OUR COMPLIANCE

Auditor General

INDEPENDENT AUDITOR'S REPORT

2023

South Metropolitan Health Service

To the Parliament of Western Australia

Report on the audit of the financial statements

Opinion

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

- the Statement of Financial Position at 30 June 2023, and the Statement of Comprehensive Income, Statement of Changes in Equity and Statement of Cash Flows for the year then ended
- Notes comprising a summary of significant accounting policies and other explanatory information.

In my opinion, the financial statements are:

- based on proper accounts and present fairly, in all material respects, the operating results and cash flows of the South Metropolitan Health Service for the year ended 30 June 2023 and the financial position at the end of that period
- in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions.

Basis for opinion

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

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

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Responsibilities of the Board for the financial statements

The Board is responsible for:

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

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

Report on the audit of controls

Basis for Qualified Opinion

I identified significant weaknesses in network security controls and controls over unauthorised connection of devices at the South Metropolitan Health Service. These weaknesses could compromise the confidentiality, integrity and availability of key systems and information. These weaknesses also exposed the WA Health network to increased vulnerabilities which could undermine the integrity of data across all systems, including the financial system.

Qualified Opinion

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

In my opinion, except for the possible effects of the matters described in the Basis for Qualified Opinion paragraph, in all material respects, the controls exercised by the South Metropolitan Health Service are sufficiently adequate to provide reasonable assurance that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with the State's financial reporting framework during the year ended 30 June 2023.

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 Engagement 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 South Metropolitan Health Service for the year ended 30 June 2023. The key performance indicators are the Under Treasurer-approved key effectiveness indicators and key efficiency indicators that provide performance information about achieving outcomes and delivering services.

In my opinion, in all material respects, the key performance indicators of the South Metropolitan Health Service are relevant and appropriate to assist users to assess the Health Service's performance and fairly represent indicated performance for the year ended 30 June 2023.

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 904 *Key Performance Indicators.*

Auditor General's responsibilities

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

An assurance engagement involves performing procedures to obtain evidence about the amounts and disclosures in the key performance indicators. It also involves evaluating the relevance and appropriateness of the key performance indicators against the criteria and guidance in Treasurer's Instruction 904 for measuring the extent of outcome achievement and the efficiency of service delivery. The procedures selected depend on my judgement, including the assessment of the risks of material misstatement of the key performance indicators. In making these risk assessments, I obtain an understanding of internal control relevant to the engagement in order to design procedures that are appropriate in the circumstances.

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

My independence and quality 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

Those charged with governance are responsible for the other information. The other information is the information in the entity's annual report for the year ended 30 June 2023, 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

The auditor's report relates to the financial statements and key performance indicators of the South Metropolitan Health Service for the year ended 30 June 2023 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.

Sandra Labuschagne

Sandra Labuschagne
Deputy Auditor General
Delegate of the Auditor General for Western Australia
Perth, Western Australia
14 September 2023

Certification of financial statements

South Metropolitan Health Service

Certification of financial statements
for the year ended 30 June 2023

The accompanying financial statements of South Metropolitan Health Service have been prepared in compliance with the provisions of the Financial Management Act 2006 from proper accounts and records to present fairly the financial transactions for the reporting period ended 30 June 2023 and the financial position as at 30 June 2023.

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

Adjunct Associate Professor Robyn Collins
Board Chair
South Metropolitan Health Service
14 September 2023

Mr Liam Roche
Board member
South Metropolitan Health Service
14 September 2023

Mr Mark Cawthorne
Chief Finance Officer
South Metropolitan Health Service
14 September 2023

