



Government of Western Australia
East Metropolitan Health Service



East Metropolitan Health Service
ANNUAL REPORT 2024 - 2025



Shaping the future of health care

EMHS has an important and trusted place at the forefront of health care in Western Australia. The high quality of our services is vitally important to our community now and will be for generations to come. Our decisions, innovations and actions today shape our present and also our future. This annual report outlines our performance and milestones for the 2024-25 financial year, another step in who we are and our vision for what we will become.

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Statement of Compliance

For year ended 30 June 2025

Hon Meredith Hammat
Minister for Health; Mental Health

In accordance with section 63 of the *Financial Management Act 2006*, we hereby submit for your information and presentation to Parliament, the Annual Report of East Metropolitan Health Service for the financial year ended 30 June 2025.

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



Pia Turcinov AM

Board Chair
East Metropolitan Health Service
8 September 2025



Melissa Grove

Chair, EMHS Board Audit
and Risk Committee
East Metropolitan Health Service
8 September 2025

Acknowledgment of Country

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

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

Acknowledgment of Aboriginal people and communities

The voice of Aboriginal people and communities is reflected in the EMHS 2024-25 Annual Report to ensure that cultural appropriateness and the health impacts on Aboriginal people have been considered and incorporated.

Cultural warning

The EMHS 2024-25 Annual Report may contain articles that display names, images and artwork of Aboriginal persons who have passed away.

EMHS respects and understands the cultural norms relating to the display of Aboriginal people who have passed away.



The Aboriginal community

Within Western Australia (WA), the term Aboriginal people is used in preference to Aboriginal and Torres Strait Islander people, in recognition that Aboriginal people are the original inhabitants of WA. No disrespect is intended to the Torres Strait Islander community.

From the Chief Executive and Board Chair

East Metropolitan Health Service (EMHS) is in a new age of health care.

Advances in technology, research and medicine, and new approaches to patient care and working with the community, have made the previously impossible possible.

In keeping with global advances and our ongoing commitment to innovation, EMHS has evolved into a service connecting traditional hospital and community services with technology-enabled hospital-at-home and community care not available to previous generations of patients.

Multi-million-dollar election commitments announced this year for major upgrades to Royal Perth Hospital (RPH) and St John of God Midland Public Hospital (SJGMPH) will help ensure these leading facilities remain at the forefront of health care and continue to best serve some of the fastest growing communities in Western Australia.

A total of \$105 million in State funding has been pledged for RPH, including \$97.3 million to modernise the Emergency Department, and \$355 million for SJGMPH in State and Commonwealth funds. Our teams are on stand-by to begin work on these as soon as final approvals are in place.

This year, we took an exciting step forward by expanding our virtual hospital services and bringing them together under the East CareConnect banner. By uniting our in-person and virtual care, we are making it easier for people to access the support they need – wherever they are. It is a reflection of our ongoing commitment to community, innovation, and making health care more inclusive and connected for everyone.

Health care is no longer confined within hospital walls; it seamlessly becomes part of daily life. East CareConnect enables patients to receive

personalised, precision care for conditions such as pneumonia, infections, wounds and heart conditions in the comfort of their homes.

The new service combines home visits from health professionals with advanced digital health technologies, including continuous remote biomedical monitoring, digital medical records, and virtual consultations. This enables proactive management of health conditions, allowing our teams to intervene earlier and prevent clinical deterioration, no matter where the patient lives.

In November 2024, we opened the EMHS Innovation Hub. The Hub is designed to bring EMHS clinicians and innovators together with industry experts and the broader innovation community, creating opportunities to develop and grow ideas that improve the health and wellbeing of all Western Australians.

The financial year also saw many other developments in key areas.

Ground works began on the \$42.2 million Byford Health Hub which will provide accessible, community-based care when it opens in 2027, reducing reliance on hospital services and offering a new model of care.

Planning progressed for the \$167 million Bentley Health Surgicentre which will streamline and alleviate pressure on our emergency departments on opening in 2029.

We established an EMHS Mental Health Directorate to oversee mental health services across our sites, reinforcing the importance we place on mental health.

For a safer workplace, we formed a new Behaviour Support Team to help frontline staff manage challenging patients under the first phase of a strategy known as CaREPlan.

Our Armadale Health Service continued to safely and successfully lower birth rates before 39 weeks and is on track to lower early term and preterm births by 20 per cent.

To minimise our environmental impact, we appointed an EMHS Chief Sustainability Officer.

Our roadmap forward is comprehensive and focused on delivering safe, high quality, ethical and sustainable health care, taking a multi-faceted approach. The goal is a health service that prioritises each patient's unique needs, is well integrated with the local community and leverages technology to enhance care.

As we enter the new financial year, we would like to thank our staff, wide network of consumer advisors, volunteers and patients for making our health service what it is, and what it will become.

Our people go above and beyond in delivering our vision of healthy people, amazing care, and our valued patients make every day an opportunity to have a positive impact.

Together, we look forward to embracing the opportunities and challenges of an evolving new age, with optimism and determination for a bright future.



Lesley Bennett
Chief Executive
East Metropolitan
Health Service



Pia Turcinov AM
Board Chair
East Metropolitan
Health Service

About EMHS

EMHS is an extensive hospital and health network that strives to maintain and improve the health and wellbeing of the community within its catchment area. It also serves residents of regional WA requiring more complex care, as well as providing a number of statewide services.

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

Our hospital and community network

EMHS consists of:

Armadale Kalamunda Group (AKG), which includes **Armadale Health Service (AHS)** and **Kalamunda Hospital (KH)**.

AHS provides a range of healthcare to the eastern corridor of the EMHS area, including emergency, maternity, intensive care and community and hospital based mental health.

KH is a small hospital that provides endoscopy services and specialist palliative care, in beautiful bush surroundings.

Royal Perth Bentley Group (RPBG) includes the inner-city **Royal Perth Hospital (RPH)** and **Bentley Health Service (BHS)**.

As a tertiary hospital, RPH provides an extensive range of healthcare including adult major trauma, emergency and highly specialised services, as well as community and hospital-based mental health

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

EMHS also manages a public private partnership (PPP) with **St John of God Health Care (SJGHC)**. This includes **St John of God Midland Public Hospital (SJGMPH)** – providing a wide range of services to the Swan and Hills community, including emergency and intensive care services – and assessment and restorative care services for public patients at **St John of God Mount Lawley (SJGML)**.

EMHS also provides East CareConnect, delivering virtual hospital services to our community, as well as a range of mental health, community services and population health programs, including Aboriginal health programs facilitated both within and outside of our catchment area.



31,495

Total Aboriginal population within EMHS catchment

29,817 in 2023-24 ▲



828,699

Total population within EMHS catchment

795,596 in 2023-24 ▲



3,647km²

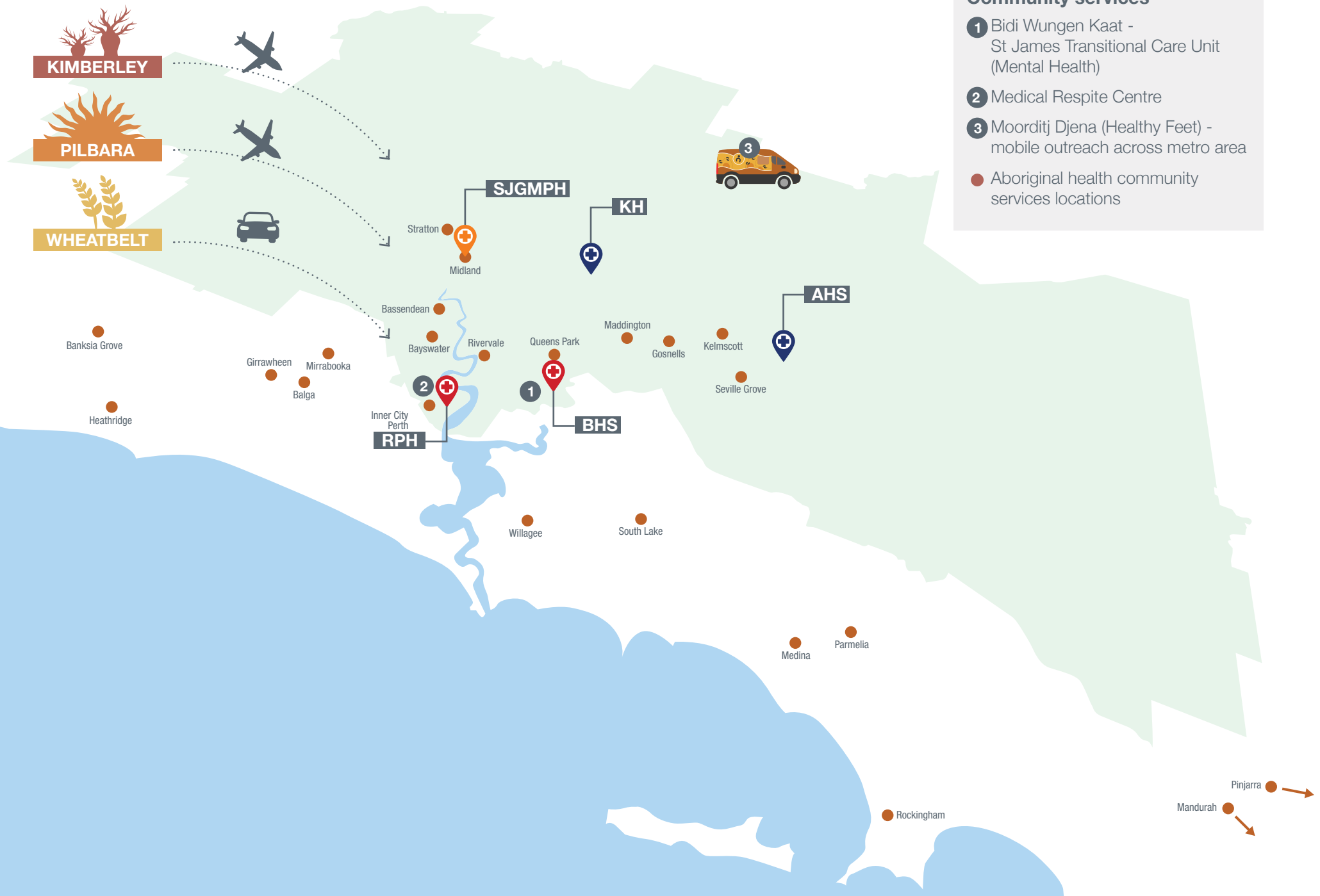
Catchment area



Legend

Community services

- 1 Bidi Wungen Kaat - St James Transitional Care Unit (Mental Health)
- 2 Medical Respite Centre
- 3 Moorditj Djena (Healthy Feet) - mobile outreach across metro area
- Aboriginal health community services locations



Our strategic direction

Our vision

Healthy people, amazing care
Koorda moort, moorditj kwabadak
(Noongar translation)

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

Our values

-  KINDNESS
-  EXCELLENCE
-  RESPECT
-  INTEGRITY
-  COLLABORATION
-  ACCOUNTABILITY

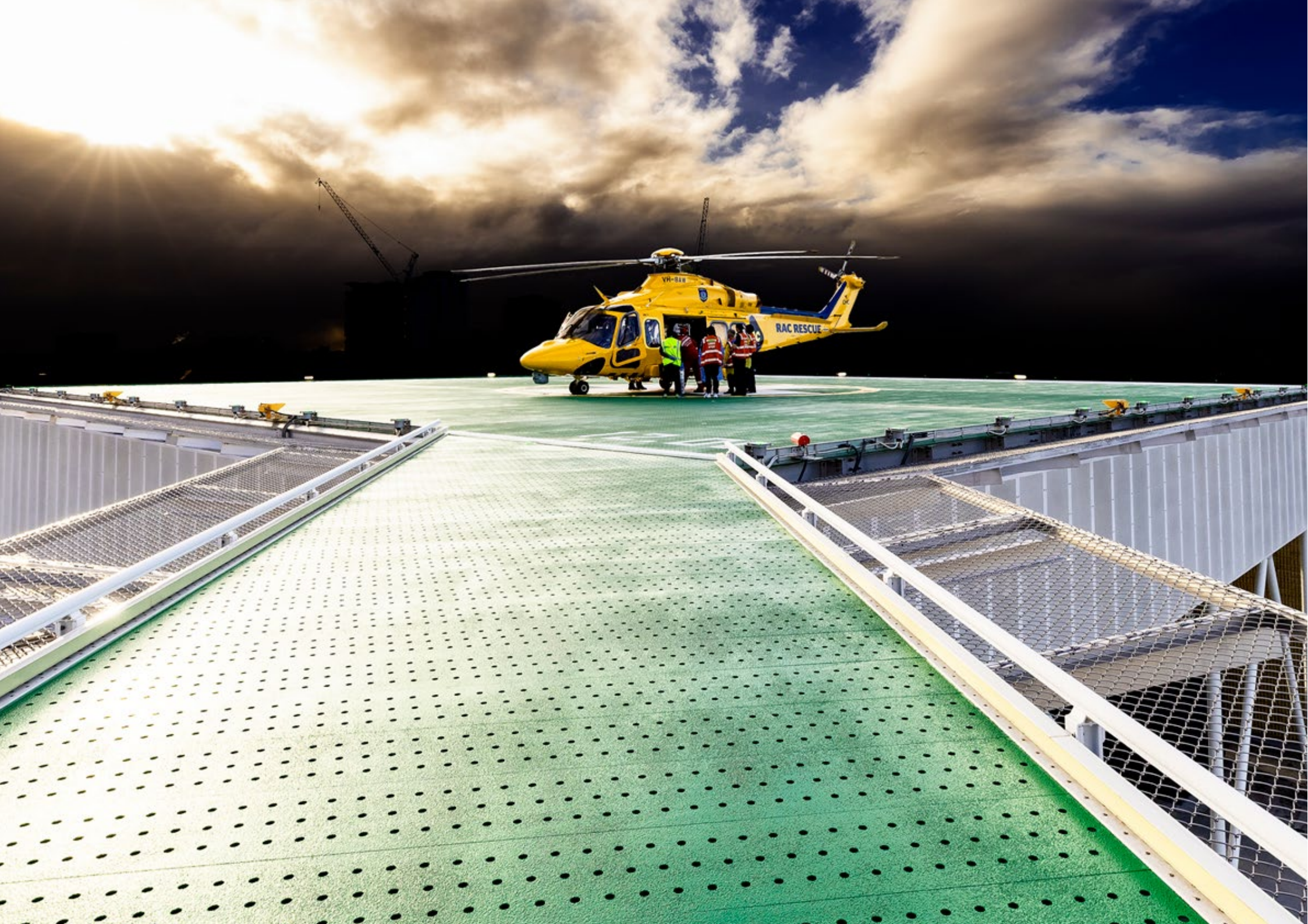
EMHS strategic and operational plans

The [EMHS Strategic Plan 2021-25](#) sets out the future direction and aspirations for the health service, in alignment with the overarching health system vision for delivery of safe, quality, financially sustainable and accountable health care for all Western Australians. The EMHS Operational Plan outlines collaborative actions which enable our health service to achieve and embed the goals of the Strategic Plan, in line with our vision and values. A new Operational Plan was launched in early 2025, hinging on four pillars – Consumers and community, Our people, The here and now, and A better tomorrow.

Supporting our strategic direction is the new EMHS Clinical Services Plan (CSP) Towards 2035. The CSP is a key strategic document that will guide EMHS clinical service development and prioritisation, informing infrastructure priorities and investment of resourcing over the next ten years. The CSP aspires to deliver, through a culturally safe, contemporary, tiered and integrated network of health services, high quality and excellent healthcare which aligns planning to ensure EMHS delivers patient-centred healthcare to meet the needs of the EMHS population.

Our strategic pillars and goals

Consumers and community	Our people	The here and now	A better tomorrow
We value consumers, seeking to connect and work with our community to understand and deliver on what is important to them.	We value our staff by providing a safe and supportive workplace culture that enables them to thrive.	We work to make each new day better than the day before, acting with purpose to provide high quality healthcare.	We focus on research, innovation and data to meet the future care needs of our consumers and the community.





Executive summary

2024-25 at a glance



217,945
Emergency
Department
presentations



193,155
Inpatients



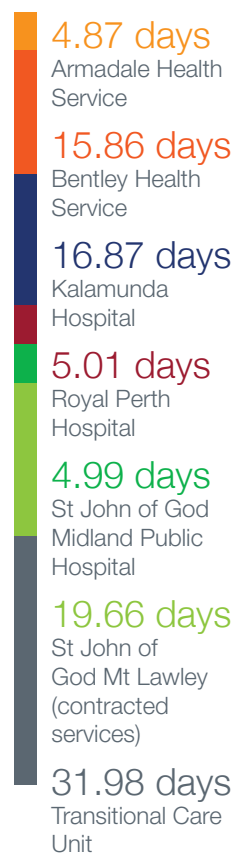
4,658
Mental health
inpatients





5.87 days Average length of stay

multi-day stay patients only



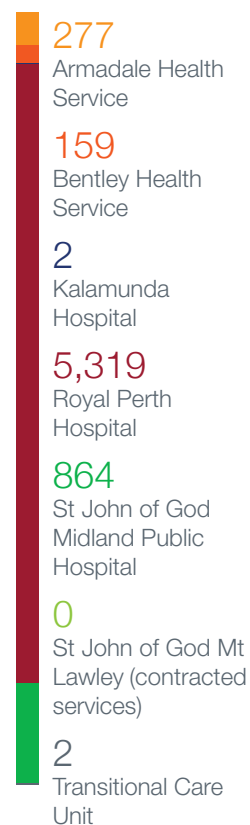
58,792 Operations



568,085 Outpatients



6,623 Occasions of care provided to people with no fixed address



4,215 Births



Top 5 countries of birth for people who accessed care at EMHS



270,974 Occasions of service – community mental health

EMHS 2024–25 financial summary

Total cost of services (expense limit)	Net cost of services	Total equity	Net increase (decrease) in cash held	Approved salary expense level
Sourced from statement of comprehensive income	Sourced from statement of comprehensive income	Sourced from statement of financial position	Sourced from statement of cash flows	Sourced from statement of comprehensive income
2024-25 Target \$000	2024-25 Target \$000	2024-25 Target \$000	2024-25 Target \$000	2024-25 Target \$000
 \$2,159,324	 \$2,036,306	 \$1,672,482	 -\$22,869	 \$1,222,239
2024-25 Actual \$000	2024-25 Actual \$000	2024-25 Actual \$000	2024-25 Actual \$000	2024-25 Actual \$000
 \$2,423,773	 \$2,273,122	 \$1,966,711	 \$11,701	 \$1,375,658
Variation \$000 \$264,449	Variation \$000 \$236,816	Variation \$000 \$294,229	Variation \$000 \$34,570	Variation \$000 \$153,419
The variance in both the Total Cost of Services and Net Cost of Services is attributable to higher than anticipated expenditure in the 2024/25 financial year, compared to initial estimates mainly related to: Employee benefits expense: a. Cost of award increases, provision of new services and the recruitment of additional staff to support healthcare service delivery, b. The resulting flow-on effects of the above leading to increases in penalty rates, allowances, superannuation contributions, workers' compensation insurance premiums, and leave provision liabilities, Contracts for service expense: c. Additional payments that were made under the Public Private Partnership (PPP) arrangement with St John of God Healthcare for the provision of additional general and mental health services.		The variance in total equity is due to: a. Substantial increase in the value of the Health Service's land and building assets resulting from Landgate's annual revaluation process, b. Increases in expenditure contributed to an underestimation of the Health Service's deficit.	The net increase in cash and cash equivalents is primarily driven by: a. Additional government funding to address award increases, price escalations (CPI) and delivery of additional health activities, b. Higher patient revenue activity and improved cash collections from fully coded patient records.	The variance in approved salary expenses is attributable to the following: a. Cost of award increases, provision of new services and the recruitment of additional staff to support healthcare service delivery, b. The resulting flow-on effects of the above leading to increases in penalty rates, allowances, superannuation contributions, workers' compensation insurance premiums, and leave provision liabilities.

EMHS 2024–25 performance summary

[See page 64 for full KPIs](#)

Key Performance Indicators (KPIs) and KPI targets assist EMHS to assess and monitor achievement of the outcomes outlined in the Outcome Based Management Policy Framework ([see page 22](#)). 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 health care for Western Australians		
Effectiveness KPIs	Target	Actual
Unplanned hospital readmissions for patients within 28 days for selected surgical procedures (per 1,000 separations)		
(a) knee replacement	≤ 21.0	14.4
(b) hip replacement	≤ 19.4	7.9
(c) tonsillectomy & adenoidectomy	≤ 84.4	147.1
(d) hysterectomy	≤ 45.8	31.3
(e) prostatectomy	≤ 40.0	42.6
(f) cataract surgery	≤ 2.3	1.5
(g) appendicectomy	≤ 29.7	26.0
Percentage of elective wait list patients waiting over boundary for reportable procedures		
(a) category 1 over 30 days	0%	8.7%
(b) category 2 over 90 days	0%	35.9%
(c) category 3 over 365 days	0%	11.4%
Healthcare-associated staphylococcus aureus bloodstream infections (HA-SABSI) per 10,000 occupied bed-days	≤ 1.00	0.63
Survival rates for sentinel conditions		
(a) Stroke		
0-49 years	≥ 95.4%	94.9%
50-59 years	≥ 94.8%	94.6%
60-69 years	≥ 94.5%	97.1%
70-79 years	≥ 92.6%	94.7%
80+ years	≥ 87.6%	93.0%
(b) Acute myocardial infarction (AMI)		
0-49 years	≥ 98.9%	98.9%
50-59 years	≥ 98.8%	99.0%
60-69 years	≥ 98.2%	99.4%
70-79 years	≥ 97.0%	95.5%
80+ years	≥ 93.1%	93.4%
(c) Fractured neck of femur (FNoF)		
70-79 years	≥ 98.8%	99.2%
80+ years	≥ 97.3%	97.7%

OUTCOME ONE: Public hospital-based services that enable effective treatment and restorative health care for Western Australians		
Effectiveness KPIs	Target	Actual
Percentage of admitted patients who discharged against medical advice		
a) Aboriginal patients	≤ 2.78%	6.90%
b) Non-Aboriginal patients	≤ 0.99%	1.29%
Percentage of live-born term infants with an Apgar score of less than seven at five minutes post delivery	≤ 1.90%	1.47%
Readmissions to acute specialised mental health inpatient services within 28 days of discharge	≤ 12.0%	14.2%
Percentage of post discharge community care within seven days following discharge from acute specialised mental health inpatient services	≥ 75.0%	86.7%
Efficiency KPIs	Target	Actual
Average admitted cost per weighted activity unit	\$7,899	\$8,148
Average Emergency Department cost per weighted activity unit	\$7,777	\$8,753
Average non-admitted cost per weighted activity unit	\$7,903	\$8,902
Average cost per bed-day in specialised mental health inpatient services	\$1,913	\$2,223
Average cost per treatment day of non-admitted care provided by mental health services	\$507	\$447

OUTCOME TWO: Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives		
Efficiency KPIs	Target	Actual
Average cost per person of delivering population health programs by population health units	\$24	\$20

● Desired result ● Undesired result

Significant challenges 2024-25

A complex mix of issues across various sectors posed significant challenges in 2024-25.

Among these was the ongoing challenge of meeting rising health service demands due to rapid population growth with existing infrastructure.

EMHS also supports many priority health groups with complex needs and cultural and linguistic diversity, including a large Aboriginal community, people with mental illness, those experiencing homelessness (especially in the inner city), and pockets of high socio-economic disadvantage.

Additionally, a sector-wide shortage of health workers continues to make workforce recruitment challenging in some areas, while protecting existing staff from burnout and patient aggression remains a priority.

Addressing these challenges requires coordinated efforts from government, health services and community stakeholders, along with sustained investment in people, infrastructure and innovation.

Our EMHS Clinical Services Plan – Towards 2035, released in May, is our roadmap for navigating many of these major challenges now and over the next decade, supported by many other detailed plans for individual areas of our operations.

Rapid population growth and demand

EMHS' catchment includes some of the fastest-growing areas in Western Australia.

Within the next 11 years we are expected to have the largest population among metropolitan health regions, reaching 903,653 people by 2031-32.

In particular, our South East health district (the location of Armadale Health Service), is expected to increase by 26.4 per cent and Swan and Hills (location of St John of God Midland Public Hospital) by 22.5 per cent.

We are also the only metropolitan health region with an increasing birth rate, particularly in our high growth rate areas.

Rapid growth increases pressure on our services, including emergency departments, inpatient beds, elective surgery, maternity care and outpatient services. There has also been a greater need for community-based care, aged care and chronic disease management.

We are tackling this on a myriad of fronts including focusing on improvements and innovation to enhance capability and capacity.

These include our community and virtual healthcare-at-home service, East CareConnect, which incorporates Home Hospital, Health in a Virtual Environment (HIVE), Co-HIVE, and GEM@home (Geriatric Evaluation and Management); and infrastructure projects such as the Bentley Health Surgicentre and Byford Health Hub, which will improve health access for our communities when they open.

Infrastructure barriers

The majority of our buildings are more than 70 years old. Maintaining and upgrading infrastructure to support modern service delivery within budgetary constraints remains a key area of focus.

The \$460 million in State and Commonwealth election commitments pledged this year for improvements at Royal Perth Hospital (RPH) and St John of God Midland Public Hospital (SJGMPH) will greatly assist us in addressing some of the most pressing infrastructure issues. The State budget in June provided \$10 million to progress planning for expansions to SJGMPH and RPH Emergency Departments.

Serving a diverse community

Our catchment has many priority groups with increased and complex medical needs.

These groups have been identified as experiencing health inequity, placing them at higher risk of poorer health outcomes and rates of healthcare usage.

People living with mental illness, experiencing homelessness, facing socio-economic hardship, living with a disability, residing in rural or remote areas, or from culturally and linguistically diverse backgrounds – as well as Aboriginal and LGBTQIA+ people – often face overlapping and multi-faceted challenges when accessing health care.

These groups often rely more heavily on the public health system than on primary care due to cost, accessibility and systemic barriers.

Emergency departments and public hospitals are often the default access points for care.

A key part of our planning is finding better ways to improve access to care for priority groups, ensuring their voices are included in shaping the solutions that affect them.

Sustainable workforce

The ongoing global shortage of healthcare workers continues to make recruitment and retention challenging.

Addressing increasing psychosocial challenges in the workplace is also a priority.

In response, we have a range of targeted initiatives.

These include innovative and proactive recruitment strategies, new safety measures to protect and empower our staff, supportive work environments, flexible working and enhanced wellbeing programs.

A key initiative in 2024–25 was the launch of our CaREPlan program, co-designed with staff to enhance our workplace environment — particularly by strengthening physical and psychological safety through our Behaviour Support Team.

Other challenges in a rapidly changing system

Other factors are adding to the mix of challenges we face.

Meeting our patients' expectations for personalised, timely and high-quality care increasingly requires access to advanced and costly technologies and services.

At the same time, gaps in community and primary care – such as access to general practitioners, local clinics and mental health support – are placing additional pressure on our system.

Driven by factors including cost and appointment availability, many people are turning to us for issues that could be managed in primary care settings.

Finally, although technology offers promising opportunities for enhancing care, the implementation of new systems and processes remains a complex and challenging task.



Governance

Enabling legislation

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

Responsible Minister

EMHS is responsible to the **Honourable Meredith Hammat MLA, Minister for Health; Mental Health**, who has overall responsibility for the Western Australian (WA) Department of Health.

In recognition of the WA Government's team approach toward Health, EMHS also acknowledges the following Ministers in their Health-related portfolios:

- Hon Stephen Dawson MLC, Minister for Medical Research
- Hon Simone McGurk MLA, Minister for Aged Care and Seniors
- Hon John Carey MLA, Minister for Health Infrastructure
- Hon Sabine Winton MLA, Minister for Preventative Health

WA Department of Health (System Manager)

The **WA Department of Health (System Manager)**, is responsible for strategic leadership, including system-wide planning, policy and performance, and enters into service agreements with HSPs for service provision. The System Manager works in collaboration with HSPs and their accountable authorities.

Accountable authority and Chief Executive

EMHS is a board-governed statutory authority.

The **EMHS Board** is directly accountable to the public through the Minister for Health and works with the Director General (DG) of the WA Department of Health.

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

Shared responsibilities with other agencies

EMHS works with the WA Department of Health (System Manager), the WA Mental Health Commission (MHC), other HSPs and a range of government and non-government agencies to deliver programs and services within the State's eastern metropolitan region.

Sustainable Health Review

Since the April 2019 release of the **Sustainable Health Review** (SHR) report, the WA Department of Health and HSPs have been progressing this ambitious reform agenda to create a modern healthcare system.

In 2024-25, EMHS continued to support prioritised recommendations ([see page 53](#)), with a focus on outpatient access reform, digital health, management of complex chronic disease, workforce culture and capability, the health of the Aboriginal community, mental health and equitable access to health care.



Elizabeth
Koff

Peter
Forbes

Pia
Turcinov

Tracey
Moroney

Ross
Keesing

Vanessa
Elliott

Denise
Glennon

Melissa
Grove



Andrew
Whitechurch
(Absent)



Steven
Patchett
(Absent)

EMHS Board

With experience in a wide range of fields including clinical services, health management, law, finance, consumer engagement and business, the EMHS Board is appointed by the Minister for Health to help determine the strategic direction of EMHS and holds overall accountability for service delivery and performance.

The EMHS Board Patient Experience and Clinical Excellence Committee has welcomed Ms Clare Grieveson to serve as an External Consultant and Mr Ben Horgan as Consumer Representative. Clare brings her experience as the Chief Executive Officer for Southern Cross Care WA to the Committee and Ben has provided valuable input and feedback to help the Board improve the patient experience and safety and quality at EMHS.

Board focus and engagement in 2024-25

To assist in strengthening the Board's understanding of its duties, the Board undertook their Code of Conduct refresher training at the December 2024 Board meeting and completed a Clinical Governance for Boards Workshop in April 2025.

The Board continued its approach to leader rounding in 2024-25, ensuring engagement with staff and consumers across the organisation. Leader rounding was held at the beginning of every Board meeting, providing the Board members opportunities to visit various areas across EMHS and staff the opportunity to discuss issues, challenges and celebrations within their place of work. Some of these engagement opportunities included:

- at Royal Perth Hospital (RPH), the Board visited the EMHS Health in a Virtual Environment team, the RPH Acute Medical Unit and the

RPH Freedom of Information team, EMHS People and Culture, RPH Stores and RPH Pharmacy teams

- at St John of God Midland Public Hospital, the Board had a tour of the Emergency Department and Ambulatory Care Unit, Mental Health Unit, Stroke Ward and Moort Boodjari Mia, a community based Aboriginal perinatal service
- meeting with the EMHS Eating Disorder Specialist Service, Cyber Security and Procurement and Contracting teams
- touring Kalamunda Hospital, including engagement with staff and patients in Palliative Care Services and the Day Procedure Unit
- a tour of the Emergency Department, Dialysis service, Allied Health and Community Rehabilitation, Kitchen and Patient Support Services at Armadale Health Service
- undertaking a patient food audit hosted by the Kalamunda Hospital Kitchen Service.

The Board also had an opportunity to engage with staff by inviting them to the Board meetings to give a presentation on their area and any initiatives currently underway or host a workshop with the Board. Some of these areas included:

- Community and Virtual Care
- Allied Health
- Nursing Directors
- Clinical Services and Voluntary Assisted Dying
- The Junior Medical Officer Society Chairs
- Clinical Strategy, Planning and Performance.

The Board also welcomed visits and discussions with the Mental Health Commissioner, Ms Maureen Lewis, Executive Director for the Health Consumers

Council, Dr Clare Mullen, Director General of WA Health, Dr Shirley Bowen and representatives from the Insurance Commission of WA.

The EMHS Board Chair and members also had the opportunity to engage with teams across EMHS at various events including:

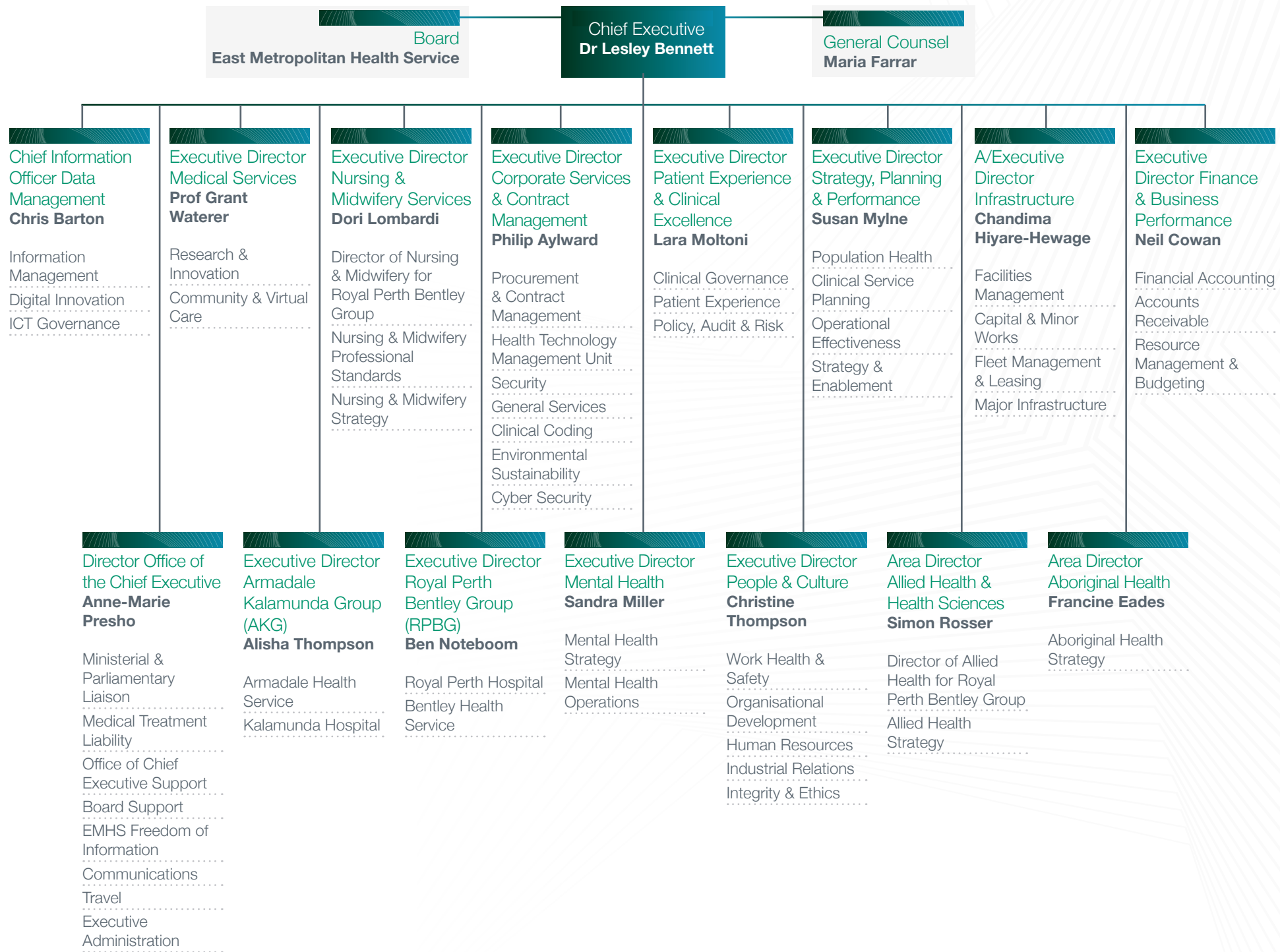
- EMHS Excellence Symposium
- RPH Art Exhibition Launch
- EMHS Reconciliation week
- RPBG Nursing and Midwifery Awards
- EMHS Values in Action Awards
- RPH Innovation Hub Launch
- Aboriginal Health Champions Onboarding Session.

In 2024-25 the EMHS Board held:

- 11 Board meetings
- 11 Finance Committee meetings
- 8 Board Patient Experience and Clinical Excellence (formerly Safety and Quality) Committee meetings
- 6 Board Audit and Risk Committee meetings
- 5 Board Operational Performance and Strategy Committee meetings
- 8 leader rounding opportunities.

Area Executive Group





Links to government goals and outcomes

To comply with legislative obligations as a WA Government agency, EMHS operates under the **Outcome Based Management (OBM) framework** determined by the Department of Health. This framework describes how outcomes, activities, services and Key Performance Indicators (KPIs) are used to measure performance against State Government priorities and desired outcomes, and is underpinned by the principles of:

- transparency of reporting performance against targets
- accountability for achieving targets
- consistency and integration of systems and policies to support the achievement of targets
- recognition and acknowledgement of performance against targets.

EMHS reports performance against KPIs for:

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

Effectiveness KPIs	
Unplanned hospital readmissions for patients within 28 days for selected surgical procedures (per 1,000 separations)	
Percentage of elective wait list patients waiting over boundary for reportable procedures	
Healthcare-associated <i>staphylococcus aureus</i> bloodstream infections (HA-SABSI) per 10,000 occupied bed-days	
Survival rates for sentinel conditions	
Percentage of admitted patients who discharged against medical advice	
Percentage of live-born term infants with an Apgar score of less than 7 at 5 minutes post delivery	
Readmissions to acute specialised mental health inpatient services within 28 days of discharge	
Percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services	
Efficiency KPIs	
Service 1: Public hospital admitted services	Average admitted cost per weighted activity unit
Service 2: Public hospital emergency services	Average emergency department (ED) cost per weighted activity unit
Service 3: Public hospital non-admitted services	Average non-admitted cost per weighted activity unit
Service 4: Mental health services	Average cost per bed-day in specialised mental health inpatient services
	Average cost per treatment day of non-admitted care provided by mental health services

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

Efficiency KPI	
Service 6: Public and community health services	Average cost per person of delivering population health programs by population health units



Our people

Building our workforce

Individual staff
11,526

10,902 in 2023-24 ▲

Full time equivalent (FTE)
8,619

8,257 in 2023-24 ▲

This included
110

Aboriginal staff members

109 in 2023-24 ▲



1,337
Administration and clerical

1,283 in 2023-24 ▲



172
Maintenance

167 in 2023-24 ▲



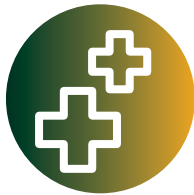
1,003
Hotel services

994 in 2023-24 ▲



3,505
Nursing

3,338 in 2023-24 ▲



1,239
Medical support

1,191 in 2023-24 ▲



1,329
Medical

1,248 in 2023-24 ▲



33
Other

36 in 2023-24 ▼

EMHS Learning and Organisational Development

Preparing today for the future of work through learning and organisational development initiatives, positioning EMHS as a great place to work.

We are committed to enhancing our workplace culture by ensuring the design of organisational development initiatives are informed by the voice of our employees. We are prioritising the feedback of our staff, signalling the culture we want to see, and identifying how our initiatives contribute to making EMHS a great place to work.

This year, we launched the Plan for Our People, a forward-facing workforce strategy which has been informed by a year-long process of research and gaining insights from our employees. The plan sets out the challenges of the future, articulates how we intend to respond, and identifies the capabilities we need to best position our workforce, our most valuable asset.

Key achievements:

We launched our EMHS staff engagement survey. The survey measures both staff satisfaction and staff engagement factors, including how content staff are with their job and the emotional commitment and investment in the organisation. The insights inform our work and ensure we are addressing what is important to our people.

We have enhanced our flexible work policy and resources to promote flexible work in areas and roles which have been subject to traditional practices, enabling leaders and teams to rethink the norms and reimagine how work can be done differently. We continue to support new ways of working to ensure we enable an inclusive culture.

Our Diversity, Equity and Inclusion team proudly participated in the Public Sector Commission and Curtin University pilot vacation program, offering 6 Aboriginal students valuable placement opportunities during the 2024 vacation period. EMHS is committed to investing in emerging talent, creating pathways for future careers in healthcare. We continue to host our biannual Aboriginal employee forums providing a dedicated event for Aboriginal employees to build connections, strengthen peer mentoring, and focus on professional and personal wellbeing. We are committed to continuing these forums and to be informed by our Aboriginal workforce on how we can work towards cultural competence, confidence and safety.

Our Learning and Development team continues to enhance our professional and leadership development programs by introducing masterclasses in inclusive leadership, managing flexible teams and Aboriginal cultural awareness.

Our digital MyLearning team has successfully trained 536 staff, equipping them with the skills to enrol staff, track attendance and update mandatory skills. This enables accurate data flow to the mandatory training dashboard, ensuring accurate competency compliance tracking. The MyLearning team supports various departments across EMHS and has now created 832 online modules and face to face courses within our learning management system.





Expanding the medical workforce: Alternative pathway for overseas doctors

The first overseas doctors to take part in our alternative pathway to practising in Australia completed a Workplace Based Assessment Program (WBA) at Armadale Health Service (AHS) in March, an important milestone for the program and the future of medical education in Western Australia.

Under the program, eligible overseas doctors spend a year under the guidance of senior AHS clinicians in adult medicine, surgery, emergency medicine, paediatrics, psychiatry and obstetrics and gynaecology.

When the doctors have successfully completed the program they are awarded an Australian Medical Council certificate, providing a path to apply for general registration with the Australian Health Practitioner Regulation Agency.

The program is part of a broader strategy to address workforce shortages and offers a

structured, supervised training pathway for qualified international medical graduates while ensuring high clinical standards.

Three overseas doctors from India and Pakistan completed the course in 2024-25 and have successfully joined the EMHS workforce. A new intake of 7 overseas doctors began the program in January.

Dr Shumail Nauman, from Pakistan, says the program provided hands-on experience in a fast-paced and supportive environment.

“The hospital’s strong focus on education and professional growth makes it an ideal setting for junior doctors starting their careers in Australia,” she says.

Armadale Kalamunda Group’s Medical Director of Medical and Speciality Services, Dr Adrija Basu, says the program is more than an assessment pathway.

“It’s a bridge that allows skilled internationally trained doctors to transition safely and confidently into the Australian healthcare system,” she says.

“By providing real-time feedback and continuous support, we’re not only ensuring patient safety but also investing in the professional growth of our future medical workforce.”

The WBA program is a critical component of the WA Health International Medical Graduates Pathway to Registration Project.

“...hands-on experience in a fast-paced and supportive environment”

Our commitment to workplace safety and wellbeing

EMHS is committed to understanding and managing its health, safety and wellbeing risks to proactively maintain worker wellbeing and prevent injuries. EMHS work health and safety (WHS) systems are regularly audited, with the last systems audit completed in August 2024. During 2024-25 EMHS was issued with 13 improvement notices and 2 prohibition notices from WorkSafe WA. 10 of the notices have been satisfactorily closed out and work is ongoing to ensure the remaining 3 are remedied within the allocated timeframe.

The potential for EMHS workers to be exposed to workplace aggression and violence persists and is the most reported category of workplace incidents. An in-depth analysis of workplace violence and aggression exposure in EMHS led to the development of a contemporary, concise and targeted strategy to manage aggression proactively. Education and training for staff has been reviewed, with particular focus on de-escalation and support for staff. This includes the introduction of the Behaviour Support Team [\(see page 28\)](#).

Manual tasks continue to be the most frequent cause of lost time injuries across EMHS. To help address this, a deep analysis was conducted into EMHS' risk management of manual tasks to identify causes, barriers and priority areas for intervention. The predominant tasks involved in manual task injuries were providing care to bariatric patients, patient transfer, turns and positioning, general loads handling, moving beds, trolleys and wheelchairs, and cleaning tasks. Priority areas for intervention include availability and suitability of equipment, hazardous manual task risk assessments to develop standard operating procedures, work design and continued data collection and learning.

Work health and safety performance indicators

Number of fatalities

YEAR	TARGET	ACTUAL
2024-25	0	0
2023-24		0
2022-23		0
2021-22		0

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

YEAR	TARGET	ACTUAL
2024-25	0*	2.76
2023-24		3.00
2022-23		2.37
2021-22		3.07

LTI/D severity rate (percentage LTI/D)

YEAR	TARGET	ACTUAL
2024-25	0*	55.46%
2023-24		44.94%
2022-23		42.01%
2021-22		40.61%

*Or 10% improvement on the previous 3 years

Percentage of injured workers returned to work within 13 weeks

YEAR	TARGET	ACTUAL
2024-25	70.0%	47.2%
2023-24		48.2%
2022-23		46.3%
2021-22		43.3%

Percentage of injured workers returned to work within 26 weeks

YEAR	TARGET	ACTUAL
2024-25	80.0%	62.3%
2023-24		61.8%
2022-23		66.5%
2021-22		60.6%

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

YEAR	TARGET	ACTUAL
2024-25	80.0%	82.0%
2023-24		73.5%
2022-23		63.1%
2021-22		72.3%

Governance, compliance and consultation

EMHS has active Work Health and Safety committees covering all departments. These committees are made up of elected health and safety representatives (HSRs) and management representatives who facilitate consultation and communication and are an escalation point for work health and safety matters. As at the end of 2024-25, EMHS had 308 elected HSRs, 278 of whom have completed a 5-day introductory course, ensuring workers are represented on all issues relating to their health and safety in the workplace. EMHS WHS facilitates an education program providing opportunities for in-service training and support for all HSRs.

Injury management

EMHS' systematic approach to workplace-based injury management services following work related injuries and illnesses fosters an environment where workers return safely to productive employment as soon as practicable. The new Workers' Compensation and Injury Management Act 2023 (the Act) came into effect on 1 July 2024, with changes implemented across EMHS in 2024-25 to meet the requirements of the new Act. EMHS has an Injury Management team within the Workplace Health and Safety department that supports managers, injured workers and treating practitioners to achieve the best outcomes for injured workers and the organisation in collaboration with the Insurance Commission of WA (ICWA).

Worker's compensation (WC) and injury management (IM) improvements were introduced in 2024-25 across four key strategy areas:

- injury prevention – in depth analysis of data such as pre-claim data, workforce demographics, hazard and incident data and WC and IM performance to examine workplace high-impact hazards including psychosocial, manual tasks, and workplace aggression in high-risk areas
- supporting workers – review to streamline Physiotherapy Early Intervention Injury Management Program, and early access to funds for medical treatment while WC claim liability is being determined through ICWA
- supporting EMHS and managers – facilitation by EMHS of a WA Health and ICWA collaborative forum for shared learning and improvement in WC and IM performance, improvements in claims review meetings with ICWA and with managers and supervisors, and improvement in long-tail claims management
- reducing re-injury – development of process to improve post-injury manual task support for patient support workers.

Injury Management services were internally audited in 2024-25.

Additionally, the IM team works with EMHS Human Resources and managers to support workers with a personal illness or injury to remain safe and productive at work wherever possible.

2024-25 workers' compensation claims by occupational category



75

Hotel services

79 in 2023-24 ▼



121

Nursing

111 in 2023-24 ▲



19

Medical support

26 in 2023-24 ▼



3

Medical

4 in 2023-24 ▼



26

Administration and clerical

16 in 2023-24 ▲



27

Maintenance

25 in 2023-24 ▲

271

Total claims 261 in 2023-24 ▲

Putting our BeST foot forward for safety

The first phase of a major new plan to ensure our health sites are respectful and physically and psychologically safe, began this year – bringing immediate benefits, with more initiatives on the way.

A Behaviour Support Team (BeST) began work at Royal Perth Hospital (RPH) in May to help with challenging patients and is planned to expand to other sites.

The team is part of a broader Managing Aggression Proactively project under our overarching safety and wellbeing blueprint, CaREPlan, which was also launched this year.

An 8-member, multidisciplinary team, BeST helped with 299 patients from its inception on May 7 to June 30, with a total of 976 patient and staff interventions logged. Patients seen by the team typically have 2 to 3 risk factors for aggression and 3 to 4 behaviours of concern.

The team provides support and coaching for staff, works with patients and their carers, helps with referrals to specialist services and connects with community care teams to better understand each patient's needs.

By doing this, the team seeks to manage any issues before they can develop.

Other CaREPlan initiatives are set to be launched in 2025-26, including:

- Wellbeing Index – a tool for EMHS staff to monitor and support their own wellbeing.
- Speak Up, Listen Up – a structured approach for respectful, clear, and safe communication for patient safety.
- I CaRE program – a focus on compassionate, accountable, respectful, and empathetic interactions among our workforce.

Our ultimate goal is to enhance staff wellbeing across all levels of the organisation, foster a workplace that is psychologically and physically safer and empower staff to confidently speak up in support of patient and colleague safety.



RPH Behaviour Support Team (BeST)

Honouring outstanding achievement

Award-winning services and people recognised in 2024-25

WA Health Excellence Awards 2024

- Endocrinologist Dr Danish Mahmud, a specialist with AHS, was named **7News Health Hero** for his compassion, diagnosis and treatment of a stroke patient with Cushing's disease.
- The Active Recovery Team (ART) pilot program, launched by EMHS to relieve pressure on emergency departments and mental health inpatient beds by offering care in the community, received the **Excellence in Mental Health** award.
- Emerging Drugs Network of Australia, an EMHS project to detect new illicit drugs in the community, won **Excellence in Research and Innovation**.
- Staff with Disabilities and Allies Network won **Excellence in Workplace Wellbeing and Culture** (multi-agency project).
- The 24/7 WA Statewide Telestroke Service – which provides round-the-clock access to specialist stroke consultants – won **Excellence in Rural and Remote Health Care** (multi-agency project).
- Health Support Services' e-Prescribing implementation won **Excellence in Safety and Quality** (multi-agency project).

WA Excellence in Allied Health Awards 2024

- Royal Perth Bentley Group (RBPBG) Aboriginal Health Liaison Officer Kim Hawke was named **Aboriginal Allied Health Professional of the Year** at the inaugural awards.

WA Nursing and Midwifery Excellence Awards 2025

- Advance Skilled Enrolled Nurse Elizabeth Troester, from Kalamunda Hospital, received the **Excellence in Enrolled Nursing** award.
- Francine Ocampo, from Royal Perth Hospital (RPH), was awarded **Graduate of the Year**.
- The EMHS Co-HIVE Aged Care Service won the **Excellence in Person Centred Care - Team** award.
- RBPBG Staff Development Nurse Noreen Elliott received the **Excellence in Education Award**.

WA Injury Prevention and Safety Promotion Awards 2025

Our Bidi Wungen Kaat Centre team was honoured with the **Excellence in Injury Recovery** award for work in reducing the stigma around mental health and promoting greater understanding of suicidal ideation.

EMHS Values in Action 2024

The annual EMHS Values in Action Awards celebrate individuals who embody our core values: excellence, respect, kindness, accountability, collaboration, and integrity.

- The Facilities Management and Infrastructure team was the overall winner, for exceptional work during a critical incident at Armadale Health Service (AHS). Team members prevented further risks and ensured minimal disruption to services. They were Richard England, Graeme Edwards, Denzil Padua, Edgardo Garrido, David Raye, Robert Kerrigan, Christopher Burden, Ramesh Patel and Hitesh Pandya.
- Other winners included AHS Aboriginal Health Liaison Officer Marra Thorne, Bentley Health Service (BHS) Advanced Sterilisation Technician Jaigeet Vijayambika Radhakrishnan and BHS Nursing and Site Director Annette Baker.





EMHS Excellence Symposium

Excellence Symposium 2025

The symposium showcases outstanding projects and services across EMHS. Five winners were chosen from 24 nominations.

RPH Injectable HIV Therapy Clinic

The RPH Injectable HIV Therapy Clinic was established to give patients living with HIV access to long-acting injectable treatment as an alternative to daily medication. Long-acting antiretroviral therapy became available in Australia in 2022.



Click to play video

Kalamunda Hospital Palliative Care Centre of Excellence

Armada Kalamunda Group (AKG) delivered the Kalamunda Hospital Palliative Care Centre of Excellence in 3 phases, delivering both the Day Hospice and 22 beds in 2022, increasing to 25 beds in 2023 and then moving to 30 beds in 2024. The service is highly rated by patients and their families ([see page 50](#)).



Click to play video

PIVC Review, Remove, Replace service

Armada Health Service is providing a specialist nurse-led service which 'reviews, removes or replaces' peripheral intravenous catheters improving patient safety and quality of care ([see page 39](#)).



Click to play video

Contemporary healthcare security practices

St John of God Midland Public Hospital security staff are seen as a part of the patient care team and are actively involved in clinical care working groups directly supporting our clinical caregivers and patients ([see page 49](#)).



Click to play video

Midwifery Birth Centre

The Midwifery Birth Centre (MBC) which opened at BHS in December is Western Australia's first fully endorsed midwife-led maternity service within a public hospital ([see page 38](#)).



Click to play video

RPBG Nursing and Midwifery Awards 2024

- Noreen Elliott won the overall RPBG Nurse of the Year award as well as the Excellence in Nursing or Midwifery Education and Research Award.
- Other winners were Wesley Leo (Excellence in Leadership), Grant Cox (Excellence in Nursing or Midwifery Bentley and Community), Beth Sperring (Excellence in Nursing or Midwifery RPH), RPH HIV Injectables team (Excellence in Person Centred Care - Team Award), Jackson Murrie (Outstanding Early Career Nurse), Charlotta Seigerschmidt (Consumer Appreciation Award).

Dual celebration for RPH Liver Service

Our outstanding RPH Liver Service celebrated its 30th anniversary in May, as well as 20 years of the Hepatology Clinical Research Fellowship program.

The RPH Liver Service, led by Dr Wendy Cheng, is recognised for pioneering Australia's first Hepatology Nurse Practitioner and Telehealth services.



Performance

Consumers and community

EMHS Multicultural Plan

The WA Multicultural Policy Framework (MPF) 2020 translates the principles and objectives of the WA Charter of Multiculturalism (2004) into multicultural policy priorities, outcomes, strategies, and measures for WA public sector agencies.

The WA Charter of Multiculturalism demonstrates the WA Government's commitment to multiculturalism and a multicultural policy position that embraces all of us, and is founded on 4 principles of civic values, fairness, equality, and participation.

In line with the MPF and EMHS' ongoing commitment to provide culturally responsive services and welcoming and inclusive workplaces, the EMHS Multicultural Plan 2024 – 2027 (the Plan) has been developed in consultation with internal and external stakeholders, including the EMHS Multicultural Advisory Group. Examples of EMHS' achievements against the priorities of the Plan are outlined below.

Policy Priority 1: Harmonious and inclusive communities

Every Western Australian values cultural, linguistic, and religious diversity and feels that they belong.

EMHS celebrates cultural events including NAIDOC, Harmony Week and Reconciliation Week across sites and services and celebrated and promoted International Translation Day on 30 September 2024.

Interpreting and translation services are promoted and available across EMHS sites.

EMHS People and Culture are pursuing an EMHS Equity, Diversity and Inclusion Working group, to analyse, identify and report on access, equity and diversity gaps, opportunities and successes. EMHS is also progressing school-based placements of culturally and linguistically diverse (CaLD) students for two paid days per week for 18 months at EMHS whilst they complete Certificate II in Government.

The Byford Health Hub (BHH) program team continue to recruit Byford Community Advisory Group members with multicultural backgrounds to provide input into the planning and engagement of the program.

Policy Priority 2: Culturally responsive policies, programs, and services

- **All Western Australians are informed of, and have equitable access to, government services.**
- **Programs and services are culturally appropriate and responsive to the needs of all Western Australians.**
- **Customised CaLD specific services are provided for those who need them.**
- **A workforce that is culturally competent and representative of its community and business and client needs.**

The directory signs at the main entrance to Royal Perth Hospital (RPH) have been updated using plain English with appropriate icons. Navigation signage in the five main languages used by clients of our services is rolling out across targeted areas at RPH commencing with the Breast Clinic.

Welcome Packs for RPH and Bentley Health Service (BHS) have been translated into five additional main languages.

The Friends of RPH also continue to actively recruit volunteers with diverse backgrounds with 50 per cent identifying as CaLD.

St John of God Midland Public Hospital (SJGMPH) has a retreat on the ground floor of the hospital, which is a reflective space used by different faith denominations and supplies supportive ritual material. SJGMPH provides caregiver and consumer events that recognise, celebrate and promote CaLD communities with a strong focus on Aboriginal communities.

SJGMPH continues to actively be targeting recruitment and is further engaging with CaLD volunteers to support areas of need across SJGMPH.

The Armadale Health Service (AHS) catering team has redesigned the hospital menu to include a more diverse range of dishes reflective of different cultures.

Signage across AHS and Kalamunda Hospital (KH) includes universal iconography where appropriate, as well as interpreter iconography, and posters with QR codes or links to access information in other languages.

The quiet room at AHS is able to accommodate the spiritual and religious needs of different faith denominations, and is available to all staff, patients and visitors.

Kalamunda Hospital (KH) utilises communication cards to support communication with non-English speaking patients and family members until an interpreter can be secured.

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

- **Western Australians from CaLD backgrounds are equitably represented in employment and on boards, committees, and other decision-making bodies.**
- **WA's CaLD community is harnessed to grow economic, social, cultural, civic, and political development.**

The Armadale Kalamunda Group has engaged with multicultural consumers on projects and working groups and connected with Armadale, Gosnells and Kalamunda Councils to increase their membership pool.

The *My Say* survey for patients is now available in Arabic, Chinese (traditional and simplified), Italian and Vietnamese at RPH, BHS, AHS and KH.

Partnering with our community

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

Improving the consumer experience

In 2024-25, EMHS completed a number of actions in support of the commitment to our community:

Complaints data is submitted by EMHS each year to the Health and Disability Services Complaints Office (HaDSCO), an independent body, and published in the HaDSCO annual report. For 2024-25, EMHS had very few complaints classified as grievances, which provides assurance that our complaints handling and management practices are sound, empathic and person-centred. HaDSCO has commended EMHS on our commitment to quality and compassionate responses to concerns.



Our EMHS Lived Experience Strategy was endorsed, and implementation planning has commenced. The Peer Support Worker Coordinator continues to work closely with EMHS mental health services in building the peer support workforce, providing extensive on the ground support to peer support workers and multidisciplinary teams.

New in 2024-25, EMHS has established a Consumer Working Group to provide assurance and advice to the EMHS Area Executive Group on consumer and carer engagement across EMHS and delivering innovative care outside of the hospital and closer to home.



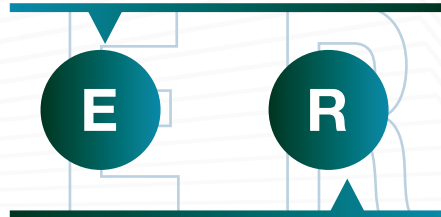
Service collaboration includes EMHS establishing an Aboriginal Health Joint Committee with membership of the Aboriginal Community Controlled Health Services to approach Aboriginal health as a shared responsibility.

Use of consumer representatives at Board Patient Experience and Clinical Excellence Committee was introduced in 2025, providing valuable consumer perspectives and a voice at the table to ensure systems and processes continue to be patient centred.



Meetings continued in 2024-25 for the EMHS Multicultural Advisory Group to support the implementation of the EMHS Multicultural Plan 2024-2027. The group engage and consult on many initiatives across EMHS including the review of policies that may impact Culturally and Linguistically Diverse (CALD) people.

Each year, staff and patients across EMHS reflect and enjoy a range of events and activities celebrating Carers Week, Patient Experience Week, International Day of Persons with a Disability and Mental Health Week.



Recognising patients living with dementia, EMHS continues to be acknowledged by Dementia Australia for our ongoing commitment towards becoming dementia friendly. Through a raft of initiatives, EMHS continues to engage with people living with dementia and their carers, participating in focus groups to better understand the healthcare experience.

Hospital quality improvements 2024-25

Our hospitals have introduced a number of local quality improvements to enhance the consumer experience, including but not limited to:

- Armadale Health Service (AHS) Emergency Department (ED) Waiting Room Video - this will be played in the waiting room, providing patients with an overview of the typical journey through the ED and highlighting key support services.
- The AHS Maternity Unit has launched the Maternity Antenatal and Postnatal Service (MAPS) - a midwifery continuity program ensuring that women receive care from a known midwife during pregnancy and postpartum.
- A lactation consultant is now available seven days a week at AHS, increasing accessibility for women seeking lactation support.
- Maternity Journey Boards have been introduced in AHS patient rooms, enhancing communication and engagement in maternity care. Additionally, a Safety and Quality Consumer Board has been implemented.
- Work is underway on a Maternity Comprehensive Plan at AHS. This initiative ensures that women are actively involved in planning their care during labour and birth.
- The Dying to Know Day event was hosted at Kalamunda Hospital to encourage open conversations about end-of-life wishes, supporting individuals and families in making informed decisions.
- Kalamunda Hospital's Compassionate Connectors Program, a three-year pilot initiative, will train community members to provide both practical and social support to individuals facing chronic and life-limiting illnesses.
- Reconfiguration of the toilet in F Block at Bentley Health Service (BHS) in response to consumer feedback regarding accessibility for persons with disability.
- Establishment of the Royal Perth Bentley Group (RPBG) Aboriginal Health Department.
- Establishment of RPBG Aboriginal Consumer Advisory Group, Emergency Department Consumer Advisory Group and incorporation of Integrated Services Consumer Advisory Group (Next Step) from Mental Health Commission to RPBG.
- Development of the Bear with Us campaign at Royal Perth Hospital (RPH), BHS and Kalamunda Hospital – to raise awareness amongst staff and patients on the importance and requirement to check three points of identification for every patient.
- Purple Bags program – providing patients with special comforts if they are expected to pass away at RPH or BHS. This is supported by our volunteers who hand-craft blankets for our patients and collate beautiful bags of items.
- Delivery of the Welcome Pack in the top five languages for RPH and BHS, as well as improving ease of access by deploying QR code stickers at patient bedsides that link to resources.
- Implementation of Day Surgery Communications Nurse at RPH - to improve communication lines between clinical staff and patients/families. This was an outcome from a complaint where a patient's surgery was cancelled on the day of surgery.
- Integration of consumer representatives into RPBG Staff Forums, to provide a patient perspective to staff.
- Establishment of the Rhythm to Recovery program, delivered by mental health consumers and carers for RPH and BHS patients in our mental health wards.
- St John of God Midland Public Hospital (SJGMPH) has broadened the scope of Net Promoter Score (NPS) Survey to include Outpatients and mental health specific questions.
- SJGMPH has implemented consumer representatives on SAC 1 (clinical incident) review panels.

Consumer feedback

Consumers provide valuable feedback and contribute to improving the safety and quality of services.

The use of the Australian Commission on Safety and Quality in Health Care’s Australian Hospital Patient Experience Question Set (AHPEQS) across EMHS hospitals has meant the capture of validated, standardised patient experience questions by way of an SMS based survey to patients following discharge or leaving the hospital.

Since September 2020, EMHS has received feedback from more than 135,000 consumers.

EMHS Net Promoter Score (NPS) rating

Period	NPS	Number of respondents	Response rate
2024-25	70.67	14,688	26.00%

AHPEQS results summary

AHPEQS question	
My views and concerns were listened to	92.95%
My individual needs were met	91.74%
I felt cared for	92.78%
I was involved as much as I wanted in making decisions about my treatment and care	89.84%
I was kept informed as much as I wanted about my treatment and care	89.95%
As far as I could tell the staff involved in my care communicated with each other about my treatment	85.85%
I received pain relief that met my needs	91.97%
When I was in the hospital I felt confident in the safety of my treatment and care	91.63%
Overall the quality of the treatment and care I received was very good	90.97%

EMHS continues to subscribe to the use of Care Opinion, an independently controlled, online platform enabling members of the public to tell us about their experience with our services. Feedback is used to improve services as well as to recognise staff and teams who go above and beyond our patients’ expectations.

In 2024-25, through our formal processes, EMHS received:



- 2,940 compliments via formal feedback processes
- 64 entirely complimentary stories via the public sharing platform, Care Opinion

While this recognises only compliments provided through a formal mechanism, it should be acknowledged that there are a multitude of compliments and thanks fed back to staff informally and directly by patients, carers and their loved ones.

EMHS also received:



- 789 complaints via formal feedback processes
- 78 complaints via the public sharing platform, Care Opinion

EMHS manages patient feedback consistent with the WA Health Complaints Management Policy (2024), with all complaints acknowledged, investigated and responded to within appropriate timeframes, and quality improvement activities initiated to address issues where appropriate.

Example of a change arising from patient feedback

Situation

Patients and their families provided feedback about the challenges of where to find the correct area to attend appointments and other facilities our hospitals have, including the triage system in Emergency and ward orientation.

Changes implemented as a result

EMHS hospitals have introduced meet and greet programs with dedicated volunteers to offer support to patients and their families. They provide a friendly face who deliver information in a warm, welcoming and personable way. Volunteers are provided training including general orientation to the ward, hand hygiene and services available to patients.

Our volunteers assist patients and consumers in many ways including:

- wayfinding
- explaining the process of Triage in Emergency, assisting in keeping the Emergency waiting room tidy and assisting visitors with their requests to go through to see a patient who has been taken through for assessment
- ward orientation covering access to bathrooms, how to use paid Television services, keeping valuables safe while in hospital, information regarding meals in hospital and where to find the gift shops run by volunteers in our hospitals
- providing company to patients who may not have family or support close by.

Evaluation of the program showed improved patient satisfaction with patients feeling welcomed on arrival to the ward where they were provided useful information which made a positive impact to the patients stay. Volunteers also felt they were able to provide a meaningful service and able to contribute positively to the patient's stay in hospital.

Examples of stories shared from Care Opinion

Story #1

Just a big thumbs up, I had a knee replacement in the Public Hospital System, and I couldn't have asked for better treatment. All staffs I saw (Doctors, Nurses, all other staffs) from Armadale Hospital, they are all awesome, respectful, courteous, helpful. Special thanks to Colyer nurse (Vicky) and discharge lounge nurse (Lisa), they are both very kind and compassionate toward me, they got me strong pain killer from the ward as I am in 10/10 pain. Armadale hospital is the best hospital in WA. Keep on the good work!



Story #2

My mum had a fall at home and was brought to RPH ED by SJWA. From the minute I called 000, right through to her being sent home, I can't fault the service we both received. When I arrived at RPH ED, I could see the immense pressure the staff were under. It was so busy, and patients kept arriving in quick succession after me. Despite this, all staff were so kind and caring. They all had a smile on their face. Nothing was too much trouble for them at all. I saw nothing but professionalism, clinical excellence and genuine dedication to caring for others, despite the circumstances and the way I saw some of them were treated by other patients. The physio who saw Mum was amazing and provided her with reassurance and advice about the fall and strategies to reduce the risk in future.

The Imaging assistant and team in the imaging department who looked after Mum were all lovely and gave her a much-needed laugh. The Nursing staff who all kept checking in on her and making sure her pain was under control, made me proud to be part of the profession. The standard of care was high, and you could see it. We couldn't have asked for better communication and information for Mum about what was happening, what to look out for and when to come back if needed. She was especially taken with Dr Ed who told her she looked too young to have a daughter my age. It's the little things. Knowing that people are quick to complain, I really wanted to make sure that the staff were aware of the amazing job they are doing, the small acts of kindness make a very scary situation much less scary for Mum. Thank you to you all.



Supporting families: Midwives lead at Bentley Birth Centre

Our \$2.6 million Midwifery Birth Centre which opened at Bentley Health Service in December is a significant development in maternity care in Western Australia.

The centre is WA's first fully endorsed midwife-led maternity service within a public hospital and gives women access to skilled midwives, a supportive home-like environment and more pregnancy care options.

The centre is entirely staffed by credentialed and endorsed midwives who are highly trained and can order pregnancy-related tests and ultrasounds, prescribe medications and refer women and babies to obstetricians or paediatricians if needed.

Women receive continuity of care from the same midwife throughout pregnancy, birth and the postnatal period – even if a hospital transfer becomes necessary.

Designed for low-risk pregnancies, the centre has 2 private birth suites (each with a large birthing pool), a consultation room, a refreshments area and a midwives' hub.

Located on the second floor of Bentley's A block, it provides a comfortable environment which supports natural, low-intervention birth.

Women in the EMHS catchment can self-refer online, making it more accessible and empowering for expectant mothers.

The centre has had a phased opening and will run at capacity in the coming financial year.



Advancing patient care: Specialist IV catheter service boosts safety

A specialist, nurse-led peripheral intravenous catheter (PIVC) service at Armadale Health Service (AHS) has meaningfully improved patient safety and quality of care for a common procedure.

A PIVC is a small flexible tube inserted into a vein for medicine and fluids. It is used in over 70 per cent of hospital patients, but in some cases, can lead to blood stream infections.

The PIVC Review, Remove, Replace service – Australia’s first of its kind – helps reduce this risk and has achieved an impressive 100 per cent drop in patient blood stream infections at AHS during service hours.

Blood stream infections carry a high mortality risk.

Under the Review, Remove, Replace service, every adult inpatient with a PIVC has it reviewed by a clinical nurse every day. During the review, the nurse decides to leave the catheter in place, remove or replace it based on clinical needs and its condition.

Each patient is also informed why they have a PIVC, what potential issues to look out for and symptoms they should report.



The daily reviews help catch early signs of infection or other problems such as blockage, dislodgement or mechanical issues, reducing the risk of bloodstream infections and other complications.

Since the service began in June 2023, it has provided 14,234 logged reviews. AHS has also had only one case of PIVC related blood stream infection – on a Christmas Day when the service was not operating.

More than 795 health professionals have been educated on accurate PIVC assessment and quality care.

The PIVC Review, Remove, Replace service has made an important contribution to care at AHS and offers a model for other hospitals aiming to reduce catheter-related bloodstream infections.



AHS PIVC Review, Remove, Replace Team



(Left to right) Ken Nicholls, Inaugural Manager of Aboriginal Health, Simon Rosser, Area Director Allied Health & Health Sciences

Working together for Aboriginal health

Two key initiatives were launched this year to further advance Aboriginal health services.

Partnerships between EMHS and Aboriginal Community Controlled Health Services (ACCHS) were bolstered through a new Aboriginal Health Joint Committee.

The committee is made up of key EMHS executive staff and representatives from the major ACCHS' Derbarl Yerrigan Health Service and Moorditj Koort Aboriginal Corporation.

It provides an open forum for members to raise and discuss issues, challenges and opportunities for partnerships in Aboriginal health within the EMHS catchment area.

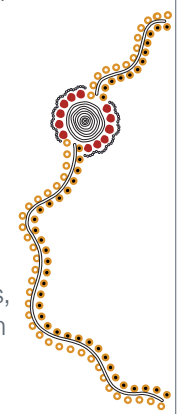
Work is currently focused on investigating ways to improve patient journeys through cooperative approaches, supporting specialist services that go to the community and creating opportunities for staff to work across different teams.

It includes improved referral pathways between Moorditj Koort Aboriginal Corporation and St John of God Midland Public Hospital and Armadale Health Service.

The committee meets quarterly and held its first meeting in November.

Royal Perth Bentley Group (RPBG) also has a fresh focus on Aboriginal health with a new RPBG Aboriginal Health department.

Inaugural Manager of Aboriginal Health, Ken Nicholls, is aiming to further develop RPBG's Aboriginal health workforce and advance support and services to Aboriginal and Torres Strait Islander peoples.



Warm welcome, big impact with our new greeting service

A volunteer service to help patients settle into their surroundings is winning hearts at Royal Perth Hospital (RPH).

The Volunteer Greeting Service, run by the Friends of RPH, offers a friendly point of contact for the small things that can make a big difference – a warm welcome, help setting up the television, a magazine or newspaper to read, or a comforting chat.

The service was first trialed on Wards 8A and 6H but later expanded to 10A, 9A, 9C, 5G, 5H and 6G, and introduced on an ongoing basis with a core group of 5 volunteers providing daily visits.

During their visits, the volunteers also remind patients about Aishwarya's CARE Call and other escalation pathways they may need.

In a 5-month evaluation period, volunteers spent more than 437 hours with 1457 patients – an average of 291 patient visits per month.

A similar service has also been introduced for palliative care patients, with our amazing volunteers including a retired palliative care consultant, retired director of nursing and retired nurses.



Consumer voices enhance care

Our network of consumer advisory groups grew significantly this year, reflecting our community members' commitment to enhancing our services and the importance we place on their input. Consumer advisory groups play a vital role in our health care by ensuring the voices of patients and community members are actively included in shaping services and policies. They help improve care quality, build trust, identify barriers and promote equity by bringing diverse perspectives into decision-making.

At Royal Perth Bentley Group (RPBG), new consumer advisory groups include the RPBG Emergency Department Consumer Advisory Group, RPBG Aboriginal Consumer Advisory Group and Next Step Integrated Services Consumer Advisory Group. They join the established RPBG Consumer Advisory Committee (which includes the chairs of the other consumer advisory groups) and Lived Experience Advisory Group (mental health). To ensure important matters are addressed at the highest level, regular catchups this year began between Consumer Advisory Committee Chair Karen Collinson and RPBG Executive Director Ben Noteboom.

Consumer advisors also visited nearly 200 patients at Royal Perth Hospital and Bentley Health Service. We are pleased to share 90 per cent of the interactions with patients and carers were about what our services are doing very well. Visits also expanded this year to include our voluntary mental health wards.

Meanwhile, the Armadale Kalamunda Group (AKG) Consumer Advisory Committee is also active in ward rounds, engaging directly with patients to hear about their experiences. Notably, during ward rounds in May, patients expressed appreciation for the quality and enjoyment of the food. The consumer advisors are also helping shape a new Mental Health Emergency Centre which will open in 2028, and their voices are central to general infrastructure decisions through the AKG Facilities and Planning Committee.

East CareConnect, our virtual health arm, has a special consumer advisory committee, which was established in May.

Teaming up for mental health in emergencies

Western Australia's first specialised ambulance service for people experiencing a mental health emergency in the community began this year – and we are proud to be a founding partner.

The new Mental Health Ambulance Co-Response service was launched in November as a partnership between EMHS, St John WA, the Mental Health Commission of Western Australia and the WA Department of Health.

The service provides virtual mental health triage for 000 ambulance callers and also has mobile teams of mental health professionals and paramedics to care for people aged 16 and above during a mental health crisis.

Launched with a \$7.9 million investment from the WA Government, it has redefined our emergency responses for mental health care.

Our staff work alongside those at St John WA in the pivotal role of triaging 000 mental health-related ambulance calls across the metropolitan area.

An EMHS-St John mobile response team was also the first to begin operating in December.

The team is made up of an EMHS authorised mental health practitioner and a St John paramedic in an unmarked St John response vehicle. It is available 7 days a week, 12pm to 10pm.

The Mental Health Ambulance Co-Response service has already helped reduce emergency department presentations due to mental health.

Many callers qualifying for mental health triage are able to be helped via a phone triage-only response. More than 80 per cent of those who do require a face-to-face response are able to be assessed in their homes instead of hospital.



Mental Health Ambulance Co-Response Team

EMHS risk management and audit

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

These lines of defence are:

1. own and manage risks
2. oversee risks
3. provide independent assurance.

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

Some of the key activities performed by the Board Audit and Risk Sub-Committee for this period included:

- oversight of significant risks including treatment action plans (TAPs)
- oversight of the cybersecurity risk program of work
- approval of changes to the Internal Audit Plan, ensuring the function responded appropriately to immediate and emerging risks
- advocacy for the building of additional internal audit capacity.

Risk and compliance management

The risk management function has continued to provide first and second line defence across EMHS. Key achievements this year have been:

- the continued high level of compliance with the WA Health Risk Management Policy and EMHS Risk Policy, including a full year of risk review and TAP compliance above the 90 per cent performance target
- working with the EMHS Board and Executive to undertake a complete review of EMHS strategic risks and identification of new risks
- piloting of a new compliance obligation system to monitor key policy compliance requirements, fully aligned with the EMHS Enterprise Risk Management System.

Internal audit

In 2024-25, Internal Audit transitioned its function to align with the new Global Internal Audit Standards issued by the Institute of Internal Auditors. Conformance with the Standards will ensure EMHS Internal Audit Function remains relevant and effective in today's complex environment, and that they are better equipped to navigate evolving risks.

To assist EMHS with meeting its operational and strategic goals, the Internal Audit function provides the Board and Management with independent, risk-based, and objective assurance, advice, insight, and foresight.

The annual risk-based Internal Audit Plan assesses high risks and high-priority areas including patient identification, injury management and Aboriginal Languages Services, to identify opportunities for improvement to strengthen EMHS' services to its patients.

In 2024-25, management was able to close 57 per cent of the internal and external recommendations logged for the year, while 43 per cent were in progress at the time of this report.

Continuing to deliver safe and high-quality care

Learning from clinical incidents

EMHS is very proud of the significant improvements we continue to make in improving the quality of health service provision and providing safe and high-quality care for our patients and consumers.

It is recognised however, that in such a complex and challenging environment, sometimes things can go wrong while accessing a hospital or health facility. EMHS is committed to finding out what happened, why it happened and how we can make changes to help prevent or reduce the risk of a similar incident occurring again.

During 2024-25, there were 193,155 patient admissions to EMHS hospitals. In addition, 217,945 patients were seen in our emergency departments and another 568,085 patients were seen in an outpatient clinic or setting.

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

In the interests of transparency, we are sharing the number of serious clinical incidents that occurred in 2024-25 at our hospitals and health services.

During 2024-25, there were 103 clinical incidents reported with a Severity Assessment Code (SAC) rating of 1 (SAC1). A SAC1 incident is a clinical incident that has, or could have, caused serious harm or death, and which is attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.

The number of SAC1 incidents is attributed to an increase in activity and a strong culture of reporting. The most reported types of incidents include patient accidents/falls, infection control and diagnostic processes/procedures. All SAC1 clinical incidents are subject to a rigorous investigation with the reports being reviewed by members of the EMHS Executive, as well as the EMHS Board Safety and Quality Committee; providing an opportunity for all EMHS hospitals to learn from incidents to improve the quality of care delivered across EMHS.

Morbidity and mortality (M&M) review is a forum for clinicians to openly and transparently discuss the quality of care provided to patients who have died or experienced significant morbidity while under the care of a health service. EMHS continues to identify opportunities for quality improvement and organisational learnings through the sharing of outcomes from M&M forums.

EMHS continues to actively participate in healthcare associated infection (HAIs) surveillance programs including the monitoring of hospital acquired blood stream infections (HABSI), enabling learning from current practice. EMHS continues to focus on providing the Vascular Access Service, which provides expert and specialist care in the insertion and management of invasive devices and provide clinicians with specialist vascular access training in the Emergency Department to enhance the skills of clinicians, particularly in handling patients with difficult intravenous access.

Of the 103 serious incidents reported in 2024-25, the patient outcome was noted as:



Access to emergency services

Outcome one // Effectiveness indicator

The Australasian College for Emergency Medicine (ACEM) developed the Australasian Triage Scale (ATS) to ensure that patients presenting to Emergency Departments (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.

ACEM targets for each ATS are outlined below:

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

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

Triage category 1

YEAR	TARGET	ACTUAL
2024-25	100%	99.9%
2023-24		98.3%
2022-23		99.0%
2021-22		99.6%

Triage category 2

YEAR	TARGET	ACTUAL
2024-25	80.0%	61.3%
2023-24		71.7%
2022-23		69.0%
2021-22		68.0%

Triage category 3

YEAR	TARGET	ACTUAL
2024-25	75.0%	13.1%
2023-24		18.8%
2022-23		17.1%
2021-22		18.8%

Triage category 4

YEAR	TARGET	ACTUAL
2024-25	70.0%	28.9%
2023-24		37.3%
2022-23		38.7%
2021-22		41.5%

Triage category 5

YEAR	TARGET	ACTUAL
2024-25	70.0%	64.6%
2023-24		72.4%
2022-23		73.3%
2021-22		78.1%

Period: 2021-22 to 2024-25 financial years

Contributing sites: Armadale/Kelmscott District Memorial Hospital, Royal Perth Hospital, St John of God Midland Public Hospital

Data source: Emergency Department Data Collection

Performance against ATS category 2-5 targets deteriorated in 2024-25, with sites experiencing ongoing demand pressures, both on their Emergency Departments as well as inpatient beds.

EMHS experienced continued changes in the complexity and acuity of patient presentations, with the volume of triage 1 and 2 presentations increasing in 2024/25.

To address growing demand and complexity, initiatives are being rolled out across EMHS sites, these include:

Launch of EMHS patient flow strategy

In December 2024, EMHS launched the Strategic Approach for Optimising Patient Flow. Primary drivers identified to improve access and reduce ED waiting times include:

- shape as well as reduce the demand for our services, so that we can provide care when it is needed most
- optimise the capacity of our services to effectively meet evolving demand
- redesign systems that are better suited to meet the needs of patients and are easier for staff to navigate.

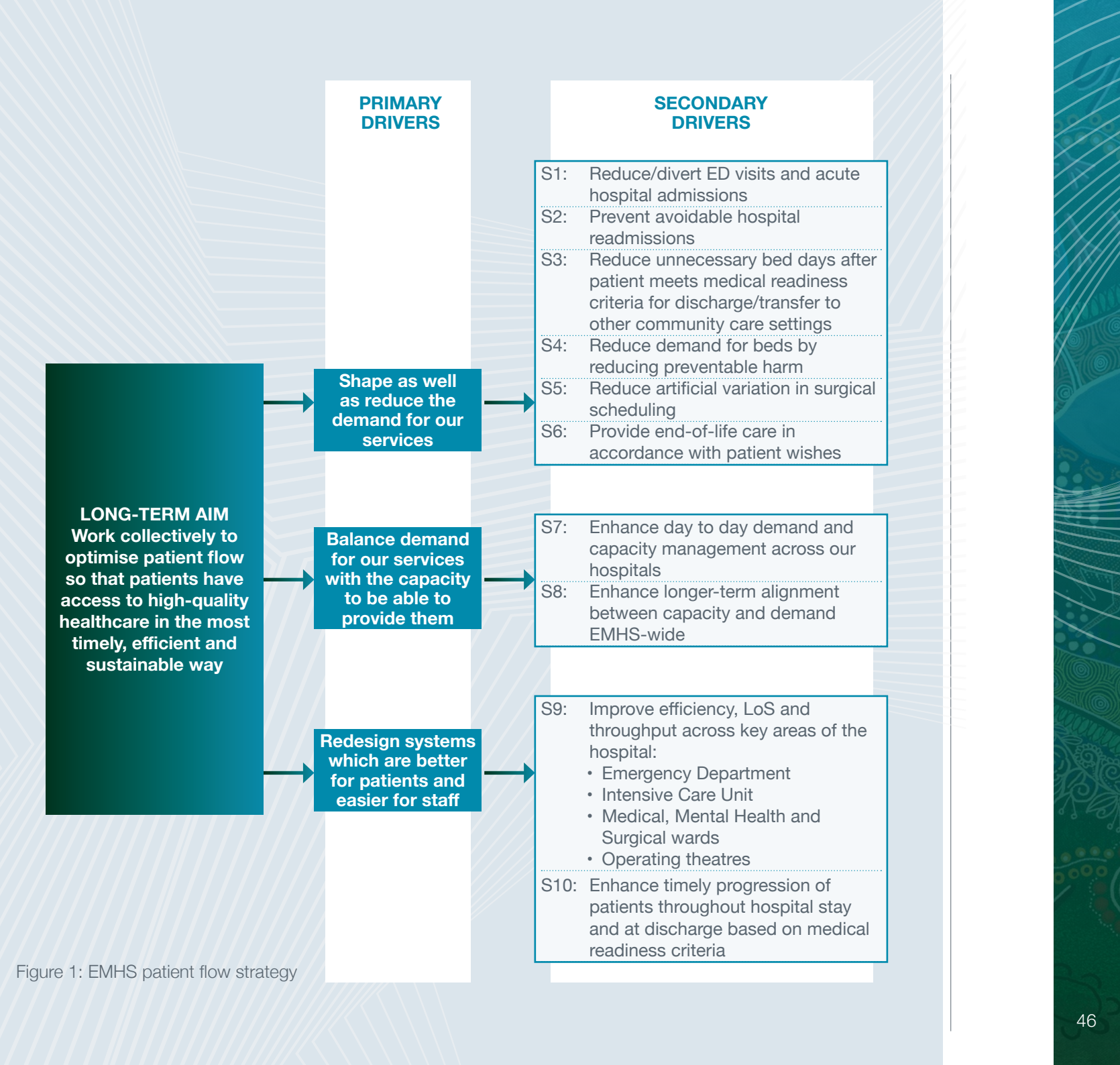


Figure 1: EMHS patient flow strategy

Demand and capacity optimisation program

The Department of Health's Demand and Capacity Optimisation and the Ambulance Ramping Strategy launched in early 2025 has several immediate priorities to improve patient flow at a system level. These priorities include:

- refining State Health Operations Centre (SHOC) functions, finalising ED benchmarking and cross system Black, Red, Amber, Green (BRAG) (capacity status indicator system), to allow for the rapid identification of capacity related pressure which then can be used to inform demand allocation at the system-wide level
- optimising State-funded aged care beds and services (including Time to Think, in-home transitional care placement, older adult mental health beds) to maintain hospital bed capacity for patients who are acutely unwell
- expansion of Home Hospital to provide care for patients in an environment which suits them the most
- Ambulance Mental Health Co-Response expansion.

Expansion of ambulatory care

The ambulatory units across EMHS continue to provide important pathways to improve flow from EDs. These units divert suitable patients from the ED for same day assessment and management.

To continue to expand the impact of Ambulatory Care Units in 2024-25 we have:

- extended Ambulatory Unit operations from 5 to 7 days per week at Royal Perth Hospital (RPH) during periods of pressure
- from April 2025, the St John of God Midland Public Hospital Ambulatory Care Unit opened 7 days a week to respond to increased demand.

Extending the Ambulatory Care Unit will improve flow and reduce ED waiting times on the weekend.

Home Hospital capacity

Home Hospital capacity was launched in 2024 for Royal Perth Hospital (RPH) and commissioned in mid-2025 for Armadale Health Service (AHS). Home Hospital will scale up to 70 beds for EMHS patients by the end of 2025. Home Hospital allows patients to safely return to their normal place of residence and receive the right care at the right place and create capacity for patients requiring acute care in a hospital setting.

Extension of operating hours of the transit lounge at RPH and discharge lounge at AHS

Transit and discharge lounges allows beds to be available earlier in the day (with a focus on moving patients before 10am), reducing access block when transferring patients from ED to the wards. RPH and AHS have extended the hours of the transit lounge to the weekends and evenings to improve patient flow and reduce access block, during periods of pressure.

Creation of Patient Access Division at Royal Perth Bentley Group (RPBG)

The creation of a Patient Access Division in August 2024 established dedicated resources to reduce access block and improve patient care on the emergency pathway. Since the creation achievements to date include:

- reintroduction of senior nursing roles to the Operations Hub
- increased Transit Lounge utilisation
- improvement in the timeliness of inter-hospital transfers
- higher proportion of discharges before noon.

Improving paediatric services at Armadale Health Service (AHS)

To improve the care provided for paediatric patients, AHS is developing a plan to trial a new Paediatric Clinical Decision Unit (CDU), launching in winter 2025. The Paediatric CDU will provide a safe and child friendly environment within the Paediatric Ward, and allow rapid access to specialty paediatric care for children arriving in ED.

Introduction of SPEAR (Senior Practitioner Early Assessment and Review) at St John of God Midland Public Hospital (SJGMPH)

In 2024, SJGMPH, began a reconfiguration in the post-triage space to stream patients into 'vertical' or 'horizontal' streams, with vertical patients placed in chairs instead of cubicles and stretchers. Building on this, in 2025 SJGMPH introduced the Senior Practitioner Early Assessment and Review (SPEAR) service which involves the improved utilisation of general practitioners and nurse practitioners to treat ATS 4 and 5 patients in a dedicated space adjacent to the ED wait room. The additional clinical staffing capacity reduces waiting times and improves access to care.

Expansion of hospital capacity at SJGMPH

The State Government has previously committed to purchasing the private patient facility within the SJGMPH site to increase public hospital inpatient capacity by 60 beds and three operating theatres from August 2026. The additional inpatient capacity will enhance timely access to beds for patients requiring acute care, and improve flow and waiting times in ED.

New patient record system now online across East

The rollout of digital medical records across all EMHS sites was successfully completed this year, as we modernise our record keeping and availability and look to even further capabilities in the future.

Royal Perth Hospital (RPH) and Bentley Health Service (BHS), along with their corresponding community mental health services, made the big transition from paper to digital records in May and March respectively.

This follows Armadale Health Service and Kalamunda Hospital introducing the change the year before.

The Digital Medical Records (DMR) system at EMHS is part of a statewide implementation across the public health system. It enables clinicians working in the public sector to simultaneously access patient records, improves record tracking and reduces physical storage needs.

By June 2025, a total of 734,793 digital records had been created at RPH and BHS since the DMR system came online at these sites. It is being used by an average 2300 staff members a day across these services.

The DMR system is part of stage one of the WA Health Electronic Medical Record Program aligned with the broader WA Health Digital Strategy 2020-2030.

Its successful implementation across EMHS has us well placed for the adoption of an even more sophisticated electronic medical record system with increased capabilities in the future.

EMHS Digital Medical Records (DMR) implementation Team





“We get to know the patients that we may potentially respond to.”

Safer hospitals: Code blacks down as security works with care team

New security practices at St John of God Midland Public Hospital (SJGMPH) have reduced the number of code blacks – personal threat emergencies – by creating a closer relationship between security and clinical staff.

During daily ward rounds, security staff work with senior care staff to identify patients who may pose a risk of violence. This allows clinical teams to raise any concerns early and gives the security team a chance to engage with patients in a calm setting – rather than encountering them for the first time during a crisis.

SJGMPH Manager of Security and Emergency Management, Brett Sutton, says the approach allows security staff to better understand a patient and manage the risks of occupational violence and aggression.

“Security is often seen as a black and white service and that doesn’t allow for patient-centred care,” he says.

“We get to know the patients that we may potentially respond to. We find out a little bit about them so we can have an appropriate response that might address their past triggers, so we don’t re-traumatise that patient in a response when they are in crisis.”

“It allows us to tailor our responses to our patients. The response to a young person with mental health will be different to someone who is outwardly aggressive or to our elderly with dementia who are acting out due to fear because of their condition.”

The new model saw an immediate reduction in code blacks, with numbers down 23 per cent since daily ward rounds were implemented in June 2023. The approach has also had a positive impact on the wellbeing of the security team and resulted in safer relationships with patients and visitors.

The SJGMPH security practices were recognised at our 2025 EMHS Excellence Symposium.



[Click to play video](#)

New beds, top marks for Kalamunda

Our world-class Kalamunda Hospital Palliative Care Centre of Excellence opened to full capacity in August 2024, confirming it as a leading provider of palliative care services in the state.

The hospital has been steadily increasing the capacity of its palliative care unit since 2017 and now has 30 specialised beds, supported by expert care teams providing high-quality symptom management and end-of-life care.

As the only public hospital in Western Australia with a dedicated palliative care unit, it is an important part of the EMHS network.

Patients and their families have rated the service exceptional, giving it a Net Promoter Score of more than 90 – a clear indicator of outstanding satisfaction and loyalty.

The top scores were recorded in October and November and place Kalamunda among the best in its field (scores of over 70 are considered world class). These results were the highest in EMHS, remarkable in Australia and came at a time the centre had above 95 per cent bed occupancy.

As well as in-patient palliative care, Kalamunda has day hospice and outpatient services. It also

supports a 24-hour, doctor-led EMHS out-of-hours palliative care advice line which handled 269 calls between 1 September 2024 (when the service was launched) and the end of the financial year.

Palliative care at Kalamunda supports the physical, emotional and spiritual needs of patients and their families and is delivered by a caring team of health professionals.

It continues to develop for the betterment of the WA community.



East CareConnect: Uniting in-person and virtual care

Our new virtual hospital is delivering hospital-quality treatment in people's homes through traditional medical care and technology.

A new arm of our health service dedicated to harnessing technology to provide hospital-quality care in the community was officially launched in June.

Transformative, state-of-the-art and patient-centred, East CareConnect marks a major step forward in how we can deliver health care and brings our virtual services together under one banner.

For the first time, patients have this year been able to choose 'hospital' treatment at home under the **East CareConnect Home Hospital service** for some conditions which in the past would have required them to physically be at a hospital site.

East CareConnect is the culmination of work which began at the start of this decade with our ground-breaking remote monitoring services **Health in a Virtual Environment (HIVE)** and **Community Health in a Virtual Environment (Co-HIVE)**.

It was preceded by our Community and Virtual Care Directorate, a strategic unit set up in December 2023 to oversee our virtual development.

An **East CareConnect consumer advisory committee** was established in May and will ensure community members continue to have a key role in shaping virtual healthcare delivery.

Virtual services are an important part of our ongoing evolution. They are giving patients more choice by enabling care and monitoring from the comfort of their homes, and in turn freeing up physical hospital beds for those who need them the most.

East CareConnect services are helping us lay the foundation for a more sustainable, accessible and equitable healthcare future.



Consumer Advisory Committee



HIVE/CO-HIVE/EastCareConnect Consumer Advisory Committee

Taking hospital care into the home

Our new Home Hospital service provides hospital-quality care in patients' homes for conditions such as pneumonia, infections, wounds and heart conditions.

It launched at Royal Perth Hospital (RPH) in July 2024 and expanded to Armadale Health Service (AHS) in June 2025.

The service offers comprehensive, multidisciplinary care through in-person visits by health professionals and virtual means, with remote monitoring of vital signs through wearable technology.

Each service can manage 20 patients at a time. Since 1 July 2024, 393 patients have used Home Hospital.

As part of its operations, Home Hospital is building patient pathways – roadmaps for care – for acute medical, post-surgical, respiratory and complex geriatric conditions.

In May, a **GEM@Home** (Geriatric Evaluation and Management) pathway was introduced to provide specialised, multidisciplinary care for another 8 older adults in their homes, and a **technology-enabled respiratory pathway** for people with acute respiratory conditions requiring monitoring and short-term oxygen therapy.

Our existing virtual services also continue to advance.

HIVE (Health in a Virtual Environment), which provides round-the-clock monitoring of vital signs for high-risk patients within EMHS hospital sites, this year supported 3,926 patients across RPH and AHS.

Launched in December 2020, it is continuing to evolve by caring for those most at risk through a dedicated sepsis pathway, and exploring mobile remote monitoring technology and digital charting, for a smarter, connected EMHS.

Co-HIVE, which uses virtual care to support older adults with complex care needs in residential aged care homes (RACH), this year supported over 587 people with more than 1,616 virtual geriatrician consultations to more than 170 RACHs.

It won the Excellence in Person Centred Care – Team Award at the WA Nursing and Midwifery Excellence awards in May 2025. The service, launched in May 2022, is continuing to expand its reach and capability in WA.



Sustainable Health Review

Since the April 2019 release of the [Sustainable Health Review](#) (SHR) report, the Department of Health and Health Service Providers (HSPs) have been progressing this ambitious reform agenda to create a modern healthcare system that includes actions to address preventative healthcare, brings care closer to home, and delivers equity in health outcomes. EMHS has prioritised 7 SHR recommendations, in line with current EMHS strategic priorities.

Recommendation 2a

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

- Our Population Health Team is actively implementing the Obesity Prevention Strategy 2020–2025 to support healthier communities.
- We piloted the CSIRO Total Wellbeing Lifestyle Plan, a community-based weight management intervention for individuals living with overweight and obesity, achieving an average weight reduction of 5.5 per cent among program completers.
- 190 people living in the EMHS catchment were recruited for the Medical Research Future Fund Chat2 Study, which supports behaviour change by helping participants build healthy habits and improve their diet.
- The Healthy Community Events project engaged local government event organisers and food truck vendors to develop feasible, easy-to-implement recommendations aimed at improving access to healthier food and beverage options at community events.

Recommendation 3a

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

- See our story on working together for Aboriginal health on [page 40](#).

Recommendation 5

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

- See our Environment, Social and Governance statement on [page 55](#).

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 has completed a number of outpatient reform actions, including:

- Implementation of the Contemporary Workforce Program to better utilise the available specialist workforce and improve patient access.
- Improved outpatient governance through establishment of the EMHS Outpatient Strategy and Performance Committee.
- Working collaboratively with the Department of Health and other HSPs to finalise the new WA Health Outpatient Services Policy, develop and implement new Referral Access Criteria (RAC), and progress the development a new end to end referral management system – Smart Referrals WA.

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.

- EMHS is undertaking a research project in partnership with Edith Cowan University to better understand the reasons for high rates of patient non-attendance for outpatient video appointments and recommend strategies to improve patient access and attendance.

Recommendation 13

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

- EMHS has continued to work in partnership with the Homeless Healthcare Consortium (with support from Uniting WA and Ruah) in piloting the 20-bed Medical Respite Centre (MRC). The MRC provides medically supported short-term medical respite for homeless persons being discharged from hospital.
 - In October, the MRC relocated permanently to a new property purchased by EMHS in Carlisle.
- During 2024-25, EMHS supported the Department of Health in scoping a proposal for supported accommodation for homeless persons exiting hospital requiring further medical or mental health support (The Woodville House Project). The service, which commenced in May, is located within the EMHS catchment and is being delivered by Uniting WA under a Memorandum of Understanding.
- EMHS is collaborating with the Department of Communities regarding partnership opportunities for the provision of in-reach healthcare services into East Perth Common Ground to help address homelessness and social housing needs.
- Service planning and commissioning has continued in 2024-25 for the Byford Health Hub (BHH), scheduled to open in 2027. The BHH will have a mix of WA Health and non-WA Health services, including primary care and enhanced primary mental health, child health and outpatient services, as well as new EMHS-run services; a Minor Injury and Minor Illness Clinic, Healthy Community Initiatives and Community Care Navigation.

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.

