staff resources. Consequently, this led to higher employment costs in the 2024–25 financial year. In addition, the expenses were impacted by price escalation resulting from negotiated wage increases and higher superannuation guarantee levy requirements.

Emergency department access performance

EDs are specialist multidisciplinary units with expertise in providing health care to acutely unwell patients in their first few hours in hospital. With demand on EDs and health services increasing, it is essential the provision of care is monitored continually to enable development of improvement strategies to ensure optimal service delivery and patient outcomes.

This indicator measures the effectiveness of EDs at the beginning of a patient's journey. When a patient first enters an ED, they are assessed on how urgently treatment should be provided. Treatment should commence within the time recommended for the allocated triage category (refer to table 4) to prevent adverse outcomes arising from deterioration in the patient's condition.

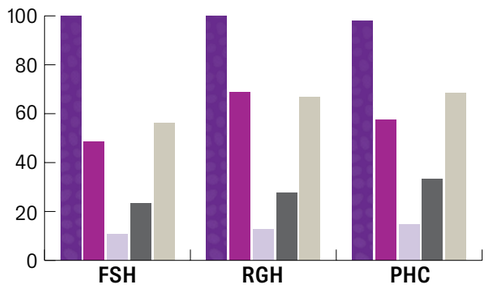
SMHS hospitals strive to treat all ED patients within the recommended period (refer to table 5.) For further information on SMHS improvement programs and SMHS hospital performance against the WA Emergency Access Target (WEAT) please refer to the Significant Issues section.

Table 4. Triage category, treatment acuity and WA performance targets

Triage category	Description	Treatment acuity	Target
1	Immediate life-threatening	Immediate (≤2 minutes)	100%
2	Imminently life-threatening	≤10 minutes	≥ 80%
3	Potentially life-threatening or important time-critical treatment or severe pain	≤30 minutes	≥75%
4	Potentially life-serious or situational urgency or significant complexity	≤60 minutes	≥70%
5	Less urgent	≤120 minutes	≥70%

Note: The triage process and scores are recognised by the Australasian College for Emergency Medicine.

Table 5. Percentage of SMHS ED patients seen within recommended times, by triage category, 2024–25



Hospital	Triage 1	Triage 2	Triage 3	Triage 4	Triage 5
FSH	100.0%	48.6%	10.8%	23.5%	56.1%
RGH	100.0%	68.8%	12.8%	27.8%	66.7%
PHC	98.0%	57.4%	14.9%	33.2%	68.6%

Patient numbers in the higher acuity ED patient groups has increased significantly across the system, resulting in increasingly difficult access for Category 2 patients into the appropriate areas of the ED.

This is always compounded by the large numbers of inpatients residing in ED cubicles awaiting an inpatient bed.

Improving systems to deliver the best possible care

Learning from clinical incidents

SMHS is committed to being a high reliability organisation consistently delivering safe, high-quality care. A key component of this commitment is the systematic review of clinical incidents, particularly those with serious adverse outcomes, to build resilient systems and enhance patient safety.

At SMHS, clinical incidents are viewed as an opportunity to learn, understand why care was not delivered as expected and make changes to improve and reduce the likelihood of a similar incident occurring in the future.

Involvement of consumer representatives is recognised as a critical feature in ensuring transparency, accountability and improvement in clinical incident investigation. At SMHS, consumer representatives are actively involved in this process, ensuring their perspective provides valuable feedback on the patient experience and that they can advocate for patients. Consumer representatives receive substantial training and support to make sure they feel confident and safe to share their insights and contribute to this process.

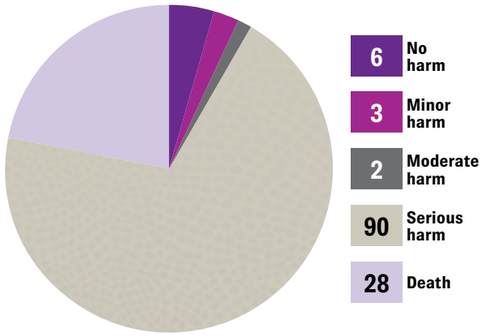
Clinical incidents are categorised by severity and reviewed accordingly. The most significant, those that have, or could have, contributed to serious harm or death, are classified as SAC 1 incidents.

In 2024–25, SMHS reported and reviewed 157 SAC 1 clinical incidents. 122 reviews were completed at the time of reporting.

Of the 122 completed reviews, 28 resulted in the incident being approved for declassification by the Patient Safety Surveillance Unit as it was determined that no health care factors contributed to the adverse patient outcome, leaving 129 SAC 1 incidents overall.

At the time of this report, 35 SAC 1 incident reviews were in progress.

Of the 129 SAC 1 investigations completed or underway, the patient outcome* was noted as:



*Note: Patient outcomes are not always fully attributable to the clinical incident. Multiple factors, including those unrelated to healthcare, may contribute to the outcome.

The incident review process ensures systemic issues are identified and addressed, recommended changes are implemented and evaluated, and lessons are shared across the organisation to prevent recurrence.

The SMHS Executive and the SMHS Board review all SAC 1 notifications, as well as the final report of incidents identified as SAC 1 of concern, due to their potential for significant learning.

OUR COMPLIANCE

Auditor General

INDEPENDENT AUDITOR'S REPORT

2025

South Metropolitan Health Service

To the Parliament of Western Australia

Report on the audit of the financial statements

Opinion

I have audited the financial statements of the South Metropolitan Health Service (Health Service) which comprise:

- the statement of financial position as at 30 June 2025, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended
- notes comprising a summary of material accounting policies and other explanatory information.

In my opinion, the financial statements are:

- based on proper accounts and present fairly, in all material respects, the operating results and cash flows of the Health Service for the year ended 30 June 2025 and the financial position as at the end of that period
- in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions.

Basis for opinion

I conducted my audit in accordance with the Australian Auditing Standards. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my report.

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

Responsibilities of the Board for the financial statements

The Board is responsible for:

- keeping proper accounts
- preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions
- such internal control as it determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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In preparing the financial statements, the Board is responsible for:

- assessing the entity's ability to continue as a going concern
- disclosing, as applicable, matters related to going concern
- using the going concern basis of accounting unless the Western Australian Government has made policy or funding decisions affecting the continued existence of the Health Service.

Auditor's responsibilities for the audit of the financial statements

As required by the *Auditor General Act 2006*, my responsibility is to express an opinion on the financial statements. The objectives of my audit are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Australian Auditing Standards will always detect a material misstatement when it exists.

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

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

Report on the audit of controls

Opinion

I have undertaken a reasonable assurance engagement on the design and implementation of controls exercised by the Health Service. The controls exercised by the Health Service are those policies and procedures established to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with the State's financial reporting framework (the overall control objectives).

In my opinion, in all material respects, the controls exercised by the Health Service are sufficiently adequate to provide reasonable assurance that the controls within the system were suitably designed to achieve the overall control objectives identified as at 30 June 2025, and the controls were implemented as designed as at 30 June 2025.

Other Matter

The Health Service has made payments using the direct payments to third parties pathway throughout the year. The Department of Health has approved this pathway to be used in limited circumstances as expenditure is not subject to levels of approval required under Treasurer's Instruction 5 Expenditure and Payments.

While this is not a primary pathway for expenditure for the Health Service, we have identified weaknesses in how this pathway is used and the types of transactions processed using this pathway, which increases the risk of fraud.

To allow for more detailed reporting of these concerns, the Auditor General has decided to report these matters separately as a performance audit to be tabled in Parliament.

My opinion is not modified in respect of this matter.

The Board's responsibilities

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

Auditor General's responsibilities

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

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

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

Limitations of controls

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

Report on the audit of the key performance indicators

Opinion

I have undertaken a reasonable assurance engagement on the key performance indicators of the Health Service for the year ended 30 June 2025 reported in accordance with the *Financial Management Act 2006* and the Treasurer's Instructions (legislative requirements). The key performance indicators are the Under Treasurer-approved key effectiveness indicators and key

efficiency indicators that provide performance information about achieving outcomes and delivering services.

In my opinion, in all material respects, the key performance indicators report of the Health Service for the year ended 30 June 2025 is in accordance with the legislative requirements, and the key performance indicators are relevant and appropriate to assist users to assess the Health Service's performance and fairly represent indicated performance for the year ended 30 June 2025.

The Board's responsibilities for the key performance indicators

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

In preparing the key performance indicators, the Board is responsible for identifying key performance indicators that are relevant and appropriate, having regard to their purpose in accordance with Treasurer's Instruction 3 Financial Sustainability – Requirement 5: Key Performance Indicators.

Auditor General's responsibilities

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

An assurance engagement involves performing procedures to obtain evidence about the amounts and disclosures in the key performance indicators. It also involves evaluating the relevance and appropriateness of the key performance indicators against the criteria and guidance in Treasurer's Instruction 3 - Requirement 5 for measuring the extent of outcome achievement and the efficiency of service delivery. The procedures selected depend on my judgement, including the assessment of the risks of material misstatement of the key performance indicators. In making these risk assessments, I obtain an understanding of internal control relevant to the engagement in order to design procedures that are appropriate in the circumstances.

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

My independence and quality management relating to the report on financial statements, controls and key performance indicators

I have complied with the independence requirements of the *Auditor General Act 2006* and the relevant ethical requirements relating to assurance engagements. In accordance with ASQM 1 *Quality Management for Firms that Perform Audits or Reviews of Financial Reports and Other Financial Information, or Other Assurance or Related Services Engagements,* the Office of the

Auditor General maintains a comprehensive system of quality management including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Other information

The Board is responsible for the other information. The other information is the information in the entity's annual report for the year ended 30 June 2025, but not the financial statements, key performance indicators and my auditor's report.

My opinions on the financial statements, controls and key performance indicators do not cover the other information and accordingly I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial statements, controls and key performance indicators my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements and key performance indicators or my knowledge obtained in the audit or otherwise appears to be materially misstated.

If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I did not receive the other information prior to the date of this auditor's report. When I do receive it, I will read it and if I conclude that there is a material misstatement in this information, I am required to communicate the matter to those charged with governance and request them to correct the misstated information. If the misstated information is not corrected, I may need to retract this auditor's report and re-issue an amended report.

Matters relating to the electronic publication of the audited financial statements and key performance indicators

This auditor's report relates to the financial statements and key performance indicators of the South Metropolitan Health Service for the year ended 30 June 2025 included in the annual report on the Health Service's website. The Health Service's management is responsible for the integrity of the Health Service's website. This audit does not provide assurance on the integrity of the Health Service's website. The auditor's report refers only to the financial statements, controls and key performance indicators described above. It does not provide an opinion on any other information which may have been hyperlinked to/from the annual report. If users of the financial statements and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to contact the entity to confirm the information contained in the website version.

Grant Robinson
Assistant Auditor General Financial Audit
Delegate of the Auditor General for Western Australia
Perth, Western Australia
19 September 2025

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Certification of financial statements

South Metropolitan Health Service

Certification of financial statements for the year ended 30 June 2025

The accompanying financial statements of South Metropolitan Health Service have been prepared in compliance with the provisions of the *Financial Management Act 2006* from proper accounts and records to present fairly the financial transactions for the financial year ended 30 June 2025 and the financial position as at 30 June 2025.

At the date of signing we are not aware of any circumstances which would render the particulars included in the financial statements misleading or inaccurate.

Adjunct Associate Professor Robyn Collins
Board Chair
South Metropolitan Health Service
22 August 2025

Mr Liam Roche
Board member
South Metropolitan Health Service
22 August 2025

Mr Mark Cawthorne
Chief Finance Officer
South Metropolitan Health Service
22 August 2025

Financial Statements

For the year ended 30 June 2025

South Metropolitan Health Service

Statement of Comprehensive Income

For the year ended 30 June 2025

	Notes	2025 $'000	2024 $'000
COST OF SERVICES			
Expenses			
Employee benefits expense	3.1.1	1,809,386	1,505,950
Fees for contracted medical practitioners	3.2	32,210	13,560
Contracts for services	3.4	32,016	160,984
Patient support costs	3.3	510,789	428,489
Finance costs	7.2	3,408	1,225
Depreciation and amortisation expense	5.1 - 5.4	96,787	91,966
Loss on disposal of non-current assets	4.6	8	-
Repairs, maintenance and consumable equipment	3.5	81,398	69,643
Other supplies and services	3.6	79,295	68,167
Other expenses	3.7	248,298	206,482
Total cost of services		**2,893,595**	**2,546,466**
INCOME			
Revenue			
Patient charges	4.2	114,735	106,718
Other fees for services	4.3	108,225	94,332
Commonwealth grants and contributions	4.4	4,320	3,407
Other grants and contributions	4.4	3,780	2,235
Donation revenue	4.6	8,273	785
Interest revenue		23	19
Commercial activities	4.5	444	(90)
Other revenue	4.6	23,239	22,352
Total revenue		**263,039**	**229,758**
Gains			
Gain on disposal of non-current assets	4.6	-	66
Total gains		**-**	**66**
Total income other than income from State Government		**263,039**	**229,824**
NET COST OF SERVICES		**2,630,556**	**2,316,642**
Income from State Government			
Department of Health - Service agreement	4.1	2,174,980	1,938,929
Mental Health - Service agreement	4.1	244,474	193,646
Income from other state government agencies	4.1	19,194	24,311
Assets (transferred)/assumed	4.1	877	10
Services received free of charge	4.1	135,546	115,647
Total income from State Government		**2,575,071**	**2,272,543**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(55,485)**	**(44,099)**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.10	403,129	104,569
Total other comprehensive income		**403,129**	**104,569**
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**347,644**	**60,470**

See also the 'Schedule of income and expenses by service'.

The statement of comprehensive income should be read in conjunction with the accompanying notes.

South Metropolitan Health Service

Statement of Financial Position

As at 30 June 2025

	Notes	2025 $'000	2024 $'000
ASSETS			
Current assets			
Cash and cash equivalents	7.3	66,908	77,563
Restricted cash and cash equivalents	7.3	27,148	27,193
Receivables	6.1	51,716	51,312
Inventories	6.3	8,597	7,219
Other current assets	6.4	6,480	5,171
Total current assets		**160,849**	**168,458**
Non-current assets			
Receivables	6.1	43,748	33,748
Amounts receivable for services	6.2	1,391,976	1,300,476
Property, plant and equipment	5.1	2,654,937	2,192,229
Service concession assets	5.3	-	69,178
Right-of-use assets	5.2	59,585	21,430
Intangible assets	5.4	2,588	4,377
Total non-current assets		**4,152,834**	**3,621,438**
Total assets		**4,313,683**	**3,789,896**
LIABILITIES			
Current liabilities			
Payables	6.5	136,409	137,973
Contract liabilities	6.6	278	303
Grant liabilities	6.7	10	4,330
Lease liabilities	7.1	10,287	7,461
Employee related provisions	3.1.2	356,655	297,887
Other current liabilities	6.8	412	2,325
Total current liabilities		**504,051**	**450,279**
Non-current liabilities			
Contract liabilities	6.6	-	-
Lease liabilities	7.1	52,084	15,131
Employee related provisions	3.1.2	92,280	84,103
Total non-current liabilities		**144,364**	**99,234**
Total liabilities		**648,415**	**549,513**
NET ASSETS		**3,665,268**	**3,240,383**
EQUITY			
Contributed equity	9.10	2,800,753	2,723,512
Reserves	9.10	980,898	577,769
Accumulated deficit	9.10	(116,383)	(60,898)
TOTAL EQUITY		**3,665,268**	**3,240,383**

The statement of financial position should be read in conjunction with the accompanying notes.

South Metropolitan Health Service

Statement of Changes in Equity

For the year ended 30 June 2025

	Notes	2025 $'000	2024 $'000
CONTRIBUTED EQUITY	9.10		
Balance at 1 July		2,723,512	2,664,915
Transactions with owners in their capacity as owners:			
Capital appropriations administered by Department of Health		77,241	58,597
Transfer of net assets (other than cash) from other agencies		-	-
Balance at 30 June		**2,800,753**	**2,723,512**
RESERVES	9.10		
Asset Revaluation Reserve			
Balance at 1 July		577,769	473,200
Other comprehensive income		403,129	104,569
Balance at 30 June		**980,898**	**577,769**
ACCUMULATED SURPLUS	9.10		
Balance at 1 July		(60,898)	(16,799)
Surplus/(deficit) for the period		(55,485)	(44,099)
Balance at 30 June		**(116,383)**	**(60,898)**
TOTAL EQUITY			
Balance at 1 July		3,240,383	3,121,316
Total comprehensive income for the period		347,644	60,470
Transactions with owners in their capacity as owners		77,241	58,597
Balance at 30 June		**3,665,268**	**3,240,383**

The statement of changes in equity should be read in conjunction with the accompanying notes.

South Metropolitan Health Service

Statement of Cash Flows

For the year ended 30 June 2025

	Notes	2025 $'000	2024 $'000
CASH FLOWS FROM STATE GOVERNMENT			
Revenues from State Government Agencies		2,345,198	2,076,537
Capital appropriations administered by Department of Health		77,241	58,597
Net cash provided by State Government	7.3.2	**2,422,439**	**2,135,134**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(1,726,486)	(1,462,040)
Supplies and services		(862,777)	(815,892)
Finance costs		-	-
Receipts			
Receipts from customers		106,489	99,611
Commonwealth grants and contributions		-	-
Other grants and contributions		3,780	2,234
Donations received		1,660	785
Interest received		23	19
Other receipts		131,597	124,086
Net cash provided by/(used in) operating activities	7.3.2	**(2,345,714)**	**(2,051,197)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
27th pay contribution		(10,000)	(5,000)
Payment for purchase of non-current physical and intangible assets		(63,790)	(47,385)
Receipts			
Proceeds from sale of non-current physical assets		-	105
Net cash provided by/(used in) investing activities		**(73,790)**	**(52,280)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Repayment of lease liabilities		(13,635)	(12,000)
Net cash provided by/(used in) financing activities		**(13,635)**	**(12,000)**
Net increase/(decrease) in cash and cash equivalents		(10,700)	19,657
Cash and cash equivalents at the beginning of the year		104,756	85,099
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.3.1	**94,056**	**104,756**

The statement of cash flows should be read in conjunction with the accompanying notes.

1. Basis of preparation

The South Metropolitan Health Service (the Health Service) is a WA Government entity and is controlled by the State of Western Australia, which is the ultimate parent. The entity is a not- for-profit entity (as profit is not its principle objective).

A description of the nature of its operations and its principle activities has been included in the first section of the annual report which does not form part of these financial statements.

The annual financial statements were authorised for issue by the Accountable Authority of the Health Service on 22 August 2025.

Statement of compliance

The financial statements constitute general purpose financial statements that have been prepared in accordance with Australian Accounting Standards (AAS), the Framework, Statement of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board (AASB) as applied by Treasurer's instructions. Several of these are modified by Treasurer's instructions to vary application, disclosure, format and wording.

The *Financial Management Act 2006* and Treasurer's instructions are legislative provisions governing the preparation of financial statements and take precedence over AASs, the Framework, Statement of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board. Where modification is required and has had a material or significant financial effect upon the reported results, details of that modification and the resulting financial effect are disclosed in the notes to the financial statements.

Basis of preparation

These financial statements are presented in Australian dollars applying the accrual basis of accounting and using the historical cost convention. Certain balances will apply different measurement basis (such as 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 effected by those judgements and/or estimates are disclosed. Estimates and associated assumptions are based on the professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances.

Accounting procedure for Goods and Services Tax (GST)

Rights to collect amounts receivable from the Australian Taxation Office (ATO) and responsibilities to make payments for 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 includes the Department of Health, Mental Health Commission, North Metropolitan Health Service, South Metropolitan Health Service, East Metropolitan Health Service, Health Support Services, PathWest Laboratory Medicine WA, WA Country Health Service, 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.

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 8 – Requirement 8.1(i) and will be credited directly to Contributed Equity.

The transfers of net assets to/from other agencies, other than as a result of a restructure of administrative arrangements, are designated as contributions by owners where the transfers are non-discretionary and non-reciprocal.

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 2017/2018 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 six key services of the Health Service under the OBM framework are listed below.

Public Hospital Admitted Patient

The provision of health care services to patients in metropolitan and major rural hospitals that meet the criteria for admission and receive treatment and/or care for a period of time, including public patients treated in private facilities under contract to 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 includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to admitted services. This service does not include any component of the Mental Health Services reported under 'Service four - Mental Health Services'.

Public Hospital Emergency Services

The provision of services for the treatment of patients in emergency departments of metropolitan and major rural hospitals, inclusive of public patients treated in private facilities under contract to 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 includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to emergency services. This service does not include any component of the Mental Health Services reported under 'Service four - Mental Health Services'.

2.1 Health Service objectives (continued)

Public Hospital Non-Admitted Services

The provision of metropolitan and major rural hospital services to patients who do not undergo a formal admission process, inclusive of public patients treated by private facilities under contract to 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 includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to non-admitted services. This service does not include any component of the Mental Health Services reported under 'Service four - Mental Health Services'.

Mental Health Services

The provision of inpatient services where an admitted patient occupies a bed in a designated mental health facility or a designated mental health unit in a hospital setting; and the provision of non-admitted services inclusive of community and ambulatory specialised mental health programs such as prevention and promotion, community support services, community treatment services, community bed-based services and forensic services. This service includes the provision of state-wide mental health services such as perinatal mental health and eating disorder outreach programs as well as the provision of assessment, treatment, management, care or rehabilitation of persons experiencing alcohol or other drug use problems or co-occurring health issues. Mental Health Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to mental health or alcohol and drug services. This service includes public patients treated in private facilities under contract to WA Health.

Aged and Continuing Care Services

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

Public and Community Health Services

The provision of health care services and programs delivered to increase optimal health and wellbeing, encourage healthy lifestyles, reduce the onset of disease and disability, reduce the risk of long-term illness as well as detect, protect and monitor the incidence of disease in the population. Public and Community Health Services includes public health programs, Aboriginal health programs, disaster management, environmental health, the provision of grants to non-government organisations for public and community health purposes, emergency road and air ambulance services, services to assist rural-based patients travel to receive care.