South Metropolitan Health Service

Statement of Comprehensive Income

For the year ended 30 June 2023

	Notes	2023 $'000	Restated (a) 2022 $'000
COST OF SERVICES			
Expenses			
Employee benefits expense	3.1.1	1,379,122	1,242,176
Fees for contracted medical practitioners		12,087	12,297
Contracts for services	3.3	140,756	141,592
Patient support costs	3.2	389,264	378,011
Finance costs	7.2	1,682	2,405
Depreciation and amortisation expense	5.1 - 5.4	91,999	91,567
Loss on disposal of non-current assets	4.6	137	-
Repairs, maintenance and consumable equipment	3.4	64,241	60,325
Other supplies and services	3.5	69,790	62,666
Other expenses	3.6	166,459	152,302
Total cost of services		**2,315,537**	**2,143,341**
INCOME			
Revenue			
Patient charges	4.2	94,823	80,200
Other fees for services	4.3	82,974	76,473
Commonwealth grants and contributions	4.4	6	129
Other grants and contributions	4.4	1,673	1,268
Donation revenue	4.6	63	148
Interest revenue		10	2
Commercial activities	4.5	154	563
Other revenue	4.6	19,705	19,014
Total revenue		**199,408**	**177,797**
Gains			
Gain on disposal of non-current assets	4.6	-	34
Gain on revaluation	4.6	-	11,011
Total gains		**-**	**11,045**
Total income other than income from State Government		**199,408**	**188,842**
NET COST OF SERVICES		**2,116,129**	**1,954,499**
Income from State Government			
Department of Health - Service agreement	4.1	1,756,624	1,683,363
Mental Health - Service agreement	4.1	177,466	159,774
Income from other state government agencies	4.1	18,049	19,223
Assets (transferred)/assumed	4.1	3,548	700
Services received free of charge	4.1	109,142	105,998
Total income from State Government		**2,064,829**	**1,969,058**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(51,300)**	**14,559**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.10	247,965	146,493
Total other comprehensive income		**247,965**	**146,493**
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**196,665**	**161,052**

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

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

(a) See note 9.2 Prior years' restatements.

South Metropolitan Health Service

Statement of Financial Position

As at 30 June 2023

	Notes	2023 $'000	Restated (a) 2022 $'000
ASSETS			
Current assets			
Cash and cash equivalents	7.3	51,657	109,677
Restricted cash and cash equivalents	7.3	33,442	35,929
Receivables	6.1	55,502	38,244
Inventories	6.3	7,377	6,446
Other current assets	6.4	4,703	3,434
Total Current Assets		**152,681**	**193,730**
Non-current assets			
Restricted cash and cash equivalents	7.3	28,748	23,748
Amounts receivable for services	6.2	1,218,166	1,126,623
Property, plant and equipment	5.1	2,122,722	1,879,459
Service concession assets	5.3	67,182	62,473
Right-of-use assets	5.2	24,535	37,059
Intangible assets	5.4	6,813	11,609
Total non-current assets		**3,468,166**	**3,140,971**
Total assets		**3,620,847**	**3,334,701**
LIABILITIES			
Current liabilities			
Payables	6.5	114,526	110,277
Contract liabilities	6.6	291	581
Grant liabilities	6.7	7,737	7,743
Lease liabilities	7.1	10,051	15,801
Employee related provisions	3.1.2	270,756	254,805
Other current liabilities	6.8	280	269
Total current liabilities		**403,641**	**389,476**
Non-current liabilities			
Contract liabilities	6.6	-	-
Lease liabilities	7.1	16,168	23,683
Employee related provisions	3.1.2	79,722	74,810
Total non-current liabilities		**95,890**	**98,493**
Total liabilities		**499,531**	**487,969**
NET ASSETS		**3,121,316**	**2,846,732**
EQUITY			
Contributed equity	9.10	2,664,915	2,586,996
Reserves	9.10	473,200	225,235
Accumulated surplus/(deficit)	9.10	(16,799)	34,501
TOTAL EQUITY		**3,121,316**	**2,846,732**

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

(a) See note 9.2 Prior years' restatements.

