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

South Metropolitan Health Service

Annual Report 2025–26

Acknowledgement of Country and Pledge

South Metropolitan Health Service acknowledges the Whadjuk and Bindjareb Noongar people as the Traditional Owners and Custodians of the land, sea and waters on which we live and work. We pay deep respect to their Ancestors and Elders past and present.

We extend this respect to all Aboriginal and Torres Strait Islander people across Australia and acknowledge their enduring connection to Country.

We recognise that Aboriginal people have cared for this land for thousands of years and sovereignty was never ceded. We pay tribute to the strength, resilience, and courage of Aboriginal people who have survived the devastation of the past, to stand strong and proud in the present.

We accept that the colonisation of what we know as Australia has come at a great cost to Aboriginal people, and continues to have an impact today. We commit to dismantling systemic racism with a no tolerance approach across our services, and to providing culturally safe health services to improve the health and wellbeing of all Aboriginal people.

We pledge to work towards a better future, where we are all respected and valued, with Aboriginal people recognised as the First Australians.

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.

Contents

Statement of compliance

South Metropolitan Health Service for the year ended 30 June 2026

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 2026.

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

Mr Liam Roche
Board Chair
South Metropolitan Health Service
31 August 2026

Mr Brian Mumme
Board Member
South Metropolitan Health Service
31 August 2026

Our **year**

Board Chair's overview

As Chair of the South Metropolitan Health Service (SMHS) Board, I am pleased to present the 2025–26 SMHS Annual Report.

This report reflects another year of dedicated service to our community and recognises the extraordinary commitment of our staff who deliver safe, compassionate and high-quality care every day.

The Board's role is to provide strategic oversight, ensure robust clinical governance and support the delivery of safe, effective and sustainable health care. Demand for health care continues to grow. Despite these pressures, I am confident SMHS has the leadership, expertise and commitment required to respond effectively to the challenges ahead while continuing to improve outcomes for the community we serve.

The Board recognises the importance of aligning our work with broader WA Health priorities, including improving access to care, strengthening emergency and elective surgery performance, supporting mental health reform, improving Aboriginal health outcomes, enhancing workforce sustainability and ensuring the long-term financial sustainability of the health system.

Improving health outcomes for Aboriginal people remains a priority for the Board. We support continued efforts to strengthen culturally safe care and improve equity of access, experience and outcomes across all SMHS services. These efforts are fundamental to our commitment to Closing the Gap and delivering health care that is respectful, inclusive and responsive to the needs of Aboriginal people and families.

Workplace safety remains one of the Board's foremost concerns. Every employee has the right to feel safe, respected, valued and supported at work. This includes continued efforts to prevent occupational violence and aggression and to create environments where staff, patients and visitors feel safe.

We remain equally focused on physical safety, staff wellbeing and effective injury management. Safe workplaces are fundamental to delivering excellent patient care and sustaining a healthy, productive and engaged workforce.

The Board is highly aware of the challenges and opportunities presented by an ageing population and increasing demand for healthcare services. Innovation, digital technology and data driven decision-making will play an increasingly important role in helping us respond. We welcome the careful and evidence-based adoption of emerging technologies, including artificial intelligence, where they can improve patient safety, enhance clinical decision-making, increase productivity and improve the experiences of patients and staff. The development of a lip-reading application that improves communication and accessibility for patients is one example of the practical innovation occurring across SMHS.

Research and innovation are important strengths of SMHS and are critical to the future of healthcare delivery. Through our partnerships with universities, research institutes and clinical collaborators, SMHS continues to contribute to advances in medical research, translational medicine and clinical trials.

Meaningful engagement with our community remains essential. Strong consumer partnerships, including the involvement of people with lived experience, help ensure services are designed around the needs and experiences of those who use them. The Board welcomes SMHS's commitment to consumer involvement in service design and its partnerships with community organisations, research institutions, universities, primary care providers and other stakeholders, recognising that better health outcomes are achieved when we work together.

Healthcare services inevitably have an environmental impact. While our priority will always be safe, high-quality care, we support initiatives that reduce waste, improve energy efficiency, use resources more responsibly and strengthen environmental sustainability across our facilities and operations. These practical actions minimise our environmental footprint and contribute to a more sustainable and resilient health service for the future.

Above all, safety and quality and the highest standards of clinical care remain the foundation of everything we do. We are encouraged by the continued implementation of the SMHS Improvement Method in partnership with the Virginia Mason Institute, which is helping to strengthen a culture of continuous improvement by empowering staff to identify opportunities, solve problems, improve communications and deliver safer, more effective care for our patients and community.

I take this opportunity, on behalf of the Board, to thank and acknowledge the outstanding contribution of outgoing Board Chair Adjunct Associate Professor Robyn Collins, together with departing Board members Kim Gibson, Julian Henderson and Yvonne Parnell for their leadership, expertise and commitment to SMHS. The Board was pleased to welcome incoming Board members, Brian Mumme, Pearl Proud and Libby Soderholm whose diverse skills and experience will further strengthen the Board.

I also thank Chief Executive Neil Doverty, the executive team, our doctors, nurses, midwives, allied health professionals, support staff, volunteers and every member of the SMHS team.

Your dedication, compassion and professionalism make a meaningful difference to the lives of our patients and communities every day.

Looking ahead, the Board is confident that SMHS is well positioned to continue improving access, strengthening quality and safety, embracing innovation and delivering exceptional care for the communities we serve. We remain committed to supporting management, our workforce and our partners as we build a health service that is sustainable, resilient and ready for the future.

Liam Roche
Board Chair

Chief Executive's report

It continues to be a privilege to lead South Metropolitan Health Service during a period of significant transformation, growth and opportunity. While the healthcare environment remains challenging, I am pleased to report strong progress across a range of priorities that are strengthening our services, improving patient outcomes and positioning SMHS to meet the needs of our community now and into the future.

Above all, our focus remains on delivering excellent care. The safety and quality of the services we provide are the foundation of everything we do, and I am encouraged by the progress we are making through the implementation of the SMHS Improvement Method working with the Virginia Mason Institute. This work is helping us build a culture that relentlessly focuses on reducing avoidable harm, improving patient outcomes and supporting continuous improvement at every level of the organisation. Importantly, the SMHS Improvement Method is not simply a set of tools; it is helping drive cultural change by improving communication, accountability, problem solving and collaboration. As this work continues to mature, it is creating the conditions for our staff to identify opportunities, address challenges early and deliver safer, more effective care for our patients and community.

A significant milestone this year was the commencement of the Governance and Leadership Transformation Project, laying the foundation for a more strategically aligned leadership model that is collectively one and locally led. This transformation aims to strengthen accountability, support more effective decision-making and better align leadership responsibilities with organisational priorities. Ultimately, it will position SMHS to work more cohesively, respond to local needs and deliver the best possible outcomes for the communities it serves. I would like to thank everyone who provided their insight, perspectives and expertise during the initial consultation process. The journey will continue throughout the next year as we work towards a future ready health service.

Our commitment to improving health services is also reflected in the significant capital investment occurring across SMHS, in partnership with the Office of Major Infrastructure Delivery and the Department of Health. These projects will deliver lasting benefits for our patients, staff and communities. Most notably, planning continues for the new hospital in Mandurah, a once-in-a-generation investment that will significantly enhance access to healthcare services for one of Western Australia's fastest-growing regions. We have also continued to expand mental health infrastructure and services across the health service, including a significant upgrade and expansion at Fremantle Hospital.

These developments support our commitment to providing contemporary facilities that enable high-quality, patient-centred care.

This year also provided an opportunity to celebrate an important milestone, with Rockingham General Hospital marking its 50th anniversary. For five decades, the hospital has provided outstanding care and support to the local community and has grown into one of the region's most important healthcare facilities. The anniversary was a fitting opportunity to recognise the dedication of the generations of staff, volunteers and community members who have contributed to the hospital's success.

Attracting and retaining a highly skilled workforce remains one of our highest priorities. Like health systems across Australia, we continue to operate in a competitive workforce environment.

Encouragingly, we have made positive progress across both medical and broader workforce recruitment. Our focus extends beyond recruitment alone to creating an environment where people want to build rewarding and meaningful careers. We are continuing to strengthen pathways for professional development, leadership growth and career progression while fostering a culture that values excellence, accountability, collaboration and innovation.

Supporting this work has been a renewed focus on executive accountability and organisational performance. The establishment of executive sub-committees aligned to portfolio responsibilities is strengthening oversight, improving strategic coordination and ensuring greater accountability for outcomes. This governance structure is providing clearer lines of responsibility while supporting a stronger performance culture across the organisation.

As we move through winter, I am pleased with how effectively the health service has responded to seasonal demand pressures. This year's success reflects the strong foundations established through the Department of Health's systemwide Winter Strategy and the outstanding work of staff across SMHS. We have leveraged SMHS Improvement Method principles, including daily operational huddles and enhanced coordination processes, to improve patient flow and bed management across the health service. These approaches have enabled earlier identification of issues, improved collaboration between sites and supported timely decision-making during periods of high demand.

Importantly, our success continues to be driven by our people. Across the organisation we are working hard to create an environment where staff feel engaged, valued and empowered to contribute ideas for improvement.

Through structured feedback mechanisms, increased opportunities for staff input and a strong focus on communication and engagement, we are ensuring our workforce remains central to the decisions that shape our future.

Thank you to the Board Chair Liam Roche and all our Board for your support and guidance. I include in that my thanks to outgoing Board Chair Adjunct Associate Professor Robyn Collins, and outgoing board members Kim Gibson, Yvonne Parnell and Julian Henderson.

I would like to conclude by thanking the Executive team for their leadership, commitment and unwavering dedication to our patients, staff and community. Their support, expertise and collaborative approach have been instrumental in delivering the progress outlined in this report. Together with our clinicians, support staff, volunteers and partners, they continue to demonstrate the professionalism, compassion and excellence that define South Metropolitan Health Service and underpin our mission to provide exceptional care for our community.

Neil Doverty
Chief Executive

Our **community**

Who we care for

784,441
people live in our primary catchment area

21,376
identify as Aboriginal

Lifestyle of our adult population

14% smoke (in line with the WA average)

30% drink alcohol at levels that could lead to long-term harm

38% get the recommended amount of physical activity per week

74% are overweight or obese

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

Top countries of birth excluding Australia

Philippines	1%
India	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

220,539
emergency department presentations
40,049 were children
19,345 most patients seen in a month
639 most patients seen in one day at FSH

1,095,215
outpatient appointments
422,838 delivered virtually
133,901 clinical home visits

202,736
community-based mental health engagements

5,548
births
180 multiple births
19 births in one day

195,660
inpatients
4,515 mental health inpatients
3,904 ICU inpatient admissions

169
transplant procedures
9 heart
25 lung
1 heart and lung
47 kidney
87 bone marrow

Our workforce

We have **16,713** staff, working across 12,015 full-time equivalent positions.

Our workforce professions

2% Midwifery

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

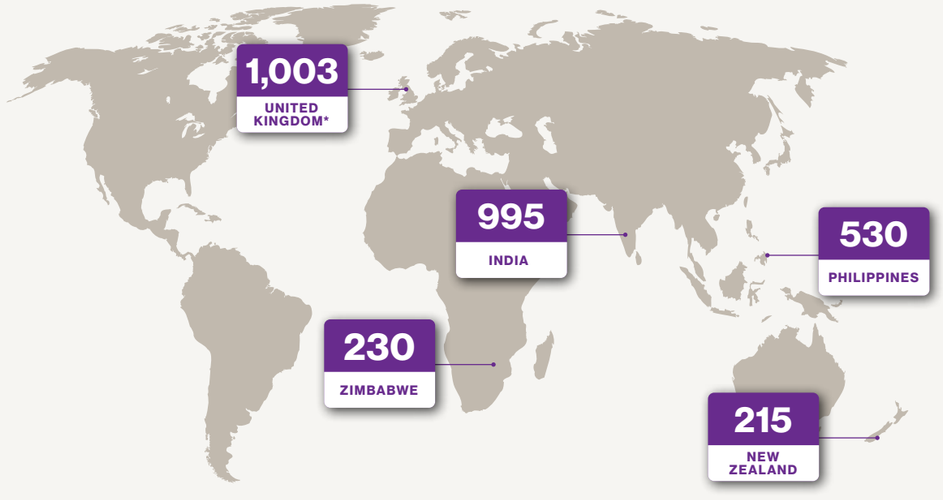
13% Administration and clerical

14% Allied health

15% Medical

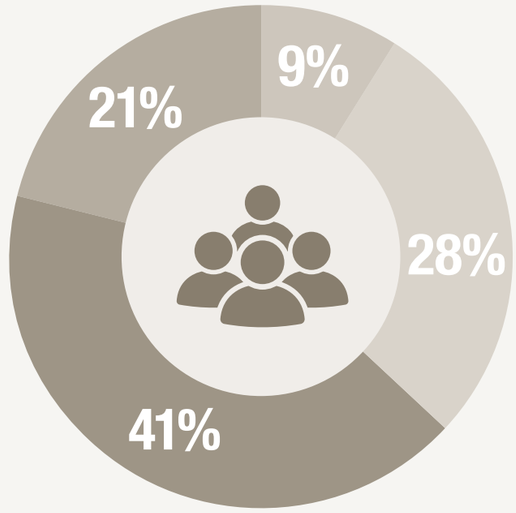
45% Nursing

Top five countries of birth (excluding Australia)



*Including England, Wales and Northern Ireland combined.

Average age of SMHS staff by generational groupings



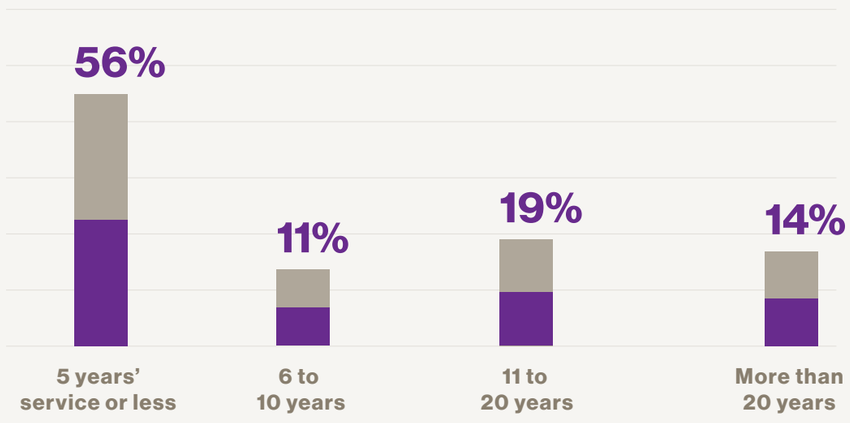
BOOMERS
8%
Born 1946 to 1964

GEN X
26%
Born 1965 to 1979

GEN Y MILLENNIALS
42%
Born 1980 to 1994

GEN Z
24%
Born 1995 to 2010

Length of service of our workforce



Our **structure**

Our structure

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.

Mr Liam Roche | Chair
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 has spent time teaching the next generation of business leaders at university.

Ms Sue Le Souef | Deputy Chair
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.

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 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.

Mr Brian Mumme (commenced October 2025)
B Eng Chem (Hons), GAICD

Mr Brian Mumme is a former senior executive with over 30 years of national and international experience in commodities (oil, gas and agriculture), with a focus on marketing, trading, risk management and optimising supply chains. Immediately prior to his appointment to the SMHS Board, Mr Mumme was an external advisor on the Board's Audit and Risk Committee and Finance and Governance Committees

Dr Stephanie Trust

Dr Stephanie 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.

Pearl Proud (commenced October 2025)
MAICD

Ms Pearl Proud is an executive consultant and strategist who advises businesses and organisations on inclusion frameworks, policy development and psychological safety. She has held senior roles in clinical service delivery, policy, and accreditation, and is a consulting psychologist and Australian Health Practitioner Regulation Agency (AHPRA)-approved clinical supervisor.

Ms Proud has extensive governance experience, having served as a board chair, non-executive director, and governance mentor across a broad range of sectors, including the arts, health and mental health, government, tertiary education and community organisations.

Ms Proud is a member of the Edith Cowan University (ECU) Council, where she serves on the Governance and Nominations Committee and the People, Safety and Culture Committee. She is also a board member of the Chamber of Arts and Culture, an invitee to the ECU School of Business and Law Advisory Board, and Chair of the ECU Master of Professional Psychology Consultative Committee. In addition, she is a TEDxPerth Curator and has served on judging panels for awards including the WA Multicultural Awards and the Kimberley Art and Photographic Prize.

Ms Elizabeth (Libby) Soderholm (commenced October 2025)
BPhty, Pg Dip. Sports Phty, GAICD, MACP

Ms Libby Soderholm is an accomplished non-executive director, consultant and sports physiotherapist with a distinguished career spanning governance, leadership and clinical practice. She built and led two successful multidisciplinary health clinics in Western Australia, demonstrating a combination of entrepreneurial vision and clinical excellence.

Libby holds a Diploma in Business Management and a graduate qualification from the Australian Institute of Company Directors. Her diverse board experience – encompassing the health, aged care, regulation, not-for-profit and education sectors – reflects both the breadth of her expertise and her commitment to contributing beyond her immediate profession.

A passionate advocate for physiotherapy, Libby is deeply engaged with the Australian Physiotherapy Association (APA), contributing to several national committees and representing Australia as the APA delegate to the International Private Physical Therapy Association. She currently also serves on the Curtin Heritage Board.

Previous Board members

The following board members concluded their board service on 30 September 2025:

- Adj Ass Prof Robyn Collins, Chair
- Kim Gibson, Deputy Chair
- Yvonne Parnell, Member
- Julian Henderson, Member.

Board committees

Liam Roche, Board Chair
South Metropolitan Health Service

- Safety and Quality Committee
- Finance and Governance Committee
- Audit and Risk Committee
- People, Culture and Engagement Committee

Safety and Quality Committee

Sue Le Souef, Chair

Amanda Boudville (Member)

Elizabeth Soderholm (Member)

Pearl Proud (Member; External member June 2025 to October 2025)

Prof Phillip Della (External member)

Yvonne Parnell
(External member from February 2026; Member June 2025 to September 2025)

Kim Gibson
Chair June 2025 to September 2025)

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.

2025–26 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.
- 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

Brian Mumme, Chair
(External member June 2025 to October 2025)

Karen Brown (Member)

Colin Murphy (Member)

Jonathan Seth (External member from February 2026)

Julian Henderson (Member June 2025 to September 2025)

Liam Roche
(Chair June 2025 to September 2025)

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.

2025–26 key achievements

- Oversight of the 2025–26 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 (Member)

Elizabeth Soderholm (Member)

Brian Mumme (Member; External member June 2025 to October 2025)

Jonathan Seth (External member from February 2026)

Julian Henderson (Member June 2025 to September 2025)

Liam Roche (Member June 2025 to September 2025)

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*.

2025–26 key achievements

- Monitored risk, control and compliance frameworks.
- Provided oversight of work health and safety compliance and performance in maintaining a safe work environment.
- Reviewed actions to ensure audit recommendations are addressed in a timely and comprehensive manner.
- Monitored compliance with the *SMHS Integrity Framework*.
- Conducted a program of internal audits across a range of areas, including patient services, leave management, bed and drug management.

People, Culture and Engagement Committee

Amanda Boudville, Chair

Pearl Proud (Member)

Dr Stephanie Trust (Member)

Fiona Payne (External member)

Julian Henderson (Member June 2025 to September 2025)

Yvonne Parnell (Member June 2025 to September 2025)

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 provides advice to the Board on workforce matters relating to organisational culture and staff engagement.

2024–25 key achievements

- Continued to provide oversight and strategic guidance on key workforce and engagement priorities, with a focus on strengthening organisational culture, supporting staff capability and wellbeing, and enhancing patient experience.
- Maintained a strong focus on medical workforce priorities, including addressing cyclical registrar shortages and supporting staff health, wellbeing, training and research opportunities.
- Increased the proportion of Aboriginal employees, with particular growth in Aboriginal health practitioner roles.
- Continued to emphasise and focus on improving patient experience across services.

Board term and meeting attendance

The SMHS Board met on 11 occasions in 2025–26.

Table 1. South Metropolitan Health Service Board term and meeting attendance

Member name	Position	Term	Meetings attended
Robyn Collins	Board Chair (until 30 September 2025)	1 July 2016 to 30 September 2025 (reappointed for a further three months from 30 June 2025)	3 of 3 meetings
Liam Roche	Board Chair (from 1 October 2025)	1 August 2019 to 11 August 2028 (reappointed for a further three years on 25 August 2025)	11 of 11 meetings
Kim Gibson	Deputy Chair (until 30 September 2025)	1 July 2016 to 30 September 2025 (reappointed for a further three months from 30 June 2025)	2 of 3 meetings
Sue Le Souef	Deputy Chair (from 1 October 2025)	9 March 2020 to 30 June 2026 (reappointed for a further two and a half years on 20 November 2023)	11 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 2028 (reappointed for a further three years on 25 August 2025)	11 of 11 meetings
Julian Henderson	Board member	1 July 2016 to 30 September 2025 (reappointed for a further three months from 30 June 2025)	3 of 3 meetings
Brian Mumme	Board member	1 October 2025 to 30 June 2028	8 of 8 meetings
Colin Murphy	Board member	9 November 2020 to 8 November 2028 (reappointed for a further three years on 9 November 2025)	11 of 11 meetings
Yvonne Parnell	Board member	1 July 2016 to 30 September 2025 (reappointed for a further three months in June 2025)	3 of 3 meetings
Pearl Proud	Board member	1 October 2025 to 30 June 2027	8 of 8 meetings
Elizabeth Soderholm	Board member	1 October 2025 to 30 June 2027	8 of 8 meetings
Stephanie Trust	Board member	15 July 2024 to 30 June 2026	11 of 11 meetings

Our executive

As at 30 June 2026

Neil Doverty
Chief Executive
South Metropolitan Health Service

Mark Cawthorne
Executive Director, Corporate and Finance

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

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

Luke Dix
Executive Director, Fiona Stanley Fremantle Hospitals Group

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

Kellie Blyth
Executive Director, Peel Health Campus

- Murray District Hospital
- Peel Health Campus

Dr Asheila Narang
Executive Director
Rockingham Peel Group

- Rockingham General Hospital
- Peel Community Health

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

Emma Davies
Executive Director, Transformation

- Digital health
- Innovation
- Organisational development
- Research

Peta Fisher*
Area Director, Nursing and Midwifery

- Area nursing and midwifery services
- VAD Statewide Care Navigator Service

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

Bryan Cook
Executive Director, Contract Management

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

Dr Mark Monaghan*
Area Director Clinical Services

- Area clinical services

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

Our **focus**

Our vision

The SMHS vision is **excellent health care, every time.**

To be an excellent health service, the focus is on the patient's journey and experience, staff engagement and support, and clinical and financial performance.

Our values

Care

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

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

Integrity

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

Noongar translation: Ngwidam Ngalak accountable ngaalang warn wer kalyakoorl yaka-l doora kartaga.

Respect

We welcome diversity and treat each other with dignity.

Noongar translation: Kaaratj Ngalak wandjoo goordawi wer noordo yennar warma-al kaaratj.

Excellence

We embrace opportunities to learn and continuously improve.

Noongar translation: Beli-beli Ngalak barang wilyan kaadadj wer kalyakoorl kwobabiny.

Teamwork

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

Noongar translation: Yaka-dandjoo Ngalak kaadadj yardi of teams wer dandjoo yaka banga.

Our values

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.

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.

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.

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.

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 WA Country Health Service (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 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 highly specialised statewide 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 and quaternary 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.

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 (PHC)

Peel Health Campus 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.

In 2025–26, governance of **Murray District Hospital (MDH)** – which provides general and geriatric medicine predominantly covering aged care services, particularly to people awaiting rehabilitation and receiving end-of-life care – transitioned to PHC from RkPG.

SMHS Mental Health

SMHS Mental Health delivers voluntary and involuntary care to youth, adult and older adult patients with both acute and complex mental health conditions in the south metropolitan area. Mental health services are provided in all settings including inpatient, community, outpatients and emergency departments through the following groups:

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

The locations from which services are offered include:

- Fiona Stanley Hospital
- Fremantle Hospital
- Fiona Stanley Hospital–Cockburn Health (Cockburn Health)
- Rockingham General Hospital
- Peel Health Campus
- Rockingham and Mandurah Community Mental Health Clinics
- Cockburn Integrated Health
- City of Cockburn Youth Centre
- Peel Health Hub.

SMHS Mental Health services are delivered by multidisciplinary teams which work together to ensure patient care is evidence-based, person-centred, recovery-oriented and responsive to individual cultural and individual needs.

SMHS Mental Health provides a range of services for consumers with acute and complex mental health conditions, including:

- **Adult mental health:** services for consumers aged 18 to 64 years, including inpatient care, Home Treatment/Hospital in the Home and community-based services.
- **Older adult mental health:** services specifically for consumers aged 65 years and over. These include inpatient care, Home Treatment/Hospital in the Home, and community-based services tailored to the needs of older adults, including support for mental disorders associated with ageing.
- **Youth mental health:** services designed for young people aged 16 to 24 years including inpatient care (Youth Mental Health Unit) and community-based support (Youth Community Assessment and Treatment Team and Youth Hospital in the Home). YouthReach South also provides specialised care for young people aged 13 to 24 years who experience severe mental health challenges and face significant barriers to accessing services, such as homelessness.
- **Women's mental health:** Cockburn Health offers inpatient services for women aged 18 to 64 years, supporting those with mental health conditions, eating disorders, and alcohol and other drug (AoD) issues, including behavioural and withdrawal management.
- **Specialist services:** SMHS Mental Health delivers specialised programs, including the Mother and Baby Mental Health Unit at FSH, and Kara Maar, the South Metropolitan Specialist Community Eating Disorder Service, located in a purpose-built facility at Cockburn Integrated Health. In addition, the Gaming Disorder Clinic, operating from the FSH Mental Health Unit and Cockburn Health, forms part of a broader addiction treatment model. Established in 2022, this statewide service provides early detection, assessment and treatment for people of all ages experiencing digital addiction and operates seven days per week with extended hours.
- **Liaison services:** Mental health and AoD consultation liaison teams provide support to general wards across all SMHS hospitals. Psychiatric liaison services are also available in the emergency departments at FSH, RGH and PHC.
- **Other services:** Additional supports address both crisis situations and ongoing mental health needs across the south metropolitan area. These include:
    - Police and Ambulance Co-Response services
    - clinical support for step-up step-down residential facilities and an NGO-operated residential rehabilitation service in Orelia
    - specialist inreach to the Specialist Dementia Care Program delivered at Villa Dalmacia by Hall and Prior.

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 the *WA Health Smoke Free Policy*, the *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 (NDIS) 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 have been legally able to 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 showcase shared learnings, valuable insights and real-life stories for the health community.

Meeting our commitments

New Mandurah Hospital (Peel Health Campus transformation)

In August 2024, PHC officially became part of SMHS, as promised by the State Government in 2020.

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

SMHS is now working closely with the Office of Major Infrastructure Delivery to support the design and delivery of the New Mandurah Hospital announced by the State Government in November 2025.

The new hospital will deliver a modern, purpose-built healthcare facility designed to replace the ageing existing hospital and significantly expand services to meet the growing healthcare needs of the Peel region. It will feature a larger, contemporary emergency department, dedicated mental health and palliative care units, increased inpatient capacity (including a new high dependency unit), a new operating theatre complex, expanded outpatient services and enhanced cancer treatment facilities. These upgrades aim to create a future-focused hospital that will strengthen community access to high-quality care by 2028–2029 financial year.

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

A dedicated women's reproductive health facility will be located at Cockburn Health and operated by specialist provider Sexual Health Quarters (SHQ).

Over the year, SMHS has worked with SHQ and DoH to prepare for the service commencement.

SMHS continues to support SHQ with the complex facility interface and licensing requirements, with their service expected to open in late 2026.

Mental health beds at Fremantle Hospital

The introduction of this service is intended to help reduce demand for hospital emergency departments by offering an alternative, dedicated pathway for urgent mental health care.

Once operational, the project will increase the number of mental health beds at FH from 64 to 104, substantially enhancing capacity to meet growing community demand and strengthening the continuum of care across the region.

Practical completion of the building was achieved in May 2026, with handover of the building in June 2026. The facilities are being introduced through a staged opening, with some services commencing from July and wards progressively opening from August.

Commissioning activities continued through to the end of June 2026, with services scheduled to commence in early July 2026 using a five-phased opening approach through until 8 September 2026 to ensure safe and effective service delivery from day one.

Mental health emergency centre at RGH

The establishment of a new, short stay mental health assessment facility and two behavioural assessment bays at RGH will improve patient and clinical outcomes for vulnerable consumers.

SMHS and the Department of Housing and Works continued to work together during 2025–26. The project has progressed through to tender stage with building works expected to commence in the second half of 2026.

The facility will be connected to the existing hospital emergency department and a new ambulance set down area will be constructed as part of the work.

Waterbirth facilities at RGH

In 2025, the government committed $300,000 in funding towards a waterbirth facility at RGH, increasing birthing options and equity for families in the local catchment area. Waterbirth is widely recognised as an effective option for birthing in low-risk pregnancies due to the comfort provided to the woman through immersion in water.

The project is currently in the planning phase, with an architect and engineer engaged to complete the detailed design. The new facility is expected to be completed in 2027.

Enhancing community-based care for older adults

The first of three hubs across metropolitan Perth, aimed at improving access to co-ordinated, multidisciplinary health care closer to home, opened in March at Cockburn.

Called the Older Adult Health Hub (OAHH), it is a specialist led service delivering integrated community based care for older adults across the SMHS catchment. As a nation leading reform, delivered in collaboration with the DoH and other health service providers, it represents a major achievement in establishing a new model of care focused on early identification and support for older adults at rising risk.

Service delivery was co designed with general practitioners, community providers and primary healthcare stakeholders, ensuring strong alignment with system needs.

In its first six months, the hub received more than 200 referrals, primarily from general practitioners. The hub provides a single point of access for primary health providers and delivers comprehensive, person-centred care tailored to the complex physical, social and emotional needs of older adults. A care navigation service supports individuals to access existing community services and resources, helping reduce fragmentation and improving continuity of care.

In its early months, the hub established geriatric, psychiatry and bone health pathways. These were delivered by a multidisciplinary team including a geriatrician, older adult psychiatrist, general practitioner, care navigators, nursing staff and allied health professionals. These pathways form the foundation of the hub's integrated approach to supporting older adults to live well in the community.

Electronic Medical Record program

SMHS has been supporting in the design and implementation of vital new safe and secure network infrastructure upgrades and a modern desktop environment in preparation for the introduction of the Electronic Medical Records (EMR) – a statewide digital transformation project to connect clinical information across WA health sites.

SMHS has actively contributed clinical input and guidance to WA Health in the development of eMR steering, governance and workshops to ensure needs and requirements are met as the program progresses to ensure SMHS organisational preparedness.

SMHS has also collaborated with the eMR program to support selection of an appropriate vendor who will become the WA Health partner to support this significant change.

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.

Interim strategic approach

The *SMHS Strategic Plan 2021–2025* concluded in December 2025. As part of a planned transition period, SMHS introduced interim strategic plans across priority areas to maintain strategic focus while recruiting a new Chief Executive and embedding the newly established Virginia Mason Institute (VMI) partnership within the organisation's long-term strategy. These plans provide continuity of strategic direction, support ongoing transformation and improvement activities, and enable focused delivery while the future strategic plan is being developed. The interim strategic plans also provide a practical foundation for identifying opportunities, challenges and emerging priorities that will inform the next phase of SMHS's strategic direction.

From July 2026, SMHS is undertaking a comprehensive strategic planning process involving environmental scanning, stakeholder consultation, consumer and community engagement, and collaboration with staff and partners. Guided by the Board and the executive team, the process will establish a clear strategic direction, strategic priorities, and measurable outcomes to guide SMHS over the next three to five years. Development is expected to occur between July 2026 and January 2027, with the new SMHS Strategic Plan scheduled for launch in February 2027.

SMHS continues to report against the *SMHS Strategic Plan 2021–2025.*

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 – the SMHS Improvement Method

In 2025–26, SMHS progressed the development and early implementation of the SMHS Improvement Method, a multi-year quality management system developed in partnership with the VMI of Seattle, USA. Designed to support SMHS's vision of delivering excellent health care, every time, the SMHS Improvement Method provides a consistent, organisation-wide approach to quality, safety and continuous improvement, under the principle of *Collectively One, Locally Led*.

A major milestone during the year was completion of the readiness phase, which assessed improvement capability across SMHS through extensive staff engagement, including more than 1,000 survey responses, over 100 stakeholder interviews, 33 site visits and almost 100 focus groups. Findings highlighted opportunities to strengthen organisational alignment, communication, patient flow and coordination of services, while building a more consistent culture of continuous improvement.

The assessment also confirmed a strong commitment to patient care across the workforce and identified opportunities to reduce variation, duplication and inefficiencies.

SMHS also commenced early implementation activities focused on leadership development and capability building. Initiatives included executive Team of Teams programs, VMI-facilitated workshops and training in improvement methodologies such as Advanced Daily Management, Healthcare Improvement for Leaders and Strategic Leadership in Healthcare Improvement. These activities strengthened staff and leadership capability in systems thinking, collaboration and improvement practices.

The SMHS Improvement Method is expected to support safer, more consistent and efficient care by reducing unwarranted variation, empowering frontline teams and embedding continuous improvement into daily practice. As implementation continues, SMHS will focus on expanding capability, strengthening supporting systems and further embedding the SMHS Improvement Method across all sites and services.

Building our QA capabilities

At SMHS, quality improvement is not a one-off activity – it is a way of working.

Our vision is to create a culture where every staff member is supported to not only do their work, but to continuously improve it. This approach is central to the SMHS Quality Improvement (QI) Strategy, which focuses on building capability across the organisation to:

- identify opportunities for improvement
- test solutions
- deliver better outcomes for patients, carers and the community.

To support this vision, in 2025–26 a wide range of QI training opportunities were available, including the:

- Institute for Healthcare Improvement (IHI) Basic Certificate in Quality and Safety, providing foundational knowledge in quality improvement, patient safety and system design
- SMHS Quality Certificate, recognising completion of key improvement modules and supporting progression to more advanced learning
- SMHS Introduction to Quality Improvement and Governance, Evidence, Knowledge, Outcomes (GEKO) session, providing foundational knowledge on quality and service delivery improvement concepts and methodologies.

These programs equip staff with the tools and confidence to lead meaningful change in their local areas.

Enabling clinical excellence

The SMHS Clinical Excellence Unit supports the delivery of safe, high-quality and evidence-informed health care through clinical governance, audit, outcomes measurement, quality improvement and digital innovation.

Working in partnership with clinicians, service leaders and governance committees, the unit provides the systems, data and expertise needed to monitor performance, identify improvement opportunities and support better patient outcomes.

As health care becomes increasingly complex and data-driven, understanding clinical variation and patient outcomes is critical to improving care. Through clinical reporting, audit programs, registry governance and digital solutions, the unit supports evidence-informed decision-making, continuous improvement and clinical excellence across SMHS.

Key achievements in 2025–26 included:

- **Clinical Variation Scanner**
  Continued implementation of the Clinical Variation Scanner, which analyses clinical activity and patient outcome data from multiple sources to identify unwarranted variation across SMHS. Monthly reports are reviewed through established governance processes at each site, enabling clinical leaders to investigate findings and implement improvement actions where required.
- **Mortality and Morbidity App**
  Development of the SMHS Mortality and Morbidity (M&M) app, designed to provide a single platform for conducting M&M reviews. The application supports case selection, streamlines clinical review processes and generates automated reports on meetings, learning themes and improvement actions. A clinical working group has guided development, with implementation planned for 2026–27.
- **Clinical Care Standards App**
  This app supports implementation and monitoring of all 20 national Clinical Care Standards across more than 250 performance indicators. The app was expanded to mental health services and in partnership with the SMHS Aboriginal Health Strategy team, enhanced to include cultural safety and equity measures for Aboriginal people.

- **Clinical Quality Registries Governance**
  Ongoing management of the Clinical Quality Registries app, including governance of registry registrations based on risk assessment and ensuring data transfer agreements are in place for all high-risk registries. These arrangements strengthen privacy, security and oversight of patient information shared with external organisations.

Improving clinical workflows

Significant work was undertaken across SMHS to develop REDCap-supported workflows that securely manage clinical information and support care processes not captured in core systems. These solutions are designed to align with clinical workflows, improve efficiency and strengthen care coordination.

Maturing multidisciplinary meeting (MDM) workflows for thoracic malignancy and interstitial lung disease are now being adopted by sites beyond SMHS. A lung nodule MDM solution was also implemented to support increasing demand for high-risk nodule monitoring and referrals through the National Lung Cancer Screening Program, helping facilitate timely treatment planning and ongoing care.