- See our story on [page 52](#) about how we are taking hospital care into the home.
- In response to the State Government 2025 Election Commitment to establish an Older Adult Integrated Health Care Centre in each metropolitan Health Service Provider, EMHS is undertaking co-design of the operational service model for the older adult hub, which will deliver a full range of services to support older adults with chronic and complex conditions to stay well in the community and avoid preventable hospitalisation.
- EMHS is participating in the National Partnership Agreement for Comprehensive Palliative Care in Aged Care, with a focus throughout 2024-25 on piloting the comprehensive implementation of the Supportive and Palliative Care Indicators Tool (SPICT). Key outcomes of the project include improved identification of patients with supportive and palliative care needs, and enhanced care planning, including the integration of Goals of Patient Care discussions. This has resulted in smoother transitions and enhanced collaboration for patients moving from hospital to residential aged care facilities.

Recommendation 23

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

- See our section on research and innovation ([page 56](#)) that demonstrates our culture and commitment to collaborate and lead the way with innovation and change.

Environment, Social and Governance statement

Our commitment to sustainability

EMHS is dedicated to contributing to the sustainability of our communities. We have the responsibility to minimise our environmental impact, focusing on supporting healthy people and providing care to the communities we operate in, and being accountable to the stakeholders we serve. As part of the public health system, we will play a key role in supporting measures to build a more adaptive, resilient, and environmentally friendly future. Through every aspect of our care business, sustainability is a value that guides our operations across three pillars of [Environment, Social and Governance \(ESG\)](#).

Environment

EMHS prioritises the environment and is striving to reduce its environmental impact while promoting sustainable healthcare practices. EMHS prioritises resource efficiency to minimise its environmental impact. Sustainable infrastructure and renewable energy are also key priorities to reduce its carbon footprint and address climate change. The EMHS Environmental Sustainability Framework 2022-2026 defines goals and prioritises initiatives for the short and medium term, such as energy efficiency and waste management. To support our sustainability priorities, EMHS has recently appointed a Chief Sustainability Officer.

Social

It is EMHS' commitment to maintain healthy people, promote good health and wellbeing, and provide amazing care to our staff and patients. EMHS strives to promote and facilitate diversity, inclusion and equity, support multiculturalism and cultural safety and provide support to the Indigenous community. EMHS values partnerships and collaborative efforts to achieve better social outcomes. In addition, EMHS places a high priority on workplace health and safety, including initiatives to promote mental health and wellbeing, to create a safe and healthy environment for everyone.

Governance

EMHS is dedicated to upholding the highest standards of governance practices and making ethical, strategic decisions that align with its vision and values. Our governance focus areas are accountability, preparedness in a digital world and future focus.

EMHS research and innovation

2024-25 research snapshot



109
New research projects



34
Investigator-initiated projects conducted by local staff and sites within WA Health



21
Projects conducted with not-for-profit organisations and institutions



38
Clinical trials commenced



16
Projects conducted with WA universities

WA Scientist of the Year

EMHS is proud to celebrate the achievements of Professor Markus Schlaich, a joint winner of the [Western Australian Premier's Science Awards 2024: Scientist of the Year](#).

Professor Schlaich's internationally-recognised, pioneering research into hypertension has led to advancements in blood pressure-lowering therapies, embodying EMHS' commitment to innovation and excellence in health care.

The research was conducted at Royal Perth Hospital (RPH) and the University of Western Australia, in conjunction with the RPH Research Foundation.



Preventing post-surgery complications

Associate Professor Andrew Toner, from the RPH Anaesthesia and Pain Management Department, has successfully recruited participants for his HYPE clinical trial into post-surgical complications.

HYPE has enrolled 95 participants and is well on track to complete the required 150 enrolments by the end of the 2025 calendar year.

The phase 2 pilot trial is examining pre-operative oral Roxadustat (Evrenzo) versus placebo in patients undergoing major elective surgery to assess the safety and effectiveness of the medication in reducing the number of people experiencing complications after surgery. It will also assess the feasibility of conducting a phase 3 international trial.

Post-operative complications are the third leading cause of death worldwide, with infective complications being particularly prevalent.



Research Innovation and Impact Grants

RPH Research Foundation Innovation and Impact Grants totalling more than \$3.5 million have been awarded to 3 inspiring doctors and their teams this year, co-funded with the Future Health Research and Innovation Fund.

A pathway to preventing leukaemia

\$1,147,285

Coordinating principal investigator: Dr Hun Chuah.

Co-investigators: Prof Wendy Erber, Prof Michael Leahy, A/Prof Kathy Fuller, Dr Henry Hui.

Associate Investigators: Dr Peter Tan, Dr Tulene Kendrick, Dr Shao Tneh, Dr Belinda Guo, Dr Malcolm Webb, A/Prof Hasib Siddiqi.

With the incidence of blood cancers in Australia projected to almost double by 2035, principal investigator Dr Hun Chuah says there is a critical need for better early detection methods.

Leukaemia can arise spontaneously or secondary to chronic bone marrow disorder, with about 50,000 Australians currently living with this disorder and at risk of developing leukaemia.

Current testing methods are not sensitive enough to detect leukaemia before symptoms appear. By this stage – even with therapy – outcomes are poor.

To develop early detection strategies for leukaemia, Dr Chuah and his team have developed a groundbreaking test called Immuno-flowFISH, which analyses hundreds of thousands of cells per test and can identify selected cell populations with new genetic changes – even when only one in 100,000 has the abnormality.

“Our project came about because of our vision – that one day we can prevent leukaemia,” Dr Chuah says.

Artificial intelligence (AI) to improve outcomes after surgery

\$1,179,424

Lead investigator: Prof Graham Hillis.

Investigator team: Prof Ferdous Sohel, Dr Janis Nolde, Prof Markus Schlaich, Dr Tim Bowles, Associate Prof Frank Sanfilippo, Adam Lloyd.

Associate investigator: Ben Horgan.

RPH Cardiology Head of Department, Professor Graham Hillis knows even the smallest cardiovascular complications following non-cardiac surgery can spiral into bigger issues.

About one in three patients suffer some damage to the heart after non-cardiac surgery, which is associated with an increased risk of death and long-term adverse health outcomes.

Professor Hillis and his team are harnessing AI to assess risks to patients.

Part of the plan is to enable clinicians to track the risk of a patient through their operation and beyond, and sooner identify the patient whose risk is changing.

“We hope that by using AI, we can have systems that will warn clinicians and tell them why that risk may be changing and what they need to do to try and intervene and hopefully avert other problems,” Professor Hillis says.

Personalised place-of-care manufactured immune cells for blood cancer

\$1,199,901

Coordinating principal investigator: Associate Professor Agnes Yong.

Principal investigators: A/Prof Zlatibor Velickovic, Dr Benedict Carnley, Dr Melita Cirillo, Dr Collin Chin, Prof Michael Leahy.

Associate investigators: A/Prof Hasib Siddiqi, Dr Bradley Augustson, Dr Sung-kai Chiu.

More than 2,600 Australians were diagnosed with the incurable blood cancer, multiple myeloma, in 2023, with patients surviving less than 6 years from diagnosis.

Associate Professor Agnes Yong and her team propose to manufacture personalised chimeric antigen receptor (CAR) T-cells that target B-cell maturation antigen (BCMA) proteins on myeloma cells for patients who have exhausted all other treatment options.

The cells will be manufactured in their place of care, in this case at the Cell and Tissue Therapies WA (CTTWA) facility in the RPH campus.

“We will be able to do this at about 10 per cent of the commercial CAR T-cell cost,” Professor Yong says.

“We will therefore be able to prioritise treating our patients without delay, because in very advanced myeloma patients, delay results in death.”

The current cost is a prohibitive US \$465,000 per patient.

Nursing and allied health grants 2025

The RPH Research Foundation this year awarded a total of \$74,693 to 5 research projects designed to directly enhance patient care.

Emotional labour in healthcare: A targeted intervention for burnout management

Dr James Clarke, \$14,850, EMHS.

This project is trialling a targeted, group-based intervention program called Skills for emotional labour in health care), which aims to equip RPH and EMHS clinicians with practical tools to avoid and manage burn-out.

Health in a Virtual Environment (HIVE): The patient perspective of continuous remote monitoring in acute care

Rebecca Crellin, \$14,907, EMHS.

The project is investigating how patients experience virtual monitoring through the HIVE program – an innovative model of care introduced at RPH in 2020.

Comparison of the efficacy and cost of central venous catheter fixation devices

Shirene Mattaboni, \$15,000, RPH.

This project is comparing the performance of 2 widely used catheter securement devices to establish clear evidence that will guide clinical best practice at RPH.

A feasibility study on nurse sensitive outcomes in the mental health setting

Dr Irene Ngune, \$15,000, Royal Perth Bentley Group.

A collaborative study to investigate which nurse-sensitive outcomes will bring the most benefit to WA's mental health services.

Exploring the experiences of haemodialysis patients with arteriovenous fistulas and grafts in hospital settings

Monique Sandford, \$14,936, RPH.

An investigation of the physical and emotional impact of vascular access care on patients who have received haemodialysis.

Raine Medical Research Foundation Clinician Research Fellowship

Doctor Martin Rabey was awarded a Raine Foundation Clinician Research Fellowship worth \$303,652 in November for the study *Changing the focus of musculoskeletal pain to strengths-based pain protection*.

Recipients are co-funded by the Raine Foundation and the Future Health Research and Innovation Fund.

RPH Research Foundation Awards

EMHS researchers were recognised at the 2024 RPH Research Foundation Awards Day in October.

Dr Martin Rabey received the **Professor Lyn Beazley AO Emerging Leader Award**.

Clinical Nurse Gabrielle Calleja was awarded the **2024 Doreen McCarthy Nursing Research Award** for the project *Exploring the patient's experience when allocated to an isolation room to manage multi-resistant organism*.

Dr Courtney Weber received the **2024 Early Career Publication Award** for her paper *Analytically confirmed illicit and novel psychoactive drug use in Western Australian emergency departments*, part of the groundbreaking Emerging Drugs Network of Australia (EDNA) project.

RPH Senior Physiotherapist Dr Meg Harrold received the **Mentorship Award**.

2024-25 innovation snapshot



481 staff attended 27 innovation events.



There were 17 submissions to the Future Health Research and Innovation Fund with EMHS as a lead in 12 and support in 5.

- There have been 2 confirmed successful applications totalling \$1,684,326.
- One application is awaiting an outcome.



3 idea campaigns have been delivered via IdeaScale, including:

- Your Hub to enhance services at the new RPH Innovation Hub
- Work Smart to streamline workflow and improve efficiencies across our services.
- Buy Nothing platform to establish a swap service for RPH office equipment.



The EMHS Youth Innovation Think Tank engaged 120 students, including from the South West, through a partnership with the WA Country Health Service.

New RPH Innovation Hub

The new RPH Innovation Hub was officially opened by the Minister for Medical Research, the Hon Stephen Dawson MLC, in November.

Serving as the central space for the EMHS Innovation program, the hub offers a dynamic line-up of activities to drive innovation.

This financial year:

- EMHS Innovation has supported 17 projects with a human-centred design thinking project management approach. Human-centred design is an immersive approach to creative problem solving that focuses on the needs and requirements of end-users throughout the design process.
- An Innovation Champions program, designed to equip staff with the foundations for applying innovative practices across their own work and teams, has been well received, and we have also launched Innovation Power-Ups – 90-minute sessions with a deep dive on a specific skill related to human-centred design thinking.
- We have partnered with the WA Data Science Innovation Hub, Perth Biodesign, WA Life Sciences Innovation Hub, and WA schools through the Youth Innovation Think Tank.
- The Hub has hosted 18 professional development or workshop events with a total 322 attendees, 72 per cent from within our organisation and 28 per cent from outside.

Minister for Medical Research,
Hon Stephen Dawson MLC

Hub spaces include:

- a lab with 3D-printing and other equipment for building prototypes, supported by an innovation technical lead with engineering expertise
- a fit-for-purpose flexible space where new virtual reality projects can be tested and trialed
- 6 dedicated desks for staff working on innovation projects
- flexible work zones for collaborative and design work, accessible for all EMHS staff.



Reverse pitch with Perth Biodesign

We completed our first collaboration with Perth Biodesign via the University of Western Australia Master of Engineering course in October. Four student teams delivered pitches for bespoke products developed in response to clinical challenges laid down by our clinicians in February.

Clinical needs statement	Proposed solution
A way to improve airborne pathogen isolation in space-limited hospitals to reduce transmission of airborne diseases	A 2-part device that attaches to the head and foot of a standard hospital bed to improve airborne pathogen isolation in space-limited hospitals to reduce transmission of airborne diseases.
A way for faster access to blood pressure in haemodynamically unstable adult patients in emergency departments, for faster administration of inotropic medication.	A non-invasive portable solution to provide accurate and constant blood pressure measurements to haemodynamically unstable patients in the emergency department.
A way to decrease the number of damaged cables in operating rooms to decrease the cost of lost resources.	An easily attachable and adjustable device designed to organise cables in the emergency department.
A way to test for jaundice severity outside of healthcare settings in discharged neonates to reduce costs associated with mild jaundice.	A screening tool for parents to monitor jaundice severity and progression in neonates over time, preventing unnecessary hospitals re-presentations.

The EMHS and Perth Biodesign partnership was renewed in early 2025 and 8 EMHS clinicians pitched 13 challenges to the cohort of 37 Master of Engineering students. Students are now developing their proposed solutions to pitch to EMHS at the end of 2025.

Innovation internships

The first EMHS Innovation Internships program began in December 2024. The initiative offers EMHS staff the opportunity to access funding, time and professional support to develop and deliver pilot projects that align with our Innovation Strategy.

Three interns were supported in 2024-25.

RPH State Trauma Unit Senior Physiotherapist Claire Mullane is working on a project to improve lateral transfers within the trauma setting, specifically for bariatric patients who need to transfer from sitting on a bed to a wheelchair or commode.

Senior Podiatrist Rachel Carle, from the RPH Podiatry Outpatients clinic and Moorditj Djena, is focused on improving patient compliance with Controlled Ankle Movement (CAM) boots by simplifying the boot design without affecting its pressure reduction value.

State Rehabilitation Centre Senior Occupational Therapist Evana Jacobson is aiming to improve staff knowledge and uptake of assistive technologies for patients, including establishing a digital library of tools and services.

Building health and community at Byford and Bentley

Two major infrastructure projects – Byford Health Hub and Bentley Surgicentre – are progressing and play a key role in meeting our community's growing needs.

In January, EMHS officially acquired the Byford Town Centre site for the \$42.2 million Byford Health Hub, which will be located within walking distance of the future Byford Metronet station.

Site preparation was completed in May, with main construction on the 2-storey, 3,000 square metre building scheduled to begin in the late 2025 calendar year.

Throughout the financial year, we worked with the Department of Finance and the architect to design a purpose-built space that will support core services while also offering flexible areas.

The adaptable design will allow the hub to evolve and continue meeting the changing needs of the community.

Scheduled to open in 2027, the hub will be operated by EMHS and offer a mix of private, not-for-profit and WA Health outpatient services.

It will bring primary, community, social and specialist health services – including child community health, maternal care, paediatrics, allied health and other specialist services – closer to home for residents of the Shire of Serpentine-Jarrahdale and surrounding areas.

An integrated service delivery charter has been developed to ensure services are connected and streamlined for the people using them.

To support culturally informed planning, the Byford Health Hub Aboriginal Advisory Group, nominated by Traditional Owners of Gnaala Karla Booja, was

established to provide cultural guidance, while service and operational planning is underway with input from clinicians, Traditional Owners and the local community.

Meanwhile, the project definition phase for the \$167 million Bentley Surgicentre is nearly complete.

The surgicentre will boost EMHS' capacity for elective surgery demands and ease pressure on Royal Perth Hospital so it can focus on unplanned and complex surgery.

It is set to include 6 surgical theatres, 2 procedure rooms, a 24-bed surgical ward and a central sterilisation services department.



Artist impressions of the Byford Health Hub

Technology and innovation: Robots in health care

Technological advances have led to robots enhancing our health care in different roles and areas.

In May, Royal Perth Hospital (RPH) added a million-dollar robotic surgical assistant (ROSA) to state-of-the-art equipment available to surgeons for knee surgery, under a 4-year agreement with global medical technology company Zimmer Biomet, which required no capital outlay by RPH.

Owned by Zimmer, the ROSA robot is available to accredited surgeons as a tool during total knee arthroplasty, or knee replacement surgery, and has proven an excellent adjunct since its introduction.

ROSA does not perform the surgery but assists the surgeon by providing real-time data and guidance to enhance precision, aiding the surgery and allowing the surgeon to make complex cases more technically feasible.

The ROSA Knee System is made up of 2 units which sit either side of the operating table — a robotic unit with an ‘arm’ and an optical unit, both with touchscreens.

Software modules will also be added to expand the robot’s capability to unicompartmental knee arthroplasty (partial knee replacement), shoulder arthroplasty and total hip arthroplasty (hip replacement surgery). Surgeon training will be conducted for the new uses.

RPH Coordinator of Nursing - Perioperative Services, Kerry Hodgkinson, says ROSA allows safer and more accurate surgery.

“As a teaching hospital, this will promote surgical excellence in this sub-specialty,” Kerry says.



“As a teaching hospital this will promote surgical excellence in this sub-specialty”

A step forward in dementia care

A new hospital-to-aged-care program at Bentley Health Service (BHS) is reshaping the way we care for elderly patients living with dementia.

The Hospital to Aged Care Dementia Support Program began at BHS in April as a 12-month pilot program.

It is part of a national initiative aimed at improving outcomes for older people with dementia who are at risk of delayed hospital discharge.

The program supports the patients to successfully transition into residential aged care. It also provides support and training to families and carers and hospital and aged care staff.

BHS staff work with Dementia Support Australia, which is delivering the program nationally for the Australian government.

Professor Christopher Etherton-Beer, who is leading the BHS pilot program, says it is a step forward in dementia care.

“We know moving to aged care can be a challenging time for people with dementia and their loved ones, and we anticipate this new service will have substantial effect in easing that transition process,” he says.

EMHS is proud to be a dementia-friendly health service provider.



Professor Christopher Etherton-Beer

“...moving to aged care can be a challenging time for people with dementia and their loved ones, and we anticipate this new service will have substantial effect in easing that transition...”



Key Performance Indicators

Certification of Key Performance Indicators

East Metropolitan Health Service

Certification of Key Performance Indicators for the year ended 30 June 2025

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

Pia Turcinov AM

Board Chair
East Metropolitan Health Service
8 September 2025

Melissa Grove

Chair, EMHS Board Audit
and Risk Committee
East Metropolitan Health Service
8 September 2025

KPIs

KPIs

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



Example KPI data

YEAR	TARGET	ACTUAL	
2024	xxx	xxx	██████████
2023		xxx	██████████
2022		xxx	██████████
2021		xxx	██████████

Introduction

In 2024-25, EMHS continued to face substantial expenditure pressures driven by several compounding factors, including award-related wage increases, elevated medical and nursing salaries, increased reliance on locums and visiting specialists, and broader inflationary impacts from the cost-of-living environment. These pressures were further intensified by the implementation of government wage policies and investments in safer service initiatives designed to enhance patient care and security.

Across core service delivery areas such as admitted, emergency, and outpatient care, the Health Service experienced growing demand and activity, which came at a higher cost. These areas reported rising average costs that exceeded prior years, reflecting challenges in maintaining efficiency amidst escalating workforce and supply costs.

Admitted mental health services also experienced increased cost pressures, primarily due to temporary bed closures for capital and safety-related works, which reduced activity throughput and in turn raised unit costs. However, EMHS demonstrated strong performance in non-admitted mental health services, maintaining efficiency and delivering care within community settings despite the higher resource needs associated with these models of care.

Despite a challenging fiscal environment, EMHS remains committed to delivering safe, high-quality care while responding to increasing complexity and demand across all areas of service. The Health Service continues to focus on improving efficiency and sustainability without compromising the wellbeing of patients and the workforce.

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

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

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

Note: This indicator is reported by calendar year. Some indicators are reported by calendar year to allow for delays associated with the clinical coding of medical records, data quality checking, data linkage processing, and the setting of targets in accordance with the Government Budget Statement.

Target

The 2024 targets for unplanned readmissions for each procedure (per 1,000 separations) are outlined below. Improved or maintained performance is demonstrated by a result below or equal to target.

- (a) knee replacement ≤ 21.0
- (b) hip replacement ≤ 19.4
- (c) tonsillectomy & adenoidectomy . ≤ 84.4
- (d) hysterectomy ≤ 45.8
- (e) prostatectomy ≤ 40.0
- (f) cataract surgery ≤ 2.3
- (g) appendicectomy ≤ 29.7

Results

(a) Knee replacement:

YEAR	TARGET	ACTUAL		
2024	21.0	14.4		
2023		14.3		
2022		10.4		
2021		15.4		

(b) Hip replacement:

YEAR	TARGET	ACTUAL		
2024	19.4	7.9		
2023		16.4		
2022		11.1		
2021		20.4		

(c) Tonsillectomy & adenoidectomy:

YEAR	TARGET	ACTUAL		
2024	84.4	147.1		
2023		58.8		
2022		84.7		
2021		138.7		

(d) Hysterectomy:

YEAR	TARGET	ACTUAL		
2024	45.8	31.3		⋮
2023		47.9		
2022		25.9		
2021		73.2		

(e) Prostatectomy:

YEAR	TARGET	ACTUAL		
2024	40.0	42.6		⋮
2023		69.4		
2022		54.5		
2021		49.3		

(f) Cataract surgery:

YEAR	TARGET	ACTUAL		
2024	2.3	1.5		⋮
2023		2.6		
2022		2.3		
2021		2.4		

(g) Appendicectomy:

YEAR	TARGET	ACTUAL		
2024	29.7	26.0		⋮
2023		22.3		
2022		25.8		
2021		30.1		

Commentary

EMHS strives to provide safe, high-quality care to its patients at all times. In 2024 improved performance can be seen across the majority of indicators relating to hospital readmission. EMHS continues to perform case reviews to drive clinical improvement across these cohorts. These reviews can identify variations in care and outcomes, fostering system-wide learning and service improvement.

In 2024 unplanned readmissions following tonsillectomy and adenoidectomy and prostatectomy exceeded target. These results are however based on a small number of cases where individual case reviews noted a high degree of patient complexity contributing to the need for readmission as well as some opportunities for quality improvement to streamline care delivery. EMHS will continue to monitor performance of these indicators and learn from these cases.

Period: 2021 to 2024 calendar years
Contributing sites: Armadale/Kelmscott District Memorial Hospital, Bentley Hospital, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital (public patients)
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.

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

Patients are prioritised based on their assigned clinical urgency category:

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

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

Target

The 2024-25 target for patients waiting over boundary for all urgency categories is 0 per cent. A result equal to target is desired.

Results

Category 1:

YEAR	TARGET	ACTUAL
2024-25	0%	8.7%
2023-24		7.3%
2022-23		11.9%
2021-22		6.5%

Category 2:

YEAR	TARGET	ACTUAL
2024-25	0%	35.9%
2023-24		33.4%
2022-23		38.5%
2021-22		28.3%

Category 3:

YEAR	TARGET	ACTUAL
2024-25	0%	11.4%
2023-24		10.8%
2022-23		15.8%
2021-22		9.3%

Commentary

In 2024-25, EMHS did not meet the elective surgery recommended target for any urgency category.

Challenges impeding EMHS’ ability to meet the elective surgery targets include demand exceeding theatre and inpatient bed capacity. In addition, ongoing workforce attraction and surgical preparatory pathways remain the key challenges and are an ongoing priority for EMHS.

Several actions were progressed to improve the elective surgery waitlist in the 2024-25 financial year:

- Outsourcing surgical services privately to support meeting high demand with a focus on orthopaedics, general surgery and urology.
- Additional theatre lists including weekend elective operating lists.
- Procurement of an orthopaedic surgical robot to support staff retention and recruitment.
- Consolidation of a tiered referral endoscopy network across EMHS sites to deliver endoscopy care in a timely manner and alleviate demand for tertiary theatres.
- Virtual care and early discharge via EMHS Hospital in the Home team.

To maintain a sustainable elective surgery waitlist, EMHS is also progressing several longer-term strategies, including:

- Dual site consultant led vascular service across Royal Perth Hospital and Armadale Hospital, inclusive of outpatient services and operating time.
- Progressing procurement of a non-orthopaedic surgical robot to support surgical staff recruitment and retention.
- Improving the pre-anaesthetic assessment model of care to optimise access, reduce cancellation and subsequently improve theatre efficiency.
- Expanding the surgical contemporary workforce model across particular specialties.
- Piloting virtual care applications to support early pre-surgical screening.

Period:	2021-22 – 2024-25 financial years (average of weekly census data)
Contributing sites:	Armadale/Kelmscott District Memorial Hospital, Bentley Hospital, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital (public patients)
Data source:	Elective Services Wait List Data Collection

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

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

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

Note: This indicator is reported by calendar year. Some indicators are reported by calendar year to allow for delays associated with the clinical coding of medical records, data quality checking, data linkage processing, and the setting of targets in accordance with the Government Budget Statement.

Target

The 2024 target for HA-SABSI is ≤1.00 per 10,000 occupied bed-days. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL		
2024	1.00	0.63		
2023		0.82		
2022		0.69		
2021		1.09		

Commentary

During 2024, EMHS achieved the target for HA-SABSI, with a result equating to 25 infections from 398,841 occupied bed-days.

EMHS participates in a state-wide surveillance program and has established thorough processes for reviewing all cases of healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI). Infection control specialists and treating clinicians work together to identify the factors contributing to each case and closely monitor infection rates.

EMHS remains committed to minimising the occurrence of HA-SABSI as demonstrated by the following initiatives which were implemented in 2024:

- Continued focus of the Vascular Access Service which provides expert and specialist care in the insertion and management of invasive devices.
- Specialist Vascular Access training in the Emergency Department to enhance the skills of clinicians, particularly in handling patients with difficult intravenous access.
- Increased cluster review methodology to identify safety and quality initiatives.

Period: 2021 to 2024 calendar years
Contributing sites: Armadale/Kelmscott District Memorial Hospital, Bentley Hospital, Kalamunda Hospital, Royal Perth Bentley Group Transitional Care Unit (Bidi Wungen Kaat Centre), Royal Perth Hospital.

Data source: Healthcare Infection Surveillance Western Australia (HISWA) Data Collection

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

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

Note: This indicator is reported by calendar year. Some indicators are reported by calendar year to allow for delays associated with the clinical coding of medical records, data quality checking, data linkage processing, and the setting of targets in accordance with the Government Budget Statement.

Target

Please see the 2024 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	
2024	95.4%	94.9%	
2023		95.2%	
2022		94.7%	
2021		96.3%	

50 – 59 years:

YEAR	TARGET	ACTUAL	
2024	94.8%	94.6%	
2023		94.0%	
2022		99.0%	
2021		96.2%	

60 – 69 years:

YEAR	TARGET	ACTUAL	
2024	94.5%	97.1%	
2023		94.7%	
2022		97.2%	
2021		95.9%	

70 - 79 years:

YEAR	TARGET	ACTUAL	
2024	92.6%	94.7%	
2023		92.2%	
2022		94.4%	
2021		95.1%	

80+ years:

YEAR	TARGET	ACTUAL	
2024	87.6%	93.0%	
2023		89.5%	
2022		89.8%	
2021		94.4%	

Commentary

EMHS' performance in the survival rate for stroke exceeded the target across 3 age ranges. Lower survival rates are often due to the complexity and severity of cases. EMHS continues to perform well when compared to the state average for in hospital mortality of patients admitted for stroke.

Results

Acute myocardial infarction (AMI)

0 – 49 years:

YEAR	TARGET	ACTUAL
2024	98.9%	98.9%
2023		98.4%
2022		99.4%
2021		97.7%

50 – 59 years:

YEAR	TARGET	ACTUAL
2024	98.8%	99.0%
2023		99.7%
2022		99.0%
2021		100%

60 – 69 years:

YEAR	TARGET	ACTUAL
2024	98.2%	99.4%
2023		98.6%
2022		99.4%
2021		98.9%

70 – 79 years:

YEAR	TARGET	ACTUAL
2024	97.0%	95.5%
2023		97.6%
2022		96.7%
2021		97.0%

80+ years:

YEAR	TARGET	ACTUAL
2024	93.1%	93.4%
2023		92.6%
2022		96.0%
2021		94.6%

Commentary

EMHS’ performance in the survival rate for acute myocardial infarction remains within the acceptable target range for most age groups. This achievement is largely due to patients receiving prompt access to invasive coronary diagnostic and interventional procedures, as well as more efficient inter-hospital transfer arrangements for patients from Armadale Hospital and St John of God Midland Public Hospital to Royal Perth Hospital.

EMHS Executive will continue to monitor throughout 2025, with all inpatient deaths subject to peer review as part of a morbidity and mortality review process.

Results

Fractured neck of femur (FNoF)

70 - 79 years:

YEAR	TARGET	ACTUAL
2024	98.8%	99.2%
2023		99.4%
2022		99.3%
2021		97.6%

80+ years:

YEAR	TARGET	ACTUAL
2024	97.3%	97.7%
2023		97.0%
2022		97.6%
2021		98.3%

Commentary

EMHS' performance in the survival rate for fractured neck of femur patients exceeded target in both age ranges.

Throughout 2025, the fractured neck of femur pathway will continuously monitor to identify opportunities for improvement. All inpatient deaths undergo peer review as part of a morbidity and mortality review process. Actions taken to address issues and lessons learnt are shared with clinical teams.

Period: 2021 to 2024 calendar years
Contributing sites: Armadale/Kelmscott District Memorial Hospital, Bentley Hospital, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital
Data source: 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. take own leave, left without notice, missing and not found, or discharge at own risk). Patients who do so have a higher risk of readmission and mortality and have been found to cost the health system 50 per cent more than patients who are discharged by their physician.

The national Aboriginal and Torres Strait Islander Health Performance Framework reports discharge at own risk under the heading ‘Self-discharge from hospital’. Between July 2019 and June 2021 Aboriginal patients (4.4%) in WA were 7.5 times more likely than non-Aboriginal patients (0.6%) to discharge at own risk, compared with 5.2 times nationally (3.8% and 0.7% respectively). This statistic indicates a need for improved responses by the health system to the needs of Aboriginal patients. This indicator is also being reported in the Report on Government Services 2024 under the performance of governments in providing acute care services in public hospitals.

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

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

Note: This indicator is reported by calendar year. Some indicators are reported by calendar year to allow for delays associated with the clinical coding of medical records, data quality checking, data linkage processing, and the setting of targets in accordance with the Government Budget Statement.

Target

The 2024 targets for admitted patients who discharged against medical advice are:

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

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

Results

Aboriginal patients:

YEAR	TARGET	ACTUAL
2024	2.78%	6.90%
2023		6.17%
2022		5.98%
2021		5.87%

Non-Aboriginal patients:

YEAR	TARGET	ACTUAL
2024	0.99%	1.29%
2023		1.14%
2022		1.09%
2021		1.16%

Commentary

Performance outcomes for EMHS in 2024 did not achieve DAMA targets, however it should be noted that at some sites, local improvement in performance was achieved:

- Armadale Hospital DAMA performance improved in 2024 when compared to 2023, going from 1.4% to 1.2% for non-Aboriginal patients and from 6.4% to 5.8% for Aboriginal patients in 2023 and 2024 respectively.
- Bentley Hospital DAMA performance also improved in 2024, going from 3.4% to 3.1% for Aboriginal patients.
- St John of God Midland Public Hospital (SJGMPH) performance improved from 4.4% to 3.6% for Aboriginal patients and stayed the same for non-Aboriginal patients.

A range of strategies and actions to support DAMA performance have been employed across EMHS and locally by sites, these include:

- Developing targeted DAMA and Did not wait (DNW) training modules as part of the Aboriginal Health Champions program for hospital staff who work in areas with high Aboriginal consumer ratios.
- Supporting implementation and compliance with EMHS DAMA policies by undertaking broad stakeholder consultation, focusing on Aboriginal consumers, cultural safety and critical success factors.
- Royal Perth Hospital (RPH) is working to enhance the ward environment to support Aboriginal patients to remain in hospital for the duration of their care.

- RPH is working to integrate the First Nations consumer voice into DAMA and Patient Initiated Discharge (PID) processes, and to implement learnings from the Aboriginal patient case review.
- At Armadale and Kalamunda Hospitals, the Aboriginal Health Team ensures that every Aboriginal client is offered access to the Aboriginal Health Liaison Officer service and contacts patients who DAMA.
- Armadale and Kalamunda Hospitals are working to embed use of the PID form to ensure safe discharges and embed active follow up with DAMA patients.
- SJGMPH have an established Aboriginal Health Strategic Framework, with progress against committed actions tracked and reported via the Midland and EMHS Aboriginal Health and Wellbeing Committees.
- The SJGMPH Aboriginal Health Team ensure referrals, medications and management plans are in place and discuss any issues with the patient before they DAMA.
- SJGMPH is working to embed strategies to reduce DAMA with a focus on enhancing culturally secure care and environments.

In late 2024 the EMHS Leave Events Action Plan 2025 was developed and strategically identifies and supports implementation of actions and initiatives to improve leave event performance across EMHS and includes DAMA events.

Period:	2021 to 2024 calendar years
Contributing sites:	Armadale/Kelmscott District Memorial Hospital, Bentley Hospital, Kalamunda Hospital, Royal Perth Bentley Group Transitional Care Unit (Bidi Wungen Kaat Centre) ¹ , Royal Perth Hospital, St John of God Midland Public Hospital
Data source:	HMDC

¹The Transitional Care Unit contributed to the DAMA KPI, however was reported under Bentley Hospital for the full calendar year.

Percentage of live-born term infants with an Apgar score of less than 7 at 5 minutes post delivery

Outcome one // Effectiveness KPI

Rationale

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

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

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

Note: This indicator is reported by calendar year. Some indicators are reported by calendar year to allow for delays associated with the clinical coding of medical records, data quality checking, data linkage processing, and the setting of targets in accordance with the Government Budget Statement.

Target

The 2024 target for the percentage of live-born term infants with an Apgar score of less than seven at five minutes post-delivery is ≤ 1.90 per cent. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2024	1.90%	1.47% 
2023		0.99% 
2022		1.05% 
2021		1.37% 

Commentary

EMHS’ performance has remained below target, which is indicative of the quality of care and skilled workforce providing maternity and neonatal services in EMHS hospitals.

EMHS closely monitors performance against this and other maternity process and outcome measures to ensure EMHS maternity services maintain a high standard of care.

Period: 2021 to 2024 calendar years

Contributing sites: Armadale/Kelmscott Memorial Hospital, Bentley Hospital (since 29/12/2024), St John of God Midland Public Hospital (public patients only)

Data source: Midwives Notification System

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. Rapid readmissions place pressure on finite beds and may reduce access to care for other consumers in need.

These readmissions mean that patients spend additional time in hospital and utilise additional resources. A low readmission rate suggests that good clinical practice is in operation. Readmissions are attributed to the facility at which the initial separation (discharge) occurred rather than the facility to which the patient was readmitted.

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

Note: This indicator is reported by calendar year. Some indicators are reported by calendar year to allow for delays associated with the clinical coding of medical records, data quality checking, data linkage processing, and the setting of targets in accordance with the Government Budget Statement.

Target

The 2024 target for readmissions to acute specialised mental health inpatient services within 28 days of discharge is ≤ 12.0 per cent. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2024	12.0%	14.2% 
2023		14.6% 
2022		14.4% 
2021		14.9% 

Commentary

With demand for mental health services and patient complexity remaining high, readmission rates remain relatively steady when compared year on year. EMHS continues to strive to build and strengthen its community-based services to better support patients following discharge.

These services include:

- The EMHS Crisis Resolution Home Treatment Team (Kadadkiny Marr Koodjal Mia) commenced at Armadale Health Service on 1 March 2023, with service capacity expanding from 5 to 8 beds in December 2024. This service delivers hospital-level, evidence-based mental health care in the consumer's home, aiming to prevent emergency department presentations and inpatient admissions. It provides intensive, multidisciplinary support during the crisis phase and includes roles such as an Aboriginal Health Liaison Officer and a Peer Support Worker to ensure culturally responsive, person-centred care.
- The EMHS Active Recovery Team (ART) provides intensive, targeted community mental health treatment through an integrated care model, supporting individuals with complex needs and frequent ED or inpatient admissions. The ART's positive impact was recognised with the 2024 WA

Health Excellence in Mental Health Award.

- Expansion of the EMHS Eating Disorders Specialist Service to include referrals from GPs and the community, provides a multidisciplinary approach focused on supporting early discharge, reducing readmissions, and preventing inpatient admissions through stepped-up community care.
- The AFTERCARE program is scheduled for commissioning in late 2025. This initiative is jointly commissioned by the Mental Health Commission (MHC) and the WA Primary Health Alliance (WAPHA). The program will provide intensive support for individuals on discharge who have presented to the emergency department or been admitted due to suicide-related risk, aiming to improve continuity of care and reduce the risk of future crises.
- WA Health Ambulance Co-Response Service was commissioned in the EMHS catchment late 2024 and expanded in February 2025. The service operates 7 days a week in partnership with St John Ambulance, offering mental health triage for 000 callers aged 16 years and over. This service is supporting a reduction in emergency department presentations and potential subsequent readmissions by resolving a significant portion of mental health crises in the community.

Period: 2021 to 2024 calendar years

Contributing sites: Armadale/Kelmscott Memorial Hospital and Health Service, Bentley Hospital and Health Service, Royal Perth Bentley Group Transitional Care Unit (Bidi Wungen Kaat Centre)², Royal Perth Hospital, St John of God Midland Public Hospital

Data source: HMDC (inpatient separations)

²The Transitional Care Unit was reported under Bentley Hospital and Health Service from 01/01/2023 to 31/07/2023.

Percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services

Outcome one // Effectiveness KPI

Rationale

In 2022, one in four (6.6 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 the measure is that continuity of care requires prompt community follow-up in the period following discharge from hospital. A responsive community support system for persons who have experienced a psychiatric episode requiring hospitalisation is essential to maintain their clinical and functional stability and to minimise the need for hospital readmissions. Patients leaving hospital after a psychiatric admission with a formal discharge plan that includes links with public community based services and support are less likely to need avoidable hospital readmissions.

Note: This indicator is reported by calendar year. Some indicators are reported by calendar year to allow for delays associated with the clinical coding of medical records, data quality checking, data linkage processing, and the setting of targets in accordance with the Government Budget Statement.

Target

The 2024 target percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services is ≥75.0 per cent. Improved or maintained performance is demonstrated by a result equal to or above target.

Results

YEAR	TARGET	ACTUAL
2024	75.0%	86.7%
2023		84.2%
2022		86.8%
2021		87.8%

Commentary

Over the past 4 years, EMHS has consistently exceeded the 75% target. This result demonstrates our commitment to connecting with our mental health consumers within a week of being discharged from hospital, to assist them through a key period of transition of care.

EMHS has developed a real-time 7-day follow-up dashboard to enhance mental health data quality and support accurate recording of follow-up contacts by staff. The dashboard improves visibility for staff, enabling timely action, supporting compliance, and driving continuous improvement in follow-up care.

Period:	2021 to 2024 calendar years
Contributing sites:	Armadale/Kelmscott Memorial Hospital and Health Service, Bentley Hospital and Health Service, Royal Perth Bentley Group Transitional Care Unit (Bidi Wungen Kaat Centre) ³ , Royal Perth Hospital, St John of God Midland Public Hospital
Data source:	Mental Health Information Data Collection (MIND) (ambulatory mental health service contacts); HMDC (inpatient separations)

³The Transitional Care Unit was reported under Bentley Hospital and Health Service from 01/01/2023 to 31/07/2023.

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 2024-25 Budget Paper No. 2, Volume 1.

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

Target

The 2024-25 target for average admitted cost per WAU is \$7,899. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2024-25	\$7,899	\$8,148
2023-24		\$7,871
2022-23		\$7,524
2021-22		\$7,197

Commentary

EMHS has performed unfavourably against the 2024-25 target with an average admitted cost per WAU of \$8,148, which is \$249 above the target of \$7,899. The 2024-25 result is also \$277 above the actual average admitted cost per unit in 2023-24.

The 2024-25 financial year saw increased activity compared to the prior year. This increased activity came at a higher cost than in previous years. Increased staffing costs including increased costs from the outcomes of enterprise bargaining agreements and cost of living increases continued to challenge the Health Service's efforts to maintain efficiency while delivering high-quality, safe care.

Period:	2021-22 – 2024-25 financial years
Contributing sites:	Armadale/Kelmscott Memorial Hospital, Bentley Hospital, Kalamunda Hospital, Royal Perth Bentley Group Transitional Care Unit (Bidi Wungen Kaat Centre), Royal Perth Hospital, St John of God Midland Public Hospital, St John of God Mount Lawley (contracted services)
Data source:	OBM allocation application; Oracle 11i financial system; HMDC extracts; webPAS; Contracted Health Entities (CHE) discharge 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 2024-25 Budget Paper No. 2, Volume 1.

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

Target

The 2024-25 target for average ED cost per WAU is \$7,777. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2024-25	\$7,777	\$8,753
2023-24		\$8,405
2022-23		\$7,630
2021-22		\$7,353

Commentary

EMHS delivered average emergency department (ED) cost per weighted activity unit (WAU) at \$8,753 per WAU. This is \$976 above the 2024-25 target of \$7,777 and \$348 higher than the actual average cost of \$8,405 in 2023-24.

The continuing upward trend in results across the four financial years reflects an overall increase in presentations to emergency departments and increased acuity of those attending emergency departments, alongside the increased staffing costs, particularly due to the 24 hours per day, 7 days per week, 365 days per year nature of emergency care services.

Period: 2021-24 – 2024-25 financial years
Contributing sites: Armadale/Kelmscott Memorial Hospital, Royal Perth Hospital, St John of God Midland Public Hospital
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 2024-25 Budget Paper No. 2, Volume 1.

The measure ensures that a consistent methodology is applied to calculating and reporting the cost of delivering non-admitted activity against the state’s funding allocation. Non-admitted services play a pivotal role within the spectrum of care provided to the WA public. Therefore, it is important that non-admitted service provision is monitored to ensure the efficient delivery of safe and high-quality care.

Target

The 2024-25 target for average non-admitted cost per WAU is \$7,903. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2024-25	\$7,903	\$8,902
2023-24		\$8,297
2022-23		\$7,778
2021-22		\$6,093

Commentary

The average non-admitted cost per WAU of \$8,902 is \$999 above the 2024-25 target of \$7,903. The current year’s cost is also \$605 higher than the actual cost of \$8,297 when compared to the cost per unit in 2023-24.

Non-admitted activity (also known as ‘outpatient’ activity) continued to grow in 2024-25. This activity is closely related to emergency and inpatient activity with patients prepared for or followed up after admissions, treatment and interventions, alongside being managed in an outpatient setting for chronic conditions to prevent admissions and reduce re-admissions.

As a result of the upward cost trend over the four reported years, outpatient services face parallel challenges to inpatient and emergency services in maintaining efficiency and quality in an environment of escalating costs.

This has directly contributed to the health service being unable to meet the target of \$7,903 per non-admitted WAU.

Period: 2021-22 – 2024-25 financial years
Contributing sites: Armadale/Kelmscott Memorial Hospital, Bentley Hospital, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital, St John of God Mount Lawley (contracted services)
Data source: OBM allocation application; Oracle 11i financial system; Non Admitted Patient Data Collection (NAP DC)

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

Outcome one // Efficiency KPI
Service four: Mental health services

Rationale

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

Target

The 2024-25 target for average cost per bed-day in specialised mental health inpatient services is \$1,913. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2024-25	\$1,913	\$2,223
2023-24		\$1,867
2022-23		\$2,156
2021-22		\$1,783

Commentary

EMHS delivered specialised mental health inpatient services at a cost per bed-day of \$2,223, which is higher (by \$310) compared to the target rate \$1,913, and it is also higher (\$356 more) compared to the 2023-24 actual result of \$1,867.

There was an increase in the average cost per bed day due to increased staffing costs including increased costs from the outcomes of enterprise bargaining agreements and cost of living increases.

Period: 2021-22 – 2024-25 financial years

Contributing sites: Armadale/Kelmscott Memorial Hospital and Health Service, Bentley Hospital and Health Service, Royal Perth Bentley Group Transitional Care Unit (Bidi Wungen Kaat Centre)⁴, Royal Perth Hospital, St John of God Midland Public Hospital

Data source: OBM allocation application; Oracle 11i financial system; BedState

⁴The Transitional Care Unit was reported under Bentley Hospital and Health Service in 2022-23 and was not operational prior to this.

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.

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

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

Target

The 2024-25 target for average cost per treatment day of non-admitted care provided by mental health services is \$507. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2024-25	\$507	\$447
2023-24		\$494
2022-23		\$451
2021-22		\$400

Commentary

The results for 2024-25 demonstrate that EMHS has performed favourably against the target of \$507 (lower by \$60). This was achieved despite a marginal increase in treatment days which ordinarily could be expected to increase the average cost per treatment day. The current year's actual performance is also lower than the actual cost of \$494 (by \$47) when compared to the performance in 2023-24.

EMHS has maintained a consistent level of efficiency and performance across the four years, despite the costs of providing support and treatment within a community setting being generally more expensive as additional effort, attention and resourcing may be needed to ensuring standards and models of care and support for mental health cases are maintained outside of a hospital environment.

Period:	2021-22 – 2024-25 financial years
Contributing sites:	Armadale/Kelmscott Memorial Hospital and Health Service, Bentley Hospital and Health Service, Royal Perth Bentley Group Transitional Care Unit (Bidi Wungen Kaat Centre), Royal Perth Hospital, St John of God Midland Public Hospital
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 2022-2026. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

The 2024-25 target for average cost per person of delivering population health programs by population health units is \$24. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2024-25	\$24	\$20
2023-24		\$18
2022-23		\$55
2021-22		\$113

Please note:

- 2021-22 is based on the 2016-20 estimates
- 2022-23 is based on the 2017-21 estimates
- 2023-24 is based on the 2018-22 estimates
- 2024-25 is based on the 2019-23 estimates

Commentary

EMHS' average cost per person of delivering population health programs is \$20 in the current financial year, and the result in 2024-25 is favourable against the 2024-25 target of \$24, and better when compared to the 2023-24 target of \$22.

Since the 2021-22 financial year the EMHS has performed efficiently when delivering population health programs, as demonstrated by the continued downward trend in the average cost per person from \$113 (2021-22) to \$20 (2024-25).

Period: 2021-22 – 2024-25 financial years
Contributing sites: East Metropolitan Health Service health region
Data source: OBM allocation application; Oracle 11i financial system; Estimated Resident Populations for 2019-23 and projection of 2024 population provided by the Epidemiology Directorate, Public and Aboriginal Health Division, WA Department of Health

Financials



Auditor General

INDEPENDENT AUDITOR'S REPORT

2025

East Metropolitan Health Service

To the Parliament of Western Australia

Report on the audit of the financial statements

Opinion

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

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

In my opinion, the financial statements are:

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

Basis for opinion

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

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

Responsibilities of the Board for the financial statements

The Board is responsible for:

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

Certification of Financial Statements

For the financial year ended 30 June 2025

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

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

Pia Turcinov AM

Board Chair
East Metropolitan Health Service
8 September 2025

Melissa Grove

Chair, EMHS Board Audit
and Risk Committee
East Metropolitan Health Service
8 September 2025

Neil Cowan

Chief Finance Officer
East Metropolitan Health Service
8 September 2025

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

Report on the audit of controls

Opinion

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

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

Other Matter

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

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

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

My opinion is not modified in respect of this matter.

The Board's responsibilities

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

Auditor General's responsibilities

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

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

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

Limitations of controls

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

Report on the audit of the key performance indicators

Opinion

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

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

The Board's responsibilities for the key performance indicators

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

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

Auditor General's responsibilities

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

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

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

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

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

Other information

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

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

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

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

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

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



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

East Metropolitan Health Service
Statement of comprehensive income
For the year ended 30 June 2025

	Note	2025 \$000	2024 \$000
Cost of services			
Expenses			
Employee benefits expense	3.1.1	1,375,658	1,223,878
Contracts for services	3.2	420,078	360,732
Patient support costs	3.3	317,888	290,610
Fees for contracted medical practitioners	3.4	34,995	33,905
Finance costs	7.2	738	636
Depreciation and amortisation expense	5.5	61,430	56,882
Repairs, maintenance and consumable equipment	3.5	43,096	37,172
Other supplies and services	3.6	16,003	13,435
Cost of sales	4.6	4,691	4,359
Other expenses	3.7	149,196	144,146
Total cost of services		2,423,773	2,165,755
Income			
Patient charges	4.3	66,215	57,321
Other fees for services	4.4	543	1,827
Commonwealth grants and contributions	4.2	15,600	-
Other grants and contributions	4.2	2,667	1,098
Donation income	4.5	567	330
Sale of goods	4.6	4,205	4,149
Other income and recoveries	4.7	60,854	57,417
Total income other than income from State Government		150,651	122,142
Net cost of services		2,273,122	2,043,613
Income from State Government			
Department of Health - Service Agreement:			
- State component	4.1	1,198,728	1,050,930
- Commonwealth component	4.1	601,711	568,483
Mental Health Commission - Service Agreement	4.1	295,968	265,460
Income from other state government agencies	4.1	49,010	53,030
Resources received	4.1	93,971	85,104
Total income from State Government		2,239,388	2,023,007
Deficit for the period		(33,734)	(20,606)
Other comprehensive income			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.9	323,588	72,322
Total other comprehensive income		323,588	72,322
Total comprehensive income for the period		289,854	51,716

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 2025

	Note	2025 \$'000	2024 \$'000
Assets			
Current assets			
Cash and cash equivalents	7.3.1	96,527	91,502
Restricted cash and cash equivalents	7.3.1	50,468	43,792
Receivables	6.1	49,337	46,108
Inventories	6.3	7,184	6,312
Other current assets	6.4	1,750	1,077
Total current assets		205,266	188,791
Non-current assets			
Receivables	6.1	42,732	34,382
Amounts receivable for services	6.2	781,637	722,253
Property, plant and equipment	5.1	1,027,472	751,876
Intangible assets	5.2	79	83
Right-of-use assets	5.3	14,523	14,895
Service concession assets	5.4	405,056	353,847
Total non-current assets		2,271,499	1,877,336
Total assets		2,476,765	2,066,127
Liabilities			
Current liabilities			
Payables	6.5	157,251	133,868
Grant liabilities	6.6	955	955
Lease liabilities	7.1	4,641	3,885
Employee benefits provisions	3.1.2	287,567	241,398
Other current liabilities	6.7	1,271	1,027
Total current liabilities		451,685	381,133
Non-current liabilities			
Employee benefits provisions	3.1.2	45,564	42,276
Lease liabilities	7.1	12,805	12,826
Total non-current liabilities		58,369	55,102
Total liabilities		510,054	436,235
Net assets		1,966,711	1,629,892
Equity			
Contributed equity	9.9	1,359,712	1,312,747
Reserves	9.9	640,739	317,151
Accumulated deficit		(33,740)	(6)
Total equity		1,966,711	1,629,892

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 2025

	Note	2025 \$000	2024 \$000
Contributed equity	9.9		
Balance at start of period		1,312,747	1,276,487
Transactions with owners in their capacity as owners:			
Contribution by Owners – Capital appropriations administered by Department of Health		35,453	36,260
Other contributions by owners		11,512	-
Balance at end of period		1,359,712	1,312,747
Reserves	9.9		
Asset revaluation reserve			
Balance at start of period		317,151	244,829
Other comprehensive income for the period		323,588	72,322
Balance at end of period		640,739	317,151
Accumulated surplus			
Balance at start of period		(6)	20,600
Deficit for the period		(33,734)	(20,606)
Balance at end of period		(33,740)	(6)
Total equity			
Balance at start of period		1,629,892	1,541,916
Total comprehensive income for the period		289,854	51,716
Transactions with owners in their capacity as owners		46,965	36,260
Balance at end of period		1,966,711	1,629,892

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 2025

	Note	2025 \$000 Inflows/(Outflows)	2024 \$000 Inflows/(Outflows)
Cash flows from State Government			
Contribution by Owners – Capital Appropriations administered by Department of Health		36,112	36,260
Service agreement - Department of Health		1,741,055	1,564,977
Service agreement - Mental Health Commission		295,968	265,460
Funds received from other state government agencies		49,010	53,030
Net cash provided by State Government		2,122,145	1,919,727
Utilised as follows:			
Cash flows from operating activities			
Payments			
Employee benefits		(1,318,273)	(1,202,736)
Supplies and services		(871,651)	(777,631)
Finance costs		(738)	(636)
Receipts			
Receipts from customers		76,917	43,783
Other grants and contributions		2,667	1,098
Donations received		95	46
Other receipts		59,961	51,034
Net cash used in operating activities	7.3.2	(2,051,021)	(1,885,042)
Cash flows from investing activities			
Payments			
Purchase of non-current assets		(48,787)	(37,087)
Receipts			
Proceeds from sale of non-current assets		(41)	20
Net cash used in investing activities		(48,828)	(37,067)
Cash flows from financing activities			
Payments			
Principal elements of lease payments		(2,752)	(2,427)
Payment to accrued salaries account		(7,843)	(7,637)
Net cash used in financing activities		(10,595)	(10,064)
Net increase/(decrease) in cash and cash equivalents		11,701	(12,446)
Cash and cash equivalents at the beginning of the period		135,294	147,740
Total cash and cash equivalents at the end of the period	7.3.1	146,995	135,294

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

Note	1	Basis of preparation
		East Metropolitan Health Service (the Health Service) is a Government not-for-profit entity controlled by the State of Western Australia, which is the ultimate parent. A description of the nature of its operations and its principal activities 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 8 September 2025. Statement of compliance The financial statements constitute general purpose financial statements that have been prepared in accordance with Australian Accounting Standards (AASs), the Financial Management Act 2006 (FMA), the Treasurer's Instructions (TIs) and other authoritative pronouncements of the Australian Accounting Standards Board (AASB) as applied by TIs. Several of these are modified by TIs to vary application, disclosure, format and wording. The FMA and TIs take precedence over AASs and other authoritative pronouncements of the AASB. Where modification is required and has a material or significant financial effect upon the reported results, details of that modification and the resulting financial effect are disclosed in the notes to the financial statements. Basis of preparation These financial statements are presented in Australian dollars applying the accrual basis of accounting and using the historical cost convention. Certain balances will apply a different measurement basis (such as the fair value basis). Where this is the case the different measurement basis is disclosed in the associated note. All values are rounded to the nearest thousand dollars (\$'000). Judgements and estimates Judgements, estimates and assumptions are required to be made about financial information being presented. The significant judgements and estimates made in the preparation of these financial statements are disclosed in the notes where amounts affected by those judgements and/or estimates are disclosed. Estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances.

East Metropolitan Health Service
Notes to the financial statements
As at 30 June 2025

Note	1	Basis of preparation (continued)
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Contributed equity

AASB Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities* requires transfers in the nature of equity contributions, other than as a result of a restructure of administrative arrangements, to be designated as contributions by owners (at the time of, or prior to, transfer) before such transfers can be recognised as equity contributions. Capital appropriations have been designated as contributions by owners by *TI 8.8 Contributions by Owners made to Wholly Owned Public Sector Entities* and will be credited directly to Contributed Equity.

Note	2	Health Service outputs
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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
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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'.

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 2025

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
	2025 \$000	2025 \$000	2025 \$000	2025 \$000	2025 \$000	2025 \$000	2025 \$000
Cost of services							
Expenses							
Employee benefits expense	819,757	156,345	163,169	197,942	12,593	25,852	1,375,658
Contracts for services	262,835	83,232	35,284	37,782	782	163	420,078
Patient support costs	216,362	32,502	42,660	13,685	2,717	9,962	317,888
Fees for contracted medical practitioners	28,255	1,309	5,282	149	(0)	-	34,995
Finance costs	15	2	9	680	14	18	738
Depreciation and amortisation expense	35,922	6,544	7,421	10,178	418	947	61,430
Repairs, maintenance and consumable equipment	27,694	3,419	6,504	4,631	296	552	43,096
Other supplies and services	5,594	1,786	2,592	5,684	48	299	16,003
Cost of sales	-	-	3,263	1,428	-	-	4,691
Other expenses	93,817	17,396	17,416	17,964	816	1,787	149,196
Total cost of services	1,490,251	302,535	283,600	290,123	17,684	39,580	2,423,773
Income							
Patient charges	54,294	3,999	7,122	800	-	-	66,215
Other fees for services	38	19	53	2	-	431	543
Commonwealth grants and contributions	15,600	-	-	-	-	-	15,600
Other grants and contributions	4	1	1	-	-	2,661	2,667
Donation income	311	53	64	73	-	66	567
Sale of goods	-	-	2,925	1,280	-	-	4,205
Other income and recoveries	35,205	746	14,911	1,328	6	8,658	60,854
Total income other than income from State Government	105,452	4,818	25,076	3,483	6	11,816	150,651
Net cost of services	1,384,799	297,717	258,524	286,640	17,678	27,764	2,273,122
Income from State Government							
Department of Health - Service Agreement:							
- State component	828,078	178,028	154,591	10,858	10,570	16,603	1,198,728
- Commonwealth component	419,458	90,180	78,308	-	5,355	8,410	601,711
Mental Health Commission - Service Agreement	3,924	237	7,375	282,757	5	1,670	295,968
Income from other state government agencies	42,392	3,644	2,374	-	71	529	49,010
Resources received	67,019	12,120	12,543	2,276	12	1	93,971
Total income from State Government	1,360,871	284,209	255,191	295,891	16,013	27,213	2,239,388
Surplus/(deficit) for the period	(23,928)	(13,508)	(3,333)	9,251	(1,665)	(551)	(33,734)

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2025

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
	2024 \$000	2024 \$000	2024 \$000	2024 \$000	2024 \$000	2024 \$000	2024 \$000
Cost of services							
Expenses							
Employee benefits expense	728,221	142,789	134,517	185,060	11,169	22,122	1,223,878
Contracts for services	225,588	71,483	30,261	32,542	725	133	360,732
Patient support costs	199,669	28,441	39,774	13,248	2,475	7,003	290,610
Fees for contracted medical practitioners	27,794	1,046	4,944	121	-	-	33,905
Finance costs	8	1	3	599	7	18	636
Depreciation and amortisation expense	33,289	6,136	6,592	9,610	381	874	56,882
Repairs, maintenance and consumable equipment	23,924	2,658	5,271	4,666	261	392	37,172
Other supplies and services	5,358	990	2,054	4,678	62	293	13,435
Cost of sales	-	-	3,032	1,327	-	-	4,359
Other expenses	90,889	17,081	16,671	16,637	786	2,082	144,146
Total cost of services	1,334,740	270,625	243,119	268,488	15,866	32,917	2,165,755
Income							
Patient charges	46,044	3,858	6,624	795	-	-	57,321
Other fees for services	572	151	126	173	5	800	1,827
Other grants and contributions	139	-	25	-	-	934	1,098
Donation income	172	29	49	35	-	45	330
Sale of goods	-	-	2,886	1,263	-	-	4,149
Other income and recoveries	33,209	1,125	14,301	1,234	11	7,537	57,417
Total income other than income from State Government	80,136	5,163	24,011	3,500	16	9,316	122,142
Net cost of services	1,254,604	265,462	219,108	264,988	15,850	23,601	2,043,613
Income from State Government							
Department of Health - Service Agreement:							
- State component	734,103	155,329	128,204	10,209	9,275	13,810	1,050,930
- Commonwealth component	400,997	84,847	70,030	-	5,066	7,543	568,483
Mental Health Commission - Service Agreement	-	-	-	265,460	-	-	265,460
Income from other state government agencies	48,498	1,882	1,990	-	57	603	53,030
Resources received	60,567	10,957	11,338	2,078	11	153	85,104
Total income from State Government	1,244,165	253,015	211,562	277,747	14,409	22,109	2,023,007
Surplus/(deficit) for the period	(10,439)	(12,447)	(7,546)	12,759	(1,441)	(1,492)	(20,606)

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2025

		2025	2024
		\$000	\$000
Note	3	Use of our funding	
		Expenses incurred in the delivery of services	
		This section provides additional information about how the Health Service's funding is applied and the accounting policies that are relevant for an understanding of the items recognised in the financial statements. The primary expenses incurred by the Health Service in achieving its objectives and the relevant notes are:	
			Note
		Employee benefits expense	3.1.1
		Employee benefits provisions	3.1.2
		Contracts for services	3.2
		Patient support costs	3.3
		Fees for contracted medical practitioners (CMP)	3.4
		Repairs, maintenance and consumable equipment	3.5
		Other supplies and services	3.6
		Other expenses	3.7
	3.1.1	Employee benefits expense	
		Employee benefits	1,242,827
		Termination benefits	867
		Superannuation - defined contribution plans (a)	131,929
		Total employee benefits expense	1,375,623
		Add: AASB 16 Non-monetary benefits (b)	35
		Net employee benefits	1,375,658
			1,108,033
			631
			115,193
			1,223,857
			21
			1,223,878
		(a) Defined contribution plans include West State Superannuation Scheme (WSS), Gold State Superannuation Scheme (GSS), the Government Employees Superannuation Board Schemes (GESBs) and other eligible funds.	
		(b) Non-monetary employee benefits that are predominantly relating to the provision of vehicle benefits recognised under AASB 16.	
		Employee benefits include salaries and wages, fringe benefits plus the fringe benefits tax component and leave entitlements including superannuation contribution components.	
		Workers' compensation insurance expense is excluded here but included in note 3.7 'Other expenses'.	
		Termination benefits are payable when employment is terminated before normal retirement date, or when an employee accepts an offer of benefits in exchange for the termination of employment. Termination benefits are recognised when the Health Service is demonstrably committed to terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy. Benefits falling due more than 12 months after the end of the reporting period are discounted to present value.	

	2025 \$000	2024 \$000
3.1.1 Employee benefits expense (continued)		
Superannuation is the amount recognised in profit or loss of the statement of comprehensive income comprises employer contributions paid to the GSS (concurrent contributions), the WSS, other GESB schemes or other superannuation funds. The employer contribution paid to the Government Employees Superannuation Board (GESB) in respect of the GSS is paid back into the Consolidated Account by the GESB. GSS (concurrent contributions) is a defined benefit scheme for the purposes of employees and whole of government reporting. It is however a defined contribution plan for Health Service purposes because the concurrent contributions (defined contributions) made by the Health Service to the GESB extinguishes the Health Service's obligations to the related superannuation liability. The Health Service does not recognise any defined benefit liabilities because it has no legal or constructive obligation to pay future benefits relating to its employees. The liabilities for the unfunded Pension Scheme and the unfunded GSS transfer benefits attributable to members who transferred from the Pension Scheme, are assumed by the Treasurer. All other GSS obligations are funded by concurrent contributions made by the Health Service to the GESB. The GESB and other fund providers administer public sector superannuation arrangements in Western Australia in accordance with legislative requirements. Eligibility criteria for membership in particular schemes for public sector employees vary according to commencement and implementation dates.		
3.1.2 Employee benefits provisions		
Provision is made for benefits accruing to employees in respect of salaries and wages, annual leave, time off in lieu and long service leave for services rendered up to the reporting date and recorded as an expense during the period the services are delivered.		
Current		
Annual leave (a)	136,038	120,232
Time off in lieu leave (a)	40,812	37,131
Long service leave (b)	109,760	83,429
Deferred salary scheme (c)	957	606
	<u>287,567</u>	<u>241,398</u>
Non-current		
Long service leave (b)	<u>45,564</u>	<u>42,276</u>
Total employee benefits provisions	<u>333,131</u>	<u>283,674</u>

	2025	2024
	\$000	\$000
3.1.2 Employee benefits provisions (continued)		

(a) Annual leave and time off in lieu leave liabilities are classified as current as there is no right at the end of the reporting period to defer settlement for at least 12 months after the reporting period.

Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

Within 12 months of the end of the reporting period	100,438	94,227
More than 12 months after the end of the reporting period	76,412	63,136
	<u>176,850</u>	<u>157,363</u>

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 unconditional long service leave provisions and classified as current where there is no right at the end of reporting period to defer settlement for at least 12 months after the reporting period. Pre-conditional and conditional long service leave provisions are classified as non-current liabilities because the Health Service has the right to defer the settlement of the liability until the employee has completed the requisite years of service.

Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

Within 12 months of the end of the reporting period	37,536	36,683
More than 12 months after the end of the reporting period	117,788	89,022
	<u>155,324</u>	<u>125,705</u>

The provision for long service leave is calculated at present value as the Health Service does not expect to wholly settle the amounts within 12 months. The present value is measured taking into account the present value of expected future payments to be made in relation to services provided by employees up to the reporting date. When assessing expected future payments, consideration is given to expected future wage and salary levels including non-salary components such as employer superannuation contributions, as well as the experience of employee departures and periods of service. The expected future payments are discounted using market yields on national government bonds at the end of the reporting period with terms to maturity that match, as closely as possible, the estimated future cash outflows.

Under the advice of Government Sector Labour Relations (GSLR), casual employees of the Health Service are entitled to long service leave even if the applicable awards provide casual loading in lieu of long service leave. The provision for casual employees who are currently employed by the Health Service has been included in the long service leave balance: \$13.8 million. The amount of obligation for the casual employees who are no longer employed by the Health Service has been included in the Payables (note 6.5): \$2.2 million.

	2025	2024
	\$000	\$000
3.1.2 Employee benefits provisions (continued)		

(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.

Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

Within 12 months of the end of the reporting period	273	270
More than 12 months after the end of the reporting period	684	336
	<u>957</u>	<u>606</u>

Key sources of estimation uncertainty - long service leave

Key estimates and assumptions concerning the future are based on historical experience and various other factors that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year. Several estimates and assumptions are used in calculating the Health Service's long service leave provision. These include expected future salary rates, discount rates, employee turnover rates and usage rates of leave in service or at termination. Changes in these estimations and assumptions may impact on the carrying amount of the long service leave provision.

Any gain or loss following revaluation of the present value of long service leave liabilities is recognised as employee benefits expense.

Sick Leave

Liabilities for sick leave are recognised when it is probable that sick leave paid in the future will be greater than the entitlement that will accrue in the future. Past history indicates that on average, sick leave taken each reporting period is less than the entitlement accrued. This is expected to continue in future periods. Accordingly, it is unlikely that existing accumulated entitlements will be used by employees and no liability for unused sick leave entitlements is recognised. As sick leave is non-vesting, an expense is recognised in the statement of comprehensive income for this leave as it is taken.

3.2 Contracts for services		
Public patient services (a)	378,497	322,713
Mental health services (a)	36,321	32,694
Home and community care (a)	783	735
Other contracts	4,477	4,590
Total contracts for services	<u>420,078</u>	<u>360,732</u>

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2025

	2025 \$000	2024 \$000
3.3 Patient support costs		
Drug supplies	78,972	71,584
Pathology	58,508	54,721
Prosthesis	33,672	30,972
Other medical supplies and services	98,530	88,279
Domestic charges	21,060	20,431
Fuel, light and power	9,570	8,906
Food supplies	10,219	9,718
Patient transport costs	6,528	5,521
Research, development and other grants	829	478
Total patient support costs	317,888	290,610
3.4 Fees for contracted medical practitioners (CMP)		
Fees for contracted medical practitioners (CMP)		
Clinical	26,250	26,559
Radiology	8,745	7,346
Total fees for contracted medical practitioners	34,995	33,905
CMP, both general practitioners and specialists, are contracted to provide medical services to a hospital via a Medical Services Agreement. CMP are independent contractors operating medical businesses and are not Health Service employees. CMP were previously known as visiting medical practitioners (VMP).		
3.5 Repairs, maintenance and consumable equipment		
Repairs, maintenance and consumable equipment		
Repairs and maintenance	31,140	28,555
Consumable equipment	11,956	8,617
Total repairs, maintenance and consumable equipment	43,096	37,172
Repairs and maintenance costs are recognised as expenses as incurred, except where they relate to the replacement of a significant component of an asset. In that case the costs are capitalised and depreciated. Consumable equipment costing less than \$5,000 is recognised as an expense (see note 5.1 'Property, plant and equipment').		
3.6 Other supplies and services		
Other supplies and services (recognised as an expense as incurred)		
Sanitisation and waste removal services	2,524	2,188
Administration and management services	3,766	2,443
Interpreter services	2,011	1,923
Security services	6,888	5,500
Outsourced health promotion	189	149
Outsourced engineering	177	185
Employee assistance	215	231
Other	233	816
Total other supplies and services	16,003	13,435

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2025

	2025	2024
	\$000	\$000
3.7 Other expenses		
Other expenses		
Services provided by Health Support Services: (a)		
ICT services	48,705	43,687
Supply chain services	8,357	8,069
Financial services	2,940	2,832
Human resources services	11,532	10,281
Workers compensation insurance	31,599	29,237
Lease expenses (b)	1,119	1,269
Other insurances	19,159	19,077
Legal services	299	991
Audit fees	1,321	1,163
Consultancy fees	5,229	4,747
Printing and stationery	3,886	3,841
Library subscription	1,616	1,656
Expected credit losses expense (c)	929	5,708
Communications	1,966	1,965
Freight, cartage and manual handling fees	919	781
Other employee related expenses	2,995	2,659
Loss on disposal of non-current assets	198	23
Motor vehicle expenses	653	647
Computer services	2,856	3,328
Accommodation (d)	435	444
Other	2,483	1,741
Total other expenses	149,196	144,146

(a) Services received free of charge. (See note 4.1 'Income from State Government').

(b) See note 5.3 'Right-of-use assets' and 7.1 'Lease liabilities'. Included within lease expenses are short-term leases with lease terms of up to 12 months and low-value leases with identified assets of up to \$5,000. 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) Lease payments to the Department of Finance for the Government Office Accommodation.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2025

		2025	2024
		\$000	\$000
Note	4	Our funding sources	

How we obtain our funding

This section provides additional information about how the Health Service obtains its funding and the relevant accounting policy notes that govern the recognition and measurement of this funding. The primary income received by the Health Service and the relevant notes are:

	Note
Income from State Government	4.1
Commonwealth and other grants and contributions	4.2
Patient charges	4.3
Other fees for services	4.4
Donation income	4.5
Commercial activities	4.6
Other income and recoveries	4.7

4.1 Income from State Government

Service Agreement received (a):			
Department of Health - Service Agreement - State component (b)	1,198,728	1,050,930	
Department of Health - Service Agreement - Commonwealth component	601,711	568,483	
Total service agreement received from Department of Health	1,800,439	1,619,413	
Mental Health Commission - Service Agreement	295,968	265,460	
Income from other state government agencies (c):			
Insurance Commission of Western Australia - patient fees (motor vehicle injuries)	32,301	41,013	
Insurance Commission of Western Australia - non patient (other recoveries)	3,069	-	
Road Safety Commission - Road Trauma Program (Injury Prevention)	577	688	
South Metropolitan Health Service - Health Technology Management Services	8,365	6,480	
South Metropolitan Health Service - Business Intelligence Services	2,795	2,359	
Child and Adolescent Health Service - Data Services	-	382	
North Metropolitan Health Service - Data Services	-	49	
Other Health Service Providers	1,903	2,060	
Total income from other state government agencies	49,010	53,030	

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2025

	2025 \$000	2024 \$000
4.1 Income from State Government (continued)		
Resources received from other state government agencies during the year (d):		
Services received free of charge:		
Health Support Services - shared services		
ICT services	48,705	43,687
Supply chain services	8,357	8,069
Financial services	2,940	2,832
Human resources services	11,532	10,281
Rapid Antigen Test Kits	-	152
PathWest - indirect costs	21,855	19,625
Department of Justice - legal services	200	434
Department of Finance - rental lease management	13	14
Assets transferred in (out):	369	10
Total resources received	93,971	85,104
Total income from State Government	2,239,388	2,023,007

- (a) Service agreement income is recognised at fair value in the period in which the Health Service gains control of the funds. The Health Service gains control of the funds at the time those funds are deposited in the bank account. If the service agreement specifies specific performance obligation(s), the income is recognised when the Health Service has satisfied its performance obligation(s).
- (b) Service agreement from Department of Health comprises a cash component and a receivable (asset) component. The receivable which is the Holding Account (see note 6.2 'Amounts receivable for services (Holding Account)') comprises the budgeted depreciation expense for the year and any agreed increase in leave liabilities.
- (c) Income from other state government agencies include amounts paid by other government agencies on a charge out basis (fee for service model).
- (d) Resources received from other state government agencies are recognised as income (and assets or expenses) equivalent to the fair value of the assets, or the fair value of those services that can be reliably determined and which would have been purchased if not donated.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2025

	2025 \$000	2024 \$000
4.2 Commonwealth and other grants and contributions		
Capital grants	15,600	-
Total commonwealth grants and contributions	15,600	-
Research and other grants	2,667	1,098
Total other grants and contributions	2,667	1,098
4.3 Patient charges		
Inpatient bed charges	50,058	42,219
Inpatient other charges	5,036	4,620
Outpatient charges	11,121	10,482
Total patient charges	66,215	57,321
4.4 Other fees for services		
Non-clinical services to other health organisations	543	1,827
Total other fees for services	543	1,827
4.5 Donation income		
General public donations	567	330
Total donations	567	330
4.6 Commercial Activities - Sale of Goods		
Sales:		
Cafeteria sales income	4,205	4,149
Cost of sales	(4,691)	(4,359)
Gross loss	(486)	(210)

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2025

	2025	2024
	\$000	\$000
4.7 Other income and recoveries		
Abatements	35	199
Royalty income	-	871
Rent from commercial properties	905	847
Parking	331	313
Commissions	173	195
Sponsorship	640	430
Training and education	35	34
Clinical trial income	5,032	3,732
Medical reports and certificates	75	84
Pharmaceutical Benefits Scheme (PBS)	50,247	45,285
Reversal asset revaluation decrement - land	2,487	4,198
Other	894	1,229
Total other income and recoveries	60,854	57,417

Income recognition

Income is recognised at the transaction price when the Health Service transfers control of the services to customers. Income is recognised for the major activities as follows:

Sale of goods

Income is recognised at the transaction price when the Health Service transfers control of the goods to customers.

Provision of services

Income is recognised on delivery of the service to the customer.

Grants, donations, gifts and other non-reciprocal contributions

Income is recognised at fair value when the Health Service obtains control over the assets comprising the contributions, usually when cash is received. Other non-reciprocal contributions that are not contributions by owners are recognised at their fair value. Contributions of services are only recognised when a fair value can be reliably determined and the services would be purchased if not donated.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2025

		2025	2024
		\$000	\$000
Note	5	Key assets	

Assets the Health Service utilises for economic benefit or service potential.

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

	Note
Property, plant and equipment	5.1
Intangible assets	5.2
Right-of-use assets	5.3
Service concession assets (SCA)	5.4
Depreciation and amortisation expense	5.5

5.1 Property, plant and equipment

Land

Carrying amount	97,524	83,441
<u>Reconciliation:</u>		
Carrying amount at start of period	83,441	80,142
Additions	1,278	-
Transfers from/(to) other reporting entities	4,760	-
Revaluation increments/(decrements)	8,045	3,299
Carrying amount at end of period	<u>97,524</u>	<u>83,441</u>

Buildings

Carrying amount	802,670	551,088
<u>Reconciliation:</u>		
Carrying amount at start of period	551,088	525,565
Additions	2,480	2,077
Transfers from/(to) other reporting entities	4,857	-
Transfers from works in progress	20,159	3,399
Revaluation increments/(decrements) (b)	256,786	49,953
Write-down of assets	-	(28)
Depreciation	<u>(32,700)</u>	<u>(29,878)</u>
Carrying amount at end of period	<u>802,670</u>	<u>551,088</u>

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2025

	2025 \$000	2024 \$000
5.1 Property, plant and equipment (continued)		
Site infrastructure		
Gross carrying amount	27,459	27,459
Accumulated depreciation	(13,825)	(12,289)
Carrying amount	13,634	15,170
<u>Reconciliation:</u>		
Gross carrying amount at start of period	27,459	27,459
Accumulated depreciation	(12,289)	(10,753)
Carrying amount at start of period	15,170	16,706
Depreciation	(1,536)	(1,536)
Carrying amount at end of period	13,634	15,170
Leasehold improvements		
Gross carrying amount	3,762	3,308
Accumulated depreciation	(2,891)	(2,542)
Carrying amount	871	766
<u>Reconciliation:</u>		
Gross carrying amount at start of period	3,308	3,227
Accumulated depreciation	(2,542)	(2,196)
Carrying amount at start of period	766	1,031
Additions	454	81
Depreciation	(349)	(346)
Carrying amount at end of period	871	766
Computer equipment		
Gross carrying amount	12,010	7,673
Accumulated depreciation	(5,818)	(3,976)
Carrying amount	6,192	3,697
<u>Reconciliation:</u>		
Gross carrying amount at start of period	7,673	6,748
Accumulated depreciation	(3,976)	(2,675)
Carrying amount at start of period	3,697	4,073
Additions	4,061	733
Transfers from works in progress	341	158
Transfers between asset classes	(40)	34
Depreciation	(1,867)	(1,301)
Carrying amount at end of period	6,192	3,697

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2025

	2025	2024
	\$000	\$000
5.1 Property, plant and equipment (continued)		
Furniture and fittings		
Gross carrying amount	1,932	1,913
Accumulated depreciation	(1,424)	(1,386)
Carrying amount	508	527
<u>Reconciliation:</u>		
Gross carrying amount at start of period	1,913	2,089
Accumulated depreciation	(1,386)	(1,386)
Carrying amount at start of period	527	703
Additions	169	319
Disposals	(15)	(18)
Transfers between asset classes	(52)	(360)
Write-off of assets	(12)	-
Depreciation	(109)	(117)
Carrying amount at end of period	508	527
Motor vehicles		
Gross carrying amount	688	375
Accumulated depreciation	(462)	(113)
Carrying amount	226	262
<u>Reconciliation:</u>		
Gross carrying amount at start of period	375	375
Accumulated depreciation	(113)	(75)
Carrying amount at start of period	262	300
Transfers between asset classes	18	-
Depreciation	(54)	(38)
Carrying amount at end of period	226	262

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2025

	2025 \$000	2024 \$000
5.1 Property, plant and equipment (continued)		
Medical equipment		
Gross carrying amount	104,899	96,346
Accumulated depreciation	(57,695)	(52,003)
Carrying amount	47,204	44,343
<u>Reconciliation:</u>		
Gross carrying amount at start of period	96,346	84,719
Accumulated depreciation	(52,003)	(45,495)
Carrying amount at start of period	44,343	39,224
Additions	10,571	13,160
Transfers from/(to) other reporting entities	1,143	10
Transfers from works in progress	141	202
Disposals	(118)	(25)
Transfers between asset classes	276	373
Write-down of assets (a)	(64)	-
Write-off of assets	(22)	-
Depreciation	(9,066)	(8,601)
Carrying amount at end of period	47,204	44,343
Other plant and equipment		
Gross carrying amount	28,009	22,627
Accumulated depreciation	(9,992)	(8,581)
Carrying amount	18,017	14,046
<u>Reconciliation:</u>		
Gross carrying amount at start of period	22,627	19,846
Accumulated depreciation	(8,581)	(6,727)
Carrying amount at start of period	14,046	13,119
Additions	2,709	1,689
Transfers from/(to) other reporting entities	82	-
Transfers from works in progress	3,283	1,160
Disposals	(5)	-
Transfers between asset classes	(202)	(31)
Write-off of assets	(5)	-
Depreciation	(1,891)	(1,891)
Carrying amount at end of period	18,017	14,046

East Metropolitan Health Service
Notes to the financial statements
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	2025 \$000	2024 \$000
5.1 Property, plant and equipment (continued)		
Artworks		
Carrying amount	1,096	1,080
<u>Reconciliation:</u>		
Carrying amount at start of period	1,080	1,080
Additions	16	-
Carrying amount at end of period	1,096	1,080
 Works in progress		
Carrying amount	39,530	37,456
<u>Reconciliation:</u>		
Carrying amount at start of period	37,456	23,852
Additions	28,119	19,227
Capitalised to asset classes	(23,925)	(4,920)
Write-down of assets (a)	(2,120)	(703)
Carrying amount at end of period	39,530	37,456
 Total property, plant and equipment		
Gross carrying amount	1,119,579	832,766
Accumulated depreciation	(92,107)	(80,890)
Carrying amount	1,027,472	751,876
<u>Reconciliation:</u>		
Gross carrying amount at start of period	832,766	775,102
Accumulated depreciation	(80,890)	(69,307)
Carrying amount at start of period	751,876	705,795
Additions	49,857	37,286
Transfers from/(to) other reporting entities	10,842	10
Disposals	(138)	(43)
Revaluation increments/(decrements) (b)	264,830	53,251
Transfers between asset classes	-	16
Write-down of assets (a)	(2,184)	(731)
Write-off of assets	(39)	-
Depreciation	(47,572)	(43,708)
Carrying amount at end of period	1,027,472	751,876

(a) Expenses capitalised in the previous financial year, expensed in the current financial year. See note 3.7 'Other expenses'.

5.1 Property, plant and equipment (continued)

(b) Of this amount, \$100 million relates to professional and project management fees, which are now included in the value of current use building assets under the current replacement cost basis as required by the prospective application of AASB 2022-10 Amendments to Australian Accounting Standards - Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities.

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 is carried at fair value and buildings are carried at fair value less accumulated depreciation (buildings) and accumulated impairment losses. All other items of property, plant and equipment are carried at historical cost less accumulated depreciation and accumulated impairment losses.

Where market-based evidence is available, the fair value of land and buildings (non-clinical sites) is determined on the basis of current market values by reference to recent market transactions.

In the absence of market-based evidence, fair value of land and buildings (clinical sites) is determined on the basis of existing use. This normally applies where buildings are specialised or where land use is restricted. Fair value for existing use buildings is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset, i.e. the current replacement cost. Fair value for restricted use land is determined by comparison with market evidence for land with similar approximate utility (high restricted use land) or market value of comparable unrestricted land (low restricted use land).

When buildings are revalued, the accumulated depreciation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount.

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

In addition, for buildings under the current replacement cost basis, estimated professional and project management fees are included in the valuation of current use assets as required by AASB 2022-10 Amendments to Australian Accounting Standards - Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities. These valuations are undertaken annually to ensure that the carrying amount of the assets does not differ materially from their fair value at the end of the reporting period.

5.1 Property, plant and equipment (continued)

Land and buildings were revalued as at 1 July 2024 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2025 and recognised at 30 June 2025. In undertaking the revaluation, fair value was determined by reference to market values for land: \$5.5 million (2024: \$22.0 million) and buildings: \$0.2 million (2024: \$2.1 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.

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.

	2025	2024
	\$000	\$000
5.1 Property, plant and equipment (continued)		

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

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

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 2025 there were no indications of impairment to property, plant and equipment and intangible assets.

5.2 Intangible assets		
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Computer software

Gross carrying amount	469	443
Accumulated amortisation	(390)	(360)
Carrying amount	79	83
Reconciliation:		
Gross carrying amount at start of the period	443	443
Accumulated amortisation	(360)	(334)
Carrying amount at start of the period	83	109
Additions	20	-
Amortisation	(24)	(26)
Carrying amount at end of the period	79	83

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.

East Metropolitan Health Service
Notes to the financial statements
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5.2 Intangible assets (continued)		
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.		
	2025 \$000	2024 \$000
5.3 Right-of-use assets		
Buildings		
Gross carrying amount	20,377	18,690
Accumulated depreciation	(7,877)	(4,839)
Carrying amount	12,500	13,851
<u>Reconciliation:</u>		
Opening net carrying amount	13,851	16,682
Additions	1,969	395
Depreciation	(3,320)	(3,226)
Carrying amount at end of the period	12,500	13,851
Vehicles		
Gross carrying amount	2,666	2,048
Accumulated depreciation	(643)	(1,004)
Carrying amount	2,023	1,044
<u>Reconciliation:</u>		
Opening net carrying amount	1,044	925
Additions	1,570	592
Disposals (leases expired)	(49)	(12)
Depreciation	(542)	(461)
Carrying amount at end of the period	2,023	1,044

	2025 \$000	2024 \$000
5.3 Right-of-use assets (continued)		
Total Right-of-use assets		
Gross carrying amount	23,043	20,738
Accumulated depreciation	(8,520)	(5,843)
Carrying amount	14,523	14,895
<u>Reconciliation:</u>		
Opening carrying amount	14,895	17,607
Additions	3,539	987
Disposals (leases expired)	(49)	(12)
Depreciation	(3,862)	(3,687)
Carrying amount at end of the period	14,523	14,895

Initial Recognition

Right-of-use assets are measured at cost which include the following:

- the net present value of the future minimum payments
- any lease payments made at or before the commencement date less any lease incentives received
- any initial direct costs, and
- restoration costs, including dismantling and removing the underlying asset (make good provision)

The Health Service has elected not to recognise right-of-use assets and lease liabilities for short-term leases (with a lease term of 12 months or less) and low value leases (with an underlying value of \$5,000 or less). Lease payments associated with these leases are expensed as incurred.

Subsequent Measurement

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

Depreciation and impairment of right-of-use assets

Right-of-use assets are depreciated on a straight-line basis over the lease term as the Health Service generally expect to fully consume the useful life of the assets over the lease term. The lease term includes option to extend the lease if it is stated in the contract and the Health Service is reasonably certain to exercise the option.

Right-of-use assets are tested for impairment when an indication of impairment is identified.

	2025 \$000	2024 \$000
5.3 Right-of-use assets (continued)		
The following amounts relating to leases have been recognised in the statement of comprehensive income.		
Depreciation expense of right-of-use assets		
Buildings	3,320	3,226
Vehicles	542	461
Total right-of-use asset depreciation	3,862	3,687
Lease interest expense (included in Finance cost)	738	636
Short-term leases (included in Other Expenses)	-	45
The statement of cash flows shows the following amounts relating to leases:		
Finance costs	738	636
Principal elements of lease payments	2,752	2,427

The Health Service has leases for vehicles and office accommodation (buildings).

The Health Service has secured the right-of-use assets against the related lease liabilities for the vehicles. In the event of default, the rights to the leased motor vehicles will revert to the lessor.

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

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

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

Key judgements have been made in determining whether there is reasonable certainty around exercising contract extension and termination options, identifying whether payments are variable or fixed in substance and determining the stand-alone selling prices for lease and non-lease components. In addition, uncertainty may arise from the estimation of the lease term, determination of the appropriate discount rate to discount the lease payments and assessing whether right-of-use assets may require impairment.

East Metropolitan Health Service
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	2025 \$000	2024 \$000
5.4 Service concession assets (SCA)		
Land SCA		
Carrying amount	14,500	12,000
<u>Reconciliation:</u>		
Carrying amount at start of period	12,000	11,100
Revaluation increments/(decrements)	2,500	900
Carrying amount at end of period	14,500	12,000
Buildings SCA		
Carrying amount	368,554	317,555
<u>Reconciliation:</u>		
Carrying amount at start of period	317,555	302,385
Revaluation increments/(decrements)	58,744	22,370
Depreciation	(7,745)	(7,200)
Carrying amount at end of period	368,554	317,555
Site infrastructure SCA		
Gross carrying amount	16,831	16,831
Accumulated depreciation	(2,195)	(1,829)
Carrying amount	14,636	15,002
<u>Reconciliation:</u>		
Gross carrying amount at start of period	16,831	16,831
Accumulated depreciation	(1,829)	(1,464)
Carrying amount at start of period	15,002	15,367
Depreciation	(366)	(365)
Carrying amount at end of period	14,636	15,002
Computer equipment SCA		
Gross carrying amount	207	211
Accumulated depreciation	(207)	(211)
Carrying amount	-	-
<u>Reconciliation:</u>		
Gross carrying amount at start of period	211	211
Accumulated depreciation	(211)	(211)
Carrying amount at end of period	-	-

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	2025	2024
	\$000	\$000
5.4 Service concession assets (SCA) (continued)		
Furniture and fittings SCA		
Gross carrying amount	776	776
Accumulated depreciation	(731)	(679)
Carrying amount	45	97
<u>Reconciliation:</u>		
Gross carrying amount at start of period	776	776
Accumulated depreciation	(679)	(628)
Carrying amount at start of period	97	148
Depreciation	(52)	(51)
Carrying amount at end of period	45	97
Medical equipment SCA		
Gross carrying amount	6,856	7,242
Accumulated depreciation	(5,908)	(5,638)
Carrying amount	948	1,604
<u>Reconciliation:</u>		
Gross carrying amount at start of period	7,242	7,288
Accumulated depreciation	(5,638)	(5,016)
Carrying amount at start of period	1,604	2,272
Disposals	(14)	-
Transfers between asset classes	-	(16)
Write-off of assets	(8)	-
Depreciation	(634)	(652)
Carrying amount at end of period	948	1,604
Other plant and equipment SCA		
Gross carrying amount	12,804	12,870
Accumulated depreciation	(7,431)	(6,281)
Carrying amount	5,373	6,589
<u>Reconciliation:</u>		
Gross carrying amount at start of period	12,870	12,904
Accumulated depreciation	(6,281)	(5,100)
Carrying amount at start of period	6,589	7,804
Disposals	(4)	-
Depreciation	(1,212)	(1,215)
Carrying amount at end of period	5,373	6,589

	2025 \$000	2024 \$000
5.4 Service concession assets (SCA) (continued)		
Artworks SCA		
Carrying amount	1,000	1,000
<u>Reconciliation:</u>		
Carrying amount at start of period	1,000	1,000
Carrying amount at end of period	1,000	1,000
Computer software SCA		
Gross carrying amount	1,068	1,068
Accumulated amortisation	(1,068)	(1,068)
Carrying amount	-	-
<u>Reconciliation:</u>		
Gross carrying amount at start of period	1,068	1,068
Accumulated amortisation	(1,068)	(1,068)
Carrying amount at end of period	-	-
Total service concession assets		
Gross carrying amount	422,596	369,553
Accumulated depreciation	(17,540)	(15,706)
Carrying amount	405,056	353,847
<u>Reconciliation:</u>		
Gross carrying amount at start of period	369,553	353,563
Accumulated depreciation	(15,706)	(13,487)
Carrying amount at start of period	353,847	340,076
Disposals	(18)	-
Revaluation increments/(decrements) (a)	61,244	23,270
Transfers between asset classes	-	(16)
Write-off of assets	(8)	
Depreciation	(10,009)	(9,483)
Carrying amount at end of period	405,056	353,847

(a) Of this amount, \$39 million relates to professional and project management fees, which are now included in the value of current use building assets under the current replacement cost basis as required by the prospective application of AASB 2022-10 Amendments to Australian Accounting Standards - Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities.

AASB 1059 'Service Concession Arrangements: Grantor' defines a service concession arrangement as an arrangement which involves an operator:

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2025

	2025 \$000	2024 \$000
5.4 Service concession assets (SCA) (continued) (continued)		
The Health Service manages a contract in relation to a 20-year public-private partnership agreement between St John of God Health Care and the State of Western Australia that was signed in 2012, to operate a hospital for public patients in Midland - St John of God Midland Public Hospital (SJOGMPH). Where the Health Service identified existing assets which meet the conditions as set under AASB 1059, these assets have been reclassified as service concession assets and measured initially at current replacement cost in accordance with the cost approach to fair value in AASB 13 Fair Value Measurement. Subsequent to initial recognition or reclassification, a service concession asset is depreciated or amortised in accordance with AASB 116 Property, Plant and Equipment with any impairment recognised in accordance with AASB 136.		

5.5 Depreciation and amortisation expense		
Depreciation and amortisation charge for the period:		
Buildings	32,700	29,878
Medical equipment	9,066	8,601
Site infrastructure	1,536	1,536
Leasehold improvements	349	346
Computer equipment	1,867	1,301
Furniture and fittings	109	117
Motor vehicles	54	38
Other plant and equipment	1,890	1,891
Right-of-use asset	3,827	3,666
Service concession asset	10,009	9,483
Total depreciation for the period	61,407	56,857
Total amortisation for the period - Computer software	23	25
Total depreciation and amortisation for the period	61,430	56,882
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.		

	2025	2024
	\$000	\$000
5.5 Depreciation and amortisation expense (continued)		

Estimated useful lives for each class of depreciable asset (including intangibles) are:

Buildings	50 years
Site infrastructure	50 years
Leasehold improvements	Term of the lease
Computer equipment	3 to 10 years
Furniture and fittings	2 to 20 years
Motor vehicles	3 to 10 years
Medical equipment	2 to 25 years
Other plant and equipment	3 to 50 years
Computer software	5 to 15 years

The estimated useful lives, residual values and depreciation or amortisation method are reviewed at the end of each annual reporting period, and adjustments should be made where appropriate.

Leasehold improvements are depreciated over the shorter of the lease term and their useful lives.

The Health Service's policy is to depreciate all items of property, plant and equipment on a straight-line basis. The exception to this are land and works of art, which are considered to have an indefinite life. Depreciation is not recognised in respect of these assets because their service potential has not, in any material sense, been consumed during the reporting period.

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

Note	6	Other assets and liabilities
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This section sets out the Health Service's other assets utilised for economic benefits and liabilities incurred during normal operations.

Assets	Note
Receivables	6.1
Amounts receivable for services (Holding Account)	6.2
Inventories	6.3
Other current assets	6.4
Liabilities	
Payables	6.5
Grant liabilities	6.6
Other current liabilities	6.7

East Metropolitan Health Service
Notes to the financial statements
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	2025 \$000	2024 \$000
6.1 Receivables		
Current		
Patient fee debtors (a)	24,139	28,848
Other receivables	6,991	3,400
Less: Allowance for impairment of receivables	(13,991)	(16,151)
Accrued income	25,507	24,568
GST receivable (b)	6,691	5,443
Total current	49,337	46,108
Non-current		
Accrued salaries suspense account (c)	42,732	34,382
Total receivables	92,069	80,490

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 \$1.19 million in ex-gratia payments for the 2024-25 period (2023-24: \$0.85 million). Receipt of ex-gratia payments from the Department have been applied by the Health Service against the patient fee invoices reducing the debtors balance.

Receivables are recognised at original invoice amount less any allowances for uncollectible amounts (i.e. impairment). The carrying amount is equivalent to fair value as it is due for settlement within 30 days.

(b) Accounting procedure for Goods and Services Tax
Rights to collect amounts receivable from the Australian Taxation Office (ATO) and responsibilities to make payments for Goods and Services Tax (GST) have been assigned to the Department of Health. This accounting procedure was a result of application of the grouping provisions of A New Tax System (Goods and Services Tax) Act 1999 whereby the Department of Health became the Nominated Group Representative (NGR) for the GST Group as from 1 July 2012. The entities in the GST group include the Department of Health, Mental Health Commission, South Metropolitan Health Service, North Metropolitan Health Service, East Metropolitan Health Service, Child and Adolescent Health Service, Health Support Services, WA Country Health Service, PathWest Laboratory Medicine WA, QE II Medical Centre Trust, and Health and Disability Services Complaints Office.

GST receivables on accrued expenses are recognised by the Health Service. Upon the receipt of tax invoices, GST receivables for the GST group are recorded in the accounts of the Department of Health.

(c) Accrued salaries suspense account contains amounts paid annually into the Treasurer’s special purpose account. It is restricted for meeting the additional cash outflow for employee salary payments in reporting periods with 27 pay days instead of the normal 26. No interest is received on this account. This account is classified as non-current for 10 out of the 11 years.

East Metropolitan Health Service
Notes to the financial statements
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	2025 \$000	2024 \$000
6.1.1 Movement of the allowance for impairment of receivables		
Balance at start of period	16,151	14,095
Expected credit losses (note 3.7 'Other expenses')	929	5,708
Amounts written off during the period	(2,407)	(2,856)
Amount recovered during the period	1	19
Debt waivers during the period (a)	(683)	(815)
Balance at end of period	13,991	16,151

(a) Debt waivers are discretionary in nature and under justifiable and reasonable circumstances, can be used by the Accountable Authority to permanently forgive a debt.

The maximum exposure to credit risk at the end of the reporting period for receivables is the carrying amount of the asset inclusive of any allowance for impairment as shown in the table at note 8.1 c) Credit risk exposure.

Key sources of estimation uncertainty - Provision for doubtful debt
Historical debt collection trends are used to estimate impairment of receivables. Changes in the economic, political and legislative environment can affect debt collection rates. These changes may impact the carrying amount of receivables.

6.2 Amounts receivable for services (Holding Account)		
Non-current	781,637	722,253
Total amounts receivable for services	781,637	722,253

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	6,253	5,435
Engineering stores - at cost	931	877
Total inventories	7,184	6,312

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.

East Metropolitan Health Service
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	2025 \$000	2024 \$000
6.4 Other current assets		
Current		
Prepayments	1,750	1,077
Total other assets	1,750	1,077

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	89,772	75,866
Trade creditors	13,803	9,629
Accrued salaries	50,153	44,725
Other creditors	3,523	3,648
Total current	157,251	133,868

Payables are recognised at the amounts payable when the Health Service becomes obliged to make future payments as a result of a purchase of assets or services. The carrying amount is equivalent to fair value, as settlement is generally within 7-30 days.

TI 5.3 Timely Payment of Accounts require payments for goods, services and constructions of less than \$1 million and not subject to an exemption, to be paid within 20 calendar days. Payments over \$1 million are required to be settled within 30 calendar days of the receipt of a correctly rendered invoice, or provision of goods or services.

Accrued salaries represent the amount due to staff but unpaid at the end of the reporting period. Accrued salaries are settled within a fortnight of the reporting period end. The Health Service considers the carrying amount of accrued salaries to be equivalent to its fair value.

6.6 Grant liabilities		
Current	955	955
	955	955
Expected satisfaction of grant liabilities		
Later than 1 year, and not later than 5 years	955	955
Balance at end of period	955	955

The Health Service received funding from the Community Health and Hospital Program for the construction of Mental Health Emergency Centre at the St John of God Midland Public Hospital. The grant liabilities represent the amount unspent at the reporting date.

East Metropolitan Health Service
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	2025	2024
	\$000	\$000
6.7 Other current liabilities		
Current		
Refundable deposits	266	256
Paid parental leave scheme	23	66
Unearned income	603	517
Other	379	188
Total current	1,271	1,027
Note 7 Financing		

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

	Note
Lease liabilities	7.1
Finance costs	7.2
Cash and cash equivalents	7.3
Reconciliation of cash	7.3.1
Reconciliation of net cost of services to net cash flows used in operating activities	7.3.2
Capital commitments	7.4

	2025 \$000	2024 \$000
7.1 Lease liabilities		
Current	4,641	3,885
Non-current	12,805	12,826
	17,446	16,711

Initial measurement

At the commencement date of the lease, the Health Service recognises lease liabilities measured at the present value of lease payments to be made over the lease term. The lease payments are discounted using the interest rate implicit in the lease. If that rate cannot be readily determined, the Health Service uses the incremental borrowing rate provided by Western Australia Treasury Corporation.

Lease payments included by the Health Service as part of the present value calculation of lease liability include:

- fixed payments (including in-substance fixed payments), less any lease incentives receivable;
- variable lease payments that depend on an index or a rate initially measured using the index or rate as at the commencement date;
- amounts expected to be payable by the lessee under residual value guarantees;
- the exercise price of purchase options (where these are reasonably certain to be exercised);
- payments for penalties for terminating a lease, where the lease term reflects the Health Service exercising an option to terminate the lease.

The interest on the lease liability is recognised in profit or loss over the lease term so as to produce a constant periodic rate of interest on the remaining balance of the liability for each period. Lease liabilities do not include any future changes in variable lease payments (that depend on an index or rate) until they take effect, in which case the lease liability is reassessed and adjusted against the right-of-use asset.

Periods covered by extension or termination options are only included in the lease term by the Health Service if the lease is reasonably certain to be extended (or not terminated).

Variable lease payments, not included in the measurement of lease liability, that are dependant on sales are recognised by the Health Service in profit or loss in the period in which the condition that triggers those payment occurs.

This section should be read in conjunction with note 5.3 Right-of-use assets.

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
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	2025 \$000	2024 \$000
7.2 Finance costs		
Finance costs		
Finance lease charges	738	636
Finance costs include the interest component of lease liability repayments.		

7.3 Cash and cash equivalents

7.3.1 Reconciliation of cash

Current		
Cash and cash equivalents	96,527	91,502
Restricted cash and cash equivalents (a)	50,468	43,792
Total cash and cash equivalents at end of period	146,995	135,294

(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.

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.

East Metropolitan Health Service
Notes to the financial statements
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		2025 \$000	2024 \$000
7.3.2 Reconciliation of net cost of services to net cash flows used in operating activities			
Net cost of services (statement of comprehensive income)		(2,273,122)	(2,043,613)
Non-cash items	Note		
Depreciation and amortisation expense	5.5	61,430	56,882
Expected credit loss expense	3.7	929	5,708
Services received free of charge	4.1	93,602	85,094
Net (gain)/loss on disposal of non-current assets	3.7	198	23
Donation of non-current assets		(473)	(284)
Write down of property, plant and equipment	3.7	2,184	-
Reversal asset revaluation decrement - land	4.7	(2,487)	(4,198)
Write-off of receivables	6.1.1	(3,090)	(3,671)
Adjustment for other non-cash items		(663)	876
(Increase)/decrease in assets			
GST receivable	6.1	(1,248)	(719)
Other current receivables	6.1	179	(12,855)
Inventories	6.3	(872)	(439)
Prepayments and other current assets	6.4	(673)	(12)
Increase/(decrease) in liabilities			
Current payables	6.5	23,383	21,900
Current employee benefits provisions	3.1.2	46,169	13,110
Other current liabilities	6.7	244	(159)
Non-current employee benefits provisions	3.1.2	3,288	(2,685)
Net cash used in operating activities (statement of cash flows)		(2,051,021)	(1,885,042)

7.4 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		23,977	42,152
Later than 1 year, and not later than 5 years		341	961
Balance at end of period		24,318	43,113

The totals presented for capital commitments are inclusive of GST.

East Metropolitan Health Service
Notes to the financial statements
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Note 8 Risks and contingencies

This note sets out the key risk management policies and measurement techniques of the Health Service.

	Note
Financial risk management	8.1
Contingent assets and liabilities	8.2
Fair value measurements	8.3

8.1 Financial risk management

Financial instruments held by the Health Service are cash and cash equivalents, restricted cash and cash equivalents, 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.

	2025 \$000	2024 \$000
8.1 Financial risk management (continued)		
The Health Service has appropriate procedures to manage cash flows including drawdowns of appropriations by monitoring forecast cash flows to ensure that sufficient funds are available to meet its commitments.		
Market risk		
Market risk is the risk that changes in market prices such as foreign exchange rates and interest rates will affect the Health Service's income or the value of its holdings of financial instruments. The Health Service does not trade in foreign currency and is not materially exposed to other price risks. The Health Service is not exposed to market risk for changes in interest rates as it does not have borrowings other than lease liabilities.		
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	96,527	91,502
Restricted cash and cash equivalents	50,468	43,792
Financial assets at amortised cost (1)	85,378	75,047
Amounts receivable for services	781,637	722,253
Total financial assets	1,014,010	932,594
Financial liabilities		
Financial liabilities measured at amortised cost	175,365	151,089
Total financial liabilities	175,365	151,089

(1) The amount of receivables and financial assets at amortised cost excludes GST recoverable from ATO (statutory receivable).

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2025

8.1 Financial risk management (continued)

c) Credit risk exposure

The following table details the credit risk exposure on the Health Service's receivables using a provision matrix.

	Total \$000	Days past due				
		Current \$000	< 30 days \$000	31-60 days \$000	61-90 days \$000	>91 days* \$000
30 June 2025						
Expected credit loss rate		2%	7%	24%	32%	73%
Estimated total gross carrying amount at default	56,637	30,541	6,690	1,623	1,518	16,265
Expected credit losses	(13,991)	(744)	(500)	(387)	(491)	(11,869)
30 June 2024						
Expected credit loss rate		3%	11%	16%	22%	68%
Estimated total gross carrying amount at default	56,816	24,939	5,279	3,602	2,919	20,077
Expected credit losses	(16,151)	(774)	(560)	(559)	(641)	(13,617)

*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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8.1 Financial risk management (continued)

Interest rate exposure and maturity analysis of financial assets and financial liabilities

	Weighted average effective interest rate %	Interest rate exposure				Maturity dates				
		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
2025										
Financial Assets										
Cash and cash equivalents		96,527	-	-	96,527	96,527	96,527	-	-	-
Restricted cash and cash equivalents		50,468	-	-	50,468	50,468	50,468	-	-	-
Receivables - non-interest bearing (1)		85,378	-	-	85,378	85,378	42,646	-	42,732	-
Amounts receivable for services		781,637	-	-	781,637	781,637	-	-	-	781,637
		<u>1,014,010</u>	<u>-</u>	<u>-</u>	<u>1,014,010</u>	<u>1,014,010</u>	<u>189,641</u>	<u>-</u>	<u>42,732</u>	<u>781,637</u>
Financial Liabilities										
Payables	-	157,251	-	-	157,251	157,251	157,251	-	-	-
Lease liabilities	4.38%	17,446	17,446	-	-	17,446	-	4,641	7,700	5,105
Other current liabilities		668			668	668	668			
		<u>175,365</u>	<u>17,446</u>	<u>-</u>	<u>157,919</u>	<u>175,365</u>	<u>157,919</u>	<u>4,641</u>	<u>7,700</u>	<u>5,105</u>
2024										
Financial Assets										
Cash and cash equivalents		91,502	-	-	91,502	91,502	91,502	-	-	-
Restricted cash and cash equivalents		43,792	-	-	43,792	43,792	43,792	-	-	-
Receivables - non-interest bearing (1)		75,047	-	-	75,047	75,047	40,665	-	34,382	-
Amounts receivable for services		722,253	-	-	722,253	722,253	-	-	-	722,253
		<u>932,594</u>	<u>-</u>	<u>-</u>	<u>932,594</u>	<u>932,594</u>	<u>175,959</u>	<u>-</u>	<u>34,382</u>	<u>722,253</u>
Financial Liabilities										
Payables	-	133,868	-	-	133,868	133,868	133,868	-	-	-
Lease liabilities	3.88%	16,711	16,711	-	-	16,711	-	3,887	8,666	4,158
Other current liabilities		510	-	-	510	510	510			
		<u>151,089</u>	<u>16,711</u>	<u>-</u>	<u>134,378</u>	<u>151,089</u>	<u>134,378</u>	<u>3,887</u>	<u>8,666</u>	<u>4,158</u>

(1) The amount of receivables excludes the GST recoverable from ATO (statutory receivable).

e) Interest rate sensitivity analysis

The Health Service does not have exposure on changes to the interest rate environment as it does not have financial instrument which depends on variable interest rates.

8.2 Contingent assets and liabilities

Contingent assets and contingent liabilities are not recognised in the statement of financial position but are disclosed and, if quantifiable, are measured at the best estimate.

Contingent assets and liabilities are presented inclusive of GST receivable or payable respectively.

8.2.1 Contingent assets

At the reporting date, the Health Service is not aware of any contingent assets.

8.2.2 Contingent liabilities

At the reporting date, the Health Service is not aware of any material contingent liabilities.

Contaminated sites

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

At the reporting date, the Health Service does not have any suspected contaminated sites reported under the Act.

8.3 Fair value measurements

Assets measured at fair value	Level 1	Level 2	Level 3	Total
2025	\$000	\$000	\$000	\$000
Land				
(notes 5.1 'Property, plant and equipment' and 5.4 'Service concession assets (SCA)')				
Vacant land	-	-	-	-
Specialised land	-	5,490	106,534	112,024
Buildings				
(notes 5.1 'Property, plant and equipment' and 5.4 'Service concession assets (SCA)')				
Residential and commercial carpark	-	234	-	234
Specialised buildings	-	-	1,170,991	1,170,991
	-	5,724	1,277,525	1,283,249

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8.3 Fair value measurements (continued)				
Assets measured at fair value 2024	Level 1 \$000	Level 2 \$000	Level 3 \$000	Total \$000
Land				
(notes 5.1 'Property, plant and equipment' and 5.4 'Service concession assets (SCA)')				
Vacant land	-	-	-	-
Specialised land	-	21,980	73,461	95,441
Buildings				
(notes 5.1 'Property, plant and equipment' and 5.4 'Service concession assets (SCA)')				
Residential and commercial carpark	-	2,100	-	2,100
Specialised buildings	-	-	866,543	866,543
	-	24,080	940,004	964,084

There were no transfers between Level 1 and 2 during the current and the previous period.

AASB 13 requires disclosure of fair value measurements by level of the following fair value measurement hierarchy:

Level 1 inputs - quoted prices (unadjusted) in active markets for identical assets.

Level 2 inputs - input other than quoted prices included within level 1 that are observable for the asset, either directly or indirectly.

Level 3 inputs - input not based on observable market data.

Vacant land that was initially classified under Level 2 and valued at \$0.85M in 2023 has been reclassified as specialised land under Level 3 in 2024, due to a structure being constructed on this land.

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.

8.3 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.

In addition, professional and project management fees estimated and added to the current replacement costs provided by Landgate for current use buildings represent significant Level 3 inputs used in the valuation process. The fair value of these assets will increase with a higher level of professional and project management fees.

8.3 Fair value measurements (continued)

The techniques involved in the determination of the current replacement costs include:

- a) Review and updating of the 'as-constructed' drawing documentation.
- b) Categorisation of the drawings using the Building Utilisation Categories (BUC's) which designate the functional areas typically provided by the following types of clinical facilities. Each BUC has different cost rates which are calculated from the historical construction costs of similar clinical facilities and are adjusted for the year-to-year change in building costs using building cost index.
 - Nursing Posts and Medical Centres
 - Metropolitan Secondary, Specialist and General Hospitals
 - Tertiary Hospitals
- c) Measurement of the general floor areas.
- d) Application of the BUC cost rates per square metre of general floor areas.

The maximum effective age used in the valuation of specialised buildings is 50 years. The effective age of buildings is initially calculated from the commissioning date and is reviewed after the buildings have undergone substantial renewal, upgrade or expansion.

The straight-line method of depreciation is applied and assumes a uniform pattern of consumption over the initial 37.5 years of asset life (up to 75% of current replacement costs). All specialised buildings are assumed to have a residual value of 25% of their current replacement costs.

The valuations are prepared on a going concern basis until the year in which the current use is discontinued. Buildings with definite demolition plan are not subject to annual revaluation. The current replacement costs at the last valuation dates for these buildings are written down to the statement of comprehensive income as depreciation expenses over their remaining useful life.

Fair value measurements using significant unobservable inputs (Level 3)

	Land \$000	Buildings \$000
2025		
Fair value at beginning of period	73,461	866,543
Additions	23,657	29,275
Revaluation increments/(decrements) recognised in profit or loss	1,360	-
Revaluation increments/(decrements) recognised in other comprehensive income	8,056	315,560
Depreciation	-	(40,387)
Fair value at end of period	<u>106,534</u>	<u>1,170,991</u>

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8.3 Fair value measurements (continued)

	Land \$000	Buildings \$000
2024		
Fair value at beginning of period	69,083	825,851
Additions	850	5,448
Revaluation increments/(decrements) recognised in profit or loss	3,528	-
Revaluation increments/(decrements) recognised in other comprehensive income	-	72,280
Depreciation	-	(37,036)
Fair value at end of period	<u>73,461</u>	<u>866,543</u>

Valuation processes
Western Australian Land Information Authority (Valuation and Property Analytics) determines the fair values of the Health Service’s land and buildings. A quantity surveyor is engaged by the Health Service to provide an update of the current construction costs for specialised buildings. Western Australian Land Information Authority (Valuation and Property Analytics) may endorse the current construction costs calculated by the quantity surveyor for specialised buildings and calculates the current replacement costs.

Note 9 Other disclosures

This section includes additional material disclosures required by accounting standards or other pronouncements, for the understanding of this financial report.

	Note
Events occurring after the end of the reporting period	9.1
Impact of Australian Accounting Standards	9.2
Initial application of Australian Accounting Standards	9.2.1
Future impact of Australian Accounting Standards not yet operative	9.2.2
Key management personnel	9.3
Related party transactions	9.4
Related bodies	9.5
Affiliated bodies	9.6
Special purpose accounts	9.7
Remuneration of auditors	9.8
Equity	9.9
Supplementary financial information	9.10
Administered trust accounts	9.11

9.1 Events occurring after the end of the reporting period

In March 2025, the Western Australian Government announced a suite of reforms, including the establishment of the Office of Major Infrastructure Delivery (OMID) within the Department of Transport and Major Infrastructure (DTMI), aimed at centralising major infrastructure delivery across government. Effective 1 July 2025, responsibility for expenditure and decision-making on major projects will transfer from the Health Service to OMID. A transition period has been confirmed through to 1 January 2026, during which capital budgets will continue to be managed by the Department of Health. During this time, the Health Service will retain responsibility for project accounting, payment processing, expenditure tracking, reporting, and forecasting.

Responsibility for managing patient and staff parking and the contract to manage the multi-storey car park at the Royal Perth Hospital will be devolved from the Metropolitan Access and Parking Department (MAPD) to the Health Service from 1 July 2025.

9.2 Impact of Australian Accounting Standards

9.2.1 Initial application of Australian Accounting Standards

The following standards are first applied for the reporting period ended on 30 June 2025:

Title	Operative for reporting periods beginning on/after
<i>AASB 2020-1 - Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-current</i>	1 Jan 2024
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.	
<i>AASB 2022-10 - Amendments to Australian Accounting Standards – Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities</i>	1 Jan 2024
This Standard amends AASB 13 including adding authoritative implementation guidance and providing related illustrative examples, for fair value measurements of non-financial assets of not-for-profit public sector entities not held primarily for their ability to generate net cash inflows.	

9.2.2 Future impact of Australian Accounting Standards not yet operative

The Health Service cannot early adopt an Australian Accounting Standard unless specifically permitted by TI 9 *Application of Australian Accounting Standards and Other Pronouncements* or by an exemption from TI 9. Where applicable, the Health Service plans to apply the following Australian Accounting Standards from their application date.

Title	Operative for reporting periods beginning on/after
<i>AASB 2024-2 Amendments to Australian Accounting Standards – Classification and Measurement of Financial Instruments</i> This Standard amends AASB 7 and AASB 9 as a consequence of the issuance of Amendments to the Classification and Measurement of Financial Instruments (Amendments to IFRS 9 and IFRS 7) by the International Accounting Standards Board in May 2024. The Health Service has not assessed the impact of the Standard.	1 Jan 2026
<i>AASB 2024-3 Amendments to Australian Accounting Standards – Annual Improvements Volume 11</i> This Standard amends AASB 1, AASB 7, AASB 9, AASB 10 and AASB 107 as a consequence of the issuance of Annual Improvements to IFRS Standards – Volume 11 by the International Accounting Standards Board in July 2024. The Health Service has not assessed the impact of the Standard.	1 Jan 2026
<i>AASB 18 (NFP) Presentation and Disclosure in Financial Statements (Appendix D)</i> This Standard replaces AASB 101 with respect to the presentation and disclosure requirements in financial statements applicable to not-for-profit entities. This Standard is a consequence of the issuance of IFRS 18 Presentation and Disclosure in financial Statements by the International Accounting Standards Board in April 2024. This Standard also makes amendments to other Australian Accounting Standards set out in Appendix D of this Standard. The Health Service has not assessed the impact of the Standard.	1 Jan 2028

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9.3

Key management personnel

The Health Service has determined that key management personnel include cabinet ministers, board members and senior officers of the Health Service. However, the Health Service is not obligated to compensate ministers and therefore disclosures in relation to ministers' compensation may be found in the *Annual Report on State Finances*.

The Board of East Metropolitan Health Service is the Accountable Authority for the Health Service.

Total compensation (includes the superannuation expense incurred by the Health Service) for key management personnel, comprising members and senior officers of the Accountable Authority for the period are presented within the following bands:

	2025	2024
Compensation of members of the Accountable Authority		
Compensation band		
\$ 10,001 - \$ 20,000	-	1
\$ 30,001 - \$ 40,000	1	-
\$ 40,001 - \$ 50,000	8	7
\$ 50,001 - \$ 60,000	-	1
\$ 80,001 - \$ 90,000	1	1
Total	10	10

9.3

Key management personnel (continued)

	2025	2024
Compensation of senior officers		
Compensation band		
\$ 0 - \$ 50,000	2	-
\$ 50,001 - \$ 100,000	2	-
\$ 150,001 - \$ 200,000	-	2
\$ 200,001 - \$ 250,000	9	3
\$ 250,001 - \$ 300,000	5	6
\$ 300,001 - \$ 350,000	-	1
\$ 400,001 - \$ 450,000	1	-
\$ 450,001 - \$ 500,000	-	1
\$ 500,001 - \$ 550,000	1	-
\$ 600,001 - \$ 650,000	-	1
Total	20	14
Short-term employee benefits (a)	4,269	3,780
Post-employment benefits	532	422
Other long-term benefits	89	258
Total compensation of key management personnel	4,890	4,460

(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.

9.4 Related party transactions

The Health Service is a wholly-owned public sector entity that is controlled by the State of Western Australia.

Related parties of the Health Service include:

- all 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
Income from State Government	4.1
Capital contributions from Department of Health	9.9
Superannuation payments to GESB	3.1.1
Remuneration for services provided by Office of the Auditor General	9.8
Lease payments to the Department of Finance (Government Office Accommodation and State Fleet motor vehicles)	3.7, 7.1

Material transactions with other related parties

Outside of normal citizen type transactions with the Health Service, there were no other related party transactions that involved key management personnel and/or their close family members and/or their controlled (or jointly controlled) entities.

9.5 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.

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9.6 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.

	2025	2024
	\$000	\$000

9.7 Special purpose accounts

Mental Health Commission Fund (East Metropolitan Health Service) Account

The purpose of the account is to receive funds from the Mental Health Commission, to fund the provision of mental health services as jointly endorsed by the Department of Health and the Mental Health Commission, in the East Metropolitan Health Service, in accordance with the annual Service Agreement and subsequent agreements.

Balance at start of period	8,475	8,611
Receipts		
Commonwealth contributions (note 4.1)	90,456	83,706
State contributions (note 4.1)	204,972	181,354
Other	540	400
	<u>304,443</u>	<u>274,071</u>
Payments	<u>(289,490)</u>	<u>(265,596)</u>
Balance at end of period	<u>14,953</u>	<u>8,475</u>

The special purpose accounts are established under section 16(1)(d) of the *Financial Management Act 2006*.

9.8 Remuneration of auditors

Remuneration paid or payable to the Auditor General in respect of the audit for the current financial year is as follows:

Auditing the accounts, financial statements, controls, and key performance indicators	469	430
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	2025 \$000	2024 \$000
9.9 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	1,312,747	1,276,487
Contributions by owners (a)		
Contribution by Owners – Capital Appropriations administered by Department of Health (b)	35,453	36,260
Transfer of net assets from Mental Health Commission (c)	11,512	-
Total contributions by owners	1,359,712	1,312,747
Total contributed equity at end of period	1,359,712	1,312,747

(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 8.8 designates non-discretionary and non-reciprocal transfers of net assets between State government agencies as contributions by owners in accordance with AASB Interpretation 1038. Where the transferee agency accounts for a non-discretionary and non-reciprocal transfer of net assets as a contribution by owners, the transferor agency accounts for the transfer as a distribution to owners.

(b) TI 8.8 'Contributions by Owners Made to Wholly-Owned Public Sector Entities' designates capital appropriations as contributions by owners in accordance with AASB Interpretation 1038 'Contributions by Owners Made to Wholly-Owned Public Sector Entities'.

(c) In accordance with the Minister's direction, the assets and liabilities relating to the Next Step Drug and Alcohol Services were transferred from the Mental Health Commission to the Health Service on 18 November 2024. This transfer of assets and liabilities was formally designated as contribution by owner under AASB 1004 and forms part of the contributed equity of the Health Service.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2025

	2025	2024
	\$000	\$000
9.9 Equity (continued)		
Breakdown of assets and liabilities transferred to the Health Service relating to the Next Step Drug and Alcohol Services is provided below. Income and expenditure attributable to the transferred activities of the Next Step Drug and Alcohol Services are not separately shown due to immateriality.		
Assets		
Cash	2,969	
Receivables (27th Pay)	507	
Land	4,760	
Buildings	4,858	
Medical equipments	1,097	
Plant and Equipments	82	
Right-of-use assets - Motor Vehicles leased	28	
Other assets	225	
Total assets	14,526	
Liabilities		
Employee benefits provisions	(2,986)	
Lease liabilities	(28)	
Total liabilities	(3,014)	
Net assets	11,512	
Equity		
Contributed equity	11,512	
Asset revaluation reserve		
Balance at start of the period	317,151	244,829
Net revaluation increments:		
Land	8,056	-
Buildings	315,532	72,322
Total asset revaluation reserve at end of period	640,739	317,151
The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets on a class of assets basis. Any increment is credited directly to the asset revaluation reserve, except to the extent that the increment reverses a revaluation decrement previously recognised as an expense (see note 5.1 'Property, plant and equipment').		
For land revaluation decrement recognised as an expense, see note 3.7 'Other expenses'.		

	2025 \$000	2024 \$000
9.10 Supplementary financial information		
a) Write-offs		
Debts written off under the authority of the Accountable Authority	2,154	2,480
Public and other property written off under the authority of the Minister	-	1,763
Debts written off under the authority of the Minister	253	376
	<u>2,407</u>	<u>4,619</u>
See also Note 6.1.1 Movement of the allowance for impairment of receivables		
b) Debt waivers		
Debts waived under the authority of the Accountable Authority	683	815
	<u>683</u>	<u>815</u>
9.10 Supplementary financial information (continued)		
Debt waivers are discretionary in nature and under justifiable and reasonable circumstances, can be used by the Accountable Authority to permanently forgive a debt.		
See also Note 6.1.1 Movement of the allowance for impairment of receivables		
Losses of public money, and public and other property through theft or default	563	1,774
Amounts recovered	(43)	(6)
	<u>520</u>	<u>1,768</u>
9.11 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.		
The Health Service administers trust accounts for the purpose of holding patients' private moneys.		
A summary of the transactions for these trust accounts are as follows:		
Balance at start of period	19	16
Add receipts	62	67
	<u>81</u>	<u>83</u>
Less payments	(69)	(64)
Balance at end of period	<u>12</u>	<u>19</u>

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2025

Note	10	Explanatory statement
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All variances between 2025 actual results and 2025 estimates (original budget) are shown below. Narratives are provided for key major variances, which are greater than 10% and \$21.59 million for the statement of comprehensive income, statement of cash flows and \$20.94 million for the statement of financial position.

		Estimates	Actuals	Variance
		2025	2025	between 2025 actuals and 2025 estimates
Statement of comprehensive income	Note	\$000	\$000	\$000
Expenses				
Employee benefits expense	1	1,222,239	1,375,658	153,419
Contracts for services	2	360,920	420,078	59,158
Patient support costs		290,442	317,888	27,446
Fees for contracted medical practitioners		33,923	34,995	1,072
Finance costs		636	738	102
Depreciation and amortisation expense		56,933	61,430	4,497
Repairs, maintenance and consumable equipment		33,771	43,096	9,325
Other supplies and services		13,435	16,003	2,568
Cost of sales		4,361	4,691	330
Other expenses		142,664	149,196	6,532
Total cost of services		2,159,324	2,423,773	264,449
Income				
Patient charges		57,729	66,215	8,486
Other fees for services		1,840	543	(1,297)
Commonwealth grants and contributions		-	15,600	15,600
Other grants and contributions		1,106	2,667	1,561
Donation income		333	567	234
Sale of goods		4,178	4,205	27
Other income and recoveries		57,832	60,854	3,022
Total income other than income from State Government		123,018	150,651	27,633
Net cost of services		2,036,306	2,273,122	236,816
Income from State Government				
Department of Health - Service Agreement:				
- State component	3	1,056,261	1,198,728	142,467
- Commonwealth component		572,548	601,711	29,163
Mental Health Commission - Service Agreement	4	267,358	295,968	28,610
Income from other state government agencies		53,415	49,010	(4,405)
Resources received		85,712	93,971	8,259
Total income from State Government		2,035,294	2,239,388	204,094
Deficit for the period		(1,012)	(33,734)	(32,722)
Other comprehensive income				
Items not reclassified subsequently to profit or loss				
Changes in asset revaluation reserve		-	323,588	323,588
Total other comprehensive income		-	323,588	323,588
Total comprehensive income/(loss) for the period		(1,012)	289,854	290,866

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2025

Note	10	Explanatory statement (continued)		
		Estimates 2025	Actuals 2025	Variance between 2025 actuals and 2025 estimates
Statement of financial position	Note	\$000	\$000	\$000
Assets				
Current assets				
Cash and cash equivalents		68,633	96,527	27,894
Restricted cash and cash equivalents		43,792	50,468	6,676
Receivables		42,786	49,337	6,551
Inventories		6,312	7,184	872
Other current assets		1,077	1,750	673
Total current assets		162,600	205,266	42,666
Non-current assets				
Receivables		43,022	42,732	(290)
Amounts receivable for services		779,187	781,637	2,450
Property, plant and equipment	5	753,461	1,027,472	274,011
Intangible assets		83	79	(4)
Right-of-use assets		11,206	14,523	3,317
Service concession assets	5	344,358	405,056	60,698
Total non-current assets		1,931,317	2,271,499	340,182
Total assets		2,093,917	2,476,765	382,848
Liabilities				
Current liabilities				
Payables		132,537	157,251	24,714
Grant liabilities		955	955	-
Lease liabilities		3,268	4,641	1,373
Employee benefits provisions	6	226,450	287,567	61,117
Other current liabilities		1,027	1,271	244
Total current liabilities		364,237	451,685	87,448
Non-current liabilities				
Employee benefits provisions	6	46,257	45,564	(693)
Lease liabilities		10,941	12,805	1,864
Total non-current liabilities		57,198	58,369	1,171
Total liabilities		421,435	510,054	88,619
Net assets		1,672,482	1,966,711	294,229
Equity				
Contributed equity		1,356,359	1,359,712	3,353
Reserves		317,151	640,739	323,588
Accumulated deficit		(1,028)	(33,740)	(32,712)
Total equity		1,672,482	1,966,711	294,229

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2025

Note	10	Explanatory statement (continued)		
		Estimates 2025	Actuals 2025	Variance between 2025 actuals and 2025 estimates
Statement of cash flows	Note	\$000	\$000	\$000
Cash flows from State Government				
Contribution by Owners – Capital Appropriations administered by Department of Health				
		43,612	36,112	(7,499)
Service agreement - Department of Health	3	1,571,875	1,741,055	169,180
Service agreement - Mental Health Commission	4	267,358	295,968	28,610
Funds received from other state government agencies		53,415	49,010	(4,405)
Net cash provided by State Government		1,936,260	2,122,145	185,885
Utilised as follows:				
Cash flows from operating activities				
Payments				
Employee benefits		(1,233,204)	(1,318,273)	(85,069)
Supplies and services	2	(789,435)	(871,651)	(82,216)
Finance costs		(636)	(738)	(102)
Receipts				
Receipts from customers		55,340	76,917	21,577
Other grants and contributions		1,106	2,667	1,561
Donations received		333	95	(238)
Other receipts		63,850	59,961	(3,889)
Net cash used in operating activities		(1,902,646)	(2,051,021)	(148,375)
Cash flows from investing activities				
Payments				
Purchase of non-current assets		(45,340)	(48,787)	(3,447)
Receipts				
Proceeds from sale of non-current assets		-	(41)	(41)
Net cash used in investing activities		(45,340)	(48,828)	(3,488)
Cash flows from financing activities				
Payments				
Principal elements of lease payments		(2,503)	(2,752)	(249)
Payment to accrued salaries account		(8,640)	(7,843)	797
Net cash used in financing activities		(11,143)	(10,595)	548
Net increase (decrease) in cash and cash equivalents		(22,869)	11,701	34,570
Cash and cash equivalents at the beginning of the period		135,294	135,294	-
Total cash and cash equivalents at the end of the period		112,425	146,995	34,570

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2025

Note	10	Explanatory statement (continued)
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All variances between actual results for 2025 and 2024 are shown below. Narratives are provided for key major variances, which are greater than 10% and \$21.66 million for the statement of comprehensive income and statement of cash flows and \$20.66 million for the statement of financial position.

		Actuals 2025 \$000	Actuals 2024 \$000	Variance between 2025 and 2024 actual results \$000
Statement of comprehensive income	Note			
Expenses				
Employee benefits expense	1	1,375,658	1,223,878	151,780
Contracts for services	2	420,078	360,732	59,346
Patient support costs		317,888	290,610	27,278
Fees for contracted medical practitioners		34,995	33,905	1,090
Finance costs		738	636	102
Depreciation and amortisation expense		61,430	56,882	4,548
Repairs, maintenance and consumable equipment		43,096	37,172	5,924
Other supplies and services		16,003	13,435	2,568
Cost of sales		4,691	4,359	332
Other expenses		149,196	144,146	5,050
Total cost of services		2,423,773	2,165,755	258,018
Income				
Patient charges		66,215	57,321	8,894
Other fees for services		543	1,827	(1,284)
Commonwealth grants and contributions		15,600	-	15,600
Other grants and contributions		2,667	1,098	1,569
Donation income		567	330	237
Sale of goods		4,205	4,149	56
Other income and recoveries		60,854	57,417	3,437
Total income other than income from State Government		150,651	122,142	28,509
Net cost of services		2,273,122	2,043,613	229,509
Income from State Government				
- State component	3	1,198,728	1,050,930	147,798
- Commonwealth component		601,711	568,483	33,228
Mental Health Commission - Service Agreement	4	295,968	265,460	30,508
Income from other state government agencies		49,010	53,030	(4,020)
Resources received		93,971	85,104	8,867
Total income from State Government		2,239,388	2,023,007	216,381
Deficit for the period		(33,734)	(20,606)	(13,128)
Other comprehensive income				
Items not reclassified subsequently to profit or loss				
Changes in asset revaluation reserve		323,588	72,322	251,266
Total other comprehensive income		323,588	72,322	251,266
Total comprehensive income/(loss) for the period		289,854	51,716	238,138

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2025

Note	10	Explanatory statement (continued)		
		Actuals 2025 \$000	Actuals 2024 \$000	Variance between 2025 and 2024 actual results \$000
Statement of financial position	Note			
Assets				
Current assets				
Cash and cash equivalents		96,527	91,502	5,025
Restricted cash and cash equivalents		50,468	43,792	6,676
Receivables		49,337	46,108	3,229
Inventories		7,184	6,312	872
Other current assets		1,750	1,077	673
Total current assets		205,266	188,791	16,475
Non-current assets				
Receivables		42,732	34,382	8,350
Amounts receivable for services		781,637	722,253	59,384
Property, plant and equipment	5	1,027,472	751,876	275,596
Intangible assets		79	83	(4)
Right-of-use assets		14,523	14,895	(372)
Service concession assets	5	405,056	353,847	51,209
Total non-current assets		2,271,499	1,877,336	394,163
Total assets		2,476,765	2,066,127	410,638
Liabilities				
Current liabilities				
Payables		157,251	133,868	23,383
Grant liabilities		955	955	-
Lease liabilities		4,641	3,885	756
Employee benefits provisions	6	287,567	241,398	46,169
Other current liabilities		1,271	1,027	244
Total current liabilities		451,685	381,133	70,552
Non-current liabilities				
Employee benefits provisions	6	45,564	42,276	3,288
Lease liabilities		12,805	12,826	(21)
Total non-current liabilities		58,369	55,102	3,267
Total liabilities		510,054	436,235	73,819
Net assets		1,966,711	1,629,892	336,819
Equity				
Contributed equity		1,359,712	1,312,747	46,965
Reserves		640,739	317,151	323,588
Accumulated deficit		(33,740)	(6)	(33,734)
Total equity		1,966,711	1,629,892	336,819

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2025

Note	10	Explanatory statement (continued)		
		Actuals 2025 \$000	Actuals 2024 \$000	Variance between 2025 and 2024 actual results \$000
Statement of cash flows	Note			
Cash flows from State Government				
Contribution by Owners – Capital Appropriations administered by Department of Health		36,112	36,260	(148)
Service agreement - Department of Health	3	1,741,055	1,564,977	176,078
Service agreement - Mental Health Commission	4	295,968	265,460	30,508
Funds received from other state government agencies		49,010	53,030	(4,020)
Net cash provided by State Government		2,122,145	1,919,727	202,418
Utilised as follows:				
Cash flows from operating activities				
Payments				
Employee benefits		(1,318,273)	(1,202,736)	(115,537)
Supplies and services	2	(871,651)	(777,631)	(94,020)
Finance costs		(738)	(636)	(102)
Receipts				
Receipts from customers	7	76,917	43,783	33,134
Other grants and contributions		2,667	1,098	1,569
Donations received		95	46	49
Other receipts		59,961	51,034	8,927
Net cash used in operating activities		(2,051,021)	(1,885,042)	(165,979)
Cash flows from investing activities				
Payments				
Purchase of non-current assets		(48,787)	(37,087)	(11,700)
Receipts				
Proceeds from sale of non-current assets		(41)	20	(61)
Net cash used in investing activities		(48,828)	(37,067)	(11,761)
Cash flows from financing activities				
Payments				
Principal elements of lease payments		(2,752)	(2,427)	(325)
Payment to accrued salaries account		(7,843)	(7,637)	(206)
Net cash used in financing activities		(10,595)	(10,064)	(531)
Net increase/(decrease) in cash and cash equivalents		11,701	(12,446)	24,147
Cash and cash equivalents at the beginning of the period		135,294	147,740	(12,446)
Total cash and cash equivalents at the end of the period		146,995	135,294	11,701

Explanation of significant variances between 2025 estimates and 2025 actuals and between 2025 and 2024 actual results

- 1. Employee Benefits**
The variance is primarily attributed to the following:
Cost of award increases, provision of new services and the recruitment of additional staff to support healthcare service delivery, contributing an increase of \$79 million.
The resulting flow-on effects of the above leading to increases in penalty rates, allowances, superannuation contributions, workers' compensation insurance premiums, and leave provision liabilities (refer to explanation 6), accounted for an additional \$72 million.
- 2. Contracts for Service**
In 2024–25, additional payments were made under the Public Private Partnership (PPP) arrangement with St John of God Healthcare for the provision of additional general and mental health services (\$59 million).
- 3. Income from State Government – Department of Health - Service Agreement**
EMHS received additional funding under its Service Agreement with the Department of Health in 2024-25:
\$125 million to address cost of award increases, price escalations, and other operational cost pressures.
\$18 million for the delivery of additional health activity.
\$7 million for specific funded initiatives.
- 4. Income from State Government – Mental Health Commission - Service Agreement**
Additional funding was received through the Mental Health Commission Service Agreement in 2024-25:
\$15 million to fund the transition of Next Step Services from the MHC to EMHS.
\$15 million to support cost of award increases and other cost pressures associated with mental health service delivery.
- 5. Property, plant and equipment**
The total increase was primarily driven by the revaluation of land and buildings, which accounted for \$326 million. This included \$139 million related to capitalised professional and project management fees that were incorporated into the updated Landgate valuation.
- 6. Employee benefits provisions**
The movement in total provisions (both current and non-current components) was primarily driven by:
An increase in the nominal value of the provisions, due to the impact of the cost of award increases and higher staffing levels to support general healthcare service delivery which in turn contributed to higher allowances and associated on-costs.
A lower discount rate resulted in a higher present value of future obligations.
A change in the actuarial survivorship factor, recognising increased retention rates within the Health Service workforce.
- 7. Receipts from customers**
Receipts from customers increased during the year, driven by higher patient revenue activity and strengthened by improved cash collections from fully coded patient records.



Compliance

Ministerial directives

Ministerial Directives

Treasurer's Instructions 8(3.1) require disclosure of information on any written ministerial directives relevant to the setting or achievement of desired outcomes or operational objectives, investment activities and financing activities.

In May 2025, the EMHS Board received the Minister for Health's Statement of Expectations regarding the priorities and accountabilities of the EMHS Board. The EMHS Board released a Statement of Intent in response.

Both documents are publicly available on the EMHS website:

<https://emhs.health.wa.gov.au/About-Us/Health-Service-Board>

On 25 July 2023, the Minister for Health; Mental Health issued a directive to EMHS to commence working with the Mental Health Commission towards transitioning the Next Step Drug and Alcohol Service from the Mental Health Commission to EMHS. The Next Step Service transitioned under Royal Perth Hospital's governance in November 2024.

EMHS continues to progress and report on election commitments including the Armadale Mental Health Emergency Centre and the Byford Health Hub, and in 2025-26 will commence reporting on new election commitments, the expansions of Emergency Departments at Royal Perth Hospital and Midland Health Campus.

Government policy requirements

Summary of board and committee remuneration

Board/committee	Total remuneration (\$)
EMHS Board	479,162
Human Research Ethics Committee	0

Work health and safety management

Please see information on [page 26](#).

WA Multicultural Policy Framework

Please see information on [page 32](#).

Other financial and governance disclosures

Pricing policy

EMHS charges for goods and services rendered on a partial or full cost recovery basis and complies with the *Health Insurance Act* 1973, the Addendum to National Health Reform Agreement (NHRA) 2020-25, the WA Health Procurement and Policy Framework, and the *Health Services Act* 2016 (WA) (HSA 2016). These fees and charges are determined through 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 Health Service Providers under the HSA 2016.

Indemnity insurance

In 2024-25, 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 \$94,050 (including GST).

Employment and staff development

Please see information on [page 24](#).

Worker’s compensation

Please see information on [page 27](#).

Industrial relations

EMHS engaged with the WA Health System in contributing to negotiations for new Industrial Agreements for 2024-25 including:

- WA Health System - Medical Practitioners - AMA Industrial Agreement 2024
- WA Health System – Australian Nursing Federation – Registered Nurses, Midwives, Enrolled (Mental Health) and Enrolled (Mothercraft) Nurses – Industrial Agreement 2024
- WA Health System – HSUWA – PACTS Industrial Agreement 2024
- WA Health System – United Workers Union (WA) – Enrolled Nurses, Assistants in Nursing, Aboriginal and Ethnic Health Workers Industrial Agreement 2024
- WA Health System – United Workers Union (WA) – Health Support Workers Industrial Agreement 2024

EMHS is now implementing new and modified conditions of employment contained in these Industrial Agreements.

EMHS continued with its commitment to a permanent workforce and to reducing its reliance on agency workers and a casual workforce.

Capital works

Incomplete capital works (as at 30 June 2025)						
Project title	Expected year of completion	Estimated remaining cost to complete (\$'000)	Estimated total cost of project in 2024-25 (\$'000)	Reported in 2023-24 (\$'000)	Variance from previous financial year (\$'000)	Explanation of Variance (>=10%)
Election Commitment - Royal Perth Hospital Aseptic Unit	2025/26	1,013	9,632	8,739	893	Approved injection of additional capital funding.
Election Commitment - Royal Perth Hospital - Intensive Care Unit	2025/26	700	28,254	28,254	0	
EMHS Health in a Virtual Environment	2025/26	2,327	22,893	22,893	0	
Medical Respite Centre	2025/26	248	1,843	0	1,843	New project.
Refurbishment of Ward 2K at Royal Perth Hospital	2025/26	727	7,000	7,000	0	
Royal Perth Hospital (RPH) Chiller	2025/26	105	881	0	881	New project.
RPH A Block Window Replacement	2025/26	1,120	1,500	1,500	0	
RPH Innovation Hub	2025/26	191	2,828	2,308	520	Approved injection of additional capital funding.
RPH High Voltage Switchgear	2025/26	1,810	3,000	3,000	0	
SJOG Midland Health Campus – Master Planning Project	2025/26	2,500	3,000	3,000	0	
Urgent Mental Health Anti-Ligature works at Bentley Hospital	2025/26	14	3,898	3,898	0	
Anti-Ligature Remediation Program - Statewide	2026/27	4,507	5,552	5,242	310	
Electronic Medical Record (EMR)	2026/27	2,265	14,545	12,358	2,187	Approved injection of additional capital funding.
EMHS Anti-ligature Remediation Program	2026/27	1,954	5,000	5,000	0	
Mental Health Emergency Centres (MHEC): Armadale	2026/27	14,407	15,766	15,766	0	
St John of God Midland Public Hospital Expansion	2026/27	80,009	81,059	81,059	0	
East Metropolitan Health Service Fire Safety Upgrades	2027/28	1,736	7,000	7,000	0	
Bentley Health Service Secure Extended Care Unit	2028/29	51,675	56,640	56,640	0	
Byford Health Hub	2028/29	38,311	42,150	42,150	0	
Royal Perth Hospital - Fire Risk	2028/29	3,957	9,963	9,963	0	
St John of God Midland Mental Health Emergency Centre	To be determined	5,086	6,021	6,021	0	
Bentley Health Service Surgicentre	2029/30	165,483	167,002	167,002	0	

Capital works completed in 2024-25				
Project title	Estimated total cost of project in 2024-25 (\$'000)	Reported in 2023-24 (\$'000)	Variance from previous financial year (\$'000)	Explanation of variance (≥ 10%)
Royal Perth Hospital Helipad	10,075	10,075	0	
EMHS Wi-Fi Rollout	11,128	11,128	0	
Election Commitment - Royal Perth Hospital MHOA	13,067	13,495	-428	
St John of God Midland Cladding	1,838	1,838	0	
Bentley Health Service Redevelopment	7,254	7,254	0	

Notes:

- The above information is based upon the:
 - 2023–24 East Metropolitan Health Service published annual report;
 - 2025–26 published State Budget Papers and 2024-25 Service Agreement for East Metropolitan Health Service.
- Completion timeframes are based upon a combination of the approved delivery schedule, scope, and budget at the time of reporting and reflect the financial completion of the project.
- Only capital projects that were administered by the East Metropolitan Health Service are reflected in the table.
- Incomplete capital works is defined to be financially incomplete projects and Completed is defined to be financially completed or fully expended projects.
- Estimated total cost of project and Estimated remaining cost to complete are reflected as per the 2025-26 Service Agreement and are subject to changes following outcomes of future Mid-Year review and budget process.
- Variance represents the difference between the estimated total cost of the project in the 2025-26 published Budget Papers in comparison to the total cost or estimated total cost of the project as reported in the 2023–24 East Metropolitan Health Service annual report. An explanation is provided where a variance is greater than or equal to 10 per cent.

Other legal disclosures

Compliance with Public Sector Standards and ethical codes

Public Sector Standards

The Public Sector Standards in Human Resource (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. The Department of Health and EMHS maintain HR policies and guidelines that are consistent with the standards. These are available to all employees on the EMHS intranet and/or the Department of Health policy frameworks internet pages.

Information about the Public Sector Standards is promoted and available to employees via:

- notification of the breach claim rights, processes including relevant deadlines applicable to the standards
- information, fact sheets, policies and guidelines on the EMHS intranet
- recruitment, selection and appointment training for recruiting managers and panel members
- the EMHS peak performance training for line managers.

The HR Directorate provides information, guidance and support to all managers to promote best practice and application of these policies and procedures and also manages any claims made against the Public Sector Standards. Advice is also provided where appropriate in order to reach a prompt, satisfactory outcome at the most appropriate level.

During 2024-25, there were:

- 6 breach of standard claims lodged against the employment standards
- 0 were resolved internally and withdrawn
- 0 are currently being managed by HR
- 6 were referred to the Public Sector Commission
- 0 breach of standard claims for grievance resolution, performance management, termination or redeployment standards.

Code of Conduct

Integrity and ethical behaviour are integral to EMHS' core business. EMHS regularly encourages staff to reflect on the EMHS values (including accountability, integrity and respect), and to incorporate these into their work.

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.

During 2024-25, in addition to mandatory training, EMHS has developed targeted training for specific areas, including:

- Code of Conduct training for the EMHS Board
- Training on investigations for managers and supervisors
- E-learning module for Medicine Discrepancies investigations.

EMHS has also updated and published the following key integrity related policies:

- Integrity and Ethical Governance Framework - to describe the principles, organisational structures and mechanisms, along with the cultural factors that guide how EMHS practices, manages and accounts for integrity
- Fraud and Corruption Control System - developed to address fraud and corruption risks and aimed at reducing EMHS' exposure to fraud and corruption
- Reporting Inappropriate Behaviours Procedure - describes staff obligations in relation to reporting any instance of inappropriate workplace behaviour or staff conduct, along with the range of pathways by which such conduct can be reported.

The EMHS Ethical Conduct Advisory Committee (ECAC) was established in 2023-24, comprising of a group of senior executive stakeholders. The ECAC has met regularly throughout 2024-25, with its main functions being the development and management of strategies to improve integrity awareness, compliance and culture.

EMHS commenced 56 disciplinary processes in relation to potential breaches of policy and/or the Code of Conduct in 2024-25. 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 external oversight agencies as required by legislation.

Recordkeeping

The *State Records Act 2000* (the Act) mandates the statutory recordkeeping practices for State Government agencies.

Section 19 of the Act states that every government organisation must have a Recordkeeping Plan (RKP) that has been approved by the State Records Commission (SRC). An amended RKP submitted by EMHS in May 2024 was approved by SRC on 27 August 2024. In accordance with the *State Records Act 2000*, a review of the plan must be submitted every 5 years.

EMHS Corporate Recordkeeping section has recently changed Directorates from Office of the Chief Executive (OCE), to the Chief Information Office, reporting to the Chief Information Officer (CIO).

Corporate records across EMHS are created and maintained in both physical and electronic formats, with electronic records managed via shared network drives or the approved Electronic Document and Records Management System (EDRMS), Hewlett Packard Records Manager 8.3. A system-wide upgrade to a newer EDRMS version is underway across all Health Service Providers, with implementation expected by the end of 2025. Following the upgrade, further rollout to non-participating corporate areas is planned to support consistent records management practices.

As of 30 June 2025, there were over 600 staff who were active in Records Manager with over 1.215 million documents and emails, created and saved since its inception in 2019.

An internal audit of EMHS recordkeeping practices was conducted in 2023 to assess compliance with the Act and the effectiveness of electronic records management controls. The audit report, received in January 2024, identified areas for improvement across the 7 Records Management Standards, with a focus on 5 key themes requiring significant improvement to support a successful uplift in records management policy and practices within EMHS. The primary recommendation, Support and Leadership for Records Management Practices, outlined that there must be demonstrated leadership and accountability from EMHS' Executive and Senior Management teams. To address this recommendation, the Corporate Information and Records Management Policy was significantly updated to provide clarity on requirements for specific positions, in alignment with the responsibilities outlined in section 3.5 of the State Record's Office *Information Management Framework for WA*. These changes were endorsed by the Area Executive Group on 11 July 2024. Progress is underway to address the remaining audit recommendations.

The Recordkeeping Awareness Training forms part of the mandatory e-learning suite and informs staff about good recordkeeping practices, including outlining the roles and responsibilities of EMHS employees in complying with the RKP and relevant policies. This is part of the staff induction process for all health staff.

The EMHS Corporate Recordkeeping team successfully developed and published a self-directed, online learning course 'HPE Records Manager E-Learning', which went live in June 2023 in 'MyLearning'. This is provided to new staff who require access to Records Manager (RM) and is accessible to all EMHS corporate staff. The course replaces the historical face-to-face method of training and staff are able to re-visit the course at any time. The Corporate Records team ensures staff are supported in their use of the EDRMS by providing one-on-one assistance when required, in addition to the online course.

Expenditure on advertising

In 2024-25, EMHS did not incur any expenditure on advertising in accordance with section 175ZE of the *Electoral Act 1907* (WA).

Act of grace payments

EMHS did not make any act of grace payments in 2024-25 pursuant to Section 80(1) of the *Financial Management Act 2006* (WA).

Disability access and inclusion

EMHS is committed to ensuring people with a disability, as well as their families and carers, have the same opportunities as others to access our services, facilities, employment and information, consistent with the EMHS vision and values. EMHS acknowledges people with disability and believes in the social model of disability which highlights that everyone has a responsibility to ensure that the environments, activities, and programs they are developing are created accessibly and inclusively.

Throughout 2024-25, EMHS hospitals and services have developed, implemented and enhanced a range of initiatives to improve outcomes for consumers and staff with disability.

General services and events

Outcome one: People with disability have the same opportunities as other people to access the services of, and any events organised by, EMHS.

EMHS has a significant, long-term commitment to improve access to its services and events. In 2024-25:

- International Day of People with Disability was celebrated across all EMHS sites with events that included staff education and awareness raising, and community engagement activities. EMHS co-hosted with Disability Health Network an event that included an engaging line-up of speakers that presented on the day, including people with disability and community experts sharing their personal stories and advice. This year's theme – 'Easy to Read. Easy to Reach' shone a spotlight on the guiding principles of Easy Read, and how we can develop and share information that is easier to access and understand.

- Commonwealth Games and Paris Paralympian Ben Wright visited Royal Perth Hospital (RPH) where he spoke candidly about his life of growing up with a disability, and the amazing highs and lows of his sporting achievements. At Bentley Health Service (BHS) staff took part in a game of ParaVolley followed by a game of wheelchair basketball that was attended by several star players from the Fremantle Dockers. At Kalamunda Hospital, afternoon tea was coupled with some fun educational activities in a bid to build understanding of the challenges people with disability experience.

Buildings and facilities

Outcome two: People with disability have the same opportunities as other people to access the buildings and other facilities of EMHS

Regular and ongoing maintenance of EMHS buildings, grounds, car parks and facilities ensure we comply with relevant disability and access requirements. Further improvements were made in 2024-25 by:

- implementation of increased dedicated senior car parking and ACROD bays above minimum requirements across sites
- ongoing review and improved signage at entry points across sites
- free call phones installed across hospital sites for patients and visitors to use and seek assistance or directions
- establishment of specialised geriatric assessment teams in Emergency Departments to improve safety and quality of care for older adults
- improved access to RPH Milligan's 150 Club, with ramp installation.

Information and communication

Outcome three: People with disability receive information from EMHS in a format that will enable them to access the information as readily as other people are able to access it.

EMHS publications and patient information are regularly reviewed to ensure it meets the needs of healthcare users, includes adequate information, is available in different formats and uses appropriate language.

Across 2024-25 EMHS has:

- continued to monitor publications, ensuring the ability to obtain in different formats for accessibility
- signage and wayfinding markers reviewed with additional aids provided at key locations including directions to amenities
- increased access to alternative 'call buttons' and communication aids on inpatient wards
- utilisation of digital solutions (e.g. computer programs activated by eye movement) to assist with communication
- audit conducted of hearing loop utilisation and accessibility.

Quality of service

Outcome four: People with disability receive the same level and quality of service from the staff of EMHS as other people receive from the staff of EMHS.

A range of strategies have been introduced at EMHS to ensure people with disability receive the same high level of care. Key actions in 2024-25 included:

- expansion of volunteer 'Forget Me Not' program which enables more time to create

meaningful connections supporting people with dementia and cognitive impairment through their hospital journey

- expansion of telehealth access and training to increase access options for outpatient services
- study days, including a dementia study day and virtual reality workshop to help staff understand how we can provide better care to patients living with dementia, and a paediatric study day focussed on supporting children with neurodiversity
- following a successful trial in 2024, the use of virtual reality technology has continued at Kalamunda Hospital for palliative care patients to engage in experiences otherwise inaccessible due to loss of physical function.

Complaints and safeguarding

Outcome five: People with disability have the same opportunities as other people to make complaints to EMHS.

EMHS regularly reviews its complaints management policy to maximise the way feedback and complaints are received and to ensure it meets the needs of healthcare users.

A variety of methods are available for providing feedback and lodging complaints including paper based, EMHS website, e-mail, verbal and via staff/volunteers assisting to compile complaints, and monitoring of patient feedback including quarterly review at Disability Access and Inclusion Committee meetings.

Visual aids and equipment (e.g. dedicated phones) regarding ‘Aishwarya’s CARE call’ and other consumer-initiated care escalation pathways are installed across EMHS hospitals, especially in emergency departments.

Consultation and engagement

Outcome six: People with disability have the same opportunities as other people to participate in any public consultation by EMHS.

Broad consultation with consumers is regularly undertaken in the delivery and design of all EMHS services.

This includes the use of consumers and staff with lived experience of physical and mental health disability within EMHS hospital Disability Access and Inclusion Committees and Consumer Advisory Committees being involved in the review of services, policies and programs. EMHS also regularly engages with the community and disability service providers as part of its service planning process.

Employment, people and culture

Outcome seven: People with disability have the same opportunities as other people to obtain and maintain employment with EMHS.

EMHS is committed to ensuring people with a disability can obtain and maintain employment. During 2024-25:

- EMHS participation in Staff with Disability and Allies Network annual conference continued to grow
- EMHS became a member of the Australian Disability Network
- new Diversity, Equity and Inclusion role created for EMHS
- ongoing review of EMHS workforce policies to ensure the inclusion of equity, diversity and inclusion principles.

Unauthorised use of credit cards

WA Government purchasing cards can be issued by EMHS to employees where their functions warrant usage of this facility.

These credit cards are not to be used for personal (unauthorised) purposes (i.e. a purpose that is not directly related to performing functions for the agency). All credit card purchases are reviewed by someone other than the cardholder to monitor compliance. If during a review it is determined that the credit card was used for unauthorised purchases, written notice must be given to the cardholder and the EMHS Board.

EMHS had three instances (total amount of \$195.39) where a purchasing card was used for personal purposes in 2024-25. 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 2024 to 30 June 2025:	Total
Instances of use for personal purposes	3
Aggregate amount of personal use expenditure	\$195.39
Aggregate amount of personal use expenditure settled by a due date	\$195.39
Aggregate amount of personal use expenditure settled after a due date	0
Aggregate amount of personal use expenditure remaining unpaid at end of financial year	0
Number of referrals for disciplinary action instigated by the notifiable authority	0

Workplace diversity and inclusion

EMHS is committed to becoming a leader in the health sector by striving for inclusion targets that reflect the diversity of the communities we serve. We are dedicated to fostering a workplace culture that values diversity and inclusion, recognising that staff who feel safe, supported, and engaged contribute to better health outcomes and stronger organisational performance.

Over the past year, EMHS has progressed several key diversity and inclusion initiatives, including:

- Continuing to host our Aboriginal employee forums, to provide a dedicated space for our Aboriginal employees to connect, share cultural experiences, and focus on wellbeing, peer mentoring, and self-care. Through open discussion and yarning, the forum strengthens support networks and reinforces our commitment to cultural safety and empowering our Aboriginal workforce.
- Being the only Health Service Provider to host 6 Aboriginal students through the Public Sector Commission/Curtin University Vacation Program pilot, offering hands-on experience and career exposure. The initiative showcased our commitment to fostering Aboriginal talent and workforce diversity, while building meaningful connections with future health professionals.
- Co-hosted the International Day of People with Disability with the Disability Health Network, featuring speakers, including EMHS staff, with lived experience and community insights. Aligned with the 2024 theme 'Easy to Read. Easy to Reach', the event promoted inclusive communication through Easy Read principles.

- Proudly took part in the 2024 Pride Parade, demonstrating our ongoing commitment to inclusion and support for the LGBTQIA+ community for both staff and consumers. Under the theme 'Together, Go West', PrideFEST celebrated authenticity, visibility, and advocacy for inclusive laws and affirming healthcare.

Through continued focus and targeted initiatives, through the implementation of our Multicultural Plan 2024–2027, Aboriginal Health Priority Area and Deliverables 2024-25 and the EMHS Disability Access and Inclusion Plan, we aim to remain a valued employer in the health sector and better reflect the diverse communities we serve.

EMHS acknowledges there are areas that can be improved, so we are committed to continuing to work towards a culture of inclusion. In June 2025, a staff survey was conducted across EMHS which sought feedback from staff, including on diversity and inclusiveness in the workplace. The results from this survey will assist in identifying areas for improvement and the development of suitable action plans.

Enrolled Nurse, Donna Czirr



Freedom of information

The *Freedom of Information Act 1992* (WA) (FOI Act) gives all Western Australians a right of access to information held by EMHS. Access to information can be made through a Freedom of Information (FOI) application, which should be addressed to the FOI Office at the appropriate EMHS site*.

FOI applications can be granted full access, partial access or access may be refused in accordance with the FOI Act.

In 2024-25, EMHS sites collectively received 2,775 new applications under FOI legislation.

New FOI applications received in 2024-25

Royal Perth Bentley Group (RPBG)

(includes Swan Districts Hospital and Midland Community Mental Health – mental health records)

502 Non-personal applications

1,713 Personal applications

Armadale Kalamunda Group (AKG)

(includes Swan Districts Hospital – general patient records)

35 Non-personal applications

491 Personal applications

EMHS Corporate

7 Non-personal applications

27 Personal applications

*Please see [page 167](#) for contact information for FOI at EMHS.





Appendix

Acronyms index

Acronym	In full
AEG	Area Executive Group
AHS	Armadale Health Service
AKG	Armadale Kalamunda Group
AM	Member of the Order of Australia
ATS	Australasian Triage Scale
BHS	Bentley Health Service
CaLD	Culturally and linguistically diverse
Co-HIVE	Community Health In a Virtual Environment
ED	Emergency Department
EMHS	East Metropolitan Health Service
HABSI	Hospital acquired blood stream infection
HIVE	Health In a Virtual Environment
HSP	Health Service Provider
KH	Kalamunda Hospital
KPI	Key Performance Indicator
OAM	Medal of the Order of Australia
OBM	Outcome Based Management
RPBG	Royal Perth Bentley Group
RPH	Royal Perth Hospital
SHR	Sustainable Health Review
SJGML	St John of God Mount Lawley
SJGMPH	St John of God Midland Public Hospital
WA	Western Australia
WAU	Weighted activity unit
WHS	Work health and safety

Site contact details

Royal Perth Bentley Group



Royal Perth Hospital
Address
197 Wellington Street, Perth WA 6000
Postal address
GPO Box X2213, Perth WA 6847
Telephone (08) 9224 2244
Fax (08) 9224 3511
rph.health.wa.gov.au



Bentley Health Service
Address
18 – 56 Mills Street, Bentley WA 6102
Postal address
PO Box 158, Bentley WA 6982
Telephone (08) 9416 3666
Fax (08) 9416 3711
bhs.health.wa.gov.au

Armadale Kalamunda Group



Armadale Health Service
Address
3056 Albany Highway, Mount Nasura WA 6112
Postal address
PO Box 460, Armadale WA 6992
Telephone (08) 9391 2000
Fax (08) 9391 2149
ahs.health.wa.gov.au



Kalamunda Hospital
Address
Elizabeth Street, Kalamunda WA 6076
Postal address
PO Box 243, Kalamunda WA 6926
Telephone (08) 9257 8100
Fax (08) 9293 2488
<https://emhs.health.wa.gov.au/Hospitals-and-Services/Hospitals/Kalamunda-Hospital>

St John of God Health Care



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
Corner Ellesmere Rd and Thirlmere Road, Mt Lawley 6050
Postal address
Thirlmere Road, Mt Lawley 6050
Telephone (08) 9370 9222
Fax (08) 9272 1229
Email info.mtlawley@sjog.org.au
sjog.org.au/mtlawley

EMHS Board and committee remuneration

Royal Perth Hospital Human Research Ethics Committee (HREC)			
Position	Name	Period of membership in 2024-25	Total remuneration in 2024-25 (\$)
Chair	Stephen Macdonald	6 months	n/a
Lay person	Hamish Milne	6 months	n/a
Lay person	Paul Hansen	2.5 weeks	n/a
Lay person	Helen Walsh	6 months	n/a
Lay person	Grace Moro	2.5 weeks	n/a
Lay person	Tresslyn Smith	2 months	n/a
Professional Care Member	Wayne Epton	6 months	n/a
Professional Care Member	Betty Thomas	6 months	n/a
Pastoral Care	Michael Hertz	6 months	n/a
Pastoral Care	Carolyn Daggers	3 months	n/a
Lawyer	Stephen Sparkes	6 months	n/a
Lawyer	Elizabeth Maynard	11 weeks	n/a
Lawyer	Brendan Ashdown	4 months	n/a
Medical Research A/Chair	Jonathon Burcham	5 months	n/a
	Jonathon Burcham	2 months	n/a
Medical Research	Dieter Weber	6 months	n/a
Medical Research	Janice Fogarty	6 months	n/a
Medical Research	Xavier Fiorilla	6 months	n/a
Medical Research	Zlatibor Velickovic	6 months	n/a
Total			0

Notes:

1. Only the Chair of HREC is eligible for payment and this only applies if the Chair is not a WA Health employee. The Chair and acting Chair in 2024-25 were WA Health employees and ineligible for remuneration.
2. The RPH HREC held meetings for the period July – Dec 2024. The A/Chair completed further duties in January 2025, following which the duties of this committee transitioned to WA Health Central HREC.

EMHS Board			
Position	Name	Period of membership in 2024-25	Total remuneration in 2024-25 (\$)*
Chair	Pia Turcinov	12 months	81,466
Deputy Chair	Denise Glennon	12 months	44,806
Member	Peter Forbes	12 months	44,806
Member	Ross Keesing	12 months	44,806
Member	Steven Patchett	12 months	44,806
Member	Elizabeth Koff	12 months	44,806
Member	Tracey Moroney	12 months	44,806
Member	Vanessa Elliott	12 months	44,806
Member	Melissa Grove	11.5 months	43,014
Member	Andrew Whitechurch	10 months	39,429
External Consultant	Clare Grieveson	4 months	1,611
Total			479,162

*Includes superannuation

FOI contact information

For information about FOI at EMHS, please refer to the EMHS FOI brochure at <https://emhs.health.wa.gov.au/~media/HSPs/EMHS/Documents/About-Us/emhs-freedom-of-information-brochure.pdf>, or visit the FOI page at the relevant EMHS site:

Armadale Kalamunda Group

(includes applications for Swan Districts Hospital (SDH) – general)

<https://ahs.health.wa.gov.au/Patients-and-Visitors/Accessing-Health-Records/Freedom-of-Information>

Royal Perth Hospital

www.rph.health.wa.gov.au/Patients-and-Visitors/Accessing-Health-Records/Accessing-Records-via-Freedom-of-Information

Bentley Health Service

(includes applications for SDH – mental health)

www.bhs.health.wa.gov.au/Patients-and-Visitors/Accessing-Health-Records/Accessing-Records-via-Freedom-of-Information

St John of God Midland Public Hospital and Mount Lawley

<https://www.sjog.org.au/patients-and-visitors/privacy>

EMHS

www.emhs.health.wa.gov.au/About-Us/Accessing-Records/Accessing-Records-via-Freedom-of-Information

Feedback and accessibility

Thank you for reading our EMHS Annual Report 2024-25.

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 the staff who have contributed to the compilation of this report.

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Email: EMHS.GeneralEnquiries@health.wa.gov.au

Website: www.emhs.health.wa.gov.au