South Metropolitan Health Service

Statement of Changes in Equity

For the year ended 30 June 2023

	Notes	2023 $'000	Restated (a) 2022 $'000
CONTRIBUTED EQUITY	9.10		
Balance at 1 July		2,586,996	2,534,903
Transactions with owners in their capacity as owners:			
Capital appropriations administered by Department of Health		45,864	52,093
Transfer of net assets (other than cash) from other agencies		32,055	-
Balance at 30 June		**2,664,915**	**2,586,996**
RESERVES	9.10		
Asset Revaluation Reserve			
Balance at 1 July		225,235	78,742
Other comprehensive income		247,965	146,493
Balance at 30 June		**473,200**	**225,235**
ACCUMULATED SURPLUS	9.10		
Balance at 1 July		34,501	29,715
Prior years restatement (a)		-	(9,773)
Balance at 1 July (restated)		**34,501**	**19,942**
Surplus/(deficit) for the period		(51,300)	14,559
Balance at 30 June		**(16,799)**	**34,501**
TOTAL EQUITY			
Balance at 1 July		2,846,732	2,643,360
Prior years restatement (a)		-	(9,773)
Balance at 1 July (restated)		**2,846,732**	**2,633,587**
Total comprehensive income for the period		196,665	161,052
Transactions with owners in their capacity as owners		77,919	52,093
Balance at 30 June		**3,121,316**	**2,846,732**

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

(a) See note 9.2 Prior years' restatements.

South Metropolitan Health Service

Statement of Cash Flows

For the year ended 30 June 2023

	Notes	2023 $'000	Restated (a) 2022 $'000
CASH FLOWS FROM STATE GOVERNMENT			
Revenues from State Government Agencies		1,864,144	1,770,878
Capital appropriations administered by Department of Health		45,864	52,093
Net cash provided by State Government	7.3.2	**1,910,008**	**1,822,971**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(1,355,516)	(1,210,299)
Supplies and services		(731,197)	(703,419)
Finance costs		-	-
Receipts			
Receipts from customers		82,789	81,596
Commonwealth grants and contributions		-	7,500
Other grants and contributions		1,673	1,268
Donations received		63	148
Interest received		10	2
Other receipts		94,889	98,314
Net cash provided by/(used in) operating activities	7.3.2	**(1,907,289)**	**(1,724,890)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Payment for purchase of non-current physical and intangible assets		(40,365)	(30,344)
Receipts			
Proceeds from sale of non-current physical assets		43	39
Net cash provided by/(used in) investing activities		**(40,322)**	**(30,305)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Repayment of lease liabilities		(17,904)	(22,402)
Net cash provided by/(used in) financing activities		**(17,904)**	**(22,402)**
Net increase/(decrease) in cash and cash equivalents		(55,507)	45,374
Cash and cash equivalents at the beginning of the year		169,354	123,980
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.3.1	**113,847**	**169,354**

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

(a) See note 9.2 Prior years' restatements.

1. Basis of preparation

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

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

The annual financial statements were authorised for issue by the Accountable Authority of the Health Service on 14 September 2023.

Statement of compliance

These general purpose financial statements are prepared in accordance with:

1 The *Financial Management Act 2006* (FMA)

2 The Treasurer's Instructions (TIs)

3 Australian Accounting Standards (AASs) including applicable interpretations

4 Where appropriate, those AAS paragraphs applicable for not-for-profit entities have been applied.

The *Financial Management Act 2006* and the Treasurer's Instructions take precedence over AASs. Several AASs are modified by the TIs to vary application, disclosure format and wording. Where modification is required and has had a material or significant financial effect upon the reported results, details of that modification and the resulting financial effect are disclosed in the notes to the financial statements.

Basis of preparation

These financial statements are presented in Australian dollars applying the accrual basis of accounting and using the historical cost convention. Certain balances will apply different measurement basis (such as fair value basis). Where this is the case the different measurement basis is disclosed in the associated note. All values are rounded to the nearest thousand dollars ($'000).

Judgements and estimates

Judgements, estimates and assumptions are required to be made about financial information being presented. The significant judgements and estimates made in the preparation of these financial statements are disclosed in the notes where amounts effected by those judgements and/or estimates are disclosed. Estimates and associated assumptions are based on the professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances.

Contributed equity

AASB Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities* requires transfers in the nature of equity contributions, other than as a result of a restructure of administrative arrangements, to be designated by the Government (the owner) as contributions by owners (at the time of, or prior, to transfer) before such transfers can be recognised as equity contributions. Capital appropriations have been designated as contributions by owners by Treasurer's Instruction 955 'Contributions by Owners made to Wholly Owned Public Sector Entities' and have been credited directly to Contributed equity.

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

South Metropolitan Health Service
Notes to the Financial Statements
For the year ended 30 June 2023

2. Health Service outputs

How the health service operates

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

	Notes
Health Service objectives	2.1
Schedule of Income and Expenses by Service	2.2

2.1 Health Service objectives

Services

To comply with its legislative obligation as a WA Government agency, the Health Service operates under an Outcome Based Management framework (OBM). The OBM framework is determined by WA Health and replaces the former activity based costing framework for annual reporting from 2017/2018 and beyond. This framework describes how outcomes, activities, services and key performance indicators (KPIs) are used to measure agency performance towards achieving the relevant overarching whole of government goal of strong communities, safe communities and supported families and the WA health system agency goal of delivery of safe, quality, financially sustainable and accountable healthcare for all Western Australians.

The six key services of the Health Service under the OBM framework are listed below.

Public Hospital Admitted Patient

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

Public Hospital Emergency Services

The provision of services for the treatment of patients in emergency departments of metropolitan and major rural hospitals, inclusive of public patients treated in private facilities under contract to WA Health. The services provided to patients are specifically designed to provide emergency care, including a range of pre-admission, post-acute and other specialist medical, allied health, nursing and ancillary services. Public Hospital Emergency Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to emergency services. This service does not include any component of the Mental Health Services reported under 'Service four - Mental Health Services'.

Public Hospital Non-Admitted Services

The provision of metropolitan and major rural hospital services to patients who do not undergo a formal admission process, inclusive of public patients treated by private facilities under contract to WA Health. This service includes services provided to patients in outpatient clinics, community based clinics or in the home, procedures, medical consultation, allied health or treatment provided by clinical nurse specialists. Public Hospital Non- Admitted Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to non-admitted services. This service does not include any component of the Mental Health Services reported under 'Service four - Mental Health Services'.

2.1 Health Service objectives (continued)

Mental Health Services

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

Aged and Continuing Care Services

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

Public and Community Health Services

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

2.2 Schedule of income and expenses by service

	Public Hospital Admitted Patient		Public Hospital Emergency Services		Public Hospital Non-Admitted Services		Mental Health Services		Aged Continuing Care Services		Public and Community Health Services		Total	
	2023 $'000	Restated (a) 2022 $'000	2023 $'000	Restated (a) 2022 $'000	2023 $'000	Restated (a) 2022 $'000	2023 $'000	Restated (a) 2022 $'000	2023 $'000	Restated (a) 2022 $'000	2023 $'000	Restated (a) 2022 $'000	2023 $'000	Restated (a) 2022 $'000
COST OF SERVICES														
Expenses														
Employee benefits expense	862,627	769,747	112,013	125,927	223,165	181,093	133,480	126,220	7,651	9,341	40,186	29,848	1,379,122	1,242,176
Fees for contracted medical practitioners	8,371	8,481	1,087	1,388	2,165	1,996	-	-	74	103	390	329	12,087	12,297
Contracts for services	97,472	97,665	12,657	15,978	25,217	22,977	4	-	865	1,185	4,541	3,787	140,756	141,592
Patient support costs	244,667	240,752	31,904	41,909	65,717	57,000	34,446	26,579	2,014	2,904	10,516	8,867	389,264	378,011
Finance costs	1,166	1,659	151	271	301	390	-	1	10	20	54	64	1,682	2,405
Depreciation and amortisation expense	58,177	64,074	5,969	6,277	20,920	13,758	6,203	6,831	277	215	453	412	91,999	91,567
Asset revaluation decrement	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Loss on disposal of non-current assets	95	-	12	-	25	-	-	-	1	-	4	-	137	-
Repairs, maintenance and consumable equipment	42,729	39,652	5,548	6,487	11,054	9,329	2,540	2,838	379	481	1,991	1,538	64,241	60,325
Other supplies and services	48,330	43,225	6,276	7,071	12,503	10,169	-	-	429	525	2,252	1,676	69,790	62,666
Other expenses	113,884	97,926	14,413	21,769	26,296	22,944	5,691	4,890	1,403	1,320	4,772	3,453	166,459	152,302
Total cost of services	**1,477,518**	**1,363,181**	**190,030**	**227,077**	**387,363**	**319,656**	**182,364**	**167,359**	**13,103**	**16,094**	**65,159**	**49,974**	**2,315,537**	**2,143,341**
INCOME														
Revenue														
Patient charges	65,667	55,319	8,527	9,050	16,988	13,015	-	-	582	671	3,059	2,145	94,823	80,200
Other fees and services	57,461	52,749	7,461	8,629	14,865	12,410	-	-	510	640	2,677	2,045	82,974	76,473
Commonwealth grants and contributions	4	89	1	15	1	21	-	-	-	1	-	3	6	129
Other grants and contributions	1,159	874	150	143	300	206	-	-	10	11	54	34	1,673	1,268
Donation revenue	44	102	6	17	11	24	-	-	-	1	2	4	63	148
Interest revenue	7	2	1	-	2	-	-	-	-	-	-	-	10	2
Commercial activities	106	388	14	64	28	91	-	-	1	5	5	15	154	563
Other revenue	13,646	13,114	1,772	2,146	3,530	3,086	-	-	121	159	636	509	19,705	19,014
Total revenue	**138,094**	**122,637**	**17,932**	**20,064**	**35,725**	**28,853**	**-**	**-**	**1,224**	**1,488**	**6,433**	**4,755**	**199,408**	**177,797**
Gains														
Gain on disposal of non-current assets	-	23	-	4	-	6	-	-	-	-	-	1	-	34
Gain on revaluation	-	7,594	-	1,243	-	1,787	-	-	-	92	-	295	-	11,011
Total gains	**-**	**7,617**	**-**	**1,247**	**-**	**1,793**	**-**	**-**	**-**	**92**	**-**	**296**	**-**	**11,045**
Total income other than income from State Government	**138,094**	**130,254**	**17,932**	**21,311**	**35,725**	**30,646**	**-**	**-**	**1,224**	**1,580**	**6,433**	**5,051**	**199,408**	**188,842**
NET COST OF SERVICES	**1,339,424**	**1,232,927**	**172,098**	**205,766**	**351,638**	**289,010**	**182,364**	**167,359**	**11,879**	**14,514**	**58,726**	**44,923**	**2,116,129**	**1,954,499**
INCOME FROM STATE GOVERNMENT														
Department of Health - Service agreement	1,212,195	1,156,413	157,404	189,183	313,599	272,062	6,203	6,831	10,752	14,033	56,471	44,841	1,756,624	1,683,363
Mental Health - Service agreement	-	-	-	-	-	-	177,466	159,774	-	-	-	-	177,466	159,774
Grants from other state government agencies	12,499	13,260	1,623	2,169	3,234	3,119	-	-	111	161	582	514	18,049	19,223
Assets (transferred)/assumed	2,457	482	319	79	636	114	-	-	22	6	114	19	3,548	700
Services received free of charge	76,459	67,187	9,687	19,263	19,035	16,072	900	754	915	930	2,146	1,792	109,142	105,998
Total income from State Government	**1,303,610**	**1,237,342**	**169,033**	**210,694**	**336,504**	**291,367**	**184,569**	**167,359**	**11,800**	**15,130**	**59,313**	**47,166**	**2,064,829**	**1,969,058**
SURPLUS/(DEFICIT) FOR THE PERIOD	**(35,814)**	**4,415**	**(3,065)**	**4,928**	**(15,134)**	**2,357**	**2,205**	**-**	**(79)**	**616**	**587**	**2,243**	**(51,300)**	**14,559**

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

(a) See note 9.2 Prior years' restatements.

3. