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

EAST METROPOLITAN HEALTH SERVICE

ANNUAL REPORT 2019-20

Next page

Our pandemic response: then and now

At East Metropolitan Health Service (EMHS), our response to COVID-19 has been rapid and effective. From restructuring our hospitals to accommodate more COVID-19 beds and resources, to restricting non-essential access to our hospitals, we have taken every action to protect our staff, patients and community.

Upon reflection, our COVID-19 response has been very similar to the way hospitals responded to the first global pandemic to come to Western Australia (WA) in 1918, the Spanish Flu, which is estimated to have killed 50 million people worldwide.

Our response to COVID-19 has been in no small part informed by the innovative and pioneering response of dedicated health professionals at Royal Perth Hospital (RPH), then known as The Perth Hospital. They faced, as we do now, the uncertainty of a global pandemic, but at a time when there were no treatments available for influenza and the invention of antibiotics was still a decade away.

WA government and hospitals had to quickly learn how to treat large numbers of unwell patients and contain the outbreak, and the vital decision to convert three wards in The Perth Hospital into a quarantine hospital, as well as the addition of 20 nurses, helped to reduce the spread of the Spanish Flu in WA.

As has been done with the COVID-19 pandemic globally, the WA health services and government of 1918 also advised the community to stay home if unwell, practice social distancing and use face masks to protect against the disease.

As a result of these decisions, approximately 600 people in WA died of the Spanish Flu, a much smaller death toll than other cities around the world.

These lessons remain crucial in infection control processes to this day.

As we continue to be innovative in the way we strive for excellence in the provision of high-quality health care during COVID-19, we do so knowing that we have a long history of overcoming adversity and caring for the WA community in uncertain times.

Acknowledgment of our Aboriginal community

The voice of the Aboriginal community is reflected in EMHS 2019-20 Annual Report, to ensure that cultural appropriateness and the health impacts on Aboriginal people have been considered and incorporated.

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Statement of compliance

For year ended 30 June 2020

HONOURABLE ROGER COOK MLA
DEPUTY PREMIER; MINISTER FOR HEALTH; MENTAL HEALTH

In accordance with section 63 of the *Financial Management Act 2006*, I hereby submit for your information and presentation to Parliament, the final Annual Report of the East Metropolitan Health Service for the financial year ended 30 June 2020.

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

Ian Smith PSM

Board Chair
East Metropolitan Health Service
23 September 2020

Peter Forbes

Chair, EMHS Board Finance Committee
East Metropolitan Health Service
23 September 2020

Sandra Miller (A/Chief Executive) and Ian Smith (Board Chair)

From our Board Chair and Acting Chief Executive

On behalf of the EMHS Board and Executive, we are pleased to share with you the 2019-20 EMHS Annual Report.

This year, undoubtedly, the spotlight has been on healthcare workers worldwide, who have worked tirelessly to support the community through the coronavirus (COVID-19) pandemic.

We could not be prouder of the **8549** staff working within EMHS who were united in their objective of delivering amazing patient care in response to the rapidly changing global health crisis.

We were continually impressed by the energy and commitment of our staff who really stepped up to the plate – driving significant change and delivering service improvements to ensure that our health service was able to manage the impacts of COVID-19.

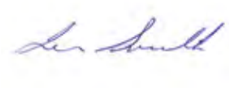
During a time when our community were feeling the pressure and uncertainty, we were keenly aware that staff working on the frontline were shouldering an additional burden. The resilience and 'can do' attitudes we witnessed amongst our teams was particularly impressive and it was wonderful to see our staff supporting each other during this challenging period. We are truly grateful to all of our staff who really went the extra yard for the greater good of our community.

Throughout this annual report, you will learn about some of the key projects and initiatives that have occurred across our health service during the past year. We have placed great emphasis on creating an environment for innovation to thrive, and this is evident through the agile and collaborative approach our teams have taken in their response to COVID-19. We look forward to continuing this positive momentum into the future and embedding lasting change across our organisation.

While the COVID-19 pandemic was certainly a unique and challenging situation, credit must also be given to the excellent work undertaken across our health service throughout the rest of the year. Our teams have maintained a keen focus on providing safe, high quality, consumer-centred care and we have been proud to launch a number of new programs, strategies and services in support of this objective.

One key area of focus during the past year was managing our hospital demand and capacity, and while COVID-19 has affected areas such as elective surgery performance, we are confident the systems and processes we have embedded across our health service will assist us to make a good recovery. We acknowledge that the cancellation of elective surgery during our COVID-19 response has had significant impact on our consumers awaiting surgery, and we are committed to doing everything we can to get back on track.

We are so proud of everything we have achieved together throughout the year and look forward to another successful year ahead. We could not have done it without the hard work and commitment of our amazing staff who continually go above and beyond to care for our community.



Ian Smith PSM
Board Chair, EMHS

Sandra Miller
A/Chief Executive, EMHS

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EXECUTIVE SUMMARY

About EMHS

EMHS comprises an extensive hospital and health service network that aims to maintain and improve the health and wellbeing of approximately 715 000 Western Australians in its catchment area.

Our hospital and health service network works together to provide a combination of tertiary, secondary and specialist health care services including emergency and critical care, state trauma, elective and emergency surgery, general medical, mental health, inpatient and outpatient services, aged care, palliative care, rehabilitation, and women's, children's and neonates' services.

EMHS also provides a range of community services to people both within our catchment and in the wider metropolitan area including Aboriginal health, rehabilitation, health promotion and public health services.

Our catchment area population

It is estimated that EMHS catchment area population consists of:

50% Male

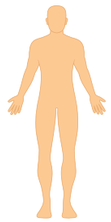
50% Female

96 935 (14%) Children < 10 years of age

94 582 (13%) Adults ≥ 65 years of age

20 563 (3%) Aboriginal community

32% Born overseas



2019-20 hospitalisations

8316 Mental health

1326 Diabetes

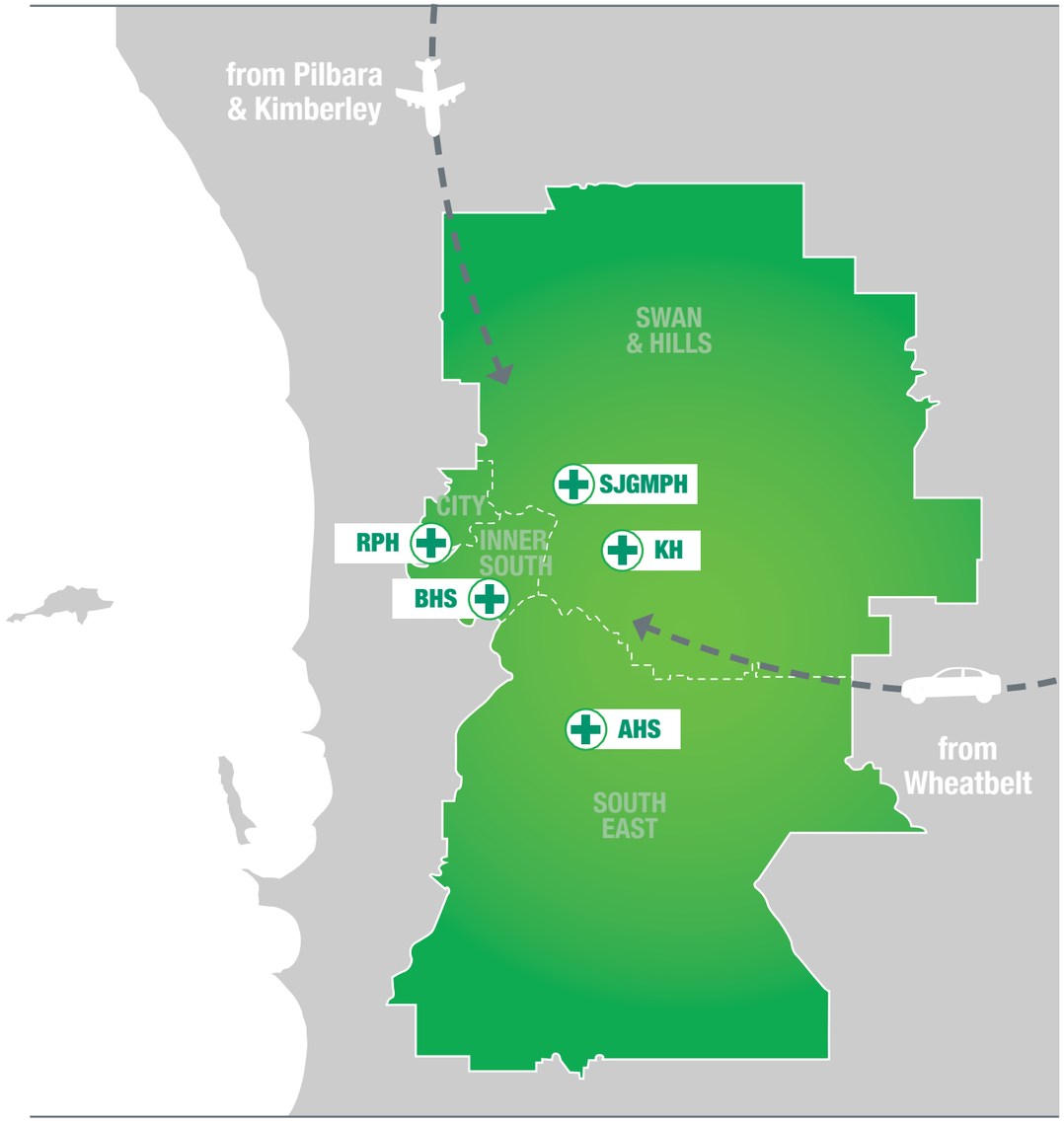
8441 Heart disease

8544 Lung disease

Childhood immunisation

93%

Children ≥ 12 months and ≤ five years were appropriately vaccinated for their age



AHS	ARMADALE HEALTH SERVICE
BHS	BENTLEY HEALTH SERVICE
KH	KALAMUNDA HOSPITAL
RPH	ROYAL PERTH HOSPITAL
SJGMPH	ST JOHN OF GOD MIDLAND PUBLIC HOSPITAL

EMHS also serves residents living in regional WA if they require more complex care, or if they are visiting Perth. These patients also have access to telehealth services, allowing them to receive amazing care from the comfort of their own home or local hospital.

Our health service

Our hospital and health service network works together to provide a combination of tertiary, secondary, specialist and community health care services.

Armadale Kalamunda Group (AKG) incorporates Armadale Health Service (AHS) and Kalamunda Hospital (KH).

Armadale Health Service

AHS is a general hospital that delivers a range of health care services including emergency, mental health, maternity and intensive care services.

Kalamunda Hospital

KH is a small hospital based in Perth's hills, providing specialist palliative care and endoscopy services.

Royal Perth Bentley Group (RPBG) incorporates Royal Perth Hospital (RPH) and Bentley Health Service (BHS).

Royal Perth Hospital

RPH is an inner-city tertiary hospital, providing an extensive range of services, including adult major trauma, emergency and highly specialised surgical services.

Bentley Health Service

BHS is a specialist hospital, with services including rehabilitation, elective and same-day surgery, aged care and mental health.

EMHS manages a public private partnership (PPP) with St John of God Health Care (SJGHC).

St John of God Midland Public Hospital (SJGMPH)

SJGMPH is a 307 bed public hospital, providing a wide range of services to the Swan and Hills community, including emergency and intensive care services.

St John of God Mount Lawley

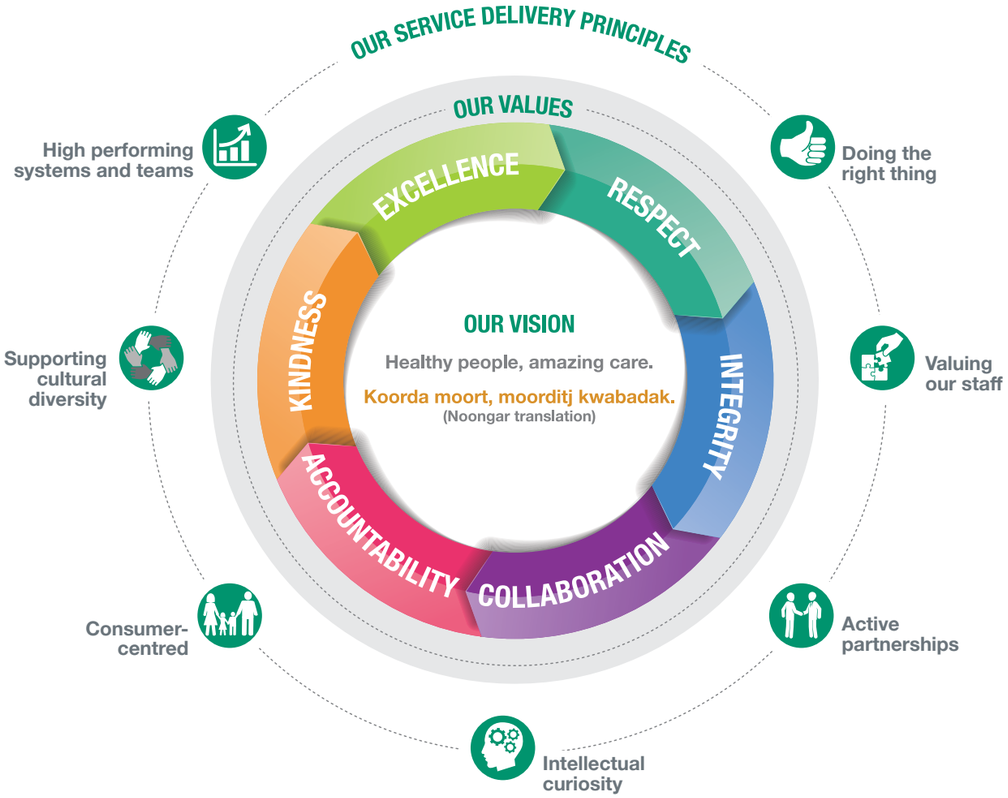
Through St John of God Mount Lawley, EMHS also provides assessment and restorative services for public patients.

Our strategic intent

EMHS strategic intent outlines a basis for which excellent healthcare will be delivered to our community. Our vision, values and service delivery principles are aligned with the overall WA health system goal for the **delivery of safe, quality, financially sustainable and accountable healthcare for all Western Australians** and the whole of Government goal of **strong communities, safe communities and supported families.**

Our **values** reflect the qualities that we demonstrate to each other and our community. Our staff make a difference every day to the patients, families and consumers they provide care, advice and support to. The EMHS values capture the shared responsibilities that we uphold.

Our **service delivery principles** guide the way our health service performs, with a strong focus on establishing EMHS as a sustainable, forward thinking organisation.



Our operational plan

In 2017, we launched our EMHS Operational Plan 2017-20, which was developed to establish areas of focus aligned to our service delivery principles; identify tasks to achieve each area of focus; and define outcomes to measure progress. As we come to the end of this inaugural plan, we are proud to have achieved a range of outcomes.

High performing systems and teams

- ✓ Implemented strict budgeting processes to maintain a balanced budget and ensure a sustainable financial future.
- ✓ Developed an EMHS performance development system (Peak Performance) for staff at all levels.
- ✓ Enhanced programs which outline value-based health care and ensure a culture of clear expectations, such as Choosing Wisely and Five Goals of Patient Care.
- ✓ Undertook robust infrastructure planning to ensure efficient management of our physical resources.

Supporting cultural diversity

- ✓ Developed a partnership protocol between EMHS and WA Primary Health Alliance (WAPHA) to facilitate joint planning, priority setting and commissioning of integrated care to enhance health outcomes for our community.
- ✓ Developed tools to improve communication with our culturally diverse population groups.
- ✓ Engaged with Aboriginal consumers, to ensure that delivery of care is culturally appropriate.
- ✓ Increased Aboriginal employment to **106** staff and embraced a culturally diverse workforce.

Valuing our staff

- ✓ Used staff feedback from Your Voice in Health surveys to improve staff satisfaction and morale.
- ✓ Implemented strategies to address aggression and violence, with increased communication of consistent messaging for both patients and staff.
- ✓ Invested in the safety and wellbeing of all staff.

Intellectual curiosity

- ✓ Launched the EMHS Research Strategy in 2019, to ensure our future in research and translation into practice.
- ✓ Continued to invest in research and innovation.
- ✓ Strengthened relationships with universities and other education providers through student placement opportunities and learning partnerships.
- ✓ Progressed the EMHS Digital Strategy, Smart EMHS: a pathway for how our organisation will harness digital technology to improve the care we provide to our community.

Doing the right thing

- ✓ Allocated resources to provide appropriate care where it is needed most, including establishing an EMHS Youth Mental Health Unit (EMyU).
- ✓ Implemented recommendations from safety and quality and service priority reviews and ensured ongoing compliance with standards and legislation.
- ✓ Invested in upgrades to our infrastructure, including AHS lift upgrades, roof upgrades at KH and ongoing progress of plans for a new helipad at RPH.

Active partnerships

- ✓ Advanced WA Government election commitments, including opening an Urgent Care Clinic and Mental Health Emergency Centre (MHEC) at RPH.
- ✓ Established a wellbeing program for junior doctors and nurses, to support the transition from student/ novice to graduate entry positions.

Consumer-centred

- ✓ Improved patient feedback mechanisms and used feedback to enable changes to practice and process.
- ✓ Used data and outcomes to measure consumer satisfaction.

2019-20 at a glance - our services

In our community

14
Population health projects

Oldest patient
108 years

8
Aboriginal health community programs

240 483
Occasions of service for community mental health services
25 995 clients

1576
Patients experiencing homelessness

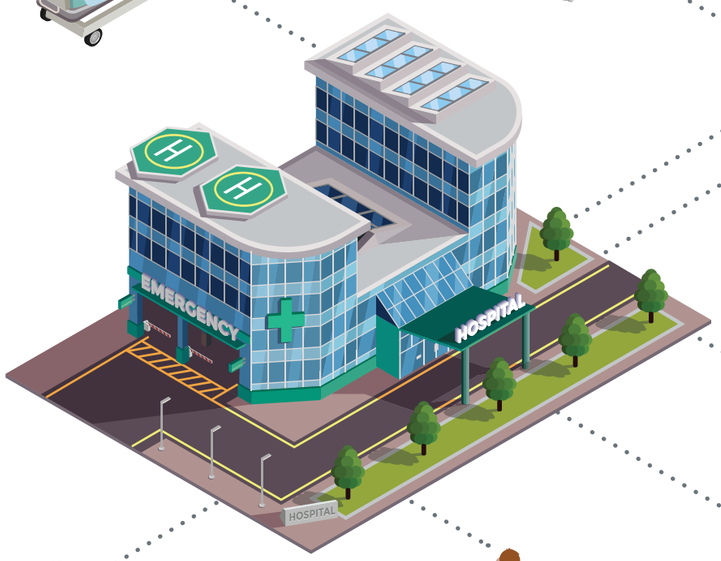
564 999
Outpatients

In our hospitals

5.07 days
Average Length of Stay (ALoS)
ALoS by age range
- 0-19 years .....3.31 days
- 20-39 years ...3.95 days
- 40-59 years ...4.73 days
- 60-79 years ...5.75 days
- 80+ years.....6.74 days

50 974
Operations
- 1044 caesareans
- 12 993 unplanned
- 36 937 planned

204 989
Emergency presentations
- 557 daily average
- 60 708 admissions from emergency presentations



52 223
Arrivals by ambulance

813
Arrivals by air
- 289 by helicopter
- 524 by Royal Flying Doctor Service

166 291
Inpatients
Top five admissions
- 39 426 for haemodialysis
- 6274 for colonoscopy
- 5734 for endoscopy
- 5591 for chemotherapy
- 4696 for childbirth

4727
Births
- 2365 male
- 2362 female
- 39 multiple births
- average age of mother was 29.4 years
- ALoS for caesareans was 3.08 days
- ALoS for vaginal births was 2.08 days

2019-20 at a glance - our finances

Total cost of services (expense limit)

Sourced from Statement of Comprehensive Income

2019-20 target $000
1,574,892

2019-20 actual $000
1,602,586

Variation $000
27,694[1]

Net cost of services

Sourced from Statement of Comprehensive Income

2019-20 target $000
788,081

2019-20 actual $000
817,744

Variation $000
29,663[2]

Total equity

Sourced from Statement of Financial Position

2019-20 target $000
1,321,782

2019-20 actual $000
1,299,624

Variation $000
22,158[3]

Net increase in cash held

Sourced from Statement of Cash Flow

2019-20 target $000
-279

2019-20 actual $000
23,685

Variation $000
23,964[4]

Approved salary expense level

Sourced from Statement of Comprehensive Income

2019-20 target $000
838,449

2019-20 actual $000
874,721

Variation $000
36,272[5]

Commentary on variation to target

[1] Subsequent to the completion of the estimates, EMHS received a budget increase of $24 million via a Service Agreement Deed of Amendment. This has resulted in an actual total cost of services variance of about $3 million and is due to cost pressures associated with the COVID-19 clinics, call centre, quarantine hotels and additional staff employed for COVID-19 planning and preparedness. The additional salary expenses associated with COVID-19 were partially offset by a reduction in non-salary expenditure due to reduced Emergency Department (ED) presentations, inpatient admissions and the scaling back of elective surgery.

[2] In addition to the $24 million budget increase (mentioned above), the total National Health Reform Agreement funding expected per the estimates was not received in full and the difference was offset by service appropriation funding (therefore not included in the net cost of services).

[3] The main variation is due to a lower capital drawdown from capital appropriation compared to the estimates. EMHS will drawdown more capital appropriation in future months as these works progress.

[4] The increase in cash held is as a result of increased service appropriation funding. This cash increase will be used to pay accrued creditors (timing difference at the reporting date) and increased leave liabilities due to reduced leave taken as a result of increased activity for COVID-19 planning and preparedness.

[5] EMHS received a salary expense budget increase of $17 million via a Service Agreement Deed of Amendment, reducing this variance to $19 million. This is mainly associated with cost pressures predominantly associated with COVID-19 clinics, call centre, quarantine hotels and additional staff employed for COVID-19 planning and preparedness.

See page 145 for full financial statements.

Rochelle Bradley, EMHS Director of Finance and Hendra Wijaya, Statutory Reporting, Corporate Finance

2019-20 at a glance - our performance

Key Performance Indicators (KPIs) and KPI targets (determined by the Department of Health (DoH)) assist EMHS to assess and monitor achievement of the outcomes outlined in the Outcome Based Management (OBM) framework (see page 115).

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

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

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

Effectiveness KPI	2019-20 target	2019-20 actual
Unplanned hospital readmissions for patients within 28 days for selected surgical procedures (per 1000 separations)		
a) Knee replacement	≤ 26.2	28.3
b) Hip replacement	≤ 17.1	15.0
c) Tonsillectomy & adenoidectomy	≤ 61.0	120.0
d) Hysterectomy	≤ 41.3	33.9
e) Prostatectomy	≤ 38.8	14.9
f) Cataract surgery	≤ 1.1	3.0
g) Appendicectomy	≤ 25.7	28.7
Percentage of elective wait list patients waiting over boundary for reportable procedures		
a) Category 1 over 30 days	0%	27.0%
b) Category 2 over 90 days	0%	18.9%
c) Category 3 over 365 days	0%	3.3%
Healthcare-associated staphylococcus aureus bloodstream infections (HA-SABSI) per 10 000 occupied bed-days	≤ 1.0	0.9
Survival rates for sentinel conditions - stroke		
a) 0-49 years	≥ 94.4%	93.4%
b) 50-59 years	≥ 93.4%	95.6%
c) 60-69 years	≥ 93.5%	96.5%
d) 70-79 years	≥ 91.3%	95.9%
e) 80+ years	≥ 83.2%	93.2%
Survival rates for sentinel conditions – acute myocardial infarction (AMI)		
a) 0-49 years	≥ 99.0%	100%
b) 50-59 years	≥ 98.9%	98.7%
c) 60-69 years	≥ 98.0%	98.6%
d) 70-79 years	≥ 96.5%	97.4%
e) 80+ years	≥ 92.2%	94.8%
Survival rates for sentinel conditions – fractured neck of femur (FNoF)		
a) 70-79 years	≥ 98.9%	100%
b) 80+ years	≥ 96.1%	98.5%

Effectiveness KPI	2019-20 target	2019-20 actual
Percentage of admitted patients who discharged against medical advice		
a) Aboriginal patients	≤ 0.77%	7.10%
b) Non-Aboriginal patients	≤ 0.77%	1.32%
Percentage of live-born term infants with an Apgar score of less than seven at five minutes post delivery	≤ 1.8%	1.29%
Readmissions to acute specialised mental health inpatient services within 28 days of discharge	≤ 12%	15.7%
Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services	≥ 75%	85.5%

Efficiency KPI	2019-20 target	2019-20 actual
Average admitted cost per weighted activity unit	$7026	$6722
Average Emergency Department cost per weighted activity unit	$7071	$7251
Average non-admitted cost per weighted activity unit	$6992	$7789
Average cost per bed-day in specialised mental health inpatient services	$1492	$1746
Average cost per treatment day of non-admitted care provided by mental health services	$420	$396

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

Efficiency KPI	2019-20 target	2019-20 actual
Average cost per person of delivering population health programs by population health units	$17	$13

Data key

Desired result

Undesired result

ORGANISATIONAL STRUCTURE

Our governance

Enabling legislation

The *Health Services Act 2016 WA (HSA 2016)* introduced changes to the governance of the Western Australian health system by clarifying roles, responsibilities and accountabilities and by devolving decision making to the local level.

Section 32 of the *HSA 2016* provides for the establishment of Health Service Providers (HSPs). EMHS was established as an HSP by the Minister for Health under section 32(1)(b) of the *HSA 2016* on 1 July 2016.

Section 70(1)(b) of the *HSA 2016* stipulates that the Board is the governing body of the statutory authority and is to perform or exercise all of the functions of EMHS under this Act or any other written law.

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

Responsible Minister

EMHS is responsible to the Deputy Premier; Minister for Health; Mental Health, the Honourable Roger Cook MLA.

Accountable authority

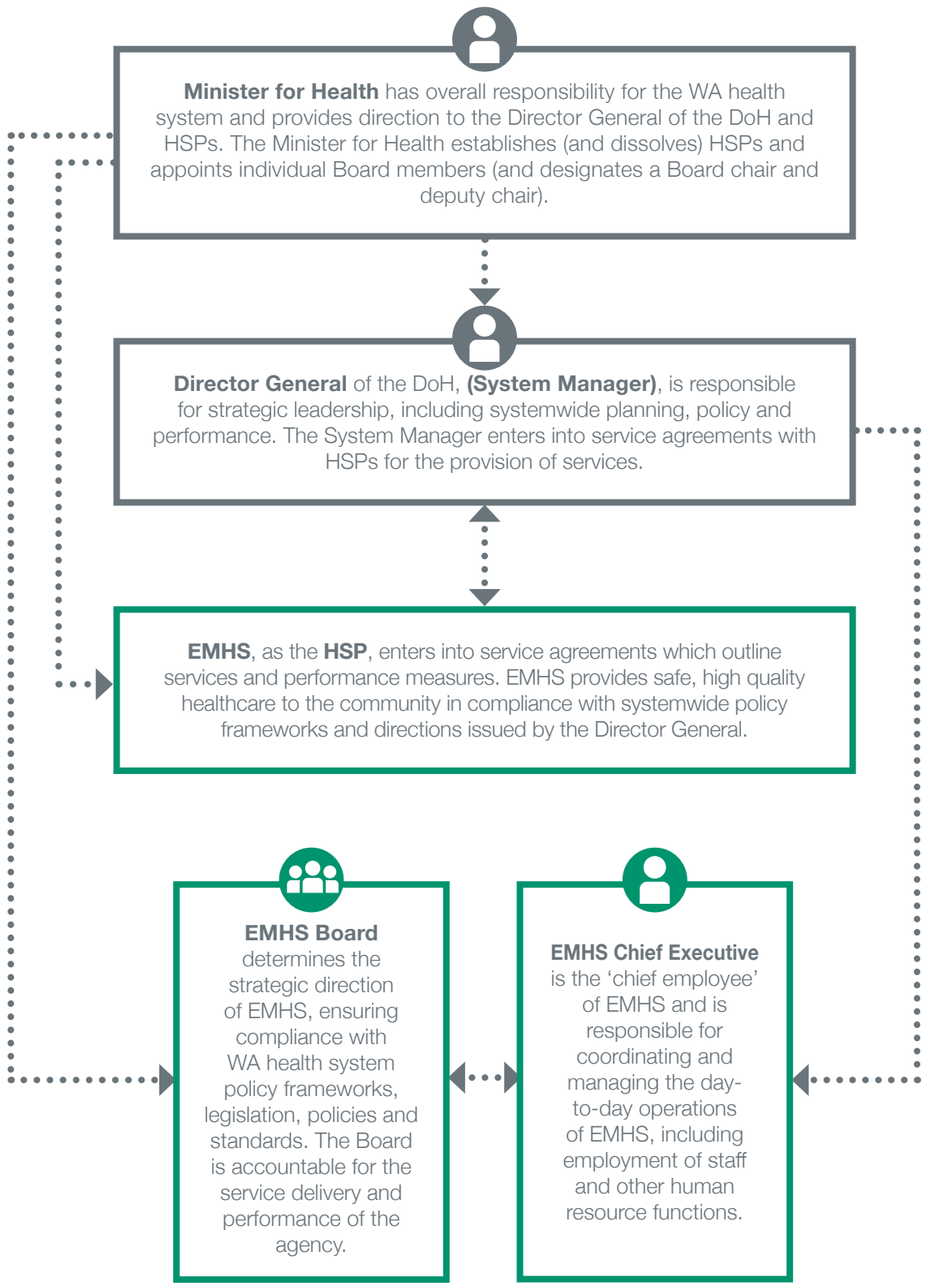
EMHS is a board governed statutory authority, where the EMHS Board is directly accountable to the public through the Minister for Health and works with the Director General of WA DoH.

The EMHS Chief Executive (CE) is employed by the Director General as the 'chief employee' of the HSP and is accountable to the Board.

Shared responsibilities with other agencies

EMHS works closely with the System Manager, other HSPs and a large number of Government and non-Government agencies to deliver programs and services to achieve better health outcomes for the community of the eastern metropolitan region.

WA Health governance structure, roles and responsibilities



Our links to government goals and outcomes

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

Outcome based management framework

EMHS reports performance against outcomes one and two, which encompass continuum of care across hospital (activity based funded) and community based settings and reflects WA Health's strategic intent.

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

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

Outcomes	Services	Effectiveness KPIs
Outcome one: **Public hospital based services that enable effective treatment and restorative health care for Western Australians**		Unplanned hospital readmissions for patients within 28 days for selected surgical procedures (per 1000 separations)
		Percentage of elective wait list patients waiting over boundary for reportable procedures
		Healthcare-associated staphylococcus aureus bloodstream infections (HA-SABSI) per 10 000 occupied bed-days
		Survival rates for sentinel conditions (stroke, acute myocardial infarction, fractured neck of femur)
		Percentage of admitted patients who discharged against medical advice
		Percentage of live-born term infants with an Apgar score of less than seven at five minutes post delivery
		Readmissions to acute specialised mental health inpatient services within 28 days of discharge
		Percentage of post discharge community care within seven days following discharge from acute specialised mental health inpatient services
		Efficiency KPIs
	1 Public hospital admitted services	Average admitted cost per weighted activity unit
	2 Public hospital emergency services	Average Emergency Department cost per weighted activity unit
	3 Public hospital non-admitted services	Average non-admitted cost per weighted activity unit
	4 Mental health services	Average cost per bed-day in specialised mental health inpatient services
		Average cost per treatment day of non-admitted care provided by mental health services
Outcome two: **Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives**	6 Public and community health services	Average cost per person of delivering population health programs by population health units

Please see page 115 for details on EMHS performance against these KPIs.

Click for further information on the OBM framework

EMHS Board

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

Click for further information about the EMHS Board

Our Board's focus this year

Throughout 2019-20, the EMHS Board continued to maintain a strong focus on the EMHS values of accountability and collaboration through a range of events held with EMHS staff, stakeholders and members of the public. The Board hosted a public consultation event in Armadale in late 2019 with consumers, advocates and community group representatives, in addition to multiple staff forums across EMHS sites.

The Board participated in a workshop on Leading a Contemporary Safety and Quality System, which explored the contemporary whole-of-system approach to safety and quality; the role of improvement science in improving safety; the role of clinical incident management in a contemporary safety and quality system and how culture and leadership can foster a robust clinical incident management system.

The Board also reviewed and approved a number of strategic documents for the health service including an Innovation Hub Plan; the Digital Infrastructure Enablement Wifi and Network Project; the Health Care of the Older Adult Service Model; a procurement plan to establish the EMHS Health in a Virtual Environment (HIVE); the Aboriginal Health and Wellbeing Framework and a Clinical Governance Framework.

Members of the Board continued leader rounding across EMHS sites, providing an opportunity for staff and patients to provide feedback, which helped inform the Board's decision-making processes.

Leader rounding at Royal Perth Hospital

EMHS board meeting via video conference, March 2020

	EMHS Board meeting	EMHS Board Audit and Risk Committee	EMHS Board Finance Committee	EMHS Board Planning and Performance Committee	EMHS Board Safety and Quality Committee
Number of meetings	11	5	10	5	10
Board member	**Attendance**				
Ian Smith (Board Chair)	9	n/a	6	n/a	8
Suzie May (Deputy Chair)	9	n/a	n/a	3	n/a
Richard Guit	9	3	n/a	n/a	n/a
Debra Zanella	10	5	7	n/a	n/a
Kingsley Faulkner	11	n/a	n/a	5	10
Ross Keesing	10	n/a	8	4	n/a
Amanda Gadsdon	10	3	n/a	n/a	n/a
Denise Glennon	10	n/a	n/a	3	9
Laura Colvin	10	n/a	n/a	n/a	8
Peter Forbes	11	4	9	n/a	n/a

n/a = attendance not required

EMHS Area Executive Group

Liz MacLeod
EMHS Chief Executive (CE)

As EMHS CE, Liz leads a team of more than 8500 staff to deliver amazing care for the community. Liz has more than 20 years management experience in the health sector, including as the former Executive Director, Commissioning Fiona Stanley Hospital (FSH), and played an integral role in the establishment of EMHS. Liz was pivotal in WA's response to COVID-19 as the CE for COVID-19 Health Operations, where she led the coordination and oversight of activities carried out by WA's healthcare providers in response to the public health emergency. Liz is passionate about the delivery of safe, high quality, consumer-centred care, financial performance and sustainability.

EMHS would also like to acknowledge Maha Rajagopal, who served as Area Director of Nursing until 3 February 2020.

Philip Aylward BBus FCHSM
Executive Director Corporate Services and Contract Management

Philip has a wealth of senior management and leadership experience across WA Health. He is a Fellow of the Australasian College of Health Service Management and currently leads the Corporate Services and Contract Management functions for EMHS, which incorporates Data and Digital Innovation, Health Technology Management Unit, Clinical Coding, Procurement and Contract Management, Security and General Services.

Dr Lesley Bennett MBChB MD FRCP FRACP
Executive Director RPBG

Lesley has worked within RPBG since 2013 in a variety of senior roles including Service 1 Co-Director, Medical Co-Director Safety and Organisational Learning, and Director of Clinical Services. Prior to this, Lesley held leadership roles in the United Kingdom. Specialising in respiratory medicine, Lesley has been published in a number of international medical journals. In her current role, Lesley oversees RPH, BHS and several community mental health services.

Steve Gregory
Area Director of Workforce

Steve has over 25 years' experience working in Human Resources (HR) and Industrial Relations (IR) related roles in the public health sector, including as Director HR North Metropolitan Health Service (NMHS), and Director HR South Metropolitan Health Service (SMHS) where he led the workforce program for the commissioning of FSH. As the Workforce lead for EMHS, Steve has oversight of HR, IR, Work Health and Safety, and Learning and Development (Area Wide), in addition to Integrity and Ethics.

Anne-Marie Presho BA(Hon) MBA
Director Office of CE

After spending more than ten years working in the National Health Service in England, Anne-Marie Presho moved to WA in 2006 and worked in a number of corporate roles across NMHS and SMHS prior to her appointment as Director of the Office of the CE at EMHS. Anne-Marie has broad business experience with oversight of corporate governance, strategic management, project management and finance.

Graeme Jones BBus Dip Management FCPA
Executive Director Finance and Infrastructure; Chief Finance Officer

Graeme Jones was appointed to the role of Executive Director Finance and Infrastructure at EMHS following a restructure of the Corporate Services portfolio in January 2018. Prior to this role, Graeme was the inaugural Chief Finance Officer for EMHS. Graeme has held a number of senior leadership roles, including as the Group Director of Finance, WA Health; and with the WA Education Department and TAFEWA.

Sandra Miller BHSc (MRA) PGDip (Epi & Biostats)
Executive Director Safety, Quality and Consumer Engagement
A/Deputy CE 4 March 2020 to 19 April 2020; A/CE from 20 April 2020

Sandra was appointed to her current role at EMHS in October 2016, after working within the NMHS and Sir Charles Gairdner Hospital (SCGH) Executive teams and leading the establishment of the Safety and Quality Units at SCGH and FSH. In her EMHS role, Sandra has oversight of the governance programs for patient safety and quality, consumer engagement, risk management and internal audit. During the COVID-19 response, Sandra acted in the roles of Deputy CE and EMHS CE.

Joel Gurr BSc (Pod) MBA GAICD
Executive Director Clinical Service Strategy and Population Health

Joel provides leadership in Clinical Planning, Innovation and Commissioning, Aboriginal Health Strategy, and Community and Population Health. Joel's clinical background is as a podiatrist and was RPH Head of Department, Podiatry from 2006-10. He is published nationally and internationally in peer reviewed journals, specialising in diabetic foot complications. Joel has extensive experience in senior strategic leadership and operational roles, including with the DoH and SMHS.

Diane Barr
Executive Director AKG

As Executive Director of AKG, Di is responsible for the delivery of a range of general hospital, mental health and community services. Di has held a number of strategic and operational roles within WA's health sector, both in public and private hospitals. Before commencing her role at AKG, Di was Director of Clinical Services at Peel Health Campus. Di is a Fellow with the Australasian College of Health Service Management and with her keen interest and commitment to safety and quality, is a surveyor with the Australian Council on Healthcare Standards (ACHS).

Professor Grant Waterer MBBS PhD MBA FRACP FCCP
Area Director of Clinical Services

Grant is responsible for overseeing the strategic direction of medical care within EMHS hospitals. He is also a Respiratory Physician at RPH, Professor of Medicine at the University of WA, Adjunct Professor of Medicine at Curtin and Edith Cowan Universities (WA), and Adjunct Professor of Medicine at Northwestern University, Chicago. Grant also co-chairs the Community-acquired Pneumonia Statement Group for the American Thoracic Society and Infectious Diseases Society of America.

Doris Lombardi BAPPSc (Nursing)
Area Director of Nursing and Midwifery

Doris has had considerable leadership experience as a former Co-Director and Director of Operations at RPH and is passionate about creating a culture of care and compassion with an unwavering patient focus. Doris provides strategic direction for the largest cohort of staff within EMHS and has implemented programs such as Amazing Nursing and Midwifery Care.

Assoc. Professor John Buchanan
Area Director of Allied Health and Health Sciences

John is a Physiotherapist who has spent many years in a range of leadership roles at RPH and within both the State and National offices of the Australian Physiotherapy Association, including National Vice President. John has held long-term memberships of both Notre Dame and Curtin University's External Advisory Board (Physiotherapy) and lectured on under and postgraduate programs. John is also an active researcher and has led a number of reform projects across clinical services to achieve more efficient models of care and better safety and quality outcomes.

OUR SIGNIFICANT ISSUES

COVID-19

The COVID-19 pandemic is a significant challenge for health care services across the globe. In a rapidly evolving situation, it was critical that EMHS was able to quickly mobilise, adjust and implement initiatives efficiently and effectively for our community.

In an outstanding demonstration of the EMHS value of collaboration, staff across all EMHS sites and services worked together to meet this challenge.

We thank all EMHS staff for their efforts in continuing to deliver care for our community, whilst also establishing new services and processes; using technology to innovate and responding to a constantly changing environment.

COVID clinics and staff call centre

Key to the fight against COVID-19 was establishing COVID testing clinics and call centres for our community. In an amazing feat, our teams planned, established, educated, staffed and opened the RPH COVID Clinic within a week. The clinic included medical, nursing, clerical and support staff to provide the clinic services, and all staff received detailed training in infection prevention and personal protective equipment (PPE) for managing COVID-19 testing. On its first day, **206** people attended the clinic for screening.

The AHS and SJGMPH COVID clinics were established shortly after and in equally tight timeframes. Establishing a clinic in these regions was vital for ensuring those in the outer suburbs were able to receive testing without needing to travel to a tertiary hospital.

EMHS also led the development of a system-wide pathway to manage the screening and testing of WA Health staff. A dedicated WA Health Staff COVID-19 Call Centre was launched on 19 March 2020 to provide up-to-date COVID-19 information. The call centre, based at RPH, is staffed by nursing and clerical teams.

Royal Perth Hospital

Armadale Health Service

St John of God Midland Public Hospital

Testing at EMHS COVID clinics

22 432
Total tests

1002
Travellers tested

1853
WA Health staff tested at EMHS

502
Most tested in a day

114
Tested positive

20 235
SMS sent

30-39 yrs
Age range with highest volume of tests

Assessment form

Core to the COVID-19 testing process was having an advanced digital patient assessment form that could be adapted depending on the patient being treated and be updated when testing criteria was changed. The EMHS Data and Digital Innovation (DDI) team quickly mobilised to develop a smart assessment form, which is used by all WA hospitals conducting testing, including hospitals operated under PPPs.

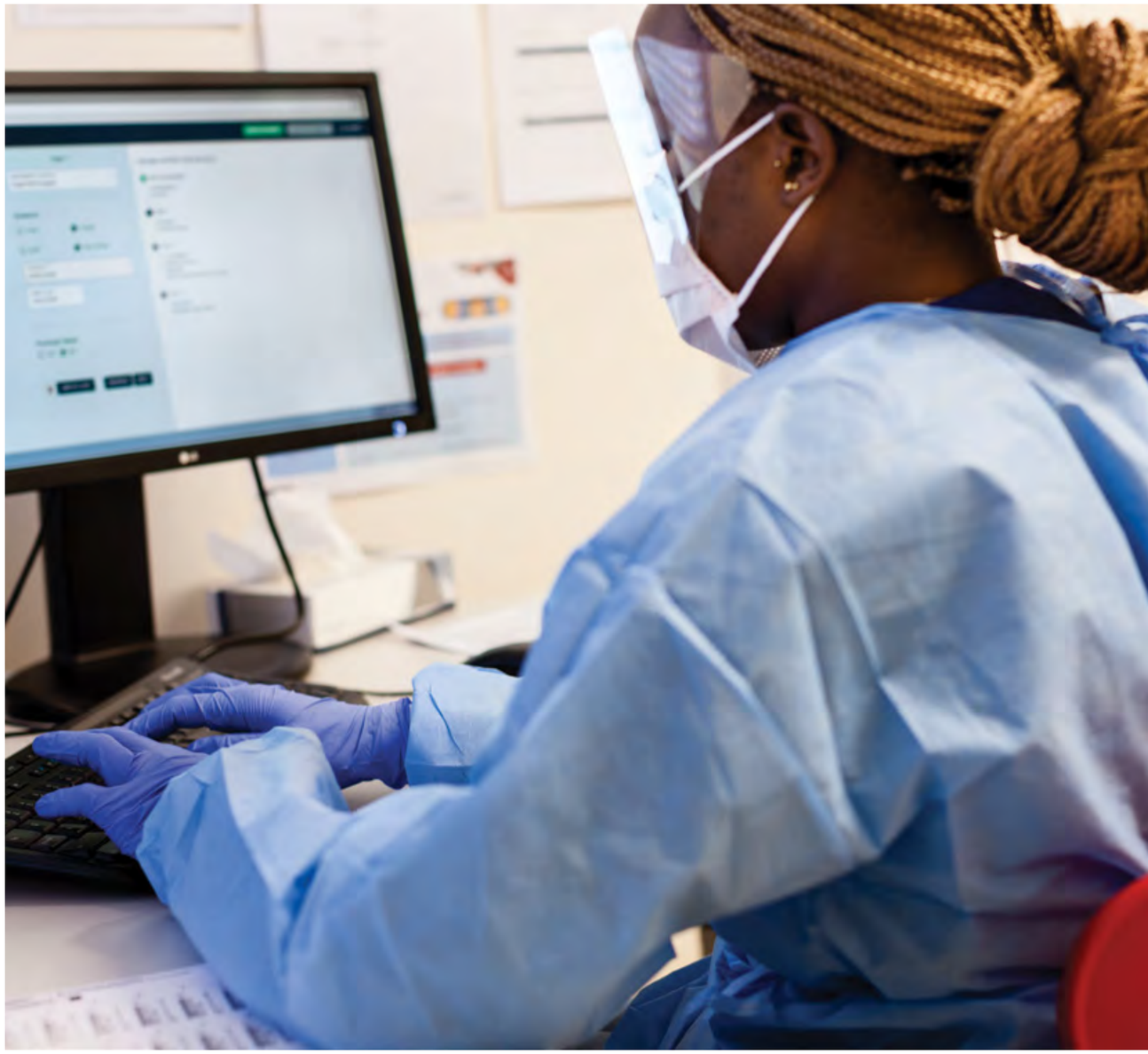
The form was integral in tracking the results from the DETECT Program, which provided COVID-19 testing to school students and asymptomatic staff working in a number of professional groups, including health care workers. This form is also used when testing those arriving in WA on international flights and being quarantined in hotels.

This form is vital in protecting Western Australians by centralising the State's testing information within one platform and providing an easy access point with real-time data for decision-making, contact tracing and mapping. As at 30 June 2020, **72 448** assessment forms were submitted within WA.

Patient SMS and call centre

DDI delivered a number of digital initiatives to support the State's effort in responding to the COVID-19 pandemic, including a SMS system that automatically notifies patients of a negative COVID-19 test result. This is the first time such a system has been utilised in WA Health. As at 30 June 2020, **81 600** SMS had been sent.

To support the COVID clinics across the WA health system, EMHS established a state-wide patient call centre based at RPH, providing patients who received COVID-19 testing with a contact for a progress update on their test results. This was a vital service during the peak testing period, as results were often delayed due the high volume. As at 30 June 2020, the patient call centre had taken **3768** calls.



Dashboards

Underpinning all the initiatives that DDI implemented during the COVID-19 response has been the development of real-time operational dashboards to monitor hospital operations and provide oversight of the response. At any time, decision-makers can tap into and query data to find COVID-19 information in relation to the WA Health response. This includes the identification of suspect and confirmed cases of COVID-19, how many COVID-19 patients are currently within WA hospitals and where they are located and results of assessment and testing, as well as providing a user-friendly interface for all data collected from the assessment form.

Emergency Operations Centre

To guide the organisation through the response and recovery phases of COVID-19, an EMHS Emergency Operations Centre was established, with executive leaders coming together to coordinate EMHS's response to COVID-19. Site-based incident management teams at RPBG, AKG and SJGMPH coordinate hospital-based responses to COVID-19.

"While a face shield might seem like a simple device, the team did a lot of hard work to come up with a design that could be manufactured locally in large quantities to a high standard"

CITRA – PPE face shields

The EMHS Centre for Implant Technology and Retrieval Analysis (CITRA) produced **10 000** face shields to help protect medical staff across WA during the COVID-19 emergency. The face shields where developed in record time by CITRA's biomedical engineers, Dr David Morrison, Dr Alan Kop, Mr Ryan Collier, Dr Moreica Pabbruwe and Dr Anastasia Nilasaroya, in collaboration with industry partners.

CITRA oversaw the production of two types of face shields at a Malaga based production company – a standard shield to be used by general hospital staff as well as a more specialised design for ear, nose and throat surgeons.

CITRA has a long history of medical device design, manufacture and regulation, and has a world-renowned team of experts who were best-placed to lead this project.

"Our team, along with the rest of EMHS, could see the devastating impact COVID-19 was having in countries where the virus was already prevalent," said Dr Morrison.

"We wanted to make sure that healthcare workers at EMHS and throughout WA could have access to the PPE they required."

Designing a high-quality face shield that meets the requirements for COVID-19 PPE was a challenge, one that required collaboration between CITRA, the Harry Perkins Institute of Medical Research (Perkins) and the University of Western Australia (UWA).

"While a face shield might seem like a simple device, the team did a lot of hard work to come up with a design that could be manufactured locally in large quantities to a high standard," said Dr Morrison.

"We worked closely with our partners from Perkins and UWA, along with our industry partners to achieve this outcome."

"There were challenges securing reliable supplies of the components which make up the face shields as these were now in high demand."

"Achieving certification from the Therapeutic Goods Administration was also a significant challenge and it is a credit to the team that we could achieve this in a very short amount of time."

This project is an example of the innovative work taking place at EMHS and made a vital contribution to the collective effort to minimise the impact of COVID-19 on the WA community.

The team at CITRA have been approached by numerous people to make PPE and other medical devices in response to the COVID-19 emergency. These requests and ideas come from a range of people from doctors, to industry groups and other scientists/engineers working outside of health.

Working closely with WA's Chief Scientist Dr Peter Klinken, who is assisting to coordinate the industry response to COVID-19, CITRA will continue to use their world class expertise in medical device design and manufacturing to help the WA community.

Dr David Morrison and Dr Alan Kop, EMHS CITRA

Education and training

Simulation scenario at Royal Perth Hospital

The COVID-19 pandemic required new processes to be implemented in a short period of time, posing significant challenges for our healthcare workers. This required prompt implementation of education and training for staff to manage the different challenges.

RPH's development of ward-based simulation training scenarios for COVID-19 patients provided practical elements to learning and test changes in processes.

Daily ward-based simulations involved multidisciplinary teams of medical, nursing and allied health staff practicing how to appropriately manage COVID-19 patients requiring the Medical Emergency Team (MET). More than **250** clinicians participated in the training, who would then embed the processes within their departments. Early simulations identified issues in processes related to communication, equipment and team structure. Rapid prototyping and testing of new solutions quickly improved processes, such as:

- a COVID-19 MET trolley with pre-prepared emergency packs with equipment and instructions which went through multiple iterations;
- laminated paper and whiteboard markers for scribing messages to communicate quickly with other clinical staff outside the room, which was more effective than using iPads;
- optimising the team structure by experimenting with different structures (e.g. one nurse with two doctors was more efficient than two nurses with one doctor).

At AKG, a comprehensive training and education program was delivered by the education and professional development/staff development team. Education was developed incorporating staff feedback and needs, resulting in unique and tailored opportunities to train, refresh and upskill, such as:

- over **50** multidisciplinary immersive COVID-19 simulation events;
- immersive in-situ simulation programs focussing on obstetrics, neonates and paediatrics;
- dedicated program offering opportunities for after-hours and night staff (self-care, MET and deteriorating patient simulations) supported by roaming education and training.

Additional education included the development of videos to help staff manage both patients and themselves during COVID-19. These videos included how to apply PPE when managing a COVID-19 patient, managing personal mental health and wellbeing, and regular updates from members of the EMHS Executive. The production of videos worked hand-in-hand with the rapid rollout of EMHS's Learning Management System (LMS), which provided a centralised and easily accessible platform for all staff to view and complete necessary COVID-19 training.

Ageing infrastructure

Across EMHS hospital sites the ageing infrastructure, plant and equipment require an increasing amount of support from the Facilities Management and Infrastructure Department to maintain, repair and update the facilities so they can meet modern clinical requirements and support hospital operations.

Strategic Asset Management Plan

In December 2018, EMHS's first Strategic Asset Management Plan (SAP) was submitted to the DoH and the Minister for Health as part of the 2019-20 budget process. The SAP provided an outline of EMHS's infrastructure and facilities challenges and the long-term capital investment requirements for each site over the next ten years.

RPH

Established in 1855, RPH is the oldest public hospital in WA. For more than 160 years, the campus has gradually expanded, with many of the original buildings still in use as operational clinical facilities today. Many of these facilities require significant investment to ensure ongoing compliance with applicable facility guidelines.

BHS

The original hospital building on the BHS site was constructed in 1966, with additional buildings added over the proceeding decades. Whilst there have been some areas of refurbishment and expansion over the past 50 years, the majority of the hospital remains in its original condition. To meet the current and future service demand and community expectations, investment is required to upgrade facilities for mental health, elective surgery and rehabilitation. There is currently a major plant upgrade program occurring across BHS which is funded by the Department of Treasury.

AHS

The original hospital building on the existing AHS site was first opened in 1963, with major refurbishment and new facilities constructed in 2001. Due to the expected population growth in its local catchment area, the AHS campus will undergo master planning to determine the increase in demand for health services. An infrastructure project is underway to support in addressing this challenge. A significant plant upgrade program will also be required at AHS in order to maintain hospital operations into the future.

KH

Upgrades to facilities and amenities are needed to enable the transition of the hospital's palliative care service to a modern, fit for purpose facility and relieve pressure on beds across EMHS. The EMHS SAP identified a staged refurbishment of the inpatient facilities and landscaping, to ensure patients and families receive the highest standard of end-of-life care and support.

Infrastructure enhancements

Work continued throughout 2019-20 to improve the ageing facilities and enhance the services provided at RPH.

A major project to improve services across EMHS was the opening of the Command Centre, based at RPH, which uses state of the art technology to dramatically transform how we provide care for our patients and how we support our staff in providing the best possible care.

The Command Centre currently houses the RPBG Operations Hub, a 24/7 service that centralises and coordinates essential hospital services to support patient flow bed management and nursing resources across the health service.

Another key component of the Command Centre will be the HIVE, which will provide 24-hour continuous monitoring of patients by an artificial intelligence platform which detects early signs of clinical deterioration and immediately notifies a team of critical care nurses and doctors. This service will commence in late 2020 and will initially monitor selected beds across AHS and RPH, with significant future expansion planned.

Additional infrastructure enhancement projects currently underway include the development of a new helipad, upgraded Intensive Care Unit (ICU), new Mental Health Unit and new Medihotel.

Future planning

In early 2020, the Facilities Management and Infrastructure Department commenced a review and update of the SAP (in line with DoH requirements) to add a strengthened strategic narrative; define the clinical relationship between the hospital campuses; update the demand modelling; and consider funding outcomes since the previous SAP was prepared. Following extensive consultation with each hospital, the SAP is anticipated to be completed by late 2020. Alongside the work being undertaken to update the SAP, a priority list of Capital Business Cases for submission in the next budget cycle and future years is being developed for endorsement by EMHS Executive and Board.

Building condition and plant replacement audit

In 2020-21 EMHS Facilities Management and Infrastructure Department is planning to undertake a building condition audit and a plant and equipment assessment at RPH. The purpose of this assessment is to gain an updated and accurate understanding of the key risks and issues in relation to structural integrity, compliance against modern standards and estimated end of life of our major plant. This is a pivotal body of information which will be required to inform future business cases, from major redevelopment to significant refurbishments of wards/clinical spaces.

Energy audit

An energy audit was completed in early 2020 across EMHS hospital sites. BHS and RPH were rated against the National Australian Built Environment Rating System as three stars (average), AHS rated as four stars (good) and KH rated as five stars (excellent). The key opportunities from the audit included to continue major plant replacement, implement energy sub metering, formalise the LED light replacement strategy and consider solar power installation on the multideck carpark roof at RPH. The Facilities Management and Infrastructure Department is currently developing a follow-up set of documents on energy sub-metering and the LED light replacement in order to progress these recommendations to the next stage.

Fire Issues Register

A new Fire Issues Register was also established during 2019-20 to ensure EMHS maintains a comprehensive overview of potential fire risks and to assist with compliance against Fire Safety Audits.

Demand

204 989
Emergency presentations
4648 from 2018-19

166 291
Inpatients admissions
14 301 from 2018-19

240 483
Occasions of service (OOS) for community mental health services
14 177 from 2018-19

50 974
Operations
1119 from 2018-19

564 999
Outpatient appointments
4150 from 2018-19

EMHS continues to focus on ensuring that our services are delivered in the most appropriate setting, within clinically appropriate timeframes and within purchased activity levels.

Demand for EMHS services was significantly impacted by COVID-19 – with **6.7 per cent** less emergency presentations and **15.6 per cent** less admissions from elective surgery wait list at AKG and RPBG during January to May 2020, when compared with the same period last year.

Emergency access

EMHS continues to carefully monitor performance against the WA Emergency Access Target (WEAT), which requires that 90 per cent of all patients presenting to a hospital ED are seen and admitted, transferred or discharged within four hours.

Governed by an EMHS WEAT Recovery Program, EMHS has progressed and expanded a range of strategies to improve WEAT performance. While these strategies take time to develop, implement and embed before results are realised, improvement targets have been established for RPH, AHS and SJGMPH which are reviewed biannually.

Programs introduced across EMHS to address WEAT performance include the introduction of a capacity and demand reporting framework, as well as improving flow of inter hospital patient transfers. RPBG and AKG have also progressed initiatives including cultural and process change, and refining patient flow pathways, to assist in clinical decision making.

For more information about EMHS emergency access, please see page 110.

Elective surgery

The reduction of elective surgery wait lists, and performance monitoring against the WA Elective Services Target (WEST), continues to remain a key focus for EMHS, with the aim to ensure timely and equitable access to public elective surgery services.

Prior to the onset of the COVID-19 pandemic, a number of theatre and surgical service reform projects across EMHS were in the process of implementation or late stage planning, including a review of surgical capacity and demand, the Quality, Efficiency and Safety in Theatres (QuEST) project at AKG; and a number of other initiatives outlined in the EMHS Clinical Services Plan.

In late March 2020, all elective surgery (apart from Category 1 and priority Category 2 cases) were cancelled across WA in response to the COVID-19 pandemic. These surgeries recommenced in a phased manner from late April, with hospitals returning to 100 per cent elective surgical activity in mid-June. The cancellation of these surgeries had a significant impact on both our consumers and the surgical wait list.

We acknowledge these cancellations were significantly disruptive to those patients booked for surgeries during this time. EMHS has developed a number of strategies to address the backlog to try and ensure patients are booked for surgery as soon as possible.

In addition to resuming the theatre and surgical service reform projects planned prior to COVID-19, EMHS will deploy a number of strategies to reduce the elective surgery waitlist including extending theatre operating hours; introducing twilight and weekend surgery lists and increasing staffing where required.

For more information on elective surgery wait lists, please see page 118.

Mental health

Demand for inpatient and community mental health services remained high throughout 2019-20, with **5330** mental health related inpatient admissions.

In addition to the opening of a MHEC at RPH, EMHS also continued work on a number of strategies to ensure our mental health services are delivered more efficiently and effectively.

In November 2019 EMHS developed a Mental Health Quality Improvement Program to support the implementation of a number of improvement projects across the health service, while aiming to ensure that we continue to meet the needs of our community with high quality care.

Areas of work include:

- Service profiling to ensure alignment with demand and best practice.
- Reviewing models of care and care pathways.
- Exploring strategies to strengthen partnerships with consumers and carers through authentic involvement and recognition of 'lived experience'.
- Further enabling partnerships with GPs and Community Managed Organisations.
- Streamlining documentation and maximising electronic platforms available to us.
- Establishing a consistent suite of outcome measures.

EMHS staff from all levels and disciplines were engaged in the design, development and implementation of these improvement projects.

Work commenced in late 2019 for the development of a Safe Haven Café at RPH, following an Expression of Interest submission to the Mental Health Commission (MHC). Due to open in 2020-21, the Safe Haven Café is intended to provide an alternative to ED for people with mental health, alcohol and other drug issues.

The implementation of the Safe Haven Café is aligned with recommendations from the Sustainable Health Review (SHR), which highlighted the need for mental health consumers to access alternative safe spaces away from the hospital ED environment.

Mental health patient flow

Following on from the full implementation of the new mental health statewide model to better manage Mental Health Patient Flow (MHPF), the Mental Health Bed Access, Capacity and Escalation Statewide Policy was released in July 2019.

The new policy provides direction for consistency in patient flow processes and sustainable bed management practices within and between mental health services in WA.

It provides a better understanding of the processes involved to coordinate the patient journey through community mental health, EDs and inpatient services for the benefit of all patients and the wider system.

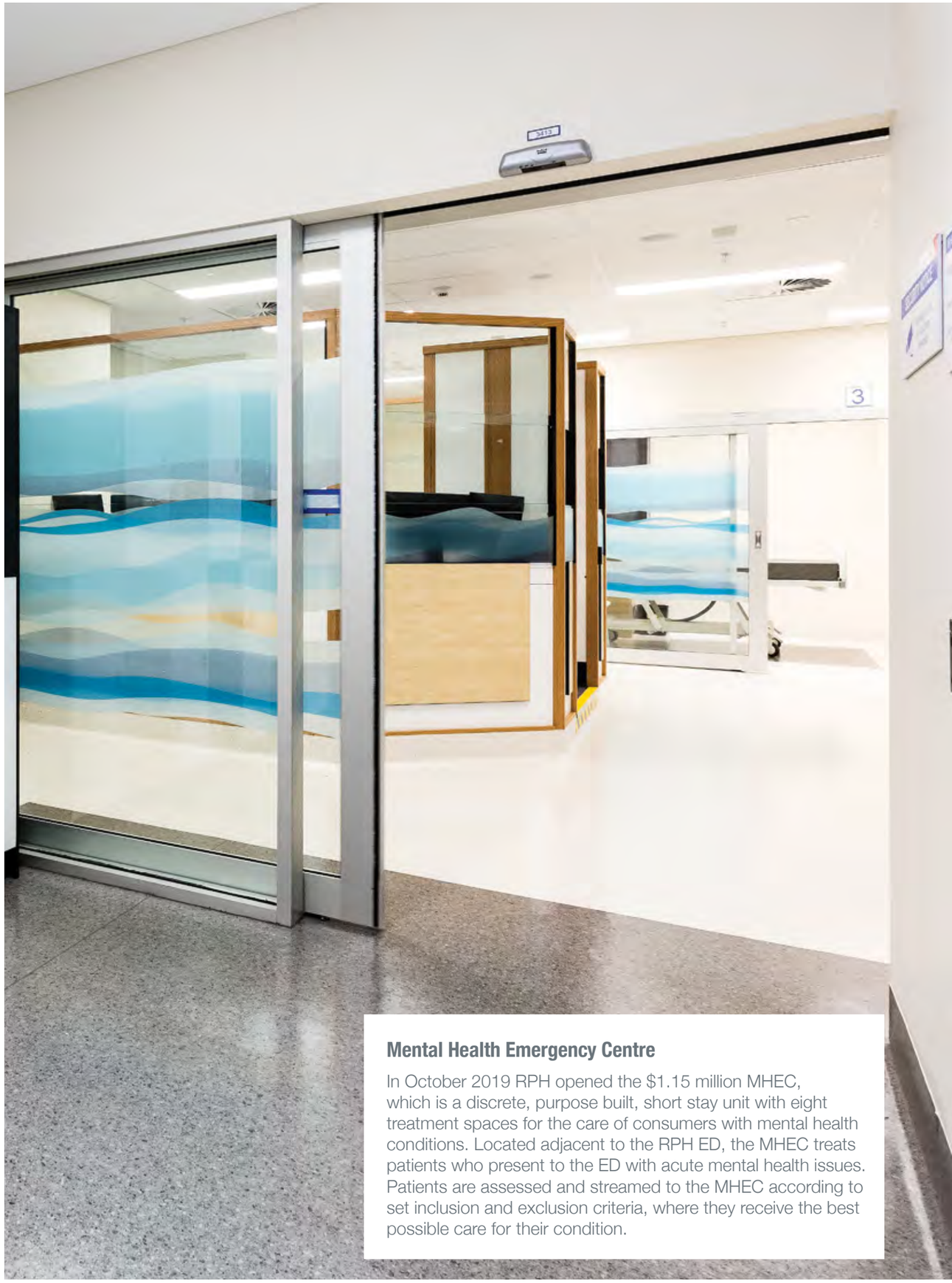
EMHS recognises that all persons requiring mental health services deserve timely and efficient access to the best possible care.

EMHS led the MHPF Steering Committee which guided the implementation of the new statewide mental health model and development of the new policy.

During 2019-20, the new MHPF model provided coordination of the referral, admission, transfer and discharge of all public mental health patients aged 16 years or older, from any location to inpatient care.

It has demonstrated that the new model provides WA health services with strengthened local accountability, while also being able to provide a response at statewide level, where clinical need is assessed to determine prioritisation for mental health admission.

EMHS also coordinated the development of a dashboard established to provide information to meet the new reporting requirements mandated by the Minister for Health; Mental Health, to provide an alert from hospitals when a patient has been in an ED for 24 hours or greater. This initiative started on 1 July 2019.



Mental Health Emergency Centre

In October 2019 RPH opened the $1.15 million MHEC, which is a discrete, purpose built, short stay unit with eight treatment spaces for the care of consumers with mental health conditions. Located adjacent to the RPH ED, the MHEC treats patients who present to the ED with acute mental health issues. Patients are assessed and streamed to the MHEC according to set inclusion and exclusion criteria, where they receive the best possible care for their condition.

Royal Perth Bentley Group Operations Hub

Your Time Counts

Launched in August 2019, the RPBG Your Time Counts program was developed to encourage staff to think differently about how they can help improve the organisation's capacity and demand, while ensuring our patients receive timely care in the most appropriate clinical setting. The program works on the ethos that every member of the hospital team has an important role in our patients' healthcare journey.

The Your Time Counts program identified four key projects to focus on in embedding and sustaining change across RPBG:

- One Team Every Patient – build and sustain a culture of staff communication and collaboration for the purpose of improving the timeliness and quality of care.
- WEAT to Wards – review and improve the operational processes and practices that impact the patient journey through RPBG.
- Centralised Patient Flow Model – develop a new operating model for RPBG patient flow, one that co-locates integral patient flow staff within a 24/7 Operations Hub.
- Acute Ambulatory Care Strategy – develop a comprehensive strategy to ensure patients are streamed safely, efficiently and appropriately away from the RPH ED.

Out of these projects, RPBG has established the Daily Stand Up, a whole of organisation safety and patient flow meeting that occurs every morning. The meeting provides an overview of the current risks and pressure points across RPBG and allows staff from across the organisation to be involved in planning solutions to reduce these stresses on the health service.

A significant achievement of the Your Time Counts program was the launch of the Operations Hub in April 2020. The service was established rapidly, and ahead of schedule, to assist with COVID-19 planning and preparedness. A new 24/7 service that provides digital oversight of the entire hospital and real time bed capacity and demand, the Operations Hub centralises essential hospital services, including hospital logistics, and allows the team to easily coordinate patient flow, bed management and nursing resources across the health service.

To further support the need for real-time visibility of bed capacity and patient demand across RPBG and more broadly across EMHS, the team developed a Capacity and Demand Report dashboard which provides users with a real-time summary of the health service's pressure points alongside the current hospital capacity, highlighting how they can improve patient flow within their department.

Aggression and violence

The prevention of aggression and violence against our staff continued to remain a key focus during 2019-20. The safety of our staff remains a priority, and we continue to implement a number of strategies as part of an extensive program of work to 'Stop the Violence'.

More than **7570** aggressive incidents against staff and patients were reported across EMHS during the year.

EMHS received $11.23 million as part of the State Government's commitment to aggression and violence prevention, which in part funded CCTV upgrades at RPBG and AKG. This funding is essential in improving how we manage aggression and violence within our EDs, as well as providing stronger oversight of aggressive incidents.

Additionally, to help protect staff even further, a new patient handover form for when WA Police transfer a patient from their custody to an ED was developed.

The form is completed by the attending Police Officers and includes detailed information about the patient's behaviour before and at the time of presentation, and their propensity for violence, aggression or self-harm. It also includes information about whether they have been searched for weapons and the types of weapons found.

The process allows ED staff to implement appropriate measures for patients who have aggressive or specific behavourial tendencies requiring attention when they first arrive, which provide staff with more immediate and greater protection against the risks associated with treating these patients.

The process was developed through a collaboration between EMHS, WA Police and other HSPs. The form was successfully trialled within the RPH ED prior to being rolled out to SCGH and FSH.

Work is underway to implement this form to other hospitals across the Perth metropolitan area.

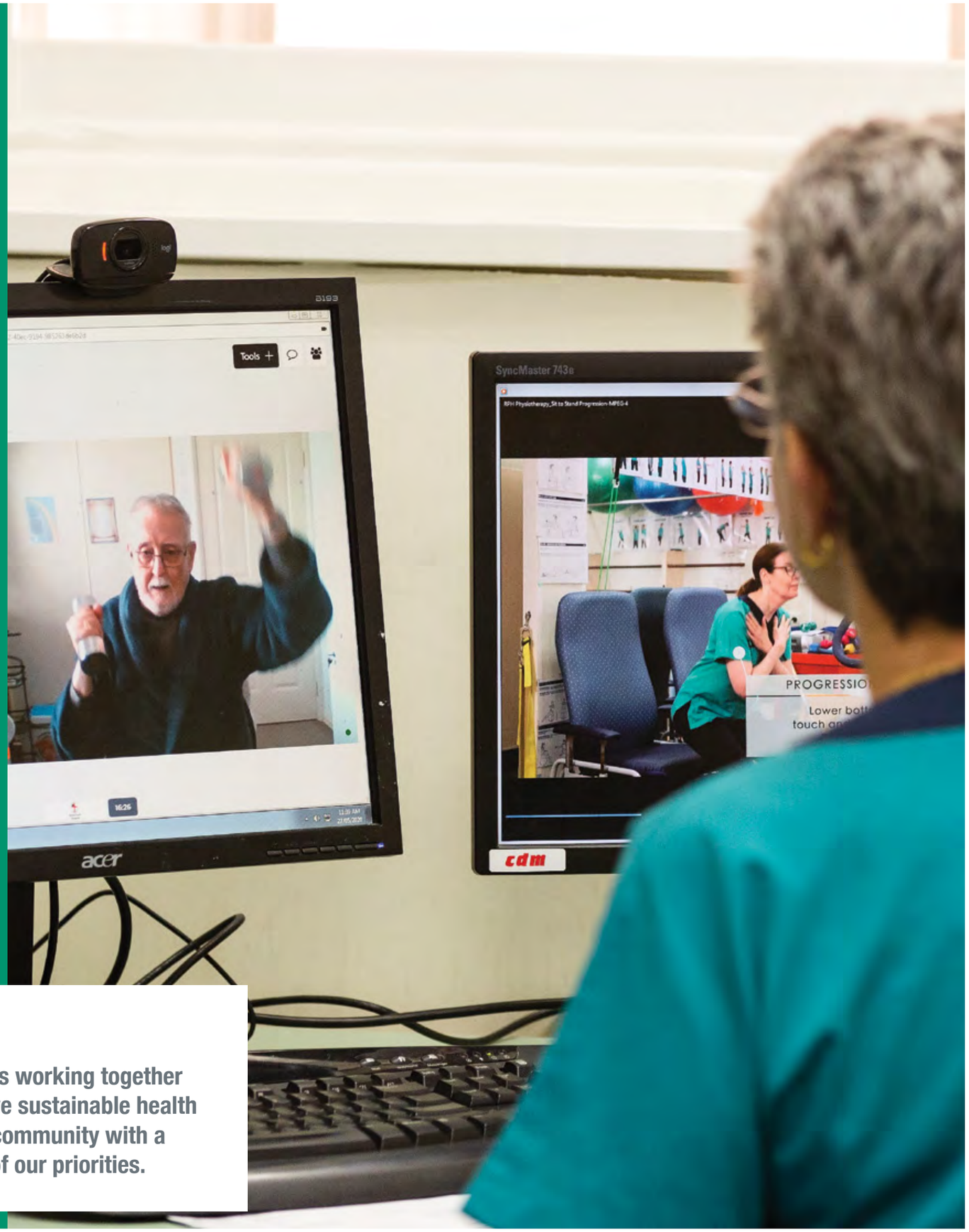
Additional measures put in place to protect our staff included:

- Community-based staff working within high risk areas were provided with duress alarms which, when triggered, instantly alert the necessary authorities.
- Stab-resistant vests were introduced for security teams and ED staff across AKG and RPBG.
- A new Environmental Aggression Risk Assessment tool was introduced, which departments are now required to complete to formally evaluate the risk of aggression within their area and assist in implementing strategies to reduce the risk.
- Additional security staff.
- Alcohol and Other Drug positions at RPH and AHS.

295
Aggresive incidents reported by staff resulted in injury, with:

- **41** resulting in a worker's compensation claim
- **230** reported by nurses.

OUR VALUES IN PRACTICE



Collaboration

Collaboration represents working together in partnership to achieve sustainable health care outcomes for our community with a shared understanding of our priorities.

Telehealth plan

Prior to the events of the COVID-19 pandemic, the expansion of telehealth had been identified as a priority for EMHS to help address issues of access and equity across the healthcare system and formed part of a recommendation from the SHR, which set ambitious targets for how telehealth will be expanded across WA Health.

Telehealth allows clinicians to treat patients using phone or video conferencing technology, which is a convenient alternative for many patients based in regional and remote areas who are unable to access a metropolitan-based hospital for their appointment.

It is for this reason that EMHS developed the EMHS Telehealth Plan – Building and Embedding Telehealth in EMHS 2020-22. The plan, released in January 2020, was shaped by extensive consultation and input from consumer representatives, staff and key partners, including the Aboriginal Health Council of WA, WA Country Health Services (WACHS) and other metropolitan HSPs. Building on the achievements made by RPH in implementing telehealth, the plan outlined the requirements to ensure the growing east metropolitan community has access to telehealth as part of normal health care practice.

Whilst initially a three-year plan, in preparation for an expected COVID-19 surge, EMHS harnessed the opportunity to drive outpatient reform and rapidly transitioned to offer telehealth services ensuring staff and patient safety whilst maximising the efficient use of time and resources.

Patients across EMHS successfully transitioned to telehealth for their clinic appointments, with **46 669** telehealth appointments (**28 769** patients) attended between April to June 2020.

Telehealth, as a model of care, is here to stay as a permanent patient option and will offer digital-appropriate patient access to a diverse range of outpatient specialties including community rehabilitation, allied health and mental health services.

Providing continuity of service has been a focus in establishing this digital technology, with consideration and planning for group appointments and interpreter services being built in to the model of care.

Megan Milligan,
EMHS Manager Health Promotion

Working with local government for a healthy community

Throughout 2019-20, the EMHS Health Promotion Team continued to work with 13 local governments across Perth's eastern suburbs to increase their understanding of their community's health needs and assist them in developing, implementing and evaluating effective public health plans.

EMHS Health Promotion Team developed community health profiles for each local government area. The profiles included local data on:

- population age and socioeconomic status;
- prevalence of risk factors such as smoking, nutrition, alcohol, physical activity, overweight and obesity and selected mental health conditions;
- immunisation levels for children;
- major causes of death;
- alcohol and other drug related hospitalisations and deaths.

By using this data going forward, the local governments will have an increased understanding of the health of their community and be able to identify effective interventions.

EMHS Health Promotion Team will continue to work closely with local governments to help achieve our vision of healthy people, amazing care across our community.

EMHS National Disability Insurance Scheme Access Project

In January 2020, EMHS initiated the EMHS National Disability Insurance Scheme (NDIS) Access Project, an initial six-month pilot project to assist consumers with psycho-social disabilities in achieving a successful transition to NDIS.

With collaboration and funding from WAPHA, this innovative service model enhances the successful transition to NDIS, as it enables comprehensive assessment and collection of evidence to support the participant's NDIS access request.

The Access Project employs a small team of mental health clinicians who work collaboratively with participants, Transition Support providers and mental health teams to create efficient NDIS processes and establish a successful service model that could be expanded to other health areas.

To be eligible for referral into the project, a participant must live within the EMHS catchment, meet NDIS eligibility, and receive Commonwealth funded Transition Support Services (due to cease in 2020). From February to June 2020, the team worked to transition **74** participants to NDIS supports, achieving a **95 per cent** success rate in access met decisions received from the NDIS.

EMHS NDIS Access Project has benefited from strong partnerships with stakeholders from EMHS, WAPHA, NDIS and the non-government sector, and feedback received from consumers and support providers has been very positive. With successful outcomes obtained by the project, funding has now been extended until the end of 2020.

Photo left to right: Sam Moore, Senior Social Worker; Jo-Anne and Clacena Van Leeuwen, Recovery Support Worker, Richmond Wellbeing

Jo-Anne's story

Jo-Anne had two previous unsuccessful attempts at applying for access to the NDIS. When Jo-Anne received the advice from NDIS that access was not met, she described feeling invalidated and frustrated. Several months later, Jo-Anne was encouraged to have another attempt and her Richmond Wellbeing Recovery Support Worker provided her with information about the EMHS NDIS Access Project.

EMHS NDIS Access Project team received and triaged Jo-Anne's referral and a telephone assessment was scheduled. She was supported throughout the assessment by her support worker so she did not feel alone. Jo-Anne stated that applying for the third time was a more pleasant experience due to the EMHS NDIS Access Project being involved, as the assessment environment was welcoming, not intrusive and empathy was felt. Her application was submitted through collaboration between the EMHS NDIS Access Project and Richmond Wellbeing and she received an NDIS access met decision shortly after.

Jo-Anne's future goals through NDIS include receiving the ongoing support she needs to attend hydrotherapy and her local Salvation Army Church, to access occupational therapy to improve her physical and mental health, re-engage with psychotherapy and have greater access to hiring a mobility scooter. Jo-Anne now feels a sense of security with lifelong support through NDIS.

Accountability

Together we have a shared responsibility for ensuring the best health care outcomes for our community.

Our EMHS value of accountability serves as a reminder that we are accountable not only to our actions, but also those actions we do not do.

Kalamunda Hospital

Amazing Nursing and Midwifery Care

Our focus continues to be on the delivery of safe, high-quality and sustainable health care that enhances the health and wellbeing of the people working and living in our community.

The Amazing Nursing and Midwifery Care program has been designed to empower our nurses and midwives through support, training and education so that they may continue to meet the diverse healthcare care needs of our patients and consumers.

The program has introduced several initiatives that are helping to strengthen partnerships between our staff, patients and their families, including:

- Team nursing, a different way of working that allows nurses and midwives to deliver care under appropriate leadership while continuing to develop their knowledge and skills on the job.
- Shift safety huddles to ensure any critical safety or patient concerns are clearly communicated between team members and the incoming shift staff.
- Bedside handover ensures that our patients and their carers are involved in, and feel supported during important discussions about their care.
- No pass call zone empowers our hospital staff with the skills and knowledge to answer requests for assistance from our patients in the shortest timeframe.

The program has been well received by nursing, midwifery, clinical and support teams at both AKG and RPBG as part of their shared responsibility for ensuring the best outcomes for our staff and patients.

Hospital Avoidance Response Team (HART)

In 2019 SJGMPH trialled the Hospital Avoidance Response Team (HART) to provide continuous care to patients who had multiple presentations within the previous 12 months.

HART puts patient care at the forefront by developing care management plans for repeat patients and providing them with assessment and referral to outpatient services. Following discharge, HART follows up with the patient and links them with local services to ensure long-term care and support.

Following the hugely successful six-month trial, HART has been funded for four years.

“The multidisciplinary HART team demonstrated that early intervention strategies and case management for patients presenting with chronic and complex health conditions is effective in reducing hospital readmissions,” said Michael Hogan, SJGMPH Chief Executive Officer (CEO).

“Of the **134** patients included in the HART trial, more than **85 per cent** of the patients were not readmitted over a six-month period.”

“The trial showed better outcomes for patients suffering from complex chronic health issues and enabling them to lead more independent lives and have a better understanding of their disease and management options.”

The multidisciplinary HART comprises a clinical nurse, occupational therapist and social worker. The team provides support to the hospital’s ED and inpatient teams in the assessment and management of patients with ambulatory care sensitive conditions and a history of frequent ED attendance and hospital readmissions.

“Without HART my mother would not be as supported in her accommodation as she now is, and she is now happy, smiling for the first time in years,” said a patient’s family member.

BeSAFE

As part of a continued focus on accountability, BHS launched a new Safety After-Hours for Everyone (SAFE) model of care in February 2020 – titled BeSAFE.

The goal of BeSAFE is to improve the after-hours services at BHS for both patients and staff by focusing on continuity of care and to provide 24/7 support to all clinical teams.

Embraced quickly by staff at BHS, the team had an instant impact by working together with clinical teams from all areas of the hospital to provide on-site care at BHS, preventing unnecessary transfers between BHS and RPH ED.

The BeSAFE team also had a considerable impact on patient centred care planning for mental health patients and consumers at BHS. The team support mental health staff to meet their patients’ physical and mental health care needs in a familiar environment and empowers ward staff to manage more complex nursing procedures.

The new BeSAFE team has greatly improved the communication and teamwork between staff, departments and hospitals. The collaborative approach to care benefits the patients and ensures they are provided with the best possible care whilst helping to reduce anxiety.

Since commencement of the service:

- **194** patients were seen;
- there were **460** Acute Medical Unit consultations;
- **60** unnecessary transfers were prevented, with care provided onsite.

Kindness

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

Kalamunda Hospital

EMHS Cancer Services Plan

As part of EMHS' commitment to reducing the impact of cancer and delivering optimal care closer to home for individuals living with cancer in our community, and in response to the WA Cancer Plan, we have developed the EMHS Cancer Services Plan – Towards 2024. This plan will guide how we integrate care and promote seamless collaboration between EMHS hospitals and external providers who care for patients with cancer and optimise our model of cancer service delivery and streamline referral pathways to the Comprehensive Cancer centres and other providers.

In 2020, RPH commenced lung cancer services for a number of patients diagnosed with Non-Small Cell Lung Cancer. Care is provided by a multidisciplinary health care team comprised of a Nurse Practitioner, Medical Day Unit Nurses, Medical Oncologists, Pharmacists and Dietitians. The team is dedicated to providing consistent and high quality, patient centred care. Commencement of the service has given patients living in the EMHS area the option of receiving oncological care, including chemotherapy, closer to home.

Kalamunda Hospital

EMHS End-of-Life Implementation Plan

The EMHS End-of-Life and Palliative Care Implementation Plan (the Plan) was released in November 2019, which is guided by the WA Health End-of-Life and Palliative Care Strategy 2018-2028.

The actions are focused on implementing strengthened end-of-life and palliative care services and enhancing support for EMHS staff who play a role in caring for people living with a life-limiting condition.

Several actions have been identified for immediate prioritisation, with work well underway to deliver on the aspirations of the Plan. In particular, planning has commenced to establish outpatient services and a Day Hospice at KH.

Alongside the existing inpatient unit, these services will form the KH Integrated Palliative Care Service which offers the flexibility required to respond to the changing needs of people living with a life-limiting condition.

The Day Hospice will use a mixed social therapeutic model, integrating social activities which provide people with the opportunity to engage with others in a similar situation, and clinical care to address specific issues. It will also offer an additional respite option for families and carers. Outpatient services are an important link in the chain of continuity of palliative care for people who are not at the stage of requiring inpatient or in-home specialist palliative care.

Alongside other actions in our four-year plan, this work will help to ensure that high-quality and dignified end-of-life and palliative care is recognised as a fundamental part of the patient journey and EMHS service delivery.

Excellence

Excellence is the result of always striving to do better. This is represented by constant improvements to the way in which we deliver our services, which results in a high performing health service.

Boodjari Yorgas Midwifery Group Practice

Excellence Symposium

On 20 August 2019 EMHS held its inaugural Excellence Symposium, celebrating a number of projects demonstrating excellence across EMHS.

Attendees had the opportunity to learn about the following programs via a video and open question and answer session:

Multidisciplinary Diabetic Foot Clinic

The RPH Multidisciplinary Diabetic Foot Unit provides care to high-risk patients with diabetes-related foot disease. The unit consists of a dedicated inpatient unit and outpatient clinics, which has been commended for their efforts in research, education and health literacy, and their ongoing service development to expand telehealth services to regional patients and remote communities.

Boodjari Yorgas Midwifery Group Practice

The AHS Boodjari Yorgas Midwifery Group Practice provides holistic and culturally safe maternity and postnatal care that helps build excellent rapport between midwives and Aboriginal mothers.

Complex Care Coordination Service

The Complex Care Coordination Service at AKG was developed to provide a coordinated patient-centred care approach to ensure safe and seamless transition of care from hospital to community-based services. It provides support and education to patients and carers on chronic disease self-management, coordinating care across multiple disciplines, linking patients to local services and developing strong relationships with community-based health care services.

Cell and Tissues Therapies WA (CTTWA)

The CTTWA team demonstrate excellence through remarkable clinical outcomes with cell therapies and tissue regeneration. As one of the few facilities in the world with multiple certifications to work with stem cells, the team helps to make ground-breaking clinical products accessible to the community.

Forget Me Not Program

The Forget Me Not volunteer program supports teams across EMHS by offering person-centred emotional support and practical assistance to patients with dementia or delirium.

Click to watch the Excellence Symposium videos

Nabeela Shihab

Organ and tissue donation

As a DonateLife Clinical Nurse Specialist and ICU nurse Nabeela Shihab is a passionate advocate for both the State organ and tissue donation service and the hospital where she works. Nabeela goes the extra mile to raise awareness about organ and tissue donation and travelled to Dubai in 2019 to present two papers at the 15th Congress of the International Society for Organ Donation and Procurement – an event where more than 650 delegates from 52 countries came together to share ideas, experiences and innovation to foster, promote and develop all aspects of organ and tissue donation.

Nabeela's presentation, which charted the journey of setting up the AHS organ donation service, received one of eight scientific awards within the scientific program presented at the congress. The sole WA award, and one of only two presented to Australian delegates, was chosen from more than 180 papers and selected based on scientific merit and abstract excellence.

In her usual humble and reflective style Nabeela professes that she is very proud of what AHS and DonateLife WA has achieved and continues to strive for.

"There are no words to describe how it is to be a part of a team that gives hope, that gives the gift of life to someone who might have been given only days to live if not for the generosity of the Australians who say yes to organ donation. If I can play a small role in that, I am very proud," said Nabeela.

"I never thought an international audience at such a prestigious event would relate to our journey as much as I do."

"The excellent work by the organ donation service is due to the culture of compassion and community spirit by the multidisciplinary team at AHS. The team is always willing to work above and beyond for their patients by volunteering to assist in organ retrieval surgeries. From the Executive to the switchboard staff, everyone is on-board to fulfil the patient's final wish, or the family's wish, and to see the bigger picture of the second chance that it gives someone else at life."

There is no denying Nabeela is passionate about what she does. When asked what she plans to do next she replies "to keep doing what I love – serving the community as a nurse."

Research

We consider research central to advancing healthcare and encourage our staff to explore and lead the translation of research into evidence-based practice and innovations. To underpin this goal and help us deliver excellent outcomes for the community, in August 2019, we launched a new three-year EMHS Research Strategy.

This strategy reinforces the value and importance research can bring to our health service. It provides us with a roadmap for further embedding research into core services, removing barriers and increasing support for research, as well as ensuring a focus on translation of findings into improved patient outcomes.

Click for further information about EMHS Research Strategy

EMHS Mental Health Research Fund

In 2019 EMHS committed $1 million to fund research into improving the services provided to consumers experiencing mental illness. Following a competitive process, funding was awarded to five mental health research programs:

- **Functional outcomes and economic efficiency of an innovative multidisciplinary model of care for people with schizophrenia treated with clozapine**
  Lead Researcher: Dr Alexander John, BHS.
  Dr John will assess the nature and severity of symptoms of consumers taking clozapine and evaluate the employment and functional benefits of current cognitive interventions and workplace support programs.
- **Non-suicidal self-injury: Reducing the impact on patients, health professionals and health services**
  Lead Researcher: A/Prof Penelope Hasking, Curtin University.
  RPH Mental Health and ED teams will work with Curtin University's A/Prof Penelope Hasking, an internationally recognised expert in non-suicidal self-injury (NSSI), to establish the extent of NSSI in RPH ED presentations and assess clinical outcomes in patients who self-injure.
- **Sustainable staff wellbeing in mental healthcare? – Yes it is possible**
  Lead Researcher: Dr Rich Read, RPBG.
  Dr Read will build on recent highly successful research projects evaluating mental health and wellbeing programs for junior doctors and nursing staff at RPBG by implementing and evaluating the benefits of staff education and peer support.
- **Machine learning and visual emotion analysis using artificial intelligence to improve suicide risk prediction**
  Lead Researcher: Prof Mohammed Bennamoun, UWA.
  The AHS and RPH Mental Health teams will work with UWA's Prof Mohammed Bennamoun, an internationally recognised expert in Artificial Intelligence (AI), to develop, validate and deploy an accurate AI driven system that will predict suicide risk among mental health consumers.
- **Emerging Drugs Network of Australia (EDNA)**
  Lead Researcher: Prof Daniel Fatovich, RPH.
  Prof Fatovich aims to develop a standardised state-based clinical registry of illicit drug use resulting in ED presentations, clinical effects, treatment approaches and outcomes.

In addition, in 2019-20 EMHS Board approved the allocation of $60 000 for a scholarship for an Aboriginal PhD student to undertake research that specifically addresses ways to improve mental health outcomes for Aboriginal people. An expression of interest will be undertaken through universities and other partners in 2020-21, with the successful applicant to be decided through a robust review process by a panel that will include Aboriginal health experts, community representatives and mental health clinicians.

Dr Olufemi Oshin, Dr Alan Kop, Dr Sudhakar Rao

CITRA research grant program

A multidisciplinary team of experts at EMHS have been awarded the RPH Research Foundation's inaugural Innovation and Impact Grant for 2020 for an innovative new method to heal complex wounds.

The project will use a combination of 3D scanning, 3D printing and stem cell therapy to produce the first tissue-engineered product for complex wounds, with a clinical trial scheduled to commence in two years.

The three-year grant, with funding up to $600,000, was created to support scientific, clinical and senior researchers who are translating novel ideas into healthcare innovations that could make a significant impact on the health and wellbeing of our community.

The Innovation and Impact Grants are awarded to new research projects that challenge existing paradigms and explore different paths from the current lines of investigation.

The project, led by Biomedical Engineer, Dr Alan Kop, in collaboration with RPH Director of Trauma, Dr Sudhakar Rao, RPH Consultant Vascular Surgeon, Dr Olufemi Oshin, and a research team at RPH, is using tissue engineering to prevent the need for multiple surgeries, or even amputation, in the treatment of complex wounds.

It is hoped that the new therapy will reduce the treatment time for patients with wounds that do not have enough viable tissue to heal. This is particularly beneficial for patients who have underlying health conditions such as diabetes or have large wounds caused by trauma.

Dr Kop said the team's vision is to reduce the physical and physiological suffering of patients with complex wounds that, traditionally, would take extensive, lengthy and complex care to treat.

Professor Michael Lawrence-Brown, Dr Toby Richards, Mr David Hartley, Hon. Roger Cook MLA, Professor Paul Parizel

Innovation secures funding for future research

In the late 1990s, Professor Michael Lawrence-Brown, Vascular Surgeon, and Mr David Hartley, Medical Imaging Technologist, developed an abdominal aortic stent graft while employed at RPH. Now, the royalties from this device sit under the governance of EMHS and have been used to fund ongoing research into radiology and vascular surgery across WA Health.

The royalties also funded the establishment of two Professorial Chairs of Vascular Surgery and Radiology. In September 2019, EMHS welcomed Professor Paul M Parizel, who was appointed as the David Hartley Chair of Radiology, based at RPH. Professor Parizel's objectives are to improve clinical governance and leadership, supervise undergraduate and postgraduate research students and fellows, and increase the opportunity for research collaboration.

Dr Toby Richards was appointed as the Michael Lawrence-Brown Chair of Vascular Surgery and based at FSH in late 2018. Dr Richards aims to develop and enhance research and practice throughout WA, and promote local vascular research on a global level.

During 2019-20, these royalties also contributed more than $279,000 of funding into radiology research, and more than $206,000 of funding into vascular research across the health system.

Click for further details about the RPH Imaging Research Fund

Smart EMHS digital strategy

December 2019 saw the release of our first digital strategy Smart EMHS: Design Digital. Create Health. Deliver Care. The strategy provides an overview of how we will implement digital initiatives and programs which support and align with our operational and strategic priorities. Smart EMHS details the components and programs of work that will allow us to improve the care we provide to our community and articulates how we will utilise digital innovation and ensure greater use of data to inform decision making.

During 2020, two programs aligned with this strategy commenced – AI and End User Computing (EUC). The AI program includes the implementation of an AI platform, a model for predicting hospital readmissions, and automating the processes involved with leave management. The EUC program is delivering a variety of exciting initiatives including a digital platform for Bedside Patient Management, Ward Rounds and Patient Pathways, the delivery of over 700 new desktop computers and a number of workstations on wheels.

Research papers

During 2019-20, EMHS teams published research papers covering a broad range of topics including general medicine, cardiology, intensive care, oncology and gastroenterology. Papers published in major medical journals included:

The hidden magnitude of polypharmacy: using defined daily doses and maximum licensed daily doses to measure antipsychotic load

International Journal of Clinical Pharmacy

Authors: M. Nguyen, B. Sunderland, S. Lim, L. Hattingh & L. Chalmers.

Antipsychotic medicines are important for the management of serious mental illnesses, such as schizophrenia or schizoaffective disorder. Clinical guidelines usually suggest that patients should only take one antipsychotic at a time, though it is recognised that therapy with a combination of more than one antipsychotic (polypharmacy) is prescribed in some cases. The risks and benefits of polypharmacy need to be carefully considered for every patient.

The Pharmacy Department at AHS conducted this study, published in the International Journal of Clinical Pharmacy, to determine how frequently patients of the hospital's inpatient and outpatient psychiatric service were taking more than one antipsychotic at a time.

The researchers also quantified the extent to which this practice occurs, to allow healthcare workers to recognise the overall burden of polypharmacy, especially when relatively low doses of multiple antipsychotics are used. More recently, they have examined the factors contributing to this practice. An awareness of antipsychotic burden and underlying causes can facilitate opportunities for medication review and rationalisation of prescribing.

Conservative versus interventional treatment for spontaneous pneumothorax

The New England Journal of Medicine

Authors: S.G.A. Brown, E.L. Ball, K. Perrin, S.E. Asha, I. Braithwaite, D. Egerton-Warburton, P.G. Jones, G. Keijzers, F.B. Kinnear, B.C.H. Kwan, K.V. Lam, Y.C.G. Lee, M. Nowitz, C.A. Read, G. Simpson, J.A. Smith, Q.A. Summers, M. Weatherall, and R. Beasley, for the PSP Investigators.

For patients attending the ED with primary spontaneous pneumothorax (collapsed lung) there has been a lack of evidence for whether the resulting air in the pleural space should be drained or a conservative approach to management taken.

This multi-site trial led by the Centre for Clinical Research in Emergency Medicine (CCREM) at RPH provided evidence that conservative management was not inferior to interventional management, with similar rates of full lung re-expansion at eight weeks. The results, published in The New England Journal of Medicine, also showed that conservative management spared 85 per cent of the patients from an invasive intervention, led to fewer days in hospital and off work, lower rates of surgery, a lower risk of serious adverse events, and a similar time to resolution of symptoms.

The Low Dose Colchicine after Myocardial Infarction (LoDoCo-MI) study: A pilot randomised placebo controlled trial of colchicine following acute myocardial infarction.

American Heart Journal

Authors: T. Hennessy, L. Soh, M. Bowman, R. Kurup, C. Schultz, S. Patel, G. Hillis.

One of the most important aspects of treating a heart attack is to prevent further cardiovascular events. This trial, conducted by the RPH Cardiology Department, investigated if low doses of the anti-inflammatory medicine, colchicine, was safe to administer to patients following acute myocardial infarction (heart attack) and could reduce levels of C-reactive protein (CRP), a biomarker associated with the risk of further events.

Recently published in the American Heart Journal, this pilot randomised, double-blind trial found that colchicine is safe and well tolerated among patients admitted following an acute myocardial infarction. While there was no significant reduction in the level of CRP, there was a trend towards lower levels in colchicine treated patients, which is consistent with prior research.

These data were instrumental in supporting a successful grant application to the National Health and Medical Research Council (NHMRC) for an upcoming large multicentre randomised controlled trial that will investigate the effect of colchicine on cardiovascular outcomes in patients with acute myocardial infarction.

A multicenter trial of vena cava filters in severely injured patients.

The New England Journal of Medicine

Authors: K.M. Ho, S. Rao, S. Honeybul, R. Zellweger, B. Wibrow, J. Lipman, A. Holley, A. Kop, E. Geelhoed, T. Corcoran, P. Misur, C. Edibam, R. Baker, J. Chamberlain, C. Forsdyke, & F. Rogers.

Blood clot formation - also known as deep vein thrombosis or venous thromboembolism - is extremely common after major trauma. Many of these patients would receive blood thinners to reduce this complication, but those who are at high-risk of bleeding or with ongoing bleeding, particularly inside the brain or spinal cord, are unable to be given any blood thinner. In this difficult situation, trauma guidelines from the United States had recommended placement of a titanium-alloy filter inside the big vein (also called inferior vena cava) in the abdomen of the patients to prevent migration of blood clots from the legs to the lungs – also known as pulmonary embolism - which can be potentially fatal. The theoretical benefits of these filters had led to its widespread use in trauma patients, and the global market for these filters was estimated to be over US$435 million in 2016. Whether these filters could practically improve patient-centred outcomes remained scientifically unproven, however. These filters are also expensive (>A$4000 per filter), and can cause serious complications if not used appropriately. The use of these filters in major trauma patients was indeed considered as one of the most contentious issues in trauma care and haematology.

This RPH-led multi-centre, randomised, controlled trial was designed to tackle this clinical problem, and found that early insertion of a retrievable vena cava filter within 72 hours after major trauma did not result in a lower incidence of symptomatic pulmonary embolism or death at 90 days compared to no placement of a filter for patients who could not receive any blood thinner within 72 hours of their major injuries. Nonetheless, for those who were at risk of bleeding and could not receive any blood thinner within seven days of their injury, the filter was highly effective in reducing blood clots in the lungs (or pulmonary embolism) compared to not using the filter.

These findings demonstrate that given the cost and risks associated with vena cava filters, these filters should be reserved only for those who cannot receive any blood thinner due to ongoing bleeding within the first seven days after major trauma. The results of this trial have been used to support the latest haematology and trauma society guidelines in the United States on when and on whom a filter should be used after major trauma. At RPH, the use of such filters in trauma patients has significantly reduced since the completion of this trial, resulting in improved patient outcomes as well as reduced unnecessary healthcare cost.

Innovation hub

Mini hackathon

As part of our ongoing focus on intellectual curiosity and continuous improvement initiatives, EMHS ran a series of 'Mini Hackathon' workshops for staff to have their say on new and innovative ways of delivering care to our community.

The workshops were held to develop solutions to contemporary health problems impacting the WA health system, while offering participants the opportunity to learn and adapt best practice innovation techniques for future innovation projects.

The workshops looked at current issues including:

- seeking alternative care pathways for patients that frequently present to EDs;
- minimising opioid misuse amongst surgical patients;
- reducing outpatient clinic appointment cancellations or no-shows.

Solutions from the workshops are currently being reviewed and developed into innovative idea proposals for review and approval for implementation.

Youth innovation think tank

EMHS is committed to collaborating with our diverse community by creating opportunities to engage directly with their health service and allow them an avenue to provide innovative health care ideas and solutions for some of our most common issues.

In October 2019, EMHS hosted a Youth Innovation Think Tank, where 40 students from five schools were welcomed to provide a fresh perspective on how to approach problems like ambulance ramping, inadequate discharge summaries, and mental health follow up.

With industry leaders on hand to provide advice, students were divided into teams and assigned a common health care issue. The teams enthusiastically generated numerous exciting and open-minded solutions for how these issues could be solved now and in the future.

The event was a success, with teachers and staff all providing feedback that it was a valued and educational initiative for all involved.

Respect

We demonstrate respect through our actions and behaviours. By showing each other respect, in turn we earn respect.

A cornerstone of our values, respect highlights our commitment to creating a health service that demonstrates respect for our diverse community each and every day.

A key component to this is establishing a diverse workplace equal to the diverse community we serve. The EMHS Aboriginal Health Strategy team do incredible work in attracting, recruiting and retaining Aboriginal staff through the development of career pathways, establishing job opportunities in clinical and non-clinical roles, and by implementing Aboriginal workforce strategies.

To aid this, work is well underway to establish a multicultural plan within EMHS. Aligned to the WA Government's Multicultural Policy Framework launched in February 2020, it will guide us in establishing a harmonious and inclusive community, being culturally responsive in our program and service delivery, and to remove barriers to ensure equitable participation and employment for our community.

In acknowledging that Aboriginal people are under-represented in the health workforce, EMHS took significant strides in 2019-20 to ensure s.51 of the *Equal Opportunity Act*, which aims to increase the employment of Aboriginal people across Government, was applied to recruitment advertising. In partnership with South Metropolitan TAFE, NMHS and SMHS, we also took on four Aboriginal Cadets, supported an Aboriginal graduate placement, and conducted two employment workshops for Aboriginal job seekers. These strategies have contributed to increasing our Aboriginal employment to **106** staff.

An EMHS Aboriginal Workforce Engagement Group provides a network to share information and gain feedback on policies, strategies and programs. This group, along with DoH's Aboriginal Workforce Working Group, is important in the continued work to increase our Aboriginal workforce and ensure that necessary support policies and strategies are in place. Both groups have a strong representation from our Aboriginal employees.

A Manager's Guide for Supporting Aboriginal Employees was developed during 2019-20, which provides EMHS Managers with the tools to create a supportive and culturally safe workplace for Aboriginal employees. Included alongside this resource was a dedicated fact sheet to educate line managers about 'Sorry Business' – the period of cultural practices and protocols associated with mourning. This resource will equip managers to better understand bereavement and funeral processes for Aboriginal people, in order to provide a more culturally informed and supportive workplace for Aboriginal employees.

Top five countries of birth for EMHS patients

Inpatients

Australia	England	New Zealand	India	Italy
98 616	17 732	5525	3765	2872

Outpatients

Australia	England	New Zealand	India	Scotland
297 380	51 671	20 612	18 022	7999

Aboriginal patients

Inpatients	Outpatients
20 165	24 243

Interpreting services

Occasions of access to interpreting services
16 485

Occasions of access to Auslan services
275

Top five languages accessed

- Mandarin
- Vietnamese
- Cantonese
- Arabic
- Farsi

Living better with lung disease through exercise

Medical research shows that a regular, tailored exercise program will help people living with lung disease feel less short-winded, increase their energy and improve their sense of wellbeing. That is why the EMHS Aboriginal Community Health and RPBG physiotherapy teams collaborated on the 'Living better with lung disease through exercise' resource, which provides practical information and exercise plans for Aboriginal patients in pulmonary rehabilitation.

"We all walk together alongside the Noongar people and other groups for the ongoing development and advancement of health and wellbeing of all Aboriginal people," said EMHS CE, Liz MacLeod.

Selena West, Manager EMHS Aboriginal Community Health Team, indicated "the aim is to produce further educational resources, creating a series of culturally appropriate health materials highlighting preventative methods and chronic disease self-management for our Aboriginal patients."

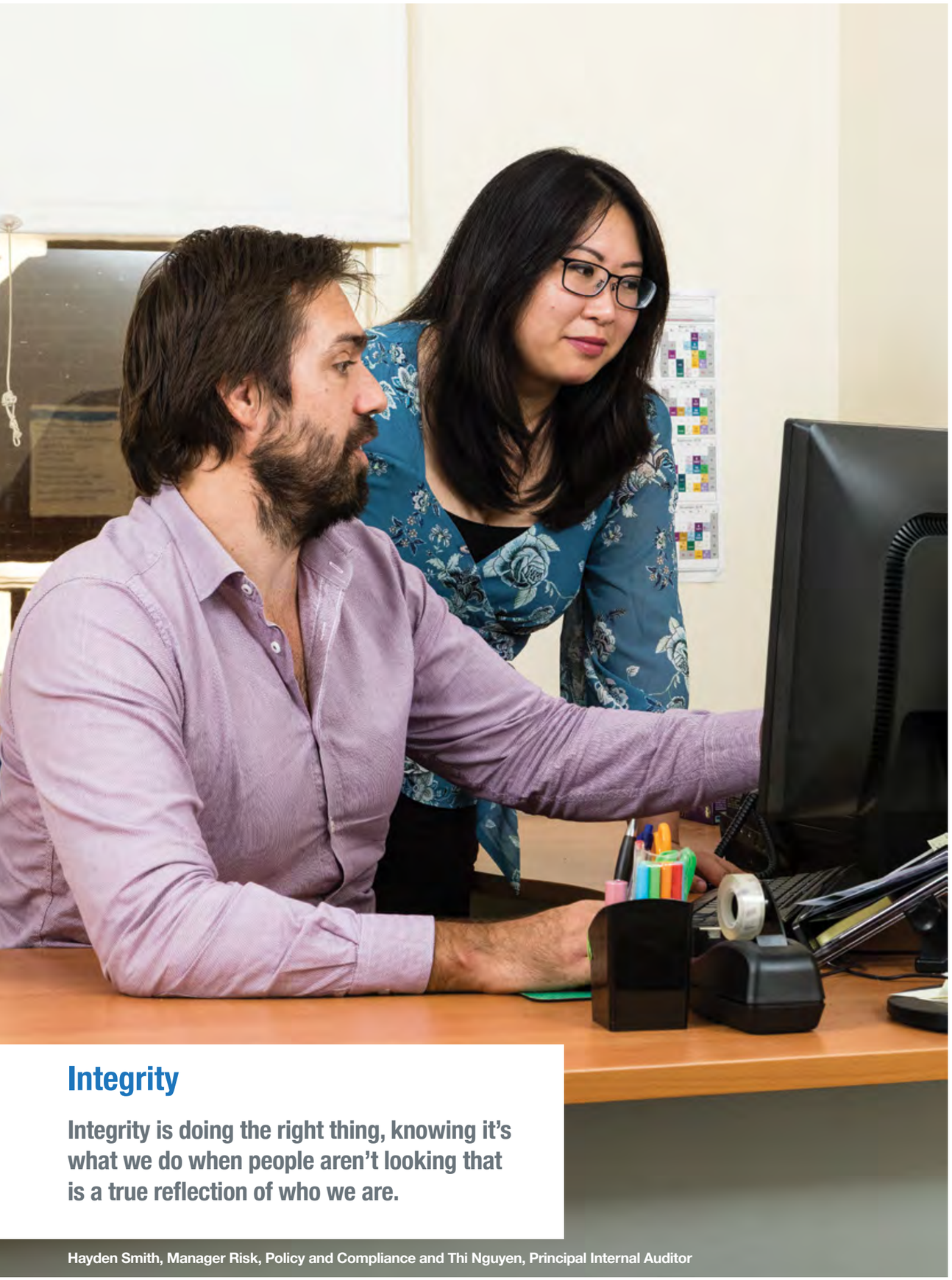
The follow up initiative for this project will be a culturally appropriate interactive video which will be played on TVs in the rehabilitation gym to provide further knowledge on the exercises and how to perform them correctly.

Aboriginal Patient Journey Continuum of Care

At EMHS we recognise how important it is to provide equitable access to healthcare and close the gap on health inequities between Aboriginal and Torres Strait Islanders and the broader community.

Crucial to achieving this is the Aboriginal Patient Journey Continuum of Care model, which aims to ensure our Aboriginal patients have positive health outcomes in a culturally supportive and appropriate manner from all EMHS staff.

Key to forming the model was meeting with our community to learn more about how they perceive the care we provide. By gaining an insight into the barriers and gaps they experienced in the Aboriginal patient journey, EMHS was able turn feedback into grounded recommendations for achieving improved culturally appropriate care for our community.



Integrity

Integrity is doing the right thing, knowing it's what we do when people aren't looking that is a true reflection of who we are.

Hayden Smith, Manager Risk, Policy and Compliance and Thi Nguyen, Principal Internal Auditor

Enhanced focus on integrity and ethics

Having an ethical and honest workforce is integral to delivering outstanding services. In 2019-20, EMHS maintained its focus on doing the right thing through an extensive program of audits and proactive actions to address risks associated with integrity, fraud and corruption.

Implementation of EMHS-wide initiatives stemming from a Corruption and Crime Committee (CCC) report into bribery and corruption within the NMHS, has been overseen by a CCC Action Plan Committee. This committee has broadened its roles and responsibilities to learn from and govern actions arising from a range of oversight agencies.

As part of this work, EMHS has proactively conducted a series of internal audits into areas of potential fraud and misconduct risk, resulting in a strengthening of governance, processes and systems.

A number of strategies have been implemented including:

- Enhanced education and training for staff and management in identifying, reporting and managing misconduct.
- Establishment of a dedicated fraud hotline for staff and the public to report any suspicious behaviour.
- Continued efforts to build a culture where all staff can feel comfortable voicing their concerns and reporting suspicions of misconduct.
- Development of a fraud analytics dashboard.

In addition, over the past few years EMHS has embarked on several strategies to strengthen procurement systems and processes and empower staff with knowledge to make informed best value for money decisions. Specialised EMHS procurement and contract management training is now mandatory for staff and management involved in purchasing and/or approving expenditure. Refresher training is required biannually to maintain current knowledge of the purchasing framework and requirements including how to manage conflict of interests with suppliers.

EMHS also assists in WA Health system-wide procurement reforms and projects looking at improving the robustness of systems and procedures.

Risk management

EMHS continues to operate an integrated Enterprise Risk Management System (ERMS) for the identification, monitoring and reporting of risks from across the organisation. Significant areas for risk analysis have been the:

- ongoing assessment and mitigation of significant clinical risks;
- impact of aggression and violence on staff safety;
- Annual Fraud and Corruption Risk and Control Assessment;
- cybersecurity and information and communications technology risk management.

The EMHS ERMS ensures that all risks are available in the same format, with information able to be updated by staff and available to decision makers in real time. Key risks are tabled at all hospital governance committees, EMHS Executive Committees and Board subcommittees.

Additional significant risk activities during 2019-20 included:

- Internal audit and maturity assessment of the EMHS ERMS. The maturity assessment defined the current and desired future maturity levels, as defined in partnership by the Board and Executive, as well as providing key recommendations for how to achieve that vision. The maturity assessment will become a regular part of the EMHS risk management system.
- Ongoing review of EMHS strategic risks. Following on from the work begun in 2018-19, the Board Audit and Risk Committee continues to monitor EMHS strategic risks twice per year, ensuring that EMHS operations are incorporating strategic risk considerations into planning processes. Additionally, new risks and trends are regularly identified and assessed for inclusion on the EMHS Strategic Risk Register.
- Assessment of the impact of COVID-19 on EMHS risks. EMHS adopted a four part strategy for managing COVID-19 risks, including a formal risk assessment, the impact of COVID-19 on current risks and controls, the inclusion of a risk register into the EMHS Emergency Response and consideration of risk through the recovery process.

Sustainability

Sustainable Health Review

In June 2017, the Government of Western Australia announced the SHR to prioritise the delivery of patient-centred, high quality and financially sustainable healthcare across the State.

The SHR was conducted by an experienced panel of experts, who in April 2019, published a final report, outlining eight enduring strategies and 30 recommendations which seek to drive a cultural and behavioural shift across the health system.

Since the release of this report, DoH and HSPs have been progressing early implementation planning, and in December 2019, EMHS prioritised seven SHR recommendations, in line with current EMHS strategic priorities.

Farron Kickett, Aboriginal Acute Care Coordinator

Enduring strategy 1:
Commit and collaborate to address major public health issues.

Recommendation 2A: Halt the rise in obesity in WA by July 2024 and have the highest percentage of population with a healthy weight of all states in Australia by July 2029.

EMHS initiative: EMHS obesity prevention strategy.

EMHS obesity prevention strategy aims to increase the proportion of people living, working and playing in east metropolitan areas who achieve and maintain a healthy weight, using evidence-based strategies to address overweight and obesity.

Recommendation 3A: Reduce inequity in health outcomes and access to care with focus on Aboriginal people and families in line with the WA Aboriginal Health and Wellbeing Framework 2015-2030.

EMHS initiative: EMHS Aboriginal workforce strategy.

EMHS Aboriginal workforce strategy aims to increase the number of Aboriginals employed with EMHS, resulting in a workforce that is reflective of the Aboriginal population within the EMHS catchment area.

Recommendation 5: Reduce the health system's environmental footprint and ensure mitigation and adaption strategies are in place to respond to the health impacts and risks of climate change. Set ongoing targets and measures aligned with established national and international goals.

EMHS initiative: EMHS environmental footprint reduction.

EMHS aims to reduce its environmental footprint by reviewing current practices and identifying opportunities to reduce our environmental impact.

Enduring strategy 4: Person-centred, equitable, seamless access.

Recommendation 11A: Improve timely access to outpatient services through moving routine, non-urgent and less complex specialist outpatient services out of hospital settings in partnership with primary care.

EMHS initiative: EMHS outpatient reform program.

EMHS outpatient reform program 2020-24 is an ambitious change program designed to transform the patient journey by making the system easier to navigate, ensuring every appointment adds value and improving access to those most in need. EMHS is actively involved in the systemwide outpatient reform program led by the System Manager, including:

- specialist referral access criteria reform;
- focus on improving data quality to underpin a move to transparent public reporting;
- rollout of Manage My Care App (at RPBG);
- Electronic Referral Management.

Recommendation 11B: Improve timely access to outpatient services through requiring all metropolitan HSPs to progressively provide telehealth consultations for 65 per cent of outpatient services for country patients by July 2022, to the prioritised recommendations.

EMHS initiative: EMHS telehealth plan.

EMHS Telehealth Plan – Building and Embedding Telehealth in EMHS 2020-22 – describes how EMHS will build and embed telehealth care in service delivery. In recent months, EMHS rapid expansion of telehealth services in response to the COVID-19 has seen digital health delivery significantly increase. In May 2020 almost half of all EMHS outpatient appointments were provided using digital health technology. The EMHS outpatient reform program intends to build on this momentum to safely and efficiently transform outpatient appointment delivery with a focus on key areas of sustainability - namely, quality and safety, cost and waste, patient experience and staff engagement.

Recommendation 13: Implement models of care in the community for groups of people with complex conditions who are frequent presenters to hospital.

EMHS initiative: Virtual self-management and remote monitoring.

Virtual self-management and remote monitoring facilitates optimising the care of patients with congestive heart failure and chronic obstructive pulmonary disease living at home. In utilising digital technology, EMHS aims to deliver a patient centred model of health care focussed on empowering patients' self-management of their chronic conditions in their own home.

In 2019, AKG partnered with Richmond Wellbeing to pilot this virtual software for a three month period. The project was led by Dr B-K Tan and Dr Joel Tate, with the Complex Care Coordination Team and Community Rehabilitation Service. Data from this pilot study was reviewed and improvements for further implementation were defined.

To further progress implementation, a proposed randomised clinical trial was registered with EMHS Human Research Ethics Committee as a research project, which received conditional approval in June 2020. AKG will commence recruitment in the second half of 2020 and will continue to work closely with Richmond Wellbeing to define the new research scope and update the technology for implementation.

Enduring strategy 7: Culture and workforce to support new models of care.

Recommendation 14: Transform the approach to caring for older people by implementing models of care to support independence at home and other appropriate settings, in partnership with consumers, providers, primary care and the Commonwealth.

EMHS initiative: EMHS Health Care of the Older Adult Service Model.

EMHS Health Care of the Older Adult service model vision is for the delivery of optimal health care for the older adult across the care continuum. This model includes priority implementation initiatives, which sites are currently progressing.

Recommendation 23: Build a systemwide culture of courage, innovation and accountability that builds on the existing pride, compassion and professionalism of staff to support collaboration for change.

EMHS initiative: EMHS leadership development and focus on culture.

EMHS aims to develop great leaders with the right skills and behaviours to lead engaged and productive teams; and to ensure a strong internal leadership talent pipeline to equip the workforce of tomorrow. A range of strategies and initiatives are being progressed for implementation in 2020-21, with a focus on leadership capacity and development.

EMHS goes green

In line with its commitment to accountability, during 2019-20, EMHS joined the Global Green and Healthy Hospitals (GGHH) network.

GGHH is a globally respected international community of hospitals, health care facilities and health services working to achieve measurable outcomes to improve sustainability and promote environmental health. The network comprises more than 1350 members in 72 countries, and collectively it represents the interests of more than 43 000 health care services throughout the world.

GGHH has developed a number of sustainability goals focused on reducing the health system's environmental footprint, and ensuring mitigation and adaptation strategies are in place to respond to the health impacts and risks of climate change.

As a direct result of joining the network, EMHS initially committed to two sustainability goals; purchasing: buy safer and more sustainable products and materials, and pharmaceuticals: prescribe appropriately, safely manage and properly dispose of pharmaceuticals.

In progressing this commitment, Philip Aylward, Executive Director Corporate Services and Contract Management is leading a review of purchasing practices to explore potential opportunities to buy from more socially and environmentally responsible vendors.

Diane Barr, Executive Director AKG, is leading an investigation into ways to reduce any over-prescription practices and minimise pharmaceutical waste disposal, with the objective to improve overall hospital practices and ultimately in turn benefit the environment.

Teams across EMHS have also implemented a number of local changes within their areas to improve sustainability. Programs introduced during the last year include waste reduction and enhancing recycling practices across the organisation. As an example, an initiative coordinated by the RPH theatre teams has seen **30 tonnes** of plastic recycled during 2019-20 through the introduction of recycling bins located throughout the hospital. EMHS will continue to explore opportunities to improve waste protocols and recycling practices across the health service into the future.

Microfibre

In 2019 RPBG Patient Support Services (PSS) implemented a new cleaning system using microfibre mops across the hospital group – a safer, more efficient and sustainable alternative to traditional wet-mop cleaning – which is greatly benefiting staff, patients and the environment.

Firstly, the damp mopping process used with microfibre has contributed to significant improvements in RPBG's environmental footprint by ensuring increased water efficiency and a reduction in chemical use.

The launderable microfibre mops have also greatly reduced the usage of single-use mops across both RPH and BHS. In the 12 months prior to implementing the launderable mops, RPH used more than **50 000** single-use string mops.

The microfibre mops greatly benefit our staff and patients by providing improved cleanliness and enhancing staff safety across the sites. This has been integral in reducing work health and safety issues, including the reduction of repetitive manual handling and resulting in less slips, trips and falls.

More than **400 staff** use microfibre mops in their daily work tasks and the benefits of microfibre mops for both PSS and clinical staff are significant and the response from staff has been very positive.

By introducing the microfibre mops and reducing the use of chemicals and single-use mops, RPBG is able to re-invest these costs to improve services that benefit our staff and patients, and help improve the environmental footprint of RPBG.

OUR STAFF

Staff profile

As at 30 June 2020, EMHS employed **8549** individual staff, or **6499** full time equivalent (FTE).

FTE by occupational group is listed below (please note individual staff totals are rounded):

1072
Administration and clerical
2018-19: 1018

811
Hotel services (including catering, cleaning, supply/ stores, laundry and transport)
2018-19: 810

952
Medical
2018-19: 910

926
Medical support
2018-19: 881

2549
Nursing
2018-19: 2500

155
Maintenance
2018-19: 145

35
Other, including Aboriginal and ethnic related occupations
2018-19: 33

106
Aboriginal staff

19%
Staff born overseas

Number of staff per age range

16 0-19yrs	**1340** 20-29yrs	**2189** 30-39yrs	**1900** 40-49yrs
1849 50-59yrs	**1144** 60-69yrs	**111** 70+yrs	

Number of staff per years of service

6574 <10yrs	**1361** 10-19yrs	**390** 20-29yrs	**190** 30-39yrs	**33** 40-49yrs	**1** 50+yrs

Staff wellness

The physical and mental health of EMHS staff is of the utmost importance.

We recognise that our staff encounter unique and at times challenging situations each day while supporting the delivery of compassionate, high-quality care. There are several dedicated programs at EMHS that aid our staff in maintaining a physically and mentally healthy workplace and lifestyle.

AKG champion wellness activities that promote a healthy workforce culture, improve staff morale and contribute to improved services for patients, employees and the community. This included smoke free programs, physical and mental wellness and sustainable environmental practices. To support these initiatives, a new wellness program and committee was launched in mid-2020.

Over the past year, the RPBG Centre for Wellbeing and Sustainable Practice (CWSP), which comprises wellbeing and spiritual care for patients and families, the associated chaplaincy training unit and staff wellbeing support and training, saw substantial growth. This included increased staff engagement with the educational support tools and resources for staff members to manage wellbeing practices as an individual, or to support their colleagues and patients. During 2019-20, CWSP introduced **two** dedicated wellbeing officers to BHS and **179** staff members graduated from the Bonstato Wellbeing training as Wellbeing Champions. The hard work and dedication of the CWSP became integral during the height of the COVID-19 pandemic as they quickly expanded their programs to support and train more than **135** staff members.

The RPH Junior Doctors Wellbeing Program continues to be well received by RPBG medical interns, with **92 per cent** of Junior Doctors participating in the program in the 2020 intake. One-on-one meetings, or peer support groups, allow the opportunity for our junior medical staff to speak candidly about professional or workplace issues that may affect them. In 2019 the CWSP team launched a Nurses Wellbeing Program pilot, which will help to inform the most appropriate means of supporting the hospital's nursing workforce going forward.

Staff development

There was a significant amount of staff development activity at EMHS during 2019-20. While there were already a number of innovations underway, the changed landscape of staff development in a COVID-19 world saw even greater and unexpected innovation and collaboration taking place.

Some staff development highlights for this year included:

- Training over **4280** employees across EMHS in the correct use of PPE, to ensure staff safety during COVID-19.
- Providing **2719** employees across EMHS with upskilling and cross training to build key skills and capabilities to manage COVID-19 response.
- Ensuring preparedness for COVID-19, by rapidly inducting **517** prospective WA Health employees who were willing to work during the COVID-19 response. Whilst not appointed to roles and only pre-selected for employment, the personnel were on-boarded to ensure they were able to be utilised as quickly as possible. EMHS was entrusted to manage the digital induction training for any potential employee that could be appointed across metropolitan HSPs.
- Developing weekly bespoke educational videos, with key clinical COVID-19 information to enable quick, real time and accessible learning.
- Providing intensive in situ coaching and support around day-to-day COVID-19 clinical challenges relating to transmission based precautions.
- Supporting the dissemination of new polices and changes in specialist practice or process specific to COVID-19 across sites.
- Delivering over **50** multidisciplinary immersive COVID-19 simulation events to prepare AKG for COVID-19 response.
- Implementing an immersive in situ simulation program focussing on obstetrics, neonates and paediatrics at AKG.
- Developing a model for an immersive and experiential learning and educational model for Goals of Care communication training at RPBG.
- Developing WA's first Surgery Registrar pilot program through RPBG.
- Establishing an EMHS-based Learning and Development function to lead digital education strategy.
- Implementing an interim LMS in response to COVID-19 within six weeks.

This year, there has been significant collaboration, agility, innovation and responsiveness in EMHS staff development. This is set to only continue in 2020-21, with the implementation of a number of significant initiatives, including the new LMS and the increased consistency, governance and reporting this will provide.

Curtin university placements

The first cohort of medical students from the recently opened Curtin University Midland Campus were welcomed at SJGMPH in February 2020.

SJGMPH is committed to providing a high-quality clinical experience to medical students, and this is an important first step in supporting the next generation of doctors.

"SJGMPH is providing **18** student placements in 2020 and this number is expected to expand over the next few years," said SJGMPH CEO Michael Hogan.

Based in a new, custom-built facility near the hospital in the old Midland Railway Workshops, the Curtin Midland Campus provides a base for Curtin Medical School students in their fourth and fifth year of study, as well as students studying other Curtin University health science disciplines.

Curtin Medical School Acting Dean Professor Sally Sandover said many of the SJGHC staff have taught the students on campus over the first three years of their course.

"Learning in the clinical setting is an exciting progression for the students and a wonderful opportunity to learn from dedicated staff," said Professor Sandover.

It is hoped that once the medical students complete their studies, many of them will return to continue their career at the hospital.

Curtin University Midland Campus medical students at St John of God Midland Public Hospital

Awards

Throughout 2019-20, our staff, programs and services were recognised with a variety of prestigious honours and awards for their excellent work.

The RPBG Prison Hepatitis C Videocall Treatment Program were winners in Category Five of the WA Health Excellence Awards – Overcoming inequities.

Dr Sherman Kwan was awarded the Western Australian 2019 Junior Doctor of the Year Award by the Post Graduate Medical Council of WA.

Professor Stephen Dunjey was recognised with a Lifetime Achievement Award from the Australasian College for Emergency Medicine in the areas of education and training.

The RPBG Endoscopy Preadmission Nurse Clinic, Gastroenterology and Hepatology, were winners in Category One of the WA Health Excellence Awards - Managing Resources Efficiently and Effectively and the winner of the prestigious Director General's Award.

Dr Richard Leslie was awarded the prestigious Buchanan Prize by the Australasian College for Emergency Medicine, for achieving the highest mark in the College's Fellowship Clinical Examination across Australia and New Zealand.

EMHS staff were awarded four out of the five available prizes in the 2019 Health Round Table Innovation Awards:

Nicola Frew
Well, well, well:
A good state of being.

Sam Hilmi and Nick May
The prescribing for safety pilot study: a different way of thinking.

Sarah Ward and Jessica O'Sullivan
Go WEST – improving access to elective surgery.

David Blythe
Establishing a follow up clinic for ICU Patients at AKG.

RPBG was recognised as an accredited Carer Friendly Employer by Carers WA.

Elaine Newman and the Forget Me Nots were awarded the Health Round Table Innovation Award for Accelerating Innovation Through Collaboration.

Cory Payne was a 2020 WA Young Australian of the Year finalist for his work establishing the Prevent Alcohol and Risk-related Trauma in Youth (PARTY) program at SJGMPH.

Staff feedback

The 2019 Your Voice in Health (YViH) survey provided an opportunity for all EMHS staff to have their say and provide genuine, confidential feedback on what they thought we did well as a health service and where we can improve. The feedback contributed to making several improvements across EMHS, focussing on valuing and recognising staff for the work they do; staff feedback and the management of poor performance; and making it safe for staff to speak up and challenge the way things are done.

Key achievements in these areas included:

- launch of the EMHS Peak Performance Program and Crucial Conversations workshops for managers and supervisors;
- development of an EMHS Recognition Framework;
- development of a Leadership Development Framework;
- launch of the AKG Futures Program and Workforce and Organisational Development Strategic Framework;
- introduction of a leadership and cultural transformation program within RPBG mental health, to support collaboration and engagement within and between teams;
- launch of the RPBG Daily Stand Up to facilitate greater communication between departments, allowing for better coordination of the hospital's response to daily demands.

The 2020 YViH survey will further inform areas for celebration and targeted improvement to increase staff engagement.

Commissioner's Instruction 23

During 2019-20, EMHS progressed the review of fixed term and casual staff eligibility for conversion to permanency provided for through the Public Sector Commissioner's Instruction 23 (CI23).

EMHS converted **175** fixed term and **140** casual staff to permanent positions. In particular, the permanent workforce profile has been significantly bolstered in PSS and professional and clerical roles, providing greater employment certainty to those staff and their families.

Amidst the uncertainty created by COVID-19, the increased job security provided by permanent employment has enabled EMHS to better retain quality staff which has further assisted in improving the overall services that EMHS delivers to its patients and the community.

Patient support services staff transitioned to permanent employment through the CI23 process

Substantive equality

EMHS is committed to achieving substantive equality by eliminating systemic forms of discrimination in the provision of services and promoting awareness of the different needs of our consumer groups.

Mental health services

EMHS is committed to providing mental health consumers with recovery-oriented mental health services, which seek to help consumers manage their condition, understand their abilities and disabilities, and assist them on their journey to leading a healthier and meaningful life. Examples demonstrating this commitment include:

- Ensuring all mental health staff receive education about recovery-oriented care and undertake continuous education regarding the physical needs of patients. Staff are also provided with trauma-informed care training and education to better assist consumers who have experienced trauma.
- Management plans are developed collaboratively with the consumer.
- Daily Stand Up meetings for bed flow ensures patients are transitioned from a busy ED as soon as possible and a daily multidisciplinary team stand up meeting occurs to discuss risks and front line needs of each admitted consumer.
- Reviewing mental health procedures, including the development of recovery-oriented standard operating procedures and implementing less seclusion and restraint for consumers.
- AKG are undertaking research with Murdoch University, with review by the Mental Health Advocacy Service, on restrictive mental health practices to ensure the consumer voice is represented.
- RPBG's Mental Health Division ensures consumers, carers and family members are included and supported to participate in care planning and delivery of care. This includes supporting consumers to make informed decisions and manage their own health care and encouraging them to learn from the experiences of lived experience representatives. The RPBG Lived Experience Advisory Group (LEAG), which provides advice and feedback on mental health services, consists of both consumers and carers of the service and has an integral role in ensuring RPBG's Mental Health Division is inclusive.

Aboriginal and Torres Strait Islanders

EMHS continues to work towards substantive equality for the Aboriginal population through a range of initiatives including:

- The EMHS Aboriginal Health and Wellbeing Framework action plan continues to address the six strategic directions of the WA Aboriginal Health and Wellbeing Framework and contributes to improved outcomes for Aboriginal people in the east metropolitan catchment area.
- Ongoing engagement with the four Aboriginal Health Community Advisory Groups (AHCAG) and the Aboriginal Health Advisory Council (AHAC), and the associated working groups continue the strategic partnership with the Aboriginal community in the catchment area.

- Through the Aboriginal Health Impact Statement and Declaration process, EMHS ensures the needs, interests of and potential impacts on Aboriginal clients and employees are considered and appropriately incorporated when developing a new or revised policy, strategy, program, practice, procedure or health initiative. In 2019-20 Aboriginal consumers and employees consulted on **62** organisational documents, including **28** policies. **22** impact statement declarations (ISDs) were completed.
- Delivering community and population health programs specifically for Aboriginal people across the metropolitan region by appropriately trained Aboriginal staff, with the aim of education, prevention and management of chronic disease and illness.
- Engaging with Aboriginal patients and families to improve access and pathways for Aboriginal people in hospital through Aboriginal Health Liaison programs, Aboriginal maternity services and Aboriginal Acute Care Coordination Team.
- Aboriginal cultural learning continues to guide staff to develop their cultural competencies. Training includes mandatory Aboriginal Cultural eLearning, Aboriginal Mental Health Training delivered by Wungen Kartup Specialist Aboriginal Mental Health Service and Aboriginal Patient Centred Care training delivered by the Training Centre in Subacute Care Western Australia.
- Implementing strategies to be culturally respectful and welcoming, including implementing cultural event protocols, having Welcome to Country and flag raising ceremonies for major events, installing acknowledgement plaques at hospital and service entrances, and incorporating Aboriginal artwork and Noongar language in consumer resources.
- Development and implementation of Aboriginal workforce strategies continue to focus on the attraction, recruitment and retention of Aboriginal employees and support the wellbeing of existing Aboriginal staff.
- The Wungen Kartup Specialist Aboriginal Mental Health Service continues to provide support to both Aboriginal consumers and carers in accessing mainstream mental health services.

Carer friendly employer

With **1 in 9** Australian employees providing care to family members or friends, it is to be expected that many of our staff are also caring for people outside of work hours. RPBG have made incredible strides to help their staff who are carers by ensuring they have the support mechanisms and resources available to assist them when they need it. To highlight this commitment, RPBG was accredited by Carers WA as a Carer Friendly Employer in December 2019.

Following extensive collaboration and consultation with staff who are carers, initiatives were introduced to ensure that any staff member who is in a caring role will have the support and flexibility to maintain their work and personal commitments. This includes:

- Developing an action plan to enhance resources and support mechanisms for our workforce following consultation with, and self-assessment of, carers within our workforce.
- Launching an intranet page with support resources and information.
- Establishing a monthly Carer's Cafe in collaboration with the CWSP.
- Upskilling of Employee Support Officers (ESO) to ensure they are aware of the program and resources available for staff.
- Rostering requests reviewed and completed if possible to aid time needed.

Additionally, EMHS sites have implemented processes to assist carers of consumers and ensure they feel included in the patient's journey. A phone number was established for carers to call as required when using an EMHS service. Information is clearly displayed across EMHS encouraging carers to provide feedback and Carers WA information and brochures are readily available. Carers are also invited to participate in family reviews with the multidisciplinary team meetings and family rooms have been set up for quiet individual meetings.

Family room at Kalamunda Hospital

Compliance with public sector standards and ethical codes

The Public Sector Standards in HR Management (the standards) set out the minimum standards of merit, equity and probity to be complied with by WA public sector bodies and their employees.

Prue Jamieson,
Senior Workforce Strategy Consultant

WA Health and EMHS maintain policies and guidelines that are consistent with the standards. These are available to all employees on the EMHS intranet and/or the WA Health policy frameworks internet pages. This includes:

- WA Health Grievance Resolution Policy and EMHS Employee Grievance Resolution Guidelines.
- WA Health Recruitment, Selection and Appointment Policy.
- WA Health Discipline Policy and EMHS Discipline Guide.
- EMHS Peak Performance Policy, guidelines, fact sheets and automated performance planning tool.
- EMHS Employee Separation Policy.
- EMHS Expression of Interest Guidelines and template.

HR Consultants are available to provide information, guidance and support to line managers in the application of these policies and procedures, and for the management of any claims of breach of standards.

EMHS maintains and supports a network of trained ESOs. These employees provide a voluntary point of contact for employees with a workplace concern or query, which may include queries about the public sector standards or related processes.

EMHS utilises WA Health's shared service centre Health Support Services (HSS) for transactional employment services. This enables consistent application of the employment standard and breach claim process to our recruitment and selection practices and provides an external mechanism for review.

Awareness of the public sector standards is communicated via:

- notification of the breach claim rights, processes and period within relevant employment and grievances processes;
- provision of information on the EMHS intranet;
- recruitment, selection and appointment training for recruiting managers and panel members; and
- peak performance training for line managers.

In September 2019, EMHS launched a new Peak Performance Program. The program, which is aligned to the Performance Management Standard (PMS), aims to improve how feedback and individual performance is managed within EMHS. A key feature of the program is to foster continuous conversations between managers and their teams.

The roll out of this program has strengthened compliance with the PMS by communicating extensively with staff about how development of their performance will be supported, and by giving our managers skills and tools to support application of the program in accordance with the principles of merit, equity, and probity.

The launch included:

- Release of an automated peak performance tool, guide and role and responsibility fact sheets.
- Conducting **18** information sessions for all staff explaining the process, tools, roles and responsibilities between September and November 2019.
- Coordinating **23** Crucial Conversations® workshops for EMHS supervisors and managers to support development of skills for effective performance conversations, attended by **408** employees.

During 2019-20, **six** breach of standard claims were lodged. Two were lodged against the grievance resolution standard, and four against the employment standard. Of the claims, one was resolved internally and was withdrawn, and five were referred to the Public Sector Commission (PSC) (three dismissed, one withdrawn after referral, one PSC declined to deal with). There were no claims against the performance management, termination or redeployment standards.

Code of conduct

Integrity and ethical behaviour are integral to EMHS's core business. We are committed to:

- putting the public interest first and fulfilling our public duty;
- making the right decisions in accordance with agreed policy and procedures;
- making decisions and taking actions that can be explained and justified.

WA Health and EMHS maintain integrity related policies and guidelines that support the implementation of the WA Public Sector Code of Ethics and the WA Health Code of Conduct Policy. This includes policies that address the management breaches of discipline; gifts, benefits and hospitality; additional employment; conflicts of interest; pre-employment integrity checking; record keeping; discrimination and harassment; workplace bullying; and use of official information. These policies are available to all employees on the EMHS intranet and/or WA Health policy frameworks page.

All EMHS employees are responsible for ensuring that their behaviour reflects the standards of conduct embodied in the WA Health Code of Conduct Policy.

To support awareness of their responsibilities, new staff receive and acknowledge the Code of Conduct as a part of their offer of employment to work with EMHS. Responsibility for workplace behaviours and conduct is reinforced at formal induction, and through completion of mandatory training including Accountable and Ethical Decision-Making, Recordkeeping Awareness and Prevention of Bullying.

We regularly encourage our staff to reflect on the EMHS values and to incorporate these into their work. This occurs formally at recruitment and within the ongoing Peak Performance Program. Additionally, regular reminders about conduct related topics are distributed across EMHS via electronic newsletters and on the EMHS intranet.

All staff are required to report suspected breaches of the Code of Conduct. Several pathways are available for staff to report concerns including speaking with their line manager, a member of HR or the Manager of Integrity and Ethics, or making contact with the EMHS Fraud Hotline, an EMHS Public Interest Disclosure (PID) Officer, the CCC, or the PSC. These options are communicated on the EMHS intranet, as well as at induction, on displayed posters and via Board and CE global messages, and newsletter reminders.

An EMHS Ethical Conduct Review Committee, which reports to the AEG, meets monthly. This committee was established to support EMHS to take a proactive approach to integrity and ethical conduct.

During 2019-20, EMHS received **81** reports of potential breaches of the Code of Conduct (breaches of discipline). All suspected breaches of discipline, including reportable misconduct were managed in accordance with the requirements of the WA Health Discipline Policy and where appropriate reported to the PSC, or the CCC as required under the *Corruption, Crime and Misconduct Act 2003*. Where appropriate, breaches of discipline are also reported to the WA Police and/or to the Australian Health Practitioner Regulation Agency (AHPRA).

Work health and safety

EMHS commitment to occupational safety and health and injury management

EMHS is committed to ensuring the safety, health and welfare of its staff, volunteers, students, contractors, patients and visitors through the following principles:

- Promoting a culture that integrates safety as a core activity into all aspects of work.
- Supporting employees in maintaining and improving their health and wellness, through facilitation of wellness programs and strategies across EMHS.
- Ensuring all employees understand their duty of care and encourage them to take responsibility for the safety and health of themselves and others at work.
- Providing practical instruction, supervision, training, and ready access to information for all employees to enable and facilitate safe work practices.
- Enabling communication, consultation and collaboration with EMHS employees and work health and safety (WHS) representatives to ensure all practicable measures are undertaken to improve WHS performance.

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

Consultation with employees is undertaken by site WHS committee members at departmental meetings through standing agenda items. All EMHS sites have WHS Committees, which are responsible for:

- Facilitating consultation and cooperation between the employer and employees in initiating, developing and implementing measures designed to ensure the safety and health of employees in the workplace.
- Ensuring members are kept informed about current safety and health standards in comparable workplaces.
- Reviewing and providing recommendations to EMHS about workplace rules and procedures in relation to the safety and health of employees.
- Providing recommendations to EMHS and employees about the establishment, maintenance and monitoring of programs, measures and procedures in the workplace that are related to the safety and health of the employees.
- Considering any matters referred to the Committee by an elected or otherwise recognised safety and health representative.
- Performing any other functions that may be prescribed in the regulations or given to the Committee, with its consent, by the employer.

WHS Committees are evaluated at least bi-annually to ensure they meet their functional requirement and objectives. Each site has an active base of safety representatives - approximately **200** staff across all EMHS sites.

All representatives are trained and provide timely advice for staff on WHS requirements and issues in the work environment.

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

EMHS has a dedicated Injury Management (IM) team that functions in accordance with the *Workers Compensation and Injury Management Act 1981*. The site-based IM consultants provide support and guidance throughout the claim process to all key stakeholders.

The IM team have an early intervention approach to assist all injured workers to return to work. They work closely with managers and leaders to assist injured workers with timely return to work programs (RTWP), IM plans, and setting goals and objectives. A positive relationship between the injured worker, their manager and the IM consultant assists with recovery both physically and mentally. IM teams also document, monitor and review RTWP on a regular basis.

The IM consultants arrange referral to specialised medical providers to facilitate diagnosis and assist with rehabilitation programs. Where required, counselling is provided through the Employee Assistance Program or through an Insurance Commission of WA (ICWA) appointed counselling service.

ICWA reporting and oversight ensure EMHS workcover claims comply with all of the appropriate legislative requirements.

Assessment of the occupational safety and health management system

In December 2019, EMHS WHS Management system was audited at AKG and BHS against the ISO Standard 45001:2018 Occupational Health and Safety Management Systems. Action plans have been developed and will be monitored by the appropriate Executive Director.

WorkSafe notices received by any EMHS site are forwarded to the executive team and any actions are addressed at site level.

In addition, new monthly WHS and quarterly performance reports have been developed, which are used to assist with monitoring performance.

Percentage of agreed actions completed following assessment of the occupational safety and health system

A number of actions following assessment of the occupational safety and health system have been completed, however work towards completing the actions was largely put on hold during the COVID-19 response. It is anticipated the majority of actions will be completed by the end of 2020.

Workers' compensation

EMHS is committed to providing staff with a safe and healthy work environment in order to deliver effective and efficient healthcare services. EMHS has a well-established IM system to assist employees who sustain an injury during the course of their work. The IM system is supported by a dedicated IM team who work with injured employees, managers, treating medical practitioners and the insurer. This allows EMHS to provide active and early intervention to assist employees to remain at work while recovering from a work-related injury or illness, or have a safe return to duties as soon as medically appropriate.

In 2019-20, a total of **274** workers' compensation claims were made, resulting in a reduction in claim lodgement by **9.6 per cent** compared to the previous financial year.

Number of workers' compensation claims by occupational group

28
Administration and clerical
2018-19: 27

97
Nursing
2018-19: 114

81
Hotel services
2018-19: 93

32
Maintenance
2018-19: 34

8
Medical
2018-19: 14

0
Other, including Aboriginal and ethnic related occupations
2018-19: 0

28
Medical support
2018-19: 21

Work health and safety performance indicators

Number of fatalities	Results 2017-18 (base year)	Results 2018-19 (prior year)	Results 2019-20 (current year)
Target	0	0	0
Actual	0	0	0

Target: 0

Commentary: Zero fatalities relating to the workplace have been reported within EMHS over the last three years.

Lost Time Injury and Disease (LTI/D) incident rate (per 100)	Results 2017-18 (base year)	Results 2018-19 (prior year)	Results 2019-20 (current year)
Target	2.41	3.08	2.90
Actual	3.56	3.22	3.50

Target: 0 (or 10 per cent improvement on prior three years).

Commentary: Target not met. WHS will be undertaking staff education and training to reduce the common causes of LTI/D and are developing WHS management KPIs to reduce incident rates.

LTI/D severity rate (percentage of LTI/D)	Results 2017-18 (base year)	Results 2018-19 (prior year)	Results 2019-20 (current year)
Target	33.57%	45.30%	40.77%
Actual	46.10%	48.80%	47.47%

Target: 0 (or 10 per cent improvement on prior three years).

Commentary: Target not met. Going forward EMHS will concentrate on reducing LTI/D incidents by implementing stronger injury prevention strategies, provisioning new manual equipment, enhancing the risk assessment process and developing a safety culture at all levels of management.

Injured workers returned to work within 13 weeks

	Results 2017-18 (base year)	Results 2018-19 (prior year)	Results 2019-20 (current year)
Target	≥ 70%	≥ 70%	≥ 70%
Actual	**54.3%**	**52.0%**	**48.0%**

Target: ≥ 70 per cent

Commentary: Target not met. This result relates to the level of recovery in the initial three months post claim. Noted contributing factors include ageing workforce, surgical interventions and extended recovery times for injured staff.

Injured workers returned to work within 26 weeks

	Results 2017-18 (base year)	Results 2018-19 (prior year)	Results 2019-20 (current year)
Target	≥ 80%	≥ 80%	≥ 80%
Actual	**64.5%**	**72.8%**	**62.6%**

Target: ≥ 80 per cent

Commentary: Target not met. This result relates to the level of recovery in the initial six months post claim. Contributing factors include ageing workforce, surgical interventions and extended recovery times for injured staff.

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

	Results 2017-18 (base year)	Results 2018-19 (prior year)	Results 2019-20 (current year)
Target	≥ 80%	≥ 80%	≥ 80%
Actual	**72.8%**	**87.1%**	**82.62%**

Target: ≥ 80 per cent

Commentary: The strong work undertaken in 2019-20 to increase manager and supervisor training continued and as a result the target was met. The slight decrease from 2018-19 is attributed to COVID-19. The introduction of the new LMS system will further improve the percentage of managers and supervisors being trained in 2020-21.

EMHS strategies to improve results

To help address the performance concerns against the PSC Code of Practice: OSH in the WA Public Sector, the EMHS WHS department has developed and is implementing a variety of strategies to help meet the performance targets in 2020-21 and beyond. These include:

- An external review of the WHS management system at AHS and BHS has been undertaken and action plans developed to address and improve the outcomes of the review.
- Progression of enhanced review of return-to-work outcomes and focus on reducing supernumerary costs to improve 13 and 26 week return-to-work results.
- The Environmental Aggression Risk Assessment tool has been introduced in all work areas throughout EMHS (previously only used in clinical areas), with the aim of achieving 100 per cent compliance.
- Approved implementation of a wellbeing program for security staff across EMHS.
- Approved new technology to improve WHS processes, introducing a cloud-based injury management software program to assist with management of all work-related injuries, to be launched late 2020.
- A state-of-the-art bariatric room at RPH has been purpose built to improve management of workplace hazards associated with the care of bariatric patients. The proposed increase of these rooms at RPH will assist to reduce injuries.
- Approved implementation of the use of electronic Visafe sensors for backs and shoulders for muscular movement reviews with the high-risk work tasks being performed, which will assist to improve the way the job is performed and reduce injuries.
- The Incident Cause Analysis Method (ICAM) tool has been introduced for evaluating serious WHS incidents.
- Developed a dashboard for monthly and quarterly safety and workers' compensation reporting.

OUR PERFORMANCE

Continuing to deliver safe and high-quality care

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

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

Learning from clinical incidents

During 2019-20, **166 291** patients were admitted to EMHS hospitals. In addition, **204 989** patients were seen in our EDs and another **564 999** patients attended an outpatient appointment.

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

In the interests of transparency, we are sharing the number of serious clinical incidents that occurred in 2019-20. Every incident provides a critical learning opportunity towards ensuring that we put in place strategies to prevent others from being harmed.

During 2019-20, there were **76** clinical incidents reported with a Severity Assessment Code rating of 1 (SAC1). A SAC1 incident is a clinical incident that has, or could have, caused serious harm or death; and which is attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.

This is a decrease compared with 122 SAC1s reported in the same period last year. The decrease is attributed to improvements in pressure injury prevention and Peripheral Intravenous Cannula (PIVC) bloodstream infections as well as decreased activity due to COVID-19. All SAC1 clinical incidents are fully investigated in line with the WA Clinical Incident Management Policy and are scrutinised by members of the EMHS Executive, as well as the EMHS Board Safety and Quality Committee.

In addition, in 2019-20, EMHS focused on strengthening its Morbidity and Mortality (M&M) review processes. An M&M review is a forum for clinicians to openly and transparently discuss the quality of care provided to patients who have died or experienced significant morbidity while under the care of a health service.

M&M review is an essential component of an integrated approach to identifying opportunities for quality improvement and organisational learning through peer review. Multiple clinical practice improvements have been implemented because of issues identified through M&M.

Of the 76 serious incidents, the patient outcome[1] was noted as:

Outcome	2019-20
No harm	4
Minor harm	0
Moderate harm	2
Serious harm	44
Death	26

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

Learning from a serious clinical incident

Situation

A middle-aged patient with a known medical history was admitted to an acute medical unit. Despite tests being performed to detect changes to the patient's heart rhythm, the patient went on to have a heart attack and needed to be transferred to the ICU.

Clinical incident

A thorough investigation of the incident concluded that there was a delay in recognising and responding to changes in the patient's heart rhythm, which if identified earlier, may have enabled an alternative treatment plan.

Contributory factors

The investigation panel identified that the patient was admitted to a bed with a heart monitoring system that only had a display located in a central area and not at the patient's bedside. While nurses and doctors could see changes in the patient's heart rhythm at the central monitor, it was difficult for the them to be alerted to these changes when they were in the patient's room. This meant staff were unaware of the alerts of changes in the heart's rhythm on the centrally located heart monitor display at the time of the incident.

Recommendations

The incident led to a review of the design of the acute medical unit, including the location of the heart monitor displays. As a result, the area was redesigned to group all patients requiring heart monitoring together and improve the alarms and alerts so that staff were made more aware of any changes in heart rhythms.

A full review of hospital treatment and escalation processes was also conducted to ensure staff roles and responsibilities were optimised during heart monitoring. This was followed up with the development of simulation exercises for staff education in recognising and managing life threatening heart rhythms.

Lessons learned

All clinical areas with heart monitoring must have a workplace design that gives a full view of monitors, together with alarm systems to ensure staff are aware of any changes in heart rhythms. Ongoing staff training and education in heart monitoring processes is vital to ensure early recognition and escalation of patient deterioration.

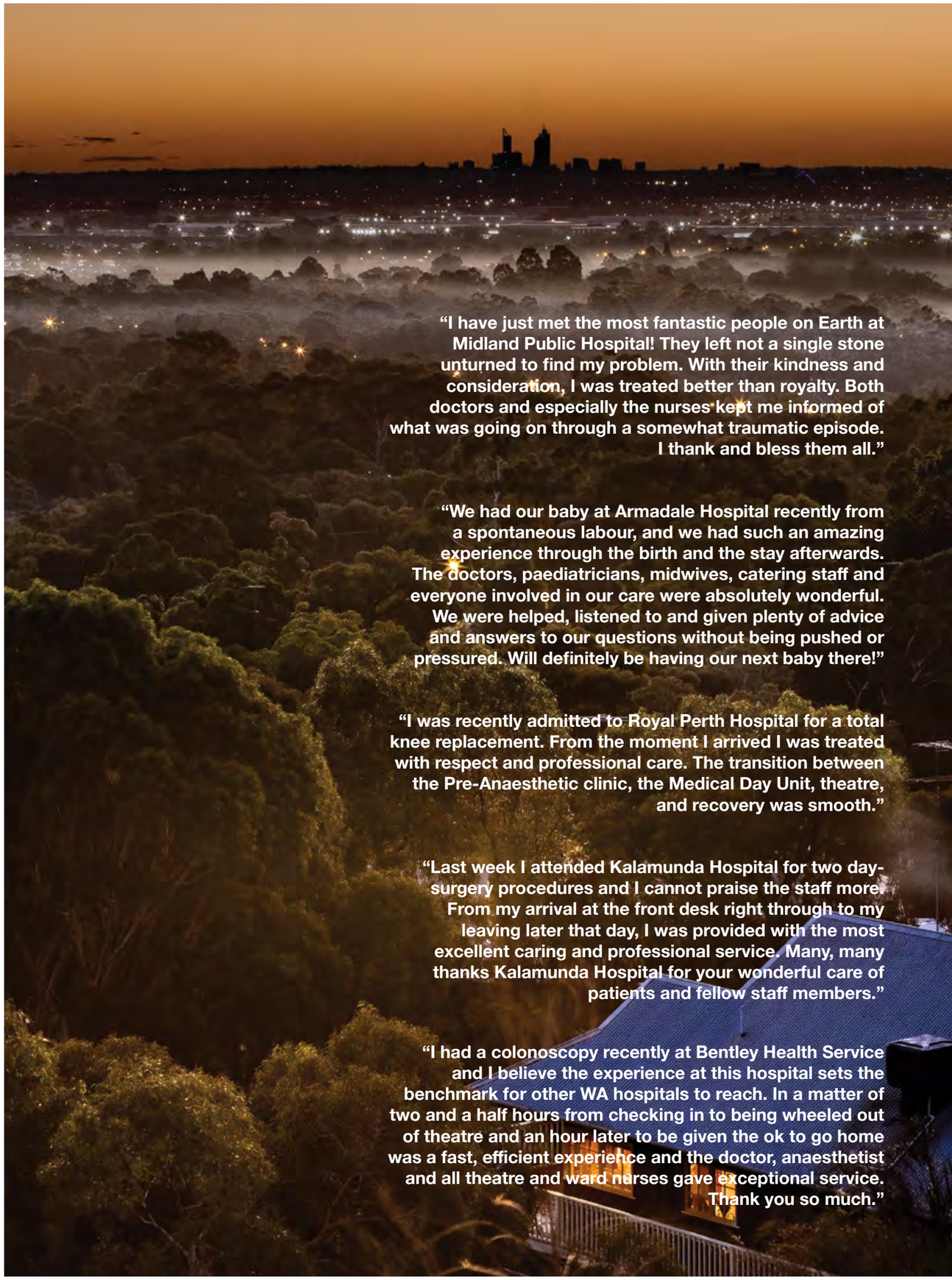
Partnering with our community

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

Improving the consumer experience

The consumer experience is at the forefront of everything we do. In 2019-20 numerous initiatives were launched to highlight this commitment to our community.

- The first Consumer Engagement Network was convened to improve the sharing and consistency of direction for staff to support consumer engagement activities across EMHS. This increased collaboration across consumer groups has promoted a shared understanding and input into policies and documents.
- EMHS put revisions to the WA Health Complaints Management Policy into practice, which improves the capturing of consumer feedback.
- Surveying mechanisms were improved, to enhance how consumer feedback is captured. This includes using a Net Promoter Score to obtain customer satisfaction metrics, implementing the Australian Commission on Safety and Quality in Health Care's Australian Hospital Patient Experience Question Set (AHPEQS) of standardised patient experience questions, and undertaking the MHC-led WA 'Your Experience Survey' (YES) of consumers of public mental health services.
- The Second Edition of the Charter of Healthcare Rights was implemented across EMHS.
- A suite of resources in various languages were implemented to assist communication with consumers of culturally and linguistically diverse backgrounds.
- EMHS endorsed and implemented the updated EMHS Consumer Representation and Participation Policy to support and strengthen the organisation's commitment to meaningful consumer participation.
- Care Opinion, an online platform for consumer feedback, was welcomed. This has replaced Patient Opinion.
- AHS Mental Health received praise for their enhanced support for patients with chronic mental health conditions. Care Opinion raised a number of consumer testimonies commending the compassionate, dedicated and hard-working staff who make the difference to the lives of individuals. The YES survey also reflected the significant efforts of AHS staff to support patients, families and carers, specifically that consumers felt safe, hopeful and respected.
- RPBG Consumer Engagement Unit received recognition for significant and sustained improvement in complaint management from the DoH's Patient Safety and Clinical Quality Directorate.



Consumer feedback

Consumers provided valuable feedback and contributed to improving the safety and quality of services.

In 2019-20, through our formal processes, EMHS received:

1190 compliments (excluding Care Opinion), including:

- 124 from consumers who identified as having a mental health condition.
- 2 from consumers who identified as being Aboriginal or Torres Strait Islander.

883 complaints (excluding Care Opinion), including:

- 134 from consumers who identified as having a mental health condition.
- 5 from consumers who identified as being Aboriginal or Torres Strait Islander.

EMHS manages patient feedback consistent with the 2020 WA Health Complaints Management Policy.

In addition, EMHS received:

77 compliments through Care Opinion, including:

- 1 from a consumer who identified as having a mental health condition.

78 complaints through Care Opinion, including:

- 4 from consumers who identified as having a mental health condition.
- 1 from a consumer who identified as being Aboriginal or Torres Strait Islander.

EMHS manages Care Opinion stories consistent with agreed KPIs and criteria for responding.

The above figures do not take into account the multitude of compliments and thanks fed back to staff informally and directly by patients, carers and their loved ones.

Click for further details about Care Opinion

Service improvement

Understanding consumer experiences and reviewing concerns is essential to improving the consumer experience across EMHS.

The main concerns shared by consumers in 2019-20 were:

- delayed and inadequate access to elective surgery, assessment and treatment;
- transfer or discharge arrangements;
- inconsiderate service.

EMHS carefully considers all feedback received and implements improvement actions where appropriate. In response to feedback received during 2019-20, a range of initiatives were progressed including:

- Surgical reform work, which will improve access to treatment and surgery.
- Multiple initiatives to increase theatre activity across RPBG were introduced to address wait lists. This included recruiting to understaffed specialties and implementing new models of care in outpatient clinics to improve patient flow through the system.
- Where appropriate, patient surgeries for day cases are now planned, instead of overnight or longer admissions. This will ensure patients are home sooner where they want to be, whilst reducing wait list times for other patients.
- Feedback from our Aboriginal community was proactively encouraged by implementing a feedback form specifically designed for Aboriginal patients. This was developed in consultation with the Aboriginal Health Strategy team to encourage feedback and is now in use.
- Activities and events focusing on the EMHS values were undertaken with staff, who were given the opportunity to focus and reflect on our organisational values and how they align with service delivery. These events demonstrate our health service's commitment to treat all consumers and staff with respect and kindness.
- Patient Centred Communication training was rolled out across EMHS and staff were provided with values-inspired mouse mats to provide a visual cue as a reminder of the EMHS values and assist with telephone courtesy.

Jennifer Booney
Aboriginal consumer representative

Heather Ryan
EMHS Aboriginal Acute Care Coordinator

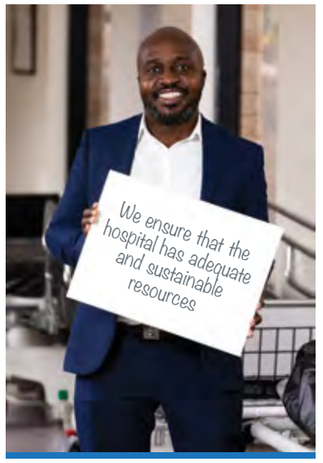
David Gow
RPBG PSS Mailroom Courier

Cassandra Eaglefield
RPBG Consumer Engagement Officer

Saki Elwes
AKG Registered Nurse

Rosamaria Sciarrone
BHS Therapy Assistant

Michael Morton
AKG HR Coordinator



Anold Maphosa
AKG Business Manager

Pey Ho
AKG Senior Occupational Therapist

Consumer Advisory Groups

Consumer Advisory Groups (CAGs) across EMHS contribute to the review, planning and development of services, policies and procedures, with 2019-20 seeing a greater focus on collaborating and sharing across areas to ensure the promotion and inclusion of EMHS's diverse community.

These CAGs have over 90 community members, and comprise:

- Four AHCAGs, as well as an Aboriginal Health Advisory Council.
- Wungen Kartup Aboriginal Consumer and Carer Advisory Group (mental health).
- Consumer Advisory Committees (CACs) at AKG, BHS and RPH.
- A mental health LEAG.

Please see page 219 for details of CAG members.

Dorothy Harrison, Chair Armadale Kalamunda Group CAC

Collaboration during COVID-19

During COVID-19 collaboration with our valued CAG members continued, despite the challenges of social distancing requirements and restricted visiting to hospitals. Staff and consumers rapidly adapted and moved standard processes and practice online, with online meetings, streamed education and forums.

CAGs also maintained regular contact with members via phone, text and email to stay engaged, including providing information on keeping safe and healthy during the pandemic.

A snapshot from our CAGs

Our consumer representatives are proactively involved in improving the patient experience across our health services. Key initiatives this past year have included:

- The co-design of the new RPH MHEC, a dedicated environment providing consultation, assessment and treatment for emergency mental health presentations.
- Input into a Safe Haven Café at RPH. This café, which is due to open in late 2020, will provide an alternative environment to hospital EDs for people to seek support for mental health, alcohol and other drug issues.
- Redesign of the City East Mental Health outpatient waiting area, providing a confidential and therapeutic environment.
- Contribution to policies, strategies and frameworks.
- Providing consultation for the development of the Aboriginal Patient Journey Continuum of Care.
- Consultation on the EMHS Health Care of the Older Adult Service Model and the EMHS Command Centre.
- Input into RPBG Clinical Services Redesign, which will improve patient outcomes by aligning functional relationships between specialties and services.
- Development of an outpatient appointment application for consumers to improve service efficiencies and the patient journey.
- Contribution to patient information sheets, including colonoscopy, physiotherapy, preventing pressure injuries and smoke-free resources.
- In response to providing mental health support during COVID-19, the LEAG consumer representatives provided a range of resources to support staff and the community. These included:
    - Participation in the My Telehealth Consult project to provide mental health consumers with remote appointments and assessments.
    - Development of posters, help cards and flyers providing wellbeing and safety advice.
    - Creation of a video offering support from mental health consumer representatives, who discussed staying well during isolation.

Emergency access

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

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

ATS timeframes and targets (thresholds)

Australasian College of Emergency Medicine target (threshold) for each ATS category is outlined below:

Australasian triage scale category		Treatment acuity (maximum waiting time for medical assessment and treatment)	Threshold
a	Triage 1	Immediate (≤ 2 minutes)	100%
b	Triage 2	10 minutes	80%
c	Triage 3	30 minutes	75%
d	Triage 4	60 minutes	70%
e	Triage 5	120 minutes	70%

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

Armadale Health Service Emergency Department

(a) Triage category 1
(patient seen within 2 minutes)

Year	Target	Actual
2019-20	**100%**	**99.8%**
2018-19	100%	100%
2017-18	100%	100%

(b) Triage category 2
(patient seen within 10 minutes)

Year	Target	Actual
2019-20	**80%**	**84.0%**
2018-19	80%	81.3%
2017-18	80%	84.0%

(c) Triage category 3
(patient seen within 30 minutes)

Year	Target	Actual
2019-20	**75%**	**43.0%**
2018-19	75%	37.6%
2017-18	75%	47.1%

(d) Triage category 4
(patient seen within 60 minutes)

Year	Target	Actual
2019-20	**70%**	**63.6%**
2018-19	70%	58.5%
2017-18	70%	64.9%

(e) Triage category 5
(patient seen within 120 minutes)

Year	Target	Actual
2019-20	**70%**	**89.8%**
2018-19	70%	89.9%
2017-18	70%	93.1%

During 2019-20, work continued on the EMHS WEAT Recovery Program which commenced in 2018. This program outlines a range of strategies to address emergency access with the aim of ensuring sustained performance and most importantly equitable access to patient care in EMHS EDs.

WEAT performance has improved since January 2020 across all EMHS sites. This has, however, coincided with the COVID-19 pandemic and an overall reduction in ED presentations across EMHS experienced since March 2020.

The focus throughout the last year has been to embed strategies which have proven effective, revise existing strategies which needed further development and implement new initiatives where appropriate.

During 2019-20, a number of key area wide and site strategies have been finalised which have a direct impact on WEAT performance. These include:

- A Capacity and Demand Reporting (CDR) dashboard was released in December 2019. The CDR brings together information from multiple enterprise systems and local site-based reference information (such as winter/summer bed plans; ED alert parameters) to present a simple fit-for-purpose holistic view of hospital capacity and demand. The CDR primarily focuses on emergency demand, inter-hospital patient transfers and hospital bed capacity, and provides greater transparency of bed status within and across EMHS hospitals to support capacity escalation decisions and operational management.
- The EMHS Inter-Hospital Patient Transfer (IHPT) policy was revised in August 2019 to include agreed transfer timeframes based on IHPT priority urgency.
- The development of a MHPF policy which incorporate bed flow expectations for HSPs, escalation protocols and local and Statewide accountability was embedded into practice in EMHS. A Statewide dashboard was developed which assists with patient flow and ensures accountability.
- The WEAT Recovery Program at RPH has been significantly strengthened through the commencement of the 'Your Time Counts' program in August 2019. This program aims to holistically address a multitude of factors across the organisation that influence the provision of timely patient care and the resulting WEAT performance at RPH. Since its launch, the program has completed a number of core projects focussing on building and sustaining a culture at RPBG where all staff communicate and collaborate as one team to improve timeliness and quality of care for every patient. Key areas of focus include implementing the CDR on RPBG wards to enable frontline staff and leaders to proactively respond to current capacity and demand pinch points, prompted by visual triggers within the real time data, and launch of the Operations Hub which enables a proactive and consistent approach to managing patient flow to improve the overall coordination, communication, timeliness and efficiency of the patient journey.
- The AKG WEAT recovery program has seen the completion of seven of the eight strategies recommended by the 2018 site review of emergency access. Planning for the commissioning of a Short Stay Unit continues. Ongoing cohort streaming in the ED has also had an impact on emergency access and shown the need for increased visibility of vulnerable cohorts including drug related psychosis, homelessness and those experiencing social isolation.
- AKG have embedded the daily huddle where key clinical and non-clinical stakeholders meet daily, demonstrating commitment to patient safety and the improvement of interdisciplinary communication. Additionally, the huddle has provided a forum for collective problem solving and shared decision making, keeping the patient and their safety central to the process. The huddle with the use of transparent information (such as the CDR), key roles in ED (Navigator) and Discharge coordinator have further strengthened care pathways into the hospital and general patient flow.

Demand for the SJGPMH ED continues to increase year on year since opening, with significant focus in 2019-20 in improving and sustaining WEAT performance. SJGPMH take a multidisciplinary approach to patient flow management including a review of the medical model of care and implementation of changes to reduce admissions and bed utilisation, with continued liaison with external providers. During 2019-20, SJGPMH have implemented:

- a rapid intervention and treatment zone (RITZ) to support management and discharge of category 3 triaged patients;
- continued collaboration with St John of God Mt Lawley for the provision of additional rehabilitation beds;
- full surge response procedure to create capacity and flow from ED.

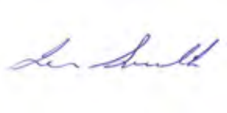
EMHS contributing sites: Armadale Health Service, Royal Perth Hospital and St John of God Midland Public Hospital.
Data period: 2017-18 to 2019-20 financial years.
Data source: Emergency Department Data Collection (EDDC).

Certification of Key Performance Indicators

East Metropolitan Health Service

Certification of Key Performance Indicators for the year ended 30 June 2020

We hereby certify that the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess East Metropolitan Health Service's performance and fairly represent the performance of the health service for the financial year ended 30 June 2020.



Ian Smith PSM
Board Chair
East Metropolitan Health Service
23 September 2020

Peter Forbes
Chair, EMHS Board Finance Committee
East Metropolitan Health Service
23 September 2020

Key Performance Indicators

Outcomes

Key Performance Indicators (KPIs) assist East Metropolitan Health Service (EMHS) to assess and monitor achievement of the following Department of Health (DoH) outcomes.

Outcome one:

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

Outcome two:

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

KPI data legend

Please note the following for KPI data:

Target

Undesired result

Desired result

For example:

Year	Target	Actual
2019	26.2	25.0
2019	26.2	27.0

Unplanned hospital readmissions for patients within 28 days for selected surgical procedures

Outcome one Effectiveness KPI

Rationale

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

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

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

Target

2019 targets for unplanned readmissions for each procedure (per 1000 separations) are outlined below. Improved or maintained performance is demonstrated by a result below or equal to target.

Procedure	Target
(a) knee replacement	≤26.2
(b) hip replacement	≤17.1
(c) tonsillectomy and adenoidectomy	≤61.0
(d) hysterectomy	≤41.3
(e) prostatectomy	≤38.8
(f) cataract surgery	≤1.1
(g) appendicectomy	≤25.7

Results

(a) Knee replacement

Year	Target	Actual
2019	**26.2**	**28.3**
2018	26.2	24.6
2017	26.2	21.0

(b) Hip replacement

Year	Target	Actual
2019	**17.1**	**15.0**
2018	17.2	25.8
2017	17.2	15.3

(c) Tonsillectomy and adenoidectomy

Year	Target	Actual
2019	**61.0**	**120.0**
2018	61.0	109.4
2017	61.0	94.4

(d) Hysterectomy

Year	Target	Actual
2019	**41.3**	**33.9**
2018	41.3	25.4
2017	41.3	68.4

(e) Prostatectomy

Year	Target	Actual
2019	**38.8**	**14.9**
2018	38.8	49.8
2017	38.8	33.8

(f) Cataract surgery

Year	Target	Actual
2019	**1.1**	**3.0**
2018	1.1	3.2
2017	1.1	1.2

(g) Appendicectomy

Year	Target	Actual
2019	**25.7**	**28.7**
2018	32.8	29.8
2017	32.9	17.5

Commentary

EMHS strives to provide safe, high-quality care to its patients at all times. In 2019, EMHS has performed well against the target of unplanned hospital readmissions within 28 days for three of the seven selected surgical procedures. Where performance has not met the target, case review has been undertaken by clinicians to identify service improvement opportunities.

Performance for hysterectomy readmissions is continuing to achieve target. Readmissions and complex case reviews are presented at the gynaecology morbidity and mortality meetings. In addition, a significant improvement in performance has been demonstrated in 2019 for prostatectomy and hip replacement, when compared with 2018. Several quality improvement actions have been identified from case reviews to streamline existing care delivery, with the aim of continuing this improved trend into 2020.

2019 is the first year the knee replacement readmission rate has been over target. A review by clinicians has identified varied themes for the readmissions and most were not directly related to the initial surgery. A number of quality improvement actions, including embedding of antibiotic governance, refinement of micro alert processes and enhancing the surgical safety checklist have been identified, which aim to reduce readmissions following a knee replacement.

EMHS continues to monitor and address performance for tonsillectomy and adenoidectomy. Instances of readmission are subject to peer review as part of a departmental morbidity and mortality review process. Case review has demonstrated that patients are often readmitted as a precaution with minor post-operative bleeding, all of which were conservatively managed. This is consistent with practice elsewhere in the health system. EMHS is considering alternative models of care for management of adult patients with minor bleeds.

Performance for cataract surgery was over target for the third year in a row. A formal ophthalmology review has been completed, with service improvements identified and initiated. This will be monitored and reported on regularly.

Although over target, overall performance for unplanned readmissions post appendicectomy has improved since 2018 (the performance target was reduced for the 2019 period from 32.8 (in 2018) to 25.7 per 1000 separations). A review of episodes of readmissions following appendicectomy noted a high degree of complexity with these individual cases, but did not identify commonality in the reasons for readmissions, nor any areas of significant concern.

EMHS contributing sites: Armadale Health Service, Bentley Health Service, Kalamunda Hospital, Royal Perth Hospital and St John of God Midland Public Hospital.
Data period: 2017 to 2019 calendar years.
Data source: Hospital Morbidity Data Collection (HMDC), WA Data Linkage System.

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

Outcome one Effectiveness KPI

Rationale

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

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

Patients are prioritised based on their assigned clinical urgency category:

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

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

Target

2019-20 target for patients waiting over boundary for all urgency categories is 0 per cent. A result equal to target is desired.

Results

(a) Urgency category 1
(within 30 days)

Year	Target	Actual
2019-20	**0.0%**	**27.0%**
2018-19	0.0%	24.1%
2017-18	0.0%	25.4%

(b) Urgency category 2
(within 90 days)

Year	Target	Actual
2019-20	**0.0%**	**18.9%**
2018-19	0.0%	20.0%
2017-18	0.0%	22.4%

(c) Urgency category 3
(within 365 days)

Year	Target	Actual
2019-20	**0.0%**	**3.3%**
2018-19	0.0%	4.7%
2017-18	0.0%	5.2%

Commentary

During 2019-20, over boundary waiting times improved for urgency categories two and three.

Improvement was noted early in the financial year, with positive trending of over boundary cases due to implementation of significant over boundary initiatives.

The temporary ceasing of elective surgery to support hospital surge capacity in response to the COVID-19 pandemic, reversed improvements in category two and three over boundary cases made in the first six months of the year, contributing to increasing wait times. Restricted recommencement also contributed to a loss of more than two months of usual activity.

EMHS has implemented a number of key initiatives to manage the elective surgery waitlist, which include:

- Additional theatre activity across EMHS particularly targeting plastic surgery, urology, gastroenterology, ophthalmology and vascular surgery.
- Redistribution of activity across EMHS to improve access and reduce wait times.
- Increased theatre utilisation of theatre sessions at Bentley Health Service (BHS).
- Introduction and embedding of an ESWL scheduling dashboard to support and guide clerical staff with bookings to align with ESWL policy.
- Armadale Health Service (AHS) commissioned a 23 hour short stay ward to support elective surgery to continue during the winter pressures.
- Review of EMHS surgical capacity and demand, seeking to support improved access to elective surgery. This included a review and benchmarking using the British Association of Day Surgery (BADS), with the aim to identify opportunities to increase same-day surgery productivity and reduce multi-day admissions.

Ongoing work continues to address challenges with urology, ear, nose and throat (ENT), ophthalmology, plastics, orthopaedics and gastroenterology. Future initiatives and programs in theatres and across the surgical journey to improve productivity and efficiency include:

- Undertaking a Transforming Theatres project (under the broader Surgical Transformation and Excellence Projects (STEPs) at Royal Perth Bentley Group (RPBG)) to progress clinician-led theatre reviews after each full six-week theatre schedule cycle. This seeks to align the RPBG theatre capacity to fluctuations in demand.
- Ongoing transition of the Quality, Efficiency and Safety in Theatres (QuEST) project to a fully operational model seeking to continuously improve waitlist management and theatre efficiency.

EMHS has also supported redirection of North Metropolitan Health Service (NMHS) gastroenterology patients' procedures to Armadale Kalamunda Group (AKG).

EMHS contributing sites: Armadale Health Service, Bentley Health Service, Kalamunda Hospital, Royal Perth Hospital and St John of God Midland Public Hospital.
Data period: 2017-18 to 2019-20 financial years (average of weekly census data).
Data source: Elective Services Wait List Data Collection (ESWLDC).

Advanced scope physiotherapy screening clinics

EMHS is committed to delivering programs and services that ensure our patients and community have access to the best possible care that is clinically appropriate and provided in a timely way.

RPBG Advanced Scope Physiotherapists (ASPs) have been supporting the spinal surgery and pain management services at RPH to deliver clinics and a new Comprehensive Spinal Pain Clinic. The service is helping to improve collaboration and communication across the multidisciplinary healthcare team while reducing surgical wait list times through evidence-based alternatives to spinal surgery, where clinically appropriate.

The ASPs work closely with Spinal Surgeons and Pain Consultants to undertake a comprehensive assessment and determine the most appropriate healthcare pathway that meets the patient's care needs. This may include discharge, physiotherapy referral, pain management, further investigations and review, surgery or orthopaedic referral.

The comprehensive ASP clinic is helping to improve the way our community access healthcare by minimising the need for multiple hospital visits and providing a single multidisciplinary treatment program.

Considerable improvements have been made to the spinal surgery wait list, with only approximately **20 per cent** of patients seen by the ASP being referred on for an appointment with a spinal surgeon within clinically appropriate timeframes.

The highly successful program is delivering evidence-based care that also addresses lifestyle factors that may be contributing to a patient's condition, including activity and exercise levels, sleep, stress, anxiety and mood management, smoking, and healthy lifestyle factors. Since 1 July 2019, **618** new patients were booked in for Spinal Surgery and Comprehensive Spinal Pain ASP Clinics.

The ASP service has contributed significantly to improved waitlist management and collaboration and communication between patients and staff across EMHS. Consequently, due to the success of this role, an ASP role is being established for the RPBG Orthopaedic Foot and Ankle Clinic to assist in maintaining a sustainable waitlist that delivers care in a timely and appropriate way.

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

Outcome one Effectiveness KPI

Rationale

Staphylococcus aureus bloodstream infection is a serious infection that may be associated with the provision of healthcare. 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).

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

A low or decreasing HA-SABSI rate is desirable and the WA target was developed based on historical results.

Target

2019 target for HA-SABSI is ≤ 1.0 per 10 000 occupied bed-days. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

Year	Target	Actual
2019	**1.0**	**0.90**
2018	1.0	0.74
2017	1.0	0.97

Commentary

EMHS again performed favourably compared with the target, achieving a result which equates to 29 infections from 321 546 bed-days.

In 2019, EMHS implemented a Hospital-Acquired Complications (HAC) Strategy, which includes strategies focused on reducing bloodstream infection rates across EMHS.

HAC reduction strategies are based on the findings and lessons arising from the clinical review of cases. For example, in late 2019, as a result of learnings from a cluster review of bloodstream infection incidents, Royal Perth Hospital (RPH) announced the implementation of an Intravenous (IV) Cannulation Team. This team has been established to directly address bloodstream infections which are largely preventable through good hand hygiene compliance and correct Peripheral Intravenous Cannula (PIVC) insertion, monitoring and timely removal.

The team plays an important role in challenging existing PIVC practices across the organisation by taking responsibility for insertion, as well as daily review of existing PIVCs. Part of this review includes:

- discussions with inpatient teams when a clear reason for a PIVC cannot be identified;
- offering medical and nursing staff advice and training on high-quality, clinically appropriate PIVC insertion.

Since being established the PIVC team has prevented over 100 PICVs being unnecessarily inserted (i.e. where alternative options were available).

In addition to implementing the EMHS HAC Strategy, well-established initiatives to minimise HA-SABSI rates are ongoing across all sites. EMHS has robust processes for the review of all potential cases of HA-SABSI by infection control specialists and treating clinicians. Additionally, education, training and regular hand hygiene auditing are ongoing.

EMHS contributing sites: Armadale Health Service, Bentley Health Service, Kalamunda Hospital, Royal Perth Hospital.
Data period: 2017 to 2019 calendar years.
Data source: Healthcare Infection Surveillance Western Australia (HISWA) Data Collection.

Sepsis

Sepsis (bloodstream infection) is estimated to affect nearly 50 million people each year globally, with approximately 11 million deaths. The EMHS Sepsis Working Group was formed to improve sepsis outcomes across our health service and has worked hard to develop and implement an evidence-based ED Sepsis Pathway, which commenced in 2019.

The implementation of the pathway has shown improved compliance with all of the processes that help identify and treat sepsis, including:

- taking two sets of blood cultures, improved from 41 per cent to 75 per cent;
- doing a lactate (blood) test, improved from 59 per cent to 95 per cent;
- timeliness of antibiotic administration, improved from 82 per cent to 95 per cent;
- giving fluids through a drip, improved from 68 per cent to 100 per cent.

This improvement in compliance demonstrates that sepsis care in EMHS EDs is improving and will lead to better outcomes for our patients.

The EMHS Sepsis Working Group have now turned their attention to implementing an inpatient sepsis pathway, as well as implementing standardised specialised sepsis pathways for paediatric and maternity patients.

Survival rates for sentinel conditions

Outcome one Effectiveness KPI

Rationale

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

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

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

Target

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

Results

Stroke

0-49 years

Year	Target	Actual
2019	**94.4%**	**93.4%**
2018	94.4%	98.7%
2017	94.3%	95.0%

50-59 years

Year	Target	Actual
2019	**93.4%**	**95.6%**
2018	93.3%	98.4%
2017	92.4%	94.4%

60-69 years

Year	Target	Actual
2019	**93.5%**	**96.5%**
2018	92.9%	95.4%
2017	92.8%	98.3%

70-79 years

Year	Target	Actual
2019	**91.3%**	**95.9%**
2018	90.0%	96.0%
2017	89.5%	95.9%

80+ years

Year	Target	Actual
2019	**83.2%**	**93.2%**
2018	82.2%	90.1%
2017	80.9%	90.8%

Commentary

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

The 0-49 year age group is slightly below target and will be monitored over the coming year. All deaths are subject to a peer review as part of a morbidity and mortality review process with actions taken to address issues and lessons learnt shared amongst clinical teams.

Acute myocardial infarction (AMI)

0-49 years

Year	Target	Actual
2019	**99.0%**	**100%**
2018	99.1%	100%
2017	99.2%	97.8%

50-59 years

Year	Target	Actual
2019	**98.9%**	**98.7%**
2018	98.9%	99.1%
2017	98.9%	99.2%

60-69 years

Year	Target	Actual
2019	**98.0%**	**98.6%**
2018	98.0%	98.7%
2017	98.1%	99.3%

70-79 years

Year	Target	Actual
2019	**96.5%**	**97.4%**
2018	96.3%	98.5%
2017	96.1%	96.8%

80+ years

Year	Target	Actual
2019	**92.2%**	**94.8%**
2018	91.9%	90.9%
2017	91.7%	94.6%

Commentary

Effective inter hospital transfer arrangements for the transfer of acute coronary syndrome patients from AHS and St John of God Midland Public Hospital (SJGMPH) to RPH for treatment continues to ensure timely access for patients to invasive coronary diagnostic and interventional procedures, leading to improved outcomes.

The 50-59 year age group is very slightly below target and will be monitored over the coming year. All deaths are subject to a peer review as part of a morbidity and mortality review process with action taken to address issues and lessons learnt shared amongst clinical teams.

Fractured neck of femur (FNoF)

70-79 years

Year	Target	Actual
2019	**98.9%**	**100%**
2018	98.7%	99.2%
2017	98.9%	98.5%

80+ years

Year	Target	Actual
2019	**96.1%**	**98.5%**
2018	95.3%	98.5%
2017	95.3%	97.2%

Commentary

It is particularly notable that a survival rate of 100 per cent was achieved for the 70-79 year age group. Improvements on performance reflects the standardisation of care provision with FNoF pathways.

EMHS contributing sites: Armadale Health Service, Bentley Health Service, Kalamunda Hospital, Royal Perth Hospital and St John of God Midland Public Hospital.
Data period: 2017 to 2019 calendar years.
Data source: Hospital Morbidity Data Collection (HMDC).

Percentage of admitted patients who discharged against medical advice

Outcome one Effectiveness KPI

Rationale

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

Between July 2013 and June 2015 Aboriginal patients in WA were almost 12.7 times more likely than non-Aboriginal patients to discharge against medical advice, compared with seven times nationally. This statistic indicates a need for improved responses by the health system to the needs of Aboriginal patients.

This indicator provides a measure of the safety and quality of inpatient care. Reporting the results by Aboriginality measures the effectiveness of initiatives within the WA health system to deliver culturally secure services to Aboriginal people and achieve equitable treatment outcomes for Aboriginal patients.

Target

2019 target for admitted patients who discharged against medical advice for both a) Aboriginal and b) non-Aboriginal patients is ≤ 0.77 per cent. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

(a) Aboriginal patients

Year	Target	Actual
2019	**0.77%**	**7.10%**
2018	0.77%	6.50%
2017	0.77%	7.48%

(b) Non-Aboriginal patients

Year	Target	Actual
2019	**0.77%**	**1.32%**
2018	0.77%	1.33%
2017	0.77%	1.33%

Commentary

While overall EMHS DAMA rates for Aboriginal patients have deteriorated, improvements for both Aboriginal and non-Aboriginal patients have been achieved at AKG and BHS.

EMHS has focused strategies to address patient DAMA rates, including:

- Further to the DAMA policy/guideline released last year, EMHS sites have enhanced awareness and education of Aboriginal Health Liaison Officers (AHLOs), including signage and uniform improvements and community lead partnerships.
- Supportive discharge workflows have been implemented, such as accessing discharge pharmacy scripts the following day.
- Redesign of the DAMA form, with prompts and supportive strategies for safe discharge for patients who are flagged to potentially DAMA.
- Connecting with drug and liaison leads in EDs.
- Training Centre in Subacute Care (TRACS) WA has developed and commenced implementation for cultural leads training across EMHS; the Supporting Aboriginal Patient Centred Care training involves upskilling local trainers to support ongoing training at sites.
- Ongoing work continues to delineate the shared patient-clinical team approach to discharge for patient initiated discharge, compared to discharge against advice.

EMHS contributing sites: Armadale Health Service, Bentley Health Service, Kalamunda Hospital, Royal Perth Hospital and St John of God Midland Public Hospital.
Data period: 2017 to 2019 calendar years.
Data source: Hospital Morbidity Data Collection (HMDC).

EMHS sites have sought to create an environment that is culturally inclusive and welcoming; recognising the importance of AHLOs and the challenges in supporting the growing demand for services. Aboriginal DAMA strategies have been developed locally by site AHLO teams.

Ken Nicholls, Aboriginal Health Liaison Officer

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

Outcome one Effectiveness KPI

Rationale

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

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

This outcome measure can lead to the development and delivery of improved care pathways and interventions to improve the health outcomes of Western Australian infants and aligns to the National Core Maternity Indicators (2019) Health, Standard 19/06/2019.

Target

2019 target for live-born term infants with an Apgar score of less than seven at five minutes post-delivery is ≤ 1.8 per cent. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

Year	Target	Actual
2019	**1.8%**	**1.29%**
2018	1.8%	1.15%
2017	1.8%	0.89%

Commentary

Performance for this indicator in 2019 is continuing to achieve target.

Although performing, the rate has increased slightly over a three year period. In order to closely monitor performance against this indicator, EMHS maternity services have implemented a clinical audit of Apgar score documentation to ensure potential subjectivity is minimised and best practice is continued across EMHS maternity services.

Findings demonstrated a high level of accuracy and remaining below target in this indicator is indicative of the quality of care and skilled workforce providing maternity and neonatal services in EMHS hospitals.

EMHS contributing sites: Armadale Health Service, Bentley Health Service and St John of God Midland Public Hospital.
Data period: 2017 to 2019 calendar years.
Data source: Midwives Notification System.

Claudia Salas; Karen Swallow, Armadale Health Service

Delivering integrated care for all

A decision made to support the WA public hospital management and response to COVID-19 saw all maternity and gynaecological services at BHS transition to AHS and King Edward Memorial Hospital in late March 2020.

This move enabled BHS to accommodate more activity as a general hospital, in preparation for an increasing demand in the WA community as the COVID-19 pandemic gained momentum.

With patient care front of mind, the AHS and BHS teams worked collaboratively to streamline the change of service location for expectant mothers and their families.

AHS welcomed the opportunity to open its doors to the Bentley patients, as part of WA Health's response to do things differently to accommodate increased demand.

The first patient and maternity staff from BHS arrived within days of the announcement, supported by an ethos of providing accessible, woman-centred care, and continuing to support them as close to home as possible.

Staff who chose to transition to AHS for the temporary change and their AHS counterparts responded proactively and professionally to implement and adapt service changes. By the end of June, the maternity service at AHS experienced a rise in usual birth numbers, welcoming **2176** babies including **22** multiple births.

With consideration given to patients and staff, a dedicated program was implemented with the intent of providing continuity of care, irrespective of service location – matching BHS mums with BHS midwives – to deliver safe, compassionate and culturally appropriate care to maternity patients.

Whilst the service transition currently remains in place, the refreshed maternity model continues to welcome expectant mothers through its doors.

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

Outcome one Effectiveness KPI

Rationale

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

While multiple hospital admissions over a lifetime may be necessary for someone with ongoing illness, a high proportion of readmissions shortly after discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was not adequate to maintain the patient's recovery out of hospital. These readmissions mean that patients spend additional time in hospital and utilise additional resources. A low readmission rate suggests that good clinical practice is in operation. Readmissions are attributed to the facility at which the initial separation (discharge) occurred rather than the facility to which the patient was readmitted.

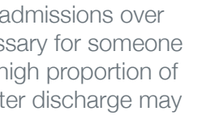
By monitoring this indicator, key areas for improvement can be identified. This can facilitate the development and delivery of targeted care pathways and interventions aimed at improving the mental health and quality of life of Western Australians.

Target

2019 target for readmissions to acute specialised mental health inpatient services within 28 days of discharge is ≤ 12 per cent. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

Year	Target	Actual
2019	**12.0%**	**15.7%**
2018	12.0%	13.3%
2017	12.0%	15.7%



Commentary

While results suggest that the 28 day readmissions rate did not improve in 2019, it is important to note that the dataset does not differentiate between planned and emergency readmissions.

EMHS has implemented a number of focused strategies to address 28 day readmission rates, including:

- Sites continue to investigate care provision and discharge planning factors which may contribute to readmission and engage in monthly analysis and trending reports on readmissions, targeting lessons learnt and future actions to address readmission rates.
- RPBG Mental Health Homeless Pathways project has provided increased clinical support and assessment for homeless mental health consumers, in order to provide accommodation options and prevent readmissions.
- Commencement of alcohol and other drug consultation and liaison service at AHS.
- Across EMHS, mental health services continue to progress the Mental Health Quality Improvement Program, which commenced in November 2019 to support implementation of improvements such as service profile mapping and gap analysis; care coordination policy framework review; a dual diagnosis model of care; and commencement of new evaluation systems.

RPBG are progressing a Mental Health Recovery Focussed Care Working Group to provide a multi-disciplinary forum to evaluate current systems, processes and care delivery, with the aim to progress incorporation of recovery principles into culture and practice within the service. This will include a number of improvements focussed on supporting consumers towards sustainable recovery, including exploring alternatives to readmission within 28 days of discharge where possible.

Kat Ahlers, Project Manager, Mental Health Homeless Pathways

EMHS contributing sites: Armadale Health Service, Bentley Health Service, Royal Perth Hospital and St John of God Midland Public Hospital. Data period: 2017 to 2019 calendar years.

Please note: comparative data for 2017 and 2018 included patients admitted to the Ursula Frayne Unit at St John of God Mount Lawley. EMHS was commissioned by the Mental Health Commission to provide inpatient services to the unit until 30 June 2018. Therefore, data is inclusive of Ursula Frayne Unit for the full 2017 calendar year and from 1 January 2018 to 30 June 2018. From 1 July 2018, inpatient services were purchased by the Mental Health Commission from another provider.

Data source: Hospital Morbidity Data Collection (HMDC) inpatient separations.

Mental health homeless pathways

Throughout 2019-20, RPBG piloted the Mental Health Homeless Pathways Project. The project aimed to improve health outcomes for mental health consumers experiencing homelessness, by strengthening their pathways to accommodation and collaborating with community organisations able to provide them with ongoing support.

The project had four clearly defined deliverables for success:

- identification and data collection of homeless patients who had attended RPH and BHS;
- build and strengthen homeless consumers pathways to accommodation;
- build collaborative partnerships with community organisations
- enhance staff training and education regarding working with homeless consumers.

The project working group commenced by identifying which mental health consumers who attended RPBG during a 12-month period were experiencing homelessness. Through this research, **943** mental health consumers were identified as being homeless. Teams were able to map how often these patients had visited the hospital within the previous two years and evaluate the ongoing health care and personal needs of these consumers.

This information was integral to the project as it allowed the working group to identify gaps within the patient journey and determine their needs beyond a hospital setting. By using this data, the working group gained approval to trial the objectives of the Mental Health Homeless Pathways Project with consumers.

This project so far has proven highly successful. The project team have permanently housed **27** mental health consumers and provided them with enhanced support and stable accommodation using the Housing First Model, which has resulted in a significant reduction in ED presentations and inpatient admissions.

114 RPBG clinicians have been trained in the Housing First Model and use of the Vulnerability Index Service Prioritisation Decision Assistance Tool (VISPDAT) and By-Name List. The VISPDAT is an international tool used as an objective measurement of service intervention and prioritises needs based on a scoring system of vulnerability.

Through this project RPBG now have access to receive and input information to the By-Name List – a real-time list of people experiencing homelessness in our community. **18** homelessness champions across RPBG will be trained in using the database to add consumers to VISPDAT and update information which informs over **40** agencies across Perth working to house and support our most vulnerable consumers.

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

Outcome one Effectiveness KPI

Rationale

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

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

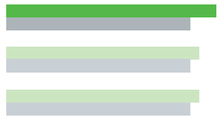
The standard underlying this measure is that continuity of care requires prompt community follow-up in the period following discharge from hospital. A responsive community support system for persons who have experienced a psychiatric episode requiring hospitalisation is essential to maintain their clinical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

Target

2019 target for post-discharge community care within seven days following discharge from acute specialised mental health inpatient services is ≥ 75 per cent. Improved or maintained performance is demonstrated by a result equal to or exceeding target.

Results

Year	Target	Actual
2019	**75.0%**	**85.5%**
2018	75.0%	78.4%
2017	75.0%	78.4%



Commentary

2019 results indicate that the community care provided within seven days post-discharge has improved significantly across most EMHS sites. It is pertinent to note that 2019 results include contact with patients' associates (e.g. advocates).

EMHS has implemented a number of key initiatives to support community care within seven days post-discharge, including:

- In 2018, it was noted that Psychiatric Services Online Information System (PSOLIS) data entry issues resulted in under reporting for this KPI. Sites have reviewed processes for monitoring seven day follow up, with ongoing education strategies (PSOLIS use) implemented.
- RPBG Mental Health Emergency Centre (MHEC) is supported by a Community Integration Nurse who is directly responsible for facilitating the seven day follow up process.
- RPBG mental health division have established a Morbidity and Mortality Committee to provide a forum to review any incidents where seven day follow up contact has not occurred.

Future plans for ongoing improvement include establishing site working groups to evaluate seven day follow up systems and inform the review of post-discharge models of care.

EMHS contributing sites: Armadale Health Service, Bentley Health Service, Royal Perth Hospital and St John of God Midland Public Hospital.
Data period: 2017 to 2019 calendar years.
Please note: comparative data for 2017 and 2018 included patients admitted to the Ursula Frayne Unit at St John of God Mount Lawley. EMHS was commissioned by the Mental Health Commission to provide inpatient services to the unit until 30 June 2018. Therefore, data is inclusive of Ursula Frayne Unit for the full 2017 calendar year and from 1 January 2018 to 30 June 2018. From 1 July 2018, inpatient services were purchased by the Mental Health Commission from another provider.
Data source: Hospital Morbidity Data Collection (HMDC) inpatient separations and Mental Health Information Data Collection (MInD).

Average admitted cost per weighted activity unit

Outcome one Efficiency KPI

Service one: Public hospital admitted services

Rationale

This indicator is a measure of the cost per weighted activity unit (WAU) compared with the State target, as approved by the Department of Treasury and published in the 2019-20 Budget Paper No. 2, Volume 1.

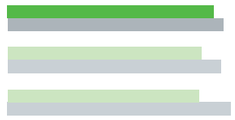
The measure ensures a consistent methodology is applied to calculating and reporting the cost of delivering inpatient activity against the state's funding allocation. As admitted services received nearly half of the overall 2019-20 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

Target

2019-20 target for average admitted cost per WAU is $7026. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

Year	Target	Actual
2019-20	**$7026**	**$6722**
2018-19	$6948	$6323
2017-18	$7285	$6230



Commentary

The target for 2019-20 was developed at a WA Health level for all Health Service Providers (HSPs). Performance against the 2019-20 target demonstrates the EMHS performed better than the target with the result demonstrating an average admitted cost per WAU of $6722 or $304 below the 2019-20 target of $7026.

When compared to the 2018-19 average admitted cost per unit, there is an increase of $399 per WAU in 2019-20. This increase is primarily related to the need to maintain fixed levels of staffing for the delivery of all admitted 'business as usual hospital services', while concurrently preparing for the expected impacts of the COVID-19 pandemic. This included recruiting additional staff, opening specific dedicated clinics, and increasing expenditure on personal protective equipment (PPE) to ensure the continued health and safety of staff and patients on hospital campuses.

EMHS contributing sites: Armadale Health Service, Bentley Health Service, Kalamunda Hospital, Royal Perth Hospital and St John of God Midland Public Hospital, St John of God Mt Lawley (contracted services).
Data period: 2017-18 to 2019-20 financial years.
Data source: OBM Allocation application, Oracle 11i financial system, Hospital Morbidity Data Collection extracts, TOPAS, webPAS and Contracted Health Entity (CHE) data extracts.

Average Emergency Department cost per weighted activity unit

Outcome one Efficiency KPI

Service two: Public hospital emergency services

Rationale

This indicator is a measure of the cost per WAU compared with the State target as approved by the Department of Treasury, which is published in the 2019-20 Budget Paper No. 2, Volume 1.

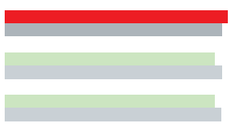
The measure ensures that a consistent methodology is applied to calculating and reporting the cost of delivering ED activity against the state's funding allocation. With the increasing demand on EDs and health services, it is important that ED service provision is monitored to ensure the efficient delivery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

Target

2019-20 target for average ED cost per WAU is $7071. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

Year	Target	Actual
2019-20	**$7071**	**$7251**
2018-19	$7072	$6835
2017-18	$7043	$6842



Commentary

The target for 2019-20 was developed at a WA Health level for all HSPs. The EMHS average ED cost per WAU is $7251 which is $180 above the target of $7071.

Comparisons with the 2018-19 average ED cost per unit, show an increase of $416 per WAU in 2019-20. This increase is primarily related to the need to maintain fixed levels of staffing for the delivery of all emergency 'business as usual hospital services', while concurrently preparing for the expected impacts of the COVID-19 pandemic. ED services were required to remain open and fully prepared for all emergency situations, and to ensure staff and patients remained safe and protected in an uncertain environment related to the pandemic.

EMHS contributing sites: Armadale Health Service, Royal Perth Hospital and St John of God Midland Public Hospital.
Data period: 2017-18 to 2019-20 financial years.
Data source: OBM Allocation application, Oracle 11i financial system, Emergency Department Data Collection (EDDC).

Average non-admitted cost per weighted activity unit

Outcome one Efficiency KPI

Service three: Public hospital non-admitted services

Rationale

This indicator is a measure of the cost per WAU compared with the state (aggregated) target, as approved by the Department of Treasury, which is published in the 2019-20 Budget Paper No. 2, 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

2019-20 target for average non-admitted cost per WAU is $6992. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

Year	Target	Actual
2019-20	**$6992**	**$7789**
2018-19	$7136	$7293
2017-18	$7160	$7238

Commentary

The target for 2019-20 was developed at a WA Health level for all HSPs. The EMHS average non-admitted cost per WAU is $7789 which is $797 above the target of $6992.

There was an increase of $496 in non-admitted cost per unit in 2019-20 when compared to 2018-19. While the pandemic caused a decrease in the number of patients seeking outpatient services, the clinics remained fully functioning and operating to service those patients who continued to require appointments and ongoing care for medical conditions. Additional costs relate primarily to ensuring sufficient PPE to ensure the continued health and safety of staff and patients on hospital campuses.

EMHS contributing sites: Armadale Health Service, Bentley Health Service, Kalamunda Hospital, Royal Perth Hospital and St John of God Midland Public Hospital, St John of God Mt Lawley (contracted services).
Data period: 2017-18 to 2019-20 financial years.
Data source: OBM Allocation application, Oracle 11i financial system, Non Admitted Patient Activity and Wait List Data Collection (NAPAAWL DC), Interim Collection of Aggregate Data (ICAD).

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

Outcome one Efficiency KPI

Service four: Mental health services

Rationale

Specialised mental health inpatient services provide patient care in authorised hospitals and designated mental health units located within hospitals. To ensure quality of care and cost effectiveness, it is important to monitor the unit cost of admitted patient care in specialised 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

2019-20 target for average cost per bed-day in specialised mental health inpatient services is $1492. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

Year	Target	Actual
2019-20	**$1492**	**$1746**
2018-19	$1456	$1581
2017-18	$1144	$1482

Commentary

The EMHS average cost per bed-day in specialised mental health inpatient services is $1746, which is $254 above the target of $1492. Mental health inpatient services require highly specialised resources to appropriately manage the demands of a highly complex patient group.

The 2019-20 average cost per bed-day in specialised mental health inpatient services of $1746 is $165 unfavourable when compared against the 2018-19 result of $1581. The increased costs relate in part to the introduction of a new model of care for mental health patients which supports increased access to mental health inpatient services, commencing in the ED; a realignment of costs for the accuracy and completeness in data collection and performance assessment; and the need to increase the level of protection to ensure the health and safety of mental health staff involved in the care of patients admitted with complex issues.

EMHS contributing sites: Armadale Health Service, Bentley Health Service, Royal Perth Hospital and St John of God Midland Public Hospital.
Data period: 2017-18 to 2019-20 financial years.
Data source: OBM Allocation application, Oracle 11i financial system, BedState.

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

Outcome one Efficiency KPI

Service four: Mental health services

Rationale

Public community mental health services consist of a range of community-based services such as emergency assessment and treatment, case management, day programs, rehabilitation, psychosocial, residential services and continuing care. The aim of these services is to provide the best health outcomes for the individual through the provision of accessible and appropriate community mental health care. Efficient functioning of public community mental health services is essential to ensure that finite funds are used effectively to deliver maximum community benefit.

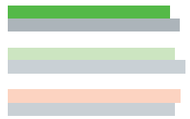
Public community-based mental health services are generally targeted towards people in the acute phase of a mental illness who are receiving post-acute care. This indicator provides a measure of the cost effectiveness of treatment for public psychiatric patients under public community mental healthcare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

Target

2019-20 target for average cost per treatment day of non-admitted care provided by mental health services is $420. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

Year	Target	Actual
2019-20	**$420**	**$396**
2018-19	$434	$409
2017-18	$409	$422



Commentary

The EMHS average cost per treatment day of non-admitted care provided by mental health services is $396 which is $24 below the target of $420. These results indicate that EMHS has efficiently provided non-admitted services to patients seeking mental health services outside of admitted hospital care. There is an observable increase in the number of treatment days recorded in 2019-20 when compared to 2018-19, indicating more mental health services are being delivered outside of mainstream hospital admission.

EMHS contributing sites: Armadale Health Service, Bentley Health Service, Royal Perth Hospital and St John of God Midland Public Hospital.
Data period: 2017-18 to 2019-20 financial years.
Data source: OBM Allocation application, Oracle 11i financial system, Mental Health Information Data Collection.

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

Outcome two Efficiency KPI

Service six: Public and community health services

Rationale

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

Population health aims to improve health by integrating all activities of the health sector and linking them with broader social and economic services and resources as described in the WA Health Promotion Strategic Framework 2017–21. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Commentary

While census data indicates that population numbers in the EMHS catchment increased over time, EMHS continues to be able to deliver an efficient level of service. This has resulted in the average cost per person of delivering population health programs being lower by $4 than the 2019-20 target of $17, a $2 improvement on the actual cost per person in 2018-19.

Target

2019-20 target for average cost per person of delivering population health programs is $17. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

Year	Target	Actual
2019-20	**$17**	**$13**
2018-19	$13	$15
2017-18	$4	$15

Please note, data for:
- 2017-18 was calculated based on the WA Health Epidemiology Branch from 2012-16 estimates.
- 2018-19 was based on 2013-17 calendar year population.
- 2019-20 is based on 2014-18 estimates.

EMHS contributing sites: East Metropolitan Health Service.
Data period: 2017-18 to 2019-20 financial years.
Data source: OBM Allocation application, Oracle 11i financial system, estimated resident populations for 2014-18 as extracted from the Epidemiology Branch calculator, Epidemiology Branch, Public and Aboriginal Health Division, WA Department of Health, projection of 2019 population by Epidemiology Branch.

FINANCIAL STATEMENTS

Certification of financial statements

Certification of Financial Statements

For the reporting period ended 30 June 2020

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

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

Ian Smith PSM
Board Chair
East Metropolitan Health Service
23 September 2020

Peter Forbes
Chair, EMHS Board Finance Committee
East Metropolitan Health Service
23 September 2020

Graeme Jones
Chief Finance Officer
East Metropolitan Health Service
23 September 2020

Auditor General

INDEPENDENT AUDITOR'S REPORT

To the Parliament of Western Australia

EAST METROPOLITAN HEALTH SERVICE

Report on the financial statements

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

In my opinion, the financial statements are based on proper accounts and present fairly, in all material respects, the operating results and cash flows of the East Metropolitan Health Service for the year ended 30 June 2020 and the financial position at the end of that period. They are in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions.

Basis for opinion
I conducted my audit in accordance with the Australian Auditing Standards. My responsibilities under those standards are further described in the Auditor's Responsibility for the Audit of the Financial Statements section of my report. I am independent of the Health Service in accordance with the *Auditor General Act 2006* and the relevant ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial statements. I have also fulfilled my other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

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

In preparing the financial statements, the Board is responsible for assessing the entity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Western Australian Government has made policy or funding decisions affecting the continued existence of the Health Service.

Auditor's responsibility for the audit of the financial statements
As required by the *Auditor General Act 2006*, my responsibility is to express an opinion on the financial statements. The objectives of my audit are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

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

Report on controls

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

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

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

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

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

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

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

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

Report on the key performance indicators

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

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

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

- Percentage of emergency department patients seen within the recommended times

The Under Treasurer's approval requires WA Health to reassess whether this indicator can be re-instated as a KPI once a new emergency department data collection system has been implemented. There is currently no set timeframe for the implementation of a new system.

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

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

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

An assurance engagement involves performing procedures to obtain evidence about the amounts and disclosures in the key performance indicators. It also involves evaluating the relevance and appropriateness of the key performance indicators against the criteria and guidance in Treasurer's Instruction 904 for measuring the extent of outcome achievement and the efficiency of service delivery.

The procedures selected depend on my judgement, including the assessment of the risks of material misstatement of the key performance indicators. In making these risk assessments I obtain an understanding of internal control relevant to the engagement in order to design procedures that are appropriate in the circumstances.

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

My independence and quality control relating to the reports on controls and key performance indicators

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

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

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

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

East Metropolitan Health Service
Statement of comprehensive income
For the year ended 30 June 2020

	Note	2020 $000	2019 $000
Cost of services			
Expenses			
Employee benefits expense	3.1(a)	874,721	841,079
Fees for visiting medical practitioners	3.4	28,327	29,710
Contracts for services	3.2	312,723	288,127
Patient support costs	3.3	218,780	215,116
Finance costs	3.4	53	40
Depreciation and amortisation expense	5.4	43,054	44,084
Asset revaluation decrement	3.4	70	2,010
Loss on disposal of non-current assets	3.4	45	805
Repairs, maintenance and consumable equipment	3.4	27,033	24,395
Other supplies and services	3.4	7,142	7,712
Commercial activities	4.7	371	-
Other expenses	3.4	90,267	79,299
Total cost of services		1,602,586	1,532,377
Income			
Revenue			
Patient charges	4.4	72,477	67,689
Other fees for services	4.5	44,986	48,184
Commonwealth grants and contributions	4.2	520,243	499,647
Other grants and contributions	4.3	134,625	132,697
Donation revenue	4.6	225	196
Commercial activities	4.7	-	154
Other revenue	4.8	12,286	18,587
Total income other than income from State Government		784,842	767,154
Net cost of services		817,744	765,223
Income from State Government			
Service appropriations	4.1	757,418	718,928
Assets assumed/(transferred)	4.1	(2)	95
Services received free of charge	4.1	62,410	53,476
Total income from State Government		819,826	772,499
Surplus for the period		2,082	7,276
Other comprehensive income			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	8	8,660	(10,443)
Total other comprehensive income		8,660	(10,443)
Total comprehensive income/(loss) for the period		10,742	(3,167)

The statement of comprehensive income should be read in conjunction with the accompanying notes.
See also note 2.2 'Schedule of income and expenses by service'.

East Metropolitan Health Service
Statement of financial position
As at 30 June 2020

	Note	2020 $000	2019 $000
Assets			
Current assets			
Cash and cash equivalents	7.3	154,098	135,893
Restricted cash and cash equivalents	7.3	30,952	28,706
Receivables	6.1	23,152	30,119
Inventories	6.3	4,497	4,519
Other current assets	6.4	1,076	1,207
Total current assets		213,775	200,444
Non-current assets			
Restricted cash and cash equivalents	7.3	12,944	9,710
Amounts receivable for services	6.2	527,618	481,822
Property, plant and equipment	5.1	860,355	875,506
Right-of-Use Assets	5.2	1,989	-
Intangible assets	5.3	692	1,221
Other non-current assets	6.4	-	37
Total non-current assets		1,403,598	1,368,296
Total assets		1,617,373	1,568,740
Liabilities			
Current liabilities			
Payables	6.5	95,193	82,321
Borrowings	7.1	-	839
Lease liabilities	7.2	535	-
Employee benefits provisions	3.1(b)	178,262	169,305
Other current liabilities	6.6	527	461
Total current liabilities		274,517	252,926
Non-current liabilities			
Employee benefits provisions	3.1(b)	41,769	40,984
Lease liabilities	7.2	1,463	-
Total non-current liabilities		43,232	40,984
Total liabilities		317,749	293,910
Net assets		1,299,624	1,274,830
Equity			
Contributed equity	8	1,146,450	1,132,398
Reserves	8	87,293	78,633
Accumulated surplus		65,881	63,799
Total equity		1,299,624	1,274,830

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

East Metropolitan Health Service
Statement of changes in equity
For the year ended 30 June 2020

	Note	2020 $000	2019 $000
Contributed equity	8		
Balance at start of period		1,132,398	1,120,444
Transactions with owners in their capacity as owners:			
Capital appropriations		14,052	11,698
Other contributions by owners		-	256
Balance at end of period		1,146,450	1,132,398
Reserves	8		
Asset revaluation reserve			
Balance at start of period		78,633	89,076
Other comprehensive income for the period		8,660	(10,443)
Balance at end of period		87,293	78,633
Accumulated surplus			
Balance at start of period		63,799	56,984
Changes in accounting policy		-	(461)
Restated balance at start of period		63,799	56,523
Surplus for the period		2,082	7,276
Balance at end of period		65,881	63,799
Total equity			
Balance at start of period		1,274,830	1,266,504
Changes in accounting policy		-	(461)
Restated balance at start of period		1,274,830	1,266,043
Total comprehensive income/(loss) for the period		10,742	(3,167)
Transactions with owners in their capacity as owners		14,052	11,954
Balance at end of period		1,299,624	1,274,830

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

East Metropolitan Health Service
Statement of cash flows
For the year ended 30 June 2020

	Note	2020 $000 Inflows/(Outflows)	2019 $000 Inflows/(Outflows)
Cash flows from State Government	7.3.3		
Service appropriations		711,606	672,398
Capital appropriations		13,212	10,901
Net cash provided by State Government		724,818	683,299
Utilised as follows:			
Cash flows from operating activities			
Payments			
Employee benefits		(857,686)	(818,493)
Supplies and services		(610,328)	(585,209)
Finance costs		(39)	(1)
Receipts			
Receipts from customers (a)		71,115	65,617
Commonwealth grants and contributions		520,243	499,647
Other grants and contributions		134,625	132,697
Donations received		223	142
Other receipts (a)		59,721	67,580
Net cash used in operating activities	7.3.2	(682,126)	(638,020)
Cash flows from investing activities			
Payments			
Purchase of non-current assets		(18,471)	(13,784)
Receipts			
Proceeds from sale of non-current assets		177	96
Net cash used in investing activities		(18,294)	(13,688)
Cash flows from financing activities			
Payments			
Principal elements of lease (2019 – finance lease)		(713)	(22)
Receipts			
Net cash used in financing activities		(713)	(22)
Net increase in cash and cash equivalents		23,685	31,569
Cash and cash equivalents at the beginning of the period		174,309	142,740
Total cash and cash equivalents at the end of the period		197,994	174,309

(a) $0.47 million has been reclassed between 'Receipts from customers' and 'Other receipts' for the figures in 2019 to align with the reporting in 2020.

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

East Metropolitan Health Service
Summary of consolidated account appropriations
For the year ended 30 June 2020

	2020 Budget Estimate $000	2020 Supplementary Funding	2020 Revised Budget	2020 Actual $000	Variance between actual and estimate $000
Delivery of Services					
Item 51 Net amount appropriated to deliver services	787,802	-	787,802	819,826	(32,024)
Total appropriations provided to deliver services	787,802		787,802	819,826	(32,024)
Capital					
Item 125 Capital appropriations	37,211	-	37,211	14,052	23,159
GRAND TOTAL	825,013		825,013	833,878	(8,865)

No supplementary income was received by the Health Service.

East Metropolitan Health Service
Notes to the financial statements
As at 30 June 2020

Note 1 Basis of preparation

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

A description of the nature of its operations and its principal activities have been included in the 'Governance/Overview' which does not form part of these financial statements.

These annual financial statements were authorised for issue by the Accountable Authority of the Health Service on 23 September 2020.

Statement of compliance

These general purpose financial statements are prepared in accordance with:

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

The Financial Management Act 2006 and the Treasurer's Instructions take precedence over AAS. Several AAS are modified by the Instructions to vary application, disclosure format and wording. Where modification is required and has had a material or significant financial effect upon the reported results, details of that modification and the resulting financial effect are disclosed in the notes to the financial statements.

Basis of preparation

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

Judgements and estimates

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

Significant judgements and estimates have been made to meet the requirements of the new standards AASB 16, AASB 15 and AASB 1058.

AASB 16:

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

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

AASB 15:

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

Uncertainty may arise from determining the transaction prices (estimating variable consideration, adjusting the consideration for the time value of money and measuring non-cash considerations), allocating the transaction price, including estimating stand-alone selling prices and allocating discounts and variable consideration.

Note 1 Basis of preparation (continued)

AASB 1058:

Key judgements include determining the timing in the satisfaction of obligations and judgements used in determining whether funds are restricted.

Refer to Note 10.2 for the impact of the initial adoption and the practical expedients applied in the initial recognition.

Contributed equity

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

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

Note 2 Health Service outputs

How the Health Service operates

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

	Note
Health Service objectives	2.1
Schedule of income and expenses by service	2.2

2.1 Health Service objectives

Services

To comply with its legislative obligation as a WA Government agency, the Health Service operates under an Outcome Based Management framework (OBM). The OBM framework is determined by WA Health and replaces the former activity based costing framework for annual reporting from 2017-18 and beyond. This framework describes how outcomes, activities, services and key performance indicators (KPIs) are used to measure agency performance towards achieving the relevant overarching whole of government goal of strong communities, safe communities and supported families and the WA health system agency goal of delivery of safe, quality, financially sustainable and accountable healthcare for all Western Australians. The Health Service is predominantly funded by Parliamentary appropriations.

The Health Service provides the following services:

Public hospital admitted services

The provision of healthcare services to patients in metropolitan hospitals that meet the criteria for admission and receive treatment and/or care for a period of time, including public patients treated in private facilities under contract to WA Health. Admission to hospital and the treatment provided may include access to acute and/or sub-acute inpatient services, as well as hospital in the home services. Public hospital admitted services include teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to admitted services. This service does not include any component of the mental health services reported under 'Mental health services'.

East Metropolitan Health Service
Notes to the financial statements
As at 30 June 2020

2.1 Health Service objectives (continued)

Public hospital emergency services

The provision of services for the treatment of patients in emergency departments of metropolitan hospitals, inclusive of public patients treated in private facilities under contract to WA Health. The services provided to patients are specifically designed to provide emergency care, including a range of pre-admission, post-acute and other specialist medical, allied health, nursing and ancillary services. Public hospital emergency services include teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to emergency services. This service does not include any component of the mental health services reported under 'Mental health services'.

Public hospital non-admitted services

The provision of metropolitan hospital services to patients who do not undergo a formal admission process, inclusive of public patients treated by private facilities under contract to WA Health. This service includes services provided to patients in outpatient clinics, community based clinics or in the home, procedures, medical consultation, allied health or treatment provided by clinical nurse specialists. Public hospital non-admitted services include teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to non-admitted services. This service does not include any component of the mental health services reported under 'Mental health services'.

Mental health services

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

Aged and continuing care services

The provision of aged and continuing care services. Aged and continuing care services include programs that assess the care needs of older people, provide functional interim care or support for older, frail, aged and younger people with disabilities to continue living independently in the community and maintain independence.

Public and community health services

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2020

2.2 Schedule of income and expenses by service

	Public hospital admitted	Public hospital emergency	Public hospital non-admitted	Mental health	Aged and continuing care	Public and community health	Total
	2020 $000	2020 $000	2020 $000	2020 $000	2020 $000	2020 $000	2020 $000
Cost of services							
Expenses							
Employee benefits expense	502,225	104,590	109,488	137,081	8,234	13,103	874,721
Fees for visiting medical practitioners	21,292	1,856	5,022	157	-	-	28,327
Contracts for services	190,658	61,444	28,396	31,649	460	116	312,723
Patient support costs	141,910	19,111	40,745	8,214	2,354	6,446	218,780
Finance costs	13	1	4	25	7	3	53
Depreciation and amortisation expense	26,921	5,426	5,304	4,942	319	142	43,054
Asset revaluation decrement	43	5	14	8	-	-	70
Loss on disposal of non-current assets	27	4	9	5	-	-	45
Repairs, maintenance and consumable equipment	15,795	2,739	4,470	2,824	287	918	27,033
Other supplies and services	3,083	1,216	768	1,771	106	198	7,142
Commercial activities	252	42	66	11	-	-	371
Other expenses	50,424	9,966	9,232	15,381	967	4,297	90,267
Total cost of services	952,643	206,400	203,518	202,068	12,734	25,223	1,602,586
Income							
Patient charges	64,296	2,297	5,245	639	-	-	72,477
Other fees for services	28,427	1,633	9,666	1,377	26	3,857	44,986
Commonwealth grants and contributions	320,625	64,607	76,303	55,381	3,285	42	520,243
Other grants and contributions	479	153	144	131,444	783	1,622	134,625
Donation revenue	1	-	-	3	-	221	225
Other revenue	5,213	1,052	859	1,502	65	3,595	12,286
Total income other than income from State Government	419,041	69,742	92,217	190,346	4,159	9,337	784,842
Net cost of services	533,602	136,658	111,301	11,722	8,575	15,886	817,744
Income from State Government							
Service appropriations	498,541	127,294	103,815	4,967	7,993	14,808	757,418
Assets assumed/(transferred)	-	3	(4)	(1)	-	-	(2)
Services received free of charge	38,061	7,270	5,846	8,708	369	2,156	62,410
Total income from State Government	536,602	134,567	109,657	13,674	8,362	16,964	819,826
Surplus/(deficit) for the period	3,000	(2,091)	(1,644)	1,952	(213)	1,078	2,082

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2020

2.2 Schedule of income and expenses by service (continued)

	Public hospital admitted	Public hospital emergency	Public hospital non-admitted	Mental health	Aged and continuing care	Public and community health	Total
	2019 $000	2019 $000	2019 $000	2019 $000	2019 $000	2019 $000	2019 $000
Cost of services							
Expenses							
Employee benefits expense	486,131	103,011	106,545	127,277	6,795	11,320	841,079
Fees for visiting medical practitioners	22,859	1,750	4,929	172	-	-	29,710
Contracts for services	178,321	57,567	22,052	29,646	492	49	288,127
Patient support costs	140,831	18,324	39,054	6,511	1,827	8,569	215,116
Finance costs	24	3	10	3	-	-	40
Depreciation and amortisation expense	27,641	5,745	5,682	4,687	245	84	44,084
Asset revaluation decrement	1,348	215	375	72	-	-	2,010
Loss on disposal of non-current assets	409	61	-	303	17	15	805
Repairs, maintenance and consumable equipment	14,859	2,818	3,533	2,772	249	164	24,395
Other supplies and services	4,082	642	904	1,833	58	193	7,712
Other expenses	45,484	9,909	7,912	14,441	708	845	79,299
Total cost of services	921,989	200,045	190,996	187,717	10,391	21,239	1,532,377
Patient charges	59,404	1,942	5,476	867	-	-	67,689
Other fees for services	28,318	2,078	11,776	1,328	56	4,628	48,184
Commonwealth grants and contributions	318,214	59,882	68,097	50,014	3,285	155	499,647
Other grants and contributions	1,613	61	242	129,073	996	712	132,697
Donation revenue	130	12	21	33	-	-	196
Commercial activities	109	17	28	-	-	-	154
Other revenue	12,664	1,878	2,733	1,196	84	32	18,587
Total income other than income from State Government	420,452	65,870	88,373	182,511	4,421	5,527	767,154
Net cost of services	501,537	134,176	102,624	5,206	5,970	15,712	765,222
Income from State Government							
Service appropriations	471,329	126,093	96,443	4,690	5,610	14,763	718,928
Assets assumed/(transferred)	95	-	-	-	-	-	95
Services received free of charge	33,796	6,444	5,230	7,448	318	240	53,476
Total income from State Government	505,220	132,537	101,673	12,138	5,928	15,003	772,499
Surplus/(deficit) for the period	3,683	(1,638)	(950)	6,932	(42)	(709)	7,276

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2020

		2020 $000	2019 $000
Note 3	Use of our funding		

Expenses incurred in the delivery of services

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

	Note		
Employee benefits expense	3.1(a)	874,721	841,079
Employee benefits provisions	3.1(b)	220,031	210,289
Contracts for services	3.2	312,723	288,127
Patient support costs	3.3	218,780	215,116
Other expenses	3.4	152,937	143,970

3.1(a) Employee benefits expense

Salaries and wages	798,119	768,724
Termination benefits	1,638	792
Superannuation - defined contribution plans (a)	74,917	71,563
Total employee benefits expense	874,674	841,079
Add: AASB 16 Non-monetary benefits (b)	47	-
Net employee benefits	874,721	841,079

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

(b) Non-monetary benefits include the provision of vehicle benefits measured at cost in accordance with the application of AASB 16.

Salaries and wages: Employee expenses include all costs related to employment including salaries and wages, fringe benefits plus the fringe benefits tax component and leave entitlements including superannuation contribution components.

Workers' compensation insurance expense is excluded here but included in note 3.4 'Other expenses'.

Termination benefits: 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: The amount recognised in profit or loss of the statement of comprehensive income comprises employer contributions paid to the GSS (concurrent contributions), the WSS, the GESBs, or other superannuation funds. The employer contribution paid to the Government Employees Superannuation Board (GESB) in respect of the GSS is paid back into the Consolidated Account by the GESB.

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

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

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2020

	2020 $000	2019 $000
3.1(b) Employee benefits provisions		

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

Current		
Annual leave (a)	87,381	79,738
Time off in lieu leave (a)	25,970	25,194
Long service leave (b)	64,395	63,959
Deferred salary scheme (c)	516	414
	178,262	169,305
Non-current		
Long service leave (b)	41,769	40,984
Total employee benefits provisions	220,031	210,289

(a) Annual leave and time off in lieu leave liabilities are classified as current as there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period.

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

Within 12 months of the end of the reporting period	79,650	73,920
More than 12 months after the end of the reporting period	33,701	31,012
	113,351	104,932

Annual leave and time off in lieu leave are not expected to be settled wholly within 12 months after the end of the reporting period and therefore considered to be 'other long-term employee benefits'. The leave liability is recognised and measured at the present value of amounts expected to be paid when the liabilities are settled using the remuneration rate expected to apply at the time of settlement.

(b) Long service leave liabilities are classified as current where there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Pre-conditional and conditional long service leave provisions are classified as non-current liabilities because the Health Service has an unconditional right to defer the settlement of the liability until the employee has completed the requisite years of service.

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

Within 12 months of the end of the reporting period	14,582	14,539
More than 12 months after the end of the reporting period	91,582	90,404
	106,164	104,943

The provision for long service leave is calculated at present value as the Health Service does not expect to wholly settle the amounts within 12 months. The present value is measured taking into account the present value of expected future payments to be made in relation to services provided by employees up to the reporting date. When assessing expected future payments, consideration is given to expected future wage and salary levels including non-salary components such as employer superannuation contributions, as well as the experience of employee departures and periods of service. The expected future payments are discounted using market yields on national government bonds at the end of the reporting period with terms to maturity that match, as closely as possible, the estimated future cash outflows.

(c) The deferred salary scheme liabilities relate to Health Service employees who have entered into an agreement to self-fund an additional twelve months leave in the fifth year of the agreement. The provision recognises the value of salary set aside for employees to be used in the fifth year. The liability is measured on the same basis as annual leave. It is classified as a current provision as employees can leave the scheme at their discretion at any time.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2020

	2020 $000	2019 $000
3.1(b) Employee benefits provisions (continued)		

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

Within 12 months of the end of the reporting period	280	221
More than 12 months after the end of the reporting period	236	193
	516	414

Key sources of estimation uncertainty - long service leave
Key estimates and assumptions concerning the future are based on historical experience and various other factors that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year. Several estimates and assumptions are used in calculating the Health Service's long service leave provision. These include expected future salary rates, discount rates, employee turnover rates and usage rates of leave in service or at termination. Changes in these estimations and assumptions may impact on the carrying amount of the long service leave provision.

Any gain or loss following revaluation of the present value of long service leave liabilities is recognised as employee benefits expense.

Sick Leave
Liabilities for sick leave are recognised when it is probable that sick leave paid in the future will be greater than the entitlement that will accrue in the future. Past history indicates that on average, sick leave taken each reporting period is less than the entitlement accrued. This is expected to continue in future periods. Accordingly, it is unlikely that existing accumulated entitlements will be used by employees and no liability for unused sick leave entitlements is recognised. As sick leave is non-vesting, an expense is recognised in the statement of comprehensive income for this leave as it is taken.

	2020 $000	2019 $000
3.2 Contracts for services		
Public patients services (a)	277,563	258,245
Mental health services (a)	32,961	28,653
Home and community care (a)	462	493
Other contracts	1,737	736
Total contracts for services	312,723	288,127

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

3.3 Patient support costs		
Drug supplies	52,856	56,528
Pathology	39,772	38,054
Prosthesis	24,136	24,479
Other medical supplies and services	68,217	62,938
Domestic charges	15,392	13,931
Fuel, light and power	7,918	8,588
Food supplies	6,714	6,438
Patient transport costs	3,332	2,793
Research, development and other grants	443	1,367
Total patient support costs	218,780	215,116

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2020

	2020 $000	2019 $000
3.4 Other expenses		
Fees for visiting medical practitioners		
Clinical	20,371	23,507
Radiology	7,956	6,203
Total fees for visiting medical practitioners	28,327	29,710

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

Finance costs		
Interest expense on Treasury loan	13	40
Finance lease charges	40	-
Total finance costs	53	40

Finance costs include costs incurred in connection with the borrowing of funds and the interest component of finance lease repayments.

Asset revaluation decrement		
Land	70	2,010
Total asset revaluation decrement	70	2,010

Land revaluation decrement recognised as an expense on the statement of comprehensive income. (See note 5.1 'Property, plant and equipment').
For building revaluation increment credited to the asset revaluation reserve, see note 8 'Equity'.

Loss on disposal of non-current assets		
Carrying amount of non-current assets disposed:		
Property, plant and equipment	222	901
Proceeds from disposal of non-current assets:		
Property, plant and equipment	(177)	(96)
Net loss on disposal	45	805
Repairs, maintenance and consumable equipment		
Repairs and maintenance	21,121	18,446
Consumable equipment	5,912	5,949
Total repairs, maintenance and consumable equipment	27,033	24,395

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2020

	2020 $000	2019 $000
3.4 Other expenses (continued)		

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

Other supplies and services		
Sanitisation and waste removal services	1,458	1,531
Administration and management services	1,902	1,643
Interpreter services	1,377	1,426
Security services	1,469	940
Library subscription (e)	-	1,317
Contract management	170	-
Outsourced health promotion	104	147
Outsourced engineering	125	110
Other	537	598
Total other supplies and services	7,142	7,712

Supplies and services are recognised as an expense as incurred.

Other expenses		
Services provided by Health Support Services: (a)		
ICT services	32,983	26,963
Supply chain services	5,102	4,583
Financial services	2,033	2,109
Human resources services	7,456	5,489
Workers compensation insurance	14,135	14,138
Lease expenses (b)	642	2,125
Other insurances	5,919	6,774
Consultancy fees	3,394	3,200
Printing and stationery	2,671	2,639
Library subscription (e)	1,466	-
Expected credit losses expense (c)	5,765	3,638
Communications	2,108	1,921
Other employee related expenses	1,831	1,609
Write-down of assets (d)	25	129
Motor vehicle expenses	695	617
Computer services	1,401	1,025
Other	2,641	2,340
Total other expenses	90,267	79,299

(a) Services received free of charge. (See note 4.1 'Income from State Government').

(b) See note 7.2 'Lease liabilities and 10.2 'Initial application of Australian Accounting Standards sub-heading AASB 16 Leases. From 2019-20, included within lease expenses are short-term leases with lease terms of up to 12 months and low-value leases with identified assets of up to $5,000 both of these exclude leases with another wholly-owned public sector lessor agency. The lease expenses also include variable lease payments and maintenance expenses related to the leased assets.

(c) Expected credit losses expense is recognised as the movement in the allowance for expected credit losses. The allowance for expected credit losses of trade receivables is measured at the lifetime expected credit losses at each reporting date. The Health Service has established a provision matrix that is based on its historical credit loss experience. (See note 6.1.1 'Movement of the allowance for impairment of receivables').

(d) See note 5.1 'Property, plant and equipment'.

(e) Library subscriptions was part of other supplies and services in prior year but is now included in other expenses.

East Metropolitan Health Service
Notes to the financial statements
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Note 4 Our funding sources

How we obtain our funding

This section provides additional information about how the Health Service obtains its funding and the relevant accounting policy notes that govern the recognition and measurement of this funding. The primary income received by the Health Service and the relevant notes are:

	Note	2020 $000	2019 $000
Income from State Government	4.1	819,826	772,499
Commonwealth grants and contributions	4.2	520,243	499,647
Other grants and contributions	4.3	134,625	132,697
Patient charges	4.4	72,477	67,689
Other fees for services	4.5	44,986	48,184
Donation revenue	4.6	225	196
Commercial activities	4.7	-	154
Other revenue	4.8	12,286	18,587

4.1 Income from State Government

	2020 $000	2019 $000
Appropriation received during the year:		
Service appropriation (funding via the Department of Health) (a)	757,418	718,928
	757,418	718,928
Assets transferred from/(to) other State government agencies during the year (b):		
- Transfer of medical equipment from Perth Children's Hospital	-	60
- Transfer of non-medical equipment from Perth Children's Hospital	-	62
- Transfer of medical equipment from South Metropolitan Health Service	66	-
- Transfer of medical equipment to South Metropolitan Health Service	(68)	(12)
- Transfer of computer equipment to Department of Health	-	(10)
- Transfer of artwork to Perth Children's Hospital	-	(5)
Total assets transferred	(2)	95
Services received free of charge from other State government agencies during the year (c):		
Health Support Services - shared services	47,574	39,144
Pathwest - indirect costs	14,823	14,332
Department of Finance - rental lease management	13	-
Total services received free of charge	62,410	53,476
Total income from State Government	819,826	772,499

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

Service appropriations fund the net cost of services delivered (as set out in note 2.2 'Schedule of income and expenses by service'). Appropriation revenue comprises a cash component and a receivable (asset). The receivable (Holding Account – note 6.2 'Amounts receivable for services (Holding Account)') comprises the budgeted depreciation expense for the year and any agreed increase in leave liabilities.

East Metropolitan Health Service
Notes to the financial statements
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4.1 Income from State Government(continued)

(b) Discretionary transfers of net assets (including grants) between State government agencies free of charge, are measured at the fair value of those net assets that the Health Service would otherwise pay for, and are reported under Income from State Government. Transfers of assets and liabilities in relation to a restructure of administrative arrangements are recognised as distribution to owners by the transferor and contribution by owners by the transferee under *AASB 1004*. Other non-discretionary non-reciprocal transfers of assets and liabilities designated as contributions by owners under *TI 955* are also recognised directly to equity.

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

4.2 Commonwealth grants and contributions

	2020 $000	2019 $000
Capital grants:		
Bentley Rehabilitation Beds (National Partnership Agreement)	100	-
Recurrent grants:		
National Health Reform Agreement (funding via the Department of Health) (a)	447,967	434,506
National Health Reform Agreement (funding via the Mental Health Commission) (a)	55,281	50,014
Other - Commonwealth specific grants (recurrent)	16,895	15,127
Total Commonwealth grants and contributions	520,243	499,647

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

4.3 Other grants and contributions

	2020 $000	2019 $000
Mental Health Commission - service delivery agreement	129,169	125,711
Mental Health Commission - other	2,272	3,362
Disability Services Commission - community aids and equipment program	832	1,358
Road Trauma Program - Injury Prevention	669	698
Research grants	948	279
Other	735	1,289
Total other grants and contributions	134,625	132,697

4.4 Patient charges

	2020 $000	2019 $000
Inpatient bed charges	58,692	54,374
Inpatient other charges	6,241	5,897
Outpatient charges	7,544	7,418
Total patient charges	72,477	67,689

4.5 Other fees for services

	2020 $000	2019 $000
Recoveries from the Pharmaceutical Benefits Scheme (PBS)	34,919	38,422
Health Technology Management Services	5,517	5,184
Business Intelligence Services	4,237	4,003
Non-clinical services to other health organisations	306	368
Other	7	207
Total other fees for services	44,986	48,184

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	2020 $000	2019 $000
4.6 Donation revenue		
General public donations	225	196
Total donations	225	196
4.7 Commercial activities		
Sales:		
Cafeteria sales revenue	2,824	3,098
Car parking fees revenue	(2)	78
Total sales	2,822	3,176
Cost of sales	(3,193)	(3,022)
Gross profit	(371)	154
4.8 Other revenue		
RiskCover insurance premium rebate	6,248	12,328
Abatements	251	440
Royalty revenues	1,265	1,514
Rent from commercial properties	781	750
Parking	538	775
Commissions	196	196
Sponsorship	735	754
Training and education	12	9
Clinical trial revenue	1,421	1,299
Medical reports and certificates	124	-
Use of hospital facilities	12	109
Other	703	413
Total other revenue	12,286	18,587

Revenue recognition
Until 30 June 2019, revenue was recognised and measured at the fair value of consideration received or receivable. From 1 July 2019, revenue is recognised at the transaction price when the Health Service transfers control of the services to customers. Revenue is recognised for the major activities as follows:

Sale of goods
Revenue is recognised from the sale of goods and disposal of other assets when the significant risks and rewards of ownership are transferred to the purchaser and can be measured reliably.

Provision of services
Revenue is recognised on delivery of the service to the customer.

Grants, donations, gifts and other non-reciprocal contributions
Revenue is recognised at fair value when the Health Service obtains control over the assets comprising the contributions, usually when cash is received. Other non-reciprocal contributions that are not contributions by owners are recognised at their fair value. Contributions of services are only recognised when a fair value can be reliably determined and the services would be purchased if not donated.

Gains
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.

East Metropolitan Health Service
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	Note	2020 $000	2019 $000
Note 5 Key assets			

Assets the Health Service utilises for economic benefit or service potential.

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

	Note		
Property, plant and equipment	5.1	860,355	875,506
Right-of-use assets	5.2	1,989	-
Intangible assets	5.3	692	1,221
Depreciation and amortisation expense	5.4	43,054	44,084

5.1 Property, plant and equipment

Land		
Carrying amount	88,858	88,928
Reconciliation:		
Carrying amount at start of period	88,928	90,938
Revaluation increments/(decrements)	(70)	(2,010)
Carrying amount at end of period	88,858	88,928
Buildings		
Carrying amount	661,626	675,145
Reconciliation:		
Carrying amount at start of period	675,145	709,654
Additions	2,592	4,264
Transfers from works in progress	3,375	574
Revaluation increments/(decrements)	8,660	(10,443)
Depreciation	(28,146)	(28,904)
Carrying amount at end of period	661,626	675,145
Site infrastructure		
Gross carrying amount	45,787	45,787
Accumulated depreciation	(8,008)	(6,106)
Carrying amount	37,779	39,681
Reconciliation:		
Gross carrying amount at start of period	45,787	45,787
Accumulated depreciation	(6,106)	(4,204)
Carrying amount at start of period	39,681	41,583
Additions	-	46
Transfers between asset classes	-	(45)
Depreciation	(1,902)	(1,903)
Carrying amount at end of period	37,779	39,681

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Notes to the financial statements
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5.1 Property, plant and equipment (continued)	2020 $000	2019 $000
Leasehold improvements		
Gross carrying amount	2,993	2,709
Accumulated depreciation	(1,162)	(847)
Carrying amount	1,831	1,862
Reconciliation:		
Gross carrying amount at start of period	2,709	2,709
Accumulated depreciation	(847)	(553)
Carrying amount at start of period	1,862	2,156
Additions	137	-
Transfers from works in progress	147	-
Depreciation	(315)	(294)
Carrying amount at end of period	1,831	1,862
Computer equipment		
Gross carrying amount	2,341	2,341
Accumulated depreciation	(2,339)	(2,121)
Carrying amount	2	220
Reconciliation:		
Gross carrying amount at start of period	2,341	2,354
Accumulated depreciation	(2,121)	(1,412)
Carrying amount at start of period	220	942
Transfers from/(to) other reporting entities	-	(9)
Transfers between asset classes	-	1
Depreciation	(218)	(714)
Carrying amount at end of period	2	220
Furniture and fittings		
Gross carrying amount	3,681	3,588
Accumulated depreciation	(1,864)	(1,387)
Carrying amount	1,817	2,201
Reconciliation:		
Gross carrying amount at start of period	3,588	4,813
Accumulated depreciation	(1,387)	(1,159)
Carrying amount at start of period	2,201	3,654
Additions	100	-
Other disposals	-	(21)
Transfers between asset classes	-	(648)
Write-down of assets (a)	(7)	(108)
Write-off of assets	-	(83)
Depreciation	(477)	(593)
Carrying amount at end of period	1,817	2,201

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Notes to the financial statements
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5.1 Property, plant and equipment (continued)	2020 $000	2019 $000
Motor vehicles		
Gross carrying amount	75	75
Accumulated depreciation	(25)	(19)
Carrying amount	50	56
Reconciliation:		
Gross carrying amount at start of period	75	13
Accumulated depreciation	(19)	(10)
Carrying amount at start of period	56	3
Additions	-	63
Depreciation	(6)	(10)
Carrying amount at end of period	50	56
Medical equipment		
Gross carrying amount	68,528	62,675
Accumulated depreciation	(32,992)	(25,465)
Carrying amount	35,536	37,210
Reconciliation:		
Gross carrying amount at start of period	62,675	57,820
Accumulated depreciation	(25,465)	(17,957)
Carrying amount at start of period	37,210	39,863
Additions	6,626	6,518
Transfers from/(to) other reporting entities	(2)	48
Other disposals	(222)	(731)
Transfers between asset classes	-	116
Write-off of assets	-	(37)
Depreciation	(8,076)	(8,567)
Carrying amount at end of period	35,536	37,210
Other plant and equipment		
Gross carrying amount	29,243	27,919
Accumulated depreciation	(8,607)	(6,249)
Carrying amount	20,636	21,670
Reconciliation:		
Gross carrying amount at start of period	27,919	25,261
Accumulated depreciation	(6,249)	(3,862)
Carrying amount at start of period	21,670	21,399
Additions	1,026	1,533
Transfers from/(to) other reporting entities	-	61
Transfers from works in progress	318	366
Other disposals	-	(21)
Transfers between asset classes	-	576
Write-off of assets	-	(7)
Depreciation	(2,378)	(2,237)
Carrying amount at end of period	20,636	21,670

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	2020 $000	2019 $000
5.1 Property, plant and equipment (continued)		
Artworks		
Carrying amount	2,062	2,052
Reconciliation:		
Gross carrying amount at start of period	2,052	2,045
Accumulated depreciation	-	-
Carrying amount at start of period	2,052	2,045
Additions	10	12
Transfers from/(to) other reporting entities	-	(5)
Carrying amount at end of period	2,062	2,052
Works in progress		
Carrying amount	10,158	6,481
Reconciliation:		
Carrying amount at start of period	6,481	3,732
Additions	7,535	3,710
Capitalised to asset classes	(3,840)	(940)
Write-down of assets (a)	(18)	(21)
Carrying amount at end of period	10,158	6,481
Total property, plant and equipment		
Gross carrying amount	915,352	917,700
Accumulated depreciation	(54,997)	(42,194)
Carrying amount	860,355	875,506
Reconciliation:		
Gross carrying amount at start of period	917,700	945,126
Accumulated depreciation	(42,194)	(29,157)
Carrying amount at start of period	875,506	915,969
Additions	18,026	16,146
Transfers from/(to) other reporting entities	(2)	95
Other disposals	(222)	(773)
Revaluation increments/(decrements)	8,590	(12,453)
Transfers between asset classes	-	1
Write-down of assets (a)	(25)	(129)
Write-off of assets	-	(127)
Depreciation	(41,518)	(43,222)
Carrying amount at end of period	860,355	875,506

(a) Expenses capitalised in the previous financial year, expensed in the current financial year. See note 3.4 'Other expenses'.

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5.1 Property, plant and equipment (continued)

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

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

Subsequent measurement
Subsequent to initial recognition as an asset, the revaluation model is used for the measurement of land and buildings and historical cost for all other property, plant and equipment. Land and buildings are carried at fair value less accumulated depreciation (buildings) and accumulated impairment losses. All other items of property, plant and equipment are carried at historical cost less accumulated depreciation and accumulated impairment losses.

Where market-based evidence is available, the fair value of land and buildings (non-clinical sites) is determined on the basis of current market values by reference to recent market transactions.

In the absence of market-based evidence, fair value of land and buildings (clinical sites) is determined on the basis of existing use. This normally applies where buildings are specialised or where land use is restricted. Fair value for existing use buildings is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset, i.e. the current replacement cost. Fair value for restricted use land is determined by comparison with market evidence for land with similar approximate utility (high restricted use land) or market value of comparable unrestricted land (low restricted use land).

When buildings are revalued, the accumulated depreciation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount.

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

Land and buildings were revalued as at 1 July 2019 by the Western Australian Land Information Authority (Valuations and Property Analytics). The valuations were performed during the year ended 30 June 2020 and recognised at 30 June 2020. In undertaking the revaluation, fair value was determined by reference to market values for land: $18.1 million (2019: $18.2 million) and buildings: $2.7 million (2019: $2.7 million). For the remaining balance, fair value of buildings was determined on the basis of current replacement cost and fair value of land was determined on the basis of comparison with market evidence for land with low level utility (high restricted use land).

Revaluation model
Where market-based evidence is available, the fair value of land and buildings (non-clinical sites) is determined on the basis of current market values by reference to recent market transactions.

In the absence of market-based evidence, fair value of land and buildings (clinical sites) is determined on the basis of existing use. This normally applies where buildings are specialised or where land use is restricted. Fair value for existing use buildings is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset, i.e. the current replacement cost. Fair value for restricted use land is determined by comparison with market evidence for land with similar approximate utility (high restricted use land) or market value of comparable unrestricted land (low restricted use land).

When buildings are revalued, the accumulated depreciation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount.

Significant assumptions and judgements
The most significant assumptions and judgements in estimating fair value are made in assessing whether to apply the existing use basis to assets and in determining estimated economic life. Professional judgement by the valuer is required where the evidence does not provide a clear distinction between market type assets and existing use assets. In order to estimate fair value on the basis of existing use, the current replacement costs are determined on the assumption that the buildings will be used for the same functions in the future. A major change in utilisation of the buildings may result in material adjustment to the carrying amounts.

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5.1 Property, plant and equipment (continued)

Derecognition
Upon disposal or derecognition of an item of property, plant and equipment, any revaluation surplus relating to that asset is retained in the asset revaluation reserve.

Impairment of assets
Property, plant and equipment and intangible assets are tested for any indication of impairment at the end of each reporting period. Where there is an indication of impairment, the recoverable amount is estimated. Where the recoverable amount is less than the carrying amount, the asset is considered impaired and is written down to the recoverable amount and an impairment loss is recognised. Where an asset measured at cost is written down to recoverable amount, an impairment loss is recognised in profit or loss. Where a previously revalued asset is written down to recoverable amount, the loss is recognised as a revaluation decrement in other comprehensive income. As the Health Service is a not-for-profit entity, unless a specialised asset has been identified as a surplus asset, the recoverable amount is the higher of an asset's fair value less costs to sell and depreciated replacement cost.

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

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

The recoverable amount of assets identified as surplus assets is the higher of fair value less costs to sell and the present value of future cash flows expected to be derived from the asset. Surplus assets carried at fair value have no risk of material impairment where fair value is determined by reference to market-based evidence. Where fair value is determined by reference to depreciated replacement cost, surplus assets are at risk of impairment and the recoverable amount is measured. Surplus assets at cost are tested for indications of impairment at the end of each reporting period.

As at 30 June 2019 there were no indications of impairment to property, plant and equipment and intangible assets.

5.2 Right-of-use assets

	2020 $000	2019 $000
Buildings		
Gross carrying amount	230	-
Accumulated depreciation	(182)	-
Carrying amount	48	-
Reconciliation:		
Opening net carrying amount	-	-
Recognition of right-of-use assets on initial application of AASB 16	230	
Restated opening carrying amount at start of the period	230	-
Additions	-	
Other disposals (leases expired)	-	
Depreciation	(182)	
Carrying amount at end of the period	48	-

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5.2 Right-of-use assets (continued)

	2020 $000	2019 $000
Vehicles		
Gross carrying amount	2,395	-
Accumulated depreciation	(454)	-
Carrying amount	1,941	-
Reconciliation:		
Opening net carrying amount	-	-
Recognition of right-of-use assets on initial application of AASB 16	1,522	-
Restated opening carrying amount at start of the period	1,522	-
Additions	959	-
Other disposals (leases expired)	(18)	
Depreciation	(522)	-
Carrying amount at end of the period	1,941	-
Total Right-of-use assets		
Gross carrying amount	2,625	-
Accumulated depreciation	(636)	-
Carrying amount	1,989	-
Reconciliation:		
Opening carrying amount	-	-
Recognition of right-of-use assets on initial application of AASB 16	1,752	-
Restated opening carrying amount at start of the period	1,752	-
Additions	959	-
Other disposals (leases expired)	(18)	
Depreciation	(704)	-
Carrying amount at end of the period	1,989	-

Initial Recognition
Right-of-use assets are measured at cost which include the following:

- the net present value of the future minimum payments
- any lease payments made at or before the commencement date less any lease incentives received
- any initial direct costs, and
- restoration costs, including dismantling and removing the underlying asset (make good provision)

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

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

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	2020 $000	2019 $000

5.2 Right-of-use assets (continued)

Depreciation and impairment of right-of-use assets
Right-of-use assets are depreciated on a straight-line basis over the lease term as the Health Service generally expect to fully consume the useful life of the assets over the lease term. The lease term includes option to extend the lease if it is stated in the contract and the Health Service is reasonably certain to exercise the option.

Right-of-use assets are tested for impairment when an indication of impairment is identified.

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

Depreciation expense of right-of-use assets		
Buildings	182	
Vehicles	522	
Total right-of-use asset depreciation	704	-
Lease interest expense (included in Finance cost)	3	
Expenses relating to variable lease payments not included in		
Lease liabilities (included in Other Expenses)	11	
Short-term leases (included in Other Expenses)	57	
Low-value leases (included in Other Expenses)	27	
The statement of cash flows shows the following amounts relating to leases:		
Finance costs	39	
Principal elements of lease payments	713	

The Health Service has leases for vehicles and office accommodation (buildings).

The Health Service has secured the right-of-use assets against the related lease liabilties for the vehicles. In the event of default, the rights to the leased motor vehicles will revert to the lessor.

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

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

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

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5.3 Intangible assets

Computer software		
Gross carrying amount	3,817	3,817
Accumulated amortisation	(3,464)	(2,596)
Carrying amount	353	1,221
Reconciliation:		
Gross carrying amount at start of the period	3,817	3,761
Accumulated amortisation	(2,596)	(1,734)
Carrying amount at start of the period	1,221	2,027
Additions	-	56
Amortisation	(868)	(862)
Carrying amount at end of the period	353	1,221
Works in progress		
Carrying amount	339	-
Reconciliation:		
Carrying amount at start of period	-	-
Additions	339	-
Carrying amount at end of period	339	-
Total intangible assets		
Gross carrying amount	4,156	3,817
Accumulated amortisation	(3,464)	(2,596)
Carrying amount	692	1,221
Reconciliation:		
Gross carrying amount at start of period	3,817	3,761
Accumulated amortisation	(2,596)	(1,734)
Carrying amount at start of period	1,221	2,027
Additions	339	56
Amortisation	(868)	(862)
Carrying amount at end of period	692	1,221

	2020 $000	2019 $000

5.3 Intangible assets (continued)

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

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

Acquisitions of intangible assets costing $5,000 or more and internally generated intangible assets costing $50,000 or more are capitalised and measured at cost. Costs incurred below these thresholds are immediately expensed directly to the statement of comprehensive income.

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

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

See note 5.1 'Property, plant and equipment' for testing assets for impairment.

5.4 Depreciation and amortisation expense

Depreciation and amortisation charge for the period		
Buildings	28,146	28,904
Medical equipment	8,076	8,567
Site infrastructure	1,902	1,903
Leasehold improvements	315	294
Computer equipment	218	714
Furniture and fittings	477	593
Motor vehicles	6	10
Other plant and equipment	2,378	2,237
Right-of-use asset	668	-
Total depreciation for the period	42,186	43,222
Computer software	868	862
Total amortisation for the period	868	862
Total depreciation and amortisation for the period	43,054	44,084

Finite useful lives
All property, plant and equipment having a limited useful life are systematically depreciated over their estimated useful lives in a manner that reflects the consumption of their future economic benefits. The exceptions to this rule include assets held for sale, land and works of art. Amortisation of finite life intangible assets is calculated on a straight-line basis at rates that allocate the asset's value over its estimated useful life. All intangible assets controlled by the Health Service have a finite useful life and zero residual value.

Estimated useful lives for each class of depreciable asset (including intangibles) are:

Buildings	50 years
Site infrastructure	50 years
Leasehold improvements	Term of the lease
Computer equipment	2 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 50 years
Computer software	5 to15 years

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

	2020 $000	2019 $000

5.4 Depreciation and amortisation expense (continued)

Leasehold improvements are depreciated over the shorter of the lease term and their useful lives.

The Health Service's policy is to depreciate all items of property, plant and equipment on a straight-line basis. The exception to this is land and works of art, which are considered to have an indefinite life. Depreciation is not recognised in respect of these assets because their service potential has not, in any material sense, been consumed during the reporting period.

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

Note 6 Other assets and liabilities

This section sets out the Health Service's other assets utilised for economic benefits and liabilities incurred during normal operations.

Assets	Note		
Receivables	6.1	23,152	30,119
Amounts receivable for services (Holding Account)	6.2	527,618	481,822
Inventories	6.3	4,497	4,519
Other assets	6.4	1,076	1,244
Liabilities			
Payables	6.5	95,193	82,321
Other liabilities	6.6	527	461

6.1 Receivables

Current		
Patient fee debtors (a)	26,615	30,662
Other receivables	4,583	6,862
Less: Allowance for impairment of receivables	(18,778)	(20,661)
Accrued revenue	7,381	10,092
GST receivable	3,351	3,164
Total current	23,152	30,119

The Health Service does not hold any collateral or other credit enhancements as security for receivables.

(a) Under the Private Patient Scheme approved by the State Government, the Department of Health provides ex-gratia payments towards private patient fees not paid in full by health insurance funds. The Health Service has received $1.3 million in ex-gratia payments for the 2019-20 period (2018-19: $2.1 million).

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

Accounting procedure for Goods and Services Tax
Rights to collect amounts receivable from the Australian Taxation Office (ATO) and responsibilities to make payments for Goods and Services Tax (GST) have been assigned to the Department of Health. This accounting procedure was a result of application of the grouping provisions of *A New Tax System (Goods and Services Tax) Act 1999* whereby the Department of Health became the Nominated Group Representative (NGR) for the GST Group as from 1 July 2012. The 'Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals' (Metropolitan Health Services) was the NGR in previous financial years. The entities in the GST group include the Department of Health, Mental Health Commission, South Metropolitan Health Service, North Metropolitan Health Service, East Metropolitan Health Service, Child and Adolescent Health Service, Health Support Services, WA Country Health Service, PathWest Laboratory Medicine WA, QE II Medical Centre Trust, and Health and Disability Services Complaints Office.

GST receivables on accrued expenses are recognised by the Health Service. Upon the receipt of tax invoices, GST receivables for the GST group are recorded in the accounts of the Department of Health.

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6.1.1 Movement of the allowance for impairment of receivables

	2020 $000	2019 $000
Balance at start of period	20,661	23,314
Remeasurement under *AASB 9*	-	461
Restated balance at start of period	20,661	23,775
Expected credit losses (note 3.4 'Other expenses')	5,765	3,638
Amounts written off during the period	(5,871)	(6,655)
Amount reversed during the period	(88)	-
Debt waivers during the period (a)	(1,689)	(97)
Balance at end of period	18,778	20,661

(a) Debt waivers are discretionary in nature and under justifiable and reasonable circumstances, can be used by the Accountable Authority to permanently forgive a debt.

The maximum exposure to credit risk at the end of the reporting period for receivables is the carrying amount of the asset inclusive of any allowance for impairment as shown in the table at note 9.1 c) Credit risk exposure.

Key sources of estimation uncertainty - Provision for doubtful debt
Historical debt collection trends are used to estimate impairment of receivables. Changes in the economic, political and legislative environment can affect debt collection rates. These changes may impact the carrying amount of receivables.

6.2 Amounts receivable for services (Holding Account)

Non-current	527,618	481,822
Total amounts receivable for services	527,618	481,822

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

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

6.3 Inventories

Current		
Pharmaceutical stores - at cost	3,923	3,964
Engineering stores - at cost	574	555
Total inventories	4,497	4,519

Inventories are measured at the lower of cost and net realisable value. Costs are assigned on a weighted average cost basis. Inventories not held for resale are measured at cost unless they are no longer required, in which case they are measured at net realisable value.

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6.4 Other assets

	2020 $000	2019 $000
Current		
Prepayments	1,076	1,207
Non-current		
Prepayments	-	37
Total other assets	1,076	1,244

Other non-financial assets include prepayments which represent payments in advance of receipt of goods or services or that part of expenditure made in one accounting period covering a term extending beyond that period.

6.5 Payables

Current		
Accrued expenses	53,291	47,910
Trade creditors	14,738	12,616
Accrued salaries	20,415	15,571
Other creditors	6,749	6,222
Accrued interest	-	2
Total current	95,193	82,321

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

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

The accrued salaries suspense account (see note 7.3.1 'Reconciliation of cash') consists of amounts paid annually, from Health Service appropriations for salaries expense, into a Treasury suspense account to meet the additional cash outflow for employee salary payments in reporting periods with 27 pay days instead of the normal 26. No interest is received on this account.

6.6 Other liabilities

Current		
Refundable deposits	193	168
Paid parental leave scheme	62	55
Unearned revenue	273	234
Other current liabilities	(1)	4
Total current	527	461

East Metropolitan Health Service
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		2020 $000	2019 $000
Note 7 Financing			

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

	Note		
Borrowings	7.1	0	839
Lease liabilities	7.2	1,998	-
Cash and cash equivalents	7.3	197,994	174,309
Reconciliation of cash	7.3.1		
Reconciliation of net cost of services to net cash flows used in operating activities	7.3.2		
Cash flows from State Government	7.3.3		
Commitments	7.4	6,318,663	6,094,364

7.1 Borrowings

Current		
Department of Treasury loans (a)	-	839
Total current	-	839
Total borrowings	-	839

(a) This debt was taken up by the Health Service on 1 July 2016 and relates to a loan provided by the Department of Treasury for capital works. Principal repayments and related interest costs are paid to the Department of Treasury by the Department of Health on behalf of the Health Service. Interest rates are linked to the State Government's debt servicing costs. This loan was fully paid in June 2020.

Borrowing costs are expensed in the period in which they are incurred.

7.2 Lease liabilities

Current	535	-
Non-current	1,463	-
	1,998	-

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	2020 $000	2019 $000

7.2 Lease liabilities (continued)

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

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

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

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

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

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

This section should be read in conjunction with note 5.2.

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2020

	2020 $000	2019 $000
7.3 Cash and cash equivalents		
7.3.1 Reconciliation of cash		
Current		
Cash and cash equivalents	154,098	135,893
Restricted cash and cash equivalents (a)	30,952	28,706
	185,050	164,599
Non-current		
Accrued salaries suspense account (b)	12,944	9,710
Total cash assets	197,994	174,309

(a) Restricted cash and cash equivalents are assets, the uses of which are restricted by specific legal or other externally imposed requirements. These include medical research grants, donations for the benefits of patients, medical education, scholarships, capital projects, employee contributions and staff benevolent funds.

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

For the purpose of the statement of cash flows, cash and cash equivalent (and restricted cash and cash equivalent) assets comprise of cash on hand and cash at bank.

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

	Note		
Net cost of services (statement of comprehensive income)		(817,744)	(765,223)
Non-cash items			
Depreciation and amortisation expense	5.4	43,054	44,084
Expected credit loss expense	3.4	5,765	3,638
Services received free of charge	4.1	62,410	53,476
Net (gain)/loss on disposal of non-current assets	3.4	45	805
Donation of non-current assets	4.6	(2)	(53)
Write down of property, plant and equipment	3.4	25	129
Interest paid by the Department of Health	3.4	16	42
Asset revaluation decrement	3.4	70	2,010
Write off of receivables	6.1.1	(7,560)	(6,752)
Remeasurement of receivables under *AASB 9*	6.1.1	-	461
Adjustment for other non-cash items		76	(2,570)
(Increase)/decrease in assets			
GST receivable	6.1	(187)	(180)
Other current receivables	6.1	9,037	4,607
Inventories	6.3	22	571
Prepayments and other current assets	6.4	131	(331)
Other non-current assets	6.4	37	113
Increase/(decrease) in liabilities			
Current payables	6.5	12,872	7,835
Current employee benefits provisions	3.1(b)	8,957	13,392
Other current liabilities	6.6	66	271
Non-current employee benefits provisions	3.1(b)	785	5,655
Net cash used in operating activities (statement of cash flows)		(682,126)	(638,020)

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	2020 $000	2019 $000
7.3.3 Cash flows from State Government		
Service appropriations (statement of comprehensive income)	757,418	718,928
Capital contributions credited directly to Contributed equity (note 8)	14,052	11,699
	771,470	730,627
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:		
Accrual appropriations	(45,056)	(46,488)
Accrual appropriations - depreciation leases	(741)	-
Repayment of interest-bearing liabilities to Department of Treasury	(839)	(797)
Interest paid to Department of Treasury	(16)	(42)
Total notional cash flows	(46,652)	(47,327)
Cash flows from State Government (statement of cash flows)	724,818	683,299

7.4 Commitments

7.4.1 Operating lease commitments

Commitments in relation to non-cancellable leases contracted for at the end of the reporting period but not recognised as liabilities are payable as follows:

Within 1 year	-	919
Later than 1 year, and not later than 5 years	-	3,064
Later than 5 years	-	749
Balance at end of period	-	4,732

The totals presented for operating lease commitments are inclusive of GST.

From 1 July 2019, the Health Service has recognised the right-of-use assets and corresponding lease liability for all non-cancellable operating lease commitments, apart from short term and low value leases. Refer to Note 5.2 Right-of-use assets and 7.2 Lease liabilities.

7.4.2 Capital commitments

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

Within 1 year	15,927	5,106
Later than 1 year, and not later than 5 years	20	-
Balance at end of period	15,947	5,106

The totals presented for capital commitments are inclusive of GST.

7.4.3 Private sector contracts for the provision of health services commitments

Expenditure commitments in relation to private sector organisations contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:

Within 1 year	372,774	352,991
Later than 1 year, and not later than 5 years	1,512,080	1,445,444
Later than 5 years, and not later than 10 years	1,897,562	1,842,196
Later than 10 years	2,484,650	2,423,939
Balance at end of period	6,267,066	6,064,570

The totals presented for private sector contracts for the provision of health services commitments are inclusive of GST.

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Notes to the financial statements
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	2020 $000	2019 $000
7.4.4 Other commitments		

Other expenditure commitments contracted for at the reporting period but not recognised as liabilities, are payable as follows:

Within 1 year	30,370	16,487
Later than 1 year, and not later than 5 years	4,831	2,905
Later than 5 years	449	564
Balance at end of period	35,650	19,956

The totals presented for other commitments are inclusive of GST.

Note 8 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.

Contributed equity		
Balance at start of the period	1,132,398	1,120,444
Contributions by owners (a)		
Capital appropriation (b)	14,052	11,698
Transfer of assets and liabilities from South Metropolitan Health	-	256
Total contributions by owners	1,146,450	1,132,398
Balance at end of the period	1,146,450	1,132,398

(a) *AASB 1004 'Contributions'* requires transfers of net assets as a result of a restructure of administrative arrangements to be accounted for as contributions by owners and distributions to owners.

TI 955 designates non-discretionary and non-reciprocal transfers of net assets between State government agencies as contributions by owners in accordance with *AASB Interpretation 1038*. Where the transferee agency accounts for a non-discretionary and non-reciprocal transfer of net assets as a contribution by owners, the transferor agency accounts for the transfer as a distribution to owners.

(b) *TI 955 'Contributions by Owners Made to Wholly Owned Public Sector Entities'* designates capital appropriations as contributions by owners in accordance with *AASB Interpretation 1038 'Contributions by Owners Made to Wholly-Owned Public Sector Entities'*.

Asset revaluation reserve		
Balance at start of the period	78,633	89,076
Net revaluation increments/(decrements):		
Land	-	-
Buildings	8,660	(10,443)
Balance at end of the period	87,293	78,633

The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets on a class of assets basis. Any increment is credited directly to the asset revaluation reserve, except to the extent that any increment reverses a revaluation decrement previously recognised as an expense (see note 5.1 'Property, plant and equipment').

For land revaluation decrement recognised as an expense, see note 3.4 'Other expenses'.

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Note 9 Risks and contingencies

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

	Note
Financial risk management	9.1
Contingent assets and contingent liabilities	9.2
Fair value measurements	9.3

9.1 Financial risk management

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

All financial assets and liabilities recognised in the statement of financial position, whether they are carried at cost or fair value, are recognised at amounts that represent a reasonable approximation of fair value unless otherwise stated in the applicable notes.

a) Summary of risks and risk management

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

Credit risk associated with the Health Service's financial assets is generally confined to patient fee debtors (see note 6.1 'Receivables'). The main receivable of the Health Service is the amounts receivable for services (holding account). For receivables other than government agencies and patient fee debtors, the Health Service trades only with recognised, creditworthy third parties. The Health Service has policies in place to ensure that sales of products and services are made to customers with an appropriate credit history. In addition, receivable balances are monitored on an ongoing basis with the result that the Health Service's exposure to bad debts is minimal. Debt will be written off against the allowance account when it is improbable or uneconomical to recover the debt. At the end of the reporting period, there were no significant concentrations of credit risk.

In circumstances where a third party is responsible for payment, or there are legal considerations, payment of accounts can be delayed considerably. Unpaid debts are referred to an external debt collection service on a case by case basis, considering financial election and reasons for non-payment.

Liquidity risk
Liquidity risk arises when the Health Service is unable to meet its financial obligations as they fall due. The Health Service is exposed to liquidity risk through its normal course of operations.

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

Market risk
Market risk is the risk that changes in market prices such as foreign exchange rates and interest rates will affect the Health Service's income or the value of its holdings of financial instruments. The Health Service does not trade in foreign currency and is not materially exposed to other price risks. The Health Service's exposure to market risk for changes in interest rates relates primarily to the long-term debt obligations. The Health Service's borrowings are limited to the Department of Treasury loans. The interest rate risk for the loans is managed by the Department of Treasury through portfolio diversification and variation in maturity dates.

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	2020 $000	2019 $000
9.1 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:

Financial assets		
Cash and cash equivalents	154,098	135,893
Restricted cash and cash equivalents	43,896	38,416
Financial assets at amortised cost (1)	19,801	26,955
Amounts receivable for services	527,618	481,822
Total financial assets	745,413	683,086
Financial liabilities		
Financial liabilities measured at amortised cost	97,191	83,160
Total financial liabilities	97,191	83,160

(1) The amount of receivables and financial assets at amortised cost excludes GST recoverable from ATO (statutory receivable).

c) Credit risk exposure

		Days past due				
	Total $000	Current $000	< 30 days $000	31-60 days $000	61-90 days $000	>91 days* $000
30 June 2020						
Expected credit loss rate		14%	26%	25%	49%	83%
Estimated total gross carrying amount at default	38,579	14,401	1,604	2,652	2,114	17,808
Expected credit losses	(18,777)	(1,948)	(411)	(662)	(1,045)	(14,711)
30 June 2019						
Expected credit loss rate		4%	12%	26%	32%	82%
Estimated total gross carrying amount at default	47,616	15,899	6,083	1,661	1,804	22,169
Expected credit losses	(20,661)	(708)	(701)	(430)	(569)	(18,253)

*Includes receivables with maturity dates greater than 2 years.

d) Liquidity risk and interest rate exposure

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

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9.1 Financial risk management (continued)

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

		Interest rate exposure				Maturity dates				
	Weighted average effective interest rate	Carrying amount	Fixed interest rate	Variable interest rate	Non-interest bearing	Nominal amount	Up to 3 months	3 months to 1 year	1 - 5 years	More than 5 years
	%	$000	$000	$000	$000	$000	$000	$000	$000	$000
2020										
Financial Assets										
Cash and cash equivalents		154,098	-	-	154,098	154,098	154,098	-	-	-
Restricted cash and cash equivalents		43,896	-	-	43,896	43,896	43,896	-	-	-
Receivables - non-interest bearing (1)		19,801	-	-	19,801	19,801	19,801	-	-	-
Amounts receivable for services		527,618	-	-	527,618	527,618	-	-	-	527,618
		745,413	-	-	745,413	745,413	217,795	-	-	527,618
Financial Liabilities										
Payables	-	95,193	-	-	95,193	95,193	95,193	-	-	-
Lease liabilities	3.12%	1,998	1,998	-	-	1,964	-	501	1,454	9
		97,191	1,998	-	95,193	97,157	95,193	501	1,454	9
2019										
Financial Assets										
Cash and cash equivalents		135,893	-	-	135,893	135,893	135,893	-	-	-
Restricted cash and cash equivalents		38,416	-	-	38,416	38,416	38,416	-	-	-
Receivables - non-interest bearing (1)		26,955	-	-	26,955	26,955	26,955	-	-	-
Amounts receivable for services		481,822	-	-	481,822	481,822	-	-	-	481,822
		683,086	-	-	683,086	683,086	201,264	-	-	481,822
Financial Liabilities										
Payables	-	82,321	-	-	82,321	82,321	82,321	-	-	-
Department of Treasury Loans	3.15%	839	-	839	-	865	216	649	-	-
		83,160	-	839	82,321	83,186	82,537	649	-	-

(1) The amount of receivables excludes the GST recoverable from ATO (statutory receivable).

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9.1 Financial risk management (continued)

e) Interest rate sensitivity analysis

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

	Carrying Amount	-100 basis points		+100 basis points	
		Surplus	Equity	Surplus	Equity
	$000	$000	$000	$000	$000
2020					
Financial assets					
Receivables	-	-	-	-	-
Financial liabilities					
Department of Treasury Loans	-	-	-	-	-
Total increase/(decrease)	-	-	-	-	-
2019					
Financial assets					
Receivables		-	-	-	-
Financial liabilities					
Department of Treasury Loans	839	8	8	(8)	(8)
Total increase/(decrease)	839	8	8	(8)	(8)

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9.2 Contingent Assets and contingent liabilites

Contingent assets and contingent liabilities are not recognised in the statement of financial position but are disclosed and, if quantifiable, are measured at the best estimate.

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

9.2.1 Contingent assets

At the reporting date, the Health Service is not aware of any contingent assets.

9.2.2 Contingent liabilities

In addition to the liabilities included in the financial statements, the Health Service has the following contingent liabilities:

Litigation in progress
There are 12 claims not recoverable from RiskCover insurance that may affect the financial position of the Health Service. The estimated claim totals $277,700.

Hospital cladding
Following concerns raised about the potential fire risk associated with the use of some aluminum composite panels (ACPs) cladding products, the Department of Health is in the process of reviewing all WA Health buildings that may have these products. The review has identified two sites of the Health Service where ACPs present potential risk and may require remediation to mitigate the risk to an acceptable level. The Department of Health is liaising with WA Treasury on the action to be taken to mitigate risks.

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

At the reporting date, the Health Service does not have any suspected contaminated sites reported under the Act.

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9.3 Fair value measurements

Assets measured at fair value 2020	Level 1 $000	Level 2 $000	Level 3 $000	Total $000
Land (note 5.1 'Property, plant and equipment')				
Vacant land	-	810	-	810
Specialised land	-	17,320	70,728	88,048
Buildings (note 5.1 'Property, plant and equipment')				
Residential and commercial carpark	-	2,720	-	2,720
Specialised buildings	-	-	658,906	658,906
	-	20,850	729,634	750,484

Assets measured at fair value 2019	Level 1 $000	Level 2 $000	Level 3 $000	Total $000
Land (note 5.1 'Property, plant and equipment')				
Vacant land	-	880	-	880
Specialised land	-	17,320	70,728	88,048
Buildings (note 5.1 'Property, plant and equipment')				
Residential and commercial carpark	-	2,720	-	2,720
Specialised buildings	-	-	672,425	672,425
	-	20,920	743,153	764,073

AASB 13 requires disclosure of fair value measurements by level of the following fair value measurement

Level 1 inputs - quoted prices (unadjusted) in active markets for identical assets.

Level 2 inputs - input other than quoted prices included within level 1 that are observable for the asset, either directly or indirectly.

Level 3 inputs - input not based on observable market data.

There were no transfers between levels 1, 2 or 3 during the current and previous periods.

Valuation techniques to derive level 2 and level 3 fair values

The Health Service obtains independent valuations of land and buildings from the Western Australian Land Information Authority (Valuations and Property Analytics) annually. Two principal valuation techniques are applied to the measurement of fair values:

Market approach (comparable sales)
The Health Service's commercial car park and vacant land are valued under the market approach. This approach provides an indication of value by comparing the asset with identical or similar properties for which price information is available. Analysis of comparable sales information and market data provides the basis for fair value measurement.

The best evidence of fair value is current prices in an active market for similar properties. Where such information is not available, Western Australian Land Information Authority (Valuations and Property Analytics) considers current prices in an active market for properties of different nature or recent prices of similar properties in less active markets, and adjusts the valuation for differences in property characteristics and market conditions.

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9.3 Fair value measurements (continued)

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.

Cost approach
Properties of a specialised nature that are rarely sold in an active market or are held to deliver public services are referred to as non-market or current use type assets. These properties do not normally have a feasible alternative use due to restrictions or limitations on their use and disposal. The existing use is their highest and best use.

For current use land assets, fair value is measured firstly by establishing the opportunity cost of public purpose land, which is termed the hypothetical alternate land use value. This approach assumes unencumbered land use based upon potential highest and best alternative use as represented by surrounding land uses and market analysis.

Fair value of the land is then determined on the assumption that the site is rehabilitated to a vacant marketable condition. This requires costs associated with rehabilitation to be deducted from the hypothetical alternate land use value of the land. Costs may include building demolition, clearing, planning approvals and time allowances associated with realising that potential.

In some instances the legal, physical, economic and socio political restrictions on land results in a minimal or negative current use land value. In this situation the land value adopted is the higher of the calculated rehabilitation amount or the amount determined on the basis of comparison to market corroborated evidence of land with low level utility. Land of low-level utility is considered to be grazing land on the urban fringe of the metropolitan area with no economic farming potential or foreseeable development or redevelopment potential at the measurement date.

The Health Service's hospitals and community centres are specialised buildings and their fair value is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset (i.e. current replacement cost). Current replacement cost is generally determined by estimating the current cost of reproduction or replacement of the building, on its current site, adjusted for physical deterioration and all relevant forms of obsolescence and optimisation. Obsolescence encompasses physical deterioration, functional (technological) obsolescence and economic (external) obsolescence. Current replacement cost is unlikely to be materially different from depreciated replacement cost as a measure of value in use of specialised assets that are rarely sold.

The techniques involved in the determination of the current replacement costs include:

a) Review and updating of the 'as-constructed' drawing
b) Categorisation of the drawings using the Building Utilisation Categories (BUC's) which designate the functional areas typically provided by the following types of clinical facilities. Each BUC has different cost rates which are calculated from the historical construction costs of similar clinical facilities and are adjusted for the year-to-year change in building costs using building cost index.
   - Nursing Posts and Medical Centres
   - Metropolitan Secondary, Specialist and General Hospitals
   - Tertiary Hospitals
c) Measurement of the general floor areas.
d) Application of the BUC cost rates per square metre of general floor areas.

The maximum effective age used in the valuation of specialised buildings is 50 years. The effective age of buildings is initially calculated from the commissioning date, and is reviewed after the buildings have undergone substantial renewal, upgrade or expansion.

The straight-line method of depreciation is applied and assumes a uniform pattern of consumption over the initial 37.5 years of asset life (up to 75% of current replacement costs). All specialised buildings are assumed to have a residual value of 25% of their current replacement costs.

The valuations are prepared on a going concern basis until the year in which the current use is discontinued.

9.3 Fair value measurements (continued)

Buildings with definite demolition plan are not subject to annual revaluation. The current replacement costs at the last valuation dates for these buildings are written down to the statement of comprehensive income as depreciation expenses over their remaining useful life.

Fair value measurements using significant unobservable inputs (Level 3)

	Land $000	Buildings $000
2020		
Fair value at beginning of period	70,728	672,425
Additions	-	5,967
Revaluation increments/(decrements) recognised in profit or loss	-	-
Revaluation increments/(decrements) recognised in other comprehensive	-	8,606
Depreciation	-	(28,092)
Fair value at end of period	70,728	658,906

	Land $000	Buildings $000
2019		
Fair value at beginning of period	70,838	706,934
Additions	-	4,838
Revaluation increments/(decrements) recognised in profit or loss	(110)	-
Revaluation increments/(decrements) recognised in other comprehensive	-	(10,497)
Depreciation	-	(28,850)
Fair value at end of period	70,728	672,425

Valuation processes

Western Australian Land Information Authority (Valuation and Property Analytics) determines the fair values of the Health Service's land and buildings. A quantity surveyor is engaged by the Health Service to provide an update of the current construction costs for specialised buildings. Western Australian Land Information Authority (Valuation and Property Analytics) may endorse the current construction costs calculated by the quantity surveyor for specialised buildings and calculates the current replacement costs.

Note 10 Other disclosures

This section includes additional material disclosures required by accounting standards or other pronouncements, for the understanding of this financial report.

	Note
Events occurring after the end of the reporting period	10.1
Initial application of Australian Accounting Standards	10.2
Future impact of Australian Accounting Standards issued not yet operative	10.3
Key management personnel	10.4
Related party transactions	10.5
Related bodies	10.6
Affiliated bodies	10.7
Special purpose accounts	10.8
Remuneration of auditors	10.9
Supplementary financial information	10.10
Administered trust accounts	10.11

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10.1 Events occurring after the end of the reporting period

The Health Service is unaware of any event occurring after the reporting date that would materially affect the financial statements.

10.2 Initial application of Australian Accounting Standards

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

AASB 15 *Revenue from Contracts with Customers* replaces AASB 118 *Revenue* and AASB 111 *Construction Contracts* for annual reporting periods on or after 1 January 2019. Under the new model, an entity shall recognise revenue when (or as) the entity satisfies a performance obligation by transferring a promised good or service and is based upon the transfer of control rather than transfer of risks and rewards.

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

- identifying contracts with customers
- identifying separate performance obligations
- determining the transaction price of the contract
- allocating the transaction price to each of the performance obligations
- recognising revenue as each performance obligation is satisfied.

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

In addition, the Health Service derives income from appropriations which are recognised under AASB 1058. AASB 1058 is applied to Not-for-Profit Entities for recognising income that is not revenue from contracts with customers. Timing of income recognition under AASB 1058 depends on whether such a transaction gives rise to a liability or other performance obligation (a promise to transfer a good or service), or a contribution by owners related to an asset (such as cash or another asset) recognised by the Health Service.

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

There is no impact to the Health Service in adopting AASB 15 and AASB 1058.

East Metropolitan Health Service
Notes to the financial statements
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10.2 Initial application of Australian Accounting Standards (continued)

AASB 16 Leases

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

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

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

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

(a) right of use assets and lease liabilities in the Statement of Financial Position, initially measured at the present value of future lease payments, discounted using the incremental borrowing rate (2.5%) on 1 July 2019;

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

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

The right-of-use assets are assessed for impairment at the date of transition and has not identified any impairments to its right-of-use assets.

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

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

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

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

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

Measurement of lease liabilities	**Buildings $000**	**Vehicles $000**
Operating Lease Commitments disclosed as at 30 June 2019	3,083	1,650
Less: Goods and Services Tax	(280)	(150)
Less: Leases with the Department of Finance not recognised as liability	(2,532)	-
Less: Short term leases not recognised as liability	(110)	-
Other adjustment	72	88
Leases qualified under AASB 16	233	1,588
Discounted using incremental borrowing rate at the date of initial application	(3)	(66)
Lease liabilities recognised at 1 July 2019	230	1,522
Current lease liabilities	230	441
Non-current lease liabilities	-	1,081

Assets and Liabilities		
Right-of-use assets	5.2	1,752
Lease liabilities	7.2	(1,752)
Equity		
Accumulated surplus		-

There was no impact on retained earnings on 1 July 2019 as a result of the above changes.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2020

10.3 Future impact of Australian Accounting Standards

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

Title	Operative for reporting periods beginning on/after
AASB 1059 Service Concession Arrangements: Grantors This Standard addresses the accounting for a service concession arrangement (a type of public private partnership) by a grantor that is a public sector entity by prescribing the accounting for the arrangement from the grantor's perspective. Timing and measurement for the recognition of a specific asset class occurs on commencement of the arrangement and the accounting for associated liabilities is determined by whether the grantee is paid by the grantor or users of the public service provided. The Health Service has not yet determined the impact of the Standard.	1 Jan 2020
AASB 2018-6 Amendments to Australian Accounting Standards – Definition of a Business The Standard amends AASB 3 to clarify the definition of a business, assisting entities to determine whether a transaction should be accounted for as a business combination or as an asset acquisition. There is no financial impact.	1 Jan 2020
AASB 2018-7 Amendments to Australian Accounting Standards – Definition of Material The Standard principally amends AASB 101 and AASB 108. The amendments refine the definition of material in AASB 101. The amendments clarify the definition of material and its application by improving the wording and aligning the definition across AASB Standards and other publications. The amendment also includes some supporting requirements in AASB 101 in the definition to give it more prominence and clarifies the explanation accompanying the definition of material. There is no financial impact.	1 Jan 2020
AASB 2019-1 - Amendments to Australian Accounting Standards – References to the Conceptual Framework This Standard sets out amendments to Australian Accounting Standards, Interpretations and other pronouncements to reflect the issuance of the Conceptual Framework for Financial Reporting (Conceptual Framework) by the AASB. There is no financial impact.	1 Jan 2020
AASB 2019-2 - Amendments to Australian Accounting Standards – Implementation of AASB 1059 This Standard makes amendments to AASB 16 and AASB 1059 to: (a) amend the modified retrospective method set out in paragraph C4 of AASB 1059; (b) modify AASB 16 to provide a practical expedient to grantors of service concession arrangements so that AASB 16 would not need to be applied to assets that would be recognised as service concession assets under AASB 1059; and (c) include editorial amendments to the application guidance and implementation guidance accompanying AASB 1059.	1 Jan 2020
AASB 2020-1 - Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-current This Standard amends AASB 101 to clarify requirements for the presentation of liabilities in the statement of financial position as current or non-current. There is no financial impact.	1 Jan 2022

East Metropolitan Health Service
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10.4 Key management personnel

The Health Service has determined that key management personnel include cabinet ministers, board members and senior officers of the Health Service. However, the Health Service is not obligated to compensate ministers and therefore disclosures in relation to ministers' compensation may be found in the *Annual Report on State Finances.*

The Board of East Metropolitan Health Service is the Accountable Authority for the Health Service.

Total compensation for key management personnel, comprising members and senior officers of the Accountable Authority for the period are presented within the following bands:

Compensation of members of the Accountable Authority

Compensation band ($)	2020	2019
$ 40,001 - $ 50,000	8	9
$ 50,001 - $ 60,000	1	-
$ 80,001 - $ 90,000	1	1
Total:	10	10

Compensation of senior officers

Compensation band ($)	2020	2019
$ 30,001 - $ 40,000	1	-
$ 80,001 - $ 90,000	-	2
$160,001 - $170,000	-	1
$170,001 - $180,000	1	4
$200,001 - $210,000	2	-
$210,001 - $220,000	2	1
$220,001 - $230,000	1	-
$230,001 - $240,000	-	2
$240,001 - $250,000	1	1
$250,001 - $260,000	1	-
$270,001 - $280,000	-	1
$290,001 - $300,000	1	-
$390,001 - $400,000	1	-
$470,001 - $480,000	1	-
$490,001 - $500,000	-	2
$580,001 - $590,000	1	-
Total:	13	14

Short-term employee benefits (a)	3,582	3,258
Post-employment benefits	379	340
Other long-term benefits	43	100
Total compensation of key management personnel	4,004	3,698

(a) The short-term employee benefits include salary, motor vehicle benefits, district and travel allowances incurred by the Health Service in respect of senior officers.

Total compensation includes the superannuation expense incurred by the Health Service in respect of senior officers.

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	2020	2019
	$000	$000

10.5 Related party transactions

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

Related parties of the Health Service include:

- all senior officers and their close family members, and their controlled or jointly controlled entities
- all members of the Accountable Authority, and their close family members, and their controlled or jointly controlled entities
- all cabinet ministers and their close family members, and their controlled or jointly controlled entities
- other departments and statutory authorities, including related bodies, that are included in the whole of government consolidated financial statements (i.e. wholly-owned public sector entities)
- the Government Employees Superannuation Board (GESB)

Significant transactions with Government-related entities
In conducting its activities, the Health Service is required to transact with the State and entities related to the State. These transactions are generally based on the standard terms and conditions that apply to all agencies. Such transactions include:

	Note
Service appropriations	4.1
Capital appropriation	8
Services received free of charge	4.1
Superannuation payments to GESB	3.1(a)
Insurance payments to the Insurance Commission and RiskCover fund	3.4
Remuneration for services provided by Office of the Auditor General	10.9
Lease payments to the Department of Finance (Government Office Accommodation and State Fleet motor vehicles)	3.4, 7.2

Material transactions with other related parties:

Outside of normal citizen type transactions with the Health Service, there were no other related party transactions that involved key management personnel and/or their close family members and/or their controlled (or jointly controlled) entities.

10.6 Related bodies

A related body is a body that receives more than half of its funding and resources from an agency and is subject to operational control by that agency.

The Health Service had no related bodies during the reporting period.

10.7 Affiliated bodies

An affiliated body is a body that receives more than half its funding and resources from an agency but is not subject to operational control by that agency.

The Health Service had no affiliated bodies during the reporting period.

East Metropolitan Health Service
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10.8 Special purpose accounts

Mental Health Commission Fund (East Metropolitan Health Service) Account

The purpose of the account is to receive funds from the Mental Health Commission, to fund the provision of mental health services as jointly endorsed by the Department of Health and the Mental Health Commission, in the East Metropolitan Health Service, in accordance with the annual Service Agreement and subsequent agreements.

	2020 $000	2019 $000
Balance at start of period	345	632
Receipts		
Commonwealth contributions (note 4.2)	55,281	50,014
State contributions (note 4.3)	129,169	125,711
Other (note 4.3)	2,272	3,362
	187,067	179,719
Payments	(186,443)	(179,374)
Balance at end of period	624	345

The special purpose accounts are established under section 16(1)(d) of the *Financial Management Act 2006*.

10.9 Remuneration of auditors

Remuneration paid or payable to the Auditor General in respect of the audit for the current financial year is as follows:

	2020 $000	2019 $000
Auditing the accounts, financial statements, controls, and key performance indicators	232	232

10.10 Supplementary financial information

a) Write-offs

	2020 $000	2019 $000
Debts written off under the authority of the Accountable Authority	4,007	6,088
Public and other property written off under the authority of the Accountable Authority	-	127
Debts written off under the authority of the Minister	1,864	567
	5,871	6,782

b) Debt waivers

Debts waived under the authority of the Accountable Authority	1,689	97
	1,689	97

Debt waivers are discretionary in nature and under justifiable and reasonable circumstances, can be used by the Accountable Authority to permanently forgive a debt.

c) Losses through theft, defaults and other causes

Losses of public money, and public and other property through theft or default	24	-
Amounts recovered	(19)	-
	5	-

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2020

10.11 Administered trust accounts

Funds held in these trust accounts are not controlled by the Health Service and are therefore not recognised in the financial statements.

a) The Health Service administers trust accounts for the purpose of holding patients' private moneys.

A summary of the transactions for these trust accounts are as follows:

	2020 $000	2019 $000
Balance at start of period	15	34
Add receipts	68	71
	83	105
Less payments	(64)	(90)
Balance at end of period	19	15

b) Other trust accounts not controlled by the Health Service:

A summary of the transactions for this trust account is as follows:

RPH Private Trust Account (a)

Balance at start of period	294	294
Add receipts	-	-
	294	294
Less payments	(1)	-
Withdrawals (a)	(293)	-
Balance at end of period	-	294

(a) The Health Service's Board supported a recommendation to close the RPH Private Trust which has been inactive for several years. The RPH Private Trust was closed on 19 May 2020 and funds distributed as per the Trust Statement.

East Metropolitan Health Service
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Note 11 Explanatory statement

All variances between actual results for 2020 and estimates (original budget) are shown below. Narratives are provided for key major variances, which are generally greater than 10% and $1 million for the statement of comprehensive income, statement of cash flows and statement of financial position.

Statement of comprehensive income	Note	Estimates 2020 $000	Actuals 2020 $000	Variance between actual and estimate $000
Expenses				
Employee benefits expense		838,449	874,721	36,272
Fees for visiting medical practitioners		29,350	28,327	(1,023)
Contracts for services		310,420	312,723	2,303
Patient support costs		223,660	218,780	(4,880)
Finance costs		529	53	(476)
Depreciation and amortisation expense		46,008	43,054	(2,954)
Asset revaluation decrement		-	70	70
Loss on disposal of non-current assets		-	45	45
Repairs, maintenance and consumable equipment	1	23,973	27,033	3,060
Other supplies and services		6,624	7,142	518
Commercial activities		-	371	371
Other expenses		95,879	90,267	(5,612)
Total cost of services		1,574,892	1,602,586	27,694
Income				
Revenue				
Patient charges	2	63,570	72,477	8,907
Other fees for services	3	58,118	44,986	(13,132)
Commonwealth grants and contributions	4	472,713	520,243	47,530
Other grants and contributions	4	180,207	134,625	(45,582)
Donation revenue		9	225	216
Commercial activities		-	-	-
Other revenue		12,194	12,286	92
Total income other than income from State Government		786,811	784,842	(1,969)
Net cost of services		788,081	817,744	29,663
Income from State Government				
Service appropriations		731,435	757,418	25,983
Assets assumed/(transferred)		-	(2)	(2)
Services received free of charge	5	56,367	62,410	6,043
Total income from State Government		787,802	819,826	32,024
Surplus / (deficit) for the period		(279)	2,082	2,361
Other comprehensive income				
Items not reclassified subsequently to profit or loss		-	-	-
Changes in asset revaluation reserve		-	8,660	8,660
Total other comprehensive income		-	8,660	8,660
Total comprehensive income/(loss) for the period		(279)	10,742	11,021

Significant variances between estimates and actuals - statement of comprehensive income

1. The increase in actual expenditure relates to preparing hospitals and clinics for the COVID-19 pandemic and related urgent repairs and maintenance.
2. The increase in patient revenue is the result of a higher number of motor vehicle trauma cases, and more overseas patients.
3. The use of highly specialised drugs decreased which resulted in a reduction in recovery of revenue from the Commonwealth under the Pharmaceutical Benefit Scheme (PBS).
4. Commonwealth grants related to mental health services were previously classified as Other Grants and Contributions in the estimates.
5. Health Support Services and PathWest charges increased as a result of preparations for the COVID-19 pandemic.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2020

Note 11 Explanatory statement (continued)

Statement of financial position	Note	Estimates 2020 $000	Actuals 2020 $000	Variance between actual and estimate $000
Assets				
Current assets				
Cash and cash equivalents	6	132,119	154,098	21,979
Restricted cash and cash equivalents		28,706	30,952	2,246
Receivables	7	32,126	23,152	(8,974)
Inventories		4,519	4,497	(22)
Other current assets		1,207	1,076	(131)
Total current assets		198,677	213,775	15,098
Non-current assets				
Restricted cash and cash equivalents		13,183	12,944	(239)
Amounts receivable for services		527,830	527,618	(212)
Property, plant and equipment		867,246	860,355	(6,891)
Right-of-Use Assets	8	10,610	1,989	(8,621)
Intangible assets		1,221	692	(529)
Other non-current assets		38	-	(38)
Total non-current assets		1,420,128	1,403,598	(16,530)
Total assets		1,618,805	1,617,373	(1,432)
Liabilities				
Current liabilities				
Payables	9	83,230	95,193	11,963
Borrowings	8	10,808	-	(10,808)
Lease liabilities	8	-	535	535
Employee benefits provisions	10	165,521	178,262	12,741
Other current liabilities		824	527	(297)
Total current liabilities		260,383	274,517	14,134
Non-current liabilities				
Employee benefits provisions	10	36,640	41,769	5,129
Lease liabilities	8	-	1,463	1,463
Total non-current liabilities		36,640	43,232	6,592
Total liabilities		297,023	317,749	20,726
Net assets		1,321,782	1,299,624	(22,158)
Equity				
Contributed equity		1,171,203	1,146,450	(24,753)
Reserves		78,633	87,293	8,660
Accumulated surplus		71,946	65,881	(6,065)
Total equity		1,321,782	1,299,624	(22,158)

Significant variances between estimates and actuals - statement of financial position

6. Cash and cash equivalents increased due to the receipt of additional service appropriation funding to cover increased expenditure and liabilities including payables and employee benefits provisions.
7. The decrease in receivables reflects a higher level of patient debt waived and written off (see note 6.1.1).
8. Lease liabilities relating to Australian Accounting Standard AASB 16 Leases were reported under Borrowings when the estimates were prepared and included all property and motor vehicle fleet leases. The actuals have been reported against the Right-of-Use assets and Lease liabilities but exclude the Government Office Accommodation (GOA) lease which is now outside the scope of AASB 16.
9. The increase in payables is a reflection of a similar increase in the level of expenditure on goods and services.
10. Employee benefit provisions have increased as staff took less leave as a result of increased activity due to the COVID-19 pandemic.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2020

Note 11 Explanatory statement (continued)

Statement of changes in equity	Estimates 2020 $000	Actuals 2020 $000	Variance between actual and estimate $000
Contributed equity			
Balance at start of period	1,132,399	1,132,398	(1)
Transactions with owners in their capacity as owners:			
Capital appropriations	37,211	14,052	(23,159)
Other contributions by owners	1,593	-	(1,593)
Distributions to owners	-	-	-
Balance at end of period	1,171,203	1,146,450	(24,753)
Reserves			
Asset revaluation reserve			
Balance at start of period	78,632	78,633	1
Other comprehensive income for the period	-	8,660	8,660
Balance at end of period	78,632	87,293	8,661
Accumulated surplus			
Balance at start of period	72,226	63,799	(8,427)
Changes in accounting policy	-	-	-
Restated balance at start of period	72,226	63,799	(8,427)
Surplus for the period	(279)	2,082	2,361
Balance at end of period	71,947	65,881	(6,066)
Total equity			
Balance at start of period	1,283,256	1,274,830	(8,426)
Changes in accounting policy	-	-	-
Restated balance at start of period	1,283,256	1,274,830	(8,426)
Total comprehensive income/(loss) for the period	(279)	10,742	11,021
Transactions with owners in their capacity as owners	38,805	14,052	(24,753)
Balance at end of period	1,321,782	1,299,624	(22,158)

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Note 11 Explanatory statement (continued)

Statement of cash flows	Note	Estimates 2020 $000	Actuals 2020 $000	Variance between actual and estimate $000
Cash flows from State Government				
Service appropriations		685,409	711,606	26,197
Capital appropriations	11	37,964	13,212	(24,752)
Net cash provided by State Government		723,373	724,818	1,445
Utilised as follows:				
Cash flows from operating activities				
Payments				
Employee benefits		(838,449)	(857,686)	(19,237)
Supplies and services		(628,167)	(610,328)	17,839
Finance costs		(511)	(39)	472
Receipts				
Receipts from customers (a)	12	58,198	71,115	12,917
Commonwealth grants and contributions		472,713	520,243	47,530
Other grants and contributions		180,207	134,625	(45,582)
Donations received		9	223	214
Other receipts (a)	13	70,312	59,721	(10,591)
Net cash used in operating activities		(685,688)	(682,126)	3,562
Cash flows from investing activities				
Payments				
Purchase of non-current assets	11	(37,210)	(18,471)	18,739
Receipts				
Proceeds from sale of non-current assets		-	177	177
Net cash used in investing activities		(37,210)	(18,294)	18,916
Cash flows from financing activities				
Payments				
Principal elements of lease (2019 – finance lease)		(754)	(713)	41
Net cash used in financing activities		(754)	(713)	41
Net increase in cash and cash equivalents		(279)	23,685	23,964
Cash and cash equivalents at the beginning of the period		174,286	174,309	23
Total cash and cash equivalents at the end of the period		174,007	197,994	23,987

Significant variances between estimates and actuals - statement of cash flows

11. The actual drawdown of cash for capital projects did not proceed as estimated as there were timing delays in some projects and other projects were placed on hold due to the focus on COVID-19 activities.

12. Refer to note 2 under "Significant variances between estimates and actuals - statement of comprehensive income".

13. Refer to note 3 under "Significant variances between estimates and actuals - statement of comprehensive income".

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Note 11 Explanatory statement (continued)

All variances between actual results for 2020 and 2019 are shown below. Narratives are provided for key major variances, which are generally greater than 10% and $1 million for the statement of comprehensive income, statement of cash flows and statement of financial position.

Statement of comprehensive income	Note	Actuals 2020 $000	Actuals 2019 $000	Variance between 2020 and 2019 results $000
Expenses				
Employee benefits expense		874,721	841,079	33,642
Fees for visiting medical practitioners		28,327	29,710	(1,383)
Contracts for services		312,723	288,127	24,596
Patient support costs		218,780	215,116	3,664
Finance costs		53	40	13
Depreciation and amortisation expense		43,054	44,084	(1,030)
Asset revaluation decrement	14	70	2,010	(1,940)
Loss on disposal of non-current assets		45	805	(760)
Repairs, maintenance and consumable equipment	15	27,033	24,395	2,638
Other supplies and services		7,142	7,712	(570)
Commercial activities		371	-	371
Other expenses	16	90,267	79,299	10,968
Total cost of services		1,602,586	1,532,377	70,209
Income				
Revenue				
Patient charges		72,477	67,689	4,788
Other fees for services		44,986	48,184	(3,198)
Commonwealth grants and contributions		520,243	499,647	20,596
Other grants and contributions		134,625	132,697	1,928
Donation revenue		225	196	29
Commercial activities		-	154	(154)
Other revenue	17	12,286	18,587	(6,301)
Total income other than income from State Government		784,842	767,154	17,688
Net cost of services		817,744	765,223	52,521
Income from State Government				
Service appropriations		757,418	718,928	38,490
Assets assumed/(transferred)		(2)	95	(97)
Services received free of charge	18	62,410	53,476	8,934
Total income from State Government		819,826	772,499	47,327
Surplus / (deficit) for the period		2,082	7,276	(5,194)
Other comprehensive income				
Changes in asset revaluation reserve		8,660	(10,443)	19,103
Total other comprehensive income		8,660	(10,443)	19,103
Total comprehensive income/(loss) for the period		10,742	(3,167)	13,909

Significant variances between 2020 and 2019 actuals - statement of comprehensive income

14. This variance is due to a large one-off land valuation decrement in prior year.

15. Refer to note 1 under "Significant variances between estimates and actuals - statement of comprehensive income".

16. The increase primarily relates to increased service costs from Health Support Services (see note 3.4), increased expenditure related to expected credit losses and COVID-19 preparedness.

17. The RiskCover insurance performance rebate decreased significantly when compared to last year.

18. Refer to note 5 under "Significant variances between estimates and actuals - statement of comprehensive income".

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2020

Note 11 Explanatory statement (continued)

Statement of financial position	Note	Actuals 2020 $000	Actuals 2019 $000	Variance between 2020 and 2019 results $000
Assets				
Current assets				
Cash and cash equivalents	19	154,098	135,893	18,205
Restricted cash and cash equivalents		30,952	28,706	2,246
Receivables	20	23,152	30,119	(6,967)
Inventories		4,497	4,519	(22)
Other current assets		1,076	1,207	(131)
Total current assets		213,775	200,444	13,331
Non-current assets				
Restricted cash and cash equivalents	21	12,944	9,710	3,234
Amounts receivable for services		527,618	481,822	45,796
Property, plant and equipment		860,355	875,506	(15,151)
Right-of-Use Assets	22	1,989	-	1,989
Intangible assets		692	1,221	(529)
Other non-current assets		-	37	(37)
Total non-current assets		1,403,598	1,368,296	35,301
Total assets		1,617,374	1,568,740	48,633
Liabilities				
Current liabilities				
Payables	23	95,193	82,321	12,872
Borrowings		-	839	(839)
Lease liabilities	22	535	-	535
Employee benefits provisions		178,262	169,305	8,957
Other current liabilities		527	461	66
Total current liabilities		274,517	252,926	21,591
Non-current liabilities				
Employee benefits provisions		41,769	40,984	785
Borrowings		-	-	-
Lease liabilities	22	1,463	-	1,463
Total non-current liabilities		43,232	40,984	2,248
Total liabilities		317,749	293,910	23,839
Net assets		1,299,625	1,274,830	24,794
Equity				
Contributed equity		1,146,450	1,132,398	14,052
Reserves		87,293	78,633	8,660
Accumulated surplus		65,881	63,799	2,082
Total equity		1,299,624	1,274,830	24,794

Significant variances between 2020 and 2019 actuals - statement of financial position

19. Refer to note 6 under "Significant variances between estimates and actuals - statement of financial position".

20. Refer to note 7 under "Significant variances between estimates and actuals - statement of financial position".

21. This increase is the cash transferred to the Department of Treasury for the 27th pay that is incurred every 11 years.

22. The variance is due to the initial application of AASB 16 Leases in 2020 (see also note 8 under "Significant variances between estimates and actuals - statement of financial position").

23. Refer to note 9 under "Significant variances between estimates and actuals - statement of financial position".

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2020

Note 11 Explanatory statement (continued)

Statement of changes in equity	Note	Actuals 2020 $000	Actuals 2019 $000	Variance between 2020 and 2019 results $000
Contributed equity				
Balance at start of period		1,132,398	1,120,444	11,954
Transactions with owners in their capacity as owners:				
Capital appropriations		14,052	11,698	2,354
Other contributions by owners		-	256	(256)
Distributions to owners		-	-	-
Balance at end of period		1,146,450	1,132,398	14,052
Reserves				
Asset revaluation reserve				
Balance at start of period		78,633	89,076	(10,443)
Other comprehensive income for the period		8,660	(10,443)	19,103
Balance at end of period		87,293	78,633	8,660
Accumulated surplus				
Balance at start of period		63,799	56,984	6,815
Changes in accounting policy		-	(461)	461
Restated balance at start of period		63,799	56,523	7,276
Surplus for the period		2,082	7,276	(5,194)
Balance at end of period		65,881	63,799	2,082
Total equity				
Balance at start of period		1,274,830	1,266,504	8,326
Changes in accounting policy		-	(461)	461
Restated balance at start of period		1,274,830	1,266,043	8,787
Total comprehensive income/(loss) for the period		10,742	(3,167)	13,909
Transactions with owners in their capacity as owners		14,052	11,954	2,098
Balance at end of period		1,299,624	1,274,830	24,794

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2020

Note 11 Explanatory statement (continued)

Statement of cash flows	Note	Actuals 2020 $000	Actuals 2019 $000	Variance between 2020 and 2019 results $000
Cash flows from State Government				
Service appropriations		711,606	672,398	39,208
Capital appropriations	24	13,212	10,901	2,311
Net cash provided by State Government		724,818	683,299	41,519
Utilised as follows:				
Cash flows from operating activities				
Payments				
Employee benefits		(857,686)	(818,493)	(39,193)
Supplies and services		(610,328)	(585,209)	(25,119)
Finance costs		(39)	(1)	(38)
Receipts				
Receipts from customers (a)		71,115	65,617	5,498
Commonwealth grants and contributions		520,243	499,647	20,596
Other grants and contributions		134,625	132,697	1,928
Donations received		223	142	81
Other receipts (a)	25	59,721	67,580	(7,859)
Net cash used in operating activities		(682,126)	(638,020)	(44,106)
Cash flows from investing activities				
Payments				
Purchase of non-current assets	24	(18,471)	(13,784)	(4,687)
Receipts				
Proceeds from sale of non-current assets		177	96	81
Net cash used in investing activities		(18,294)	(13,688)	(4,606)
Cash flows from financing activities				
Payments				
Principal elements of lease (2019 – finance lease)		(713)	(22)	(691)
Net cash used in financing activities		(713)	(22)	(691)
Net increase in cash and cash equivalents		23,685	31,569	(7,884)
Cash and cash equivalents at the beginning of the period		174,309	142,740	31,569
Total cash and cash equivalents at the end of the period		197,994	174,309	23,685

Significant variances between 2020 and 2019 actuals - statement of cash flows

24. Refer to note 11 under "Significant variances between estimates and actuals - statement of cash flows".

25. Refer to note 3 under "Significant variances between estimates and actuals - statement of comprehensive income" and note 17 under "Significant variances between actuals 2020 and actuals 2019 - statement of comprehensive income".

DISCLOSURES AND COMPLIANCE

Ministerial directives

Treasurer's Instructions 903(12) require disclosing information on any Ministerial directives relevant to the setting or achievement of desired outcomes or operational objectives, investment activities and financing activities. EMHS did not receive any formal Ministerial directives during 2019-20.

The Minister for Health's Statement of Expectation outlines the priorities and accountabilities of the EMHS Board, to which the EMHS Board released a Statement of Intent in response. Both of these documents are publicly available on the EMHS website.

These Statements outlined the ongoing focus on progression of the Government's election commitments; implementation of the recommendations of the SHR; consumer engagement; safety and quality; culture; performance; and governance.

Click for further details about the Statement of Expectation and Statement of Intent

Summary of board and committee remuneration

The total annual remuneration for each EMHS State Government board or committee (i.e. EMHS boards and committees where members may receive a sitting fee) is listed in the following table. For full EMHS board or committee details, please see page 217.

EMHS committee	Total remuneration ($)
EMHS Board	504,538
RPH Animal Ethics Committee	14,470
RPH Human Research Ethics Committee	18,530
AKG Consumer Advisory Committee	5955
BHS Community Advisory Committee	2190
RPH Community Advisory Committee	2440
Armadale Aboriginal Health Community Advisory Group	4747
Bentley Aboriginal Health Community Advisory Group	5355
RPH and Inner City Aboriginal Health Community Advisory Group	8050
Swan Hills / Midland Aboriginal Health Community Advisory Group	6528
Aboriginal Health Advisory Council	2730
Lived Experience Advisory Group	2971
Wungen Kartup Community and Carer Advisory Group (mental health)	1680

Pricing policy

EMHS charges for goods and services rendered on a partial or full cost recovery basis and complies with the *Health Insurance Act 1973*, the National Health Reform Agreement (NHRA) 2011, and the WA *HSA 2016*. These fees and charges are determined though the WA Health Costing and Pricing authorities and approved by the Minister for Health.

Guidelines for rules in relation to fees and charges are outlined in the WA Health Fees and Charges Manual. This is a mandatory document in the WA Health Financial Management Policy Framework and binding to all HSP under the *HSA 2016*. The current list of fees and charges were Gazetted on 30 June 2020 and published in the WA Fees and Charges Manual on 1 July 2020.

Click for further details about WA Fees and Charges Manual

Expenditure on advertising

In 2019–20, in accordance with section 175Z of the *Electoral Act 1907*, EMHS incurred a total advertising expenditure of $6471.

Expenditure	Organisation	Amount ($)	Total ($)
Advertising		0	
Market research		0	
Polling		0	
Direct mail		0	
Media advertising	Initiative Media Australia Pty Ltd	5721	6471
	Noongar Media Enterprises Pty Ltd	750	
Total		6471	6471

Unauthorised use of corporate credit cards

WA Government purchasing cards can be issued by EMHS to employees where their functions warrant usage of this facility.

These credit cards are not to be used for personal (unauthorised) purposes (i.e. a purpose that is not directly related to performing functions for the agency). All credit card purchases are reviewed by someone other than the cardholder to monitor compliance. If during a review it is determined that the credit card was used for unauthorised purchases, written notice must be given to the cardholder and the EMHS Board.

EMHS had five instances (total amount of $216) where a purchasing card was used for personal purposes in 2019-20. A review of these transactions confirmed they were immaterial and the result of genuine and honest mistakes, and no further action was deemed necessary as prompt notification and full restitution was made by the individuals concerned.

These were not referred for disciplinary action.

Within the period of 1 July 2019 to 30 June 2020:

	Total
Instances of use for personal purposes.	5
Aggregate amount of personal use expenditure.	$216
Aggregate amount of personal use expenditure settled by a due date.	$121
Aggregate amount of personal use expenditure settled after the due date.	$95
Aggregate amount of personal use expenditure remaining unpaid at end of financial year.	$0
Number of referrals for disciplinary action instigated by notifiable authority.	0

Indemnity insurance

In 2019-20, the amount of the insurance premium paid to indemnify directors of the EMHS Board (with 'director' defined as per Part 3 of the *Statutory Corporations (Liability of Directors) Act 1996)* against a liability incurred under sections 13 or 14 of that Act was $59,893 (including GST).

Capital works

EMHS has made a substantial investment in the improvement and development of its infrastructure during 2019-20.

Incomplete capital works (as at 30 June 2020)

Capital works	Expected period of completion	Estimated cost to complete ($000)	Estimated total cost 2018-19 ($000)	Estimated total cost 2019-20 ($000)	Estimated total cost variation ($000)
SJGMPH MHEC	30/06/2022	5,781	4,928	6,000	1,072
BHS redevelopment	30/06/2023	7,130	0	7,254	7,254
EMHS fire safety upgrades	30/06/2023	6,646	0	7,000	7,000
RPH redevelopment stage 1	30/06/2021	687	19,500	19,500	0
RPH helipad	30/06/2022	7,482	6,800	9,500	2,700
RPH fire risk	30/06/2023	8,164	9,962	9,962	0
RPH Mental Health Observation Area	30/06/2023	10,031	11,785	11,785	0
RPH Intensive Care Unit	30/06/2023	22,440	0	22,685	22,685
RPH Aseptic Unit	30/06/2022	4,140	0	4,140	4,140
RPH Medihotel	30/06/2021	2,275	0	3,035	3,035
Stop the Violence	30/06/2021	1,260	0	1,420	1,420

- SJGMPH MHEC: During 2019-20 the total project Treasury budget of $4,928,000 was replaced by Commonwealth funding of $6,000,000.
- RPH helipad: Additional funds were approved and allocated to EMHS to meet the revised estimated total cost in 2019-20.
- All other variations to estimated total costs were due to commencement of new capital projects in 2019-20.

Capital works completed in 2019-20

Capital works	Total cost ($000)	Estimated total cost 2018-19 ($000)	Total cost variation ($000)
SJGMPH	359,948	360,200	-252

Artist's impression of new RPH helipad

Recordkeeping

The *State Records Act 2000 (SRA 2000)* is the legislation affecting the management of State records. The *SRA 2000* strengthens public sector accountability through effective recordkeeping by providing set standards, the monitoring and investigative functions reportable directly to Parliament, and considers technological and administrative trends in recordkeeping.

The EMHS Recordkeeping Plan (RKP) was approved by the State Records Commission in April 2017 in accordance with the *SRA 2000*. An RKP review will be submitted to the State Records Commission in 2020 to provide an accurate reflection of EMHS's current recordkeeping position.

In 2018 HPE Records Manager (RM) was adopted by EMHS as the compliant corporate recordkeeping system and was piloted by six business areas. A Corporate Recordkeeping Coordinator was appointed in late 2019 and has led the rollout of RM to 11 business areas and 118 staff, with the focus being Area Group business areas. The full rollout of RM across EMHS is expected to take up to five years. As at 30 June 2020, **172 831** records have been uploaded to RM by EMHS staff.

All staff at EMHS are required to complete Recordkeeping Awareness Training as part of their mandatory training.

In addition, an intranet site for records management incorporates advice, policies and guidelines that staff must adhere to when undertaking recordkeeping activities has been established. A Recordkeeping Working Group was also established to assist in the role out of RM and raise recordkeeping awareness. The Working Group will be involved in testing and providing feedback on the implementation of RM.

Freedom of information

Click for further details:

AKG FOI

BHS FOI

RPH FOI

EMHS FOI

The WA *Freedom of Information Act 1992 (FOI 1992)* gives all Western Australians a right of access to information held by EMHS.

Access to information can be made through a Freedom of Information (FOI) application which should be addressed to the FOI Office at the appropriate EMHS site. FOI applications can be granted full access, partial access or access may be refused in accordance with the WA *FOI 1992*. Note: please see page 224 for site contact details.

In the 2019-20 financial year, EMHS received **3305** new applications under FOI legislation. This included:

EMHS site	Non-personal applications	Personal applications
AHS	182 + 2 (amended)	423
Swan District Hospital (SDH) records - general (applications via AHS)	8	56
KH	0	4
BHS (includes SDH records - mental health)	10	347
RPH	374	1885
EMHS	12	2
Total	**588**	**2717**

Disability access and inclusion

Click for further information about EMHS DAIP

EMHS is committed to creating an environment that enables people with disability, their families and carers, to have full access to all EMHS services, facilities and information.

EMHS Disability Access and Inclusion Plan (DAIP) 2017-22 outlines strategies to ensure seven desired disability outcome areas identified in the *Disability Services Act 1993*. In 2019-20, EMHS has progressed a number of initiatives to further improve these outcomes for our consumers.

General services and events

Outcome one: People with disability have the same opportunities as other people to access the services of, and any events organised by, a public authority.

To raise awareness of the needs of people with disability, on 3 December 2019, EMHS celebrated the International Day for People with Disability. Celebrations included onsite poster displays, interactive stations, accounts of achievements and electronic messaging. BHS also included disability related information as part of their Safety Week in September 2019 and will now include this on an annual basis.

In addition, in an effort to ensure accessibility for people with disability, SJGMPH sponsored the hire and installation of wheelchair accessible toilets at local Midland community events.

Buildings and facilities

Outcome two: People with disability have the same opportunities as other people to access the buildings and other facilities of a public authority.

In August 2019, RPH created additional ACROD parking bays in the outpatient clinic block, and all parking signage was updated. A larger car turning circle area was also developed in the car park, for ease of access to the expanded disabled parking area.

As part of COVID-19 initiatives, AHS lowered hand sanitiser dispensers adjacent to automatic door switches for therapy and outpatient clinics. Work is also underway to improve access by installing a covered walkway and widened paths in the garden.

Information and communication

Outcome three: People with disability receive information from a public authority in a format that will enable them to access the information as readily as other people are able to access it.

In 2019-20, RPH increased the availability of information on access and directions to clinic locations (including maps) and patient and visitor enquiry desks. This information is now available on the RPH website and is included with patient appointment letters.

Click for further information about RPH outpatient clinic locations

Quality of service

Outcome four: People with disability receive the same level and quality of service from the staff of a public authority as other people receive from the staff of that public authority.

In 2020, the RPBG Staff Induction Handbook was updated to specifically refer to relevant Disability Legislation; include key objectives employees should take into consideration whilst performing usual duties; and assist staff to identify barriers to providing care for people with disability.

RPBG's 'Take-5' education team have developed a five-slide education email for staff, which covers EMHS DAIP; a definition of disability; examples of achievements that have improved access and inclusion; initiatives for staff to assist people with disability; and links to resources and available contacts. This will be launched in August 2020.

EMHS Aboriginal Community Health and RPBG physiotherapy teams collaborated to develop a 'Living better with lung disease through exercise' program and resource, designed to engage with the Aboriginal community and deliver culturally appropriate pulmonary recovery.

Complaints and safeguarding

Outcome five: People with disability have the same opportunities as other people to make complaints to a public authority.

RPBG DAIP Committee monitors consumer feedback on disability related issues on a bi-monthly basis. In 2019-20, valuable feedback was provided on particular areas for improvement, including:

- Clinic location information on outpatient appointment letters did not match information on touch screens at entrances. This led to changes to patient information, as outlined on the previous page.
- Providing directions on alternate lift locations during periods of lift unavailability.
- Providing extra wheelchairs at main entrances.
- Distance and difficult access from car park/train station to clinics and wards, causing fatigue for frail visitors and patients. In response, in August 2019, RPH commenced trialling a variety of seating types, with comfortable spacing of distances between seating. This resulted in ‘rest stations’, which will be implemented in late 2020.

Consultation and engagement

Outcome six: People with disability have the same opportunities as other people to participate in any public consultation by a public authority.

RPBG implemented a new Safety and Quality Governance Structure based on four founding pillars of Culture of Continuous improvement; Deliver What Matters Most; Consistent High Quality Care; and No Patient Harm. Disability and Inclusion is one of four key items listed under Deliver What Matters Most. Consumer representatives are invited and actively participate within this governance framework.

In 2020, in partnership with WAPHA and the non-Government sector, EMHS initiated a program to assist consumers living in EMHS area with psychosocial disabilities achieve transition to NDIS supports. This innovative service model enables comprehensive assessment and collection of evidence (especially including implications of diagnoses on function and physical health) for consumers currently linked to community supports with non-government organisations. A high success rate has been achieved to request access to NDIS supports. (Please see page 52 for additional information).

Employment, people and culture

Outcome seven: People with disability have the same opportunities as other people to obtain and maintain employment with a public authority.

As part of graduate placements that occur each year at Public Sector Agencies, in early 2019 EMHS proposed for a graduate to undertake a supervised project for an Employment Plan for People with Disability. The key elements scoped were to provide direction towards an engaged and committed workforce at an inclusive workplace, how to better understand level of competence that informs work design, managers enabling and creating genuine occupational roles, and to develop the workforce skills in the disability sector. The project was completed in May 2020 for EMHS to progress.

APPENDIX

Acronyms

AHAC.....Aboriginal Health Advisory Council
AHCAG...Aboriginal Health Community Advisory Group
AHLO.....Aboriginal Health Liaison Officers
AHS.....Armadale Health Service
AI.....Artificial Intelligence
AKG.....Armadale Kalamunda Group
ALoS.....Average Length of Stay
AMI.....Acute Myocardial Infarction
BHS.....Bentley Health Service
CAC.....Consumer Advisory Committee
CAG.....Consumer Advisory Group
CAHS.....Child and Adolescent Health Service
CCC.....Corruption and Crime Commission
CCTV.....Closed Circuit Television
CE.....Chief Executive
CEO.....Chief Executive Officer
CITRA.....Centre for Implant Technology and Retrieval Analysis
DDI.....Data and Digital Innovation
DoH.....Department of Health
ED.....Emergency Department
EMHS.....East Metropolitan Health Service
ESWL.....Elective Surgery Wait List
ESO.....Employee Support Officers
FNoF.....Fractured Neck of Femur
FSH.....Fiona Stanley Hospital
FTE.....Full Time Equivalent
HIVE.....Health In a Virtual Environment
HSA.....Health Services Act 2016
HSP.....Health Service Provider
HSS.....Health Support Services
ICU.....Intensive Care Unit
IM.....Injury Management
IV.....Intravenous
KH.....Kalamunda Hospital
KPI.....Key Performance Indicator
LEAG.....Lived Experience Advisory Group
LMS.....Learning Management System
LTI/D.....Lost Time Injury and Disease
M and M.Morbidity and Mortality
MET.....Medical Emergency Team
MHC.....Mental Health Commission
MHEC.....Mental Health Emergency Centre
MHPF.....Mental Health Patient Flow
NDIS.....National Disability Insurance Scheme
NMHS.....North Metropolitan Health Service
OBM.....Outcome Based Management
OOS.....Occasions of service
PIVC.....Peripheral Intravenous Cannula
PPE.....Personal Protective Equipment
PPP.....Public Private Partnership
PSC.....Public Sector Commission
PSS.....Patient Support Services
QuEST....Quality, Efficiency and Safety in Theatres
RPBG.....Royal Perth Bentley Group
RPH.....Royal Perth Hospital
SAC.....Severity Assessment Code
SAP.....Strategic Asset management Plan
SCGH.....Sir Charles Gairdner Hospital
SHR.....Sustainable Health Review
SJGHC....St John of God Health Care
SJGMPH St John of God Midland Public Hospital
SMHS.....South Metropolitan Health Service
WA.....Western Australia
WACHS..WA Country Health Service
WAPHA...Western Australian Primary Health Alliance
WAU.....Weighted Activity Unit
WEAT.....WA Emergency Access Target
WEST.....WA Elective Services Target
WHS.....Work Health and Safety

Board and committee remuneration

EMHS Board

Position	Name	Type of remuneration	Period of membership in 2019-20 (months)	Total renumeration for financial year ($)*
Chair	Ian Smith	Sessional	12	87,757
Deputy Chair	Suzie May	Sessional	12	51,045
Board member	Ross Keesing	Sessional	12	45,717
Board member	Kingsley Faulkner	Sessional	12	45,717
Board member	Denise Glennon	Sessional	12	45,717
Board member	Richard Guit	Sessional	12	45,717
Board member	Debra Zanella	Sessional	12	45,717
Board member	Amanda Gadsdon	Sessional	12	45,717
Board member	Laura Colvin	Sessional	12	45,717
Board member	Peter Forbes	Sessional	12	45,717
			Total	**$504,538**

*Includes superannuation.

RPH Animal Ethics Committee (AEC)

Position	Name*	Type of remuneration	Period of membership in 2019-20 (months)	Total renumeration for financial year ($)
Chair	Member 1	Sessional	12	10,470
Executive officer	Member 2	n/a	12	0
Category A (vet)	Member 3	Per meeting	12	800
Category A (vet)	Member 4	Per meeting	12	600
Category B (animal-based research)	Member 5	n/a	12	0
Category B (animal-based research)	Member 6	Per meeting	12	600
Category C (animal welfare)	Member 7	Per meeting	12	800
Category C (animal welfare)	Member 8	Per meeting	12	400
Category D (community)	Member 9	Per meeting	12	800
Category D (community)	Member 10	nil	2	0
			Total	**$14,470**

n/a = WA Health employee, not eligible for payment.
*Personal details suppressed with permission from the Minister for Health.

RPH Human Research Ethics Committee (HREC)

Position	Name	Type of remuneration	Period of membership in 2019-20 (months)	Total renumeration for financial year ($)
Chair	Frank van Bockxmeer	Sessional	12	18,530
Lay person (male)	David Wilding	n/a	6	0
Lay person (male)	Hamish Milne	n/a	12	0
Lay person (female)	Helen Walsh	n/a	12	0
Lay person (female)	Grace Moro	n/a	12	0
Professional care member	Wayne Epton	n/a	12	0
Professional care member	Tonia Naylor	n/a	12	0
Pastoral care	Michael Hertz	n/a	12	0
Pastoral care	Ken Devereux	n/a	12	0
Lawyer	Stephen Sparkes	n/a	12	0
Lawyer	Melanie Binet	n/a	12	0
Medical research	Ramin Gharbi	n/a	12	0
Medical research	Ed Litton	n/a	10	0
Medical research	Dieter Weber	n/a	12	0
Medical research	Jenny McCloskey	n/a	12	0
Medical research	Richard Herrmann	n/a	12	0
Medical research	Janice Fogarty	n/a	12	0
Medical research	Xavier Fiorilla	n/a	12	0
			Total	**$18,530**

n/a = Aside from the Chair, HREC members do not receive payment.

Please note:

Community members are paid in accordance with the Health Consumers' Council Consumer Participation Policy. From July to November 2019, this payment was $30 per hour, however was increased to $35 per hour from November 2019.

A number of community committee meetings were suspended in early-mid 2020 due to COVID-19.

AKG Consumer Advisory Committee (CAC)

Position	Name	Type of remuneration	Period of membership in 2019-20 (months)	Total renumeration for financial year ($)
Chair	Dorothy Harrison	Per meeting	12	2520
Vice Chair	Julie Hoey	Per meeting	12	1400
Community member	Sheryl Little	Per meeting	12	770
Community member	Member 4*	Per meeting	6	965
Community member	Sherrin Roberts	Per meeting	12	300
			Total	**$5955**

*Personal details suppressed with permission from the Minister for Health.

BHS CAC

Position	Name	Type of remuneration	Period of membership in 2019-20 (months)	Total renumeration for financial year ($)
A/Chair	Colin Stevenson	Per meeting	12	320
Community member	Philip Lim	Per meeting	12	460
Community member	Linda Beresford	Per meeting	12	530
Community member	Barbara Hislop	Per meeting	8	340
Community member	Karen Collinson	Per meeting	7	340
Community member	Jaskaranbir Kaur	Per meeting	8	200
			Total	**$2190**

RPH CAC

Position	Name	Type of remuneration	Period of membership in 2019-20 (months)	Total renumeration for financial year ($)
Chair	Robert McCormack	Per meeting	12	530
Community member	Member 2*	Per meeting	6	310
Community member	Greg Swensen	Per meeting	12	260
Community member	Patricia Clark	Per meeting	12	250
Community member	Peter Evans	Per meeting	12	250
Community member	Peter Grocott	Per meeting	12	260
Community member	Nigel Hanwell	Per meeting	12	70
Community member	Joanne Treacy	Per meeting	12	320
Community member	Maureen Meixner	Per meeting	12	190
			Total	**$2440**

*Personal details suppressed with permission from the Minister for Health.

Armadale Aboriginal Health Community Advisory Group (AHCAG)

Position	Name	Type of remuneration	Period of membership in 2019-20 (months)	Total renumeration for financial year ($)*
Chair	Leon Hayward	Per meeting	12	700
Vice Chair	Delson Stokes	Per meeting	12	438
Community member	Yvonne Yarran	Per meeting	12	70
Community member	Eunice Bynder	Per meeting	12	613
Community member	Ian Taylor	Per meeting	12	438
Community member	Raelene Hayward	Per meeting	12	438
Community member	Victor Ronan	Per meeting	12	753
Community member	Clive Hayden	Per meeting	12	228
Community member	Tammy Bennell Yarran	Per meeting	12	228
Community member	Olive Bennell	Per meeting	12	455
Community member	Madge Hill	Per meeting	12	158
Community member	Wendy Hayden	Per meeting	12	228
			Total	$4747

*Total may include payments for participation other than at AHCAG meetings.

Bentley AHCAG

Position	Name	Type of remuneration	Period of membership in 2019-20 (months)	Total renumeration for financial year ($)*
Chair	Brenda Greenfields	Per meeting	12	1015
Vice Chair	Kerry Thorne	Per meeting	12	805
Community member	Nina Chadd	Per meeting	12	595
Community member	Albert Knapp	Per meeting	12	595
Community member	Joanna Hayward	Per meeting	12	595
Community member	Shirley Voss	Per meeting	12	735
Community member	Kay Jones	Per meeting	12	280
Community member	Margaret Ogilvie	Per meeting	12	280
Community member	Katherine Quartermaine	Per meeting	12	175
Community member	Darryl Ogilvie	Per meeting	12	280
			Total	$5355

*Total may include payments for participation other than at AHCAG meetings.

Royal Perth Inner City AHCAG

Position	Name	Type of remuneration	Period of membership in 2019-20 (months)	Total renumeration for financial year ($)**
Chair	Member 1*	Per meeting	6	1190
Vice Chair	Barbara McGillivray	Per meeting	12	805
Community member	Courtney Williams	Per meeting	12	280
Community member	Amanda Barber	Per meeting	12	420
Community member	Chris McGibbon	Per meeting	12	560
Community member	Alanna Barber	Per meeting	12	420
Community member	Graham Blacklock	Per meeting	12	665
Community member	Fredrick Penny	Per meeting	12	385
Community member	Gail Wynne	Per meeting	12	280
Community member	Jennifer Bonney	Per meeting	12	875
Community member	Rex Wright	Per meeting	12	420
Community member	Shirley Lumai	Per meeting	12	350
Community member	Vicki Blurton	Per meeting	12	420
Community member	Rose Michael	Per meeting	12	490
Community member	Valerie Dorrizi	Per meeting	12	490
			Total	$8050

*Personal details suppressed with permission from the Minister for Health.
**Total may include payments for participation other than at AHCAG meetings.

Swan Hills Midland AHCAG

Position	Name	Type of remuneration	Period of membership in 2019-20 (months)	Total renumeration for financial year ($)*
Chair	Denis Hayward	Per meeting	12	805
Vice Chair	Yolande Yarran Ward	Per meeting	12	1015
Community member	Joan Lyndon	Per meeting	12	333
Community member	Neeba Ward	Per meeting	12	525
Community member	Charon Ryder	Per meeting	12	490
Community member	Darryl Indich	Per meeting	12	595
Community member	Chelsea Bell	Per meeting	12	735
Community member	Doreen Creed	Per meeting	12	735
Community member	Tina Yarran	Per meeting	12	280
Community member	John Kailin	Per meeting	12	490
Community member	Nikita Dean	Per meeting	12	70
Community member	Kylie Cross	Per meeting	12	140
Community member	Shaydeen Stocker	Per meeting	12	105
Community member	Tramaine Dukes	Per meeting	12	210
			Total	$6528

*Total may include payments for participation other than at AHCAG meetings.

Aboriginal Health Advisory Council (AHAC)

Position	Name	Type of remuneration	Period of membership in 2019-20 (months)	Total renumeration for financial year ($)**
Chair	Leon Hayward	Per meeting	12	420
Vice Chair	Brenda Greenfields	Per meeting	12	420
Community member	Darryl Indich	Per meeting	12	140
Community member	Delson Stokes	Per meeting	12	280
Community member	Member 5*	Per meeting	6	280
Community member	Jennifer Bonney	Per meeting	12	140
Community member	Joanne Hayward	Per meeting	12	140
Community member	Rose Michael	Per meeting	12	210
Community member	Shirley Voss	Per meeting	12	280
Community member	Yolande Yarran	Per meeting	12	280
Community member	Denis Hayward	Per meeting	12	140
			Total	**$2730**

*Personal details suppressed with permission from the Minister for Health.
**Total may include payments for participation other than at AHCAG meetings.

Wungen Kartup Aboriginal Consumer and Carer Advisory Group (mental health)

Position	Name	Type of remuneration	Period of membership in 2019-20 (months)	Total renumeration for financial year ($)*
Chair	Yvonne Winmar	Per meeting	6	990
Vice Chair	Phillip Moncrieff	Per meeting	6	180
Community member	Colleen Glass	Per meeting	6	30
Community member	Christine Winmar	Per meeting	6	70
Community member	Kristine Mallard	Per meeting	6	250
Community member	Steven Samson	Per meeting	6	160
			Total	**$1680**

*Total may include payments for participation other than at group meetings.

Lived Experience Advisory Group (LEAG)

Position	Name	Type of remuneration	Period of membership in 2019-20 (months)	Total renumeration for financial year ($)
Chair	Melody Birrell	n/a		0
Co-chair	Tegan Leahy	Per meeting	5	335
Community member	Ann Barber	Per meeting	1	52
Community member	Beverley Barndon	Per meeting	1	70
Community member	Carli Sheers	Per meeting	1	60
Community member	Emily Winterburn	Per meeting	4	265
Community member	Janine Mans	Per meeting	1	52
Community member	Jodi Nicholas	Per meeting	6	387
Community member	Joshua O'Donnell	Per meeting	1	52
Community member	Juanita Koeijers	Per meeting	2	122
Community member	Julienne Smout	Per meeting	7	447
Community member	Lorenzo Martinez	Per meeting	1	52
Community member	Michael Harris	Per meeting	1	70
Community member	Ron Deng	Per meeting	6	365
Community member	Member 15*	Per meeting	5	302
Community member	Phillip Moncrieff	Per meeting	2	140
Community member	Yvonne Winmar	Per meeting	3	200
			Total	**$2971**

n/a = WA Health employee, not eligible for payment.
*Personal details suppressed with permission from the Minister for Health.

Site contact details

East Metropolitan Health Service (area office)

Address
10 Murray Street
Perth WA 6000

Postal address
GPO Box X2213
Perth WA 6847

Royal Perth Bentley Group (RPBG)

Royal Perth Hospital

Address
Victoria Square
Perth WA 6000

Postal address
GPO Box X2213
Perth WA 6847

Telephone (08) 9224 2244
Fax (08) 9224 3511

rph.health.wa.gov.au

Bentley Health Service

Address
18 – 56 Mills Street
Bentley WA 6102

Postal address
PO Box 158
Bentley WA 6982

Telephone (08) 9416 3666
Fax (08) 9416 3711

bhs.health.wa.gov.au

Armadale Kalamunda Group (AKG)

Armadale Health Service

Address
3056 Albany Highway
Mount Nasura WA 6112

Postal address
PO Box 460
Armadale WA 6992

Telephone (08) 9391 2000
Fax (08) 9391 2149

ahs.health.wa.gov.au

Kalamunda Hospital

Address
Elizabeth Street
Kalamunda WA 6076

Postal address
PO Box 243
Kalamunda WA 6926

Telephone (08) 9257 8100
Fax (08) 9293 2488

St John of God Health Care (SJGHC)

St John of God Midland Public Hospital

Address
1 Clayton Street
Midland WA 6056

Postal address
GPO Box 1254
Midland WA 6936

Telephone (08) 9462 4000
Fax (08) 9462 4050

Email
info.midland@sjog.org.au

sjog.org.au/midland

St John of God Mt Lawley (contracted services)

Address
Thirlmere Road, Mt Lawley 6050

Postal address
Thirlmere Road, Mt Lawley 6050

Telephone (08) 9370 9222
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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. No disrespect is intended to our Torres Strait Islander colleagues and community.

FEEDBACK AND ACCESSIBILITY

Thank you for reading our EMHS Annual Report 2019-20. We invite you to contact us to provide feedback on the report, or if you would like additional information about EMHS. For accessibility this document is available in other formats upon request.

EMHS would like to acknowledge all of the staff who have contributed to the compilation of this report. We extend our thanks also to Mr Robert McCormack for his valuable input as an EMHS consumer representative.

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