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2.2 Schedule of income and expenses by service

	Public Hospital Admitted Patient		Public Hospital Emergency Services		Public Hospital Non-Admitted Services		Mental Health Services		Aged Continuing Care Services		Public and Community Health Services		Total	
	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000
COST OF SERVICES														
Expenses														
Employee benefits expense	1,089,891	939,430	170,522	145,915	261,724	216,694	211,057	142,316	12,455	10,656	63,737	50,941	1,809,386	1,505,952
Fees for contracted medical practitioners	21,965	9,340	3,436	1,451	5,274	2,155	-	-	251	106	1,284	507	32,210	13,559
Contracts for services	21,831	110,895	3,416	17,225	5,242	25,580	1	13	249	1,258	1,277	6,013	32,016	160,984
Patient support costs	330,833	265,983	51,448	41,040	82,513	64,230	24,326	41,015	3,542	2,805	18,127	13,409	510,789	428,482
Finance costs	2,323	843	363	131	558	195	1	-	27	10	136	46	3,408	1,225
Depreciation and amortisation expense	57,724	57,577	5,998	5,724	21,914	21,732	6,152	6,136	359	317	4,640	480	96,787	91,966
Loss on disposal of non-current assets	6	-	1	-	1	-	-	-	-	-	-	-	8	-
Repairs, maintenance and consumable equipment	52,726	43,617	8,250	6,775	12,662	10,061	4,074	6,330	603	495	3,083	2,365	81,398	69,643
Other supplies and services	54,071	46,960	8,460	7,294	12,984	10,832	-	-	618	533	3,162	2,546	79,295	68,165
Other expenses	169,934	140,511	24,126	19,827	38,075	30,709	5,613	7,128	2,228	1,825	8,322	6,494	248,298	206,494
Total cost of services	**1,801,304**	**1,615,156**	**276,020**	**245,382**	**440,947**	**382,188**	**251,224**	**202,938**	**20,332**	**18,005**	**103,768**	**82,801**	**2,893,595**	**2,546,470**
INCOME														
Revenue														
Patient charges	78,237	73,520	12,241	11,420	18,788	16,959	-	-	894	834	4,575	3,987	114,735	106,720
Other fees and services	73,798	64,987	11,546	10,094	17,722	14,990	-	-	843	737	4,316	3,524	108,225	94,332
Commonwealth grants and contributions	2,946	2,347	461	365	707	541	-	-	34	27	172	127	4,320	3,407
Other grants and contributions	2,578	1,541	403	239	619	355	-	-	29	17	151	83	3,780	2,235
Donation revenue	5,641	541	883	84	1,355	125	-	-	64	6	330	29	8,273	785
Interest revenue	16	13	2	2	4	3	-	-	-	-	1	1	23	19
Commercial activities	303	(62)	47	(10)	73	(14)	-	-	3	(1)	18	(3)	444	(90)
Other revenue	15,847	15,398	2,479	2,392	3,805	3,552	-	-	181	175	927	835	23,239	22,352
Total revenue	**179,366**	**158,285**	**28,062**	**24,586**	**43,073**	**36,511**	**-**	**-**	**2,048**	**1,795**	**10,490**	**8,583**	**263,039**	**229,760**
Gains														
Gain on disposal of non-current assets	-	46	-	7	-	10	-	-	-	1	-	2	-	66
Total gains	**-**	**46**	**-**	**7**	**-**	**10**	**-**	**-**	**-**	**1**	**-**	**2**	**-**	**66**
Total income other than income from State Government	**179,366**	**158,331**	**28,062**	**24,593**	**43,073**	**36,521**	**-**	**-**	**2,048**	**1,796**	**10,490**	**8,585**	**263,039**	**229,826**
NET COST OF SERVICES	**1,621,938**	**1,456,825**	**247,958**	**220,789**	**397,874**	**345,667**	**251,224**	**202,938**	**18,284**	**16,209**	**93,278**	**74,216**	**2,630,556**	**2,316,644**
INCOME FROM STATE GOVERNMENT														
Department of Health - Service agreement	1,478,910	1,331,531	231,387	206,817	355,143	307,139	6,152	6,136	16,901	15,104	86,487	72,203	2,174,980	1,938,930
Mental Health - Service agreement	1	1	-	-	-	-	244,473	193,646	-	-	-	-	244,474	193,647
Income from other state government agencies	13,088	16,749	2,048	2,601	3,143	3,863	-	-	150	190	765	908	19,194	24,311
Assets (transferred)/assumed	597	7	94	1	144	2	-	-	7	-	35	-	877	10
Services received free of charge	95,236	81,233	12,125	10,346	23,204	19,912	1,112	951	1,136	940	2,733	2,265	135,546	115,647
Total income from State Government	**1,587,832**	**1,429,521**	**245,654**	**219,765**	**381,634**	**330,916**	**251,737**	**200,733**	**18,194**	**16,234**	**90,020**	**75,376**	**2,575,071**	**2,272,545**
SURPLUS/(DEFICIT) FOR THE PERIOD	**(34,106)**	**(27,304)**	**(2,304)**	**(1,024)**	**(16,240)**	**(14,751)**	**513**	**(2,205)**	**(90)**	**25**	**(3,258)**	**1,160**	**(55,485)**	**(44,099)**

The Schedule of income and expenses by service should be read in conjunction with the accompanying notes.

3. Use of our funding

Expenses incurred in the delivery of services

This section provides additional information about how the Health Service's funding is applied and the accounting policies that are relevant for an understanding of the items recognised in the financial statements. The primary expenses incurred by the Health Service in achieving its objectives and the relevant notes are:

	Notes	2025 $'000	2024 $'000
Employee benefits expenses	3.1.1	1,809,386	1,505,950
Employee related provisions	3.1.2	448,935	381,990
Fees for contracted medical practitioners	3.2	32,210	13,560
Patient support costs	3.3	510,789	428,489
Contracts for services	3.4	32,016	160,984
Repairs, maintenance and consumable equipment	3.5	81,398	69,643
Other supplies and services	3.6	79,295	68,167
Other expenses	3.7	248,298	206,482

3.1.1 Employee benefits expenses

	2025 $'000	2024 $'000
Salaries and wages	1,636,493	1,365,575
Termination benefits	22	334
Superannuation - defined contributions plans [(a)]	172,871	140,041
Total employee benefits expenses	**1,809,386**	**1,505,950**
Add: AASB 16 Non-monetary benefits	51	32
Less: Employee Contribution	(29)	(27)
Net employee benefits	**1,809,408**	**1,505,955**

(a) Defined contribution plans include West State Superannuation (WSS), Gold State Superannuation (GSS), Government Employees Superannuation Board (GESB) and other eligible funds.

Salaries and wages include all costs related to employment including salaries and wages, fringe benefits tax (FBT), leave entitlements, paid sick leave, and non-monetary benefits recognised under accounting standards other than AASB 16 (such as medical care, housing, cars and free or subsidised goods or services) for employees.

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.

Superannuation is the amount recognised in the statement of comprehensive income comprises employer contributions paid to the GSS (concurrent contributions), WSS, GESB, and other superannuation funds. The employer contribution paid to the GESB in respect of the GSS is paid back into the consolidated account by 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's purposes because the concurrent contributions (defined contributions) made by the Health Service to GESB extinguishes the Health Service's obligations to the related superannuation liability.

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

3.1.1 Employee benefits expenses (continued)

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

AASB 16 Non-monetary benefits are non-monetary employee benefits predominantly relating to the provision of the vehicle and housing benefits that are recognised under AASB 16 which are excluded from employee benefits expense.

Employee Contributions are contributions made to the Health Service by employees towards employee benefits that have been provided by the Health Service. This includes both AASB 16 and non-AASB 16 employee contributions.

3.1.2 Employee related 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.

	2025 $'000	2024 $'000
Current		
Employee benefits provisions		
Annual leave	180,497	152,196
Time off in lieu	60,574	51,142
Long service leave	113,484	92,920
Deferred salary scheme	2,100	1,629
	356,655	**297,887**
Non-Current		
Employee benefits provisions		
Long service leave (ii)	92,280	84,103
	92,280	**84,103**
Total employee related provisions	**448,935**	**381,990**

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

Within 12 months of the end of the reporting period	125,229	111,577
More than 12 months after the end of the reporting period	115,842	91,761
	241,071	**203,338**

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

3.1.2 Employee related provisions (continued)

Long service leave liabilities are unconditional long service leave provisions and are classified as current liabilities as the Health Service does not have an 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 required years of service. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

	2025 $'000	2024 $'000
Within 12 months of the end of the reporting period	27,114	22,463
More than 12 months after the end of the reporting period	178,650	154,560
	205,764	**177,023**

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

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

Within 12 months of the end of the reporting period	2,100	1,629
More than 12 months after the end of the reporting period	-	-
	2,100	**1,629**

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 significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year.

Several estimates and assumptions are used in calculating the Health Service's long service leave provision. These include, expected future salary rates, discount rates employee retention rates and expected future payments. Changes in these estimates and assumptions may impact on the carrying amount of the long service leave provisions. Any gain or loss following revaluation of the present value of long service leave is recognised as employee benefits expenses.

3.2 Fees for contracted medical practitioners

Fees for contracted medical practitioners	32,210	13,560

Contracted medical practitioners (CMPs), both general practitioners and specialists, are contracted to provide medical services to a hospital via a Medical Services Agreement. CMPs are independent contractors operating medical businesses and are not Health Service employees.

3.3 Patient support costs

	2025 $'000	2024 $'000
Medical supplies and services	399,650	331,676
Domestic charges	34,239	29,695
Pathology services provided by PathWest [a] [b]	32,327	28,575
Fuel, light and power	17,302	15,411
Food supplies	12,859	11,239
Patient transport costs	14,307	11,494
Rapid antigen testing kits provided by HSS [b] [c]	-	360
Research, development and other grants	105	39
Total patient support costs	**510,789**	**428,489**

(a) Pathology services provided by PathWest are in addition to the fee for services (FFS) charges already paid to PathWest, within medical supplies and services shown above.

(b) Refer to Note 4.1 Income from State Government.

(c) Rapid antigen testing kits provided by HSS for ongoing testing against COVID-19.

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

3.4 Contracts for services

Public patients services [a]	25,526	156,110
Mental Health	3,461	2,721
Home and Comm Care (HACC)	1,846	1,238
Child, community and primary health	410	410
Blood & Organs	361	320
Patient transport service	298	176
Chronic diseases	-	3
Other contracts	114	6
Total contracts for services	**32,016**	**160,984**

(a) Private hospitals and non-government organisations are contracted to provide various services to public patients and the community.

Contracts for services are recognised as an expense in the reporting period in which they are incurred.

3.5 Repairs, maintenance and consumable equipment

Repairs and maintenance	13,730	10,266
Consumable equipment	67,668	59,377
Total repairs, maintenance and consumable equipment	**81,398**	**69,643**

Repairs, maintenance and consumable equipment costs are recognised as expenses as incurred, except where they relate to the replacement of a significant component of an asset. In that case, the costs are capitalised and depreciated.

3.6 Other supplies and services

Sanitisation and waste removal services	3,755	2,810
Administration and management services	70,235	59,508
Interpreter services	2,821	2,637
Security services	1,490	153
Other	994	3,059
Total other supplies and services	**79,295**	**68,167**

Other supplies and services are recognised as an expense in the reporting period in which they are incurred.

3.7 Other expenses

	2025 $'000	2024 $'000
Communications	7,698	7,068
Computer services	43,050	30,342
Workers' compensation insurance	28,894	24,042
Lease expenses	3,214	2,366
Other insurances	26,076	21,093
Consultancy fees	8,830	8,830
Other employee related expenses	3,788	2,950
Printing and stationery	4,619	3,901
Expected credit losses	6,425	10,427
Freight and cartage	789	637
Periodical subscription	1,906	1,708
Services provided by HSS	103,004	86,580
Motor vehicle expenses	1,293	1,119
Audit fees	879	750
Waivers	1,019	87
Legal expenses	133	(9)
Legal services provided free of charge	175	105
Other	6,506	4,486
Total other expenses	**248,298**	**206,482**

Employee on-cost include workers' compensation insurance only. Any on costs liability associated with the recognition of annual and long service leave liabilities are included in note 3.1.2 Employee related provisions. Superannuation contributions accrued as part of the provision for leave are employee benefits and are not included in employment on-costs.

Lease expenses include low value leases with an underlying value of $5,000 or less, variable lease payments which are recognised in the period in which the event or condition that triggers the payment occurs and lease maintenance expenses. Refer to note 5.2 Right-of-use for variable lease payments and low value leases.

Expected credit losses is an allowance for trade receivables, 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, adjusted for forward looking factors specific to the debtors and the economic environment. Refer to note 6.1.1 Movement in the allowance for impairment of receivables.

Services provided by Health Support Services (HSS) are services received free of charge or for nominal cost and are recognised as expenses at the fair value of those services that can be reliably measured, and which would have been purchased if they were not donated.

Motor vehicle expenses include expenses associated with the operation, repair and maintenance and management of motor vehicles.

Audit fees include the final audit fee for the previous year's audit and any interim audit fees (if any) for the current year's audit and an accrual for the current year's final audit fee. This is represented by external audit fees ($0.469 million) and internal audit fees ($0.410 million).

Other operating expenses generally represent the day-to-day running costs incurred in normal operations and are recognised as an expense in the period it is incurred.

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:

	Notes	2025 $'000	2024 $'000
Income from State Government	4.1	2,575,071	2,272,543
Patient charges	4.2	114,735	106,718
Other fees for services	4.3	108,225	94,332
Grants and contributions	4.4	8,100	5,642
Commercial activities	4.5	444	(90)
Other revenue	4.6	23,239	22,352
Donation revenue	4.6	8,273	785
Gains/(losses) on disposal	4.6	(8)	66

4.1 Income from State Government

Income received from other public sector entities during the period: [(a)]		
Department of Health - Service agreement	2,174,980	1,938,929
Mental Health - Service agreement	244,474	193,646
Income from other state government agencies	19,194	24,311
Total income received	**2,438,648**	**2,156,886**
Assets transferred from/(to) other State government agencies during the period: [(b)]		
- Transfer of medical equipment from Health Support Services	877	10
Total assets (transferred)/assumed	**877**	**10**
Services received free of charge from other State Government agencies during the period: [(c)]		
HSS Support Services (HSS)		
ICT Services	69,731	60,585
Supply chain services	14,609	11,002
Financial services	3,278	2,357
Human resources services	15,386	12,636
Rapid Antigen Test Kits	-	360
PathWest - Pathology Services	32,327	28,575
Department of Finance - Lease Management Services	40	27
Department of Justice - State Solicitors Office Legal Services	175	105
Total services received	**135,546**	**115,647**
Total income from State Government	**2,575,071**	**2,272,543**

(a) **Income received from other public sector entities** are recognised as income when the Health Service has satisfied its performance obligations under the funding agreement. If there are no performance obligations, income will be recognised when the Health Service receives the funds.

For **non-reciprocal grants**, the Health Service recognises revenue when the grant is receivable at its fair value as and when its fair value can be reliably measured.

Activity based funding and block grant funding have been received from the Commonwealth Government under the National Health Reform Agreement for services, health teaching, training and research provided by local hospital networks (Health Services). The funding arrangement established under the Agreement requires the Commonwealth Government to make funding payments to the State Pool Account from which distributions to the local hospital networks (Health Services) are made by the Department of Health and Mental Health Commission.

4.1 Income from State Government (continued)

(b) **Assets transferred** from other parties are recognised as income at fair value when the assets are transferred.

(c) **Services received free of charge** or for nominal cost, that the Health Service would otherwise purchase if not donated, are recognised as income at the fair value of the services where they can be reliably measured. A corresponding expense is recognised for the services received.

Pathology services provided by PathWest are in addition to the FFS charges already paid to PathWest included in Note 3.3 Patient support costs.

4.2 Patient charges

	2025 $'000	2024 $'000
Inpatient bed charges	94,046	84,499
Inpatient other charges	8,315	8,569
Outpatient charges	12,374	13,650
Total patient charges	**114,735**	**106,718**

Revenue relating to patient charges is recognised at a point-in-time. The performance obligations for patient charges are satisfied when the services have been provided; in this case the patient has been treated and discharged by the Health Service.

4.3 Other fees for services

Recoveries from the Pharmaceutical Benefits Scheme (PBS)	99,632	86,362
Non-clinical services to other health organisations	8,593	7,970
Total other fees for services	**108,225**	**94,332**

4.4 Grants and contributions

Commonwealth grants and contributions

Recurrent grants:		
Community Health and Hospitals Program	4,320	3,407

Other grants and contributions

Research Grant Revenue	3,780	2,235
Total grants and contributions	**8,100**	**5,642**

Grants and contributions are recognised as revenue when the grants or contributions are received or receivable.

Income from grants to acquire/construct a recognisable non-financial asset to be controlled by the Health Service is recognised when the Health Service satisfies its obligations under the transfer. The Health Service typically satisfies its obligations under the transfer when it achieves milestones specified in the grant agreement and amounts received in advance of obligation satisfaction are reported in note 6.6 Contract liabilities and 6.7 Grant liabilities

4.5 Commercial activities

	2025 $'000	2024 $'000
Income from commercial activities		
Pharmacy clinical trials and research activity revenue	1,094	803
Research and development activity revenue	310	278
Ramsay Health Care Australia Pty Ltd (PHC) rent revenue	10	143
	1,414	**1,224**
Expenses from commercial activities		
Pharmacy clinical trials and research activity revenue	(718)	(926)
Research and development activity revenue	(191)	(210)
Ramsay Health Care Australia Pty Ltd (PHC) rent revenue	(61)	(178)
Profit/(loss) from commercial activities	**444**	**(90)**

Revenue is recognised at the transaction price when the Health Service transfers control of the goods and/or services to customers.

The Health Service has engaged in a number of commercial activities including the provision of pharmacy services to commercially sponsored clinical trials, provision of services to support research into pharmaceutical and medication usage and the leasing of space at public hospitals.

4.6 Other revenue

Donation revenue

General public contributions	8,273	785
Total donation revenue	**8,273**	**785**

Other revenue

Use of hospital facilities	35	9
Rent from commercial properties	4,709	4,014
Rent from residential properties	58	71
Boarders' accommodation	34	6
Parking	7,895	7,325
Research and clinical trial revenue	9,965	10,337
Course fees	201	216
Other	342	374
Total other revenue	**23,239**	**22,352**

Gains/(losses)

Net proceeds from disposal of non-current assets		
Property, plant and equipment	-	105
Carrying amount of non-current assets disposed		
Property, plant and equipment	(8)	(39)
Net gains/(losses) on disposal of non-current assets	**(8)**	**66**

4.6 Other revenue (continued)

Realised and unrealised gains are usually recognised on a net basis. These include gains arising on the disposal of non-current assets and some revaluations of non-current assets.
Gains and losses on the disposal of non-current assets are presented by deducting from the proceeds on disposal the carrying amount of the asset and related selling expenses. Gains and losses are recognised in profit or loss in the statement of comprehensive income (from the proceeds of sale).

5. Key assets

This section includes information regarding the key assets the Health Service utilises to gain economic benefits or provide service potential. The section sets out both the key accounting policies and financial information about the performance of these assets.

	Notes	2025 $'000	2024 $'000
Property, plant and equipment	5.1	2,654,937	2,192,229
Right-of-use assets	5.2	59,585	21,430
Service concession assets	5.3	-	69,178
Intangible assets	5.4	2,588	4,377
Total key assets		**2,717,110**	**2,287,214**

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5.1 Property, plant and equipment

	Land $'000	Buildings $'000	Site infrastructure $'000	Computer equipment $'000	Furniture and fittings $'000	Motor vehicles $'000	Medical equipment $'000	Other plant and equipment $'000	Artworks $'000	Work in progress $'000	Total $'000
1 July 2023											
Gross carrying amount	75,471	1,879,127	125,044	35,029	5,900	-	55,244	26,964	8	5,014	2,207,801
Accumulated depreciation	-	-	(20,439)	(26,260)	(1,426)	-	(24,141)	(12,813)	-	-	(85,079)
Carrying amount at start of year	**75,471**	**1,879,127**	**104,605**	**8,769**	**4,474**	**-**	**31,103**	**14,151**	**8**	**5,014**	**2,122,722**
Additions	1,440	11,896	95	858	106	-	13,358	3,439	-	14,555	45,747
Transfers to/(from) work in progress	-	3,458	-	-	-	-	-	-	-	(3,458)	-
Transfer from/(to) other reporting entities	-	-	-	-	-	-	10	-	-	-	10
Revaluation increments / (decrements)	3,555	96,646	-	-	-	-	-	-	-	-	100,201
Disposals	-	-	-	-	-	-	(39)	-	-	-	(39)
Depreciation	-	(57,569)	(2,961)	(5,436)	(525)	-	(7,719)	(2,223)	-	-	(76,433)
Transfers between asset classes	-	-	-	(479)	58	-	461	(19)	-	-	21
Carrying amount at 30 June 2024	**80,466**	**1,933,558**	**101,739**	**3,712**	**4,113**	**-**	**37,174**	**15,348**	**8**	**16,111**	**2,192,229**
Gross carrying amount	80,466	1,933,558	125,139	35,214	6,209	-	67,717	30,288	8	16,111	2,294,710
Accumulated depreciation	-	-	(23,400)	(31,502)	(2,096)	-	(30,543)	(14,940)	-	-	(102,481)
1 July 2024											
Gross carrying amount	80,466	1,933,558	125,139	35,214	6,209	-	67,717	30,288	8	16,111	2,294,710
Accumulated depreciation	-	-	(23,400)	(31,502)	(2,096)	-	(30,543)	(14,940)	-	-	(102,481)
Carrying amount at start of year	**80,466**	**1,933,558**	**101,739**	**3,712**	**4,113**	**-**	**37,174**	**15,348**	**8**	**16,111**	**2,192,229**
Additions	-	252	1,716	57	1,423	19	27,364	2,048	-	37,905	70,784
Transfer to Expense	-	-	-	-	-	-	-	-	-	(116)	(116)
Transfers to/(from) work in progress	-	8,225	20	285	60	-	51	10	-	(8,542)	109
Revaluation increments / (decrements)(a)	20,922	382,207	-	-	-	-	-	-	-	-	403,129
Disposals	-	-	-	-	(3)	-	(3)	(2)	-	-	(8)
Depreciation	-	(62,627)	(3,187)	(1,849)	(630)	(4)	(9,377)	(2,484)	-	-	(80,158)
Transfers between asset classes	7,560	59,295	4,748	1,083	13		(5,569)	1,838	-	-	68,968
Carrying amount at 30 June 2025	**108,948**	**2,320,910**	**105,036**	**3,288**	**4,976**	**15**	**49,640**	**16,758**	**8**	**45,358**	**2,654,937**
Gross carrying amount	108,948	2,320,910	132,546	36,877	7,692	19	89,306	34,589	8	45,358	2,776,253
Accumulated depreciation	-	-	(27,510)	(33,589)	(2,716)	(4)	(39,666)	(17,831)	-	-	(121,316)

(a) Of this amount, $261.396 million relates to professional and project management fees, which are now included in the value of current use building assets under the current replacement cost basis as required by the prospective application of AASB 2022-10 Amendments to Australian Accounting Standards – Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities.

5.1 Property, plant and equipment (continued)

Initial recognition

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

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

The initial cost for a non-financial physical asset under a finance lease is measured at amounts equal to the fair value of the leased asset or, if lower, the present value of the minimum lease payments, each determined at the inception of the lease.

Subsequent measurement

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

- Land
- buildings

Land is carried at fair value. Buildings are carried at fair value less accumulated depreciation and accumulated impairment losses. All other items of property, plant and equipment are stated at historical cost less accumulated depreciation and accumulated impairment losses.

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

Land and buildings were revalued as at 1 July 2024 by the Western Australian Land Information Authority (Landgate). The valuations were performed during the year ended 30 June 2025 and recognised at 30 June 2025. In undertaking the revaluation, fair value was determined by reference to market values for land: $3.198 million (2024: $2.967 million) and buildings: $1.482 million (2024: $1.400 million). For the remaining balance, fair value of buildings was determined on the basis of depreciated 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).

In addition, for buildings under the current replacement cost basis, estimated professional and project management fees are included in the valuation of current use assets as required by AASB 2022-10 *Amendments to Australian Accounting Standards – Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities.*

Revaluation model:

1. Fair Value 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 determined by reference to recent market transactions. When buildings are revalued by reference to recent market transactions, the accumulated depreciation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount.

2. Fair value in the absence of market-based evidence

   Where buildings are specialised or where land is restricted, the fair value of land and buildings (clinical sites) is determined on the basis of existing use.

   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 depreciated replacement cost. Where the fair value of buildings is determined on the depreciated replacement costs basis, the accumulated depreciation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount.

5.1 Property, plant and equipment (continued)

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.

5.1.1 Depreciation and impairment

	2025 $'000	2024 $'000
Charge for the period		
Buildings	62,627	57,569
Site infrastructure	3,187	2,961
Computer equipment	1,849	5,436
Furniture and fittings	630	525
Motor vehicles	4	-
Medical equipment	9,377	7,719
Other plant and equipment	2,484	2,223
Total depreciation for the period	**80,158**	**76,433**

Impairment

As at 30 June 2025 there were no indications of impairment to property, plant and equipment.

All surplus assets at 30 June 2025 have either been classified as assets held for sale or have been written-off.

Refer to note 5.4 Intangible assets for guidance in relation to the impairment assessment that has been performed for intangible assets.

Finite useful lives

All property, plant and equipment having 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 items under operating leases and land.

Depreciation is calculated on a straight-line basis, at rates that allocate the asset's value, less any estimated residual value, over its estimated useful life.

Estimated useful lives for the different asset classes for current and prior years are included in the table below:

Asset	Useful life:
Buildings	50 years
Site infrastructure	50 years
Computer equipment	4 to 20 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 25 years

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

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

5.1.1 Depreciation and impairment (continued)

Impairment

Non-financial assets, including items of property, plant and equipment, are tested for impairment whenever there is an indication that the asset may be impaired and 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 its recoverable amount, an impairment loss is recognised through profit and loss in statement of comprehensive income.

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.

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.

5.2 Right-of-use assets

	Land $'000	Buildings non-accommodation $'000	Plant and equipment $'000	Motor vehicles $'000	Information, computer and telecommunications equipment $'000	Furniture fittings $'000	Medical equipment $'000	Total $'000
1 July 2023								
Gross carrying amount	**-**	**7,789**	**7,775**	**3,539**	**49,482**	**7,470**	**53,469**	129,524
Accumulated amortisation	**-**	**(582)**	**(6,005)**	**(2,285)**	**(43,058)**	**(6,505)**	**(46,554)**	(104,989)
Carrying amount at start of period	**-**	**7,207**	**1,770**	**1,254**	**6,424**	**965**	**6,915**	**24,535**
Additions	349	-	4,351	2,334	194	-	(1)	7,227
Disposals	-	(79)		-	-	-		(79)
Depreciation	(51)	(887)	(1,540)	(878)	(3,117)	(463)	(3,317)	(10,253)
Carrying amount at 30 June 2024	**298**	**6,241**	**4,581**	**2,710**	**3,501**	**502**	**3,597**	**21,430**
Gross carrying amount	298	7,025	9,095	5,266	49,676	7,470	53,469	132,299
Accumulated amortisation	-	(784)	(4,514)	(2,556)	(46,175)	(6,968)	(49,872)	(110,869)
1 July 2024								
Gross carrying amount	298	7,025	9,095	5,266	49,676	7,470	53,469	132,299
Accumulated amortisation	-	(784)	(4,514)	(2,556)	(46,175)	(6,968)	(49,872)	(110,869)
Carrying amount at start of period	**298**	**6,241**	**4,581**	**2,710**	**3,501**	**502**	**3,597**	**21,430**
Additions	354	50,166	(26)	1,650	615	-	46	52,805
Disposals	-	-	-	(7)	-	(1)	-	(8)
Depreciation	(289)	(7,596)	(1,241)	(1,074)	(2,143)	(279)	(2,020)	(14,642)
Carrying amount at 30 June 2025	**363**	**48,811**	**3,314**	**3,279**	**1,973**	**222**	**1,623**	**59,585**
Gross carrying amount	363	56,757	8,995	6,022	50,178	7,470	53,515	183,300
Accumulated amortisation	-	(7,946)	(5,681)	(2,743)	(48,205)	(7,248)	(51,892)	(123,715)

5.2 Right-of-use assets (continued)

Initial recognition

At the commencement date of the lease, the Health Service recognise right-of-use assets measured at cost, including the following:

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

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 over a straight- line basis over the lease term.

Subsequent measurement

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

Depreciation and impairment of right-of-use assets

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

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

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

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

	2025 $'000	2024 $'000
Depreciation expense of right-of-use assets	14,642	10,253
Lease interest expense	3,408	1,225
Lease maintenance expense	1,885	1,631
Short-term leases	-	-
Low-value leases	4	4
Gains or losses arising from sale and leaseback transactions	(71)	(176)
Total amount recognised in the statement of comprehensive income	**19,868**	**12,937**

The total cash outflow for leases in 2025 was $13.563 million (2024: $11.733 million).

As at 30 June 2025 there were no indications of impairment to right-of-use assets.

The Health Services leasing activities and how these are accounted for:

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

The Health Service has also entered into a Memorandum of Understanding Agreements (MOU) with the Department of Finance for the leasing of office accommodation. These are not recognised under AASB 16 because of substitution rights held by the Department of Finance and are accounted for as an expense as incurred.

The Health Service recognises leases as right-of-use assets and associated lease liabilities in the Statement of Financial Position

The corresponding lease liabilities in relation to these right-of-use assets have been disclosed in note 7.1 Lease liabilities.

South Metropolitan Health Service
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5.3 Service concession assets

	Land $'000	Buildings $'000	Site infrastructure $'000	Other plant and equipment $'000	Medical equipment $'000	Works in progress $'000	Total $'000
1 July 2023							
Gross carrying amount	6,900	54,474	5,672	771	487	-	68,304
Accumulated depreciation	-	-	(717)	(266)	(139)	-	(1,122)
Carrying amount at start of period	**6,900**	**54,474**	**4,955**	**505**	**348**	**-**	**67,182**
Additions	-	-	-	-	-	-	-
Transfers	-	-	-	-	-	-	-
Revaluation increments / (decrements)	660	3,708	-	-	-	-	4,368
Depreciation	-	(2,070)	(191)	(50)	(61)	-	(2,372)
Carrying amount at 30 June 2024	**7,560**	**56,112**	**4,764**	**455**	**287**	**-**	**69,178**
Gross carrying amount	7,560	56,112	5,672	771	487	-	70,602
Accumulated amortisation	-	-	(908)	(316)	(200)	-	(1,424)
1 July 2024							
Gross carrying amount	7,560	56,112	5,672	771	487	-	70,602
Accumulated depreciation	-	-	(908)	(316)	(200)	-	(1,424)
Carrying amount at start of period	**7,560**	**56,112**	**4,764**	**455**	**287**	**-**	**69,178**
Transfers	(7,560)	(55,927)	(4,748)	(451)	(282)	-	(68,968)
Depreciation		(185)	(16)	(4)	(5)		(210)
Carrying amount at 30 June 2025	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Gross carrying amount	-	-	-	-	-	-	-
Accumulated amortisation	-	-	-	-	-	-	-

Initial recognition

A service concession arrangement is an arrangement which involves an operator:

- that is contractually obliged to provide public services related to a service concession asset on behalf of the grantor; and
- managing at least some of those services under its own discretion, rather than at the direction of the grantor.

The health service as the grantor had one service concession arrangement in operation during the reporting period.

Peel Health Campus (PHC) is a general hospital established in September 1997 by the State Government. The hospital was operated on behalf of the State Government under a 20-year service contract, by Health Solutions WA until 2013 when the remainder of licence transferred to Ramsay Health Care. The agreement was made between South Metropolitan Health Service (State / Grantor) and Ramsay Health Care Australia Pty Ltd (Operator).

PHC returned to State Government control under the care of South Metropolitan Health Service on 13th August 2024.

On the transition date, service concession assets previously identified in the service agreement were reclassified from service concession assets to property, plant, and equipment at net book value.

5.3 Service concession assets (continued)

Subsequent to initial recognition or reclassification, a service concession asset is depreciated or amortised in accordance with AASB 116 Property, Plant and Equipment with any impairment recognised in accordance with AASB 136.

Subsequent measurement

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

- land
- buildings

The policy in connection with the revaluation model is outlined in note 5.1 Property, plant and equipment.

Depreciation and impairment of service concession assets

	2025 $'000	2024 $'000
Charge for the period		
Buildings	185	2,070
Site infrastructure	16	191
Medical equipment	5	61
Other plant and equipment	4	50
Total depreciation for the period	**210**	**2,372**

Finite useful lives

Service concession assets are systematically depreciated over their estimated useful lives in a manner that reflects the consumption of their future economic benefits.

Depreciation is calculated on a straight-line basis, at rates that allocate the asset's value, less any estimated residual value, over its estimated useful life.

Estimated useful lives for the different asset classes for current and prior years are included in the table below:

Asset	Useful life:
Buildings	50 years
Site infrastructure	50 years
Medical equipment	2 to 25 years
Other plant and equipment	3 to 25 years

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

Land, which is considered to have an indefinite life, is not depreciated. Depreciation is not recognised in respect of land because their service potential had not, in any material sense, been consumed during the reporting period.

Impairment

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

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

As at 30 June 2025 there were no service concession assets held by the Health Service.

5.4 Intangible assets

	Computer software $'000	Works in progress $'000	Total $'000
Year ended 30 June 2024			
1 July 2023			
Gross carrying amount	29,685	-	29,685
Accumulated amortisation	(22,872)	-	(22,872)
Carrying amount at start of year	**6,813**	**-**	**6,813**
Additions	385	108	493
Transfers to expense	(21)	-	(21)
Amortisation expense	(2,908)	-	(2,908)
Carrying amount at 30 June 2024	**4,269**	**108**	**4,377**
Year ended 30 June 2025			
1 July 2024			
Gross carrying amount	30,049	108	30,157
Accumulated amortisation	(25,780)	-	(25,780)
Carrying amount at start of year	**4,269**	**108**	**4,377**
Additions	96	-	96
Transfers from work in progress	-	(108)	(108)
Amortisation expense	(1,777)	-	(1,777)
Carrying amount at 30 June 2025	**2,588**	**-**	**2,588**

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, that comply with the recognition criteria of AASB 138.57 *Intangible Assets* are capitalised.

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

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

Costs incurred in the research phase of a project and those costs below these thresholds are immediately expensed directly to the Statement of Comprehensive Income.

Subsequent measurement

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

5.4.1 Amortisation and impairment

	2025 $'000	2024 $'000
Charge for the period		
Computer software	1,777	2,908
Total amortisation for the year	**1,777**	**2,908**

As at 30 June 2025 there were no indications of impairment to intangible assets.

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

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

The estimated useful lives for each class of intangible asset are:

Computer software	5 to 15 years

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

Impairment of intangible assets

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

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

6. Other assets and liabilities

This section sets out those assets and liabilities that arose from the Health Services controlled operations and includes other assets utilised for economic benefits and liabilities incurred during normal operations.

	Notes	2025 $'000	2024 $'000
Receivables	6.1	95,464	85,060
Amounts receivable for services	6.2	1,391,976	1,300,476
Inventories	6.3	8,597	7,219
Other current assets	6.4	6,480	5,171
Payables	6.5	136,409	137,973
Contract liabilities	6.6	278	303
Grant liabilities	6.7	10	4,330
Other liabilities	6.8	412	2,325

6.1 Receivables

Current		
Patient fee debtors [(a)]	41,181	40,856
Other receivables	6,881	5,871
Less: Allowance for impairment of receivables	(22,287)	(19,792)
Accrued revenue	22,680	19,418
GST receivable	3,261	4,959
Total current	**51,716**	**51,312**
Non-current		
27th pay contribution held at Treasury [(b)]	43,748	33,748
Total Non-current	**43,748**	**33,748**
Total receivables	**95,464**	**85,060**

(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 total amount of ex-gratia payments is $3.406 million for 2025 ($2.488 million for 2024).

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

Receivables are initially recognised at their transaction price, or for those receivables that contain a significant financing component, at fair value. The Health Service holds the receivables with the objective to collect the contractual cashflows and therefore subsequently measured at the amortised cost using the effective interest method, less any allowance for impairment.

The Health Service recognises a loss allowance for expected credit losses (ECLs) on receivable not held at fair value through the profit and loss. The ECLs are based on the difference between the contractual cash flows and the cash flows that the entity expects to receive, discounted at the original effective interest rate. Individual receivables are written off when the Health Service has no reasonable expectations of recovering the contractual cashflows.

For receivables, the Health Service recognises an allowance for ECLs 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, adjusted for forward-looking factors specific to the debtors and the economic environment. Refer to note 3.7 Other expenses for the amount expensed for ECLs during this financial year.

6.1 Receivables (continued)

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

6.1.1 Movement in the allowance for impairment of trade receivables

	2025 $'000	2024 $'000
Reconciliation of changes in the allowance for impairment of trade receivables		
Opening Balance	19,792	15,147
Expected credit losses expense	6,425	10,427
Amount written off during the period	(3,969)	(5,831)
Amount recovered during the period	39	49
Allowance for impairment at end of period	**22,287**	**19,792**

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) Financial instruments disclosures.

The Health Service does not hold any collateral as security or other credit enhancements for receivables.

6.2 Amounts receivable for services (Holding Account)

Non-current	1,391,976	1,300,476
Total amounts receivable for services at the end of period	**1,391,976**	**1,300,476**

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

Amounts receivable for services are financial assets at amortised cost and are not considered impaired (i.e., there is no expected credit loss of the holding accounts).

6.3 Inventories

Current		
Pharmaceutical stores - at cost	8,461	7,082
Engineering stores - at cost	136	137
Total inventories end of period	**8,597**	**7,219**

Inventories are measured at the lower of cost or 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 assets

	2025 $'000	2024 $'000
Current		
Prepayments	6,375	5,277
Other	105	(106)
Total other assets at end of period	**6,480**	**5,171**

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		
Trade creditors	14,679	9,613
Other creditors [(a)]	38	37
Accrued expenses	53,549	74,100
Accrued salaries	67,900	51,831
Professional development payable	243	2,392
Total payables at end of period	**136,409**	**137,973**

(a) Includes $0.027 million Fringe Benefits Tax due to the ATO for 2025 Fringe Benefits Tax liability.

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 15-20 days.

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

The 27th pay suspense account (refer to note 6.1 Receivables) consists of amounts paid annually, from the Health Service's appropriations for salaries expense, into a Department of 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.

6.6 Contract liabilities

Current	278	303
Non-current	-	-
Total contract liabilities	**278**	**303**

The Health Services contract liabilities relate to revenue received in advance of contract obligations being satisfied, including rental contracts, prepaid patient revenue and salary funding.

6.6.1 Movement in contract liabilities

Reconciliation of changes in contract liabilities		
Opening balance	303	291
Additions	261	285
Revenue recognised in the reporting period	(286)	(273)
Total contract liabilities at end of period	**278**	**303**

The Health Service expects to satisfy the performance obligations unsatisfied at the end of the reporting period, within the next 12 months for all current contract liabilities.

6.7 Grant liabilities

	2025 $'000	2024 $'000
Current	10	4,330
Non-current	-	-
Total Grant liabilities	**10**	**4,330**

The Health Service's grant liabilities relate to grant revenue received in advance of the performance obligations being satisfied.

6.7.1 Movement in grant liabilities

Reconciliation of changes in grant liabilities		
Opening balance	4,330	7,737
Additions	-	-
Income recognised in the reporting period	(4,320)	(3,407)
Total grant liabilities at end of period	**10**	**4,330**

6.7.2 Expected satisfaction of grant liabilities

Income recognition		
1 year	10	4,330
1 to 5 years	-	-
Over 5 years	-	-
	10	**4,330**

6.8 Other liabilities

Current		
Refundable deposits	78	78
Paid parental leave scheme	397	402
Other	(63)	1,845
Total other liabilities at end of period	**412**	**2,325**

Revenue is recognised at the transactions price when the Health Service transfer controls of the services to customers.

Income received in advance relating to patient charges is disclosed in note 6.6 Contract liabilities. The performance obligations for patient charges are satisfied when the Health Service has treated and discharged the patient.

7. Financing

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

	Notes	2025 $'000	2024 $'000
Lease liabilities	7.1	62,371	22,592
Finance costs	7.2	3,408	1,225
Cash and cash equivalents	7.3	94,056	104,756
Capital commitments	7.4.1	91,410	46,403
Private sector contracts	7.4.2	120,179	233,557
Other expenditure commitments	7.4.3	574,236	806,343

7.1 Lease liabilities

Current		
Finance lease - Fiona Stanley [(a)]	953	4,783
Leases - State Fleet	735	645
Leases - Other	8,599	2,033
Total current	**10,287**	**7,461**
Non-current		
Finance lease - Fiona Stanley [(a)]	2,993	3,946
Leases - State Fleet	2,551	1,986
Leases - Other	46,540	9,199
Total non-current	**52,084**	**15,131**
Total lease liabilities	**62,371**	**22,592**

Initial Measurement

The Health Service measures a lease liability, at the commencement date, at the present value of the 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 dependent on sales are recognised by the Health Service in profit or loss in the period in which the condition that triggers those payments occurs.

This section should be read in conjunction with Note 5.2 Right-of-use assets.

7.1 Lease liabilities (continued)

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.

(a) During the 2012 financial year, the 'Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals' entered into a facilities management contract for a minimum period of 10 years for FSH with Serco Limited, whereby, subject to approval by the Health Service, Serco is to acquire specified assets for use at the hospital. The specified assets are to be acquired under a lease facility with a bank. Under the terms of the Facilities Management Contract and the related agreements, an element of the fee paid to Serco is linked to the fixed lease payments detailed on each leasing schedule for each group of assets, and at the end of the lease period for each group of assets, the Health Service is required to take ownership directly or dispose of the asset.

Although the arrangement, that is under a Tripartite Agreement between the Minister for Health, the private sector provider and the bank, is not in the legal form of a lease, the Health Service concluded that the arrangement contains a lease of assets, because fulfilment of the arrangement is economically dependent on the use of the assets and the Health Service receives the full service potential from the assets through the services provided at FSH.

The Health Service is able to determine the fair value of the lease element of the Facilities Management Contract with direct reference to the underlying lease payments agreed on each leasing schedule between Serco and the bank, which has been authorised by the Health Service. Therefore, at lease inception, being the various dates on which the leasing schedules for the individual assets are entered into, the Health Service recognises the leased asset and liability at the lower of the fair value or present value of future lease payments. The imputed finance costs on the liability were determined based on the interest rate implicit in the lease.

	2025 $'000	2024 $'000
The carrying amounts of non-current assets pledged as security are:		
Right-of-use assets - Plant and equipment leased	139	318
Right-of-use assets - Motor vehicles leased	-	-
Right-of-use assets - Information, computer and telecommunications equipment (ICT) leased	1,479	3,327
Right-of-use assets - Furniture and fittings leased	222	501
Right-of-use assets - Medical equipment leased	1,598	3,598
Total assets pledged as security	**3,438**	**7,744**

7.2 Finance costs

Lease interest expense	3,408	1,225
Finance costs expensed	**3,408**	**1,225**

Finance costs expensed include interest costs associated with the lease liabilities repayments.

7.3 Cash and cash equivalents

	2025 $'000	2024 $'000
Cash and cash equivalents	66,908	77,563
Restricted cash and cash equivalents	27,148	27,193
Balance at end of period	**94,056**	**104,756**

7.3.1 Reconciliation of cash

Cash assets at the end of the financial year as shown in the statement of cash flows are reconciled to the related items in the statement of financial position as follows:

Cash and cash equivalents		
Current [(a)]	**66,908**	**77,563**
Restricted cash and cash equivalents		
Current		
Restricted cash assets held for other specific purposes [(b)]	26,614	26,682
Fiona Stanley Hospital - Upgrade Works Account [(c)]	534	511
Total current	**27,148**	**27,193**
Balance at end of period	**94,056**	**104,756**

(a) Includes cash assigned to meet ongoing internal obligations arising from allocated donations, research program commitments, education and training grants, funds directed and quarantined under medical industrial agreement and funds directed and quarantined under previous Ministerial Directive.

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

(b) These include medical research grants, donations for the benefits of patients, medical education, scholarships, capital projects, employee contributions and staff benevolent funds.

(c) The moneys deposited to the Fiona Stanley Hospital (FSH) Upgrade Works Account must be used for the purposes of the upgrade works in respect of the building and site services assets.

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

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

	Notes	2025 $'000	2024 $'000
Net cost of services		(2,630,556)	(2,316,642)
Non-cash items:			
Expected credit losses expense	3.7	6,425	10,427
Write off of receivables	6.1.1	(3,969)	(5,831)
Receivables amount recovered during the period	6.1.1	39	49
Depreciation and amortisation expense	5.1 - 5.4	96,787	91,966
WIP assets relating to prior years expensed	5.1 - 5.4	116	-
Net (gain)/loss from disposal of non-current assets	4.6	8	(66)
Write off of inventories	3.6	(378)	(203)
Capitalisation of finance lease charges	7.2	3,408	1,225
Net donation of non-current assets	3.6	(7,013)	(211)
Services received free of charge	4.1	135,586	115,646
Lease termination expenses	3.6	71	-
Recognition of revenue received in prior years	4.4	(4,220)	(3,387)
Adjustments for other non-cash items		-	291
(Increase)/decrease in assets:			
GST receivable		1,698	(687)
Other current receivables		(2,102)	4,877
Inventories		(1,378)	158
Prepayments and other current assets		(1,309)	(468)
Increase/(decrease) in liabilities:			
Payables		(1,564)	23,447
Current provisions		58,768	27,131
Non-current provisions		8,177	4,381
Other current liabilities		37	95
Contract liabilities		(25)	12
Grant liabilities		(4,320)	(3,407)
Net cash used in operating activities		**(2,345,714)**	**(2,051,197)**

Cash flows from State Government		
Revenues from government agencies as per statement of comprehensive income	2,437,575	2,156,897
Revenues from government agencies received in advance	-	1,950
Capital contributions credited directly to Contributed equity (refer note 9.10 Equity)	77,241	58,597
	2,514,816	**2,217,444**
Less notional cash flows: Items paid directly by the Department of Health for the Health Service and are therefore not included in the statement of cash flows:		
Assets purchased via Department of Health	(877)	-
Accrual appropriations	(91,500)	(82,310)
Cash flows from State Government as per statement of cash flows	**2,422,439**	**2,135,134**

At the end of the reporting period the Health Service had fully drawn on all financing facilities, details of which are disclosed in the financial statements.

7.4 Commitments

The commitments below are inclusive of GST where relevant.

7.4.1 Capital expenditure commitments

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

	2025 $'000	2024 $'000
Capital expenditure commitments being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows:		
Within 1 year	54,860	44,300
Later than 1 year and not later than 5 years	36,550	2,103
Later than 5 years	-	-
	91,410	**46,403**

7.4.2 Private sector contracts for the provision of health services

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:

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	61,939	77,934
Later than 1 year and not later than 5 years	58,240	130,254
Later than 5 years	-	25,369
	120,179	**233,557**

7.4.3 Other expenditure commitments

Other expenditure commitments contracted for at the reporting period but not recognised as liabilities are payable as follows:

Other expenditure commitments contracted for at the reporting period but not recognised as liabilities are payable as follows:		
Within 1 year	241,976	214,113
Later than 1 year and not later than 5 years	279,935	524,079
Later than 5 years	52,325	68,151
	574,236	**806,343**

8. Risks and Contingencies

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

	Notes
Financial risk management	8.1
Contingent assets	8.2
Contingent liabilities	8.2
Fair value measurements	8.3

8.1 Financial risk management

Financial instruments held by the Health Service are cash and cash equivalents, restricted cash and cash equivalents, receivables 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.

(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 minimised. Debt will be written-off against the allowance account when it is improbable or uneconomical to recover the debt. At the end of the reporting period, there were no significant concentrations of credit risk.

Liquidity risk

Liquidity risk arises when the Health Service is unable to meet its financial obligations as they fall due. The Health Service is exposed to liquidity risk through its normal course of operations.

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.

8.1 Financial risk management (continued)

(b) Categories of financial instruments

The carrying amounts of each of the following categories of financial assets and financial liabilities at the end of the reporting period are:

	2025 $'000	2024 $'000
Financial assets		
Cash and cash equivalents	66,908	77,563
Restricted cash and cash equivalents	70,896	60,941
Receivables [(a)]	1,440,431	1,346,829
Total financial assets	**1,578,235**	**1,485,333**
Financial liabilities		
Financial liabilities measured at amortised cost [(b)]	198,780	160,565
Total financial liabilities	**198,780**	**160,565**

(a) The amount of receivables / financial assets at amortised cost excludes GST recoverable from the ATO (statutory receivable).

(b) The amount of financial liabilities at amortised cost excludes GST payable to the ATO (statutory payable).

(c) Credit risk exposure

The following table details the credit risk exposure on the Health Service's receivables using a provision matrix.

		Days past due				
	Total $'000	Current $'000	<30 days $'000	31 - 60 days $'000	61 - 90 days $'000	>90 days $'000
30 June 2025						
Expected credit loss rate	32%	1%	28%	33%	41%	69%
Estimated total gross carrying amount at default	70,741	35,132	4,050	1,946	1,761	27,852
Expected credit losses	22,287	485	1,153	651	728	19,270

		Days past due				
	Total $'000	Current $'000	<30 days $'000	31 - 60 days $'000	61 - 90 days $'000	>90 days $'000
30 June 2024						
Expected credit loss rate	30%	2%	24%	38%	34%	57%
Estimated total gross carrying amount at default	66,145	28,760	4,045	1,831	2,005	29,504
Expected credit losses	19,792	595	962	701	690	16,844

8.1 Financial risk management (continued)

(d) Liquidity risk and Interest rate exposure

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

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

		Interest rate exposure				Maturity dates					
	Weighted average effective interest rate %	Carrying amount $'000	Fixed interest rate $'000	Variable interest rate $'000	Non-interest bearing $'000	Nominal amount $'000	Up to 3 months $'000	3 months to 1 year $'000	1 to 5 years $'000	More than 5 years $'000	
2025											
Financial Assets											
Cash and cash equivalents		66,908	-	-	66,908	66,908	66,908	-	-	-	
Restricted cash and cash equivalents		27,148	-	-	27,148	27,148	27,148	-	-	-	
Receivables		92,203	-	-	92,203	92,203	48,455	-	43,748	-	(b)
Amounts receivable for services		1,391,976	-	-	1,391,976	1,391,976	-	-		1,391,976	
		1,578,235	**-**	**-**	**1,578,235**	**1,578,235**	**142,511**	**-**	**43,748**	**1,391,976**	
Financial Liabilities											
Payables		136,409	-	-	136,409	136,409	136,409	-	-	-	
Finance lease - Fiona Stanley Hospital	7.03%	3,946	3,946	-	-	3,946	231	722	2,993	-	
Leases - State Fleet	7.19%	3,286	3,286	-	-	3,286	67	668	2,454	97	
Leases - Other	5.33%	55,139	55,139	-	-	55,139	2,286	6,312	32,725	13,816	
		198,780	**62,371**	**-**	**136,409**	**198,780**	**138,993**	**7,702**	**38,172**	**13,913**	
2024											
Financial Assets											
Cash and cash equivalents		77,563	-	-	77,563	77,563	77,562	-	-	-	
Restricted cash and cash equivalents		27,193	-	-	27,193	27,193	27,193	-	-	-	
Receivables		80,101	-	-	80,101	80,101	46,353	-	33,748	-	(a)
Amounts receivable for services		1,300,476	-	-	1,300,476	1,300,476	-			1,300,476	
		1,485,333	**-**	**-**	**1,485,333**	**1,485,333**	**151,108**	**-**	**33,748**	**1,300,476**	
Financial Liabilities											
Payables		137,973	-	-	137,973	137,973	137,973	-	-	-	
Finance lease - Fiona Stanley Hospital	6.35%	8,729	8,729	-	-	8,729	1,496	3,287	3,946	-	
Leases - State Fleet	6.64%	2,631	2,631	-	-	2,631	175	470	1,747	239	
Leases - Other	4.94%	11,232	11,232	-	-	11,232	433	1,600	6,899	2,300	
		160,565	**22,592**	**-**	**137,973**	**160,565**	**140,077**	**5,357**	**12,592**	**2,539**	

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

(b) The amount of financial liabilities at amortised cost excludes GST payable to the ATO (statutory payable).

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 retrospectively.

Contingent assets

	2025 $'000	2024 $'000
Other		
There are facilities management matters under negotiation that may or may not become assets. The negotiations are an ongoing part of contract management processes invoking formal contractual dispute mechanisms. These matters have not progressed to the 'litigation in process' stage.	545	-
Number of disputes	1	-

Contingent liabilities

In addition to the liabilities included in the financial statements, the Health Service has the following contingent liabilities:

Other		
There are facilities management matters under negotiation that may or may not become liabilities. The negotiations are an ongoing part of contract management processes invoking formal contractual dispute mechanisms. These matters have not progressed to the 'litigation in process' stage.	18,701	19,612
Number of disputes	**8**	**15**

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. In accordance with the Act, the Department of Water and Environmental Regulation classifies these sites on the basis of the risk to human health, the environment and environmental values. Where sites are classified as contaminated – remediation required or possibly contaminated – investigation required, the Health Service may have a liability in respect of investigation or remediation expenses.

At the reporting date, the Health Service does not have any suspected contaminated sites reported under the Act.

8.3 Fair value measurements

Fair value hierarchy

AASB 13 requires disclosure of fair value measurements by level of the following fair value measurement hierarchy:

1) quoted prices (unadjusted) in active markets for identical assets (level 1)
2) input other than quoted prices included within level 1 that are observable for the asset either directly or indirectly (level 2)
3) inputs for the asset that are not based on observable market data (unobservable input) (level 3).

	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
2025				
Assets measured and recognised at fair value:				
Land				
Specialised	-	3,198	105,750	108,948
Buildings				
Residential and commercial car park	-	-	76,351	76,351
Specialised	-	1,482	2,243,077	2,244,559
	-	**4,680**	**2,425,178**	**2,429,858**

	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
2024				
Assets measured and recognised at fair value:				
Land				
Specialised	-	4,407	83,619	88,026
Buildings				
Residential and commercial car park	-	-	66,109	66,109
Specialised	-	8,185	1,915,144	1,923,329
	-	**12,592**	**2,064,872**	**2,077,464**

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 (Landgate Valuation Services) annually. Two principal valuation techniques are applied to the measurement of fair values:

Market approach (comparable sales)

The Health Service's residential properties, 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, Landgate Valuation Services 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.

The Health Service's residential properties mainly consist of residential buildings that have been re-configured to be used as health centres or clinics.

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 medical centres are specialised buildings valued under the cost approach. Staff accommodation on hospital grounds is also considered as specialised buildings for valuation purpose.

This approach uses the depreciated replacement cost method which estimates the current cost of reproduction or replacement of the buildings, on its current site, less deduction for physical deterioration and relevant forms of obsolescence. Depreciated replacement cost is the current replacement cost of an asset less, where applicable, accumulated depreciation calculated on the basis of such cost to reflect the already consumed or expired future economic benefits of the asset.

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) 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 hospitals

(c) measurement of the general floor areas

(d) application of the BUC cost rates per square meter of general floor areas

(e) application of the applicable regional cost indices, which are used throughout the construction industry to estimate the additional costs associated with building construction in locations outside of the Perth area.

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.

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8.3 Fair value measurements (continued)

The straight-line method of depreciation is applied to derive the depreciated replacement cost, assuming a uniform pattern of consumption over the initial 37 years of asset life (up to 75 per cent of current replacement costs). All specialised buildings are assumed to have a residual value of 25 per cent 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 depreciated 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)

The following table represents the changes in level 3 items for the period ended 30 June 2025 and 30 June 2024.

	Land $'000	Buildings $'000	Total $'000
2025			
Fair value at start of period	83,619	1,981,254	2,064,873
Additions	-	12,157	12,157
Transfers from/(to) Level 2	1,440	6,785	8,225
Revaluation increments/(decrements) recognised in profit or loss	-	-	-
Revaluation increments/(decrements)	20,691	382,096	402,787
Depreciation	-	(62,864)	(62,864)
Fair value at end of period	**105,750**	**2,319,428**	**2,425,178**
2024			
Fair value at start of period	79,322	1,932,551	2,011,873
Additions	-	8,337	8,337
Revaluation increments/(decrements) recognised in profit or loss	-	-	-
Revaluation increments/(decrements)	4,297	99,984	104,281
Depreciation	-	(59,618)	(59,618)
Fair value at end of period	**83,619**	**1,981,254**	**2,064,873**

Valuation processes

The Health Service manages its own valuation processes. This includes the provision of property information to a quantity surveyor, Landgate, and the review of valuation reports. Valuation processes and results are discussed with the chief finance officer at least once every year.

Landgate determines the fair values of the Health Service's land and building. A quantity surveyor is engaged by the Health Service to provide an update of the current replacement costs for specialised buildings. Landgate endorses the current replacement costs calculated by the quantity surveyor for specialised buildings and calculates the depreciated replacement costs.

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

There were no events occurring after the reporting period which had significant financial effects on these financial statements.

9.2 Changes in accounting policy

AASB 2022-10 introduces changes to AASB 13 Fair Value, effective from the 2024–25 financial year, aimed at clarifying how not-for-profit entities apply the cost approach (i.e. current replacement cost). Specifically, the update confirms that 'once-only' costs—expenses incurred during initial construction must be included when valuing a reference asset. Treasurers Guidance Handbook (TG) Chapter 8 section 5.7.7, indicates that Landgate's valuations do not include project management and professional fees, and that agencies need to estimate these fees and add them to the valuations provided by Landgate.

The impact of this change in accounting policy on the Health Service is summarised below:

	Land $'000	Buildings $'000
Carrying amount at start of year	80,466	1,933,558
Additions	-	252
Transfers to/(from) work in progress	-	8,225
Landgate revaluation increments/(decrements) (a)	20,922	120,810
Project management and professional fees (b)	-	261,397
Depreciation	-	(62,627)
Transfers between asset classes	7,560	59,295
Carrying amount at 30 June 2025	**108,948**	**2,320,910**

(a) Amount relates to the revaluation of land provided by Landgate effective 1 July 2024.

(b) Amount relates to professional and project management fees, which are now included in the value of current use building assets under the current replacement cost basis as required by the prospective application of AASB 2022-10 Amendments to Australian Accounting Standards – Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities.

9.3 Future impact of Australian Accounting Standards not yet operative

The Health Service cannot early adopt an Australian Accounting Standard unless specifically permitted by TI 9 – Requirement 4 *Application of Australian Accounting Standards and Other Pronouncements* or by an exemption from TI 9. Where applicable, the Agency plans to apply the following Australian Accounting Standards from their application date.

		Operative for reporting periods beginning on/after
Operative for reporting periods beginning on/after 1 Jan 2025		
AASB 2023-5	*Amendments to Australia Accounting Standards – Lack of Exchangeability* This Standard amends AASB 121 and AASB 1 to require entities to apply a consistent approach to determining whether a currency is exchangeable into another currency and the sport exchange rate to use when it is not exchangeable. The Standard also amends AASB 121 to extend the exemption from complying with the disclosure requirements for entities that apply AASB 1060 to ensure Tier 2 entities are not required to comply with the new disclosure requirements in AASB 121 when preparing their Tier 2 financial statements.	**1 Jan 2025**
Operative for reporting periods beginning on/after 1 Jan 2026		
AASB 2024-2	*Amendments to Australian Accounting Standards – Classification and Measurement of Financial Instruments.* This Standard amends AASB 7 and AASB 9 as a consequence of the issuance of *Amendments to the Classification and Measurement of Financial Instruments* (Amendments to IFRS 9 and IFRS 7) by the International Accounting Standards Board in May 2024. The Agency has not assessed the impact of the Standard	**1 Jan 2026**
AASB 2024-3	*Amendments to Australian Accounting Standards –Annual Improvements Volume 11.* This Standard amends AASB 1, AASB 7, AASB 9, AASB 10 and AASB 107 as a consequence of the issuance of *Annual Improvements to IFRS Standards – Volume 11* by the International Accounting Standards Board in July 2024. The Agency has not assessed the impact of the Standard.	**1 Jan 2026**
AASB 18(NFP /super)	*Presentation and Disclosure in Financial Statements (Appendix D) [for not-for-profit and superannuation entities]* This Standard replaces AASB 101 with respect to the presentation and disclosure requirements in financial statements applicable to not-for-profit and superannuation entities This Standard is a consequence of the issuance of IFRS 18 Presentation and Disclosure in financial Statements by the International Accounting Standards Board in April 2024. This Standard also makes amendments to other Australian Accounting Standards set out in Appendix D of this Standard. The Agency has not assessed the impact of the Standard.	**1 Jan 2028**

9.4 Key management personnel

The Health Service has determined that key management personnel include ministers, members and senior officers of the Authority. 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 total fees, salaries, superannuation, non-monetary benefits and other benefits for senior officers of the for the reporting period are presented within the following bands:

	2025	2024
Compensation of members of the accountable authority		
Compensation band ($)		
50,001 - 100,000	1	1
0 - 50,000	9	9

Compensation of senior officers		
Compensation band ($)		
650,001 - 700,000	1	-
600,001 - 650,000	-	1
550,001 - 600,000	1	-
500,001 - 550,000	-	1
450,001 - 500,000	-	-
400,001 - 450,000	1	-
350,001 - 400,000	-	2
300,001 - 350,000	-	-
250,001 - 300,000	4	1
200,001 - 250,000	3	5
150,001 - 200,000	2	1
100,001 - 150,000	2	-
50,001 - 100,000	2	-

	2025 $'000	2024 $'000
Short-term employee benefits	4,017	3,447
Post-employment benefits	458	375
Other long-term benefits	82	259
Termination benefits	-	-
Total compensation of key management personnel	**4,557**	**4,081**

Total compensation includes the superannuation expense incurred by the Health Service in respect of senior officers.

9.5 Related party transactions

The Health Service is a wholly owned and controlled entity of the State of Western Australia. In conducting its activities, the Health Service is required to pay various taxes and levies to the State and entities related to the State. The payment of these taxes and levies, is based on the standard terms and conditions that apply to all tax and levy payers.

Related parties of the Health Service include:

- all senior officers 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 public sector entities, including related bodies included in the whole of government consolidated financial statements
- associates and joint ventures, that are included in the whole of government consolidated financial statements
- the Government Employees Superannuation Board (GESB).

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

Significant transactions with government related entities

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

- income from State Government (note 4.1)
- capital appropriations (note 9.10)
- superannuation payments to GESB (note 3.1.1)
- lease rentals payments for accommodation and fleet leasing to the Department of Finance (note 3.7)
- commitments for future lease payments to the Department of Finance (note 7.4)
- insurance transactions with the Insurance Commission (note 3.7)
- remuneration for services provided by the Office of the Auditor General (note 9.9)
- utility payments to Water Corporation (note 3.3)
- utility payments to Electricity Generation and Retail Corporation (Synergy) (note 3.3)
- payments for legal advice to Department of the Attorney General (note 3.7)
- maintenance transactions with the Department of Fire and Emergency Services (note 3.5 and note 3.6)
- funding agreement with Disability Services Commision (note 3.4)
- transactions with the Department of Health and other Metropolitan and Country Health Services (note 4.1).

Material transactions with related parties

The Health Service had no material related party transaction with Ministers/senior officers or their close family members or their controlled (or jointly controlled) entities for disclosure.

9.6 Related bodies

A related body is a body which receives more than half its funding and resources from the Health Service and is subject to operational control by the Health Service.

The Health Service had no related bodies during the financial year.

9.7 Affiliated bodies

An affiliated body is a body which receives more than half its funding and resources from the Health Service but is not subject to operational control by the Health Service.

The Health Service had no affiliated bodies during the financial year.

9.8 Special purpose accounts

Mental Health Commission Fund (South Metropolitan Health Service) Account

The purpose of the special purpose 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 South Metropolitan Health Service, in accordance with the annual Service Agreement and subsequent agreements.

	2025 $'000	2024 $'000
Balance at start of period	-	2,204
Add receipts		
Service delivery arrangement:		
Commonwealth contributions	64,562	59,398
State contributions	180,424	134,248
	244,986	**193,646**
Payments	(244,473)	(195,850)
Balance at end of period	**513**	**-**

9.9 Remuneration of auditors

Remuneration paid or payable to the Auditor General in respect of the audit is as follows:

Auditing the accounts, controls, financial statements and key performance indicators	469	430
	469	**430**

9.10 Equity

Contributed 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.

	2025 $'000	2024 $'000
Balance at start of period	2,723,512	2,664,915
Contribution by owners [a]		
Capital Appropriations administered by Department of Health	77,241	58,597
	77,241	**58,597**
Distributions to owners [a] [b] [c] [d]		
Transfer of net assets (other than cash) to other agencies [d]	-	-
Total contribution by owners	**-**	**-**
Balance at end of period	**2,800,753**	**2,723,512**

(a) TI 8 - Requirement 8 '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'.

(b) 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 8 - Requirement 8 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.

(c) TI 8 - Requirement 8 requires non-reciprocal transfers of net assets to Government to be accounted for as distribution to owners in accordance with AASB Interpretation 1038.

(d) Transfer of net assets (other than cash) to other agencies.

Reserves

Asset revaluation reserve [a]		
Balance at the start of period	577,769	473,200
Net revaluation increments/(decrements) [b]*:*		
Land	20,922	4,215
Buildings	382,207	100,354
Balance at end of period	**980,898**	**577,769**

(a) The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets.

(b) Any increment is credited directly to the asset revaluation reserve, except to the extent that any increment reverses a revaluation decrement previously recognised as an expense.

9.10 Equity (continued)

Accumulated surplus

	2025 $'000	2024 $'000
Accumulated surplus/(deficit)		
Balance at start of period	(60,898)	(16,799)
Result for the period	(55,485)	(44,099)
Balance at end of period	**(116,383)**	**(60,898)**

9.11 Supplementary financial information

(a) Revenue, public and other property written off

Revenue and debts written off under the authority of the Accountable Authority	3,908	3,403
Revenue and debts written off under the authority of the Minister	251	2,710
Public and other property written off under the authority of the Accountable Authority	76	29
Public and other property written off under the authority of the Minister	-	-
	4,235	**6,142**

(b) Forgiveness of Debts

Forgiveness (or waiver) of debts by the Health Service	1,019	87
	1,019	**87**

(c) Losses of public monies and other property

The Health Service did not incur losses of public monies or other property during the financial year.

(d) Gifts of public property

The Health Service did not provide gifts of public property during the financial year.

10. Explanatory statement

This section explains variations in the financial performance of the Health Service undertaking transactions under its own control, as represented in the primary financial statements.

	Notes
Explanatory statement for controlled operations	10.1

All variances between annual estimates (original budget) and actual results for 2025, and between the actual results for 2025 and 2024 are shown below. Narratives are provided for key major variances which vary more than 10 per cent from their comparative and that the variation is more than 1 per cent of the following variance analyses for the:

1. Estimate and actual results for the current year
   - Total cost of services of the estimate for the Statements of comprehensive income and Statement of cash flows (i.e. 1% of $2,615.755 million)
   - Total assets of the estimate for the Statement of Financial Position (i.e. 1% of $3,896.086 million)
2. Actual results for the current year and the prior year actual
   - Total cost of services of the previous year for the Statements of comprehensive income and Statement of cash flows (i.e. 1% of $2,546.466 million)
   - Total assets of the previous year for the Statement of Financial Position (i.e. 1% of $3,789.896 million)

10.1.1 Statement of Comprehensive Income Variances

	Variance Notes	Estimate 2025 $'000	Actual 2025 $'000	Actual 2024 $'000	Variance between actual and estimate $'000	Variance between actual results for 2024 and 2025 $'000
COST OF SERVICES						
Expenses						
Employee benefits expense	1	1,632,302	1,809,386	1,505,950	177,084	303,436
Fees for contracted medical practitioners		14,700	32,210	13,560	17,510	18,650
Contracts for services	2	28,100	32,016	160,984	3,916	(128,968)
Patient support costs	3	467,740	510,789	428,489	43,049	82,300
Finance costs		1,018	3,408	1,225	2,390	2,183
Depreciation and amortisation expense		88,838	96,787	91,966	7,949	4,821
Loss on disposal of non-current assets		-	-	-	-	-
Repairs, maintenance and consumable equipment		64,427	81,398	69,643	16,971	11,755
Other supplies and services		70,177	79,295	68,167	9,118	11,128
Other expenses	4	248,453	248,298	206,482	(155)	41,816
Total cost of services		**2,615,755**	**2,893,595**	**2,546,466**	**277,840**	**347,129**
INCOME						
Revenue						
Patient charges		113,923	114,735	106,718	812	8,017
Other fees for services		109,092	108,225	94,332	(867)	13,893
Commonwealth grants and contributions		-	4,320	3,407	4,320	913
Other grants and contributions		426	3,780	2,235	3,354	1,545
Donation revenue		44	8,273	785	8,229	7,488
Interest revenue		-	23	19	23	4
Commercial activities		-	444	(90)	444	534
Other revenue		25,088	23,239	22,352	(1,849)	887
Total revenue		**248,573**	**263,039**	**229,758**	**14,466**	**33,281**
Gains						
Gain on disposal of non-current assets		-	-	66	-	(66)
Gain on revaluation		-	-	-	-	-
Total gains		**-**	**-**	**66**	**-**	**(66)**
Total income other than income from State Government		**248,573**	**263,039**	**229,824**	**14,466**	**33,215**
NET COST OF SERVICES		**2,367,182**	**2,630,556**	**2,316,642**	**263,374**	**313,914**
INCOME FROM STATE GOVERNMENT						
Department of Health - Service agreement	5	2,035,256	2,174,980	1,938,929	139,724	236,051
Mental Health - Service agreement	6	195,486	244,474	193,646	48,988	50,828
Income from other state government agencies		14,526	19,194	24,311	4,668	(5,117)
Assets (transferred)/assumed		-	877	10	877	867
Services received free of charge		124,368	135,546	115,647	11,178	19,899
Total income from State Government		**2,369,636**	**2,575,071**	**2,272,543**	**205,435**	**302,528**
Surplus/(deficit) for the period		**2,454**	**(55,485)**	**(44,099)**	**(57,939)**	**(11,386)**
Other comprehensive income						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve		**-**	403,129	104,569	403,129	298,560
Total other comprehensive income		**-**	**403,129**	**104,569**	**403,129**	**298,560**
Total comprehensive income for the period		**2,454**	**347,644**	**60,470**	**345,190**	**287,174**

Major variance narratives

Variances between estimate and actual results for 2025

1. Employee benefits expense

During the 2024–25 financial year, SMHS experienced several operational changes that significantly impacted employee benefit expenses and the categorisation of financial data. A key driver was the transition of PHC from RHC to SMHS, effective 13 August 2024, which resulted in nearly 1,100 staff joining the WA Health system, along with a government commitment to honour existing entitlements such as long service leave.
Additional staffing requirements were driven by the staged opening of 75 beds at the Cockburn Mental Health Facility and the expansion of 80 inpatient beds at the Murdoch Medihotel adjacent to Fiona Stanley Hospital. These developments, combined with renegotiated industrial agreements that increased pay scales and leave liabilities, contributed to higher employee benefit costs. SMHS also expanded services to support earlier patient discharge and responded to rising activity levels by increasing staffing to maintain safe and effective care. Annual actuarial revaluations of outstanding leave obligations further added to the overall growth in employee benefit provisions.

6. Mental Health Service Agreement

Increased funding levels were obtained from the Mental Health Commission largely due to the higher activities levels from opening of the new Cockburn Mental Health Facility.

Variances between actual results for 2025 and 2024

1. Employee benefits expense

Refer point 1 above.

2. Contract for Services

The $129.0 million decrease is primarily due to the transition of operational responsibility for PHC from RHC to SMHS, effective 13 August 2024. Prior to this date, costs associated with PHC were recorded under the privatised service delivery contract category, holding payments made to RHC for service provision. Following the transition, these costs are now reflected across other expense categories, including employee benefits and patient support services, as SMHS assumed direct responsibility for service delivery. This shift in accounting treatment shows the structural change in service management and aligns with the broader financial reporting framework of the WA health system.

3. Patient support costs

The $82.3 million increase in patient support costs compared to the previous financial year is largely attributable to the transition of operational responsibility for PHC to SMHS. This change, effective 13 August 2024, resulted in $42.0 million in direct costs now being recognised under patient support services, following the shift from contracted service payments to internal operational expenses. The remaining increase is driven by the continued growth in service delivery across SMHS, as the organisation expands its capacity to meet rising healthcare demands and maintain high standards of patient care.

4. Other Expenses

Expenses increased by $41.8 million compared to the 2023-24 financial year. The significant increases were noted in HSS shared services costs $16.4 million, Facilities Management $12.0 million, and Insurances charges $10.0 million to address business changes due to the PHC transition, establishment of the new Cockburn and Medihotel facilities and general cost growth.

5. Department of Health - Service agreement

Funding received through the Department of Health (DoH) service agreement increased by $236.1 million compared to the previous financial year. This uplift reflects the State Government's commitment to supporting key operational and workforce changes across SMHS. The additional funding accommodated the financial impact of revised industrial agreement pay rates, the integration of PHC into SMHS and WA Health systems, and the associated recognition of long service leave entitlements for transitioning RHC staff. It also supported the commissioning of new beds at the Murdoch Medihotel, and broader growth in inpatient and outpatient activity across the health service.

6. Mental Health Service Agreement

Funding from the Mental Health Commission grew to enable the set-up and delivery of higher activity levels largely from the opening of the new Cockburn Mental Health Facility.

10.1.2 Statement of Financial Position Variances

	Variance Notes	Estimate 2025 $'000	Actual 2025 $'000	Actual 2024 $'000	Variance between actual and estimate $'000	Variance between actual results for 2024 and 2025 $'000
ASSETS						
Current assets						
Cash and cash equivalents		109,681	66,908	77,563	(42,773)	(10,655)
Restricted cash and cash equivalents		27,193	27,148	27,193	(45)	(45)
Receivables		44,647	51,716	51,312	7,069	404
Inventories		7,219	8,597	7,219	1,378	1,378
Other current assets		5,171	6,480	5,171	1,309	1,309
Total current assets		**193,911**	**160,849**	**168,458**	**(33,062)**	**(7,609)**
Non-current assets						
Restricted cash and cash equivalents		-	-	-	-	-
Receivables		43,748	43,748	33,748	-	10,000
Amounts receivable for services		1,389,314	1,391,976	1,300,476	2,662	91,500
Property, plant and equipment	7	2,189,356	2,654,937	2,192,229	465,581	462,708
Service concession assets	8	66,911	-	69,178	(66,911)	(69,178)
Right-of-use assets	9	11,248	59,585	21,430	48,337	38,155
Intangible assets		1,598	2,588	4,377	990	(1,789)
Total non-current assets		**3,702,175**	**4,152,834**	**3,621,438**	**450,659**	**531,396**
Total assets		**3,896,086**	**4,313,683**	**3,789,896**	**417,597**	**523,787**
LIABILITIES						
Current liabilities						
Payables		137,974	136,409	137,973	(1,565)	(1,564)
Contract liabilities		303	278	303	(25)	(25)
Grant liabilities		4,330	10	4,330	(4,320)	(4,320)
Lease liabilities		4,121	10,287	7,461	6,166	2,826
Provisions	10	326,287	356,655	297,887	30,368	58,768
Other current liabilities		2,326	412	2,325	(1,914)	(1,913)
Total current liabilities		**475,341**	**504,051**	**450,279**	**28,710**	**53,772**
Non-current liabilities						
Contract liabilities		-	-	-	-	-
Lease liabilities	11	11,686	52,084	15,131	40,398	36,953
Provisions		88,703	92,280	84,103	3,577	8,177
Total non-current liabilities		**100,389**	**144,364**	**99,234**	**43,975**	**45,130**
Total liabilities		**575,730**	**648,415**	**549,513**	**72,685**	**98,902**
NET ASSETS		**3,320,356**	**3,665,268**	**3,240,383**	**344,912**	**424,885**
EQUITY						
Contributed equity		2,801,032	2,800,753	2,723,512	(279)	77,241
Reserves		577,769	980,898	577,769	403,129	403,129
Accumulated surplus/(deficit)		(58,445)	(116,383)	(60,898)	(57,938)	(55,485)
TOTAL EQUITY		**3,320,356**	**3,665,268**	**3,240,383**	**344,912**	**424,885**

South Metropolitan Health Service
Notes to the Financial Statements
For the year ended 30 June 2025

Major variance narratives

Variances between estimate and actual results for 2025

7. Property, plant and equipment

The large change in asset values this year was mainly due to a revaluation of land and buildings by Landgate, updates to accounting rules, and the transition of PHC to SMHS.
Landgate's revaluation added $142.4 million, reflecting the property market situation and rising construction costs.
An additional $261.4M was recognised after changes to accounting standards clarified that project management and professional fees should be included in the building values, especially as these were not captured by Landgate in the revaluation processes.
The PHC transition also led to $69.2 million in reclassification from the Service Concession Assets line.

8. Service concession assets

Since 13 August 2025 operational responsibility for service delivery at the PHC was transitioned from the RHC to SMHS. This change also resulted in the re-classification of the underlying assets to the 'Property, plant and equipment' line at $69.2 million.

9. Right-of-use assets

In line with accounting standards, this category reflects leased assets used by SMHS, including new leases negotiated by DOH, for the Cockburn Mental Health Facility and Murdoch Medihotel, totalling $50.4 million as at 30 June 2025. A smaller lease was also established for additional parking at FSH, while ongoing payments reduced existing obligations from the original 2014–15 FSH hospital build.

11. Lease liabilities

The issues outlined in point 9, also explain the non-current lease liabilities variations. This line item shows the lease obligations that extend beyond a 12 month period.

Variances between actual results for 2025 and 2024

7. Property, plant and equipment

Refer point 7 above.

8. Service concession assets

Refer point 8 above.

9. Right-of-use assets

Refer point 9 above.

10. Provisions

Employee benefit provisions across SMHS continued to rise during the year, with current liabilities increasing by $58.8 million and non-current liabilities by $8.2 million. This growth was primarily driven by several key factors:

- Repricing of outstanding leave balances following the renegotiation of industrial agreements, resulting in an uplift of $18.5 million.
- Higher staff leave balances, contributing $33.9 million to the increase in provisions. This reflects expanded staffing numbers to support the transition of PHC and the commissioning of new facilities at Cockburn and Murdoch.
- Application of future value assessments in line with Australian accounting standards, which added a further $14.0 million to the provisions.

These changes highlight the financial impact of workforce expansion and associated leave obligations across the organisation.

11. Lease liabilities

Refer point 11 above.

10.1.3 Statement of Cash Flows Variances

	Variance Notes	Estimate 2025 $'000	Actual 2025 $'000	Actual 2024 $'000	Variance between actual and estimate $'000	Variance between actual results for 2024 and 2025 $'000
CASH FLOWS FROM STATE GOVERNMENT						
Revenues from State Government Agencies	12	2,156,430	2,345,198	2,076,537	188,768	268,661
Capital appropriations administered by Department of Health		77,520	77,241	58,597	(279)	18,644
Net cash provided by State Government		**2,233,950**	**2,422,439**	**2,135,134**	**188,489**	**287,305**
Utilised as follows:						
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits	13	(1,599,302)	(1,726,486)	(1,462,040)	(127,184)	(264,446)
Supplies and services	14	(762,564)	(862,777)	(815,892)	(100,213)	(46,885)
Finance costs		(1,018)	-	-	1,018	-
Receipts						
Receipts from customers		113,923	106,489	99,611	(7,434)	6,878
Commonwealth grants and contributions		-	-	-	-	-
Other grants and contributions		426	3,780	2,234	3,354	1,546
Donations received		44	1,660	785	1,616	875
Interest received		-	23	19	23	4
Other receipts		134,180	131,597	124,086	(2,583)	7,511
Net cash used in operating activities		**(2,114,311)**	**(2,345,714)**	**(2,051,197)**	**(231,403)**	**(294,517)**
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
27th pay contribution		(10,000)	(10,000)	(5,000)	-	(5,000)
Payment for purchase of non-current physical and intangible assets		(70,735)	(63,790)	(47,385)	6,945	(16,405)
Receipts						
Proceeds from sale of non-current physical assets			-	105	-	(105)
Net cash used in investing activities		**(80,735)**	**(73,790)**	**(52,280)**	**6,945**	**(21,510)**
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Repayment of lease liabilities		(6,785)	(13,635)	(12,000)	(6,850)	(1,635)
Net cash used in financing activities		**(6,785)**	**(13,635)**	**(12,000)**	**(6,850)**	**(1,635)**
Net increase/(decrease) in cash and cash equivalents	15	32,119	(10,700)	19,657	(42,819)	(30,357)
Cash and cash equivalents at the beginning of the year		104,755	104,756	85,099	1	19,657
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**136,874**	**94,056**	**104,756**	**(42,818)**	**(10,700)**

Major variance narratives

Variances between estimate and actual results for 2025

14. Supplies and services

The initial 2024–25 budget did not account for the activity growth and business costs realised at the end of 2023–24 ($46.9 million), nor for key developments in 2024-25, including the PHC transition ($18.2 million), the opening of new facilities at Cockburn and Murdoch ($24.8 million), and the increase in outpatient services. As outlined in point 13, these changes led to one-off setup costs and increased patient activity, driving higher service delivery expenses. Additionally, the new facilities at Cockburn and Murdoch are supported by external lease arrangements that were factored in the original budget or prior year figures.

15. Net increase/(decrease) in cash and cash equivalents

Despite substantial government support for overall operational costs, funding gaps remained. SMHS's cash position declined by $42.8 million, requiring the use of cash reserves to offset the shortfall. The cash deficit was primarily driven by activity levels exceeding targets and the financial impact of updated industrial agreements, which placed additional pressure on available resources.

Variances between actual results for 2025 and 2024

12. Revenues from State Government Agencies

Funding through the Department of Health (DoH) service agreement increased by $268.7 million, or 13%, compared to the previous year. This increase accommodated the transition of the PHC, the opening of new beds at the Medithotel, the general increase in inpatient and outpatient activity, wage price and CPI cost increases.

13. Employee Benefits

Refer to explanation at point 1. The increase in employee benefits during 2024–25 was driven by the transition of PHC to SMHS, the opening of beds at the Cockburn Mental Health Facility and Murdoch Medihotel, higher pay rates from industrial agreement updates, and rising activity levels requiring additional staffing to maintain safe care.

15. Net increase/(decrease) in cash and cash equivalents

Refer point 15 above.

Certification of key performance indicators

South Metropolitan Health Service

Certification of key performance indicators for the year ended 30 June 2025

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

Adjunct Associate Professor
Robyn Collins
Board Chair
South Metropolitan Health Service
22 August 2025

Mr Liam Roche
Board member
South Metropolitan Health Service
22 August 2025

Key performance indicators

For the year ended 30 June 2025

Key performance indicators

Unplanned hospital readmissions for patients within 28 days for selected surgical procedures: (a) knee replacement; (b) hip replacement; (c) tonsillectomy and adenoidectomy; (d) hysterectomy; (e) prostatectomy; (f) cataract surgery; (g) appendicectomy
Percentage of elective wait list patients waiting over boundary for reportable procedures (a) % Category 1 over 30 days (b) % Category 2 over 90 days (c) % Category 3 over 365 days
Healthcare-associated Staphylococcus aureus bloodstream infections (HA-SABSI) per 10,000 occupied bed-days
Survival rates for sentinel conditions: (a) Stroke; (b) Acute Myocardial Infarction; (c) Fractured Neck of Femur
Percentage of admitted patients who discharged against medical advice: a) Aboriginal patients; and b) Non-Aboriginal patients
Percentage of live-born term infants with an Apgar score of less than 7 at 5 minutes post delivery
Readmissions to acute specialised mental health inpatient services within 28 days of discharge
Percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services
Average admitted cost per weighted activity unit
Average Emergency Department cost per weighted activity unit
Average non-admitted cost per weighted activity unit
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
Average cost per person of delivering population health programs by population health units

OUTCOME 1 – EFFECTIVENESS KPI

Unplanned hospital readmissions for patients within 28 days for selected surgical procedures: (a) knee replacement; (b) hip replacement; (c) tonsillectomy and adenoidectomy; (d) hysterectomy; (e) prostatectomy; (f) cataract surgery; (g) appendicectomy

Rationale

Unplanned hospital readmissions may reflect less than optimal patient management and ineffective care pre-discharge, post-discharge and/or during the transition between acute and community-based care[1]. These readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

Readmission reduction is a common focus of health systems worldwide as they seek to improve the quality and efficiency of healthcare delivery, in the face of rising healthcare costs and increasing prevalence of chronic disease.[2]

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

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

Target

The target is represented as the upper limit per 1,000 separations. Improved or maintained performance is demonstrated by a result below or equal to the target.

Results

For the period January to December 2024, SMHS unplanned readmission rates for selected surgical procedures are presented in Table 6.

Unplanned readmissions are monitored at monthly safety and quality performance meetings. For procedures where the target is not met, case reviews are undertaken with the outcomes discussed in order to identify any system issues that may require improvement.

Knee replacement

The readmission rate for knee replacement increased in 2024 and was above the target. The majority of readmissions were related to post operative pain and infection, with individual case reviews not identifying any system issues in the delivery of care.

Hip replacement

The readmission rate for hip replacement increased in 2024 but remains well below the target.

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

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

Tonsillectomy and adenoidectomy

The readmission rate for tonsillectomy and adenoidectomy (T&A) was unchanged from 2023 and remains above the target. Individual case reviews of readmissions demonstrated that the majority related to known complications including post-operative bleeding and pain management, with patients returning to hospital in line with discharge planning advice.

Hysterectomy

The hysterectomy readmission rate in 2024 was the lowest rate for five years and was within the target.

Prostatectomy

The readmission rate for patients undergoing prostatectomy has reduced in 2024 and was within the target.

Cataract

The readmission rate for cataract surgery in 2024 was within the target, with the lowest rate in four years.

Appendicectomy

The readmission rate for appendicectomy has reduced in 2024 and was within the target.

Table 6. Rate of unplanned readmissions within 28 days for selected surgical procedures

	Calendar year					
Surgical Procedure	**2020 actual (per 1,000)**	**2021 actual (per 1,000)**	**2022 actual (per 1,000)**	**2023 actual (per 1,000)**	**2024 actual (per 1,000)**	**Target (per 1,000)**
Knee replacement	7.9	10.7	10.7	15.8	23.1	≤21.0
Hip replacement	21.8	12.6	20.9	3.8	8.9	≤19.4
Tonsillectomy & adenoidectomy	93.3	69.8	91.4	99.4	99.4	≤84.4
Hysterectomy	47.1	24.8	23.3	42.3	20.7	≤45.8
Prostatectomy	44.9	29.3	16.9	35.2	25.9	≤40.0
Cataract surgery	0.5	2.8	2.4	0.8	0.6	≤2.3
Appendicectomy	30.9	19.0	16.9	24.1	17.0	≤29.7

Data source: Hospital Morbidity Data Collection.

Note: As these are calendar KPIs, the latest and most up to date information reported refers to the 2024 calendar year results.

OUTCOME 1 – EFFECTIVENESS KPI

Percentage of elective wait list patients waiting over boundary for reportable procedures (a) % Category 1 over 30 days (b) % Category 2 over 90 days (c) % Category 3 over 365 days

Rationale

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

Elective surgical services delivered in the WA health system are those deemed to be clinically necessary. Excessive waiting times for these services can lead to deterioration of the patient's condition and/or quality of life, or even death[3]. Waiting lists must be actively managed by hospitals to ensure fair and equitable access to limited services, and that all patients are treated within clinically appropriate timeframes.

Patients are prioritised based on their assigned clinical urgency category:

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

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

Target

The target requires that no patients (0 per cent) on elective waiting lists for reportable procedures wait longer than the clinically recommended time, according to their urgency category.

Results

During 2024-25, SMHS continued to work towards reducing over boundary cases and improve the timeliness of treatment for elective surgery waitlisted patients.

The improvement on last year's results was achieved through proactive management of elective waitlist patients. Innovative internal and external solutions continue to be implemented to reduce over boundary cases across all urgency categories.

Physical theatre capacity is a key constraint to reducing the number of cases on the elective surgery waitlist.

Table 7. Percentage of elective wait list patients waiting over boundary for reportable procedures

	2020-21 actual (%)	2021-22 actual (%)	2022-23 actual (%)	2023-24 actual (%)	2024-25 actual (%)	Target (%)
Urgency category 1	11.2	30.5	37.9	37.0	33.6	0
Urgency category 2	10.9	29.2	38.5	37.7	34.7	0
Urgency category 3	4.6	10.7	24.4	19.2	19.0	0

Data source: Elective Services Wait List Data Collection.

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

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 per cent[4].)

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 target is an infection rate of ≤1.0 per 10,000 occupied bed days in public hospitals.

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

Results

The rate of HA-SABSI decreased to 0.8 per 10,000 occupied bed days in 2024, which is a reduction on the previous year and within the target.

Continuing to drive performance at SMHS has been the successful application of quality improvement methodologies with a focus on minimising the transmission of infection in clinical areas.

Table 8. Hospital infection rate

	Calendar year					
	2020	2021	2022	2023	2024	Target
Infection rate per 10,000 bed days	1.1	1.3	1.0	1.0	0.8	≤1.0

Data source: Healthcare Infections Surveillance WA Data Collection (HISWA).

Note: As these are calendar KPIs, the latest and most up to date information reported refers to the 2024 calendar year results.

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

Survival rates for sentinel conditions: (a) Stroke; (b) Acute Myocardial Infraction; (c) Fracture Neck of Femur

Rationale

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

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

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

Target

The target is based on the state average result for the previous five calendar years excluding the most recent calendar year.

An improved or maintained performance is demonstrated by a result exceeding or equal to the target.

The following table illustrates the target for each condition by age group.

	Sentinel conditions		
Age group (years)	**Stroke (%)**	**AMI (%)**	**FNOF (%)**
0–49	≥95.4	≥98.9	Not reported
50–59	≥94.8	≥98.8	Not reported
60–69	≥94.5	≥98.2	Not reported
70–79	≥92.6	≥97.0	≥98.8
80+	≥87.6	≥93.1	≥97.3

Note: The FNOF KPI only reports against two aged groups being 70-79 and 80+ years.

Results

A review is undertaken of all in-hospital deaths, including those resulting from stroke, AMI or FNOF, in order to determine if the care delivered to patients was appropriate or could have been delivered differently, and to identify any areas for improvement.

The survival rate for patients diagnosed with stroke was above the target indicating good performance in all areas, including the 80+ years age group which improved in 2024 compared with the previous year.

Table 9. Survival rate for stroke, by age group

	Calendar year					
Age group (years)	**2020 (%)**	**2021 (%)**	**2022 (%)**	**2023 (%)**	**2024 (%)**	**Target (%)**
0–49	97.7	98.4	97.7	99.1	99.3	≥95.4
50–59	96.8	97.6	96.3	95.4	98.6	≥94.8
60–69	95.6	97.1	97.0	96.7	96.2	≥94.5
70–79	91.7	95.3	94.8	95.4	93.8	≥92.6
80+	88.6	86.1	88.5	85.1	87.7	≥87.6

Data source: Hospital Morbidity Data Collection.

Note: As these are calendar KPIs, the latest and most up to date information reported refers to the 2024 calendar year results.

The survival rate for patients diagnosed with AMI exceeded the target in the 0–49 and 70–79 years age groups; this is an improvement on the preceding year.

In the 50–59, 60–69 and 80+ years age groups, survival rates were slightly below the target in 2024. Factors impacting survival in the 50–59 age group were late presentation to hospital and pre-existing conditions including diabetes and hypertension. A number of deaths in the 60–69 age group were as a result of out of hospital cardiac arrests. The outcomes for this group and the 80+ age group were also complicated by a range of patient co-morbidities including cardiac and respiratory disease and diabetes.

Table 10. Survival rate for acute myocardial infarction, by age group

	Calendar year					
Age group (years)	**2020 (%)**	**2021 (%)**	**2022 (%)**	**2023 (%)**	**2024 (%)**	**Target (%)**
0–49	98.6	98.3	99.1	97.7	99.1	≥98.9
50–59	99.3	98.8	97.2	99.2	98.7	≥98.8
60–69	97.3	97.8	97.5	97.7	97.0	≥98.2
70–79	97.6	97.5	97.1	96.6	97.4	≥97.0
80+	93.7	94.8	96.9	93.4	92.2	≥93.1

Data source: Hospital Morbidity Data Collection.

Note: As these are calendar KPIs, the latest and most up to date information reported refers to the 2024 calendar year results.

The survival rate for patients admitted with FNOF was above the target for the 70–79 years age group with a 100 per cent survival rate, which remains unchanged from 2023. The 80+ years age group survival was below the target at 94.6 per cent. For many of these elderly patients, their recovery was complicated by co-morbidities including cancer, respiratory and cardiac disease.

Table 11. Survival rate for fractured neck of femur, by age group

	Calendar year					
Age group (years)	**2020 (%)**	**2021 (%)**	**2022 (%)**	**2023 (%)**	**2024 (%)**	**Target (%)**
70–79	99.4	98.1	98.5	100.0	100.0	≥98.8
80+	99.4	97.6	98.2	95.2	94.6	≥97.3

Data source: Hospital Morbidity Data Collection.

Note: As these are calendar KPIs, the latest and most up to date information reported refers to the 2024 calendar year results.

OUTCOME 1 – EFFECTIVENESS KPI

Percentage of admitted patients who discharged against medical advice: a) Aboriginal patients; and b) Non-Aboriginal patients

Rationale

Discharge against medical advice (DAMA) refers to patients leaving hospital against the advice of their treating medical team or without advising hospital staff, e.g. take own leave, left without notice, or missing and not found. Patients who do so have a higher risk of readmission and mortality[5] and have been found to cost the health system 50 per cent more than patients who are discharged by their physician.[6]

The national *Aboriginal and Torres Strait Islander Health Performance Framework* reports discharge at own risk under the heading 'Self-discharge from hospital'. Between July 2019 and June 2021 Aboriginal patients (4.4 per cent) in WA were 7.5 times more likely than non-Aboriginal patients (0.6 per cent) to discharge at own risk, compared with 5.2 times nationally (3.8 per cent and 0.7 per cent respectively)[7]. This statistic indicates a need for improved responses by the health system to the needs of Aboriginal patients. This indicator is also being reported in the *Report on Government Services 2024* under the performance of governments in providing actuate care services in public hospitals[8].

This indicator provides a measure of the safety and quality of inpatient care. Reporting the results by Aboriginal status measures the effectiveness of initiatives within the WA health system to deliver culturally secure services to Aboriginal people.

While the aim is to achieve equitable treatment outcomes, the targets reflect the need for a long-term approach to progressively closing the gap between Aboriginal and non-Aboriginal patient cohorts.

Discharge against medical advice performance measure is also one of the key contextual indicators of Outcome 1 "Aboriginal and Torres Strait Islander people enjoy long and healthy lives" under the new *National Agreement on Closing the Gap*, which was agreed to by the Coalition of Aboriginal and Torres Strait Islander Peak Organisations, and all Australian Governments in July 2020[9].

Target

The target for Aboriginal patients is less than or equal to 2.78 per cent. This target is based on a 50 per cent reduction in the gap between performance for WA Aboriginal and non-Aboriginal patients from the period of 2016–17 to 2017–18.

The target for non-Aboriginal patients is less than or equal to 0.99 per cent and is based on the national performance for non-Aboriginal patients over the 2016–17 to 2017–18 period, as provided by the Australian Institute of Health and Welfare.

An improved or maintained performance is demonstrated by a result below or equal to the target.

5 Yong et al. Characteristics and outcomes of discharges against medical advice among hospitalised patients. Internal medicine journal 2013:43(7):798-802.

6 Aliyu ZY. Discharge against medical advice: sociodemographic, clinical and financial perspectives. International journal of clinical practice 2002:56(5):325-27.

7 Australia Institute of Health and Welfare (2024) Measure 3.09 Self-discharge from hospital data visualisation, Aboriginal and Torres Strait Islander Health Performance Framework website, accessed date. Available at: https://www.indigenoushpf.gov.au/measures/3-09-discharge-against-medical-advice

8 For more information see 12 Public hospitals - Report on Government Services 2023 - Productivity Commission (pc.gov.au)

9 https://www.closingthegap.gov.au/national-agreement

Results

The SMHS rate of non-Aboriginal DAMA remained unchanged from last year and was within the target at 0.70 per cent.

The rate of DAMA for Aboriginal patients was 3.80 per cent, which is above target and a slight increase on last year. SMHS sites continue to support individual patient early discharge decision making by ensuring that patients have appropriate services in place in the community prior to discharge. The *SMHS DAMA Policy* was also revised in 2024 to provide further guidance to staff around responding proactively to all patients who request early discharge.

The multidisciplinary SMHS Aboriginal Access Working Group continues to progress interventions focused on improving Aboriginal patient service access across all sites. One of the priority areas in 2024 was the establishment of Aboriginal Health Practitioner positions in high priority clinical areas to better support Aboriginal patients and their families, with a plan to expand the coverage of Aboriginal support staff to 24 hours in some areas. Additionally, the introduction of an Aboriginal Health Training Coordinator role in 2025 will ensure SMHS staff are provided with the knowledge and skills to deliver culturally safe care to Aboriginal people accessing our sites and services.

Table 12. Percentage of patients who discharge against medical advice

	Calendar year					
	2020 (%)	2021 (%)	2022 (%)	2023 (%)	2024 (%)	Target (%)
Aboriginal	3.59	3.07	3.80	3.50	3.80	≤2.78
Non-Aboriginal	0.71	0.72	0.80	0.70	0.70	≤0.99

Data source: Hospital Morbidity Data Collection.

Note: As these are calendar KPIs, the latest and most up to date information reported refers to the 2024 calendar year results.

Percentage of live-born term infants with an Apgar score of less than 7 at 5 minutes post delivery

Rationale

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

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

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

Target

An Apgar score of less than seven at five minutes after birth is considered to be an indicator of complications and compromise for the infant.

The target for live born infants with an Apgar score of seven or less at five minutes post-delivery is less than or equal to 1.9 per cent and is based on the national average from the Australian Institute of Health and Welfare publication '*Australian's mothers and babies*'. In 2024–25 the target is the 2021 national figure.

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

Results

SMHS continues to perform well, with the percentage of live born term infants with an Apgar score below seven remaining well within target at 1.0 per for the past five years.

Table 13. Percentage of live-born term infants with an Apgar score of less than seven, five minutes post-delivery

	Calendar year					
	2020 (%)	2021 (%)	2022 (%)	2023 (%)	2024 (%)	Target (%)
Percentage of live born infants	1.0	1.0	1.2	1.0	1.0	≤1.9

Data source: Midwives Notification System.

Note: As these are calendar KPIs, the latest and most up to date information reported refers to the 2024 calendar year results.

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

Rationale

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

While multiple hospital admissions over a lifetime may be necessary for someone with ongoing illness, a high proportion of readmissions shortly after discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was not adequate to maintain the patient's recovery out of hospital[10]. Rapid readmissions place pressure on finite beds and may reduce access to care for other consumers in need.

These readmissions mean that patients spend additional time in hospital and utilise additional resources. A low readmission rate suggests that good clinical practice is in operation. Readmissions are attributed to the facility at which the initial separation (discharge) occurred rather than the facility to which the patient was readmitted.

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

Target

The target is less than or equal to 12 per cent. The source of the target is the *Fourth National Mental Health Plan Measurement Strategy* (May 2011) produced by the Mental Health Information Strategy Subcommittee, AHMAC, Mental Health Standing Committee.

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

Results

The SMHS rate of readmissions within 28 days to an acute specialised mental health inpatient unit was 14 per cent and above the target. This represents an improvement on the previous year and an overall reduction in the rate of mental health readmissions over the past five years.

The SMHS Mental Health service is maintaining a focus on improving discharge planning for patients and furthering partnerships with community services, to better support patients and their families following discharge and prevent readmission.

Table 14. Rate of Readmissions to acute specialised mental health inpatient services within 28 days of discharge

	Calendar year					
	2020 (%)	2021 (%)	2022 (%)	2023 (%)	2024 (%)	Target (%)
Readmissions rate	16	15	16	15	14	≤12

Data source: Hospital Morbidity Data System.

Note: As these are calendar KPIs, the latest and most up to date information reported refers to the 2024 calendar year results.

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

Percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services

Rationale

In 2022, one in four (6.6 million) Australians reported having a mental or behavioural condition[11]. Therefore, it is crucial to ensure effective and appropriate care is provided not only in a hospital setting but also in the community.

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

The standard underlying 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 target is ≥75 per cent.

The target is an endorsed value from the Australian Health Minister's Advisory Council Mental Health Standing Committee, in May 2011.

Improved or maintained performance is demonstrated by a result greater than or equal to the target.

Results

SMHS performance in relation to mental health patients receiving community follow up within seven days of discharge from hospital was at 88 per cent in 2024 and has remained within the target for five years.

Table 15. Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services

	Calendar year					
	2020 (%)	2021 (%)	2022 (%)	2023 (%)	2024 (%)	Target (%)
Post discharge community-based contact	82	82	86	88	88	≥75

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

Note: As these are calendar KPIs, the latest and most up to date information reported refers to the 2024 calendar year results.

11 National Health Survey 2022: National Health Survey, 2022 | Australian Bureau of Statistics

Service 1: Public Hospital Admitted Average admitted cost per weighted activity unit

Rationale

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

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

Target

The target is $7,899 per WAU.

A result on or below the target is desirable.

Results

In 2024–25, SMHS delivered admitted activity at a cost of $8,219 per WAU, exceeding both the previous year's rate and the target benchmark.

Although the cost per WAU was above target, its growth rate of 4.9 per cent remained below the combined impact of public sector wage indexation and the increase in the superannuation guarantee rate.

Additional cost pressures arose from the opening of the Medihotel at Fiona Stanley Hospital and the transition of Peel Health Campus into SMHS management. The Medihotel added 80 beds, expanding capacity, but the associated costs were not fully offset by revenue from increased activity.

Table 16. Average admitted cost per WAU

	2020–21 ($)	2021–22 ($)	2022–23 ($)	2023–24 ($)	2024–25 ($)	Target ($)
Average cost	6,638	7,399	7,619	7,837	8,219	7,899

Data source: Hospital Morbidity Data Collection, Oracle 11i financial system, Outcome Based Management Allocation Application.

Note: This key performance indicator includes Peel Health Campus.

Service 2: Public Hospital Emergency Services Average Emergency Department cost per weighted activity unit

Rationale

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

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

Target

The target is $7,777 per WAU.

A result on or below the target is desirable.

Results

In 2024–25, the cost per WAU was $8,284, exceeding the target set for the year. This represents a 3.8 per cent increase from the 2023–24 cost, remaining well below the wage indexation rate outlined in the Government's public sector wages policy, including the superannuation guarantee.

The 2024–25 target was deliberately set below the 2023–24 cost, despite anticipated award-related cost increases. This created a highly challenging benchmark that could not be met without compromising service quality and patient safety.

Inflationary pressures throughout 2024–25, combined with resource capacity constraints that limited activity growth, contributed to the higher-than-target cost per WAU. This outcome was expected under the prevailing conditions.

To maintain safe and accessible emergency department services, SMHS invested additional resources in 2024–25. This included the recruitment of extra medical and nursing staff to address priority response needs, manage increasing patient complexity, and ensure adequate staffing during periods of high furlough and elevated sick leave.

Table 17. Average Emergency Department cost per WAU

	2020–21 ($)	2021–22 ($)	2022–23 ($)	2023–24 ($)	2024–25 ($)	Target ($)
Average cost	6,520	7,534	7,509	7,983	8,284	7,777

Data source: Emergency Department Data Collection, Oracle 11i financial system, Outcome Based Management Allocation Application..

Note: This key performance indicator includes Peel Health Campus.

Service 3: Public Hospital Non-Admitted Services
Average non-admitted cost per weighted activity unit

Rationale

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

The measure ensures that a consistent methodology is applied to calculating and reporting the cost of delivering non-admitted activity against the State's funding allocation. Non-admitted services play a pivotal role within the spectrum of care provided to the WA public. Therefore, it is important that non-admitted service provision is monitored to ensure the efficient delivery of safe and high-quality care.

Target

The target is $7,903 per WAU.

A result on or below the target is desirable.

Results

For 2024–25, the cost per WAU for non-admitted activity remained below the target, driven by strong growth in activity despite significant inflationary pressures.

Compared to 2023–24, non-admitted services saw a notable increase, particularly in outpatient clinics, as elective surgeries rose to meet key performance indicators and growing demand. This expansion in activity was anticipated and successfully delivered.

As with other efficiency metrics, rising costs associated with public sector wage policy, the superannuation guarantee increases, and higher insurance premiums contributed to the overall cost of delivering non-admitted services. However, these pressures were effectively managed, keeping the cost within or below the expected range.

Table 18. Average non-admitted cost per WAU

	2020–21 ($)	2021–22 ($)	2022–23 ($)	2023–24 ($)	2024–25 ($)	Target ($)
Average cost	6,233	6,126	6,908	6,871	7,227	7,903

Data source: Non-Admitted Data Collection, Oracle 11i financial system, Outcome Based Management Allocation Application.

Note: This key performance indicator includes Peel Health Campus

Service 4: Mental Health Services
Average cost per bed-day in specialised mental health inpatient services

Rationale

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

Target

The target is $1,975 per bed-day in specialised mental health inpatient services.

A result on or below the target is desirable.

Results

SMHS delivered specialised mental health inpatient services at a cost per bed-day higher than the target rate. Several factors have contributed to this outcome and should be considered in assessing this measure.

Notably, the target rate decreased from the prior year, despite expectations of an increase. The Government's public sector wages policy and the increase in the superannuation guarantee rate added to the cost pressures.

A significant increase in patient complexity also contributed to higher costs. While WAU-based measures account for service complexity, the bed-day metric does not, limiting its effectiveness to reflect the true cost of care.

Additionally, the establishment of the Cockburn Mental Health facility introduced stepwise cost increases. As the service scaled up progressively, staffing and resources were required ahead of bed-day realisation. These costs were incurred at multiple points throughout the financial year, further impacting the cost per bed-day.

Table 19. Average cost per bed-day in specialised mental health inpatient units

	2020–21 ($)	2021–22 ($)	2022–23 ($)	2023–24 ($)	2024–25 ($)	Target ($)
Average cost per bed day	1,637	1,853	1,813	1,908	2,170	1,975

Data sources: Bed State, Oracle 11i financial system, Outcome Based Management Allocation Application.

OUTCOME 1 – EFFICIENCY KPI

Service 4: Mental Health Services
Average cost per treatment day of non-admitted care provided by mental health services

Rationale

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

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

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

Target

The target is $604 per treatment day of non-admitted care provided by mental health services.

A result on or below the target is desirable.

Results

The average cost per treatment day of non-admitted mental health care was higher than the target rate, however, has decreased when compared to 2023–24.

Despite inflationary cost pressures that impact service delivery, 6.4 per cent more treatment days were delivered compared to 2023–24.

As treatment days are not adjusted for patient complexity, this measure is also unreliable with regards to benchmarking against targets or across time.

Table 21. Average cost per treatment day of non-admitted care provided by mental health services

	2020–21 ($)	2021–22 ($)	2022–23 ($)	2023–24 ($)	2024–25 ($)	Target ($)
Average cost	476	581	660	663	642	604

Data sources: Mental Health Information Data Collection, Oracle 11i financial system, Outcome Based Management Allocation Application.

OUTCOME 2 – EFFICIENCY KPI

Service 6: Public and Community Health Services
Average cost per person of delivering population health programs by population health units

Rationale

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

Population health aims to improve health by integrating all activities of the health sector and linking them with broader social and economic services and resources as described in the *WA Health Promotion Strategic Framework 2022–202*6. 12 This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

The target is $18 per person of delivering health programs by population health units.

A result below the target is desirable.

Results

The cost per person of delivering health programs through population health units increased in 2024–25 compared to the previous year and remains above the target rate.

While this may appear unfavourable from a cost-efficiency perspective, increased investment in population health, particularly in preventative and educational programs, is generally viewed as a positive outcome. Such programs are widely considered a cost-effective strategy for reducing long-term health expenditure growth.

The rise in costs within this indicator is attributed to inflationary pressures and the inclusion of new program funding introduced during the 2024–25 financial year.

Table 22. Average cost per person of delivering programs by Population Health Units

	2020–21 ($)	2021–22 ($)	2022–23 ($)	2023–24 ($)	2024–25 ($)	Target ($)
Average cost per person	23	25	18	24	28	18

Data sources: 2024 calendar year population as projected by the Epidemiology Directorate, Public and Aboriginal Health Division, WA Department of Health; Oracle 11i financial system; OBM Allocation Application.

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

Governance and legal compliance

Ministerial directives

There were no ministerial directives received by SMHS during 2024–25.

Pricing policy

The *National Health Reform Agreement* sets the policy framework for the charging of public hospital fees and charges. Under the agreement, an eligible person who receives public hospital services as a public patient in a public hospital or a publicly contracted bed in a private hospital is treated 'free of charge'. This arrangement is consistent with the Medicare principles which are embedded in the *Health Services Act 2016 (WA)*. The majority of hospital fees and charges for public hospitals are set under *Schedule 1 of the Health Services (Fees and Charges) Order 2016* and are reviewed annually.

The following informs WA public hospital patients' fees and charges.

Nursing home type patients

The State charges public patients who require nursing care and/or accommodation after the 35th day of their stay in hospital, providing they no longer need acute care and they are deemed to be nursing home type patients. The total daily amount charged is no greater than 87.5 per cent of the current daily rate of the single aged pension and the maximum daily rate of rental assistance.

Compensable or Medicare ineligible patients

Patients who are either 'private' or 'compensable' and Medicare ineligible (overseas residents) may be charged an amount for public hospital services as determined by the State. The setting of compensable and Medicare ineligible hospital accommodation fees is set close to, or at, full cost recovery.

Private patients (Medicare eligible Australian residents)

The Commonwealth Department of Health regulates the minimum benefit payable by health funds to privately insured patients for private shared ward and same day accommodation. The Commonwealth also regulates the nursing home type patient 'contribution' based on March and September pension increases. To achieve consistency with the *Commonwealth Private Health Insurance Act 2007*, the State sets these fees at a level equivalent to the Commonwealth minimum benefit.

Veterans

Hospital charges of eligible war service veterans are determined under a separate Commonwealth-State agreement with the Department of Veterans' Affairs. Under this agreement, DoH does not charge medical treatment to eligible war service veteran patients; instead medical charges are fully recouped from the Department of Veterans' Affairs.

The following fees and charges also apply:

- The Pharmaceutical Benefits Scheme regulates and sets the price of pharmaceuticals supplied to outpatients, patients on discharge and for day admitted chemotherapy patients. Inpatient medications are supplied free of charge.
- The Dental Health Service charges to eligible patients for dental treatment are based on the Department of Veterans' Affairs Fee Schedule of dental services for dentists and dental specialists.

Eligible patients are charged the following co–payment rates:

- 50 per cent of the treatment fee if the patient holds a current Health Care Card or Pensioner Concession Card
- 25 per cent of the treatment fee if the patient is the current holder of one of the above cards and receives a near full pension or an allowance from Centrelink or the Department of Veterans' Affairs.

There are other categories of fees specified under Health Regulations through Determinations, which include the supply of surgically implanted prostheses, magnetic resonance imaging services and pathology services. The pricing for these hospital services is determined according to their cost of service.

Capital works

SMHS continues to facilitate re-modelling and development of health infrastructure within its area of responsibility.

Table 23. Capital works completed in 2024–25 financial year

Project	Total cost in 2024–25 $,000)
COVID-19 SMHS 24 beds	13,150
FSH Bridge Murdoch Medihotel	5,447
FSH ICT – Intensive Care Clinical Information Systems	4,200
FSH ICT Capital Replacement	39,300
PHC Development Stage 1	7,261

Table 24. Capital works in progress in 2024–25 financial year

Project	Estimated total cost in 2024–25 ($ '000)	Reported in 2023–24 ($ '000)	Variance ($ '000)	Expected completion year	Variation to cost explanation (>=10%)
Bethesda Health Care	2,700	2,700	0	Completed	
FSH Cladding [refer note (d)]	49,740	17,440	32,300	Ongoing	Funding revised
FSH Critical Works	6,253	6,253	0	2026	
FH Acute Mental Health Beds	63,780	63,780	0	2026	
PHC Transition	2,583	2,583	0	Completed	
PHC Reconfiguration of Emergency Department	4,927	4,927	0	Completed	
PHC Redevelopment	152,047	152,047	0	To be determined	
RGH Mental Health Emergency Centre	19,777	12,037	7,740	2028	Funding revised
Anti-Ligature Remediation Program	6,026	0	6,026	Ongoing	New project
Electronic Medical Record (EMR)	5,890	4,409	1,481	Ongoing	Funding revised
Installation of automated sprinkler system in Rockingham Peel Region	66	0	66	2026	New project
SMHS Safety, Fire Compliance and Critical Electrical Infrastructure	21,985	0	21,985	2028	New project
South Emergency Care Navigation Centre (previously VEM)	200	200	0	Completed	

Notes of relevance as footnote to tabular information above:

(a) The above information includes the Budgeted Expense Capital allocation.

(b) The allocation from the medical equipment and minor works programs are not included as these are reported by the DOH.

(c) The timeframe for the 'Expected Completion Date' are updated for the latest information at the time of reporting.

(d) The funding was revised to include Fiona Stanley Hospital – B Block.

Employee profile

WA Government agencies are required to report a summary of the number of employees, by category, compared to the previous financial year.

Administration and clerical

Includes all clerical-based occupations together with patient-facing (ward) clerical support staff.

2024–25	2023–24
1,615.63	1,470.2

Agency nursing

Includes workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest.

2024–25	2023–24
26.75	20

Assistants in nursing

Support registered nurses and enrolled nurses in delivery of general patient care.

2024–25	2023–24
330.10	318.9

Dental nursing

Includes dental nurses and dental clinic assistants.

2024–25	2023–24
3.5	3.5

Hotel services

Includes catering, cleaning, stores/ supply laundry and transport occupations.

2024–25	2023–24
1,120.37	936.3

Maintenance services

Includes engineering, garden and security-based occupations.

2024–25	2023–24
83.39	43.4

Medical

Includes all salary-based medical occupations including interns, registrars and specialist medical practitioners.

2024–25	2023–24
1,835.25	1,625.7

Medical support

Includes all allied health and scientific/ technical related occupations.

2024–25	2023–24
1,624.57	1,531.6

Nursing and Midwifery

Includes all nursing occupations including enrolled, registered and clinical nurses, and midwives. Does not include agency nurses.

2024–25	2023–24
4,421.53	3,970

Other occupations

Not limited to but primarily includes Aboriginal and ethnic health specialist positions.

2024–25	2023–24
15.80	N/A

***Notes:**

1. Data source: HR Data Warehouse

2. Year-To-Date FTE True divides the total FTE paid in every pay fortnight to date by the number of periods possible during the financial year up to the date specified.

3. FTE includes ordinary hours, overtime, all paid leave categories, public holidays, time-off-in-lieu and workers compensation. Penalties, allowances, unpaid leave, leave cash-outs and terminations do not incur FTE.

Equity, diversity and inclusion

SMHS is committed to creating an equitable, diverse and inclusive workforce which reflects the diversity of our SMHS community. The development of the *SMHS Equity, Diversity and Inclusion Plan 2021–25* is an important part of this commitment and is aligned to the Public Sector Commission's (PSC) Workforce Diversification and Inclusion Strategy. This encompasses action plans for identified diversity groups as well as specific and aspirational targets for some of these groups to increase their representation in public sector employment.

In 2025–26 SMHS will work collaboratively with relevant stakeholders and employees to develop a new SMHS Equity, Diversity and Inclusion Plan.

In 2024–25, achievements included the following:

- Service agreements with disability employment service providers BIZLINK and Edge Employment were renewed for a further two years and continue to facilitate increased recruitment and support for people with disability. SMHS was nominated for BIZLINK Employer of the Year Award 2024 for its ongoing commitment to inclusive employment.
- Disability awareness learning opportunities were provided through face-to-face disability awareness training, disability inclusion eLearning and Hidden Disability Sunflower online education.
- The Staff with Disability and Allies Network (SDAN) Champions Group, with representatives from SMHS and other HSPs, meet regularly to advance strategies for people with disability, including the SDAN Conference held in June. Additionally, the SMHS SDAN and Disability Access and Inclusion Plan (DAIP) Committees continue to promote and support inclusivity and diversity across all SMHS sites.
- SMHS sought to support women in our workplace by raising awareness and providing a one-stop-shop containing information and resources on the SMHS Women@work intranet page. This includes a menopause page and a parental leave support page.

The SMHS LGBTIQA+SB Inclusivity Working Group (Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual plus Sistergirl Brother Boy – Inclusivity Working Group) developed a 12-month strategy plan from April 2024–2025.

Education:

- The working group's Sharepoint intranet page was updated to reflect updates/activities of group, links to education, training, research articles and key surveys for input from across WA Health or other community/university entities.
- Proactively encouraged participation and completion on equity, diversity and inclusion eLearning course with specific focus on LGBTIQA+SB module to ensure knowledge and skills around LGBTIQA+SB meets the needs of consumers and colleagues.

Elevated partnerships:

- Across sites by promoting an inclusive/safe environment i.e. LGBTIQA+SB My Healthcare Rights poster, Progressive/Rainbow flag pin, inclusive and respectful language to both consumers and colleagues.
- Keynote speakers, where presenters identified how their services can be utilised and linked into HSPs promoting informed information, and creating safe inclusive environment.

Calendar milestones:

- Promoted and celebrated across SMHS events such as Wear it Purple Day, International Day against Homophobia, Biphobia, Intersexism and Transphobia and Pride Month (reflecting three keynote speakers plus morning and afternoon gatherings across four sites facilitating QAs).

Community

- Participated in community activities, Pride Fairday and Pride March.

Industrial relations

The *Industrial Relations Policy MP 0025/16* established under the *DoH Employment Policy Framework* defines the service delivery responsibilities of SMHS for industrial relations (IR).

DoH is responsible for systemwide IR matters including negotiation and registration of industrial instruments.

SMHS is responsible for:

- the application of the WA public sector legislative and regulatory frameworks regulating employment and IR
- management of misconduct matters
- representation and advocacy in industrial tribunals and courts
- engagement with unions and other external stakeholders in industrial matters.

Key activities for 2024–25 included:

- continued coordination and advice on the implementation of conversion to permanency provisions introduced into industrial agreements, including ongoing management and monitoring of reviews, as required within the industrial agreements
- continued coordination, planning and advice on the implementation of permanency conversion policy for senior medical practitioners
- continued coordination, strategy and advice on implementation of job security initiatives within target areas of high casual and fixed term contract use within SMHS
- coordination of submissions informing DoH of upcoming enterprise bargaining negotiations affecting SMHS allied health and support worker employment groups
- representation on matters before various industrial tribunals and courts

- education of managers regarding substandard performance, decision maker training, fitness for work procedures, and appointment of fixed-term contract and casual staff to permanent employment
- continued monitoring and coordination of measures in relation to retirement on grounds of ill health policies
- negotiation with unions and other relevant external stakeholders in response to workplace industrial disputes and workplace change initiatives
- advice and assistance to managers and HR relating to change management
- advice and assistance relating to transition of PHC staff to WA Health control within SMHS
- advice on parking changes related to commencement of construction on the new Women and Babies Hospital.

Worker's compensation

SMHS is committed to providing staff with a safe and healthy work environment and recognises this is essential to attracting and retaining the workforce we need to deliver safe, effective and efficient healthcare services.

A total of 303 claims were made in 2024–25.

For the purposes of this section, employee categories are defined as:

- administration and clerical (administration staff and executives, ward clerks, receptionists and clerical staff)
- medical support (physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dieticians and social workers)
- hotel services (cleaners, caterers and patient service assistants).

Workers compensation claims profile

Employee category	Number of claims in 2024-25
Nursing services/dental care assistants	139
Administration and clerical	18
Medical support	38
Hotel services	88
Maintenance	8
Medical (salaried)	12
Total	303

Work health and safety

SMHS remains dedicated to helping injured workers return to meaningful employment.

Our work health and safety (WHS) management system complies with the new *Workers' Compensation and Injury Management Act 2023*. We have an established injury management system, documented in the *SMHS Injury Management Policy and Procedure*, which is accessible on the SMHS WHS intranet.

Injured workers at SMHS are provided with access to a workplace injury EIP, which includes medical reviews and physiotherapy treatments. The program prioritises immediate care advice and injury assessment to ensure effective management and expedite a safe and sustainable return to work after a workplace injury or illness.

Our managers are actively involved in the management and workplace rehabilitation of injured workers, offering opportunities for both full and modified return to work programs based on medically indicated restrictions.

We continuously review our workers' compensation claim performance and work closely with our insurer, focusing on strategies to decrease the frequency, severity, and volume of compensable injuries.

Our commitment

At SMHS, we are committed to ensuring the safety, health and wellbeing of our staff, volunteers, students, contractors and visitors. We all have a part to play in building a safe and healthy workplace. This commitment is outlined in our WHS Commitment Statement.

- Lead by example demonstrating a visible commitment to promoting our core values of Care, Integrity, Respect, Excellence and Teamwork, with safety and wellbeing at the heart of everything we do.
- We aspire to create and maintain a workplace culture that prioritises physical safety and mental health. Our goal is to support each other and foster an environment where safety and mental wellbeing are elevated and prioritised.
- We remain committed to a zero-tolerance response to any form of aggression, whether physical or verbal, directed at our staff. We stand by and support our staff in seeking police action against individuals who threaten or engage in physical and emotional violence.
- Continuously refine our health and safety management system through active consultation with our staff, ensuring our organisation enhances WHS practices, and remains compliant with all relevant legislation.
- Support our leaders in managing risks and developing and implementing strategies to improve safety and wellbeing in our workplaces.
- Embed a work health and safety reporting culture to ensure we continue to learn, improve and measure our work health and safety performance.
- Continue to provide early intervention initiatives and support staff with injuries or illness, to assist recovery and a safe return to full duties.

Our WHS Commitment statement is reviewed annually by our WHS Executive Committee and endorsed by Area Executive Group. The commitment is communicated to staff, volunteers, students, contractors and visitors through the SMHS intranet and visual displays around our hospital locations.

Consulting with employees

Workforce consultation at SMHS is facilitated through a structured, three-tier WHS Committee framework that spans departments, work areas, hospital groups and the broader SMHS network. These committees provide strategic oversight and direction on WHS matters, addressing a wide range of issues relevant to their respective areas.

Our 370 health and safety representatives play a vital role in this consultation process. Each representative is linked to a WHS Committee that meets at least quarterly, offering a formal platform to raise, discuss and resolve WHS concerns. Where necessary, matters can be escalated in accordance with the SMHS WHS Issue Resolution process.

Consultation on the WHS Management System is conducted through WHS Committees and departmental channels, as well as via the SMHS WHS intranet during designated consultation periods.

Assessment of the WHS management system

In early 2022, Ernst & Young conducted an audit of the SMHS WHS management system to verify compliance with the new WHS legislation. The resulting action items were completed by the end of 2022.

SMHS maintains an internal WHS audit system. WHS departments regularly assess the activities at each SMHS site to ensure adherence to our WHS Management System's requirements at the local level.

Measure	Actual results		Results against target	
	2023–24	2024–25	Target	Comment on result
Number of fatalities	0	**0**	0	
Lost time injury (LTI) and/or disease incident rate	2.38%	**2.43%**	0 or 10% reduction	There was a slight increase in the incident rate compared to the previous financial year. It's important to note that this coincided with a significant rise in FTE across SMHS in 2024–25, driven by the opening of PHC, Cockburn Health and the Medihotel. Key improvement strategies include a focus on proactive injury management, early intervention, injury prevention, safety leadership, and the development of targeted WHS actions to address high-risk hazards, which will be captured under the new *SMHS WHS Strategy 2025–27*.
Lost time injury and/or disease severity rate	43.17%	**54.28%**	0 or 10% reduction	There was a slight increase in the LTI severity rate compared to the previous financial year. This coincided with a significant rise in FTE across SMHS in 2024–25, following the opening of PHC, Cockburn Health and the Medihotel. It's also important to note that SMHS's EIP is highly utilised, which reduces the number of minor claims lodged. While this reflects proactive injury management, it also results in a lower proportion of total claims, inadvertently impacting the severity rate. Additionally, delays in claim settlements at WorkCover – due to the implementation of new workers' compensation and injury management legislation—contributed to a backlog of cases. This affected the number of claims that could be closed, further influencing the severity rate. Improvement strategies include quarterly reviews with the insurer (ICWA) to monitor claim severity trends, and the development of targeted WHS action plans addressing high-risk hazards such as psychological stress and manual handling injuries.
Percentage of injured workers returned to work within 13 weeks	40.91%	**40.00%**	Greater than or equal to 60%	There has been minimal change compared to the previous financial year, with performance remaining below the established target. Improvement strategies include a focus on strengthening injury management practices to enable early intervention, support effective recovery, and facilitate successful return-to-work outcomes. These improvement strategies have also been embedded in the new *SMHS WHS Strategy 2025–27*.
Percentage of injured workers returned to work within 26 weeks	57.2%	**54.8%**	Greater than or equal to 70%	Slight decrease from previous financial year and remains below the target. Improvement strategies include a focus on strengthening injury management practices to enable early intervention, support effective recovery, and facilitate successful return-to-work outcomes. These improvement strategies have also been embedded in the new *SMHS WHS Strategy 2025–27*.
Percentage of managers trained in occupational, health and injury management responsibilities	59.6%	**60.2%**	Greater than or equal to 80%	There has been a slight improvement in compliance from the previous financial year. SMHS is currently the only HSP requiring managers to complete WHS training annually. However, in line with recent updates to public sector reporting requirements, this compliance cycle will transition to a biennial (two-yearly) schedule starting from the new financial year. Improvement strategies will include ongoing reviews to ensure appropriate identification of staff cohorts with managerial responsibilities who are required to complete the training.

Asbestos management

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

Annual review of asbestos registers and management plans of all sites/ buildings under SMHS remit is conducted by Prensa (Environmental Service Contractor). Asbestos registers and management plans are updated accordingly.

SMHS asbestos registers and management plans define the risk of each identified or assumed asbestos material. Risk rating is consistent across all asbestos registers and management plans with recommendations on each on how to manage or maintain in its current state to not disturb or introduce further risks to the SMHS staff, patients, contractors, or visitors.

If demolition or refurbishment is to occur a review of the asbestos register and management plan for the area is completed and where required intrusive testing is conducted to identify all asbestos.

When asbestos is identified in any areas that require demolition or refurbishment, all asbestos must be removed prior to works commencing under the strict guidelines in place as per the WA WHS legislation.

Where trade staff may be required to work with asbestos and while undertaking that work may disturb the asbestos, they must review the asbestos registers to ensure the material is or isn't asbestos. Where this is not defined, testing of the material is required prior to the works and if the material is positive regarding containing asbestos then appropriate steps must be taken to remove the asbestos prior to works commencing.

Where removal has occurred, air monitoring is conducted throughout the removal, clearance certification and removal notice must be provided, and this information is passed on to Prensa to update the asbestos registers.

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

Asbestos management plans are in place. Identified risks for each known or assumed asbestos material and how to manage these risks are embedded within the plan.

SMHS does not have a schedule created for the planned removal of asbestos.

Removal only occurs when demolition, refurbishment or tasks that may disturb asbestos is to occur.

All removal is captured in the asbestos register once completed.

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

No compliance or enforcement issues in relation to asbestos over the 2024–25 period to date.

Asbestos awareness, including training, publications, and guidance materials

Facilities management conducts annual asbestos awareness sessions for their staff (trade staff, shift engineers).

There are no current overarching awareness sessions for the remainder of the organisation.

No information is provided during induction or onboarding of non-facilities management staff.

Health Safety and Wellbeing Department are currently creating an organisation-wide awareness package with the intent being that each worker will be required to complete this as a once-off where they do not work with asbestos.

Asbestos, either confirmed or assumed is identified via asbestos identification stickers.

Unauthorised use of credit card

Table 25. Unauthorised use of credit card

Credit card personal use expenditure	July 2024 to June 2025
Aggregate amount of personal use expenditure for the reporting period	226.85
Aggregate amount of personal use expenditure settled by the due date (within 5 working days)	nil
Aggregate amount of personal use expenditure settled after the period (after 5 working days)	226.85
Aggregate amount of personal use expenditure outstanding at the end of the reporting period	nil

The above relates to two cardholders.

Advertising

SMHS incurred a total advertising expenditure of $146,401 in 2024–25.

Table 26. Media advertising organisations

Person, agency or organisation	Amount ($)
Initiative Media Australia Pty Ltd	136,930
Adcorp Australia Limited	3,256
Government Education And Business Directories Pty Ltd	2,419
The Australasian College For Emergency Medicine	1,331
Meta Platforms Ireland Limited	962
Carat Australia Media Services Pty Limited	843
Perth Now	660
Total	146,401

Acts of Grace, ex-gratia payments

SMHS did not make any charitable gifts or ex-gratia payments over $100,000 in 2024–25.

Pecuniary interests

Senior officers of government are required to declare any interest in or proposed contract that has, or could result in, the member receiving a financial benefit.

SMHS Board member Karen Brown declared her position as Non-Executive Chair of Purple, in which she has a one per cent share. Purple held contracts with the Child and Adolescent Health Service and North Metropolitan Health Service in 2024–25. This interest is declared and managed through the conflict-of-interest process.

SMHS Board member Liam Roche declared his position as a Board member of the Multiple Sclerosis Society of WA (MSWA). This not-for-profit organisation currently has a contract to develop a high support accommodation facility in Shenton Park. This contract is supported in part by the State Government through a building grant deed provided by DoH. As a Board member, no personal benefits have been received.

SMHS Executive member Neil Doverty declared his position as Board member of the Health Roundtable of Australia and New Zealand. The Health Roundtable has a contract with both FSFHG and DoH. As an Executive member, Mr Doverty receives paid flights and accommodation at Health Roundtable events and national Board meetings.

SMHS Executive member Kate Gatti declared her position as Director on the MSWA Board. MSWA receives funding from the DoH. As an Executive member, Ms Gatti is not a paid Board member nor involved in negotiations, and no personal benefits have been received.

Multicultural framework

The *South Metropolitan Health Service (SMHS) Multicultural Plan 2021–25* demonstrates its commitment to supporting equal opportunities for all consumers and staff and fostering an inclusive and welcoming environment for all. SMHS is proud of its diverse workforce, with 39 per cent of staff indicating they are from a cultural or linguistically diverse background.

This year we commenced work on the development of our next multicultural plan, collaborating with an external agency to coordinate extensive staff and community engagement. This plan aims to enhance patient, carer and family experiences by ensuring we provide culturally responsive policies and a welcoming and inclusive health service for staff and the community.

Following are highlights from the last year:

- The promotion of Drop the Jargon Day in October 2024 encouraged staff to swap jargon for plain language and implement strategies to improve communication and understanding with patients, carers and families. A community engagement page was developed and promoted through the Put it to the People platform, raising community awareness of Drop the Jargon initiatives and providing strategies to support consumers to communicate with health service staff. This included 'Checkback', a process to help patients prepare for their appointment and understand the information they receive. The community engagement page has a translator function, so consumers can view the information in an option of 10 languages.
- Cultural and linguistically diverse data was updated on our patient administration system to include patient ancestry and ethnicity data, as well as the main language spoken at home. This new data set allows opportunities to identify and address disparities in health outcomes and ensure culturally appropriate service delivery.
- As part of Harmony Week 2025, celebrations, displays were set up across four hospital sites to promote inclusiveness, respect and a sense of belonging for all. Staff were encouraged to wear orange and come together sharing food from across the globe. During the week, cultural competency and language services education was promoted to make SMHS a culturally respectful and inclusive place to work.

Substantive equality

SMHS is committed to achieving substantive equality in health care by identifying and eliminating systemic forms of discrimination and promoting awareness of the distinct needs of different people and groups of people. SMHS continue to address these needs through the *SMHS Aboriginal Health and Wellbeing Action Plan* which aligns with the *WA Aboriginal Health and Wellbeing Policy, WA Aboriginal Health and Wellbeing Framework 2015–2030* and *WA Health Aboriginal Workforce Policy.*

The SMHS Aboriginal Health Strategy team develop strategic initiatives and deliver programs aimed at increasing cultural security levels across SMHS to provide:

- a competent and culturally responsive service
- increased workforce opportunities for Aboriginal people
- strengthened engagement between the Health Service and key Aboriginal community and consumer stakeholders in line with the *SMHS Aboriginal Community and Consumer Engagement Framework*.

The establishment of the SMHS Aboriginal Health Advisory Group drives cultural governance for Aboriginal health matters across SMHS sites and involves Aboriginal staff from all SMHS sites, Aboriginal Community and Aboriginal Elders. The *Aboriginal Health Impact Statement and Declaration Policy* ensures new policy and major initiatives are assessed for their impact on Aboriginal people.

The Aboriginal health liaison officers (AHLO) provide face-to-face patient services, while providing advocacy and support during the patients' hospital journey.

Developing the cultural capability of the SMHS workforce will further strengthen relationships with Aboriginal patients, their family, and supports and is promoted through:

- *Patient Centred Cultural Care Guidelines*
- Aboriginal Health Champions Program
- Aboriginal cultural learning, including mandatory Aboriginal Cultural eLearning and Aboriginal Person-Centred Care Training.

Effective communication with Aboriginal patients is further promoted via the SMHS Clinical Yarning practices.

SMHS Welcome to Country Protocols recognise Aboriginal people's traditional ownership of country and support culturally respectful practices across SMHS sites.

Aboriginal workforce

SMHS is committed to increasing the Aboriginal workforce and providing a workplace that supports and retains its Aboriginal staff by providing a culturally safe and supportive environment. Through its *Aboriginal Workforce Strategy 2023–26*, SMHS aim to increase workforce opportunities and support career pathways for Aboriginal people through initiatives such as:

- the Aboriginal Cadetship Program
- the Aboriginal Graduate Program
- Aboriginal health practitioner (AHP) roles
- traineeships
- Section 50(D) and Section 51 employment
- Aboriginal leadership programs.

During 2024–25 a range of initiatives was undertaken to support SMHS to promote a culturally safe and inclusive workforce:

- SMHS continues to participate in the WA Health Aboriginal Cadetship Program and currently has five Aboriginal Cadet positions.
- An Allied Health Aboriginal Graduate position was established, and a new Aboriginal Graduate commenced in the role in 2025.
- Traineeships for Aboriginal students were facilitated through an Aboriginal School based trainee appointed at PHC and an Aboriginal Business Trainee at FSH.
- SMHS continues to work collaboratively with key stakeholders to progress key strategies to recruit, retain and develop the Aboriginal workforce through the SMHS Aboriginal Workforce Working Group and participation in the systemwide Aboriginal Workforce Committee and Working Group.
- PHC undertook a drop-in session at the hospital to promote Aboriginal community employment with PHC.
- SMHS has established relationships with Waalitj Foundation and attended the Deadly Futures Careers Expo to promote employment opportunities to Aboriginal students.
- SMHS Aboriginal employees participate in the WA Health Aboriginal Leadership Excellence and Development program run by the Institute for Health Leadership in conjunction with the Aboriginal Health Policy Directorate, and the Australian Institute of Management WA.
- SMHS identified a cultural space for Aboriginal patients and families which also provides Aboriginal staff with a space for Cultural Yarning and debriefing. Nitja Ngala Maya (This Here is Our Place) is expected to be opened in 2025–26.
- A Coordinator Aboriginal Health Training (50D) position was established to lead a comprehensive cultural education plan including coordination, delivery and cultural oversight to the statewide Aboriginal Person-Centred Care training program.
- Aboriginal Health Strategy implemented yarning sessions with Aboriginal workforce including AHPs, AHLOs and cadets and senior leads provide cultural supervision to Aboriginal staff when required.

- National Reconciliation Week 2025 was celebrated across the SMHS sites including morning teas/lunches, links to online events and a 'Tree of Stories' to showcase the impactful initiatives and actions taken by SMHS service delivery teams.

Aboriginal health practitioners

The AHP role was implemented into key operational areas with structured work placements, orientation, competency development, mentoring and cultural support, including cultural yarning sessions. Promoting cultural safety and security, the AHPs provide essential clinical care, cultural guidance and advocacy for the health and wellbeing of Aboriginal patients and their families.

Ten AHP positions and five senior AHP positions were established in SMHS, and recruitment and retention of this workforce is ongoing. There continues to be ongoing engagement with Marr Moorditj training organisation to promote employment pathways for AHPs and provide student clinical placements.

A nurse and midwife educator – Dandjoo Maladjiny 'Together Growing' was established to:

- support the Aboriginal clinical workforce
- develop culturally appropriate strategies to support the retention and management of AHPs including cultural obligations and cultural safety.

A clinical facilitator role is being piloted with a focus on upskilling and ensuring clinical competence for the AHP workforce.