The workplace-based assessment program for overseas-trained doctors at RGH and PHC continues to benefit from automation of the multi-source feedback process. The initiative received a 2026 SMHS Excellence Award and has since been adopted by WACHS. The solution has reduced administrative burden and received positive feedback from both candidates and staff.

During 2025–26, SMHS introduced a new category of workflow support to assist teams delivering complex models of care. Developed in partnership with the FSH inflammatory bowel disease and colorectal cancer teams, and the SMHS Older Adult Health Hub, these solutions replace spreadsheet-based case management with more secure, integrated and automated processes. The Older Adult Health Hub solution has been recognised by DoH as a leading approach for delivering this new community-based service.

Enhancing clinical audit tools and accreditation readiness

Collaborative work has been undertaken across all SMHS sites to revise clinical audit tools to incorporate the latest SMHS-wide approach to the management of peripheral intravenous cannulas. A new WeCAN tool in development to support the expanding SMHS Home Hospital services and a range of sepsis-related audit tools have been introduced across SMHS sites.

Existing inpatient and perioperative WeCAN tools and comprehensive reporting dashboards have undergone enhancement cycles to maintain currency with safety, quality and risk standards, and alignment to Clinical Care Standards. Maintaining robust core clinical audit systems is key to accreditation readiness and preparation for short notice assessments.

Improving surgical access

The TheatreFlow+ clinical services redesign initiative is aimed at improving surgical service delivery across FSFHG by increasing theatre capacity, improving patient flow and optimising the use of existing resources.

Commencing in the second half of 2025–26, the project supports SMHS priorities to reduce surgical wait times, improve access to emergency surgery and deliver high-quality, equitable care.

During 2025–26, a governance framework was established to support a consistent, data-driven and clinically led approach to theatre performance improvement. Several initiatives were progressed across scheduling, workforce planning and operational workflows, including:

- development and implementation of a surgical estimator to support scheduling reform and improve theatre efficiency
- co-design of standardised business rules for theatre list ordering and ‘golden case’ selection
- introduction of clearer theatre workflows, including defined surgical huddle processes and patient ‘wheels in’ times
- commencement of pre-admission optimisation activities across day admission and waitlist teams to improve patient preparedness and support early identification of clinical risks.

In May 2026, the project reached a significant milestone with the soft launch of the On-Time Start Initiative, aimed at achieving consistent 8:15am theatre starts. The initiative has focused on staff education, data transparency and clinician-led process improvement. Consistent on-time starts are expected to increase theatre productivity, improve completion of scheduled operating lists and reduce overtime, overruns and avoidable cancellations.

Early achievements included:

- revised arrival times for elective surgery patients across both FSFHG sites
- alignment of anaesthetic registrar start times with patient arrival in the holding bay to support earlier clinical review and consent
- collaboration with nursing and ward teams to streamline first-case patient transfers and improve timely access to the perioperative holding bay
- development of patient preparation resources
- introduction of real-time morning audits to identify and address delays as they occur.

The project was informed by data analysis, stakeholder consultation and benchmarking which identified opportunities to improve start times, reduce turnaround delays and optimise theatre utilisation. Expected benefits include reduced waiting times, fewer same-day cancellations, improved access to surgery and a more efficient and sustainable operating theatre service. Through strong multidisciplinary collaboration, TheatreFlow+ is supporting improved patient outcomes and enhanced surgical service performance across SMHS.

Enhancing post-operative care for patients

Building on the successful implementation of Fremantle Hospital's Short Stay Arthroplasty Project in 2024–25, the program progressed to optimisation and benefits realisation during 2025–26.

The multidisciplinary model of care continued to integrate care coordination, patient education, preoperative optimisation, evidence-based symptom management and early mobilisation strategies, supported by digital engagement through Personify Care.

New initiatives included a pharmacist partnered charting model, the first of its kind in Western Australia for orthopaedic patients, which strengthened medication safety, reduced duplication and improved workflow efficiency. The project continued to be underpinned by strong clinical leadership, consumer partnership and a structured change management approach that supported sustainable practice change.

During 2025–26, more than 500 hip and knee arthroplasty patients were managed through the pathway, achieving a median length of stay of 1.4 days compared with a pre-project average of 3.5 days. Seventy per cent of patients mobilised on the day of surgery and 65 per cent were discharged home on day one, while 96 per cent of patients returned directly home or to planned accommodation following discharge.

These improvements have enhanced patient flow, increased bed availability and demonstrated that short-stay arthroplasty can be successfully delivered in a complex public hospital environment without compromising quality of care.

Patient experience remained a key strength of the program. Most patients reported feeling well prepared for surgery, satisfied with the information and support provided, and confident managing their recovery at home.

Satisfaction with care exceeded 85 per cent across multiple measures, while 96 per cent of patients reported their pain was manageable following discharge and 97 per cent were successfully managing their activities of daily living.

The project has demonstrated that coordinated, patient-centred care, supported by digital tools and multidisciplinary collaboration, can deliver better outcomes for patients while improving service efficiency and sustainability.

Boosting mental health crisis support

Commencing in March 2026, the FSFHG Aftercare program provides short-term, recovery-oriented support for people who present to FSH Emergency Department (ED) following a suicide attempt or suicidal crisis. Within SMHS, Mental Health Services delivers the Hospital Service Provider component in partnership with the commissioned non-government organisation, Neami.

The program supports people aged 16 years and over who present in suicidal crisis, do not require admission, and are not currently engaged with community mental health services. Eligible consumers receive timely mental health assessment, collaborative safety planning and facilitated referral to Neami Aftercare services, promoting rapid intervention, continuity of care and person-centred support.

An outpatient Aftercare clinic, operating up to three days per week, provides short-term therapeutic interventions, medication review and prescribing within nurse practitioner scope of practice.

The service is delivered by a multidisciplinary team comprising a nurse practitioner, clinical nurse specialists, a social worker, peer worker, Aboriginal health liaison officer, senior psychiatric registrar and administrative support.

This diverse workforce supports culturally responsive, recovery-focused care and strengthens access to early intervention and ongoing support for people experiencing suicidal distress.

Strengthening suicide risk assessment and intervention

SafeSide is an international suicide prevention organisation that provides evidence-based training and resources to strengthen suicide risk assessment and intervention. In partnership with the MHC, SafeSide training has been adapted to the Western Australian context to align with local service delivery and priorities.

The SafeSide Connect, Assess, Respond, Extend (CARE) program uses video-based learning and practical demonstrations to build clinicians' skills in engaging with, assessing and supporting people experiencing suicidal distress. The framework promotes person-centred, compassionate and safety-focused care.

SMHS Mental Health Services commenced a staged implementation of SafeSide training across all services in May 2026, with 56 staff attending the initial session. Participant feedback was highly positive, highlighting the training's practical relevance and value to clinical practice.

Training will continue across all sites throughout 2026–27 and is being incorporated into staff orientation programs, including onboarding for the FH Vblock development. SMHS aims to train 70 per cent of its mental health workforce – approximately 1,000 staff – in the SafeSide CARE framework by June 2027, strengthening suicide prevention capability, clinical confidence and outcomes for people experiencing suicidal crisis.

Enhancing youth mental health care and engagement

Developed by Orygen Digital and co-designed with young people, MOST is an evidence-based digital mental health platform for young people aged 12–25. It has demonstrated reductions in psychological distress and strong user satisfaction.

The platform provides access to evidence-based therapeutic resources, a moderated online community and support from clinicians, peer workers and vocational specialists. Designed to complement face-to-face care, it enables SMHS clinicians to refer young people directly, integrate digital resources into treatment, and collaborate with Orygen Digital's clinical team.

A formal collaboration agreement in place between SMHS Mental Health and Orygen Digital supports clinical governance, confidentiality and service delivery. Young people can continue accessing MOST throughout their mental health journey until the age of 26, enhancing continuity of care.

Implementation across SMHS youth mental health services has progressed strongly, with staff training completed and referral pathways established. Approximately 57 per cent of referred young people have successfully onboarded to the platform, a positive outcome for a digital mental health service. Future efforts will focus on expanding access across adult services and strengthening referral consistency.

Delivering integrated recovery services for vulnerable consumers

Active Recovery Team (ART) continued to deliver recovery-focused support across SMHS through services at FSH and Peel.

In partnership with MIND and MIFWA, ART provides up to 90 days of wraparound care for people with complex mental health and/or AoD needs, complementing clinical treatment with community-based psychosocial support.

In Peel, the service achieved positive outcomes.

At FSH, ART is integrated with the Youth Community Assessment and Treatment Team, delivering a flexible model that combines clinical, psychosocial and peer support. Through early intervention and assertive outreach, the service engages young people who may not otherwise access traditional care.

The program has demonstrated strong recovery outcomes, including improved engagement in education and employment and enhanced support for families and carers.

Progressing implementation of designated RN prescribing

The endorsement of Scheduled Medicines – Designated Registered Nurse Prescriber came into effect on 30 September 2025. This enhanced model of registered nursing practice in Australia enables suitably educated and experienced registered nurses (RNs) to prescribe medicines under a formal prescribing agreement with an authorised health practitioner, such as a medical practitioner or nurse practitioner.

In June this year, SMHS initiated an inaugural workshop focused on progressing the implementation of designated RN prescribing within Western Australia. The discussion sought to align stakeholders on the approach to operationalise this new legislative capability, support early adopters, and ensure a coordinated, systemwide approach to developing and implementing models of care.

A key theme was enabling early adoption, alongside recognition that collaboration, shared learning and consistent governance would be critical to successful implementation.

Ongoing consultation processes, including feedback on supporting frameworks and continued engagement with cross functional healthcare groups, were largely supportive.

Further discussions, with an emphasis on continued collaboration, consultation opportunities and sharing of exemplar models of care to guide implementation, will follow as the initiative unfolds across SMHS.

Bringing high-acuity care closer to home

The Nurse Specials Unit at PHC was established to provide high-acuity inpatient care closer to home, reducing the need for transfers to tertiary hospitals.

The unit supports patients requiring advanced interventions, including telemetry monitoring, high-flow nasal cannula therapy and management of diabetic emergencies, while improving patient flow and reducing ED demand.

Since commencing in June 2025, the unit has cared for 120 patients, saving almost 4,000 ED hours. A 23 per cent reduction in code blue patients returning to the ED has also demonstrated improved continuity and stability of care.

The success of the unit reflects the commitment of a specially trained nursing workforce delivering safe, compassionate and patient-centred care. The initiative has strengthened local capability, enhanced the patient and family experience and provided a sustainable model of care for the Peel community.

Improving access to respiratory care

RGH has strengthened care for patients with respiratory illness through the implementation of a respiratory clinical nurse specialist (CNS) role. Respiratory conditions represent the hospital's largest inpatient cohort, accounting for 22 per cent of total inpatients, with chronic obstructive pulmonary disease admissions increasing by 12 per cent. The role was introduced to improve access to specialist respiratory care closer to home, support earlier assessment and intervention, and provide targeted education for patients, families and staff.

The Respiratory CNS provides support across inpatient and outpatient settings, including nurse-led airway disease clinics, education on inhaler technique and chronic obstructive pulmonary disease management, smoking cessation support, preventative care advice, pulmonary function testing and follow-up assessment. The role also supports the chronic obstructive pulmonary disease Rapid Access Clinic, working with the multidisciplinary team to provide timely testing, education and care planning for patients who may otherwise be at higher risk of hospital presentation or longer inpatient stays.

During 2025–26, the service provided care to 229 patients in outpatient settings, including chronic obstructive pulmonary disease management, smoking cessation support, spirometry, fractional exhaled nitric oxide testing and symptom follow-up.

A further 77 patients were supported through the chronic obstructive pulmonary disease Rapid Access Clinic. The role has also contributed to safer inpatient care through respiratory consultation, chest drain support, education for junior doctors and bedside nurses, policy review and hospital-wide education sessions. For some patients, including those requiring asthma monoclonal antibody treatment, the service has reduced the need to travel to FSH by delivering more care locally.

Transitioning Murray District Hospital governance

Following the transition of PHC to public management in August 2024, MDH governance was realigned from RkPG to PHC. The change supports WA Health's strategic focus on improving access, coordination and continuity of care closer to home for the Peel community.

The transition was guided by the priorities of the *SMHS Older Adult Service Strategy*, including equitable access, improved care and service navigation, workforce capability, consumer involvement and strengthened care coordination.

Extensive collaboration between MDH, RkPG and PHC ensured effective planning, risk management and change support for staff and patients. The transition was completed in two phases, with services successfully transferring on 23 March and 29 June 2026.

The successful governance transition has strengthened service integration across the Peel region, supporting more coordinated and patient-centred care for the local community.

Strengthening collaboration between endocrinology and diabetes care

In January 2026 PHC, in partnership with FSFHG, established a hub-and-spoke Endocrinology and Diabetes Service for the Peel community.

The service provides specialist inpatient consultations and a multidisciplinary outpatient model supported by endocrinologists, diabetes educators and dietitians. Care is available for patients with Type 1 diabetes, complex Type 2 diabetes, selected endocrine conditions and gestational diabetes, enabling more people to access specialist care closer to home.

As the first hub-and-spoke medical specialist service established at PHC, the model strengthens collaboration between PHC and FSFHG while improving access, continuity of care and patient experience for people living in the Peel region.

Strengthening perioperative care through structured nursing pathway

RGH has strengthened the safety and quality of perioperative care through the introduction of a structured 'novice to expert' nursing pathway.

Developed to support nurses entering a complex and high-risk clinical environment, the program provides a consistent and supported transition into practice. It was introduced in response to a significant intake of new staff, with a focus on ensuring patients receive care from clinicians who are confident, capable and well prepared.

The pathway replaces traditional task based orientation with a more deliberate approach to workforce development. It combines theory, simulation, supervised clinical practice and reflective learning to support nurses to build both technical skills and clinical judgement. This approach has strengthened consistency in practice, supported adherence to governance standards and reduced variation in how care is delivered across perioperative services.

The program is contributing to a safer and more reliable patient experience. By supporting nurses to develop confidence and competence in a structured way, patients benefit from care that is both technically sound and delivered with greater assurance. The program has also strengthened team capability more broadly, supporting a more stable workforce and contributing to a culture of continuous learning and improvement within perioperative services.

Streamlining theatre scheduling and patient flow

RGH has strengthened the coordination and flow of surgical care through the successful implementation of the BASE electronic theatre booking system.

The transition followed months of planning and collaboration across the hospital, with RGH becoming the first site to implement the system for both elective and emergency bookings at the same time.

The move to an electronic booking system has improved how theatre activity is managed, providing a more consistent and transparent approach to scheduling. This reduces reliance on paper-based processes and supports better alignment between clinical teams. For patients, this means a more organised pathway into surgery, with clearer coordination and fewer delays across the perioperative journey.

The change is also supporting broader improvements in quality and sustainability. Streamlined workflows and reduced administrative effort allow staff to focus more on patient care, while the shift away from paper supports environmental goals. Together, these changes are contributing to a more efficient, reliable and patient-centred surgical service at RGH.

Providing advanced orthopaedic care closer to home

RGH introduced the VELYS robotic-assisted system for knee replacement surgery, becoming the first WA Health hospital to implement this technology. The system provides real-time data during procedures, allowing surgeons to make more precise decisions about alignment, movement and implant positioning. This supports a more consistent surgical approach and reduces the likelihood of unexpected outcomes.

For patients, the benefits are practical and immediate. The system allows for more accurate restoration of natural knee movement, which is expected to improve comfort and overall satisfaction following surgery. It also removes the need for a pre-operative CT scan, reducing radiation exposure and streamlining the care pathway by eliminating additional appointments. This results in a simpler and more efficient experience for patients preparing for surgery.

The introduction of this technology has also improved efficiency across the surgical service, with fewer instrument trays required and reduced manual handling for staff. Local patients can now access advanced orthopaedic care closer to home, particularly those requiring more complex procedures. Alongside benefits for current patients, the system is also enhancing training opportunities, supporting the development of a skilled workforce and reinforcing RGH's commitment to high-quality, patient-centred care.

Supporting safer, efficient and consistent care

RGH strengthened patient safety in its Intensive Care Unit through the introduction of a total closed loop enteral feeding system, becoming the first site within SMHS to implement this approach. The system delivers nutrition through a sterile, sealed pathway, removing the need to open or decant feeds. This reduces the risk of contamination and infection, which is particularly important for critically unwell patients who are more vulnerable to complications.

The change has also improved efficiency and consistency of care. Previously, manual processes were required to manage feeding and hydration, increasing workload for nursing staff and creating potential for variability.

The new system simplifies this process, allowing feeds to run for longer periods and reducing preparation steps. This gives clinicians more time to focus on direct patient care, supporting a more responsive and patient-centred experience.

In addition to clinical benefits, the system is delivering improvements in sustainability and resource use. Reduced waste, fewer preparation errors and more efficient use of consumables are contributing to both cost savings and a lower environmental footprint. The initiative reflects how practical innovation at the frontline can improve safety, support staff and enhance the overall quality of care delivered to patients at RGH.

Achieving accreditation excellence

In 2025–26, RGH and SMHS Mental Health hospitals underwent accreditation.

Accreditation is not a single milestone but a reflection of everyday practice. The result reinforces the role of all staff in maintaining high standards and continuously improving care. For patients, this translates to safer, more reliable and more consistent care, supported by teams who are engaged, accountable and committed to delivering quality outcomes.

RkPG

RkPG achieved full accreditation against the *National Safety and Quality Health Service Standards* in 2025, under 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.

The assessment process included a comprehensive review of clinical governance, safety systems and patient care practices, with strong feedback from surveyors on teamwork, professionalism and the standard of care experienced by patients and families.

The outcome reflects a sustained focus on improvement, with targeted work undertaken to address recommendations identified during the initial assessment. This included strengthening key clinical processes such as delirium pathways and medical device reprocessing, ensuring care is delivered safely, consistently and in line with best practice. The result also highlights the organisation's growing maturity in areas such as clinical trials and consumer involvement, supporting a more responsive and evidence-informed health service.

SMHS Mental Health

SMHS Mental Health obtained a major milestone by achieving accreditation to the National Safety Quality Health Service Standards (NSQHSS) in August 2025. This was the first accreditation under the SMHS Mental Health directorate, and it was undertaken as an announced assessment.

Assessors provided positive feedback on all mental health services, noting consistent standards in care and a clear sense of purpose and cohesion within teams.

SMHS Mental Health is actively preparing for the next accreditation, which will be undertaken as a short notice assessment with only 24 hours' notice. This preparation reinforces SMHS Mental Health's commitment to providing safe, high-quality care every day for all consumers, across all services.

Laying the groundwork for future clinical trial success

Established in November 2025 with funding from the DoH Office of Medical Research and Innovation, the Clinical Trials Program has laid the foundations for a coordinated and sustainable clinical trials ecosystem across SMHS.

Key achievements in 2025–26 included approval of the inaugural *SMHS Clinical Trials Governance Framework*, achievement of clinical trials accreditation at FSH, FH, RGH and SMHS Mental Health Services, and establishment of the SMHS Clinical Trials Network.

The program also strengthened organisational capability through the development of 12 standard operating procedures, a clinical trials competency framework, a training needs analysis and a clinical trials education plan for 2026. Additional initiatives included implementation of a trial support referral pathway, completion of a digital uplift survey and commencement of three new clinical trial support services.

This work has established the governance, workforce and operational foundations required to expand clinical trial activity and research capability across SMHS.

Investing in research innovation

The SMHS Biobank supports 18 research projects to date and houses a large number of samples, including blood, stool, urine, cerebrospinal fluid and tissue. A total of 10,200 samples have been managed. Its footprint was expanded this year with the procurement of a third –80 °C freezer. This procurement was achieved though the Future Health Research & Innovation Research Infrastructure Support Grant funding. The SMHS Biobank further strengthened its laboratory capabilities by procuring an advanced automated EZ2 DNA extraction system through matched funding from the McCusker Charitable Foundation.

Delivering research with purpose

SMHS is working in accordance with the *SMHS Research Strategy 2023–2033*.

The following initiatives were completed in 2025–26 to align with the SMHS Research Strategy.

Community

- Convened the SMHS Research Consumer Advisory Group and held a workshop with researchers.
- The Consumer Bank Fund had 11 applications approved.
- 32 consumers registered interest in joining the Consumer Registry.

Data

- Developed the *Annual Research Report 2025*: 158 new projects were approved to proceed, increasing number of active projects to over 1,300.
- Updated processes for data management and legal review to increase efficiency of review.

Collaboration

- The Consultant Engagement Program continued as a way to bring together senior medical researchers and the SMHS Chief Executive.
- Established the inaugural Doctors in Training program for research, with four junior doctors appointed in March 2026.
- Worked in partnership with WACHS to promote and encourage teletrials.
- Worked with PathWest, FSH Pharmacy and FSH Medical Imaging on a new initiative to streamline applications in the Research Governance Service system.

Culture

- Embedded the Research Grants Strategy. A total of 64 research grant and fellowship expressions of interest and applications were submitted: 17 were successful, 22 unsuccessful, and 25 pending an outcome. A total of 39 research grants and fellowships were ongoing and active from previous years.
- Celebrated International Clinical Trials Day 20 May 2026.
- Worked with other health service providers to request a formal Grant Management System to improve grant efficiency and reporting.
- Facilitated an event for International Women's Day in March 2026.

Support

- Continued the Research Mentoring program.
- Publication Fund: 6 applications approved.
- SMHS was a successful applicant for the FHRI Research Infrastructure Support (RIS) Grant funding for a third year.
- The SMHS Human Research Ethics Committee closed in November 2025, moving to the centralised model at DoH.
- The Research intranet site was comprehensively updated to ensure researchers can source information efficiently.

Dr Daniela Vecchio recognised as Western Australia's Australian of the Year

Dr Daniela Vecchio, Consultant Psychiatrist and Head of Service for SMHS Mental Health at Fiona Stanley Hospital, was honoured in recognition of her pioneering work in establishing Australia's first publicly funded Gaming Disorder Clinic.

The award acknowledged Dr Vecchio's leadership in addressing the emerging health impacts of problematic gaming and excessive social media use, and highlighted SMHS's role in developing innovative responses to complex mental health challenges affecting children and young people.

Since opening in 2022, the clinic has supported more than 300 young people and their families, providing specialised assessment, treatment and recovery support. The service addresses a growing area of need, helping young people experiencing social isolation, disengagement from education, and difficulties maintaining connections with family, friends and their communities. Through early intervention and evidence-based care, the clinic is improving outcomes for some of the community's most vulnerable young people.

Dr Vecchio's recognition on the national stage brought increased awareness to the risks associated with screen and gaming addiction and the importance of prevention, education and early intervention. The achievement reflects SMHS's commitment to innovation, clinical excellence and the development of services that respond to emerging health issues and improve the wellbeing of Western Australians.

Provide a great patient experience

Improving outcomes through continuity of care

In February 2026, FSH commenced a trial of the Maternity Antenatal Postnatal Service, introducing a continuity of care model designed to support women throughout their pregnancy and postnatal journey.

The model enables eligible women with low-risk pregnancies to receive antenatal and postnatal care from a known midwife, promoting continuity, stronger therapeutic relationships and a more personalised maternity experience. During labour and birth, women are cared for by the birthing suite team before transitioning back to their known midwife following discharge from hospital.

Introduction of the service has also enabled endorsed midwives to work to their full scope of practice, providing comprehensive maternity care while facilitating timely access to medications and diagnostic tests. Continuity of midwifery care is associated with improved outcomes for women and babies and contributes to enhanced workforce satisfaction, professional autonomy and staff retention.

Since commencement, the service has supported approximately 50 women each month. Feedback from participating women has been overwhelmingly positive, highlighting the value of receiving care from a familiar and trusted midwife throughout key stages of pregnancy and early parenthood. Midwives have similarly reported positive experiences, noting increased opportunities to provide holistic care across the continuum of maternity services.

This trial demonstrates our commitment to delivering evidence-based, woman-centred maternity care and exploring innovative models that enhance both patient experiences and workforce sustainability.

Delivering hospital-level care at home

Home Hospital continued to deliver hospital-level care in patients' homes, providing a safe and effective alternative to traditional inpatient admission and supporting care closer to home. Through a multidisciplinary model of care, patients received hospital-equivalent treatment, monitoring and support in their homes, with high standards of safety, quality and clinical governance maintained.

During 2025–26 Home Hospital expanded and established bases at RGH and PHC enabling full service for patients across the entire SMHS catchment.

It also managed 1,084 inpatient episodes of care across 22 clinical specialties. The service delivered the equivalent of 6,057 bed-days of hospital care in the community, helping to reduce demand on inpatient capacity and improve patient flow across SMHS.

Home Hospital also supported hospital avoidance, with 126 patients admitted directly from the emergency department, enabling them to receive acute care at home rather than in a traditional hospital bed.

The service cared for a clinically complex patient cohort, with 40 per cent of admissions classified as major complexity and 53 per cent as intermediate complexity (noting complexity coding data are subject to a two- to three-month reporting lag).

With an average length of stay of 5.5 days, Home Hospital continued to improve patient access to care closer to home while increasing health system capacity and enhancing patient choice.

Getting eligible patients home sooner

In 2025, Rehabilitation in the Home (RITH) celebrated 20 years of providing hospital substitution services for public patients at home.

Throughout 2025–26, RITH provided services to over 13,000 patients, creating capacity and improving patient flow within public hospitals. Demand for RITH continues to grow, with referrals experiencing an 8 per cent growth this financial year.

RITH reduces the burden on the public hospital system by diverting care into the community directly from ED or reducing inpatient length of stay. In 2025–26, new referral pathways have been established between RITH and the WA Virtual Emergency Department.

RITH continues to adapt to the public health climate with new initiatives including:

- centralising all metropolitan referrals to a single point of access
- research collaboration with Curtin University.

Promoting wellbeing through coordinated care

The Complex Needs Coordination Team (CoNeCT), including the CoNeCT Mental Health Expansion (CoNeCT MHE), provides comprehensive assessment and goal-directed care coordination for individuals in the community who frequently present to hospital with complex health and/or social needs.

Its multidisciplinary approach with embedded clinical pharmacy support has demonstrated effectiveness in reducing avoidable hospital presentations and admissions. By strengthening patients' capacity to manage their health conditions and navigate social challenges, the program supports improved wellbeing, greater independence, and more proactive engagement in care – contributing to more stable health outcomes and reducing the likelihood of unplanned hospital use.

Supporting access to voluntary assisted dying

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

The Western Australia Voluntary Assisted Dying Statewide Care Navigator Service supports all Western Australians seeking information about, or access to, voluntary assisted dying, no matter where they live. This includes patients, their family and carers, community members, health professionals and service providers.

Supporting recovery through therapeutic spaces

The new rehabilitation garden within the Aged Care Rehabilitation Unit at RGH has been designed to directly improve the patient experience, recognising that recovery is not confined to clinical spaces alone. For many patients, particularly those with longer lengths of stay or functional decline, access to fresh air, natural light and a change of environment are important their physical and emotional recovery.

The garden provides a safe, purpose-built space where patients can step outside the ward while remaining supported within their care environment. The space has been intentionally designed to support rehabilitation goals in a more natural and engaging way. It enables patients to practise mobility, balance and independence in a setting that better reflects everyday environments, helping to build confidence before discharge. It also creates opportunities for more meaningful therapy interactions, where clinicians can incorporate functional activities into care in a way that feels less clinical and more connected to real life.

The garden also offers a space for connection. Patients spend time with family and visitors in a more relaxed setting, which can ease the stress of hospitalisation and support overall wellbeing. For staff, it provides another way to deliver person-centred care, particularly for patients who may become distressed or disengaged in traditional ward settings.

Together, these changes are supporting a more holistic model of care, where the environment actively contributes to recovery rather than simply accommodating it.

Connecting community generosity with vulnerable patients

RGH has strengthened support for vulnerable patients and families through the Kindness Cave, an initiative led by the Social Work team to provide practical assistance at times of crisis. The space offers essential items such as clothing, toiletries and comfort items, helping patients who may be experiencing homelessness, domestic violence or financial hardship. By addressing these immediate needs, the initiative supports a more dignified and compassionate care experience.

A key strength of the Kindness Cave is its connection to the local community. Donations from community members, local organisations and volunteers ensure the space remains stocked and responsive to patient needs. This shared effort reflects a broader model of care, where community support plays an active role in improving patient wellbeing beyond clinical treatment.

The initiative enables staff to respond to patient needs in a practical and timely way. Rather than focusing solely on clinical care, teams can provide immediate support that can make a significant difference to a patient's ability to recover and transition safely back into the community.

Enabling consistent and coordinated delirium care

RGH has strengthened care for patients with delirium and cognitive impairment through the introduction of a comprehensive acute delirium pathway. Delirium affects a significant number of patients each year and can lead to poorer outcomes if not identified early.

The pathway was designed to improve early recognition and ensure a more consistent, coordinated response across clinical teams.

The approach provides clear guidance for staff across disciplines, supporting timely assessment, documentation and management from the point delirium is suspected.

It also promotes daily monitoring and structured interventions, reducing variation in care and improving communication between teams. For patients, this means a more consistent and responsive care experience, where cognitive changes are identified and addressed earlier.

The pathway supports a more person-centred approach to care. It encourages family involvement, supports decision-making and improves transitions between care settings. By strengthening how delirium is managed, RGH is improving both patient safety and the overall experience for patients and their families during what can be a distressing time.

Embedding cultural safety in the patient experience

RGH strengthened culturally responsive care by including bush tucker meals in its patient menu, creating a more inclusive and meaningful hospital experience for Aboriginal patients. The initiative recognises that food plays an important role in identity, connection and wellbeing, particularly for patients who may feel disconnected from their community while in hospital.

Developed in collaboration between Aboriginal health liaison officers, dietitians and catering services, the menu was carefully designed to meet both cultural and clinical needs. Meals were tested and reviewed to ensure they are nutritionally appropriate and suitable across a range of patient groups. This approach ensures that cultural inclusion is embedded in a way that aligns with safe, high-quality care.

Providing culturally familiar meals has helped patients feel recognised and respected, supporting trust and engagement with care. This is particularly important in a setting such as RGH which cares for a high proportion of Aboriginal patients. The initiative reflects a broader commitment to delivering care that is not only clinically effective, but culturally safe and responsive to the needs of the community.

Delivering collaborative and compassionate cancer care

RGH has strengthened support for people undergoing cancer treatment through a partnership with the McGrath Foundation, introducing a dedicated cancer care nurse to guide patients and their families through the clinical pathway.

The role provides consistent support from the point of diagnosis, helping patients understand their care, navigate services and feel more confident during what can be an uncertain time. The service is available at no cost and without the need for a referral, improving access to specialist support when it is most needed.

Patients receive practical and emotional support, along with clear, evidence based information to help them make informed decisions about their care. This approach helps reduce confusion and anxiety, while strengthening communication between patients, families and clinical teams.

Working closely with teams across the hospital and community, the role also improves care coordination and access to additional services. This supports a more connected, personalised experience for patients where care is shaped around their individual needs. The initiative reflects a broader commitment at RGH to delivering coordinated, compassionate and patient-centred cancer care.

Improving access to community mental health care

The new purpose-built mental health facility at Montsalvat Drive in Mandurah commenced operations on 3 March 2026, welcoming its first consumers and marking a significant milestone for mental health service delivery in the Peel region.

The facility accommodates Peel Community Mental Health Services and the Kara Maar Specialist Community Eating Disorder Service, enabling these services to be delivered in a dedicated community-based setting for the first time, rather than within a hospital environment.

Designed using trauma-informed principles, the centre provides outpatient, day, and community-based care to support consumer safety, dignity and recovery.

The successful transition to the new facility reflects the strong collaboration and commitment of multiple teams. Particular acknowledgement is extended to the Peel Community Mental Health and Kara Maar teams, who maintained continuity of care and consumer support throughout the move, as well as the Peel Redevelopment team for delivering a high-quality facility tailored to the needs of both staff and the community.

Improving maternity outcomes through culturally safe care

The Boodjari Mia Antenatal Clinic at PHC is a nurse led, multidisciplinary service delivering culturally safe, holistic antenatal care for Aboriginal women and their families. Operating fortnightly, the clinic provides continuity of care from early pregnancy through to six weeks post partum, supported by midwives and Aboriginal health workers who ensure care is culturally informed, responsive, and person centred.

Boodjari Mia – meaning *Family Pregnancy House* – provides a safe, welcoming environment where women are supported through education, advocacy and strong connections to community services.

The model incorporates culturally appropriate antenatal education, emotional support and linkages to Aboriginal Community Controlled Health Services and local programs, strengthening engagement and empowering women to make informed decisions throughout their pregnancy journey.

Since commencing in October 2025, the clinic has supported more than 40 Aboriginal women. Outcomes to date include increased engagement with antenatal care, reductions in premature births, improved birth weights and higher rates of smoking cessation. A total of 30 babies have been born through the program, demonstrating positive early impact on maternal and infant health outcomes.

In recognition of its impact, the clinic team was awarded the PHC Yaka Dandjoo Team of the Season for Djeran. The award acknowledged the team's outstanding commitment to culturally safe, compassionate, and community-centred care, reflecting core values of integrity, respect and collaboration. Their work has strengthened trust within the community, improved health outcomes and set a strong example of holistic, culturally responsive antenatal care.

The team is widely recognised for going above and beyond to ensure women and families feel supported, informed and empowered. Through strong relationships, tailored care and culturally respectful engagement, Boodjari Mia continues to uplift families with dignity and compassion while contributing to Closing the Gap priorities.

Delivering excellence in older adult care

FSFHG Service 4 delivers specialised care for older adults across FSH, FH, Cockburn Health and FSH Fiona Stanley Hospital – M Block (Medihotel). Older patients often present with complex health needs, including multiple chronic conditions, cognitive impairment, medication-related risks and functional decline, while increasing demand for aged care placement continues to impact hospital flow and discharge pathways.

Throughout 2025–26, the service maintained a strong focus on delivering safe, high-quality care through collaboration, innovation and service improvement.

Supporting the SMHS Older Adult Services Strategy, FH commenced implementation of the Age-Friendly Health Systems framework. The initiative brought together consumers and multidisciplinary teams to strengthen care for older people. In recognition of this achievement, the hospital was awarded Committed to Care Excellence for Older Adults, the highest level of recognition within the Age-Friendly Health Systems program.

The framework focuses on four key areas: what matters, medication, mentation and mobility, supporting personalised, safe and effective care for older adults while promoting independence, wellbeing and quality of life.

Engage, develop and provide opportunities for our workforce

Preparing for recruitment reform implementation

New public sector recruitment rules which came into effect on 1 July 2026 represent a significant modernisation of recruitment and employment practices across the Western Australian public sector, including SMHS. As part of this reform agenda, a suite of updated Commissioner's Instructions was released, providing contemporary, mandatory standards for recruitment, selection, appointment, and employee movement:

- *Commissioner's Instruction 48: Recruitment, Selection and Appointment to Permanent Vacancies,*
- *Commissioner's Instruction 49: Recruitment, Selection and Appointment to Fixed Term Vacancies*
- *Commissioner's Instruction 50: Backfilling Temporary Vacancies*
- *Commissioner's Instruction 51: Transfer Standard*

As a result, the following Commissioner's Instructions were rescinded:

- *Commissioner's Instruction 2: Filling a Public Sector Vacancy*
- *Commissioner's Instruction 39: Interim Arrangements to Fill Public Sector Vacancies*

In addition, a new more rigorous Recruitment Standard has replaced the previous Employment Standard. The standard is contained in the 3 new Commissioner's Instructions – Commissioner's Instruction 48, 49 and 50. The *WA Health Recruitment, Selection and Appointment Policy was revised*. The revised *WA Health Recruitment Pool Governance Procedure document* is now available.

In 2025–26, in readiness for the 1 July 2026 implementation, SMHS Workforce:

- completed a *Recruitment Reform SMHS Implementation Plan*
- completed active recruitment pool cleansing
- created a Recruitment Reform intranet page for all staff, with other related intranet pages, such as Expressions of Interest and Job Description Form also updated
- updated the Face-to-face Recruitment Refresher course, along with updating the current Recruitment and Applying for Jobs training packages
- provided access to Introduction to Public Sector Recruitment Rules via the SMHS MyLearning Learning Management System
- reviewed and updated the Job Description Guidelines and EOI Guidelines.

Embedding Aboriginal health practitioners across clinical services

During 2025–26, FSH expanded its Aboriginal health practitioners (AHPs) program into key clinical areas, including renal and dialysis, cardiology and cardiothoracic services, maternity, neonatal and paediatric services, and the antenatal Aboriginal clinic.

Registered with AHPRA, AHPs contribute as members of multidisciplinary healthcare teams, providing clinical care, supporting the cultural needs of patients and families, and advocating for the health and wellbeing of Aboriginal people throughout their healthcare journey.

The expansion of the AHP role represents a significant milestone in strengthening culturally safe and responsive healthcare services at FSH. AHPs play an important role in building trust, supporting communication between patients and care teams, and enhancing continuity of care for Aboriginal patients and their families.

Early feedback from patients and staff highlights the value of these roles in improving patient experiences and providing culturally informed support during some of life's most significant and vulnerable moments, including hospital admissions, chronic disease management, pregnancy, birth and neonatal care.

The initiative reflects SMHS's ongoing commitment to improving health outcomes for Aboriginal people and embedding culturally secure care across its services.

Driving collaborative nursing and midwifery leadership

Established in 2025, the South Metropolitan Nursing and Midwifery Executive Council brings together directors of nursing, midwifery and mental health to provide strategic leadership and oversight of SMHS-wide initiatives.

In 2025–26, the council led key priorities including International Nursing and Midwifery Day celebrations, implementation of Designated Registered Nurse Prescribing legislation, transition to nurse-to-patient ratios, and the Nursing and Midwifery Community of Practice. It also provided professional leadership across priority areas including Aboriginal health, community services, the expansion of voluntary assisted dying services and the sepsis program.

SMHS nurses and midwives were recognised through the WA Nursing and Midwifery Excellence Awards, with six staff members named finalists across categories including Aboriginal health, leadership, person-centred care, research and midwifery excellence.

The council also supported the establishment of the South Metropolitan Nursing and Midwifery Advisory Council, further strengthening nursing and midwifery leadership and engagement across the health service. It advises on best practice, facilitating the exchange of information and drawing on the expertise of the leadership group to support the strategic direction across SMHS Nursing and Midwifery Professional Senior Registered Nursing group.

Building a connected nursing and midwifery community

The SMHS Area Director of Nursing and Midwifery Community of Practice brings nursing and midwifery clinical leaders together to a forum that strengthens professional connection, shared purpose and collective capability. It additionally supports nursing and midwifery staff working in service-wide, portfolio-based, specialist or cross service roles. The forum:

- has fostered a cohesive and connected nursing and midwifery professional community across SMHS
- provides a safe and inclusive forum for shared learning, reflection and peer support
- enables collaboration across services, portfolios and sites where staff may not be co-located or operationally aligned
- aligns with SMHS values and strategic priorities.

Advancing enrolled nurse opportunities

Enrolled nurses (ENs) play a vital role in the delivery of safe, high-quality patient care, working collaboratively with and under the supervision of registered nurses and multidisciplinary teams to support patients across a range of clinical settings.

In 2025–26, FSFHG comprehensively reviewed its EN workforce to identify opportunities to strengthen workforce sustainability and support future service needs. The review examined current EN representation, benchmarked workforce profiles across health services, and explored barriers and opportunities to increasing EN employment within the organisation.

At the commencement of the review, FSFHG employed 194.25 full-time equivalent enrolled nurses, representing 8.0 per cent of the nursing workforce. The project informed a range of initiatives aimed at increasing EN participation, including the phased growth of EN positions across clinical areas, expansion of EN graduate opportunities, and investigation of opportunities for EN roles within critical care settings.

By September 2025, EN representation within the FSFHG nursing workforce had increased to 8.47 per cent, reflecting early progress towards a more sustainable and diverse workforce model. Further workforce planning and implementation activities will continue to support the growth of the EN workforce and strengthen nursing career pathways, from novice to expert, across the service.

This work aligns with broader health workforce priorities to ensure a skilled, adaptable and sustainable nursing workforce capable of meeting the evolving healthcare needs of the community.

Transitioning to nurse/midwife to patient ratios

SMHS has commenced implementation of the *WA Health Nurse/Midwife to Patient Ratios Policy*, transitioning from the nursing hours per patient day model to mandated minimum staffing ratios.

Nurse/midwife to patient ratios establish the minimum number of registered nurses, midwives and enrolled nurses required on a ward, unit or department for each shift, ensuring safe staffing levels and high-quality patient care.

A dedicated SMHS Ratios Steering Committee, established in March 2025, provides governance and oversight of planning, implementation, monitoring and evaluation across all sites, supported by site-based and specialty working groups.

Implementation is being delivered through a phased approach.

Phase 1 commenced in July 2025, with six medical and surgical wards transitioning to ratios. Phase 2 was successfully implemented in February 2026 across critical care areas, including the Coronary Care Unit, Intensive Care Unit and neonatal services. Further expansion is planned across 35 additional clinical areas in 2026–27.

The staged rollout aligns with statewide policy and industrial requirements while supporting workforce readiness and service continuity.

The transition is supported by strong governance, stakeholder engagement and change management, including consultation with clinical leaders, workforce monitoring and ongoing refinement of implementation models. Led by the Office of the Area Director of Nursing and Midwifery, this significant workforce reform aims to support safer workloads, greater staffing transparency, workforce sustainability and improved patient care outcomes across SMHS.

Implementation of the ratios has required significant workforce planning, recruitment and service redesign across FSFHG to meet increased staffing requirements and ensure compliance with the new model of care. This work has strengthened workforce capability and positioned SMHS to support the ongoing rollout of ratios across additional clinical areas.

Expanding and strengthening the nurse practitioner workforce

Nurse practitioners (NPs) are advanced practice nurses who provide expert, clinically focused care within an extended scope of practice. Working collaboratively with multidisciplinary teams, they undertake advanced assessment, diagnosis, treatment, referral and care coordination, helping improve access to timely and high-quality healthcare services.

During 2025–26, FSFHG employed 21 NPs across a range of specialties, including advanced heart failure and cardiac transplant services, sexual health, vascular, respiratory, valve intervention, emergency medicine and Rottnest Island Nursing Post. These clinicians play a critical role in delivering patient-centred care, improving service accessibility and supporting innovative models of care.

Recognising the growing importance of this workforce in meeting future healthcare needs, FSFHG developed a five-year *Nurse Practitioner Strategy* to support the growth of an integrated, sustainable and contemporary NP workforce. The strategy provides a framework for strengthening nurse practitioner career pathways, optimising models of care and identifying priority areas for workforce expansion across the organisation.

Aligned with national and state workforce priorities, the strategy focuses on four key themes: pathways to practice, workforce stewardship, systems of working and future-focused service delivery. Implementation commenced during 2025–26, with several foundational initiatives completed, including the establishment of a Nurse Practitioner Committee, development of a standard operating procedure for nurse practitioner studies and position creation and revision of the *Nurse Practitioner Clinical Practice Guideline*.

These initiatives position SMHS to further expand and strengthen the nurse practitioner workforce, supporting innovative and sustainable models of care that improve outcomes for patients and the community.

Guiding senior nursing and midwifery role creation

Senior registered nurses (RNs) and midwives play a critical role in leading clinical services, supporting multidisciplinary teams and driving the delivery of safe, high-quality, patient-centred care.

These positions provide advanced clinical leadership and are responsible for influencing service delivery, workforce capability, quality improvement and patient outcomes across a range of healthcare settings.

During 2025–26, FSFHG commenced a project to establish a consistent framework for the creation and classification of senior RN and midwife positions. The project focused on key leadership roles including:

- nurse unit manager/midwifery manager
- clinical nurse/midwifery manager
- associate nurse/midwifery manager
- clinical nurse/midwifery specialist
- clinical nurse/midwifery consultant positions.

A comprehensive review of industrial, workforce and position classification frameworks was undertaken, including benchmarking against comparable health service providers. This work informed the development of a set of principles outlining the expected level of responsibility, scope of practice, sphere of influence and supervisory responsibilities associated with each senior nursing and midwifery role.

The principles were endorsed by the FSFHG Nursing and Midwifery Executive Council and provide a consistent, evidence-informed approach to workforce planning and position development across the organisation. The framework supports transparent decision-making, strengthens governance and ensures senior nursing and midwifery roles are aligned with service needs and organisational priorities.

The initiative represents an important step in strengthening nursing and midwifery leadership capability and supporting a sustainable workforce equipped to meet the evolving healthcare needs of the community.

Building a respectful workplace culture

In November 2025, SMHS launched the Respect in the Workplace campaign and a centralised intranet site to strengthen awareness of workplace behaviour expectations and support compliance with positive duty obligations under workplace relations and work health and safety legislation. The campaign focuses on:

- promoting respectful workplace behaviours
- increasing awareness of reporting pathways
- supporting managers to meet their legislative responsibilities
- building staff understanding of bullying, harassment and other inappropriate workplace behaviours.

The campaign's intranet site is a central source of information and resources for staff and managers, bringing together guidance, tools, education materials and reporting information to support a safe, respectful and inclusive workplace culture.

During 2025–26, education and training initiatives focused on developing consistent learning resources, including positive duty and sexual harassment awareness materials, and planning the integration of respectful workplace principles into existing leadership and workforce development programs across SMHS.

A dedicated communications program continued throughout the year, using targeted and multi-channel approaches to promote resources, reporting options and support services. Activities included executive communications, staff forum resources, digital signage, intranet updates, newsletters and staff stories that reinforced respectful workplace expectations and encouraged positive workplace behaviours.

This work reflects SMHS's ongoing commitment to fostering a safe, respectful and inclusive workplace for all employees.

Growing organisational capability in quality improvement

A key milestone in 2025–26 was the introduction of the SMHS Applying QI course, a locally developed program designed to build staff capability in QI and support the practical application of improvement science across SMHS.

The 10-month program combines education, mentoring and workplace-based projects, enabling participants to apply QI methodologies to service priorities.

The inaugural cohort delivered projects focused on improving outpatient attendance, strengthening clinical documentation and medication safety, enhancing workforce efficiency and reducing waste to landfill.

In March 2026, SMHS recognised staff who had completed the Applying QI pilot, alongside colleagues who achieved quality and safety qualifications through the Institute for Healthcare Improvement and SMHS quality programs. This acknowledged their contribution to improving safety, quality and patient outcomes.

Following the success of the pilot, a second cohort of 13 participants commenced the program, supported by graduates of the inaugural course who now serve as QI mentors. The continued expansion of the program reflects growing organisational capability and a commitment to embedding continuous improvement across SMHS.

Building clinical capability through workplace based assessment

RGH strengthened its medical workforce through the successful delivery of the Workplace Based Assessment program, supporting international medical graduates to transition into clinical practice in Australia.

In a first for the site, junior doctors completed the 12-month program, which provides structured, on the job assessment across a range of clinical settings. The program ensures doctors are evaluated in real clinical environments, supporting a high standard of clinical capability aligned with patient care needs.

The model supports both safety and patient experience by ensuring clinicians are assessed consistently across multiple domains before progressing to independent practice.

Participants receive structured feedback from senior clinicians and are supported in real time to build confidence, capability and consistency in their day-to-day practice. This creates a more stable and supported workforce, where clinicians are better prepared to deliver safe, patient-centred care.

The program was recognised through a SMHS Excellence Award in 2026 for developing and engaging staff, highlighting its impact beyond training alone.

By investing in clinicians and creating a supportive learning environment, RGH is strengthening teamwork, improving continuity of care and supporting a workforce that is more likely to remain local. This translates to more consistent care for patients and a stronger, more sustainable health service for the community.

Embracing virtual allied health care

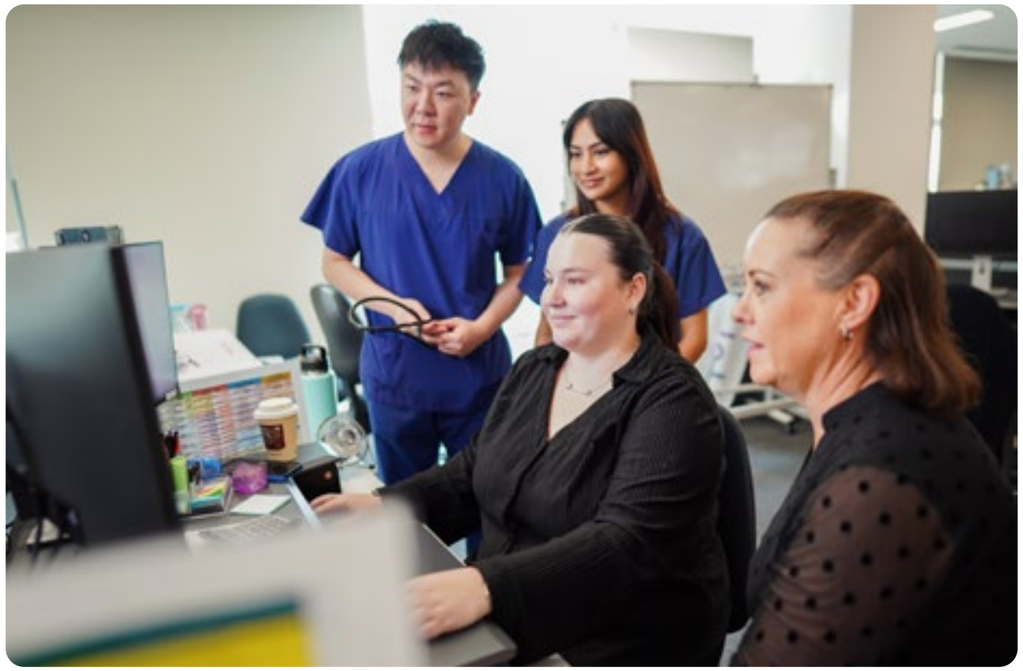
RkPG expanded access to care through the expansion of allied health virtual care clinics, supporting patients to receive appointments via phone or video where clinically appropriate with the allied health professional also working from home. Initially introduced as a pilot, the model has now become an established part of service delivery, providing a flexible option that continues to prioritise safe, person centred care.

The approach enables suitable patients to access care without needing to attend in person, improving convenience and supporting better engagement with services. At the same time, it allows the hospital to make more effective use of clinical space and manage demand across outpatient services. The model has been applied across a range of disciplines, including physiotherapy, occupational therapy, social work and speech pathology.

The model supports staff wellbeing while maintaining quality of care. By providing greater flexibility in how services are delivered, it contributes to a more sustainable workforce, while continuing to monitor patient outcomes, satisfaction and access.

Strengthening international medical education partnerships

RGH continued to build its future workforce and strengthen care through partnerships with international universities, welcoming UK medical students to undertake clinical placements onsite. These placements provide students with exposure to a broad range of clinical settings, including emergency and surgical services, while contributing to a dynamic learning environment within the hospital.



Hosting students supports the ongoing development of a skilled and capable workforce, which directly benefits patient care. A strong teaching culture encourages reflection, knowledge sharing and continuous improvement, creating an environment where both learners and experienced clinicians contribute to better outcomes. Patients benefit from this approach through more engaged teams, up-to-date clinical practice and a service that is actively investing in its future capability.

These placements also strengthen international links and contribute to longer-term workforce opportunities, with students gaining a positive experience of working within the RkPG.

By providing high-quality supervision and exposure to a supportive clinical environment, the hospital is positioning itself as a place where future doctors may choose to return, supporting workforce sustainability and continuity of care for the local community.

Recognising values-driven excellence

In 2025–26, RkPG launched the inaugural Luminary Awards to recognise staff who demonstrate the SMHS values of care, integrity, respect, excellence and teamwork in their everyday work. The awards acknowledge the behaviours that underpin high-quality care, with a focus on individuals who consistently go above and beyond for patients, colleagues and the community.

Award recipients reflected the hospital's strong clinical and cultural foundations. From ensuring patients feel safe and supported during vulnerable moments, to upholding high standards of clinical practice and working collaboratively across teams, each recognised contribution highlights the link between staff values and patient experience. This includes improving safety through better systems and processes, supporting patients to maintain dignity during care, and creating environments where compassionate, patient-centred care is the standard.

The awards reinforce a culture where positive behaviours are recognised and shared. By celebrating these examples, the organisation is strengthening expectations around how care is delivered, not just what is delivered. This contributes to a more consistent and high-quality experience for patients, supported by teams who are engaged, accountable and committed to continuous improvement.

Building emergency care capability through immersive training

RGH continued to strengthen ED clinical capability through innovative approaches to staff training, including the use of a custom-built medical training room. Designed as an alternative to traditional teaching methods, the simulation challenged staff to work through a fictional outbreak scenario, managing deteriorating patients and competing priorities in a time-pressured environment that closely reflects real clinical practice.

This approach supports a more practical and immersive form of learning, where clinicians are required to apply knowledge, communicate clearly and make decisions in the moment. Recreating the complexity and uncertainty of emergency care in a safe setting enabled staff to build confidence and refine skills. Structured briefing and debriefing sessions also allowed teams to reflect on performance and identify opportunities for improvement.

Initiatives like this strengthen teamwork and preparedness across the service. Bringing together staff from different levels of experience supports shared learning and reinforces effective communication under pressure. This contributes to a more capable and coordinated workforce, ultimately improving the safety and reliability of care delivered to ED patients.

Fostering quality improvement through collaboration

RkPG established project cafés as a walk-in, consultative service for frontline staff to develop QI ideas using expertise from clinical, education and quality teams. It provides a practical option for staff who may not otherwise engage with formal project structures, helping to turn ideas into actions that directly benefit patient care.

A key strength of the initiative is its focus on collaboration. By working alongside staff from across disciplines, the project cafés support the development of solutions grounded in real clinical experience. Early projects included improvements to nutrition delivery systems, strengthening bereavement support for families and updates to models of care. These examples reflect small but meaningful changes that improve how care is delivered and experienced by patients.

The project cafés are helping build a culture where improvement is seen as part of everyday work. Staff are supported to test ideas, learn from each other and take ownership of change within their areas. This contributes to a more engaged workforce and a more responsive health service, where innovation is not limited to large programs but is embedded in day-to-day practice

Building assistant in nursing workforce capability

As part of the governance transition of Peel Health Campus from a public private partnership operated by Ramsay Health Care to SMHS in August 2024, the workforce model shifted from patient care assistants (PCAs) to assistant in nursing (AIN) roles. To support alignment with this model, all PCAs employed at the time were offered a fully funded opportunity to upskill to AIN.

17 PHC staff enrolled in and completed a six-month training program delivered by South Metropolitan TAFE. Despite challenges – including limited previous digital experience and extended periods since prior formal study – participants demonstrated strong commitment and all successfully met the program requirements.

This initiative resulted in a skilled workforce aligned to the SMHS care model. Graduates reported increased confidence, an expanded scope of practice and a stronger sense of professional value, contributing positively to team capability and service delivery.

Collaborative education enhances workforce capability

In 2025–26, PHC adopted the FSFHG education model, establishing a consistent and standardised framework for nursing and midwifery education across SMHS. The model supports staff induction, core competency assessment, in-service training and continuing education through the *Induction, Core Competency, In-service and Continuing Education framework*.

Education services at PHC are delivered through a decentralised model that provides professional development, clinical orientation, mandatory training and specialist clinical skills development across the campus. The service is led by the Quality, Education, Safety and Training (QuEST) team, under the leadership of the Director of Nursing and Midwifery, and is supported by nurse educators and clinical-based staff development nurses and midwives.

The framework was implemented for nursing and midwifery staff in January 2026 and aims to strengthen workforce capability by supporting the ongoing development of knowledge, skills and professional competence. Future expansion of the framework will include Aboriginal health practitioners.

Throughout implementation, the QuEST team provided coordinated governance, education support and oversight to ensure consistent delivery across services. Regular monitoring, stakeholder engagement and risk management processes supported achievement of key milestones and the successful rollout of the framework.

This initiative has strengthened educational governance at PHC and supports the development of a skilled, capable and adaptable workforce committed to delivering safe, high-quality patient care.

Building a culture of wellbeing

Staff wellbeing continues to be a strategic priority and has been led by the SMHS Chief Wellbeing Practitioner, the only role of this kind in Western Australian hospitals. In strong collaboration with staff (clinical and non-clinical), as represented on the SMHS Wellbeing Committee, the first *SMHS Wellbeing Framework (2022–2025)* achieved strong implementation outcomes, with 35 of 36 actions completed:

SMHS Wellbeing Framework	Actions 2022–2025	Actions completed 2025	Actions 2026–2029
Healthy Culture	12	12	10
Healthy Mind	9	9	9
Healthy Body	9	9	8
Healthy Places	6	5	4
Total	36	35	31

The SMHS Wellbeing Committee continues to grow, representing the diversity of our workforce. Key achievements include:

- SMHS Wellbeing Initiatives Exchange, an online central repository, highlighting nearly 100 locally developed wellbeing initiatives.
- Development and curation of an online wellbeing hub of resources on topics including women's health (perimenopause and menstrual/hormonal health), financial health, mental health, work flexibility, physical health and alcohol/substance use (including nicotine replacement).
- Development of the SMHS Women's Health sub-committee-raising awareness and consistently making small meaningful changes to SMHS process to improve women's health and wellbeing.

Following the successful implementation of the first Wellbeing Framework, our second *SMHS Wellbeing Framework (2026–2029)* has been finalised, building on the existing actions, priorities and pillars. This was completed in collaboration with Organisational Development, Work Health and Safety, Health Promotion, Workforce, Mental Health, Pastoral Care, wellbeing representatives from operational areas and the SMHS Wellbeing Committee. Retaining the four pillars (Healthy Culture, Mind, Body and Places) and strengthening the approach to supporting consistent, locally driven implementation, key enhancements of the new framework include:

- local accountability and leadership capability – emphasising the crucial role that local team leads have in supporting day-to-day staff wellbeing (rosters, overtime, flexibility, leave, education)
- psychosocial risk management
- psychological safety and positive duty
- access and coordination.

Further to this, the SMHS-wide roll-out of our comprehensive workplace psychosocial risks and hazards program continued and was embedded into our operational approach. The factors addressed fall under job demands, job resources, workplace violence and aggression and bullying. To date, this program has been implemented within 26 identified areas at SMHS, all at various stages of the iterative process.

Investing in our future medical workforce

Building a strong future medical workforce begins with attracting, supporting and retaining junior doctors throughout their training journey.

The SMHS Doctor Support Unit (DSU) continued to expand and mature during 2025–26, strengthening support for doctors in training across FSFHG, RkPG and PHC.

The unit brings medical workforce, medical education, strategy and innovation functions into a single service, providing a coordinated 'one-stop' support model for junior doctors. The initiative reflects our commitment to creating a supportive, responsive and collaborative environment where doctors are recognised, valued and able to thrive throughout their training and professional development.

A key focus during the year was improving the experience of junior doctors through practical support, stronger engagement and enhanced workforce systems. The unit continued to operate its 'no wrong door' approach to wellbeing, providing coordinated pathways for doctors seeking support and ensuring access to appropriate wellbeing, educational and workforce services. Regular engagement with junior doctor representatives and continued use of the Maali Yarning feedback platform strengthened communication between doctors and the organisation, helping identify issues early and drive service improvements informed by the experiences of doctors in training.

Several initiatives progressed during 2025–26 to support workforce sustainability and improve training and working conditions. These included:

- expansion of the roster coverage and leave program
- ongoing roster optimisation activities
- development of innovative recruitment pathways
- enhancement of leave management processes
- implementation of initiatives designed to improve visibility of workforce needs and support fatigue management.

DSU Medical Education continued to expand opportunities for extradepartmental education and professional development, supporting broader clinical exposure, interdisciplinary learning and career development opportunities for doctors in training. Work also commenced on creating a structured Head of Department Development Program to strengthen leadership capability, workforce stewardship and management practices.

An important milestone was the development of the DSU Balanced Scorecard, providing a structured framework to monitor performance across wellbeing, support, workforce stability, education, governance and engagement. The scorecard supports ongoing evaluation of outcomes important to doctors and provide greater visibility of trends affecting the medical workforce, enabling continuous improvement and informed decision-making.

The RGH DSU relocated into a dedicated standalone facility, increasing its visibility and providing a more accessible and welcoming environment for junior doctors.

SMHS attracted a record number of Category 1 internship applications and retained all but three of the previous year's interns. This has strengthened workforce stability and significantly reduced reliance on mid-year recruitment activity.

By bringing workforce, education and innovation functions together, the unit is helping create a more connected and supportive experience for junior doctors. This work contributes to SMHS priorities relating to workforce sustainability, staff wellbeing, organisational culture and safe, high-quality patient care. Supporting doctors to succeed in their training and careers ultimately supports better experiences for patients, consumers and the broader community.

Advancing organisational development and capability

SMHS places a strong focus on organisational development to develop team and inter-team trust, respect and effective collaboration and communication, leading to a values-based, psychologically safe organisation.

Care to Lead

In 2025–26, SMHS continued delivery of the Care to Lead program as a key component of its leadership development framework. The program supports the development of compassionate, reflective and collaborative leadership, aligned with the SMHS strategic priority to engage and develop a compassionate workforce.

The Organisational Development team delivered six cohorts across the Care to Lead and Emerging Leader programs, providing multidisciplinary learning opportunities for participants from both clinical and non-clinical disciplines across SMHS. The program combines facilitated workshops, workplace-based leadership projects and peer learning, with a focus on applying leadership skills within local service environments.

Through structured reflection, practical application and peer engagement, participants strengthened their leadership capability and confidence. Evaluation findings demonstrated improvements in self-awareness, reflective practice, coaching and feedback skills, compassionate leadership behaviours, and team engagement. Participants also reported increased confidence in leading conversations, supporting teams through change and responding effectively to workplace challenges.

The program continues to provide a coordinated and sustainable approach to leadership development across SMHS, supporting improved workforce experience, stronger team performance and the delivery of safe, compassionate and person-centred care.

SMHS Human Factors Training Program

The SMHS Human Factors Training (SHFT) Program was launched in early 2024 to support a culture of safety, collaboration and continuous improvement across SMHS.

The team-based program provides staff with practical tools to apply Human Factors principles in everyday work. By focusing on factors such as communication, teamwork, leadership, workload and decision-making, the program helps staff work more safely and effectively in complex healthcare environments.

In 2025–26, the program was strategically redesigned to improve flexibility and sustainability. While participation continues to be impacted by competing operational priorities and increased clinical demand, the program remains an important component of SMHS's safety and capability agenda.

A key highlight during the year was the leadership demonstrated by PHC championing Human Factors across both clinical and corporate teams. Human Factors Ambassadors played an important role in promoting the program and embedding Human Factors principles into everyday practice, including participation in safety and quality discussions. PHC also achieved strong leadership engagement, with 74 per cent of the executive team and heads of department completing SHFT training.

Key achievements in 2025–26 included:

- 398 staff completed SHFT training
- 156 staff enrolled in one or more SHFT modules
- 26 new Human Factors Ambassadors trained, increasing the ambassador network to 56 members
- continued growth in awareness and engagement through local champions, peer conversations and team referrals.

The program strengthens psychological safety, communication and teamwork, helping staff manage complexity and deliver safer, more coordinated care. At an organisational level, it supports workforce capability, clinical governance and a positive safety culture.

It continues to build momentum as a practical and scalable initiative that embeds Human Factors into everyday practice.

Beyond training, SMHS remains committed to integrating Human Factors principles into leadership, service design and systems improvement to support safer care and better outcomes for patients, staff and the community.

SMHS Leadership Alumni

The alumni initiative continued to strengthen leadership capability, collaboration and a culture of compassionate and collective leadership across the organisation during 2025–26.

Established to connect leaders from across SMHS, the Alumni provides an ongoing forum for networking, knowledge sharing and professional development, supporting leaders to address challenges, foster innovation and enhance healthcare delivery.

A key achievement during the year was the delivery of a Leadership Alumni event focused on Human Factors in health care.

The event brought together executive leaders, Alumni members and Human Factors Ambassadors to explore approaches that support patient safety, teamwork and effective decision-making in complex healthcare environments.

Recognising the increasing pace of change across the health system, a dedicated leadership coaching event was also delivered. This will support SMHS coaches in strengthening their capability to assist staff and leaders through periods of uncertainty and transition.

The alumni community continued to grow during the year, with eligibility for the SMHS Leadership Alumni pin expanded to include graduates of the Senior Leader as Coach Program. Inspired by the Forest Red-tailed Black Cockatoo (Karak), the pin symbolises leadership, renewal and a shared commitment to fostering a supportive and inclusive leadership culture.

Through continued investment in leadership development, professional networks and coaching capability, the alumni initiative supports a resilient and connected leadership workforce, contributing to positive workforce culture, organisational performance and high-quality patient care.

Leadership mentoring

The SMHS Leadership Mentoring Program continued to strengthen leadership capability and support a culture of compassionate, inclusive and accountable leadership across SMHS during 2025–26.

Building on leadership development programs such as Care to Lead and Care to Manage, the program provides emerging and established leaders with structured opportunities for professional growth through mentoring relationships with experienced leaders. During the year, 10 mentor-mentee partnerships were established across SMHS, with participants completing dedicated mentoring training prior to commencing their partnerships.

A key achievement was the continued engagement of experienced mentors, whose ongoing contribution has strengthened the quality, sustainability and impact of the program. Their commitment reflects a culture of collective leadership and a shared investment in developing future leaders across the organisation.

Participant feedback highlighted the value of the program in building leadership confidence, broadening perspectives, supporting career development and strengthening connections across SMHS. Mentors also reported benefits through enhanced leadership practice and the opportunity to contribute to the development of others.

By investing in leadership mentoring, SMHS continues to strengthen its leadership pipeline, foster cross-organisational collaboration and develop leaders equipped to navigate complexity, lead positive change and deliver high-quality, person-centred care.

SMHS Coach Training through Senior Leader as Coach

In 2026, SMHS sustained its investment in leadership capability through the Senior Leader as Coach Program, with 19 senior leaders completing the initiative. The program forms part of SMHS's broader focus on strengthening collective leadership, positioning coaching as an integral component of leadership practice across the organisation.

The program provided 30 hours of structured learning over a three-month period. Participants were drawn from across SMHS sites and represented a mix of clinical and non-clinical roles, including hospital executive, service directors and medical consultants. This cross-site and cross-disciplinary participation supported shared approaches to leadership and strengthened connection across services.

The program focused on building practical coaching capability that could be applied within day-to-day leadership contexts. Participants developed skills in structured coaching conversations, active listening and reflective inquiry, supporting a shift towards more facilitative and development-oriented leadership practices. This included embedding coaching approaches within performance discussions, team engagement and decision-making processes, reinforcing coaching as an ongoing and applied leadership capability rather than a discrete intervention.

Across the program, participants described measurable shifts in how they understood themselves and engaged with others in their professional roles. Development was most evident in areas associated with reflective leadership practice and relational capability. Commonly reported themes included:

- deepened self-awareness alongside more consistent application of emotional intelligence in workplace interactions
- increased use of reflective practice, supporting more deliberate and compassionate responses to staff and organisational challenges
- greater confidence in applying a structured, evidence-based coaching methodology to guide conversations and support behavioural change
- broader peer connection, with strengthened relationships and collaboration across sites.

Participants demonstrated an increased capacity to integrate coaching into everyday leadership interactions, including performance conversations, development discussions, and team engagement. Following completion, graduates transitioned into the SMHS Coach Consultancy.

SMHS Coach Consultancy: supporting staff through coaching

The SMHS Coach Consultancy continued to expand its reach and impact during 2025–26, embedding coaching as an accessible and sustainable workforce development initiative across the organisation.

Supported by approximately 90 trained internal coaches who dedicate a portion of their working time to coaching, the consultancy provides staff with access to individual coaching tailored to their professional development goals. The service enables staff to connect with coaches whose experience and areas of expertise align with their learning and career development needs.

The consultancy has become an important component of the SMHS workforce development framework, supporting reflective practice, professional growth and leadership capability across a broad range of disciplines. Coaching provides staff with opportunities to explore challenges, build self-awareness and strengthen skills in communication, leadership and team engagement.

By leveraging internal expertise, the consultancy offers a sustainable and cost-effective approach to capability development while fostering a culture of continuous learning, collaboration and coaching-informed leadership. Through this work, SMHS continues to strengthen workforce capability and support a positive and high-performing organisational culture.

Optimising workforce learning and development

In 2025–26, SMHS successfully completed the MyLearning Learning Management System Optimisation Project, improving the functionality, governance and user experience of the organisation's learning management platform. The project strengthens SMHS's ability to support workforce development and deliver education and training at scale across an increasingly digital health service.

Key achievements included rationalising and updating training content, improving system configuration and user account management, redesigning course catalogues and templates and enhancing online learning resources. Significant improvements were also made to reporting and analytics through the implementation of Power BI dashboards and enhancements to mandatory training reporting.

The project established strengthened governance arrangements, including standard operating procedures, user guidance materials and consistent processes for managing online education and training.

User support was also enhanced through the re-establishment of the SMHS MyLearning User Group, development of a dedicated resource hub and integration of support services with the Digital Health Service Desk.

A major outcome of the project was the introduction of a new support and ticketing system, which significantly improved responsiveness to staff enquiries. Process improvements reduced average response times from several months to less than 24 hours, enhancing the overall user experience and supporting more efficient administration of workforce education and training.

Following project completion in December 2025, responsibility for the system transitioned successfully to business-as-usual operations in March 2026. The project has established a more reliable, efficient and sustainable learning management platform to support the ongoing development of the SMHS workforce.

Strengthen relationships with our community and partners

Integrating lived experience across mental health services

Integration of lived experience across health service planning, design and delivery remains a key priority for SMHS Mental Health Services. This approach aligns with the *National Safety and Quality Health Service Standards* and *National Standards for Mental Health Services*, reinforcing the importance of meaningful consumer and carer participation.

In October 2025, the Western Australian Mental Health Commission's Joint Leadership Group endorsed the *Statement of Commitment*, signalling a systemwide commitment to lasting cultural transformation. The statement supports the *Mental Health and Alcohol and Other Drug Strategy 2026–2031*, including development of a strong Lived Experience (Peer) workforce as a cornerstone of recovery-oriented care.

In 2026, significant progress was made through the development of a *Lived Experience Integration Plan (LEIP)*, informed by extensive consultation and engagement. The *LEIP Project Initiation Document* was endorsed by the SMHS Mental Health Executive on 23 June 2026 and subsequently presented to the MHC. This milestone provides a coordinated framework for embedding lived experience across service delivery, governance and workforce development.

Key priorities include:

- **Workforce development and capability building:** strengthening recruitment, retention and professional development of the Lived Experience workforce.
- **Engagement, co-design, co-production and community alignment:** enhancing partnerships with consumers, carers and community to inform service design, delivery and evaluation.
- **Policy, systems and organisational infrastructure:** embedding lived experience principles within governance, policy and operational frameworks.

These initiatives strengthen SMHS Mental Health Services' commitment to inclusive, person-centred and recovery-oriented care, ensuring lived experience perspectives remain central to service excellence.

Expanding collaboration with primary healthcare providers

In 2025–26, SMHS strengthened partnerships with primary healthcare providers through the GP Engage Program, supporting better integration between hospital and community-based care.

As part of the program's expansion and in response to growing interest from general practitioners (GPs) and primary care providers, GP Engage events were held for the first time at PHC and RkPG. The events brought together GPs, allied health professionals, SMHS clinicians and executives to discuss referral pathways, models of care, service developments and local health priorities, and strengthened collaboration across the healthcare system.

The program also supported stakeholder engagement for the Older Adult Health Hubs initiative, a State Government election commitment to improve access, coordination and continuity of care for older people with complex and chronic health needs. Through established GP Engage networks, SMHS engaged GPs, community providers and primary healthcare stakeholders early in the planning and co-design process.

Stakeholder feedback highlighted the need for more integrated care pathways, improved service navigation and stronger coordination between acute, community and aged care services. Planning activities focused on developing service models that support earlier intervention, multidisciplinary care coordination and stronger connections between hospitals, general practice and community services.

The initiative aligns with broader health priorities to support an ageing population, reduce avoidable hospital presentations and help older people remain healthy and independent at home. The partnerships established through GP Engage provide a strong foundation for continued consultation and collaboration as the hubs progress.

Valuing the consumer voice in service planning

RGH continued to place consumer voices at the centre of service planning and improvement, creating more opportunities for patients, families and community members to directly influence the care they receive.

Through advisory groups and targeted consultation activities, consumers are helping shape services by sharing their experiences, identifying priorities and contributing ideas for change. During the year, considerable effort was also invested in broadening representation across consumer groups, including through the RkPG Consumer Advisory Council, to better reflect the diversity of the community, ensuring a wider range of lived experiences and perspectives inform service planning and decision-making.

The Maternity Advisory Group remained an active partner throughout the year, providing feedback on maternity services and helping explore the experiences of women and families receiving care. In partnership with the SMHS Patient Experience team, the group contributed to discussions about what matters most to service users and where improvements could have the greatest impact. The group continues to provide an important connection between consumers and clinicians, ensuring the perspectives of local families help inform future planning.

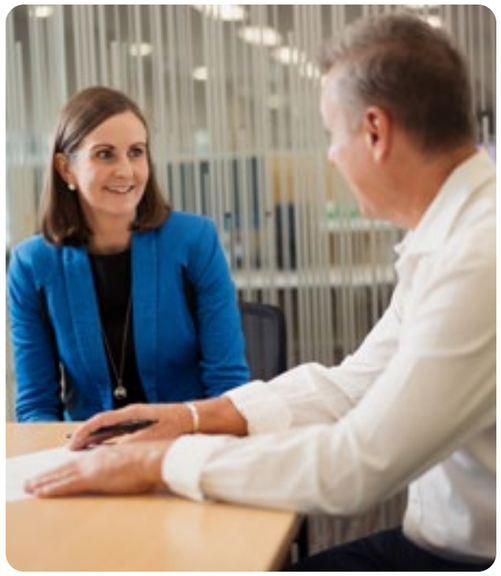
This focus on listening to consumers has also expanded into other areas. The establishment of a cancer focus group for people aged under 55 created a forum for younger patients to share their experiences and influence service development. Building on this work, plans are underway to broaden engagement opportunities across cancer services and through dedicated Aboriginal consultation activities, ensuring a wider range of community voices are represented in decisions about future care delivery.

Improving specialised care through partnerships

The Cockburn Health Transition Project commenced following the State Government's decision to transition Cockburn Clinic from a privately operated facility to a public mental health service governed by SMHS.

As part of this transition, Cockburn Health was established as a ward of FSH, providing voluntary inpatient care. Following service planning, the facility now delivers specialised services across three streams: women's mental health, eating disorders, and alcohol and other drugs (AoD). In addition, one ward was fitted out to care for patients who are medically ready for discharge but awaiting suitable community placement.

In 2026, the Cockburn Health Women's Mental Health Service received a SMHS Excellence Award for excellence in strengthening partnerships, recognising its commitment to delivering trauma-informed, culturally responsive care through collaboration with community, cultural, lived experience, academic and specialist partners.



These partnerships support holistic care by connecting consumers with women's health services, family and domestic violence supports, peer support programs and community organisations that assist with recovery and transition back into the community. Partnerships with academic institutions also support continuous learning and service improvement.

The transition of Cockburn Health strengthens the continuum of care across SMHS, improving access to specialised mental health services and supporting better patient flow and recovery outcomes for the community.

Supporting recovery through community physiotherapy

The Community Physiotherapy Service (CPS) delivers group-based physiotherapy assessment and rehabilitation programs aimed at restoring and optimising function, improving quality of life, and reducing the risk of hospital readmission following hospitalisation. Services are provided in accessible community venues close to patients' homes, with short-term programs combining structured exercise and education to support self-management and long-term health maintenance.

During 2024–2025, CPS partnered with West Australian Primary Health Alliance (WAPHA) to deliver a Community Physiotherapy–GP Linkage Program. The program supports individuals aged over 65 years to remain safely at home by reducing avoidable ED presentations and hospital admissions. While the formal WAPHA program was completed, its strong outcomes have led to the successful embedding of GP referral pathways within the CPS model. In 2025–26 these pathways continued to support clients identified as being at increased risk of falls or ED presentation, ensuring ongoing access to early intervention in the community.

Integrating social work into the CPS model as a result of the WAPHA project strengthened the service's ability to address unmet social needs. This enables a more holistic response to the social complexities impacting the physical health and wellbeing of patients and their carers.

The service also continued its partnership with Curtin University through a research-funded, student-supported service delivery model. This collaboration has grown over the reporting period, with increased referrals and higher participation rates, supporting more patients to enter and progress through pulmonary rehabilitation programs. The initiative aims to develop innovative, sustainable and scalable approaches to improving access to and utilisation of pulmonary rehabilitation services across SMHS.

Supporting healthier communities through prevention

SMHS has a dedicated Health Promotion team which works in partnership with SMHS hospitals, community organisations and local governments to improve population health and wellbeing.

Key focus areas include healthy eating and active living, reducing nicotine use, minimising alcohol-related harm, injury prevention and promoting mental health and wellbeing.

Across SMHS, the team supported staff health and wellbeing and led implementation of the *WA Health Smoke Free Policy* and *WA Healthy Options Food and Nutrition Policy.* This included strengthening relationships with hospital food vendors, promoting healthy catering and fundraising practices, and delivering initiatives to support smoke-free and vape-free environments. In collaboration with pharmacy services across all SMHS sites, the team provided free nicotine replacement therapy and support for staff wishing to quit smoking or vaping. World No Tobacco Day was marked across FH, FSH, RGH and PHC with information displays and cessation support available to staff.

The Community Health Promotion team also supported nine local governments within the SMHS catchment area to develop public health plans. In partnership with the DoH Epidemiology Department, the team provided health and wellbeing data analysis and interpretation to inform local planning. Recognising the increasing focus on climate change within the *State Public Health Plan 2025–2030*, the team developed and delivered a webinar series exploring the relationship between climate change and health in a local government context. The webinars attracted strong statewide participation, including regional locations, and increased participants' confidence to apply practical strategies within local public health plans. This work aligns with the *SMHS Environmental Sustainability Strategy 2026–2030.*

Health Promotion partnered with the RGH Integrated Cancer Service to support cancer prevention and community awareness. Working with the City of Kwinana and the City of Rockingham, the team established a collaborative network to better understand the patient journey through cancer screening, treatment and recovery, and to identify opportunities to strengthen prevention initiatives. Key outcomes included improved access to health information through hospital-based resources, digital promotion of community health programs, and enhanced online information and support for people affected by cancer.

Strengthening community-centred cancer care

RGH improved support for people living with cancer through a partnership between the RGH Integrated Cancer Service, SMHS Health Promotion and local government. This work recognises that cancer care extends beyond treatment, particularly in the Rockingham and Kwinana communities where cancer rates are higher than the state average. The partnership focuses on improving access to information, prevention and support, helping patients better understand their care journey while staying connected to services in their local community.

A key focus was ensuring patients feel supported at every stage of their experience, from screening through to treatment and recovery. By working closely with local government teams, the service built awareness of the patient journey and strengthened links to community-based programs that support both physical and mental health.

This approach helps patients navigate care more confidently and reduces the sense of isolation that can come with a cancer diagnosis.

By connecting hospital care with services already available in the community, the partnership is also helping create more coordinated, patient-centred pathways. Patients are better able to access lifestyle programs, education and support close to home, complementing their clinical care.

Alongside this, the team strengthened its focus on community voice and engagement. A dedicated focus group for people under 55 years was established to better understand the needs of younger patients, whose experiences and challenges can differ from older cohorts. Outreach was expanded, with clinical and consumer representatives presenting to community groups and district leaders, including during Men's Health Week in Kwinana. This work is helping to build trust, improve awareness and ensure services are shaped with direct input from the people they are designed to support.

Reflecting on 50 years of compassionate care

In May 2026 RGH celebrated 50 years of caring for the community by reflecting on the role the hospital has played in the lives of local families over generations. Since opening in 1976, the hospital has grown alongside the community it serves, while remaining closely connected to it. For many people in the region, the hospital has been part of life's most important moments, from birth through to recovery and end-of-life care.

While services and facilities have expanded over time, the defining feature of the hospital has always been its people. Staff and volunteers have built trust with the community through consistent, compassionate care, often delivered under pressure but always with a strong sense of responsibility. This continuity has helped create a culture where patients feel known, supported and cared for, which continues to shape the experience of care today.

The 50-year milestone also highlights the strength of connection between the hospital, its workforce and the community. Many staff have long-standing ties to the hospital, including families with multiple generations contributing to care. This shared history underpins a strong sense of pride and collective responsibility, supporting a care environment where relationships matter and patients benefit from a warm, collaborative culture grounded in community.

Enriching the patient experience through the arts

RGH has developed a valued partnership with Koorliny Arts Centre, welcoming cast members from local productions into the hospital to perform for patients, staff and visitors. These visits bring arts and community together in a very practical way, adding something different to the hospital environment and creating small moments of connection throughout the day.

Performances within areas such as the Aged Care Rehabilitation Unit provide a welcome break from the routine of care, helping to lift mood and create a more positive patient experience. The Shrek performance in November 2025 and the Billy Elliot performance in February 2026 showed how live music and theatre can engage patients in a way that is simple but meaningful, with visible enjoyment across patients, families and staff.

This ongoing collaboration reflects a broader approach to care at RGH, where community partnerships are used to complement clinical care. By bringing creativity into the hospital, these initiatives support wellbeing, reduce isolation and contribute to a more human, connected experience for patients.

Improving outcomes for vulnerable community members

Homelessness places increasing demand on Perth's emergency services, with homeless people:

- six times more likely to present at EDs
- experiencing hospital stays three times longer than the general population
- four times more likely to return for ED care.

The RkPG Social Work department offers necessary accommodation, community support liaison, food, clothing, warm sleeping needs and much more to vulnerable patients.

By working with services such as Backpack Bed, using tools such as the By Name List and engaging with local government and community organisations, the team attempts daily to assist one of the most vulnerable cohorts of our community.

Support extends beyond the inpatient setting. Social workers continue to engage with vulnerable patients in outpatient contexts, ensuring access to ongoing supports and services that reduce the likelihood of re presentation to hospital. This more proactive and connected approach helps improve patient outcomes, supports dignity and safety, and strengthens the hospital's role in working alongside the community to care for those most at risk.

Integrating safety and healing

RGH has developed a purpose-built firewise garden, the first of its kind within a State Government facility. Located in a bushfire-prone area, the garden was designed to reduce fire risk to the hospital and surrounding community, using fire-resistant landscaping and low-flammability materials. This proactive approach supports the hospital's preparedness while ensuring safety measures are integrated into the broader care setting.

Beyond its protective function, the garden has been intentionally designed as a therapeutic outdoor space. Native plantings, accessible pathways and quiet seating areas provide patients, families and staff with a place to step away from the clinical environment. The space encourages time outdoors, supports wellbeing and offers moments of calm, which are especially important for patients in mental health and rehabilitation settings.

Developed in partnership with local government, community organisations and cultural advisers, the garden reflects a strong connection to place. Its design includes a central yarning circle to promote connection and inclusion, reinforcing the role of culturally informed spaces in healing.

The project demonstrates how safety, environment and patient experience can be brought together to create a more supportive and resilient healthcare setting at RGH.

Bringing creativity and kindness into health care

RkPG continues to boost its connection with local schools, recognising the value these partnerships bring to the patient experience. Collaboration with students and teachers created opportunities to introduce creativity, colour and kindness into the hospital environment, in ways that are meaningful for patients, families and staff. These partnerships reflect a shared commitment to community, where local schools are actively contributing to the care environment.

This included creation of a large-scale mural outside the paediatric ward. Inspired by clinical staff and designed in partnership with students, the mural brightens the ward for young patients. The artwork draws on natural themes and colour to create a more welcoming and calming space, while also holding meaning for staff through its connection to a respected former colleague. This type of environment plays an important role in reducing anxiety and improving the overall experience for children and their families during hospital stays.

Alongside this, school-led initiatives such as kindness displays and small acts of giving have brought moments of connection across the hospital. Students have contributed handmade items, messages and gifts, engaging directly with patients, staff and volunteers. These gestures have lifted morale and reinforced a culture of compassion.

Together, these partnerships demonstrate how community involvement can directly enhance the patient experience and strengthen the sense of connection within RGH.

Sharing knowledge through international collaboration

2026 saw the SMHS and SingHealth nursing and midwifery collaboration enter its third year of collaboration under a twinning partnership.

In May SMHS welcomed three delegates, reinforcing a growing international partnership focused on nursing initiatives and workforce innovation with a shared aim to improve patient care and staff experience.

The engagement enabled strong bilateral learning, particularly in wellbeing and service models. It also reinforced organisational relationships through formal communications and networking events, supporting sustained strategic value beyond the initial visit.

Showcasing excellence in care through community engagement

The PHC Open Day on Saturday 11 April 2026 provided a valuable opportunity to showcase the people, services and teams who provide care at PHC.

Through staff-led stalls, displays, hands-on activities and guided tours, visitors were able to learn more about the hospital and the many roles that contribute to supporting patients and families.

Guided tours were a highlight, with more than 100 visitors gaining insight into the breadth of work that happens across the hospital each day.

Staff from across the hospital contributed their time, knowledge and enthusiasm to help create a positive and welcoming experience for the community. Their involvement brought the 'We are PHC' message to life, highlighting the pride staff have in their work, their colleagues and the care they provide.

By opening its doors in this way, PHC strengthened its connection with the local community and celebrated the collective effort, professionalism and heart that underpins excellent care.

Leading a collective approach to mental health care

Led by SMHS, the multi-agency Bindjareb Mental Health Collective (formerly the Peel Mental Health Taskforce) provides a systemic approach to coordinate and improve mental health service delivery across the Peel Health District (Mandurah, Waroona and Murray local governments).

The collective comprises high level representation from organisations, including:

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

The collective is informed by local representative sub-groups. Overall, the partnership approach engages representatives from over 50 government and non-government organisations, who participate in consultations and working groups to deliver projects that improve mental health outcomes.

Major initiatives progressed in partnership over 2025–26 include the following.

Wandjoo Gateway ‘no wrong door’ approach

The approach has seen 10 public and private schools deliver streamlined mental health support for students through a series of best-practice processes and engagement tools, with 184 referrals conducted using the innovative ‘story capture sheet’ universal referral form.

The approach has also commenced roll-out to the mental health and community services sector, plus a trial adaptation with local GPs.

Peel Collaborative Commissioning Project

A multi-commissioner Working Group was established with SMHS providing project coordination. The collaborative successfully delivered the Peel Youth Mental Health & Social Wellbeing Needs Analysis which investigated the issues, gaps, strengths and opportunities for service system improvements to better meet the needs of young people in the region, through a commissioning lens.

Recommendations from the report will inform the direction of the Working Group activities beyond 2025–26.

Peel Youth Pathway navigation and coordination service

Following a successful taskforce funding proposal, the youth mental health navigation and coordination service was awarded to 360 Health+Community.

The service model is designed to sit within the ‘middle’ of the continuum and provide young people, their families and service providers with a central point of guidance, system entry and clinical intervention.

To date, the focus has been on building strong foundations for safe and effective delivery, including workforce development, governance and clinical frameworks, system alignment and sustainability.


REGISTERED
MIDWIFE

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

Implementing sustainable healthcare practices

SMHS is committed to being an environmentally sustainable and climate-resilient organisation, supporting our vision of excellent health care, every time.

The *SMHS Environmental Sustainability Strategy 2023–2026* provides the framework for achieving net zero emissions by 2040 and improving sustainability outcomes for the health of current and future generations.

In 2025–26, SMHS continued to strengthen its leadership in environmental sustainability and climate resilience. A key achievement was the development and endorsement of the *SMHS Environmental Sustainability Strategy 2026–2030*, which established a renewed roadmap to achieving net zero emissions by the target date of 2040 while enhancing organisational resilience to climate-related risks. Implementation planning commenced across all sites, with a focus on governance, performance monitoring, integration into clinical and operational practice, and staff-led innovation.

Significant progress was achieved across a range of sustainability initiatives. Work advanced on the whole-of-government emissions reporting platform, Envizi, improving the organisation's capacity to measure emissions and inform future reduction strategies. Waste reduction initiatives included:

- the introduction of biodegradable blood product delivery bags at FSH, replacing more than 30,000 plastic bags annually
- expansion of reusable clinical products
- food rescue programs at multiple sites
- blister pack recycling at FSH and RGH.

Clinical sustainability initiatives also delivered positive outcomes. Clinical sustainability programs such as 'Think Before You Test', trialling extended infusion tubing use in FSH Intensive Care Unit patients from three to seven days, and nitrous oxide piping decommissioning at Fremantle and Rockingham hospitals demonstrated measurable reductions in consumables, waste, costs, and emissions while maintaining high-quality patient care.

Implementation of the National Safety and Quality Health Service Healthcare Sustainability and Resilience Module also commenced, supported by self-assessments and governance improvements.

Collaboration remained central to progress. More than 500 members of the Green Ambassador network actively promoted sustainable practices across SMHS, while Carbon Literacy Scholarships and targeted education programs strengthened workforce capability.

Partnerships with health services, funding organisations and community groups further supported training, recycling, food rescue and clinical consumable donation initiatives.

Challenges remain, including data maturity, and the integration of sustainability initiatives across a complex multi-site environment.

Continued investment in governance, capability development and performance monitoring will be critical to supporting future accreditation requirements, meeting evolving sustainability expectations and delivering lower-carbon, high-value care for patients, staff and the community.

Upgrading infrastructure

During 2025–26, the State Government-funded Aluminium Composite Panel (ACP) Replacement Program at FSH achieved significant milestones in improving fire safety and building compliance.

Practical completion of these replacement works on the administration building and car park overpasses was achieved ahead of schedule and under budget. Detailed investigations of the hospital's main building progressed to support planning for future stages of the program.

The investigations provided critical information to refine design, cost estimates and risk management strategies, ensuring works can be delivered while minimising disruption to hospital operations.

Extensive consultation with clinical, operational and project stakeholders supported planning and decision-making throughout the year.

Streamlining inventory and procurement practices

During 2025–26, FSFHG implemented the Streamlining Usage of Products and Leaning of Inventory project to improve inventory management, reduce waste and standardise clinical products. The initiative aimed to reduce variation in supplies, improve procurement efficiency and release nursing time for patient care.

The project delivered significant benefits through the removal of unused inventory, optimisation of stock holdings and rationalisation of duplicate products. Savings of more than $159,000 were realised at FSH, with a further $14,000 achieved at FH. Lean-based improvements to storage management and stock control processes strengthened inventory oversight and reduced waste from surplus and expiring products.

The project enhanced governance and staff capability through procurement guidance, education and improved inventory management practices. Product standardisation across key clinical categories supported consistency, efficiency and alignment with best practice.

The success of the initiative has established a foundation for ongoing inventory optimisation and sustainable procurement across FSFHG, attracting interest from other WA health service providers.

Piloting generative artificial intelligence across SMHS

During 2025–26, SMHS participated in a WA Health corporate generative artificial intelligence (AI) pilot to assess the potential of AI tools to improve productivity, enhance the quality of work outputs and strengthen digital capability.

The pilot involved 150 corporate and clinical leadership staff using AI to support activities such as document drafting, report preparation, meeting summarisation and information synthesis.

The pilot also identified practical applications to enhance stakeholder communication, reporting and access to information across the organisation.

Participants reported improved efficiency, particularly for routine administrative tasks, and greater capacity to distil complex information and support decision-making.

The initiative provided valuable insights into governance, security and information management requirements for AI adoption in a healthcare setting. Findings will inform the ongoing implementation of AI capability across SMHS, supported by appropriate governance, training and risk management controls to ensure safe, responsible and sustainable use of the technology.

Building a cyber-aware workforce

Protecting patient, staff and organisational information remains a key priority SMHS. During 2025–26, the Cyber Shield program strengthened cyber security capabilities across the organisation, improving visibility, governance, compliance and protection through the implementation of a risk-based program of work.

A strong focus on cyber awareness helped build a more proactive security culture. Monthly awareness campaigns, phishing simulations, webinars and site-based engagement activities increased staff awareness and reporting of suspicious emails, reducing the risk of cyber incidents and supporting the protection of sensitive information.

SMHS remains committed to strengthening cyber resilience through continued investment in security controls, workforce capability and emerging threat preparedness. Future initiatives will focus on addressing evolving risks, including AI-enabled scams and deepfakes, while maintaining patient privacy, service continuity and community trust.

Advancing strategic governance of digital health investments

During 2025–26, SMHS developed and implemented the Digital Investment Governance Cycle to strengthen oversight, prioritisation and decision-making for digital health investments.

The framework establishes a consistent approach to identifying, assessing, funding, delivering and evaluating digital initiatives, ensuring investments align with organisational priorities and deliver value.

Key achievements included the introduction of a standardised intake and assessment process, development of the Digital Investment Governance Initiative tool to manage investment requests, improved visibility of the digital portfolio, and clearer prioritisation based on organisational value, risk and readiness. Governance pathways were also streamlined, supporting more consistent and timely decision-making.

Aligned with DoH's emerging Digital Investment Framework, the governance cycle has strengthened the connection between strategy, funding and delivery.

This supports greater transparency, accountability and evidence-based investment decisions. Further enhancements to reporting, benefits realisation and governance processes are underway to maximise the value of digital investments across SMHS.

Upgrading technology to support contemporary healthcare delivery

SMHS continued to invest in modernising its Microsoft technology environment, including upgrading end-user devices and core digital platforms used across the health service.

These improvements provide a more secure, reliable and contemporary digital workplace for staff, supporting access to essential clinical and business systems.

By strengthening the technology that underpins day-to-day operations, SMHS is helping to enhance the delivery of safe, efficient and connected patient care while supporting future digital health initiatives.

Strengthening our digital foundations

The completion of Critical Health IT Infrastructure Program-funded work at FH uplifted network infrastructure at a key SMHS site. This addressed a key Office of the Auditor General (OAG) finding surrounding our ageing and unsegmented connections within the site.

This program now moves onto our other HSS supported sites through the 2026–27 calendar year and crucially, sets the foundations for implementation of major digital reforms like the Electronic Medical Record (EMR).

Safeguarding our digital infrastructure

SMHS initiated the Next Generation Firewall project to address an OAG finding relating to our lack of control of 'internet of things' devices connecting to our network.

Installing these firewalls at RGH, FH and MDH addressed a critical cyber security risk and the OAG finding whilst SMHS awaited the rollout of the Critical Health IT Infrastructure Program.

Reducing administrative burden through automated solutions

During 2025–26, the Automate Everything initiative reduced manual processes and rework across digital health products SMHS-wide. Enhancements were delivered to MyDigitalHealth, Health Applications Training and Support, the Solution Registry and support reporting, improving efficiency and streamlining administrative workflows.

Transforming cannula management through digital innovation

The Digital Cannulation Management Project progressed in 2025–26 as an innovation initiative supported by the Future Health Research and Innovation Fund. The project aims to improve peripheral intravenous cannula care through a standardised digital platform that strengthens documentation, visibility and risk identification throughout the cannula lifecycle.

A key achievement was the development of a comprehensive clinical dataset to support research into AI-enabled assessment and predictive risk identification. In partnership with Murdoch University, early testing demonstrated the potential for AI to assist in identifying complications and supporting clinical decision-making.

The project provided valuable insights into opportunities to improve monitoring, identify high-risk patients earlier and strengthen adherence to best-practice cannula care. Through its combination of digital innovation, research and clinical collaboration, the project is establishing an evidence-based approach to improving patient safety and vascular access outcomes, with potential application across the broader health system.

Accelerating healthcare innovation through real-world collaboration

Throughout 2025–26, SMHS continued to develop the HealthReady Innovation Pipeline, an initiative that enables clinicians, researchers and innovators to co-design, test and validate healthcare solutions within a real-world clinical environment. As the first structured innovation pipeline of its kind in the Western Australian public health system, HealthReady supports the translation of new ideas into practical, patient-centred solutions.

Key achievements included:

- establishing program governance and assessment processes
- expanding the portfolio of innovators participating in the pipeline to 27 projects
- supporting seven grant collaborations.

Through clinical consultation, health system expertise and validation activities, participating innovators secured more than $1 million in innovation funding.

HealthReady strengthened partnerships across SMHS, universities, industry and the broader health sector, providing innovators with access to clinical expertise and real-world testing environments. These collaborations supported the progression of several projects into clinical assessment and research pathways.

The program is helping build a sustainable innovation ecosystem within SMHS, supporting the safe adoption of new technologies, improved models of care and enhanced healthcare outcomes for patients and the community.

Translating frontline ideas into healthcare solutions

During 2025–26, the SMHS Kaartdijin Innovation Centre continued to foster a culture of innovation across the organisation, supporting employees to identify challenges, develop new ideas and test solutions to improve healthcare delivery.

A total of 39 new ideas were submitted to the innovation pipeline during the year, bringing the number of active initiatives under development to 55.

The centre continued to support clinician-led innovation through the SMHS Innovation Fellowship program, providing participants with training and mentoring in innovation methodologies, project management and change leadership. The program helps build innovation capability and supports the translation of frontline ideas into practical solutions that improve patient care and service delivery.

A key initiative during the year was the ReversePitch pilot program, which invites clinicians and operational staff to present priority healthcare challenges and collaborate with academia and industry to develop solutions. The inaugural challenge focused on reducing outpatient 'did not attend' appointments. In partnership with Murdoch University, a multidisciplinary team developed a machine-learning prototype capable of predicting non-attendance, demonstrating the potential to support targeted interventions and improve outpatient service efficiency.

The centre also strengthened partnerships across healthcare, research, industry and government sectors through participation in state and national innovation forums. These activities supported knowledge sharing, collaboration and the continued growth of the SMHS innovation ecosystem. Through initiatives such as HealthReady, Innovation Fellowships and ReversePitch, the Kaartdijin Innovation Centre is supporting the development and adoption of innovative solutions that improve patient outcomes, service delivery and health system performance.

Enhancing surgical readiness through digital prehabilitation

During 2025–26, SMHS continued to deliver SurgFit, its digitally enabled prehabilitation program supporting patients preparing for elective surgery. Through the Digital Companion platform, SurgFit promotes prevention, health optimisation and patient-centred care, enhancing engagement and surgical readiness.

Since its launch in April 2023, more than 3,450 patients have participated in SurgFit School through virtual group sessions and telephone consultations. The program has strengthened early intervention, with 60 per cent of participants subsequently referred to targeted prehabilitation services, including physiotherapy, dietetics, geriatrics, health coaching, Quitline and lifestyle programs.

Patient engagement with the Digital Companion remained strong, with 89 per cent of participants completing electronic assessments through the platform. This demonstrates high levels of accessibility, usability and patient acceptance of digitally enabled models of care.

In 2025–26, the Digital Companion secured funding through the Future Health Research and Innovation Fund Targeted Call: Health System Solution grant program.

This funding will support further development of the platform, including enhanced patient monitoring and engagement capabilities and expansion into post-surgical care. Ongoing collaboration with consumers, clinicians and operational stakeholders is supporting the continued evolution of the program and its contribution to improved patient outcomes.

Transforming communication in critical care settings

Throughout 2025–26, SMHS continued development of LipReader, an innovative digital health solution designed to improve communication for patients unable to speak due to mechanical ventilation, tracheostomy or critical illness.

Developed by SMHS Speech Pathologist Jason Hall and supported through a Kaartdijin Innovation Fellowship, LipReader uses AI to convert silent mouth movements into text and voice output, helping patients communicate more effectively with clinicians and their families.

A key achievement during the year was the development of a functional prototype and completion of consumer testing involving former patients, family members and clinicians. Participants rated the application highly for usability and clinical usefulness, demonstrating strong acceptance and potential value in supporting patient-centred care. Feedback informed further refinements to improve communication accuracy and user experience.

In recognition of its impact, LipReader received both the 2026 SMHS Excellence in Improving the Patient Experience Award and the Southern Star Award. The project has also demonstrated the potential of emerging technologies to improve patient autonomy, participation in care and communication outcomes.

As the project progresses towards clinical validation and broader implementation, LipReader represents an important example of clinician-led innovation, supporting more equitable, person-centred and efficient healthcare delivery across WA Health.

Advancing digitally enabled neonatal care

Across 2025–26, the Neonatal Intensive Care Unit Mobile Application became part of routine care at FSH, supporting families participating in the Gastric Enteric Tube Feeding Early Discharge (GET FED) program. The digitally enabled model of care provides parents with access to tailored education, feeding and weight monitoring tools, and direct communication with clinicians. This supports the safe transition of premature and medically complex babies from hospital to home.

During the year, more than 90 babies were enrolled in the program, with approximately 79 per cent of families engaging actively with the application. The platform enabled clinicians to remotely monitor feeding and growth while improving access to information and support for families, strengthening communication and continuity of care following discharge.

Evaluation findings demonstrated positive outcomes for families. Participants reported increased understanding of their baby's condition, greater confidence in caring for their child at home and reduced anxiety during the transition from hospital to home. The application has helped parents play a more active role in their baby's care and strengthened connections with their healthcare team.

The digital platform has also supported the ongoing success of the GET FED program, contributing to an average reduction in length of stay of approximately 10 days per patient.

By replacing paper-based processes with a structured digital model, the initiative has improved visibility of patient progress, streamlined clinical workflows and established a scalable approach to supporting neonatal care.

Improving access to specialist neurological diagnostics closer to home

During 2025–26, SMHS and WACHS continued to progress the Rural Electroencephalogram Diagnostic Service (REDS) Project, an innovative telehealth initiative designed to improve access to neurophysiology services for regional Western Australians.

Building on the successful proof-of-concept between FSH and Bunbury Regional Hospital, the project advanced towards implementation through development of clinical service models, patient pathways and operational frameworks to support the delivery of remote electroencephalography (EEG) services. Significant progress was also made in digital governance, infrastructure planning and technical design to support a secure and scalable service.

The project has strengthened collaboration between SMHS, WACHS and system partners, establishing the foundations for broader rollout across WA Health. Once implemented, the service is expected to improve access to specialist neurological diagnostics, reduce the need for patient travel and support more timely, patient-centred care for people living in regional and remote communities.

Our issues

SMHS has established an Access to Care and Clinical Services Strategy (ACCeSS) Executive Subcommittee which provides weekly strategic oversight of patient access, flow and capacity across the health service.

The committee brings executive leaders and clinical services together to monitor performance, identify systemwide pressures and oversee the implementation of local initiatives that improve access to timely, safe and equitable care.

During 2025–26, the committee continued to drive a coordinated approach to access improvement across emergency, elective, outpatient and community care services.

A key focus was the development and implementation of ACCeSS interim strategic plans, which established focused strategic priorities for the 12 months and improvement actions to address access challenges and support sustainable performance improvement across the health service.

The committee also strengthened performance monitoring and governance arrangements, providing executive oversight of initiatives aimed at improving patient flow, reducing delays to care and optimising capacity across SMHS. This included oversight of emergency department access and flow, elective surgery demand and capacity, outpatient reform initiatives, virtual models of care and strategies to support timely discharge and hospital avoidance.

Through a focus on data-informed decision making, cross-site collaboration and continuous improvement, the committee supported health service-wide efforts to improve patient access and experience while responding to increasing demand for healthcare services.

A persistent challenge affecting access to care across the health system is delayed discharge for patients who are medically fit to leave hospital but are unable to access appropriate aged care or community placement options. In 2025–26, ongoing shortages in the aged care sector continued to contribute to bed-blocking pressures, reducing the availability of inpatient beds for people requiring acute care.

To help address this issue, SMHS expanded dedicated Care Awaiting Placement capacity through wards at other sites, providing appropriate interim care for patients awaiting residential aged care or other community placements.

These initiatives helped improve patient flow, support more timely access to hospital services and ensure acute care beds were available for those with the greatest clinical need.

Winter strategy

SMHS strengthened its winter preparedness in 2025–26 through a coordinated week-to-week response aligned with the WA Health Winter Strategy. Recognising the increased demand associated with winter – including higher rates of respiratory illness, pressures on patient flow and bed capacity, and workforce challenges – SMHS focused on early planning, coordinated action and the delivery of safe, timely care across the continuum.

The strategy centres on key priorities including prevention, patient flow, bed capacity and care for older people. Initiatives across these areas, such as additional bed turnaround teams and an additional medical consultant-led multidisciplinary team at FSH, have supported more efficient movement of patients through the health system, timely access to appropriate care, and improved coordination of services during periods of increased demand.

Winter Commanders played an important role in coordinating the whole-of-system response. At SMHS, successful implementation of the DoH milestones as well as daily winter huddles, local operational stand-ups and regular reporting processes enhanced visibility of emerging pressures and risks and supported timely decision-making and collaboration across clinical, operational and support services.

Supporting staff is a key component of the winter response. Leadership communications, executive rounding, staff engagement activities, wellbeing resources and feedback mechanisms help ensure staff remained informed, connected and supported throughout the season.

The winter response also provides opportunities to identify effective and sustainable practices that may be embedded into ongoing service delivery to strengthen future system resilience and patient care.

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 220,500 people attended a SMHS ED, which is an average of 604 presentations per day. Of these presentations, just over 50 per cent were seen at FSH, making it one of the busiest EDs in Australia.

Compared to 2024–25, there was 3.5 per cent more ambulances this year and a 4.2 per cent decline in average daily ramping hours across SMHS.

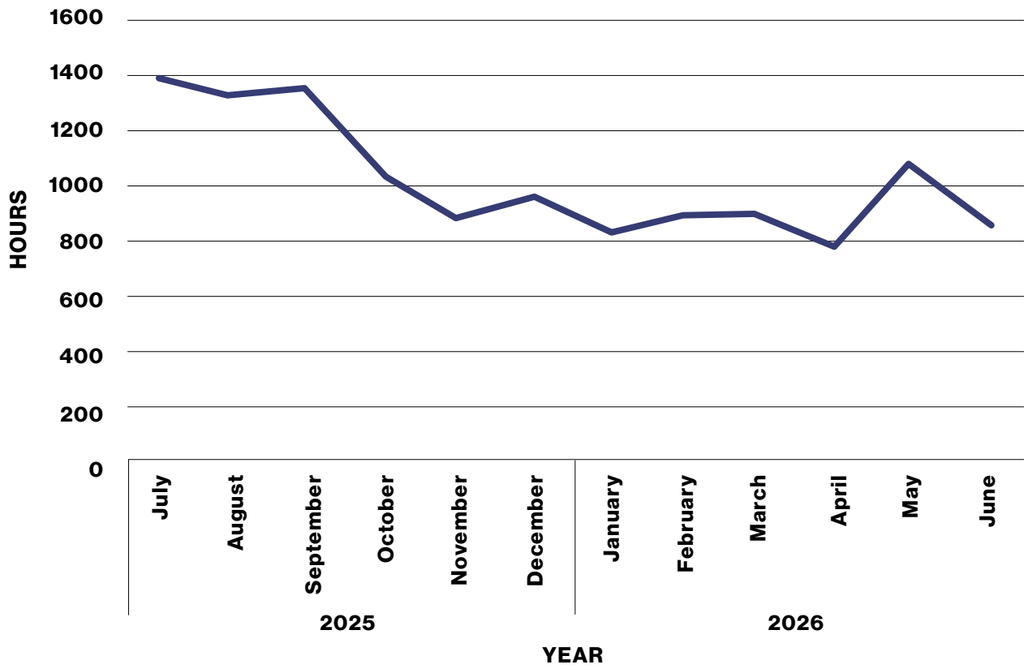
FSH saw 110,794 emergency patients in 2025–26, received an average of 100 ambulances per day (an 0.7 per cent increase is ambulance attendances) and a 4.0 per cent decrease in ambulance ramping. Of note, the number of Australasian Triage Scale (ATS) 1 to 3 presenting to FSH ED increased by 1.9 per cent when compared to 2025–26. These are patients whose conditions are classed as immediately life-threatening, potentially life-threatening or imminently life-threatening and/or in very severe paining or requiring time-critical treatment. This group represents the most acutely unwell patients who present to ED.

RGH saw 60,010 and PHC saw 49,735 emergency patients in 2025–26.

Table 2: ED presentations by triage category

Hospital	Triage category 1	Triage category 2	Triage category 3	Triage category 4	Triage category 5	Total
FSH	2,481	27,374	45,909	32,020	3,010	110,794
	2.2%	24.7%	41.4%	28.9%	2.7%	-
PHC	363	6,757	18,768	22,013	1,834	49,735
	0.7%	13.6%	37.7%	44.3%	3.7%	-
RGH	661	11,526	25,670	20,019	2,134	60,010
	1.1%	19.2%	42.8%	33.4%	3.6%	-
SMHS total	3,505	45,657	90,347	74,052	6,978	220,539
	1.6%	20.7%	41.0%	33.6%	3.2%	

Image 1. Total ramped hours trend for FSH, PHC and RGH 2025–26



2025–26 initiatives

During the year, SMHS commenced the following initiatives.

FSFHG

During 2025–26, Fiona Stanley Fremantle Hospital Group (FSFHG) progressed a broad program of work focused on strengthening access to care. A key milestone was the permanent establishment of the Improving Patient Access to Care Team (IMPACT) in December 2025, creating a dedicated capability for patient flow analytics and clinical service redesign. The SMHS Improvement Strategy continued to shape the development, implementation and monitoring of access initiatives across the organisation.

A range of initiatives were delivered throughout the reporting period:

- The ED-to-Ward Redesign program commenced in June 2025 to review and streamline admission processes, while the FSFHG Access to Care Committee was established in the same month to strengthen hospital-wide engagement in access improvement.
- During Winter 2025, several pilots were implemented, including the reopening of the FH Transit Lounge, introduction of a Discharge Flow Nurse, and early phlebotomy rounds.
- The AMU Morning Discharge Initiative commenced in July 2025 and delivered a sustained improvement in morning discharge activity.
- In October 2025, the FH Placement Coordination Team was established to support placement pathways for older adults requiring residential aged care.
- A dedicated TIA Clinic commenced in March 2026 to support admission avoidance for patients presenting with transient ischaemic attacks and minor stroke.

- Medihotel optimisation continued throughout the year through notional bed allocations, transit lounge pathways, enhanced portering arrangements, and the transition of M5 to Surgical Specialties in May 2026.
- During the year, the FSFHG Code Yellow response framework was revised and supported by an enhanced activation dashboard, selected seven-day services were expanded, and a Rehabilitation Response Team was established in June 2026 following the repurposing of Adult Rehabilitation Unit beds.
- A Care Awaiting Placement ward opened at Cockburn Health (June 2026) to support patients awaiting residential aged care placement.

Managing winter demand remained an organisational priority in 2026. The SMHS Winter approach has greatly enhanced our ability to work together as a HSP. New winter strategies included expansion of State Rehabilitation Service bed base and creation of a Rehabilitation Inreach Team. There was also a establishment of a multidisciplinary Winter Care Team to support flow through high-demand clinical pathways and a reprioritisation of emergency surgery.

TheatreFlow+

This clinical services redesign initiative aims to enhance surgical service delivery at FSFHG by increasing theatre capacity, improving patient outcomes and equity, and establishing a scalable, sustainable model that optimises timelines, reduces waste and supports staff engagement.

The project responds to increasing system pressures across elective and emergency surgery by improving operating theatre utilisation, optimising patient flow, and strategically aligning workforce capability to activity demand.

Commencing in the latter half of the 2025–26 financial year, this work directly supports SMHS priorities to reduce surgical waitlist times, improve timely access to emergency surgery and deliver high-quality, equitable care across the system.

RkPG

Initiatives at RkPG included:

- Opening the 20-bed Peninsula Ward at Waikiki Private Hospital and an eight-bed surge unit in June 2026 as part of its winter capacity response.
- Introducing a bed turnaround team to improve access to cleaned beds after discharge, with early reporting showing reduced bed clean and turnover times compared with 2025.
- Introducing SpotFire rapid respiratory testing in ED to support faster clinical decision-making during periods of high respiratory demand.
- Opening a 10-bay Transit Lounge in May 2026, creating a dedicated space for patients being admitted from the ED, and supporting earlier movement for patients ready for discharge and those being transferred between sites.
- Opening 10 beds opening for Rockingham patients in February 2026, expanding to 20 beds by June as part of the SMHS Home Hospital expansion.
- Creating A-bays as a clinically safe waiting space for patients, supporting improved transfer of care during periods of ED pressure, and writing a new ED handover model to reduce repeated handovers and support more efficient communication between teams.
- Strengthening long-stay patient oversight through a new reporting process and continued weekly long-stay meetings, supporting a reduction in medically cleared patients remaining in RGH.

PHC

In collaboration with SMHS sites, the PHC Access to Care initiative aims to improve patient experience and outcomes by reducing the total number of patients who wait longer than they should in ED and hospital wards.

Key achievements in 2025–26 include:

- Continued focus on ED processing of ambulances ensured continued success with transfer of care and ramping hours.
- Improved admission WA Emergency Access Target (WEAT) due to focus on translating early discharges through the Transit Lounge, supporting early flow from ED.
- Increasing bed capacity at MDH from 15 beds to a total of 28 beds.
- Reduction in length of stay for MDH patients following embedding processes to streamline patient placement pathways.
- Transitioned to electronic journey boards with clearer discharge planning identification and shared communication.

PHC emergency department access

PHC ED saw 49,735 presentations over 2025–26, an average of 137 per day. This represents an average growth of 8 per cent in 2025–26 from 2024–25 (45,975 presentations).

PHC made significant progress in improving emergency access and patient flow performance throughout 2025–26, achieving an outstanding reduction in ramping hours over the year. Whilst ED presentations are increasing, PHC's ramping hours consistently remain under statewide targets at an average of 2.7 hours per day compared to an average of 7.5 hours per day in 2024–25 – a 64 per cent improvement in ramping hours, supporting the provision of safe and timely care to the Peel community.

PHC's 2025–26 performance reflects sustained pressure, driven by consistent growth in demand and ongoing capacity constraints. Continued focus remains on improving discharge efficiency, reducing long stay patients, and enhancing bed capacity to continually improve PHC's Access to Care outcomes.

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.

During 2025–26, 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 over boundary numbers for the nine specialties that account for more than 80 per cent of over boundary cases via internal and external strategies. General surgery, paediatric surgery, plastic 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 allowing them to receive a diagnosis, procedure, assessment, treatment or education without admission to hospital.

These appointments play a vital role in the patient's care journey. 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 and remain 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 2025–26 included:

- continued enhancement of the Virtual Immunology Clinic
- 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:
    - o strengthening virtual care support structures across sites
    - o considering alternative models of work
- ongoing primary care engagement to explore opportunities for co-designing shared models of care with specialist outpatient services.
- participating in systemwide outpatient reform initiatives, including preparation and planning for the pilots of Smart Referral WA and the GP Accessing Specialist Hospital Knowledge program.

SMHS outpatient data 2025–26

- 280,618 new patients were seen in outpatient clinics.
- Overall outpatient activity grew, with 1,206,014 outpatient appointments, a 1.4 per cent increase in activity compared to the last financial year.
- Of these, 368,676 (or 30.5 per cent) were delivered using telephone and video.

Supporting and growing the workforce

Workforce recruitment and planning efforts in 2025–26 supported ongoing service expansion as well as the temporary workforce uplift required to deliver winter demand strategies.

Staff have been recruited for the following permanent service expansions.

Fremantle Hospital expansion

There was a significant workforce uplift to cater for expansion of mental health beds at FH, with approximately 150 new employment contracts offered across the various disciplines.

The hospital's 40-bed mental health expansion will increase mental health inpatient bed capacity from 64 beds to 104 beds in the 2026–27 year. The 40 beds comprise 20 secure adult, 10 open adult and 10 neurobehavioral older adults.

All wards are expected to be open and operational by September 2026.

Cockburn Health care awaiting placement ward

Cockburn Health opened as a new 25-bed care awaiting placement ward supporting care for the older patient and improving patient flow.

Home Hospital expansion

In 2025–26 phased expansion of Home Hospital was achieved, increasing bed capacity for SMHS and building our workforce for community and home-based care.

Winter strategy staffing and recruitment

As part of the SMHS winter strategy, staff were recruited for the following temporary initiatives:

- A 20-bed care awaiting placement ward in Waikiki opened by RGH to help ease pressure for medically cleared patients awaiting their next place of care.
- Additional patient support services staff for bed turnaround teams at RGH, PHC and FSH to support improved bed moves and cleaning times so patients can move to the right place for their care with less delay.
- An additional 6 beds at FSH, giving a total of 40 ICU beds, providing much-needed critical care capacity for the state.
- FSH Transit Lounges operating hours were extended to 24 hours, seven days a week, helping ensure smoother patient flow and a better patient experience.

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:

Transparency **Accountability** **Consistency** **Recognition** **Integration**

Transparency: transparent reporting of performance against agreed outcome targets.

Accountability: clearly defined roles and responsibilities to achieve agreed outcome targets.

Consistency: consistent systems to support the achievement of agreed outcome targets.

Recognition: acknowledgment of performance against agreed outcome targets.

Integration: integrated systems and policies to support the achievement of agreed outcome targets.

The 2025–26 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 and 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 3 aligns the SMHS KPIs to the WA Health system outcomes and State Government goals.

Performance against these activities and outcomes is summarised on page 125 and described in detail within the compliance section of this report.

Table 3. 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 (MP011519), 2025–26 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 2025 Target	2025 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	≤	18.8	8.5	10.3
(b) Hip replacement	≤	18.3	26.3	8.0
(c) Tonsillectomy and adenoidectomy	≤	79.2	65.4	13.8
(d) Hysterectomy	≤	44.1	41.3	2.8
(e) Prostatectomy	≤	37.5	19.9	17.6
(f) Cataract surgery	≤	2.2	1.4	0.8
(g) Appendicectomy	≤	27.8	19.7	8.1
Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days	≤	1.0	1.1	0.1
Survival rates for sentinel conditions				
(a) Survival rate for stroke, by age group				
0–49	≥	95.3%	100.0%	4.7%
50–59	≥	94.7%	98.1%	3.4%
60–69	≥	94.3%	92.6%	-1.7%
70–79	≥	92.4%	92.7%	0.3%
80 and above	≥	87.2%	87.3%	0.1%
(b) Survival rate for acute myocardial infarction, by age group				
0–49	≥	98.9%	98.2%	-0.7%
50–59	≥	99.0%	98.4%	-0.6%
60–69	≥	98.3%	99.3%	1.0%
70–79	≥	96.9%	96.4%	-0.5%
80 and above	≥	93.1%	94.2%	1.1%
(c) Survival rate for fractured neck of femur, by age group				
70–79	≥	98.8%	98.2%	-0.7%
80 and above	≥	97.0%	97.2%	0.2%
Percentage of admitted patients who discharged against medical advice				
(a) Aboriginal	≤	2.78%	3.00%	-0.22%
(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%	1.5%	0.40%
Readmissions to acute specialised mental health inpatient services within 28 days of discharge	≤	12%	13%	-1.00%
Percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services	≥	75%	82%	7.0%

Summary of Key PerformanceIndicators continued

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

Key Performance indicator (KPI)		Financial year 2025-26 Target	2025-26 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%	28.7%	-28.7%
(b) Category 2 over 90 days		0.0%	31.2%	-31.2%
(c) Category 3 over 365 days		0.0%	16.1%	-16.1%
Key Effectiveness Indicators				
Average admitted cost per weighted activity unit	≤	$8,183	$8,593	-$410
Average Emergency Department cost per weighted activity unit	≤	$8,094	$8,954	-$860
Average non-admitted cost per weighted activity unit	≤	$8,328	$7,934	$394
Average cost per bed-day in specialised mental health inpatient services	≤	$2,707	$1,928	$779
Average cost per treatment day of non-admitted care provided by mental health services	≤	$893	$861	$32

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

Key Effectiveness Indicators				
Average cost per person of delivering population health programs by population health units	≤	$24	$34	-$10

Financial targets

Table 4. Financial results

	2025-26 target ($ ‘000	2025-26 actual ($ ‘000)	Variation (+/-) ($ ‘000)
Total cost of services	2,891,178	3,189,447	298,269
Net cost of services	2,628,860	2,901,970	273,110
Total Equity	3,749,159	3,927,763	178,604
Net increase/ decrease in cash held	49,479	16,136	(33,343)
Approved full time equivalent staff level (salary associated with FTE)	1,802,334	2,028,033	225,699

Explanation of variance

Total cost of services variation

Total cost of services was $298.3 million (10.3%) higher than target. The increase reflects higher than anticipated service demand and activity across SMHS during 2025–26, including the full-year impact of the MediHotel and Cockburn facilities, the transition of Peel Health Campus services into the public health system, and expanded service delivery initiatives.

Expenditure growth was principally in employee benefits and patient support costs, together with increases in workforce-related costs arising from industrial agreement outcomes and other cost pressures.

Net cost of services variation

Net cost of services was $273.1 million (10.4%) higher than target. While revenue from patient charges and State Government funding increased during the year, these increases did not fully offset the higher cost of services associated with increased activity levels, service expansion and workforce-related expenditure.

Total equity variation

Total equity was $178.6 million (4.8%) higher than target. The increase was primarily driven by the revaluation of land and buildings during 2025–26, which resulted in an increase in the asset revaluation reserve and was partially offset by the operating deficit recorded for the year.

Net increase/decrease in cash variation

The net increase in cash held was $33.3 million lower than target. While additional funding was received during the year to support increased service demand and activity, higher operating expenditure and growth in employee entitlement liabilities reduced the increase in cash balances compared with the target.

Approved salary expense level variation

Salary expenditure was $225.7 million (12.5%) higher than target. The increase reflects higher clinical activity and service demand than originally anticipated, including the full-year impact of expanded service capacity. Salary expenditure was also affected by industrial agreement outcomes, implementation of workforce initiatives, and increases in employer superannuation contribution rates.

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 5) 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 6). For further information on SMHS improvement programs and SMHS hospital performance against the WA Emergency Access Target (WEAT) please refer to the 'Our issues' section.

Table 5: 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 6: Percentage of SMHS ED patients seen within recommended times, by triage category, 2025–26

Hospital	Triage 1	Triage 2	Triage 3	Triage 4	Triage 5
FSH	99.8%	47.4%	8.6%	19.0%	44.3%
RGH	99.4%	71.9%	15.1%	28.2%	56.5%
PHC	99.2%	52.9%	15.9%	34.2%	67.0%

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

This can be 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 proud of the improvements we continue to make to ensure safe, high-quality care for our patients and consumers. We are committed to providing care that reflects our values and puts people at the centre of everything we do.

We recognise that health care can be complex, and at times things may not go as expected when people access hospital or health services. When this occurs, particularly in cases with serious outcomes, SMHS is committed to understanding what happened, why it happened and making changes to help prevent it happening again.

Our focus is on learning and continuous improvement through the review of clinical incidents. Consumers are actively involved in these reviews, providing valuable insight and advice to help ensure the patient perspective remains central to the process.

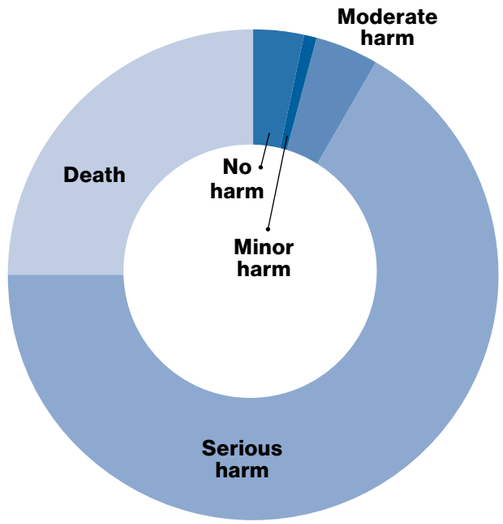
Clinical incidents are categorised according to their severity and reviewed accordingly. The most serious incidents – those that have or could have resulted in serious harm or death – are classified as severity assessment code 1 (SAC 1) incidents.

The number of SAC 1 incidents reflects our strong reporting culture and undergo rigorous investigation to identify any underlying system issues. Identified issues are addressed through implemented and evaluated recommendations, with lessons shared across the organisation to support learning and prevent recurrence. The SMHS Executive and SMHS Board review all SAC 1 notifications, as well as the final report of incidents identified as SAC 1s of concern, due to their potential for significant learning.

In 2025–26, SMHS reported and reviewed 144 SAC 1 clinical incidents. 107 reviews were completed at the time of reporting.

Of the 107 completed reviews, 24 resulted in the incident being approved for declassification by the Patient Safety Surveillance Unit as it was determined that there were no health care factors that contributed to the adverse patient outcome. 37 SAC 1 incident reviews are in progress at the time of this report.

Of the 144 SAC 1 investigations that were completed or are underway, the patient outcome* was noted as:



- 1 Minor harm
- 36 Death
- 5 No harm
- 96 Serious harm
- 6 Moderate harm

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

Our **compliance**

Auditor General

INDEPENDENT AUDITOR'S REPORT

2026

South Metropolitan Health Service

To the Parliament of Western Australia

Report on the audit of the financial statements

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

- the statement of financial position as at 30 June 2026, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended
- notes comprising a summary of material accounting policies and other explanatory information.

In my opinion, the financial statements are:

- based on proper accounts and present fairly, in all material respects, the operating results and cash flows of the Health Service for the year ended 30 June 2026 and the financial position as at the end of that period
- in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions.

Basis for opinion

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

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

Responsibilities of the Board for the financial statements

The Board is responsible for:

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

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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 2026, and the controls were implemented as designed as at 30 June 2026.

The Board's responsibilities

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

Auditor General's responsibilities

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

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

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

Limitations of controls

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

Report on the audit of the key performance indicators

Opinion

I have undertaken a reasonable assurance engagement on the key performance indicators of the Health Service for the year ended 30 June 2026 reported in accordance with the *Financial Management Act 2006* and the Treasurer's Instructions (legislative requirements). The key performance indicators are the Under Treasurer-approved key effectiveness indicators and key efficiency indicators that provide performance information about achieving outcomes and delivering services.

In my opinion, in all material respects, the key performance indicators report of the Health Service for the year ended 30 June 2026 is in accordance with the legislative requirements, and the key performance indicators are relevant and appropriate to assist users to assess the Health Service's performance and fairly represent indicated performance for the year ended 30 June 2026.

The Board's responsibilities for the key performance indicators

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

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

Auditor General's responsibilities

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

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

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

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

I have complied with the independence requirements of the *Auditor General Act 2006* and the relevant ethical requirements relating to assurance engagements. In accordance with ASQM 1 *Quality Management for Firms that Perform Audits or Reviews of Financial Reports and Other Financial Information, or Other Assurance or Related Services Engagements,* the Office of the Auditor General maintains a comprehensive system of quality management including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Other information

The Board is responsible for the other information. The other information is the information in the entity's annual report for the year ended 30 June 2026, but not the financial statements, key performance indicators and my auditor's report.

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

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

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

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

This auditor's report relates to the financial statements and key performance indicators of the Health Service for the year ended 30 June 2026 included in the annual report on the Health Service's website. The Health Service's management is responsible for the integrity of the Health Service's website. This audit does not provide assurance on the integrity of the Health Service's website. The auditor's report refers only to the financial statements, controls and key performance indicators described above. It does not provide an opinion on any other information which may have been hyperlinked to/from the annual report. If users of the financial statements and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to contact the Health Service to confirm the information contained in the website version.

Patrick Arulsingham
Senior Director Financial Audit
Delegate of the Auditor General for Western Australia
Perth, Western Australia
1 September 2026

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Certification of financial statements

South Metropolitan Health Service

Certification of financial statements for the year ended 30 June 2026

The accompanying financial statements of the 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 reporting period ended 30 June 2026 and the financial position as at 30 June 2026.

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

Mr Liam Roche
Board Chair
South Metropolitan Health Service
31 August 2026

Mr Brian Mumme
Board Member
South Metropolitan Health Service
31 August 2026

Mr Mark Cawthorne
Chief Financial Officer
South Metropolitan Health Service
31 August 2026

Financial **statements**

For the year ended 30 June 2026

South Metropolitan Health Service

Statement of Comprehensive Income

For the year ended 30 June 2026

	Notes	2026 $'000	2025 $'000
COST OF SERVICES			
Expenses			
Employee benefits expense	3.1.1	2,028,033	1,809,386
Fees for contracted medical practitioners	3.2	36,213	32,210
Contracts for services	3.4	9,978	32,016
Patient support costs	3.3	569,450	510,789
Finance costs	7.2	3,139	3,408
Depreciation and amortisation expense	5.1 - 5.4	108,193	96,787
Impairment losses	5.1.1	1,937	-
Loss on disposal of non-current assets	4.6	126	8
Repairs, maintenance and consumable equipment	3.5	86,266	81,398
Other supplies and services	3.6	88,247	79,295
Other expenses	3.7	257,865	248,298
Total cost of services		**3,189,447**	**2,893,595**
INCOME			
Revenue			
Patient charges	4.2	132,854	114,735
Other fees for services	4.3	121,273	108,225
Commonwealth grants and contributions	4.4	374	4,320
Other grants and contributions	4.4	2,924	3,780
Donation revenue	4.6	1,992	8,273
Interest revenue		24	23
Commercial activities	4.5	854	444
Other revenue	4.6	27,182	23,239
Total revenue		**287,477**	**263,039**
NET COST OF SERVICES		**2,901,970**	**2,630,556**
Income from State Government			
Department of Health - Service agreement	4.1	2,401,139	2,174,980
Mental Health - Service agreement	4.1	283,602	244,474
Income from other state government agencies	4.1	12,365	19,194
Assets (transferred)/assumed	4.1	21	877
Services received free of charge	4.1	143,425	135,546
Total income from State Government		**2,840,552**	**2,575,071**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(61,418)**	**(55,485)**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.9	180,776	403,129
Total other comprehensive income		**180,776**	**403,129**
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**119,358**	**347,644**

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

For the year ended 30 June 2026

		$'000	$'000
ASSETS			
Current assets			
Cash and cash equivalents	7.3	80,358	66,908
Restricted cash and cash equivalents	7.3	29,834	27,148
Receivables	6.1	60,506	51,716
Inventories	6.3	8,774	8,597
Other current assets	6.4	10,945	6,480
Total current assets		**190,417**	**160,849**
Non-current assets			
Receivables	6.1	56,748	43,748
Amounts receivable for services	6.2	1,487,560	1,391,976
Property, plant and equipment	5.1	2,858,571	2,654,937
Service concession assets	5.3	-	-
Right-of-use assets	5.2	53,759	59,585
Intangible assets	5.4	1,731	2,588
Total non-current assets		**4,458,369**	**4,152,834**
Total assets		**4,648,786**	**4,313,683**
LIABILITIES			
Current liabilities			
Payables	6.5	162,688	136,409
Contract liabilities	6.6	323	278
Grant liabilities	6.7	-	10
Lease liabilities	7.1	11,200	10,287
Employee related provisions	3.1.2	407,650	356,655
Other current liabilities	6.8	509	412
Total current liabilities		**582,370**	**504,051**
Non-current liabilities			
Lease liabilities	7.1	44,737	52,084
Employee related provisions	3.1.2	93,916	92,280
Total non-current liabilities		**138,653**	**144,364**
Total liabilities		**721,023**	**648,415**
NET ASSETS		**3,927,763**	**3,665,268**
EQUITY			
Contributed equity	9.9	2,943,890	2,800,753
Reserves	9.9	1,161,674	980,898
Accumulated deficit	9.9	(177,801)	(116,383)
TOTAL EQUITY		**3,927,763**	**3,665,268**

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 2026

	Notes	2026 $'000	2025 $'000
CONTRIBUTED EQUITY	9.9		
Balance at 1 July		2,800,753	2,723,512
Transactions with owners in their capacity as owners:			
Capital appropriations administered by Department of Health		137,653	77,241
Transfer of appropriation from Main Roads WA		5,484	-
Balance at 30 June		**2,943,890**	**2,800,753**
RESERVES	9.9		
Asset Revaluation Reserve			
Balance at 1 July		980,898	577,769
Other comprehensive income		180,776	403,129
Balance at 30 June		**1,161,674**	**980,898**
ACCUMULATED SURPLUS	9.9		
Balance at 1 July		(116,383)	(60,898)
Surplus/(deficit) for the period		(61,418)	(55,485)
Balance at 30 June		**(177,801)**	**(116,383)**
TOTAL EQUITY			
Balance at 1 July		3,665,268	3,240,383
Total comprehensive income for the period		119,358	347,644
Transactions with owners in their capacity as owners		143,137	77,241
Balance at 30 June		**3,927,763**	**3,665,268**

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 2026

	Notes	2026 $'000	2025 $'000
CASH FLOWS FROM STATE GOVERNMENT			
Revenues from State Government Agencies		2,601,522	2,345,198
Capital appropriations administered by Department of Health		137,653	77,241
Transfer of appropriation from Main Roads WA		5,484	-
Net cash provided by State Government	7.3.2	**2,744,659**	**2,422,439**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(1,963,049)	(1,726,486)
Supplies and services		(882,390)	(862,777)
Finance costs		-	-
Receipts			
Receipts from customers		116,164	106,489
Commonwealth grants and contributions		364	-
Other grants and contributions		2,906	3,780
Donations received		566	1,660
Interest received		24	23
Other receipts		146,380	131,597
Net cash provided by/(used in) operating activities	7.3.2	**(2,579,035)**	**(2,345,714)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
27th pay contribution		(13,000)	(10,000)
Payment for purchase of non-current physical and intangible assets		(122,112)	(63,790)
Receipts			
Proceeds from sale of non-current physical assets		6	-
Net cash provided by/(used in) investing activities		**(135,106)**	**(73,790)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Repayment of lease liabilities		(14,382)	(13,635)
Net cash provided by/(used in) financing activities		**(14,382)**	**(13,635)**
Net increase/(decrease) in cash and cash equivalents		16,136	(10,700)
Cash and cash equivalents at the beginning of the year		94,056	104,756
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.3.1	**110,192**	**94,056**

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 government not-for-profit entity controlled by the State of Western Australia, which is the ultimate parent.

A description of the nature of its operations and its principal 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 31 August 2026.

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 affected 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)

Income, expenses and assets are recognised net of the amount of goods and services tax (GST), except that the:

(a) amount of GST incurred by the Agency as a purchaser that is not recoverable from the Australian Taxation Office (ATO) is recognised as part of an asset's cost of acquisition or as part of an item of expense; and
(b) receivables and payables are stated with the amount of GST included.

Cash flows are included in the Statement of cash flows on a gross basis. However, the GST components of cash flows arising from investing and financing activities which are recoverable from, or payable to, the ATO are classified as operating cash flows.

Contributed equity

AASB Interpretation 1038 Contributions by Owners Made to Wholly-Owned Public Sector Entities requires transfers in the nature of equity contributions, other than as a result of a restructure of administrative arrangements, to be designated as contributions by owners (at the time of, or prior to, transfer) before such transfers can be recognised as equity contributions. Capital appropriations have been designated as contributions by owners by TI 8 – Requirement 8.1(i) and will be credited directly to Contributed Equity.

South Metropolitan Health Service
Notes to the Financial Statements
For the year ended 30 June 2026

2. Health Service outputs

How the health service operates

This section includes information regarding the nature of funding the Health Service receives and how this funding is utilised to achieve the Health Service's objectives:

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	
	2026 $'000	2025 $'000	2026 $'000	2025 $'000	2026 $'000	2025 $'000
COST OF SERVICES						
Expenses						
Employee benefits expense	1,227,660	1,089,891	199,392	170,522	302,834	261,724
Fees for contracted medical practitioners	24,443	21,965	3,970	3,436	6,030	5,274
Contracts for services	6,731	21,831	1,093	3,416	1,661	5,242
Patient support costs	344,495	330,833	55,452	51,448	88,314	82,513
Finance costs	2,118	2,323	344	363	523	558
Depreciation and amortisation expense	63,779	57,724	6,473	5,998	24,657	21,914
Asset impairment expense	1,308	-	212	-	323	-
Loss on disposal of non-current assets	85	6	14	1	21	1
Repairs, maintenance and consumable equipment	53,562	52,726	8,699	8,250	13,212	12,662
Other supplies and services	59,566	54,071	9,674	8,460	14,693	12,984
Other expenses	172,572	169,934	25,025	24,126	39,245	38,075
Total cost of services	**1,956,319**	**1,801,304**	**310,348**	**276,020**	**491,513**	**440,947**
INCOME						
Revenue						
Patient charges	89,674	78,237	14,565	12,241	22,120	18,788
Other fees and services	81,857	73,798	13,295	11,546	20,192	17,722
Commonwealth grants and contributions	253	2,946	41	461	62	707
Other grants and contributions	1,973	2,578	321	403	487	619
Donation revenue	1,345	5,641	218	883	332	1,355
Interest revenue	16	16	3	2	4	4
Commercial activities	576	303	94	47	142	73
Other revenue	18,348	15,847	2,980	2,479	4,526	3,805
Total revenue	**194,042**	**179,366**	**31,517**	**28,062**	**47,865**	**43,073**
NET COST OF SERVICES	**1,762,277**	**1,621,938**	**278,831**	**247,958**	**443,648**	**397,874**
INCOME FROM STATE GOVERNMENT						
Department of Health - Service agreement	1,615,684	1,478,910	262,413	231,387	398,550	355,143
Mental Health - Service agreement	-	1	-	-	-	-
Income from other state government agencies	8,345	13,088	1,356	2,048	2,059	3,143
Assets (transferred)/assumed	15	597	2	94	3	144
Services received free of charge	100,638	95,236	12,843	12,125	24,837	23,204
Total income from State Government	**1,724,682**	**1,587,832**	**276,614**	**245,654**	**425,449**	**381,634**
SURPLUS/(DEFICIT) FOR THE PERIOD	**(37,595)**	**(34,106)**	**(2,217)**	**(2,304)**	**(18,199)**	**(16,240)**

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

2.2. Schedule of income and expenses by service (continued)

	Mental Health Services		Aged Continuing Care Services		Public and Community Health Services		Total	
	2026 $'000	2025 $'000	2026 $'000	2025 $'000	2026 $'000	2025 $'000	2026 $'000	2025 $'000
COST OF SERVICES								
Expenses								
Employee benefits expense	209,226	211,057	15,421	12,455	73,500	63,737	2,028,033	1,809,386
Fees for contracted medical practitioners	-	-	307	251	1,463	1,284	36,213	32,210
Contracts for services	5	1	85	249	403	1,277	9,978	32,016
Patient support costs	57,958	24,326	4,029	3,542	19,202	18,127	569,450	510,789
Finance costs	-	1	27	27	127	136	3,139	3,408
Depreciation and amortisation expense	7,466	6,152	444	359	5,374	4,640	108,193	96,787
Asset impairment expense	-	-	16	-	78	-	1,937	-
Loss on disposal of non-current assets	-	-	1	-	5	-	126	8
Repairs, maintenance and consumable equipment	6,913	4,074	673	603	3,207	3,083	86,266	81,398
Other supplies and services	-	-	748	618	3,566	3,162	88,247	79,295
Other expenses	10,179	5,613	2,348	2,228	8,496	8,322	257,865	248,298
Total cost of services	**291,747**	**251,224**	**24,099**	**20,332**	**115,421**	**103,768**	**3,189,447**	**2,893,595**
INCOME								
Revenue								
Patient charges	-	-	1,126	894	5,369	4,575	132,854	114,735
Other fees and services	-	-	1,028	843	4,901	4,316	121,273	108,225
Commonwealth grants and contributions	-	-	3	34	15	172	374	4,320
Other grants and contributions	-	-	25	29	118	151	2,924	3,780
Donation revenue	-	-	17	64	80	330	1,992	8,273
Interest revenue	-	-	-	-	1	1	24	23
Commercial activities	-	-	7	3	35	18	854	444
Other revenue	-	-	230	181	1,098	927	27,182	23,239
Total revenue	**-**	**-**	**2,436**	**2,048**	**11,617**	**10,490**	**287,477**	**263,039**
NET COST OF SERVICES	**291,747**	**251,224**	**21,663**	**18,284**	**103,804**	**93,278**	**2,901,970**	**2,630,556**
INCOME FROM STATE GOVERNMENT								
Department of Health - Service agreement	7,466	6,152	20,295	16,901	96,731	86,487	2,401,139	2,174,980
Mental Health - Service agreement	283,602	244,473	-	-	-	-	283,602	244,474
Income from other state government agencies	-	-	105	150	500	765	12,365	19,194
Assets (transferred)/assumed	-	-	-	7	1	35	21	877
Services received free of charge	1,194	1,112	1,146	1,136	2,767	2,733	143,425	135,546
Total income from State Government	**292,262**	**251,737**	**21,546**	**18,194**	**99,999**	**90,020**	**2,840,552**	**2,575,071**
SURPLUS/(DEFICIT) FOR THE PERIOD	**515**	**513**	**(117)**	**(90)**	**(3,805)**	**(3,258)**	**(61,418)**	**(55,485)**

3. Use of our funding

Expenses incurred in the delivery of services

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

	Notes	2026 $'000	2025 $'000
Employee benefits expenses	3.1.1	2,028,033	1,809,386
Employee related provisions	3.1.2	501,566	448,935
Fees for contracted medical practitioners	3.2	36,213	32,210
Patient support costs	3.3	569,450	510,789
Contracts for services	3.4	9,978	32,016
Repairs, maintenance and consumable equipment	3.5	86,266	81,398
Other supplies and services	3.6	88,247	79,295
Other expenses	3.7	257,865	248,298

3.1.1 Employee benefits expenses

	2026 $'000	2025 $'000
Salaries and wages	1,823,866	1,636,493
Termination benefits	237	22
Superannuation - defined contributions plans [(a)]	203,930	172,871
Total employee benefits expenses	**2,028,033**	**1,809,386**
Add: AASB 16 Non-monetary benefits	100	51
Less: Employee Contribution	(34)	(29)
Net employee benefits	**2,028,099**	**1,809,408**

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

Employee benefits include wages, salaries and social contributions, accrued and paid leave entitlements and paid sick leave, and non-monetary benefits recognised under accounting standards other than AASB 16 (such as medical care, housing, cars and free or subsidised goods or services) for employees.

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.

South Metropolitan Health Service
Notes to the Financial Statements
For the year ended 30 June 2026

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.

	2026 $'000	2025 $'000
Current		
Employee benefits provisions		
Annual leave	201,906	180,497
Time off in lieu	67,534	60,574
Long service leave	135,888	113,484
Deferred salary scheme	2,322	2,100
	407,650	**356,655**
Non-current		
Employee benefits provisions		
Long service leave	93,916	92,280
	93,916	**92,280**
Total employee related provisions	**501,566**	**448,935**

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

Within 12 months of the end of the reporting period	141,574	125,229
More than 12 months after the end of the reporting period	127,866	115,842
	269,440	**241,071**

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

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 the right at the end of the reporting period to defer settlement of the liability for at least 12 months after the reporting period.

Pre-conditional and conditional long service leave provisions are classified as non-current liabilities because the Health Service has the right to defer the settlement of the liability until the employee has completed the requisite years of service. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

	2026 $'000	2025 $'000
Within 12 months of the end of the reporting period	98,840	27,114
More than 12 months after the end of the reporting period	130,964	178,650
	229,804	**205,764**

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

Within 12 months of the end of the reporting period	2,322	2,100
More than 12 months after the end of the reporting period	-	-
	2,322	**2,100**

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	36,213	32,210

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

3.3 Patient support costs

	2026 $'000	2025 $'000
Medical supplies and services	446,138	399,650
Domestic charges	36,323	34,239
Pathology services provided by PathWest [(a) (b)]	36,806	32,327
Fuel, light and power	20,115	17,302
Food supplies	14,142	12,859
Patient transport costs	15,237	14,307
Research, development and other grants	689	105
Total patient support costs	**569,450**	**510,789**

(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

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)]	2,528	25,526
Mental Health	3,148	3,461
Home and Comm Care (HACC)	2,807	1,846
Child, community and primary health	205	410
Blood & Organs	776	361
Patient transport service	257	298
Other contracts	257	114
Total contracts for services	**9,978**	**32,016**

(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	16,249	13,730
Consumable equipment	70,017	67,668
Total repairs, maintenance and consumable equipment	**86,266**	**81,398**

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	3,932	3,755
Administration and management services	80,018	70,195
Interpreter services	3,007	2,821
Security services	512	1,490
Other	737	994
Lease management services provided free of charge	41	40
Total other supplies and services	**88,247**	**79,295**

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

3.7 Other expenses

	2026 $'000	2025 $'000
Communications	8,652	7,698
Computer services	36,951	43,050
Workers' compensation insurance	29,727	28,894
Lease expenses	1,576	3,214
Other insurances	29,971	26,076
Consultancy fees	12,472	8,830
Other employee related expenses	4,291	3,788
Printing and stationery	4,680	4,619
Expected credit losses	11,683	6,425
Freight and cartage	899	789
Periodical subscription	2,037	1,906
Services provided by HSS	106,479	103,004
Motor vehicle expenses	1,296	1,293
Audit fees	800	879
Waivers	359	1,019
Legal expenses	124	133
Legal services provided free of charge	99	175
Other	5,769	6,506
Total other expenses	**257,865**	**248,298**

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 trade 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 ($0.478 million) and internal audit fees ($0.322 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	2026 $'000	2025 $'000
Income from State Government	4.1	2,840,552	2,575,071
Patient charges	4.2	132,854	114,735
Other fees for services	4.3	121,273	108,225
Grants and contributions	4.4	3,298	8,100
Commercial activities	4.5	854	444
Other revenue	4.6	27,182	23,239
Donation revenue	4.6	1,992	8,273
Gains/(losses) on disposal	4.6	(126)	(8)

4.1 Income from State Government

Service agreement revenue received during the period:		
Department of Health - Service agreement	2,401,139	2,174,980
Mental Health - Service agreement	283,602	244,474
Total service agreement funding received	**2,684,741**	**2,419,454**
Income received from other public sector entities during the period:		
Income from other state government agencies	12,365	19,194
Total income from other public sector entities	**12,365**	**19,194**
Assets transferred from/(to) other State government agencies during the period: (a)		
- Transfer of medical equipment from Health Support Services	-	877
- Transfer of medical equipment to WA Country Health Services	(22)	-
- Transfer of medical equipment to East Metropolitan Health Service	(5)	-
- Transfer of medical equipment from East Metropolitan Health Service	48	-
Total assets (transferred)/assumed	**21**	**877**
Services received free of charge from other State Government agencies during the period: (b)		
HSS Support Services (HSS)		
ICT Services	74,617	69,731
Supply chain services	14,740	14,609
Financial services	2,403	3,278
Human resources services	14,719	15,386
PathWest - Pathology Services	36,806	32,327
Department of Finance - Lease Management Services	41	40
Department of Justice - State Solicitors Office Legal Services	99	175
Total services received	**143,425**	**135,546**
Total income from State Government	**2,840,552**	**2,575,071**

Service agreement funding is recognised as income at fair value in the period in which the Health Service gains control of the funds as appropriated under the Service Agreement. The Health Service gains control of the appropriated funds at the time those funds are deposited in the bank account. If there are no performance obligations, income will be recognised when the Health Service receives the funds.

Income from other public sector entities is recognised as income when the Agency has satisfied its performance obligations under the funding agreement. If there is no performance obligation, income will be recognised when the Agency receives the funds.

4.1 Income from State Government (continued)

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

(b) **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 in Note 3.6 Other supplies and services and Note 3.7 Other expenses.

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

	2026 $'000	2025 $'000
Inpatient bed charges	108,810	94,046
Inpatient other charges	9,590	8,315
Outpatient charges	14,454	12,374
Total patient charges	**132,854**	**114,735**

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)	110,299	99,632
Clinical services to other health organisations	11	-
Non-clinical services to other health organisations	10,963	8,593
Total other fees for services	**121,273**	**108,225**

4.4 Grants and contributions

Commonwealth grants and contributions

Recurrent grants:		
Community Health and Hospitals Program	374	4,320

Other grants and contributions

Research Grant Revenue	2,924	3,780
Total grants and contributions	**3,298**	**8,100**

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

	2026 $'000	2025 $'000
Income from commercial activities		
Pharmacy clinical trials and research activity	1,350	1,094
Research and development activity	484	310
Fundraising activity	9	-
Ramsay Health Care Australia Pty Ltd (PHC)	-	10
	1,843	**1,414**
Expenses from commercial activities		
Pharmacy clinical trials and research activity	(736)	(718)
Research and development activity	(245)	(191)
Fundraising activity	(8)	-
Ramsay Health Care Australia Pty Ltd (PHC)	-	(61)
	(989)	**(970)**
Profit/(loss) from commercial activities	**854**	**444**

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	1,992	8,273
Total donation revenue	**1,992**	**8,273**

Other revenue

Use of hospital facilities	20	35
Rent from commercial properties	5,184	4,709
Rent from residential properties	55	58
Boarders' accommodation	37	34
Parking	8,889	7,895
Research and clinical trial revenue	12,379	9,965
Course fees	214	201
Other	404	342
Total other revenue	**27,182**	**23,239**

Gains/(losses)

Net proceeds from disposal of non-current assets		
Property, plant and equipment	60	-
Carrying amount of non-current assets disposed		
Property, plant and equipment	(186)	(8)
Net gains/(losses) on disposal of non-current assets	**(126)**	**(8)**

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	2026 $'000	2025 $'000
Property, plant and equipment	5.1	2,858,571	2,654,937
Right-of-use assets	5.2	53,759	59,585
Service concession assets	5.3	-	-
Intangible assets	5.4	1,731	2,588
Total key assets		**2,914,061**	**2,717,110**

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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	Leasehold Improvements $'000	Work in progress $'000	Total $'000
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)
1 July 2025												
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)
Carrying amount at start of year	**108,948**	**2,320,910**	**105,036**	**3,288**	**4,976**	**15**	**49,640**	**16,758**	**8**	**-**	**45,358**	**2,654,937**
Additions	5,484	1,288	4,764	67	828		13,090	508	59	558	92,864	119,510
Transfer to Expense	-		-	(37)	-	-	-	-	-	-	-	(37)
Transfers to/(from) work in progress	-	3,105	-	67	-	-	-	-	-	-	(3,172)	-
Revaluation increments / (decrements)[a]	23,523	157,253	-	-	-	-	-	-	-	-	-	180,776
Disposals	-	-	-	-	(51)	-	(71)	(109)	-	-	-	(231)
Depreciation	-	(74,524)	(4,496)	(1,246)	(677)	(5)	(10,903)	(2,457)	-	(139)	-	(94,447)
Impairment losses	-	-	-	-	-	-	-	(1,937)	-	-	-	(1,937)
Transfers between asset classes	-	-	-	-	19	-	(19)	-	-	-	-	-
Carrying amount at 30 June 2026	**137,955**	**2,408,032**	**105,304**	**2,139**	**5,095**	**10**	**51,737**	**12,763**	**67**	**419**	**135,050**	**2,858,571**
Gross carrying amount	137,955	2,408,032	137,310	35,475	8,151	19	99,724	32,758	67	558	135,050	2,995,099
Accumulated depreciation	-	-	(32,006)	(33,336)	(3,056)	(9)	(47,987)	(19,995)	-	(139)	-	(136,528)

(a) Of this amount, $277.723M relates to professional and project management fees, which are included in the value of current use building assets under the current replacement cost basis.

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 2025 by the Western Australian Land Information Authority (Landgate). The valuations were performed during the year ended 30 June 2026 and recognised at 30 June 2026. In undertaking the revaluation, fair value was determined by reference to market values for land: $3.851 million (2025: $3.198 million) and buildings: $1.823 million (2025: $1.482 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

	2026 $'000	2025 $'000
Charge for the period		
Buildings	74,524	62,627
Site infrastructure	4,496	3,187
Computer equipment	1,246	1,849
Furniture and fittings	677	630
Motor vehicles	5	4
Medical equipment	10,903	9,377
Other plant and equipment	2,457	2,484
Leasehold improvements	139	-
Total depreciation for the period	**94,447**	**80,158**

Impairment

During 2025–26, engineering consultants determined that two gas-powered generators and an associated integrated energy system (trigeneration system) installed at FSH, and originally capitalised as emergency power assets, were not compliant for use as emergency power generation in a hospital environment.

It was recommended that the gas generators be removed from emergency electrical capacity calculations, with reliance transitioned to a compliant diesel generator.

The assets remain installed due to the high cost of removal and are subject to minimum maintenance. The generators and trigeneration system are no longer fit for purpose and are functionally redundant.

On this basis, the Health Service concluded that these assets were fully impaired in accordance with AASB 136, and an impairment loss was recognised.

Charge for the period	
Carrying amount of other plant and equipment	
Generator, Gas Fired (Tri-Gen)	756
Generator, Gas Fired (Tri-Gen)	756
Grouped, Trigeneration System	425
Total carrying amount	**1,937**
Recoverable amount	-
Total recoverable amount	**-**
Impairment loss	**1,937**

All surplus assets at 30 June 2026 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.

5.1.1 Depreciation and impairment (continued)

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.

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. 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, the recoverable amount of regularly revalued specialised assets is anticipated to be materially the same as fair value.

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

The risk of impairment is generally limited to circumstances where an asset’s depreciation is materially understated, where the replacement cost is falling or where there is a significant change in useful life. Each relevant class of assets is reviewed annually to verify that the accumulated depreciation/amortisation reflects the level of consumption or expiration of the asset’s future economic benefits and to evaluate any impairment risk from declining replacement costs.

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 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)
1 July 2025								
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)
Carrying amount at start of period	**363**	**48,811**	**3,314**	**3,279**	**1,973**	**222**	**1,623**	**59,585**
Additions	587	3,763	307	2,408				7,065
Disposals				(2)				(2)
Depreciation	(701)	(8,540)	(1,193)	(1,313)	(634)	(59)	(449)	(12,889)
Carrying amount at 30 June 2026	**249**	**44,034**	**2,428**	**4,372**	**1,339**	**163**	**1,174**	**53,759**
Gross carrying amount	249	50,734	9,281	7,515	50,178	7,470	53,515	178,942
Accumulated amortisation	-	(6,700)	(6,853)	(3,143)	(48,839)	(7,307)	(52,341)	(125,183)

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 leases for equipment, furniture and fittings, vehicles, office and residential accommodations.

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.

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

The Health Service has elected not to recognise right-of-use assets and lease liabilities for short-term leases (with a lease term of 12 months or less) and low value leases (with an underlying value of $5,000 or less). 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:

	2026 $'000	2025 $'000
Depreciation expense of right-of-use assets	12,889	14,642
Lease interest expense	3,139	3,408
Lease maintenance expense	2,086	1,885
Short-term leases	-	-
Low-value leases	42	4
Gains or losses arising from sale and leaseback transactions	(2,043)	(71)
Total amount recognised in the statement of comprehensive income	**16,113**	**19,868**

The total cash outflow for leases in 2026 was $14.382 million (2025: $13.563 million).

As at 30 June 2026 there were no indications of impairment to right-of-use assets.

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 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**
Additions	-	-	-	-	-	-	-
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	-	-	-	-	-	-	-
1 July 2025							
Gross carrying amount	-	-	-	-	-	-	-
Accumulated depreciation	-	-	-	-	-	-	-
Carrying amount at start of period	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Transfers						-	-
Depreciation		-	-	-	-		-
Carrying amount at 30 June 2026	**-**	**-**	**-**	**-**	**-**	**-**	**-**
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.

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

5.3 Service concession assets (continued)

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

	2026 $'000	2025 $'000
Charge for the period		
Buildings	-	185
Site infrastructure	-	16
Medical equipment	-	5
Other plant and equipment	-	4
Total depreciation for the period	**-**	**210**

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 2026 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 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 to work in progress	-	(108)	(108)
Amortisation expense	(1,777)	-	(1,777)
Carrying amount at 30 June 2025	**2,588**	**-**	**2,588**
Year ended 30 June 2026			
1 July 2025			
Gross carrying amount	30,145	-	30,145
Accumulated amortisation	(27,557)	-	(27,557)
Carrying amount at start of year	**2,588**	**-**	**2,588**
Amortisation expense	(857)	-	(857)
Carrying amount at 30 June 2026	**1,731**	**-**	**1,731**

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

	2026 $'000	2025 $'000
Charge for the period		
Computer software	857	1,777
Total amortisation for the year	**857**	**1,777**

As at 30 June 2026 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	2026 $'000	2025 $'000
Receivables	6.1	117,254	95,464
Amounts receivable for services	6.2	1,487,560	1,391,976
Inventories	6.3	8,774	8,597
Other current assets	6.4	10,945	6,480
Payables	6.5	162,688	136,409
Contract liabilities	6.6	323	278
Grant liabilities	6.7	-	10
Other liabilities	6.8	509	412

6.1 Receivables

Current		
Patient fee debtors [(a)]	44,957	41,181
Other receivables	8,061	6,881
Less: Allowance for impairment of receivables	(26,695)	(22,287)
Accrued revenue	30,170	22,680
GST receivable	4,013	3,261
Total current	**60,506**	**51,716**
Non-current		
27th pay contribution held at Treasury [(b)]	56,748	43,748
Total Non-current	**56,748**	**43,748**
Total receivables	**117,254**	**95,464**

(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 $2.601 million for 2026 ($3.406 million for 2025).

(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

	2026 $'000	2025 $'000
Reconciliation of changes in the allowance for impairment of trade receivables		
Opening Balance	22,287	19,792
Expected credit losses expense	11,683	6,425
Amount written off during the period	(7,309)	(3,969)
Amount recovered during the period	34	39
Allowance for impairment at end of period	**26,695**	**22,287**

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	1,487,560	1,391,976
Total amounts receivable for services at the end of period	**1,487,560**	**1,391,976**

Amounts receivable for services represents 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	8,637	8,461
Engineering stores - at cost	137	136
Total inventories end of period	**8,774**	**8,597**

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

	2026 $'000	2025 $'000
Current		
Prepayments	10,953	6,375
Other	(8)	105
Total other assets at end of period	**10,945**	**6,480**

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	16,580	14,679
Other creditors [(a)]	54	38
Accrued expenses	67,365	53,549
Accrued salaries	78,689	67,900
Professional development payable	-	243
Total payables at end of period	**162,688**	**136,409**

(a) Includes $0.043 million Fringe Benefits Tax due to the ATO for 2026 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.

6.6 Contract liabilities

Current	323	278
Total contract liabilities	**323**	**278**

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	278	303
Additions	323	261
Revenue recognised in the reporting period	(278)	(286)
Total contract liabilities at end of period	**323**	**278**

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

	2026 $'000	2025 $'000
Current	-	10
Total Grant liabilities	**-**	**10**

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	10	4,330
Income recognised in the reporting period	(10)	(4,320)
Total grant liabilities at end of period	**-**	**10**

6.7.1 Expected satisfaction of grant liabilities

Income recognition		
1 year	-	10
	-	**10**

6.8 Other liabilities

Current		
Refundable deposits	78	78
Paid parental leave scheme	436	397
Other	(5)	(63)
Total other liabilities at end of period	**509**	**412**

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.

South Metropolitan Health Service
Notes to the Financial Statements
For the year ended 30 June 2026

7. Financing

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

	Notes	2026 $'000	2025 $'000
Lease liabilities	7.1	55,937	62,371
Finance costs	7.2	3,139	3,408
Cash and cash equivalents	7.3	110,192	94,056
Capital commitments	7.4	28,066	91,410

7.1 Lease liabilities

Current		
Finance lease - Fiona Stanley [(a)]	1,022	953
Leases - State Fleet	1,033	735
Leases - Other	9,145	8,599
Total current	**11,200**	**10,287**
Non-current		
Finance lease - Fiona Stanley [(a)]	1,971	2,993
Leases - State Fleet	3,441	2,551
Leases - Other	39,325	46,540
Total non-current	**44,737**	**52,084**
Total lease liabilities	**55,937**	**62,371**

Initial Measurement

At the commencement date of the lease, the Health Service recognises lease liabilities measured at the present value of lease payments to be made over the lease term. The lease payments are discounted using the interest rate implicit in the lease. If that rate cannot be readily determined, the Agency 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.

	2026 $'000	2025 $'000
The carrying amounts of non-current assets pledged as security are:		
Right-of-use assets - Plant and equipment leased	101	139
Right-of-use assets - Motor vehicles leased	-	-
Right-of-use assets - Information, computer and telecommunications equipment (ICT) leased	1,086	1,479
Right-of-use assets - Furniture and fittings leased	163	222
Right-of-use assets - Medical equipment leased	1,172	1,598
Total assets pledged as security	**2,522**	**3,438**

7.2 Finance costs

Lease interest expense	3,139	3,408
Finance costs expensed	**3,139**	**3,408**

Finance costs expensed include interest costs associated with the lease liabilities repayments.

7.3 Cash and cash equivalents

	2026 $'000	2025 $'000
Cash and cash equivalents	80,358	66,908
Restricted cash and cash equivalents	29,834	27,148
Balance at end of period	**110,192**	**94,056**

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]	**80,358**	**66,908**
Restricted cash and cash equivalents		
Current		
Restricted cash assets held for other specific purposes [b]	29,277	26,614
Fiona Stanley Hospital - Upgrade Works Account [c]	557	534
Total current	**29,834**	**27,148**
Balance at end of period	**110,192**	**94,056**

(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	2026 $'000	2025 $'000
Net cost of services		(2,901,970)	(2,630,556)
Non-cash items:			
Expected credit losses expense	3.7	11,683	6,425
Write off of receivables	6.1.1	(7,309)	(3,969)
Receivables amount recovered during the period	6.1.1	34	39
Depreciation and amortisation expense	5.1 - 5.4	108,193	96,787
Impairment expense	5.1	1,937	-
WIP assets relating to prior years expensed	5.1 - 5.4	37	116
Net (gain)/loss from disposal of non-current assets	4.6	126	8
Write off of inventories	3.6	(228)	(378)
Capitalisation of finance lease charges	7.2	3,139	3,408
Net donation of non-current assets	3.6	(1,426)	(7,013)
Services received free of charge	4.1	143,425	135,586
Lease termination expenses	3.6	(2,043)	71
Recognition of revenue received in prior years	4.4	(28)	(4,220)
Adjustments for other non-cash items		(215)	-
(Increase)/decrease in assets:			
GST receivable		(752)	1,698
Other current receivables		(8,038)	(2,102)
Inventories		(177)	(1,378)
Prepayments and other current assets		(4,465)	(1,309)
Increase/(decrease) in liabilities:			
Payables		26,279	(1,564)
Current provisions		50,995	58,768
Non-current provisions		1,636	8,177
Other current liabilities		97	37
Contract liabilities		45	(25)
Grant liabilities		(10)	(4,320)
Net cash used in operating activities		**(2,579,035)**	**(2,345,714)**

Cash flows from State Government		
Revenues from government agencies as per statement of comprehensive income	2,697,127	2,437,575
Revenues from government agencies received in advance	-	-
Capital contributions credited directly to Contributed equity (refer note 9.9 Equity)	137,653	77,241
Transfer of appropriation from Main Roads WA	5,484	
	2,840,264	**2,514,816**
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	(21)	(877)
Accrual appropriations	(95,584)	(91,500)
Cash flows from State Government as per statement of cash flows	**2,744,659**	**2,422,439**

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 Capital expenditure commitments

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

	2026 $'000	2025 $'000
Capital expenditure commitments being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows:		
Within 1 year	24,395	54,860
Later than 1 year and not later than 5 years	3,671	36,550
Later than 5 years	-	-
	28,066	**91,410**

The commitments presented are inclusive of GST where relevant.

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, payables and leases. The Health Service has limited exposure to financial risks. The Health Service's overall risk management program focuses on managing the risks identified below.

(a) Summary of risks and risk management

Credit risk

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

Credit risk associated with the Health Service's financial assets is 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. The Health Service is not exposed to market risk for changes in interest rates as it does not have borrowings other than lease liabilities.

8.1 Financial risk management (continued)

(b) Categories of financial instruments

The carrying amounts of each of the following categories of financial assets and financial liabilities at the end of the reporting period are:

	2026 $'000	2025 $'000
Financial assets		
Cash and cash equivalents	80,358	66,908
Restricted cash and cash equivalents	86,582	70,896
Receivables [(a)]	1,544,053	1,440,431
Total financial assets	**1,710,993**	**1,578,235**
Financial liabilities		
Financial liabilities measured at amortised cost [(b)]	218,625	198,780
Total financial liabilities	**218,625**	**198,780**

(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 2026						
Expected credit loss rate	32%	2%	21%	30%	51%	79%
Estimated total gross carrying amount at default	83,188	42,926	5,632	2,978	3,746	27,906
Expected credit losses	26,695	675	1,207	881	1,910	22,022

		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

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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	
2026											
Financial Assets											
Cash and cash equivalents		80,358	-	-	80,358	80,358	80,358	-	-	-	
Restricted cash and cash equivalents		29,834	-	-	29,834	29,834	29,834	-	-	-	
Receivables		113,241	-	-	113,241	113,241	56,493	-	56,748	-	(b)
Amounts receivable for services		1,487,560	-	-	1,487,560	1,487,560	-			1,487,560	
		1,710,993	**-**	**-**	**1,710,993**	**1,710,993**	**166,685**	**-**	**56,748**	**1,487,560**	
Financial Liabilities											
Payables		162,688	-	-	162,688	162,688	162,688	-	-	-	
Finance lease - Fiona Stanley Hospital	7.03%	2,993	2,993	-	-	2,993	248	774	1,971	-	
Leases - State Fleet	7.44%	4,474	4,474	-	-	4,474	84	949	3,268	173	
Leases - Other	5.22%	48,470	48,470	-	-	48,470	2,309	6,836	37,351	1,974	
		218,625	**55,937**	**-**	**162,688**	**218,625**	**165,329**	**8,559**	**42,590**	**2,147**	
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	-	(a)
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**	

(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

	2026 $'000	2025 $'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.	103	545
Number of disputes	1	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.	18,844	18,701
Number of disputes	**8**	**8**

Contaminated sites

Under the Contaminated Sites Act 2003, the Agency is required to report known and suspected contaminated sites to the Department of Water and Environmental Regulation (DWER). In accordance with the Contaminated Sites Act 2003, DWER classifies these sites on the basis of the risk to human health, the environment and environmental values. Where sites are classified as contaminated – remediation required or possibly contaminated – investigation required, the Agency 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

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
2026				
Assets measured and recognised at fair value:				
Land				
Specialised	-	3,851	134,104	137,955
Buildings				
Residential and commercial car park	-	-	78,773	78,773
Specialised	-	1,823	2,326,418	2,328,241
	-	**5,674**	**2,539,295**	**2,544,969**

	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**

There were no transfers between Levels 1, 2 or 3 during the current period.

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 2026 and 30 June 2025.

	Land $'000	Buildings $'000	Total $'000
2026			
Fair value at start of period	105,750	2,319,428	2,425,178
Additions	5,484	3,375	8,859
Revaluation increments/(decrements)	22,870	156,883	179,753
Depreciation	-	(74,495)	(74,495)
Fair value at end of period	**134,104**	**2,405,191**	**2,539,295**
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)	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**

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 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 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**

9.2 Future impact of Australian Accounting Standards not yet operative (continued)

AASB 2025-1	*Amendments to Australian Accounting Standards – Contracts Referencing Nature-dependent Electricity* This Standard amends AASB 7 and AASB 9 as a consequence of the issuance of IFRS *Contracts Referencing Nature-dependent Electricity* (Amendments to IFRS 9 and IFRS 7) by the International Accounting Standards Board in December 2024. There is no financial impact.	**1 Jan 2026**
Operative for reporting periods beginning on/after 1 Jan 2028		
AASB 2014-10	*Amendments to Australian Accounting Standards – Sale or Contribution of Assets between an Investor and its Associate or Joint Venture* This Standard amends AASB 10 and AASB 128 to address an inconsistency between the requirements in AASB 10 and those in AASB 128 (August 2011), in dealing with the sale or contribution of assets between an investor and its associate or joint venture. There is no financial impact.	**1 Jan 2028**
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**

9.3 Key management personnel

The Health Service has determined that key management personnel include ministers, members and senior officers of the Authority. The Health Service does not incur expenditures to compensate Ministers and those disclosures 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:

	2026	2025
Compensation of members of the accountable authority		
Compensation band ($)		
50,001 - 100,000	3	1
0 - 50,000	10	9

Compensation of senior officers		
Compensation band ($)		
650,001 - 700,000	1	1
600,001 - 650,000	1	-
550,001 - 600,000	-	1
400,001 - 450,000	-	1
300,001 - 350,000	2	-
250,001 - 300,000	5	4
200,001 - 250,000	2	3
150,001 - 200,000	1	2
100,001 - 150,000	-	2
50,001 - 100,000	1	2
0 - 50,000	2	-

	$'000	$'000
Short-term employee benefits	4,232	4,017
Post-employment benefits	479	458
Other long-term benefits	(147)	82
Termination benefits	-	-
Total compensation of key management personnel	**4,564**	**4,557**

Total compensation includes the superannuation expense incurred by the Health Service in respect of senior officers.

9.4 Related party transactions

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

Related parties of the Health Service include:

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

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 9.9)
- 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 9.8)
- 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 Commission (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.

9.5 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.

9.6 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.

9.7 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.

	2026 $'000	2025 $'000
Balance at start of period	513	-
Add receipts		
Service delivery arrangement:		
Commonwealth contributions	91,302	64,562
State contributions	193,326	180,424
	285,141	**244,986**
Payments	(284,114)	(244,473)
Balance at end of period	**1,027**	**513**

The special purpose account has been established under section 16(1)(d) of the *Financial Management Act 2006*.

9.8 Remuneration of auditors

Remuneration paid or payable to the Auditor General in respect of the audit for the reporting period is as follows:

Auditing the accounts, controls, financial statements and key performance indicators	478	469
	478	**469**

9.9 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.

	2026 $'000	2025 $'000
Balance at start of period	2,800,753	2,723,512
Contribution by owners [a] [b] [c]		
Capital Appropriations administered by Department of Health	137,653	77,241
Transfer of appropriation from Main Roads WA	5,484	-
Total contribution by owners	**143,137**	**77,241**
Balance at end of period	**2,943,890**	**2,800,753**

(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.

Reserves

Asset revaluation reserve [a]		
Balance at the start of period	980,898	577,769
Net revaluation increments/(decrements) [b]*:*		
Land	23,523	20,922
Buildings	157,253	382,207
Balance at end of period	**1,161,674**	**980,898**

(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.

Accumulated surplus

Accumulated surplus/(deficit)		
Balance at start of period	(116,383)	(60,898)
Result for the period	(61,418)	(55,485)
Balance at end of period	**(177,801)**	**(116,383)**

9.10 Supplementary financial information

(a) Revenue, public and other property written off

	2026 $'000	2025 $'000
Revenue and debts written off under the authority of the Accountable Authority	6,662	3,908
Revenue and debts written off under the authority of the Minister	254	251
Public and other property written off under the authority of the Accountable Authority	107	76
Public and other property written off under the authority of the Minister	-	-
	7,023	**4,235**

(b) Forgiveness of Debts

Forgiveness (or waiver) of debts by the Health Service	359	1,019
	359	**1,019**

(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 2026, and between the actual results for 2026 and 2025 are shown below. Narratives are provided for key major variances which vary more than 10 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, 891.178 million); and
    - Total assets of the estimate for the Statement of Financial Position (i.e. 1% of $4,436.859 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 $2,893.595million); and
    - Total assets of the previous year for the Statement of Financial Position (i.e. 1% of $4,313.683 million).

10.1.1 Statement of Comprehensive Income Variances

	Variance Notes	Estimate 2026 $'000	Actual 2026 $'000	Actual 2025 $'000	Variance between actual and estimate $'000	Variance between actual results for 2025 and 2026 $'000
COST OF SERVICES						
Expenses						
Employee benefits expense	1	1,802,334	2,028,033	1,809,386	225,699	218,647
Fees for contracted medical practitioners		34,470	36,213	32,210	1,743	4,003
Contracts for services		9,790	9,978	32,016	188	(22,038)
Patient support costs	2	500,152	569,450	510,789	69,298	58,661
Finance costs		1,843	3,139	3,408	1,296	(269)
Depreciation and amortisation expense		90,766	108,193	96,787	17,427	11,406
Impairment loess		-	1,937	-	1,937	1,937
Loss on disposal of non-current assets		-	126	8	126	118
Repairs, maintenance and consumable equipment		74,689	86,266	81,398	11,577	4,868
Other supplies and services		89,374	88,247	79,295	(1,127)	8,952
Other expenses	3	287,760	257,865	248,298	(29,895)	9,567
Total cost of services		**2,891,178**	**3,189,447**	**2,893,595**	**298,269**	**295,852**
INCOME						
Revenue						
Patient charges	4	101,093	132,854	114,735	31,761	18,119
Other fees for services		110,599	121,273	108,225	10,674	13,048
Commonwealth grants and contributions		-	374	4,320	374	(3,946)
Other grants and contributions		756	2,924	3,780	2,168	(856)
Donation revenue		3,158	1,992	8,273	(1,166)	(6,281)
Interest revenue		-	24	23	24	1
Commercial activities		-	854	444	854	410
Other revenue		46,712	27,182	23,239	(19,530)	3,943
Total revenue		**262,318**	**287,477**	**263,039**	**25,159**	**24,438**
Gains						
Gain on disposal of non-current assets		-	-	-	-	-
Gain on revaluation		-	-	-	-	-
Total gains		**-**	**-**	**-**	**-**	**-**
Total income other than income from State Government		**262,318**	**287,477**	**263,039**	**25,159**	**24,438**
NET COST OF SERVICES		**2,628,860**	**2,901,970**	**2,630,556**	**273,110**	**271,414**
INCOME FROM STATE GOVERNMENT						
Department of Health - Service agreement	5	2,265,132	2,401,139	2,174,980	136,007	226,159
Mental Health - Service agreement	6	236,338	283,602	244,474	47,264	39,128
Income from other state government agencies		9,305	12,365	19,194	3,060	(6,829)
Assets (transferred)/assumed		-	21	877	21	(856)
Services received free of charge		127,932	143,425	135,546	15,493	7,879
Total income from State Government		**2,638,707**	**2,840,552**	**2,575,071**	**201,845**	**265,481**
Surplus/(deficit) for the period		**9,847**	**(61,418)**	**(55,485)**	**(71,265)**	**(5,933)**
Other comprehensive income						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve		**-**	180,776	403,129	180,776	(222,353)
Total other comprehensive income		**-**	**180,776**	**403,129**	**180,776**	**(222,353)**
Total comprehensive income for the period		**9,847**	**119,358**	**347,644**	**109,511**	**(228,286)**

Major variance narratives

Variances between estimate and actual results for 2026

1. Employee benefits expense

Employee benefits expense was $225.7 million (13%) higher than estimate and $218.6 million (12%) higher than 2025. The increase reflects higher than anticipated clinical activity and service demand during 2025-26. Activity levels were approximately 3% above initial targets, driven by the full-year operation of the Medihotel and Cockburn facilities, the transition of Peel Health Campus services into the public health system, and initiatives introduced to improve patient flow and hospital capacity, including winter demand strategies and expanded community-based services. Workforce costs also increased due to salary and wage adjustments arising from industrial agreements, implementation of nurse-to-patient staffing requirements, and increases in employer superannuation contribution rates.

2. Patient support costs

Patient support costs were $69.3 million (14%) higher than estimate and $58.7 million (11%) higher than 2025. The increase reflects growth in patient activity and service demand across SMHS during 2025-26, including the full-year impact of the Medihotel and Cockburn facilities and the transition of Peel Health Campus services. Increased activity resulted in higher expenditure on pharmaceuticals, pathology and diagnostic services, outsourced clinical services and utilities.

3. Other expenses

Other expenses were $29.9 million (10%) lower than estimate. The variance primarily reflects changes made during the year to align budget allocations with expected operating requirements across expenditure categories. As part of this process, funding originally included within other expenses was reallocated to areas experiencing greater service demand, including employee benefits, patient support costs and repairs and maintenance. As a result, expenditure reported within other expenses was lower than the initial estimate.

4. Patient charges

Patient charges were $31.8 million (31%) higher than estimate and $18.1 million (16%) higher than 2025. The estimate was revised during the year following a review of revenue classifications, which resulted in the reallocation of some revenue previously budgeted within other revenue categories. The actual result also reflects higher patient fee rates and increased billable patient activity, particularly for privately insured patients, workers' compensation cases and overseas visitors.

6. Mental Health – Service agreement

Funding received under the Mental Health Commission Service Agreement was $47.3 million (20%) higher than estimate and $39.1 million (16%) higher than 2025. The increase reflects additional funding provided during the year to support higher than anticipated demand for mental health services. Inpatient activity significantly exceeded initial targets, with growth supported by the full-year operation of the Cockburn mental health facility and increasing demand for mental health services across the region.

Variances between actual results for 2026 and 2025

1. Employee benefits expense

Employee benefits expense increased by $218.6 million (12%) compared with 2025.
The increase reflects growth in clinical activity and service demand, including the full-year impact of the Medihotel and Cockburn facilities, the transition of Peel Health Campus services into the public health system, and expanded community-based services. Workforce costs were also affected by industrial agreement outcomes, implementation of nurse staffing requirements and increases in employer superannuation contribution rates.

Variances between actual results for 2026 and 2025 (continued)

2. Patient support costs

Patient support costs increased by $58.7 million (11%) compared with 2025. The increase is consistent with higher patient activity levels and expanded service capacity across SMHS. Expenditure growth was most evident in pharmaceuticals, pathology and diagnostic services, outsourced clinical services and utilities, reflecting increased service delivery requirements during the year

4. Patient charges

Patient charges were $31.8 million (31%) higher than estimate and $18.1 million (16%) higher than 2025. The estimate was revised during the year following a review of revenue classifications, which resulted in the reallocation of some revenue previously budgeted within other revenue categories. The actual result also reflects higher patient fee rates and increased billable patient activity, particularly for privately insured patients, workers' compensation cases and overseas visitors.

5. Department of Health – Service agreement

Funding received under the Department of Health Service Agreement increased by $226.2 million (10%) compared with 2025. The increase reflects additional funding provided to support higher activity levels and service delivery requirements across SMHS. Key drivers included the full-year operation of the Medihotel facility, the transition of Peel Health Campus services into the public health system, initiatives to improve patient flow and capacity, and expansion of Hospital in the Home and community-based services. Funding also recognised broader cost pressures associated with workforce, contracted services and insurance costs.

6. Mental Health – Service agreement

Funding received under the Mental Health Commission Service Agreement increased by $39.1 million (16%) compared with 2025. The increase reflects additional funding to support continued growth in mental health service demand. Activity levels increased significantly during the year, supported by the full-year operation of the Cockburn mental health facility and increased utilisation of inpatient mental health services.

10.1.2 Statement of Financial Position Variances

	Variance Notes	Estimate 2026 $'000	Actual 2026 $'000	Actual 2025 $'000	Variance between actual and estimate $'000	Variance between actual results for 2025 and 2026 $'000
ASSETS						
Current assets						
Cash and cash equivalents		116,387	80,358	66,908	(36,029)	13,450
Restricted cash and cash equivalents		27,148	29,834	27,148	2,686	2,686
Receivables		44,085	60,506	51,716	16,421	8,790
Inventories		8,597	8,774	8,597	177	177
Other current assets		6,480	10,945	6,480	4,465	4,465
Total current assets		**202,697**	**190,417**	**160,849**	**(12,280)**	**29,568**
Non-current assets						
Receivables		56,748	56,748	43,748	-	13,000
Amounts receivable for services		1,482,742	1,487,560	1,391,976	4,818	95,584
Property, plant and equipment		2,640,542	2,858,571	2,654,937	218,029	203,634
Service concession assets		-	-	-	-	-
Right-of-use assets		52,401	53,759	59,585	1,358	(5,826)
Intangible assets		1,729	1,731	2,588	2	(857)
Total non-current assets		**4,234,162**	**4,458,369**	**4,152,834**	**224,207**	**305,535**
Total assets		**4,436,859**	**4,648,786**	**4,313,683**	**211,927**	**335,103**
LIABILITIES						
Current liabilities						
Payables		136,409	162,688	136,409	26,279	26,279
Contract liabilities		278	323	278	45	45
Grant liabilities		10	-	10	(10)	(10)
Lease liabilities		15,161	11,200	10,287	(3,961)	913
Provisions	7	396,094	407,650	356,655	11,556	50,995
Other current liabilities		412	509	412	97	97
Total current liabilities		**548,364**	**582,370**	**504,051**	**34,006**	**78,319**
Non-current liabilities						
Contract liabilities		-	-	-	-	-
Lease liabilities		41,495	44,737	52,084	3,242	(7,347)
Provisions		97,841	93,916	92,280	(3,925)	1,636
Total non-current liabilities		**139,336**	**138,653**	**144,364**	**(683)**	**(5,711)**
Total liabilities		**687,700**	**721,023**	**648,415**	**33,323**	**72,608**
NET ASSETS		**3,749,159**	**3,927,763**	**3,665,268**	**178,604**	**262,495**
EQUITY						
Contributed equity		2,874,797	2,943,890	2,800,753	69,093	143,137
Reserves		980,898	1,161,674	980,898	180,776	180,776
Accumulated surplus/(deficit)		(106,536)	(177,801)	(116,383)	(71,265)	(61,418)
TOTAL EQUITY		**3,749,159**	**3,927,763**	**3,665,268**	**178,604**	**262,495**

Major variance narratives

Variances between actual results for 2026 and 2025

7. Provisions

Employee benefit provisions (current and non-current) increased by $52.6 million (12%) compared with 2025 The growth was primarily driven by several key factors:

- repricing of outstanding leave balances following rate increases negotiated in industrial agreements, resulting in an uplift of $23.2 million.
- higher staff leave balances, contributing $26.7 million to the increase in provisions.
- application of future value assessments in line with Australian accounting standards, which added a further $2.7 million to the provisions.

These changes highlight the financial impact of workforce expansion and associated leave obligations across the organisation.

10.1.3 Statement of Cash Flows Variances

	Variance Notes	Estimate 2026 $'000	Actual 2026 $'000	Actual 2025 $'000	Variance between actual and estimate $'000	Variance between actual results for 2025 and 2026 $'000
CASH FLOWS FROM STATE GOVERNMENT						
Revenues from State Government Agencies	8	2,420,009	2,601,522	2,345,198	181,513	256,324
Capital appropriations administered by DOH	9	74,044	137,653	77,241	63,609	60,412
Transfer of appropriation from Main Roads WA		-	5,484	-	5,484	5,484
Net cash provided by State Government		**2,494,053**	**2,744,659**	**2,422,439**	**250,606**	**322,220**
Utilised as follows:						
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits	10	(1,757,334)	(1,963,049)	(1,726,486)	(205,715)	(236,563)
Supplies and services		(860,671)	(882,390)	(862,777)	(21,719)	(19,613)
Finance costs		(1,843)	-	-	1,843	-
Receipts						
Receipts from customers		101,093	116,164	106,489	15,071	9,675
Commonwealth grants and contributions		-	364	-	364	364
Other grants and contributions		756	2,906	3,780	2,150	(874)
Donations received		3,158	566	1,660	(2,592)	(1,094)
Interest received		-	24	23	24	1
Other receipts		157,311	146,380	131,597	(10,931)	14,783
Net cash used in operating activities		**(2,357,530)**	**(2,579,035)**	**(2,345,714)**	**(221,505)**	**(233,321)**
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
27th pay contribution		(13,000)	(13,000)	(10,000)	-	(3,000)
Payment for purchase of non-current physical and intangible assets	11	(68,329)	(122,112)	(63,790)	(53,783)	(58,322)
Receipts						
Proceeds from sale of non-current physical assets		-	6	-	6	6
Net cash used in investing activities		**(81,329)**	**(135,106)**	**(73,790)**	**(53,777)**	**(61,316)**
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Repayment of lease liabilities		(5,715)	(14,382)	(13,635)	(8,667)	(747)
Receipts						
			-	-	-	-
Net cash used in financing activities		**(5,715)**	**(14,382)**	**(13,635)**	**(8,667)**	**(747)**
Net increase/(decrease) in cash and cash equivalents	12	49,479	16,136	(10,700)	(33,343)	26,836
Cash and cash equivalents at the beginning of the year		94,056	94,056	104,756	-	(10,700)
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**143,535**	**110,192**	**94,056**	**(33,343)**	**16,136**

Major variance narratives

Variances between estimate and actual results for 2026

9. Capital appropriations administered by DOH

Capital appropriations administered by the Department of Health were $63.6 million (86%) higher than estimate. The original estimate was based on approved budget settings at the commencement of the financial year. During the year, additional capital appropriation funding was provided for the Peel Health Campus Redevelopment / New Mandurah Hospital project, which was not included in the original budget, and for the Fremantle Hospital Acute Mental Health Beds project through revised budget allocations. These additional appropriations were partly offset by lower drawdowns on a number of projects due to changes in the timing of planned expenditure; Fiona Stanley Hospital Cladding Building B project ($11.8 million) and the SMHS Safety, Fire Compliance and Critical Electrical Infrastructure program ($8.3 million).

10. Employee benefits

Refer to Variance Note 1 in the Statement of Comprehensive Income Variances.

11. Payment for purchase of non-current physical and intangible assets

Payments for capital assets were $53.8 million (79%) higher than estimate. The variance reflects the timing and progress of capital projects across the SMHS capital works program. Higher expenditure occurred on the New Mandurah Hospital project ($56.4 million), Fremantle Hospital Acute Mental Health Beds project ($9.2 million), land acquisitions within the Murdoch Health Precinct ($5.5 million), and temporary car parking associated with the New Women's and Babies Hospital project ($5.3 million).
These increases were partly offset by lower expenditure due to changes in timing of planned, including the Fiona Stanley Hospital Cladding Building B project ($11.8 million) and the SMHS Safety, Fire Compliance and Critical Electrical Infrastructure program ($8.3 million). A number of smaller project timing variations account for the remainder of the variance.

12. Net increase/(decrease) in cash and cash equivalents

The net increase in cash and cash equivalents was $33.3 million lower than estimated. While SMHS received additional funding during 2025-26, operating expenditure increased in response to higher service activity and workforce-related cost pressures. In particular, growth in employee entitlement liabilities and other operating costs reduced the extent to which funding increases translated into higher cash balances at year end.

Variances between actual results for 2026 and 2025

8. Revenues from State Government Agencies

Cash funding received from State Government agencies increased by $256.3 million (11%) compared with 2025. The increase reflects additional funding provided to support growth in service demand and activity levels across SMHS. During 2025-26, activity increased across inpatient, mental health inpatient, emergency and outpatient services, including the full-year impact of the transition of Peel Health Campus services into the public health system and the operation of additional capacity at the Medihotel and Cockburn facilities.

9. Capital appropriations administered by DOH

Capital appropriations administered by the Department of Health increased by $60.4 million (78%) compared with 2025. The increase reflects higher levels of activity across the capital works program during 2025-26, particularly for the New Mandurah Hospital project, which accounted for approximately $50.4 million of the increase. Additional growth in capital expenditure was also recorded for the Fremantle Hospital Acute Mental Health Beds project and other Fiona Stanley Hospital cladding works.

10. Employee benefits

Refer to Variance Note 1 in the Statement of Comprehensive Income Variances.

South Metropolitan Health Service
Notes to the Financial Statements
For the year ended 30 June 2026

Variances between actual results for 2026 and 2025 (continued)

11. Payment for purchase of non-current physical and intangible assets

Payments for capital assets increased by $58.3 million (91%) compared with 2025. The increase primarily reflects higher expenditure on the New Mandurah Hospital project, which was $52.0 million higher than the previous year as the project progressed through delivery phases. Additional expenditure was also incurred on Fiona Stanley Hospital cladding works, land acquisitions within the Murdoch Health Precinct and temporary car parking infrastructure associated with the New Women's and Babies Hospital project.
These increases were partially offset by the completion of several significant projects during prior years, including Peel Health Campus transition works, the Medihotel project and the Cockburn facility expansion, which did not recur in 2025-26.

Certification of key performance indicators

South Metropolitan Health Service

Certification of key performance indicators for the year ended 30 June 2026

We hereby certify that the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess South Metropolitan Health Service's performance and fairly represent the performance of South Metropolitan Health Service for the financial year ended 30 June 2026.

Mr Liam Roche
Board Chair
South Metropolitan Health Service
31 August 2026

Mr Brian Mumme
Board Member
South Metropolitan Health Service
31 August 2026

Key performance indicators

For the year ended 30 June 2026

Key performance indicators

1	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
2	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
3	Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days
4	Survival rates for sentinel conditions: (a) Stroke; (b) Acute Myocardial Infarction; (c) Fractured Neck of Femur
5	Percentage of admitted patients who discharged against medical advice: a) Aboriginal patients; and b) Non-Aboriginal patients
6	Percentage of live-born term infants with an Apgar score of less than 7 at 5 minutes post delivery
7	Readmissions to acute specialised mental health inpatient services within 28 days of discharge
8	Percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services
9	Average admitted cost per weighted activity unit
10	Average Emergency Department cost per weighted activity unit
11	Average non-admitted cost per weighted activity unit
12	Average cost per bed-day in specialised mental health inpatient services
13	Average cost per treatment day of non-admitted care provided by mental health services
14	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).[3]

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 2025, SMHS unplanned readmission rates for selected surgical procedures are presented in Table 7.

SMHS strives to provide safe, high-quality care to patients at all times. In 2025 improved performance can be seen in relation to knee replacement and tonsillectomy and adenoidectomy, with the lowest readmission rates reported in the past five years. Hysterectomy, prostate, cataract and appendix readmissions were all within the target. SMHS continues to perform case reviews to drive clinical improvement across all cohorts, in order to identify variations in care and support system-wide clinical service improvement.

In 2025 unplanned readmissions following hip replacement exceeded the target. These results are however based on a small number of cases where individual case reviews noted a high degree of patient complexity contributing to the need for readmission.

1. Australian Institute of Health and Welfare (2009). Towards national indicators of safety and quality in health care. Cat. no. HSE 75. Canberra: AIHW. Available at: https://www.aihw.gov.au/reports/health-care-quality-performance/towards-national-indicators-of-safety-and-quality/summary
2. Australian Commission on Safety and Quality in Health Care. Avoidable Hospital Readmissions: Report on Australian and International indicators, their use and the efficacy of interventions to reduce readmissions. Sydney: ACSQHC; 2019. Available at: https://www.safetyandquality.gov.au/publications-and-resources/resource-library/avoidable-hospital-readmission-literature-review-australian-and-international-indicators
3. https://meteor.aihw.gov.au/content/index.phtml/itemId/742756

Table 7: Rate of unplanned readmissions within 28 days for selected surgical procedures

	Calendar Year					
Surgical procedure	**2021 actual (per 1,000)**	**2022 actual (per 1,000)**	**2023 actual (per 1,000)**	**2024 actual (per 1,000)**	**2025 actual (per 1,000)**	**Target (per 1,000)**
Knee replacement	10.7	10.7	15.8	23.1	8.5	≤18.8
Hip replacement	12.6	20.9	3.8	8.9	26.3	≤18.3
Tonsillectomy & adenoidectomy	69.8	91.4	99.4	99.4	65.4	≤79.2
Hysterectomy	24.8	23.3	42.3	20.7	41.3	≤44.1
Prostatectomy	29.3	16.9	35.2	25.9	19.9	≤37.5
Cataract surgery	2.8	2.4	0.8	0.6	1.4	≤2.2
Appendicectomy	19.0	16.9	24.1	17.0	19.7	≤27.8

Data source: Hospital Morbidity Data Collection.
Note: As these are calendar KPIs, the latest and most up to date information reported refers to the 2025 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, resulting in placement of the patient on an elective surgery waiting list.

Elective surgical services delivered in the WA health system are those deemed to be clinically necessary. Excessive waiting times for these services can lead to deterioration of the patient's condition and/or quality of life, or even death[4]. Waiting lists must be actively managed by hospitals to ensure fair and equitable access to limited services, and that all patients are treated within clinically appropriate timeframes.

Patients are prioritised based on their assigned clinical urgency category:

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

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 2025–26, 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 8: Percentage of elective wait list patients waiting over boundary for reportable procedures

	2021–22 actual (%)	2022–23 actual (%)	2023–24 actual (%)	2024–25 actual (%)	2025–26 actual (%)	Target (%)
Urgency category 1	30.5	37.9	37.0	33.6	28.7	0
Urgency category 2	29.2	38.5	37.7	34.7	31.2	0
Urgency category 3	10.7	24.4	19.2	19.0	16.1	0

Data source: Elective Services Wait List Data Collection.

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

OUTCOME 1 – EFFECTIVENESS KPI

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[5].)

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

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 increased to 1.1 per 10,000 occupied bed-days in 2025, which is an increase on the previous year and just above target.

HA-SABSIs are an area of focus for SMHS, with a range of health service wide interventions underway aiming to minimise the transmission of infection in clinical areas.

SMHS has also introduced specialist nursing leadership roles in Sepsis and is progressing the implementation of related pathways in Sepsis identification and management.

Table 9: Hospital infection rate

	Calendar Year					
	2021	2022	2023	2024	2025	Target
Infection rate per 10,000 bed-days	1.3	1.0	1.0	0.8	1.1	≤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 2025 calendar year results.

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

OUTCOME 1 – EFFECTIVENESS KPI

Survival rates for sentinel conditions: (a) Stroke; (b) Acute Myocardial Infarction; (c) Fractured 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.

Table 10

Age group (years)	Sentinel conditions		
	Stroke (%)	AMI (%)	FNOF (%)
0–49	≥95.3	≥98.9	Not reported
50–59	≥94.7	≥99.0	Not reported
60–69	≥94.3	≥98.3	Not reported
70–79	≥92.4	≥96.9	≥98.9
80+	≥87.2	≥93.1	≥97.0

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 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 other than the 60–69 age group. The outcomes for this age group were complicated by other co-morbidities including diabetes, hypertension and cancer which impacted post stroke survival rates.

Table 11: Survival rate for stroke, by age group

Age group (years)	Calendar Year					
	2021 (%)	2022 (%)	2023 %)	2024 (%)	2025 (%)	Target (%)
0–49	98.4	97.7	99.1	99.3	100.0	≥95.3
50–59	97.6	96.3	95.4	98.6	98.1	≥94.7
60–69	97.1	97.0	96.7	96.2	92.6	≥94.3
70–79	95.3	94.8	95.4	93.8	92.7	≥92.4
80+	86.1	88.5	85.1	87.7	87.3	≥87.2

Data source: Hospital Morbidity Data Collection.
Note: As these are calendar KPIs, the latest and most up to date information reported refers to the 2025 calendar year results.

The survival rate for patients diagnosed with AMI exceeded the target in the 60–69 and 80+ age groups, with an improvement in both groups from the preceding year.

In the 0–49, 50–59, 70–79 year age groups, survival rates were slightly below the target in 2025. The majority of deaths (80%) in the 0–49 and 50–59 age groups were as a result of out of hospital cardiac arrests, these patients did not survive despite medical intervention. Factors impacting survival in the 70–79 age group included pre-existing patient conditions such as respiratory, renal and heart disease, diabetes and cancer.

Table 12: Survival rate for acute myocardial infarction, by age group

Age group (years)	Calendar Year					
	2021 (%)	2022 (%)	2023 %)	2024 (%)	2025 (%)	Target (%)
0–49	98.3	99.1	97.7	99.1	98.2	≥98.9
50–59	98.8	97.2	99.2	98.7	98.4	≥99.0
60–69	97.8	97.5	97.7	97.0	99.3	≥98.3
70–79	97.5	97.1	96.6	97.4	96.4	≥96.9
80+	94.8	96.9	93.4	92.2	94.2	≥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 2025 calendar year.

The survival rate for patients admitted with FNOF in the 80+ years age group was above the target in 2025. For the 70–79 years age group, survival was just below the target at 98.2%. The survival of these elderly patients was complicated by co-morbidities including diabetes, respiratory and cardiac disease.

Table 13: Survival rate for fractured neck of femur, by age group

Age group (years)	Calendar Year					
	2021 (%)	2022 (%)	2023 %)	2024 (%)	2025 (%)	Target (%)
70–79	98.1	98.5	100.0	100.0	98.2	≥98.9
80+	97.6	98.2	95.2	94.6	97.2	≥97.0

Data source: Hospital Morbidity Data Collection.
Note: As these are calendar KPIs, the latest and most up to date information reported refers to the 2025 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, missing and not found or discharged at own risk). Patients who do so have a higher risk of readmission and mortality[6] and have been found to cost the health system 50 per cent more than patients who are discharged by their physician.[7]

The national Aboriginal and Torres Strait Islander Health Performance Framework reports discharge at own risk under the heading 'Self-discharge from hospital'. Between July 2019 and June 2021 Aboriginal patients (4.4%) in WA were 7.5 times more likely than non-Aboriginal patients (0.6%) to discharge at own risk, compared with 5.2 times nationally (3.8% and 0.7% respectively)[8]. This statistic indicates a need for improved responses by the health system to the needs of Aboriginal patients. This indicator is also being reported in the Report on Government Services under the performance of governments in providing acute care services in public hospitals[9].

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

The discharge against medical advice performance measure is also one of the key contextual indicators of Outcome 1 "Aboriginal and Torres Strait Islander people enjoy long and healthy lives" under the new National Agreement on Closing the Gap, which was agreed to by the Coalition of Aboriginal and Torres Strait Islander Peak Organisations, and all Australian Governments in July 2020[10].

Target

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.

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 per cent, this is above the target but is an improvement on last year and represents the lowest DAMA rate in the past five reporting years.

The SMHS Aboriginal Access Working Group continues to progress initiatives focused on improving Aboriginal access to care across sites and services. One of the priority areas in 2025 was the expansion of Aboriginal Health Practitioner (AHP) positions in high priority clinical areas to better support Aboriginal patients and their families. The AHP workforce continues to grow across inpatient, outpatient and emergency department settings.

An Aboriginal Health Training Coordinator role was introduced in late 2025, to strengthen the knowledge and skills of our workforce in delivering culturally safe, person-centred care to Aboriginal people accessing SMHS services.

Table 14: Percentage of patients who discharge against medical advice

Discharge against medical advice	Calendar Year					
	2021 (%)	2022 (%)	2023 %)	2024 (%)	2025 (%)	Target (%)
Aboriginal	3.07	3.80	3.50	3.80	3.00	≤2.78
Non-Aboriginal	0.72	0.80	0.70	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 2025 calendar year results.

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

OUTCOME 1 – EFFECTIVENESS KPI

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 (2025) Health, Standard 04/12/2024.

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'.

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

Results

The SMHS percentage of live born term infants with an Apgar score below seven increased in 2025 to 1.5 per cent but remains below the target.

Table 15: Percentage of live-born term infants with an Apgar score of less than seven, five minutes post-delivery

	Calendar Year					
Percentage of live born infants	**2021 (%)**	**2022 (%)**	**2023 %)**	**2024 (%)**	**2025 (%)**	**Target (%)**
	1.0	1.2	1.0	1.0	1.5	≤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 2025 calendar year results.

OUTCOME 1 – EFFECTIVENESS KPI

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

Rationale

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

While multiple hospital admissions over a lifetime may be necessary for someone with ongoing illness, a high proportion of readmissions shortly after discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was not adequate to maintain the patient's recovery out of hospital[11]. Rapid readmissions place pressure on finite beds and may reduce access to care for other consumers in need.

These readmissions mean that patients spend additional time in hospital and utilise additional resources. A low readmission rate suggests that good clinical practice is in operation. Readmissions are attributed to the facility at which the initial separation (discharge) occurred rather than the facility to which the patient was readmitted.

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

Target

The 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 13 per cent and just above the target. This represents a continuing improvement on the previous year and is the lowest rate of mental health readmissions for the past five years.

The result reflects the SMHS Mental Health service maintaining a focus on effective discharge planning for patients and ongoing partnerships with community service providers, in order to support patients and their families in the community and avoid readmissions.

Table 16: Rate of Readmissions to acute specialised mental health inpatient services within 28 days of discharge

	Calendar Year					
	2021 (%)	**2022 (%)**	**2023 %)**	**2024 (%)**	**2025 (%)**	**Target (%)**
Readmissions rate	15	16	15	14	13	≤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 2025 calendar year results.

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

OUTCOME 1 – EFFECTIVENESS KPI

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[12]. Therefore, it is crucial to ensure effective and appropriate care is provided not only in a hospital setting but also in the community.

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

The standard underlying 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 82 per cent, which is a reduction on the previous year but remains within the target for 2025.

Table 17: Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services

	Calendar Year					
	2021 (%)	2022 (%)	2023 %)	2024 (%)	2025 (%)	Target (%)
Post discharge community-based contact	82	86	88	88	82	≥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 2025 calendar year results.

12. National Health Survey 2022: National Health Survey, 2022 | Australian Bureau of Statistics

OUTCOME 1 – EFFECTIVENESS KPI

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 2025–26 Budget Paper No. 2, Volume 1.

The measure ensures that a consistent methodology is applied to calculating and reporting the cost of delivering inpatient activity against the State's funding allocation. As admitted services received nearly half of the overall 2025–26 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

Target

The target is $8,183 per WAU.

A result on or below the target is desirable.

Results

In 2025–26, SMHS delivered admitted activity at a cost of $8,593 per WAU, exceeding both the previous year's rate, and the target benchmark, but in line with cost of award increases. The target is highly challenging given that it is set below 2024–25 cost.

The cost per WAU result reflects increased staffing costs which includes the impact of industrial awards and agreements that regulate staff entitlements, and superannuation guarantee.

The 2025–26 result sees the full year impact of the opening of the Medihotel at Fiona Stanley Hospital contributing to the higher cost base during the year. The associated costs were not fully offset by revenue from increased activity.

Ongoing challenges in transitioning some patients to appropriate community, and aged care services have contributed to increased cost of service delivery.

Table 18: Average admitted cost per WAU

	2021 -22 (%)	2022 -23 (%)	2023 -24 %)	2024 -25 (%)	2025 -26 (%)	Target (%)
Average Cost	7,399	7,619	7,837	8,219	8,593	8,183

Data source: Hospital Morbidity Data Collection, Oracle 11i financial system, Outcome Based Management Allocation Application.
Note: This key performance indicator includes Peel Health Campus.

OUTCOME 1 – EFFECTIVENESS KPI

Service 2: Public Hospital Emergency Services

Average Emergency Department cost per weighted activity unit

Rationale

This indicator is a measure of the cost per WAU compared with the State target as approved by the Department of Treasury, which is published in the 2025–26 Budget Paper No. 2, Volume 1.

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

Target

The target is $8,094 per WAU.

A result on or below the target is desirable.

Results

In 2025–26, the cost per WAU was $8,954, exceeding the target set for the year. This represents an 8.1 per cent increase from the 2024–25 cost, which is impacted by the wage indexation rate outlined in the Government's public sector wages policy, including the superannuation guarantee.

The 2025–26 target was deliberately set below the 2024–25 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 2025–26, 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.

Ongoing challenges to maintain ED services at safe and accessible levels have resulted in increased staffing costs. This included the recruitment of extra medical and nursing staff to address priority response needs, manage increasing patient complexity, and ensure adequate staffing.

Greater patient complexity has resulted in longer stays and higher demand on ED resources. Increasing delays in transferring medically cleared patients to the most appropriate setting has contributed to constrained patient flow which has impacted ED.

Table 19: Average Emergency Department cost per WAU

	2021 -22 (%)	2022 -23 (%)	2023 -24 %)	2024 -25 (%)	2025 -26 (%)	Target (%)
Average Cost	7,534	7,509	7,983	8,284	8,954	8,094

Data sources: Emergency Department Data Collection, Oracle 11i financial system, Outcome Based Management Allocation Application.
Note: This key performance indicator includes Peel Health Campus.

OUTCOME 1 – EFFECTIVENESS KPI

Service 3: Public Hospital Non-Admitted Services

Average non-admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per WAU compared with the State (aggregated) target, as approved by the Department of Treasury, which is published in the 2025–26 Budget Paper No. 2, Volume 1.

The measure ensures that a consistent methodology is applied to calculating and reporting the cost of delivering non-admitted activity against the State's funding allocation. Non-admitted services play a pivotal role within the spectrum of care provided to the WA public. Therefore, it is important that non-admitted service provision is monitored to ensure the efficient delivery of safe and high-quality care.

Target

The target is $8,328 per WAU.

A result on or below the target is desirable.

Results

For 2025–26, the average cost per weighted activity unit for non-admitted services was $7,934, remaining below the target of $8,328. While the result increased compared with 2024–25, it continued to demonstrate efficient service delivery despite significant cost pressures.

The increase in cost per weighted activity unit was partly influenced by revisions to Independent Health and Aged Care Pricing Authority non-admitted activity weightings, reducing the weighted activity and therefore increasing the cost per WAU when compared to the prior year.

As with other efficiency measures, rising employee-related costs associated with public sector wage outcomes, increases in the superannuation guarantee rate and higher insurance premiums contributed to the overall cost of delivering non-admitted services. Increased expenditure on contracted services also contributed to the higher cost of service delivery during the year.

Table 20: Average non-admitted cost per WAU

	2021 -22 (%)	2022 -23 (%)	2023 -24 %)	2024 -25 (%)	2025 -26 (%)	Target (%)
Average Cost	6,126	6,908	6,871	7,227	7,934	8,328

Data sources: Non-Admitted Data Collection, Oracle 11i financial system, Outcome Based Management Allocation Application.
Note: This key performance indicator includes Peel Health Campus.

OUTCOME 1 – EFFECTIVENESS KPI

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 $2,707 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 lower than the target rate and lower than the 2024–25 result. Several factors have contributed to this outcome and should be considered in assessing this measure.

Despite, cost pressures driven by the Government's public sector wages policy and the rise in the superannuation guarantee rate, a significant increase in bed-days has offset these effects.

While WAU-based measures account for service complexity, the bed-day metric does not, limiting its effectiveness to reflect the true cost of care.

Table 21: Average cost per bed-day in specialised mental health inpatient units

	2021 -22 (%)	2022 -23 (%)	2023 -24 %)	2024 -25 (%)	2025 -26 (%)	Target (%)
Average cost per bed-day	1,853	1,813	1,908	2,170	1,928	2,707

Data sources: Bed State, Oracle 11i financial system, Outcome Based Management Allocation Application.

OUTCOME 1 – EFFECTIVENESS 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 $893 per treatment day of non-admitted care provided by mental health services.

A result on or below the target is desirable.

Results

SMHS delivered a non-admitted mental health care services at a cost per treatment day below the target rate of $893.

The per unit cost grew as a result of higher costs and additional services. Inflationary cost pressures have impacted service delivery despite providing 9 per cent more treatment days when compared to 2023–24. The result can also vary from period to period as treatment days are not adjusted for patient complexity.

Table 22: Average cost per treatment day of non-admitted care provided by mental health services

	2021 -22 (%)	2022 -23 (%)	2023 -24 %)	2024 -25 (%)	2025 -26 (%)	Target (%)
Average cost	581	660	663	642	861	893

Data sources: Mental Health Information Data Collection, Oracle 11i financial system, Outcome Based Management Allocation Application.

OUTCOME 1 – EFFECTIVENESS 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 2022–2026. [13] 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 $24 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 2025–26 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.

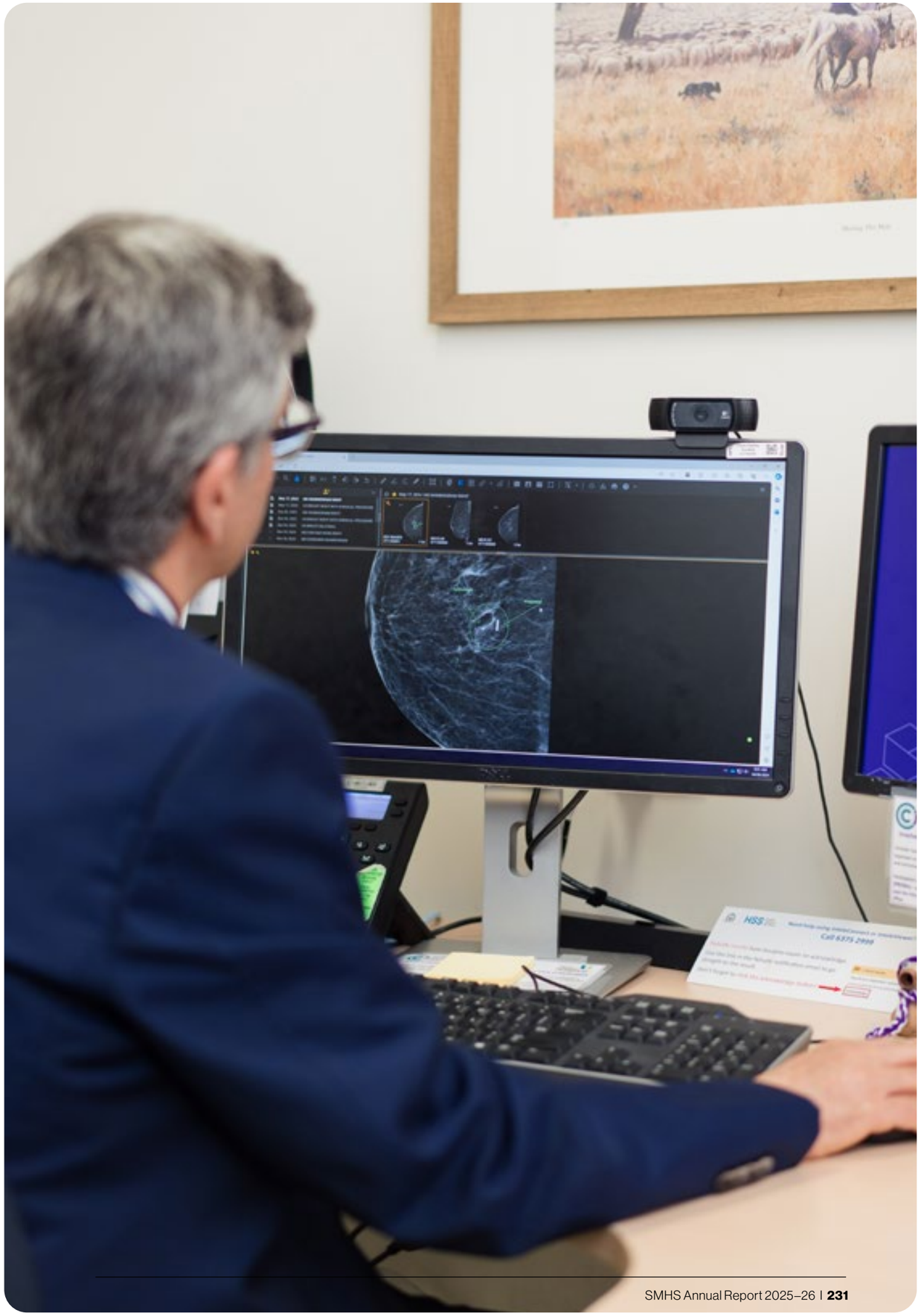
The rise in costs within this indicator is mainly attributed the inclusion of new program introduced during the 2025–26 financial year. This includes the 2025–26 commissioning of the Older Adult Health Hub as part of the State's election commitment.

Table 23: Average cost per person of delivering programs by Population Health Units

	2021 -22 (%)	2022 -23 (%)	2023 -24 %)	2024 -25 (%)	2025 -26 (%)	Target (%)
Average cost per person	25	18	24	28	34	24

Data sources: 2025 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.

13. 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 2025–26.

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 24. Capital works completed in 2025–26 financial year

Project	Total cost in 2025–26 ($ '000)	Reported in 2024–25 ($ '000)	Variance in total cost ($ '000)	Explanation of variance (>=10%)
Electronic Medical Record (EMR)	5,890	5,890		
Automated sprinkler system	0	66	(66)	Grant returned
FSH Critical Works	6,253	6,253		
South Emergency Care Navigation Centre (previously VEM)	200	200		

Table 25. Capital works in progress in 2025–26 financial year

Project	Expected completion date	Estimated remaining cost to complete ($'000)	Estimated total cost in 2025–26 ($ '000)	Reported in 2024–25 ($ '000)	Variance in total cost ($ '000)	Explanation of variance (>=10%)
Bethesda Health Care	2026	294	2,700	2,700		
Fiona Stanley Hospital – Cladding (f)	2026	812	13,640	49,740	(36,100)	Funding for Building B cladding separated from other FSH cladding remediation works
Fremantle Acute Mental Health Beds	2026	10,242	85,527	63,780	21,747	Approved injection of additional capital funding
Expansion of the Peel Health Campus (d)	2027	488	4,927	4,927		
Fiona Stanley Hospital Catheterisation Lab	2027	7,365	7,632	New		New project
Water Birthing Facility at Rockingham General Hospital	2027	300	300	New		New project
Mental Health Emergency Centre: Rockingham	2028	18,050	19,777	19,777		
SMHS Safety, Fire Compliance Critical Electrical Infrastructure	2028	19,763	21,985	21,985		
Fiona Stanley Hospital - Cladding Building B (e)	Ongoing	32,528	33,300	New		Funding for Building B cladding separated from other FSH cladding remediation works
Peel Health Campus Redevelopment (f)	To be determined	Unknown	35,030	152,047	(117,017)	Management of project transferred to Office of Major Infrastructure Development with budget retained by the DOH

Notes of relevance as footnote to tabular information above:

(a) The above information includes the Budgeted Expense Capital allocation.
(b) The allocation from the statewide programs (eg medical equipment and minor works programs) are not included as these are reported by the DOH.
(c) The timeframe for the 'Expected completion year' are updated for the latest information at the time of reporting.
(d) Formerly reported as PHC Reconfiguration of Emergency Department. Funds redirected and name updated
(e) FSH Building B Cladding funding separated from other FSH buildings and new standalone project created.
(f) Management of this project transferred to Office of Major Infrastructure Development (OMID); budget held by DOH.

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.

1,707.91	**2025–26**
1,615.63	2024–25

Agency nursing
Includes workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest.

28.90	**2025–26**
26.75	2024–25

Assistants in nursing
Support registered nurses and enrolled nurses in delivery of general patient care

384.01	**2025–26**
330.10	2024–25

Dental nursing
Includes dental nurses and dental clinic assistants.

4.50	**2025–26**
3.50	2024–25

Hotel services
Includes catering, cleaning, stores/supply laundry and transport occupations.

1,190.39	**2025–26**
1,120.37	2024–25

Maintenance services
Includes engineering, garden and security-based occupations

106.86	**2025–26**
83.39	2024–25

Medical
Includes all salary-based medical occupations including interns, registrars and specialist medical practitioners.

2,000.95	**2025–26**
1,835.25	2024–25

Medical Support
Includes all allied health and scientific/ technical related occupations.

1,762.13	**2025–26**
1,624.57	2024–25

Nursing and Midwifery
Includes all nursing occupations including enrolled, registered and clinical nurses, and midwives. Does not include agency nurses.

4,814.74	**2025–26**
4,421.53	2024–25

Other occupations
Not limited to but primarily includes Aboriginal and ethnic health specialist positions.

19.90	**2025–26**
15.80	2024–25

***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 recognises the need for an open and inclusive workplace culture where diversity is valued, and the social and cultural backgrounds of all employees are respected. At SMHS everyone should feel safe with the opportunity to contribute to and be a part of our team.

During 2025–26, SMHS completed the *Equity, Diversity and Inclusion Plan 2021–2025* and commenced development of a new E*quity, Diversity and Inclusion (EDI) Strategy 2026–2030* and *Equity, Diversity and Inclusion Action Plan 2026–2027*.

Extensive consultation with staff and stakeholders informed the development of the new strategy and action plan, which outline SMHS's continued commitment to fostering a workplace where people feel safe, valued, respected and able to contribute. The strategy focuses on creating equitable employment opportunities, supporting career development and leadership pathways, strengthening culturally safe and inclusive workplaces, and enhancing how SMHS listens to and learns from workforce experiences.

The *EDI Action Plan 2026–2027* incorporates new initiatives, enhanced existing activities and ongoing actions from the previous plan, ensuring a coordinated and sustainable approach to diversity and inclusion across the organisation.

The strategy prioritises initiatives to strengthen inclusion, participation and representation for six key workforce groups:

- Aboriginal people
- people from culturally and linguistically diverse backgrounds
- people with disability
- people of diverse sexualities and genders (LGBTIQA+SB)
- women
- young people.

SMHS recognises that a diverse and inclusive workforce strengthens organisational culture, enhances decision-making and innovation, and supports the delivery of responsive, high-quality healthcare services. Through continued investment in equity, diversity and inclusion, SMHS is fostering a workplace where all employees feel a sense of belonging and are supported to achieve their full potential.

LGBTIQA+SB inclusivity

During 2025–26, SMHS continued to promote inclusive, culturally safe and welcoming healthcare environments for consumers, carers and staff who identify as lesbian, gay, bisexual, transgender, intersex, queer, asexual plus sistergirls and brotherboys (LGBTIQA+SB).

Guided by a 12-month action plan aligned with WA Health LGBTIQA+SB strategic priorities, a range of initiatives focused on education, engagement and community partnership were delivered.

Education and awareness activities included presentations across leadership and clinical forums to increase understanding of LGBTIQA+SB terminology, history and inclusive practice. Participation in the Equity, Diversity and Inclusion eLearning program was also promoted to strengthen staff capability in providing inclusive and affirming care.

A key initiative during the year was the pilot of the 15 Steps Rainbow Walk across six SMHS service areas. The initiative supports staff and consumers to identify opportunities to enhance the healthcare experience by creating environments that are safe, welcoming, respectful and inclusive of diverse sexualities, genders and identities.

The Working Group strengthened partnerships and knowledge sharing through delivery of the *LGBTIQA+SB Inclusivity in WA Health Care* education program and presentations at sector-wide forums, including the WA Health Town Hall. SMHS also marked significant inclusion and diversity events, including Transgender Day of Visibility, the International Day Against Homophobia, Biphobia, Intersexism and Transphobia (IDAHOBIT), Pride Month and Wear it Purple Day.

Members of the Working Group further demonstrated SMHS's commitment to inclusion through participation in community events, including PrideFEST activities and the Pride March.

These initiatives support the SMHS commitment to fostering a diverse, inclusive and culturally safe workplace and healthcare environment, where all people feel respected, valued and supported.

Industrial relations

The *Industrial Relations Policy MP 0025/16* established under the Department of Health *(DoH) Employment Policy Framework* defines the service delivery responsibilities of SMHS for industrial relations.

DoH is responsible for systemwide industrial relations 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 industrial relations
- 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 2025–26 included:

- continued advice on the conversion to permanency provisions introduced into industrial agreements, including ongoing management and monitoring of reviews, as required within the industrial agreements
- conclusion of conversion to permanency for over 900 senior medical practitioners in 12 months, together with management and settlement of appeals against decisions
- continued coordination, strategy and advice on implementation of job security initiatives within target areas of high casual and fixed term contract use within SMHS
- continuing advice and education on large scale changes to the *Minimum Conditions of Employment Act 1993* and *Industrial Relations Act 1979*

- industrial support on WA Health project regarding career pathways progressions for specified allied health cohorts resulting from government commitments in the last major industrial agreement for this group
- industrial support on changes to Public Sector Commissioner instructions, including advice and coordination of permanency review evaluations for staff formerly excluded from permanency by dint of temporary visa status
- representation on matters before various industrial tribunals and courts, including appellate jurisdictions
- 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 consequent issues on transition of PHC staff to WA Health control within SMHS
- advice and assistance relating to consequent issues on transition of Cockburn Health to FSH control within SMHS
- advice and assistance relating to expansion of mental health services at Fremantle and Cockburn facilities
- 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 health care services.

A total of 357 claims were made in 2025–26.

As per previous years, for the purposes of the Annual Report employee categories are defined as:

- administration and clerical – includes administration staff and executives, ward clerks, receptionists and clerical staff
- medical support – includes physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dieticians and social workers
- hotel services – includes cleaners, caterers and patient service assistants.

Worker's compensation claims profile

Employee category	Number of claims in 2025–26
Nursing services/dental care assistants	175
Administration and clerical	27
Medical support	42
Hotel services	101
Maintenance	7
Medical (salaried)	5
Total	**357**

Work health and safety

Our commitment

At SMHS we are committed to ensuring the safety, health and psychological safety of our workers, volunteers, students, contractors and visitors. We all have a part to play in building a physically and psychologically safe workplace.

We will:

- Be visible and lead by example demonstrating a commitment to promoting our core values of Care, Integrity, Respect, Excellence and Teamwork, with health and safety at the heart of everything we do.
- Aspire to create and maintain a healthy workplace culture that prioritises physical and psychological safety. Our goal is to support each other and foster an environment where physical safety and psychological safety are elevated and prioritised.
- Remain committed to providing a safe workplace through the prevention and effective management of aggression, violence, bullying, discrimination, harassment (including sexual harassment) and other behaviours that pose a risk to our workers' safety. Aggression and violence are never acceptable as part of our roles, and we will take appropriate and consistent action to protect our people.
- Continuously refine and evaluate our health and safety management system through active consultation with our staff, ensuring our organisation enhances work health and safety (WHS) practices, and remains compliant with WHS legislation and best practice.
- Support our leaders, health and safety representatives, safety committees and stakeholders in managing risks and developing and implementing strategies to improve physical and psychological safety in our workplaces.
- Embed a WHS reporting culture to ensure we continue to learn, improve and measure our WHS 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 the Area Executive Group (AEG). 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 383 health and safety representatives play a vital role in this consultation process. Each 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 procedure and processes.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Celebrating
100 Years
2025

Consultation on the WHS Management System is conducted through WHS Committees and departmental channels, as well as via the SMHS WHS intranet page during designated consultation periods.

The SMHS WHS Consultation Procedure sets out these requirements to ensure that arrangements are in place across SMHS workplace to enable:

- effective consultation with workers around WHS matters
- worker participation in WHS activities
- appropriate representation of workers' perspectives in decision-making about WHS matters.

Injury management and return to work

SMHS is committed to supporting injured workers in their recovery and return to meaningful employment. Our WHS Management System aligns with the requirements of the *Workers' Compensation and Injury Management Act 2023*.

We have a comprehensive injury management system in place, as outlined in the *SMHS Injury Management Policy and Procedure* and accessible via the SMHS WHS intranet page.

Injured workers have access to the Early Intervention Program, which provides timely medical reviews and physiotherapy services.

This program focuses on early care, injury assessment and proactive management to facilitate a safe and sustainable return to work following a workplace injury or illness.

Managers play an active role in the rehabilitation process, supporting both full and modified return to work arrangements based on medical advice and individual capacity.

SMHS continuously monitors workers' compensation claim performance and collaborates closely with our insurer to implement strategies aimed at reducing the frequency, severity, and overall volume of compensable injuries.

Assessment of the WHS management system

In 2022, Ernst & Young conducted an independent audit of the SMHS WHS Management System to assess compliance with the updated WHS legislation. All resulting action items were addressed and completed by the end of 2022.

SMHS also maintains a robust internal WHS audit framework. WHS departments conduct regular assessments across all SMHS sites to ensure ongoing compliance with the requirements of the WHS Management System at a local level.

The next independent audit is scheduled to commence in first quarter of the next financial year (2026–27).

Assessment of the WHS management system

Measure	Actual results		Results against target	
	2024–25	2025–26	Target	Comment on result
Number of fatalities	0	**0**	0	
Lost time injury and/or disease incident rate	2.84%	**3.03%**	0 or 10% reduction	The lost time injury (LTI) incident rate has increased slightly compared with the previous financial year. This should be considered in the context of significant workforce growth across SMHS during 2025–26. As the largest HSP by both FTE and headcount, workforce expansion may influence comparative performance measures and incident rate outcomes. Key improvement initiatives continue to focus on injury prevention, early intervention, proactive injury management, safety leadership and the implementation of targeted WHS risk controls. These priorities are aligned with the *SMHS WHS Strategy 2025–27* and site-based WHS operational plans, which target critical WHS risks across the health service.
Lost time injury and/or disease severity rate	54.28%	**54.83%**	0 or 10% reduction	The LTI severity rate increased marginally compared to the previous financial year, occurring alongside substantial growth in SMHS workforce numbers over the past 12 months. It is also important to recognise the strong uptake of SMHS's Workplace Early Intervention Program, which supports early injury management and assists in reducing the number of lower-severity claims progressing to workers' compensation. While this reflects a positive and proactive approach to injury management, it can influence the overall claim severity profile. Improvement activities include regular claim performance reviews with insurer ICWA to monitor severity trends and identify emerging risks, alongside targeted WHS initiatives addressing key injury drivers including psychosocial hazards and manual handling risks.
Percentage of injured workers returned to work within 13 weeks	40.00%	**39.72%**	There is no target in the updated public sector requirements report.	Performance remained relatively stable over the reporting period, with results consistent with those recorded in the previous financial year. Ongoing improvement efforts are focused on enhancing injury management processes, promoting timely intervention, and supporting sustainable return-to-work outcomes. These priorities are reflected in the *SMHS WHS Strategy 2025–27* and corresponding site WHS Operational Plans.
Percentage of injured workers returned to work within 26 weeks	54.8%	**52.4%**	Greater than or equal to 70%	Performance has remained relatively stable over the reporting period, with results consistent with those recorded in the previous financial year. Ongoing improvement efforts are focused on enhancing injury management processes, promoting timely intervention, and supporting sustainable return-to-work outcomes. These priorities are reflected in the *SMHS WHS Strategy 2025–27* and corresponding site WHS operational plans.
Percentage of managers trained in occupational, health and injury management responsibilities	60.2%	**74.5%**	Greater than or equal to 80%	Compliance performance improved significantly from the previous financial year and is now approaching the KPI target. This improvement is likely attributable, in part, to a change in SMHS training requirements. Historically, SMHS mandated annual WHS training for managers, whereas the requirement has now been aligned with public sector reporting requirements through a biennial completion cycle. This change has contributed to improved compliance outcomes. Ongoing improvement actions will focus on regular reviews of workforce profiles to ensure employees with managerial and supervisory responsibilities are appropriately identified and assigned the required WHS 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, they 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 2025–26 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 provided during induction or onboarding of non-facilities management staff.

Asbestos, either confirmed or assumed, is identified via asbestos identification stickers.

Unauthorised use of credit card

Table 26. Unauthorised use of credit card

Credit card personal use expenditure	July 2025–June 2026
Aggregate amount of personal use expenditure for the reporting period	$156.23
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)	$156.23
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 $67,826 in 2025–26

Table 27. Media advertising organisations

Person, agency or organisation	Amount ($)
Initiative Media Australia Pty Ltd	66,748
Meta Platforms Ireland Limited	1,078
Total	67,826

Acts of Grace, ex-gratia payments

SMHS did not make any charitable gifts or ex-gratia payments over $100,000 in 2025–26.

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 Elizabeth Soderholm declared her position as a lessor of property at units 6,7 and 8 of 5 Goddard Street, Rockingham, leased to DoH for which she receives commercial rent. 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. 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.

Multicultural framework

At SMHS we care for one of the most diverse communities in Western Australia. Every day, our staff support people from many different cultural, linguistic and lived experience backgrounds.

Creating a health service where everyone – staff and consumers – feel safe, welcome and respected is essential to delivering excellent care.

Over the past year, we have continued to strengthen our commitment to culturally responsive, inclusive and equitable health care. This has included progressing the final year of the *Multicultural Plan 2021–2025*, while working in partnership with staff, consumers and community organisations to develop the *Multicultural Action Plan 2026–2030*. This engagement has helped us better understand the needs, experiences and priorities of culturally and linguistically diverse (CaLD) communities. These insights are shaping how we design services, communicate with consumers and support our workforce.

Our vision is clear: By 2030, SMHS will be recognised for delivering culturally responsive care, supporting a diverse and inclusive workforce, and fostering a culture of respect and belonging for all. This aligns with the *WA Multicultural Policy Framework* and the SMHS vision of excellent health care, every time.

Celebrating diversity and creating belonging

Throughout the year, we continued to promote inclusion and cultural diversity across the organisation. In March, Harmony Week activities across hospital and community sites brought staff together to share cultural experiences and reflect on the importance of inclusion in health care.

These events are about more than celebration – they help build understanding, strengthen connections and create a sense of belonging for both staff and the people we care for.

Making communication clearer and more accessible

Clear communication is essential to safe and effective care.

SMHS has continued to focus on improving health literacy by supporting staff to use plain, understandable language when communicating with patients, carers and families. Initiatives such as Drop the Jargon Day encouraged staff to simplify communication and focus on what matters most to consumers. This initiative was supported by staff education and the development of accessible consumer resources, with community consultation using the Put it to the People platform. These resources included practical tools such as teach-back, an evidence-based, simple communication tool that helps staff to involve consumers in meaningful conversations about their health care.

Importantly, more information is now available in community languages and easy-read formats, and patient experience surveys include translated content – making it easier for more people to share their feedback and have their voices heard.

Strengthening culturally responsive services

SMHS also strengthened culturally responsive service delivery by continuing to promote the use of interpreter and language services. Resources such as posters, stickers and staff prompts across all sites have increased awareness and supported more consistent use of interpreters. Innovative approaches such as on-demand video interpreting trials were trialled in high-risk clinical settings to support timely and effective communication with consumers. These changes are helping ensure language is not a barrier to safe, high-quality care.

Building a culturally capable workforce

Delivering inclusive care starts with a workforce that feels confident and supported.

Throughout 2025–26, SMHS continued to promote cultural competency and equity, diversity and inclusion training through induction, education programs and internal communications. This work is helping staff develop the knowledge, skills and confidence to provide culturally responsive care.

It also aligns with the development of the *SMHS Equity, Diversity and Inclusion Strategy 2026–2030*, which sets a clear direction for creating a more inclusive and supportive workplace.

Using data to better understand our community

Understanding who we care for is key to improving how we deliver care.

Enhancements to the patient administration system (webPAS) now allow SMHS to capture more detailed cultural and linguistic information, including ancestry, ethnicity and language spoken at home.

This improved data will help us:

- better understand the needs of our community
- identify gaps and inequities in care
- inform future planning and service improvements.

Planning for diversity

Looking forward, the *Multicultural Action Plan 2026–2030* represents an important step for SMHS. The plan introduces a clear and structured approach to:

- building a culturally intelligent workforce
- improving communication and access
- creating culturally safe environments
- strengthening partnerships with diverse communities.

Together, these actions will support SMHS to continue delivering care that is inclusive, respectful and responsive – so that every person who walks through our doors feels safe, welcome and supported.

Promoting substantive equality

SMHS continues to progress key initiatives to increase recruitment of Aboriginal people including the application of section 50(d) and section 51 of the *Equal Opportunity Act*.

SMHS participated in the WA Health Aboriginal Cadet recruitment process and expanded the Aboriginal Cadetship program in SMHS to employ an additional five Aboriginal cadets.

Targeted engagement activities further expanded pathways into healthcare careers for Aboriginal people, including the inaugural FSH Aboriginal Careers Expo and PHC Open Day, which showcased employment opportunities and led to successful recruitment outcomes.

SMHS also participated in the Kadadjiny Mia Aboriginal Employer Showcase at South Metropolitan TAFE Rockingham, the Marr Mooditj Graduation Ceremony career stall and the Care Sector Showcase at South Metropolitan TAFE Mandurah.

The Aboriginal Health Practitioner program continues to grow through partnerships with Marr Mooditj Training Organisation and increased recruitment of AHPs across services.

Patient experience feedback

Every day across SMHS, thousands of people come into our hospitals and services at moments that matter most – welcoming a new baby, recovering from illness, receiving care in the community or supporting a loved one through treatment.

Patient experience is about more than clinical care – it's about how people feel: whether they are heard, treated with dignity and supported in ways that matter to them and their families.

Consumers, carers and families can now provide feedback in more ways than ever before through channels such as patient experience surveys, compliments, complaints and the Care Opinion online platform.

Over the past year through our *Consumer Feedback Strategy* we worked hard to improve access to feedback by:

- developing clear, accessible information on how to share feedback
- creating resources tailored for different patient/consumer groups, including mental health clients, Aboriginal people and children and young people
- piloting a carer experience survey.

These help ensure everyone has the opportunity to be heard. This feedback gives us a powerful, real-time understanding of what we are doing well, and where we need to do better.

Patient experience surveys

For the 2025–26 period we heard from 60,716 patients via the MySay surveys – see table 28.

A modified version of the MySay survey for carers was trialled between October 2024–October 2025, with 108 carers responding to the survey. One carer commented, *"We received wonderful support from all staff in what was a very difficult time for us."* The MySay Carer survey will run as a three-month snapshot in 2026 to coincide with National Carers Week.

Mental health patients are asked to complete the Your Experience of Service (YES) Survey. One mental health patient commented that the best thing about the service was, *"Having consistent and genuine care shown by the entire team. I always felt listened to and never felt that help was out of reach. The team's empathy and services made a meaningful difference in my recovery and overall wellbeing."*

Table 28. MySay survey responses 2025–2026.

Survey type	# responses	% who rated overall quality of care as good or very good	Quote
Inpatients	28,797	93.9	"I felt like a person, not a number." - FSH inpatient
Emergency department	5,938	82.1	"Top class service! I felt safe and well cared for... I was very impressed with the treatment I received." - Rockingham ED patient
Outpatients	22,976	95.4	"The staff were amazing and always smiling. Sometimes that's all you need..." - PHC outpatient
Community services	3,005	97.2	"Classes were designed for my needs... my improvement was way beyond my expectations." - Community Physiotherapy Services client

Care Opinion

In 2025–26, SMHS received a total of 149 stories via Care Opinion. 68 of these stories were positive and 81 consumers shared their experience with some suggested areas for improvement.

Some of the feedback shared via Care Opinion:

"I began to feel very faint and wanting to pass out. The nurse held both of my hands the whole time. The after care and education was above and beyond. Tea and snacks were given generously while I was explained in thorough detail the procedure and what to expect afterwards. I could not have had a better experience..." – Fremantle Hospital patient

"My husband lost his memory 5 years ago after he got cancer ... I look after him by myself but sometimes I need to ask to someone how to do this one because I don't know how to start... They listen carefully... I understand what they say and we try to practice because they give us so clear information and leave us the paper so we can practice every day what they teach us to do everything. They give really beautiful support now... I feel really comfortable now because I tell my husband now I'm not alone." –RITH and CoNeCT patient

Compliments, complaints and contacts

In 2025–26, 4,815 compliments, 3,062 contacts and concerns and 1,485 complaints were received via formal feedback processes.

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.*

Responding with compassion

We know that how we respond to feedback matters. This year, we introduced a new approach to support staff to provide compassionate, respectful responses to consumers. A dedicated guide and audit tool help ensure that every response:

- acknowledges the person's experience
- demonstrates empathy and understanding
- clearly explains what has happened and what will change

This focus on compassion is improving the quality of responses and helping to rebuild trust when things don't go as expected.

Strengthening how we use feedback

Collecting feedback is only the first step. Using it to improve care is where real change happens.

Over the past year, through our *Consumer Feedback Strategy* we have strengthened how we collect, understand and act on patient experience feedback.
This includes:

- bringing together feedback from multiple sources into a single patient experience dashboard to better identify trends and priorities
- using internationally recognised tools to analyse feedback and identify themes in patient care
- training staff across SMHS in quality improvement and how to use consumer feedback to drive change
- exploring new ways to communicate changes made as a result of feedback.

This ensures feedback is not just heard, but acted on, and is helping us move beyond individual stories to systemwide insights – so that every experience contributes to better care for all.

Case example: supporting people with hidden disabilities

Feedback from a parent following an emergency department experience highlighted the challenges faced by people with autism and other non-visible disabilities when accessing care.

The feedback described how sensory factors such as noise, bright lighting and unexpected touch can be overwhelming, and how small changes – such as asking before touching, reducing stimuli and improving communication – can make a significant difference to a person's experience. This feedback provided valuable insight into the lived experience of navigating health care with a hidden disability and identified opportunities to improve care across the system.

"Sometimes you can't see the challenge someone is facing – but small adjustments can make a huge difference." – Parent of an ED patient

In response, SMHS strengthened its focus on supporting people with non-visible disabilities, including the introduction and expansion of the Hidden Disabilities Sunflower program. During 2025–26, the program reached full implementation across all SMHS sites, with every site formally registered.

This included:

- promoting the use of the Hidden Disabilities Sunflower to help staff easily recognise when a person may need additional support
- increasing staff awareness and education to build understanding of non-visible disabilities
- encouraging more flexible, person-centred approaches to care.

The program provides a simple, recognisable way for consumers to signal they may need additional time, patience or support without needing to repeatedly explain their condition. This initiative is helping to create a more inclusive and responsive healthcare environment, where people with hidden disabilities feel acknowledged, supported and safe.

"My experience was so, so different from last time. To see the sunflowers everywhere, the big 'waiting time' screen on the wall, and all the other changes was amazing. I was treated with respect... I walked out just over an hour later absolutely overwhelmed by the difference."
– ED patient

What matters to you?

The What Matters to You? program is a key part of how we bring patient experience to life at SMHS. Rather than only focusing on clinical needs, it encourages staff to ask a simple but powerful question: "What matters to you?" This shifts conversations from what is the matter to what matters most, helping staff understand each person's priorities, values and preferences.

Importantly, it connects directly with how we use feedback – it helps ensure that improvement efforts are grounded in what truly matters to patients and families.

Case example: personalising care

A patient admitted for treatment shared that their main concern was not their condition, but being able to stay connected with their family and maintain their independence.

By asking "What matters to you?", staff were able to adjust care to support regular family communication, involve the patient more actively in care decisions and tailor discharge planning to meet their personal goals.

"They didn't just treat my condition – they treated me as a person. That made all the difference." – Patient


CLINICAL
NURSE
Fiona Stanley
Fremantle
Hospitals Group

Throughout 2025–26 SMHS led the statewide working group to embed the program into clinical practice as part of the *Improving Safety and Quality in Healthcare: a strategic plan for action in WA 2024 – 2026*. This resulted in the development of tools and resources to support staff to have these conversations, standardised branding and messaging and the development of metrics to evaluate implementation progress.

We are now working to further integrate the program into our services and hospitals by:

- supporting staff education and consumer awareness of the program
- embedding program principles into policies
- starting to collect data to measure our progress.

Disability access and inclusion

The *SMHS Disability Access and Inclusion Plan (DAIP) 2022–2027* 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*.

Outcome 1 – People with disabilities have the same opportunities as other people to access the services of, and events organised by, a public authority

During 2025–26, SMHS progressed a range of initiatives to support people with disability to access services and events in an inclusive and equitable way.

International Day of People with Disability was celebrated across multiple sites, promoting awareness, inclusion and positive community attitudes. These activities provide opportunities to reflect on the importance of inclusion and the role we all play in creating welcoming environments.

Work also commenced to strengthen governance processes, including embedding accessibility considerations into policy development and review. This helps ensure that disability access and inclusion are routinely considered as part of planning, decision-making and service delivery.

Outcome 2 – People with disabilities have the same opportunities as other people to access the buildings and other facilities of a public authority

SMHS continued to improve the accessibility of buildings and facilities through targeted infrastructure and environmental changes.

Key improvements included increasing the number of accessible parking bays at PHC and progressing annual wayfinding audits to identify and address barriers to navigation. Work also continued to support universal access to bathroom facilities, including compliance with Changing Places standards at FSH.

These changes help create environments that are safer, easier to navigate and support greater independence for consumers, carers and staff.

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

Improving access to information remained a key focus throughout the year.

SMHS has continued to expand its library of Easy Read resources to support people with disability, their families and carers to better understand their care and navigate health services. Recent resources developed for SMHS hospitals include:

- Getting ready for stay at hospital
- When you are at hospital
- Feedback form.

Accessible formats of key information, including the *Disability Access and Inclusion Plan*, are available to support equitable access. Internal resources have also been strengthened through updated intranet content and improvements to staff orientation and onboarding materials, supporting staff to provide accessible and inclusive communication.

This work reflects a shift towards more person centred communication, helping patients and carers to understand their care, participate in decision-making and share their feedback.

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

SMHS continued to enhance service quality for people with disability through workforce development and care improvements. Disability awareness education was delivered across sites, including training on hidden disabilities, autism and inclusive care practices. Sensory friendly spaces were implemented within the FSH ED to better support both adult and paediatric patients.

The Hidden Disabilities Sunflower Program reached full implementation across SMHS, with all sites now formally registered members. This builds on the initial implementation at FSFHG and growing adoption across SMHS. Achieving systemwide registration represents a significant milestone in embedding a consistent, recognisable approach to supporting people with non-visible disabilities.

Ongoing staff education and local promotion continue to strengthen workforce capability to respond with understanding, flexibility and compassion.

As proud members of the global Hidden Disabilities Sunflower network, SMHS is continuing to build an environment where people feel acknowledged, supported and understood when accessing care.

Outcome 5 – People with disabilities have the same opportunities as other people to make complaints to a public authority

SMHS strengthened the accessibility of feedback and complaints processes to support people with disability to share their experiences and concerns. Easy Read consumer feedback forms were implemented across all SMHS sites and existing feedback processes were also reviewed to ensure they are accessible and inclusive. These improvements help ensure that people with disability can provide feedback in ways that suit them, have their voices heard and contribute to ongoing service improvement.

Outcome 6 – People with disabilities have the same opportunities as other people to participate in any public consultation by a public authority

SMHS continued to strengthen opportunities for people with disability to participate in consultation and service design.

DAIP committees across sites include representation from staff and individuals with lived experience of disability, supporting more inclusive and informed decision-making. Work is ongoing to review consumer engagement processes to further improve accessibility and awareness of participation opportunities.

Through the Put it to the People community engagement platform, SMHS has provided additional opportunities for people with disability to participate in public consultation. Recent programs and projects have included:

- Disability Health Profile Form
- Hidden Disabilities Sunflower
- Hospital Stay Guidelines
- International Day of People with Disability.

These approaches help ensure the voices of people with disability are heard and embedded in service planning and improvement.

Outcome 7 – People with disability have the same opportunities as other people to obtain and maintain employment

SMHS made significant progress in supporting employment opportunities for people with disability.

A Workplace Adjustment Policy and Passport Toolkit was implemented, providing a consistent, transparent and person-centred framework to support workplace adjustments and reduce barriers to employment and career progression.

This work has been supported by strengthened partnerships with employment support providers and ongoing monitoring of workforce diversity data.

These initiatives contribute to a more inclusive workplace culture that values diversity and supports the wellbeing, participation and retention of staff with disability

Across all outcomes, SMHS has continued to embed disability access and inclusion into everyday practice, with a focus on sustainability, workforce capability and meaningful engagement with people with lived experience. This ongoing work supports more equitable access and better outcomes for the communities we serve.

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 in SMHS 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.
- Managing breach of standard claims in accordance with the *Public Sector Management (Breaches of Public Sector Standards) Regulations 2005*.
- Regularly developing, reviewing and implementing HR policies, procedures and practices. In 2025–26, the SMHS Discipline Guidelines were reviewed and endorsed by the SMHS Area Executive Group following extensive consultation with stakeholders.
- Providing ongoing HR training and development opportunities that benefit all employees.
- Recruitment and selection training occurs for panel members to ensure compliance with relevant Standards.
- Recommended and unsuccessful applicants are advised of the breach process.
- SMHS HR has a confidential HR database/register to retain breach information. HSS also maintains information relating to breaches against the Employment Standard.
- Ensuring equitable and timely resolution of employee grievances and promoting a commitment to providing a safe and positive workplace. The SMHS Respect in the Workplace campaign and centralised intranet site was launched on 10 November 2025.
- Availability of:
  - senior human resource business partners and consultants
  - recruitment teams at FH, FSH (HR Connect/Serco), RkPG and PHC
  - SMHS Industrial Relations team.

Public Sector Management (Breaches of Public Sector Standards) Regulations 2005 amendments

Taking effect on 1 July 2025, amendments were made to the *Public Sector Management (Breaches of Public Sector Standards) Regulations 2005.*

The Public Sector Commission continues to have jurisdiction over claims alleging breaches of the Employment Standard excluding claims about transfer.

The Western Australian Industrial Relations Commission has jurisdiction over claims alleging breaches of public sector standards relating to transfer, performance management, grievance resolution, redeployment and termination of employment.

Taking effect on 1 July 2026

A new and more rigorous Recruitment Standard replaced the previous Employment Standard. The standard is contained in the three new Commissioner's Instructions –

- *Commissioner's Instruction 48: Recruitment, Selection and Appointment to Permanent Vacancies*
- *Commissioner's Instruction 49: Recruitment, Selection and Appointment to Fixed Term Vacancies*
- *Commissioner's Instruction 50: Backfilling Temporary Vacancies.*

Commissioner's Instruction 51: Transfer Standard was created to provide efficient and applicant focused recruitment practices when transferring employees.

Summary of SMHS Breach of Standards Claims

During 2025–26:

- 12 claims were lodged against the employment standard:
  - 5 claims were resolved by SMHS and did not result in a breach of standard.
  - 7 claims were sent to the Public Sector Commission (PSC) for review and were dismissed with no breach of standard.
- 3 claims were lodged against the grievance resolution standard:
  - 2 claims were resolved by SMHS and did not result in a breach of standard.
  - 1 claim was sent to the Western Australian Industrial Relations Commission for review and was dismissed with no breach of standard.

There were no breach claims against the other Public Sector Standards in HR Management.

Code of Ethics and Code of Conduct

SMHS works in accordance with the *DoH Code of Conduct*, with an expectation that SMHS employees adhere to the *Code of Conduct* and the *WA Public Sector Code of Ethics*.

The *Public Sector Code of Ethics* sets out the minimum standards of conduct and integrity:

- integrity
- impartiality
- respect for others
- trust and accountability.

Integrity is fundamental to achieving the SMHS vision of excellent health care, every time, ensuring that decisions and behaviours are transparent, accountable and centred on high-quality patient care.

The *SMHS Integrity Framework* aligns with the *Public Sector Commission Integrity Model* and supports compliance with ethical standards, legislative requirements and Commissioner's Instructions.

SMHS champions a culture of integrity and accountability, supported by established disciplinary and reporting mechanisms to ensure appropriate decision-making and oversight. Expected behaviours are promoted through a combination of preventative and responsive measures, including access to policies and guidance, targeted education, and mechanisms that support staff to report concerns.

Monitoring and compliance

SMHS monitors and assesses compliance with the *Code of Conduct* and the *WA Public Sector Code of Ethics* through established governance, reporting and assurance processes aligned with the *SMHS Integrity Framework* and the *Public Sector Commission Integrity Model*. The SMHS Area Executive Group, SMHS Audit and Risk Board Sub-Committee and full Board regularly monitor integrity and ethics reports, data and HR matters to ensure appropriate oversight and compliance with the ethical code and best practice.

Compliance is supported through staff education, policy review, targeted guidance, disciplinary and reporting processes, and oversight mechanisms that promote accountability and continuous improvement.

Staff feedback mechanisms, including the Public Sector Commission Annual Agency Survey, provide insight into the integrity culture and inform continuous improvement initiatives.

Together, these processes support ongoing monitoring, early identification of risks, and continuous assessment of compliance with ethical obligations across the organisation.

Compliance with ethical codes

SMHS demonstrates a high level of compliance with the *WA Public Sector Code of Ethics* and the *DoH Code of Conduct*, supported by established governance, education and oversight mechanisms. Staff are expected to adhere to defined standards of ethical conduct at all times, and compliance is reinforced through policies, training and organisational values.

No systemic issues of non-compliance were identified during the reporting year. Matters that arose were managed in accordance with established disciplinary and reporting frameworks, ensuring appropriate oversight and timely resolution.

Communication of Code of Conduct to employees

During the reporting period, SMHS communicated the *Code of Conduct* to employees through a range of formal and ongoing mechanisms.

All new staff members are provided with information on the *Code of Conduct* and expected standards of behaviour as part of the induction and onboarding process. Ongoing communication is supported through access to policies and guidance materials, as well as targeted education and awareness sessions on ethical conduct matters.

The *Code of Conduct* is reinforced through organisational values, leadership messaging and day-to-day management practices, ensuring expectations of professional and ethical conduct are clearly understood.

In addition, staff are regularly reminded of their obligations through internal communication channels and engagement activities, supporting a culture of integrity, accountability and transparency across the organisation.

Complaints of non-compliance with Code of Ethics or Code of Conduct

SMHS received and assessed a range of matters alleging non-compliance with the *Code of Conduct* during the reporting period.

Reported matters were also assessed in accordance with reporting obligations, including classification as suspected serious misconduct (reported to the Corruption and Crime Commission), suspected minor misconduct (reported to the Public Sector Commission), or non-reportable matters where thresholds were not met.

The data below reflect the total number of disciplinary matters during the reporting period. Note that the 2025–26 data include the addition of PHC employees.

Misconduct reports 2025–26

In 2025–26, there was a total of 120 cases of suspected breaches of discipline.
Of the these:

- 45 were assessed as serious misconduct and reported to the CCC
- 36 were assessed as minor misconduct and reported to the PSC
- 36 were assessed as non-reportable
- 3 matters were pending assessment.

The outcomes of these 120 conduct matters reported in 2025–26 were:

- 85 involved allegations that were substantiated
- 11 involved cases that were unsubstantiated
- 21 cases remain active
- 3 pending assessments.

Recordkeeping plan

SMHS maintains the Record Keeping Plan, endorsed in accordance with the *State Records Act 2000*. During 2025–26, SMHS continued its recordkeeping and information improvement program, including expansion of the WA Health Electronic Document and Records Management System (EDRMS) and remediation of recommendations arising from an internal audit recommendation. Remaining actions to finalise recommendations are scheduled for completion by December 2026.

The most recent evaluation included a comprehensive review of digital and physical records to ensure compliance with patient privacy requirements and changes to Public Records Office Information Schedule policies.

During 2025–26, progress against improvement actions and the effectiveness of recordkeeping controls were monitored through governance reporting, audit follow-up activities, system oversight and compliance reviews, and delivered through a comprehensive program of work.

SMHS continued to monitor recordkeeping compliance and system effectiveness through governance oversight, audit follow-up activities and training compliance reporting.

Recordkeeping responsibilities are embedded within employee induction and supported through mandatory training, policies and guidance, specialist advice, compliance monitoring and governance reporting.

Appendices

Appendix 1 – SMHS Board remuneration 2025–26

Member position	Member name	Type of remuneration	Period of membership (in months) for 2025–26	Term of appointment and tenure	Base salary/ sitting fee ($)	Gross/actual remuneration ($)
Board Chair (until 30 Sept 2025)	**Robyn Collins**	Annual	3 months	1 July 2016 to 30 September 2025 (reappointed a further 3 months from 30 June 2025)	$22,503.16	$25,204.16
Board Chair (from 1 Oct 2025)	**Liam Roche**	Annual	12 months	1 July 2016 to 30 June 2025 (reappointed for a further three years on 1 July 2022)	$65,859.68	$73,762.92
Deputy Chair (until 30 Sept 2025)	**Kim Gibson**	Annual	3 months	1 July 2016 to 30 September 2025 (extended for a further three months from 30 June 2025)	$14,086.57	$15,776.98
Deputy Chair (from 1 Oct 2025)	**Sue Le Souef**	Annual	12 months	9 March 2020 to 30 June 2026 (reappointed for a further 31 months on 20 November 2023)	$44,290.72	$49,605.72
Board member	**Amanda Boudville**	Annual	12 months	17 July 2017 to 30 June 2026 (reappointed for a further 34 months on 21 August 2023)	$41,791.88	$46,807.02
Board member	**Karen Brown**	Annual	12 months	1 July 2022 to 30 June 2028 (reappointed for a further 34 months from 25 August 2025)	$41,791.88	$46,807.01
Board Member	**Julian Henderson**	Annual	3 months	1 July 2016 to 30 September 2025 (extended for a further three months from 30 June 2025)	$12,376.83	$13,862.08
Board member	**Brian Mumme**	Annual	8 months	1 October 2025 to 30 June 2028 (appointed for 32 months)	$29,415.05	$32,944.94
Board member	**Colin Murphy**	Annual	12 months	9 November 2020 to 8 November 2028 (reappointed for a further 35 months from 9 November 2025)	$41,791.88	$46,807.02
Board member	**Yvonne Parnell**	Annual	3 months	1 July 2016 to 30 September 2025 (extended for a further three months in June 2025)	$12,376.83	$13,862.08
Board member	**Pearl Proud**	Annual	8 months	1 October 2025 to 30 June 2027 (appointed for 32 months)	$29,415.05	$33,113.47
Board member	**Elizabeth Soderholm**	Annual	8 months	1 October 2025 to 30 June 2027 (appointed for 32 months)	$29,415.05	$33,626.77
Board member	**Stephanie Trust**	Annual	12 months	15 July 2024 to 30 June 2026 (appointed for 23 months)	$41,791.88	$46,807.02

Appendix 2 – List of acronyms

ACP	Aluminium composite panel
AAS	Australian Accounting Standards
AASB	Australian Accounting Standards Board
AHP	Aboriginal health practitioner
AHPRA	Australian Health Practitioner Regulation Agency
AI	Artificial intelligence
AMI	Acute myocardial infarction
AoD	Alcohol and other drugs
ART	Active Recovery Team
ASAE	Assurance Engagements Standard
ASQM	Quality Management for Firms that Perform Audits
ATO	Australian Taxation Office
ATS	Australasian Triage Scale
BUC	Building Utilisation Categories
CH	Fiona Stanley Hospital–Cockburn Health
CMP	Contracted Medical Practitioners
CNS	Clinical nurse specialist
CoNeCT	Complex Needs Coordination Team
CoNeCT MHE	Complex Needs Coordination Team Mental Health Expansion
CPS	Community Physiotherapy Service
DAMA	Discharge against medical advice
DoH	Department of Health
DSU	Doctor Support Unit
ECL	Expected credit losses
ECU	Edith Cowan University
ED	Emergency department
EDI	Equity, diversity and inclusion
EMR	Electronic medical record
EN	Enrolled nurse
EOI	Expression of interest
FFS	Fee for service(s)
FH	Fremantle Hospital
FNOF	Fractured Neck of Femur
FSFH Mental Health	Fiona Stanley Fremantle Hospital Mental Health
FSFHG	Fiona Stanley Fremantle Hospitals Group
FSH	Fiona Stanley Hospital
GEKO	Governance, Evidence, Knowledge, Outcomes
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
HACC	Home and Community Care
HA SABSI	Healthcare-associated *Staphylococcus aureus* bloodstream infection
HISWA	Healthcare Infections Surveillance WA
HITH	Hospital in the Home
HSP	Health service provider
HSS	Health Support Services
ICT	Information and communications technology
ICU	Intensive Care Unit
IHI	Institute for Healthcare Improvement
KPI	Key performance indicator
LEIP	Lived Experience Integration Plan
LGBTIQA+SB	Lesbian, gay, bisexual, transgender, intersex, queer, asexual plus sistergirls and brotherboys
M&M	Mortality and morbidity
MDH	Murray District Hospital
MDM	Multidisciplinary meeting
MSA	Medical service agreement
Medihotel	FSH Fiona Stanley Hospital – M Block
MOU	Memorandum of Understanding
NDIS	National Disability Insurance Scheme
NGO	Non-government organisation (check)
NP	Nurse practitioner
NSQHSS	National Safety and Quality Health Service Standards
OAG	Office of the Auditor General
OBM	Outcome based management
OMID	Office of Major Infrastructure Development
PaRK	Peel and Rockingham Kwinana Mental Health
PBS	Pharmaceutical Benefits Scheme
PCA	Patient care assistant
PHC	Peel Health Campus
QI	Quality improvement
QuEST	Quality, Education, Safety and Training
REDS	Rural Electroencephalogram Diagnostic Service
RGH	Rockingham General Hospital
RITH	Rehabilitation in the Home
RkPG	Rockingham Peel Group
RN	Registered nurse
SABSI	*Staphylococcus aureus* bloodstream infection
SAC	Severity assessment code
SHFT	SMHS Human Factors Training
SHQ	Sexual Health Quarters
SMHS	South Metropolitan Health Service
SNA	Short notice assessment
VAD	Voluntary assisted dying
VEM	Virtual Emergency Medicine
VMI	Virginia Mason Institute
WACHS	WA Country Health Service
WAPHA	West Australian Primary Health Alliance
WAU	Weighted activity unit
WAVED	WA Virtual Emergency Department
WEAT	WA Emergency Access Target
WHS	Work health and safety
WSS	West State Superannuation

Appendix 3 – Addresses and contacts

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Produced by South Metropolitan Health Service

2026-SMHS-3000