Patient experience feedback

Providing a great patient experience is a strategic priority for SMHS, and listening to our patients' feedback is critical to the health service understanding what we are doing well and where we can improve when delivering care. Consumer feedback also allows us to recognise when staff and teams deliver compassionate care and exceed our patients' expectations.

MySay surveys

The suite of MySay healthcare surveys includes same day and multi-day inpatients, outpatients, ED patients and community patients.

MySay surveys provide patients an opportunity to complete questions on their experience with our service. The aggregated survey data is available to all staff across SMHS and used to celebrate great care and identify areas for improvement.

For the 2024–25 period we heard from a total of 58,693 patients. This included 27,660 people regarding their overnight or same day admission. Of these, 94 per cent rated their overall quality of care as 'very good' or 'good'.

Of the 5,790 people who provided feedback regarding their care in our emergency departments, 80 per cent rated their quality of care as 'very good' or 'good'. A **patient who visited RGH ED** reported, *"I was really happy with the compassion provided by everyone involved. I was having chest pains and a really bad panic attack, the staff showed nothing but compassion even when they were overflowing with patients."*

Feedback regarding visits to our outpatient departments was provided by 22,459 people. Of these, 95 per cent rated their overall quality of care as 'very good' or 'good'. A **PHC outpatient** reported, *"From the reception staff, nurses, and the oncologist, there was nothing but help, support, and a level of professionalism that could not be bettered."*

REACH survey

The REACH survey captured feedback from patients who received care from our community services, and 2,794 people responded to the survey. Of these, 97 per cent rated their overall quality of care as 'very good' or 'good'. A **patient using RITH services** reported, *"I was very impressed by the care and dedication to my needs and I felt very comfortable in their care… I strongly recommend this team to anyone in need of care."*

Carers Experience Survey

A pilot of the Carers MySay Survey commenced in 2024. This survey helps identify what is important to carers and how they can be better supported in their critical caring role.

A carer for a patient using **FSH services** reported, *"All staff at the hospital show respect to not only the patient but the carers along with acknowledging the input that carers can provide and listening to what they say.'*

More feedback shared via the MySay survey included those from a:

RkPG patient who reported, *"I was treated with respect from start to finish. I spent from 2.30 pm till midnight and the hospital was crazy busy. The doctors, nurses and administrators handled it with care and respect to everyone. Thanks."*

FH patient who reported, *'I was terrified about my surgery but everyone from the admitting staff, nurses, doctors were all so reassuring, attentive and empathetic so I didn't feel silly, I really felt like they cared and I'm very grateful."*

PHC patient who reported, *"I came in to ED while suffering a heart attack. The care, reassurance and professionalism given to me made a terrible experience as best it could be under the circumstances.'*

Mental health patients are asked to complete the Your Experience of Service Survey. According to patient feedback, some of the best things about SMHS mental health services were:

"All staff here are so kind and professional at their job."

"I felt listened to and received the best treatment the entire duration of my stay."

"I felt welcomed and supported and it gave me hope for the future."

Care Opinion

In 2024–25, SMHS received a total of 174 stories via Care Opinion, an online platform that allows members of the public to tell us about their experience with our services. Of these stories, 73 were positive and 101 consumers shared their experience with some suggested areas for improvement.

Some of the feedback shared via Care Opinion:

FH – *"At every step of the way, I was informed on what was happening, and all questions were answered. Any worries I had were quickly put to rest, especially when told that I would be the most important person in the theatre and everything was all about me. Yes, I did feel special, because any operation is a worry and that comment did put me at ease. Thank you to all of the staff who looked after me so very well."*

FSH – *"I want to thank everyone who cared for me, from the volunteers at the door to the nurse at the desk and all the way through to the nurses and doctors who attended to me. I can't thank you enough for the calmness and kindness you presented me with knowing how anxious and scared I was. You made me feel much more relieved and gave me more of an understanding of my situation and safety. Thank you and please know I really appreciated it."*

RITH – *"They were absolutely fantastic. I was blown away with the service that's provided. It's just amazing. It certainly really did help my husband, even with the setback he's had, there was physiotherapist, occupational therapist, speech therapist – I can't speak highly enough of them all."*

RGH – *"A family friend received end-of-life care at Rockingham Hospital until he died peacefully. The care he and his family received was exceptional; medical, nursing, catering, volunteer and cleaning staff. No problem was left unsolved. It did my heart good to see such compassion alive and well in our health service."*

PHC – *"I just wanted to congratulate all the staff I saw and show my appreciation for how the experience was right from the beginning. Everyone I saw was great. A real working team environment, everyone was happy and cheery. It seems they just can't do enough for you. Doesn't matter what—it's just incredible. Treated like royalty—and we're in the public health system!"*

Compliments, contacts and complaints

In 2024–25, there were 5,366 compliments, 3,003 contacts and concerns and 1,367 complaints received via formal feedback processes.

Feedback is an opportunity to identify opportunities for improvement. An example is feedback received via Care Opinion related to patients smoking on hospital premises. This experience highlighted the need to communicate that hospital premises are totally smoke and vape-free and promote smoking cessation. The SMHS community were invited to help choose a fresh smoke and vape-free audio message to replace the existing message at SMHS hospital sites via the Put it to the People platform. The message chosen was recorded by Health Promotion and reinforced the commitment to clean, fresh air for all patients, visitors and staff. This initiative underscores the ongoing efforts to create healthier environments and support patients in their smoking cessation journey.

As per the *WA Health Complaints Management Policy 2020*:

Complaint is defined as an expression of dissatisfaction by an individual regarding any aspect of a service provided by the health service.

Contact/concern is defined as feedback from an individual regarding any aspect of service where:

- they state they do not wish to lodge a formal complaint.
- the issues can be resolved without going through the formal complaint management process.

Disability access and inclusion

The *SMHS Disability Access and Inclusion Plan (DAIP) 2022–27* supports the delivery of services to consumers and staff with disability to ensure equitable access to health services, information and facilities.

FSFHG and RkPG have developed site specific DAIP implementation plans. PHC – a new addition to SMHS – established its DAIP Committee in October 2024.

SMHS reports annually on progress towards the seven desired outcomes outlined in the *Disability Services Regulations 2024*. In 2024–25, positive progress was seen across the health service, particularly with respect to outcome 4 (quality of care) and outcome 7 (employment opportunities for people with disability).

Outcome 1

People with disabilities have the same opportunities as other people to access the services of, and events organised by, a public authority.

The Fiona Wood Public Lecture Series provides members of the community the opportunity to hear about a range of health topics presented by leading healthcare professionals from across SMHS. The events are held in Lecture Theatre 1 at FSH which is easily accessible to people with disability. They are also recorded and available to the public via the SMHS internet page.

SMHS celebrated International Day of Disability in December 2024 with displays across FSH, FH, RGH and PHC. SMHS staff were invited to attend an 'Easy to Read, Easy to Reach' International Day of Disability event hosted by Disability Health Network and EMHS. A week-long display to promote AUSLAN and the introduction of the Hidden Disability Sunflower scheme, as well as the Disability Health Profile Form, was assembled at RGH. As part of the promotion, a video of a hospital staff member speaking and using AUSLAN was displayed on screens in the main area of the hospital.

Outcome 2

People with disabilities have the same opportunities as other people to access the buildings and other facilities of a public authority.

To identify and reduce barriers to access health services, wayfinding audits are completed annually across SMHS sites. The audits aim to make it easier for people with disability to navigate SMHS health services, ensuring clear information and signage is available.

In 2024, high contrast signage was installed across RGH and MDH to improve awareness of accessible bathroom facilities. Recent wayfinding audits at PHC identified actions to improve accessibility, including reviewing internal accessibility throughout the hospital, such as seating, handrails and accessible public toilets, and increasing the number of accessible parking bays.

RkPG DAIP committee membership has been extended to include a WHS representative to help inform actions regarding the accessibility of building and facilities.

Outcome 3

People with disabilities 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.

In conjunction with the Council of Intellectual Disability, SMHS commenced developing a library of Easy Read consumer resources. Completed documents include a pressure injury information booklet and FSH patient information booklet. Patient information documents for FH, RkPG and PHC are in development.

The SMHS Sharepoint intranet has been reviewed and updated to ensure disability related information and resources are current and are easily accessible to support all staff when caring for people with disability.

Outcome 4

People with disabilities 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 the 2023–24 reporting period, FSFHG became the first WA hospital to be registered with the Hidden Disabilities Sunflower program. Over the past year over 1,000 FSFHG staff have completed the eLearning and currently wear a Sunflower badge or lanyard, identifying them as staff who can support people with hidden disabilities. In December 2024, the program was expanded, with RGH officially registering membership as well. The roll out at RGH initially prioritised volunteer 'meet and greet' staff and ED clinical and administrative staff. The expansion of the program will continue throughout 2025, with roll out to other sites across RkPG and PHC planned.

The promotion and use of the Disability Health Profile Form has expanded and is now available across all SMHS sites, including PHC. The form is completed by patients and carers and supports hospital staff to provide more holistic, individualised care to the person with disability. Posters raising awareness of these forms are in place across SMHS emergency departments and outpatient areas.

Disability awareness training continues to be promoted across SMHS sites. In December 2024, RGH hosted an education session from the Autism Association of WA on autism and neurodiversity, which was widely attended. Staff were also provided opportunities to attend SMHS Disability Awareness training for managers and colleagues of people with disability, which was presented in conjunction with BIZLINK.

Outcome 5

People with disabilities have the same opportunities as other people to make complaints to a public authority.

Patient and carer feedback forms across SMHS sites have been converted into printed and digital Easy Read resources. Staff can access these through the SharePoint intranet and they available to consumers via the various SMHS websites.

In response to consumer feedback, FSH created two sensory-friendly waiting spaces within the ED for adult and paediatric patients. The rooms were developed in consultation with the Autism Association of WA and consumers to ensure there is a space for patients who may be anxious, agitated or in early stages of distress. The rooms have dimmable lighting, soft, comfortable furniture, interactive equipment including a sensory board and well-considered colour schemes. The sensory-friendly spaces provide patients and carers with a safe space to self-regulate while awaiting access to emergency care, reducing the number of Did Not Wait occurrences.

Outcome 6

People with disabilities have the same opportunities as other people to participate in any public consultation by a public authority.

To help inform actions and programs across SMHS service, the site DAIP Committees have reserved membership for staff or consumers with lived experience. These consumer representatives have input and provide feedback on how SMHS can improve access to services and information for people with disability.

Outcome 7

People with disability have the same opportunities as other people to obtain and maintain employment.

The SMHS job description form template was updated to include an equity, diversity and inclusion statement and enhanced screen reader accessibility.

SMHS was named a finalist in the BIZLINK Employer of the Year award for demonstrating support and commitment to equal employment opportunity and workforce diversity. Having engaged employees through BIZLINK for some years now, the service agreement helps SMHS facilitate opportunities for people with all types of disabilities, barriers and backgrounds to secure and maintain employment with the organisation. The partnership enables SMHS to provide a range of support tailored to employees living with disabilities, throughout the recruitment, selection and appointment process and to support their ongoing employment. BIZLINK also supports managers and teams through the provision of staff education and tailored support. Last year, BIZLINK assisted 11 people with disability to secure employment within SMHS.

SMHS supports employment flexibility for people with disability through *SMHS Reasonable Adjustment Guidelines and SMHS Flexible Working Arrangements Policy*. A dedicated SharePoint intranet page for reasonable adjustment guidelines and resources guides managers and employees on flexibility in the recruitment, onboarding, and employment of people with disability and includes 'Immersive Reader' option to improve accessibility. These guidelines extend to SMHS volunteers. As an example, the FSFHG volunteers program engaged volunteers with disability, providing reasonable adjustments as required to accommodate their needs and facilitate ongoing participation in the program. This experience created a pathway to employment for two volunteers with disability.

Compliance with public sector standards

The Public Sector Standards in Human Resource Management (the Standards) set out the minimum standards of merit, equity and probity required of all Western Australian public sector bodies and their employees.

Compliance with the Public Sector Standards in Human Resource Management is maintained as follows:

- SMHS informs and communicates to our staff the requirement of complying with the Standards within the relevant policies and induction handbooks, as well as with information provided on the SMHS intranet.
- Recruitment and selection training occurs for panel members to ensure compliance with relevant standards.
- Recommended and unsuccessful applicants are advised of the breach process.
- Each SMHS site has a confidential human resources (HR) database/register to retain breach information. HSS also maintains information relating to breaches against the Employment Standard.
- Availability of HR business partners and consultants, recruitment teams at FH, FSH and PHC and the SMHS Industrial Relations team to assist staff and managers.

Examples of SMHS compliance include:

- The *SMHS Redeployment and Redundancy Policy* was reviewed and endorsed by the SMHS Area Executive Group following consultation with stakeholders. Following endorsement of policies SMHS employees are informed of the reviewed policy via site and SMHS enewsletters.
- SMHS Workforce continues its commitment to updating staff in current HR policy and processes by providing ongoing HR training and development opportunities that benefit all employees. In 2024–25 this included updating the Respect in the Workplace: Bullying, Sexual Harassment and Sex Discrimination eLearning module. This mandatory training provides SMHS employees with an understanding of bullying, sexual harassment and sex discrimination.

During 2024–25:

10 claims were lodged against the employment standard.
Five claims were resolved by SMHS and did not result in a breach of standard.
Five claims were sent to the Public Sector Commission (PSC) for review and were dismissed with no breach of standard.

4 claims were lodged against the grievance resolution standard.
Three sent to the PSC for review and were dismissed with no breach of standard.
One is still pending within the agency.

1 claim was lodged against the performance management standard.
This claim was sent to the PSC for review and was dismissed with no breach of standard.

1 claim was lodged against the redeployment standard.
This claim was sent to the PSC for review and was dismissed with no breach of standard.

There were no breach claims against the other Public Sector Standards in HR Management.

Please note one claimant lodged breach claims against multiple standards.

Code of Ethics and Code of Conduct

SMHS staff are expected to adhere to the *DoH Code of Conduct* in all the work they do. The Code applies to employees and extends other staff groups including contractors, trainees, students, volunteers, researchers and visiting professionals and agency staff.

SMHS employees deserve to be treated with mutual respect, compassion and fairness. By setting clear expectations, the WA health system Code of Conduct ensures a working environment where individuals can work safely and flourish professionally.

The code identifies core values and are underpinned by the *WA Public Sector Code of Ethics*, which refers to the principles of personal integrity, relationships with others and accountability.

SMHS is dedicated to the CORE values. This is demonstrated in the SMHS Integrity Framework which describes how we practice, manage and account for integrity.

The framework is structured according to the Public Sector Commission's *Integrity Model for WA Public Authorities*. Regular reviews of the framework ensure satisfaction requirements of the *Commissioner's Instruction 40: Ethical Foundations*.

The framework provides information about many key instruments, structure and cultural factors that form our approach and contribute to the achievement of our vision. They also help to continuously strengthen SMHS's high-integrity culture and facilitate compliance with integrity-related legislation.

Integrity is fundamental to achieve SMHS' vision of 'excellent health care, every time'. It is one of our core values and provides accountability for all staff with respect to our actions; we must act professionally with integrity, even when no-one is watching.

Compliance with the Code of Conduct is promoted in many ways.

- All employees are required to complete compulsory induction programs relating to:
  - The WA Health Code of Conduct and Breaches of Discipline
  - Respect in the Workplace (including workplace bullying, sexual harassment and sex discrimination)
- SMHS vision, values and strategic priorities
- Accountable and ethical decision making (including refresher training every three years).

The SMHS Integrity and Ethics team also carries out supplementary engagement and education sessions to all staffing areas who request the training, and as part of general nursing staff inductions.

Integrity and Ethics have implemented an annual communication and engagement program targeting specific working groups to more accurately address identified risks present in their working environments.

On the occasion where a staff member may observe what they believe to be below-the-line behaviours, there are multiple reporting pathways open to them to report their concerns. Recognition is also provided to acknowledge how challenging it can be to report concerns of misconduct; to address this, an anonymous reporting hotline was implemented.

The published pathways include, but may not be limited to:

- consumer complaints
- employee complaints via line management, HR or Integrity and Ethics
- SMHS Misconduct Hotline
- public interest disclosure
- registering complaints, either anonymously or openly, direct to the Corruption and Crime Commission (CCC) or PSC.

All reporting pathways are promoted and explained within the Integrity SharePoint information pages, which are available to all staff.

Once a complaint has been received by HR, an assessment undertaken and the matter presented to a disciplinary decision maker. A determination will then be made, based on the available materials, to determine the most appropriate management of the complaint. This may include a disciplinary process. All disciplinary matters are recorded and reported on accordingly (having been appropriately redacted), in accordance with the SMHS Integrity Framework and WA health system Notifiable and Reportable Conduct Policy.

Misconduct reports 2024–25

In 2024–25, there was a total of 92 cases of suspected breaches of discipline. Of the 92 cases:

The outcomes of these 92 conduct matters reported 2024–25 were:

- 44 involved allegations that were substantiated
- 19 involved cases that were unsubstantiated
- 29 cases remain active.

31	cases assessed as serious misconduct and reported to the CCC
28	cases assessed as minor misconduct and reported to the PSC
22	cases assessed as non-reportable
11	matters were pending assessment

Recordkeeping plan

SMHS has a *Record Keeping Plan 2023*, which sets out the minimum requirements for record keeping, ensuring appropriate storage, management and destruction of records, pursuant to the *State Records Act 2000*.

SMHS has developed a record keeping plan for 2025 including a new custodian policy, implementing the modernised WA Health electronic records management system, and the remainder of the internal audit recommendations.

APPENDICES

Appendix 1 – SMHS Board remuneration 2024–25

Member position	Member name	Type of remuneration	Period of membership (in months) for 2024–25	Term of appointment and tenure	Base salary/ sitting fee ($)	Gross/actual remuneration ($)
Chair	**Robyn Collins**	Annual	12 months	1 July 2016 to 30 June 2025 (reappointed for a further 19 months on 20 November 2023)	$75,986.56	$84,724.90
Deputy Chair	**Kim Gibson**	Annual	12 months	1 July 2016 to 30 June 2025 (reappointed for a further three years on 1 July 2022)	$43,896.17	$48,944.26
Member	**Stephanie Trust**	Annual	12 months	15 July 2024 to 30 June 2026	$27,486.20	$30,647.13
Member	**Amanda Boudville**	Annual	12 months	17 July 2017 to 30 June 2026 (reappointed for a further three years on 21 August 2023)	$41,791.88	$46,597.98
Member	**Karen Brown**	Annual	12 months	1 July 2022 to 30 June 2025	$41,791.88	$46,597.98
Member	**Julian Henderson**	Annual	12 months	1 July 2016 to 30 June 2025 (reappointed for a further 19 months on 20 November 2023)	$41,791.88	$46,597.98
Member	**Sue Le Souef**	Annual	12 months	9 March 2020 to 30 June 2026 (reappointed for a further two and a half years on 20 November 2023)	$41,791.88	$46,597.98
Member	**Colin Murphy**	Annual	12 months	9 November 2020 to 30 June 2025 (reappointed for a further three years on 1 July 2022)	$41,791.88	$46,597.98
Member	**Yvonne Parnell**	Annual	12 months	1 July 2016 to 30 June 2025 (reappointed for a further two years on 21 August 2023)	$41,791.88	$46,597.98
Member	**Liam Roche**	Annual	12 months	1 August 2019 to 30 June 2025 (reappointed for a further three years on 1 July 2022)	$41,791.88	$46,597.98

Appendix 2 – List of acronyms

AAS	Australian Accounting Standards
ACHSM	Australasian College of Health Service Management
AHLO	Aboriginal health liaison officer
AHP	Aboriginal health practitioner
AMC	Australian Medical Council
AMI	Acute myocardial infarction
AoD	Alcohol and other drug
Apgar	Appearance, pulse, grimace, activity and respiration
ATO	Australian Taxation Office
ATS	Australasian Triage Scale
CAC	Consumer Advisory Council
CCC	Corruption and Crime Commission
CCS	Clinical Care Standards
CMP	Contracted Medical Practitioner
Cockburn Health	Fiona Stanley Hospital–Cockburn Health
CoNeCT	Complex Needs Coordination Team
CoNeCT MHE	Complex Needs Coordination Team Mental Health Expansion
CPS	Community Physiotherapy Service
CWP	Chief Wellbeing Practitioner
DAIP	Disability Access and Inclusion Plan
DAMA	Discharge against medical advice
DiT	Doctors in training
DMR	Digital medical record
DNA	Did not attend
DNW	Did not wait
DoH	Department of Health
DSU	Doctor Support Unit
ED	Emergency department
EIP	Early Intervention Program
EMHS	East Metropolitan Health Service
eMR	Electronic medical record
ePrescribing	Electronic prescribing
FBT	Fringe benefits tax
FFS	Fee for service
FH	Fremantle Hospital
FHRI	Future Health Research and Innovation
FNOF	Fractured neck of femur
FSFHG	Fiona Stanley Fremantle Hospitals Group
FSH	Fiona Stanley Hospital
FTE	Full time equivalent
GESB	Government Employees Superannuation Board
GET FED	Gastric Enteric Tube Feeding Early Discharge
GP	General practitioner
GSS	Gold State Superannuation
GST	Goods and services tax
HAC	Hospital acquired complication
HA-SABSI	Healthcare associated Staphylococcus aureus bloodstream infection
HISWA	Healthcare Infections Surveillance WA
HITH	Hospital in the Home
HR	Human resources
HREC	Human Research Ethics Committee
HSP	Health service provider
HSS	Health Support Services
ICT	Information and communications technology
ICU	Intensive care unit
IMG	International medical graduate
IR	Industrial relations
KPIs	Key performance indicators
LOS	Length of stay
MBA	Medical Board of Australia
MDH	Murray District Hospital
MDM	Multidisciplinary meeting
MDT	Multidisciplinary team
Medihotel	Fiona Stanley Hospital – M Block (Med-hotel)
MET	Medical Emergency Team
MHC	Mental Health Commission
MSF	Multi-source feedback
NGO	Non-government organisation
NICU	Neonatal Intensive Care Unit
OB	Over boundary
OBM	Outcome based management
PAW	People at Work
PHC	Peel Health Campus
PSC	Public Sector Commission
QI	Quality improvement
RGH	Rockingham General Hospital
RIS	Research Infrastructure Support
RITH	Rehabilitation in the Home
RkPG	Rockingham Peel Group
SAC	Severity assessment code
SDNA	Staff with Disabilities and Allies Network
SHFT	SMHS Human Factors Training
SHQ	Sexual Health Quarters
SMHS	South Metropolitan Health Service
SNA	Short notice assessment
SNMC	Sarojini Naidu Medical College
TI	Treasurer's Instruction
VAD	Voluntary assisted dying
VMI	Virginia Mason Institute
WA	Western Australia
WACHS	WA Country Health Service
WAPHA	WA Primary Health Alliance
WAU	Weighted activity unit
WEAT	Western Australian Emergency Access Target
WHS	Work health and safety
WSS	West State Superannuation

Appendix 3 – Addresses and contacts

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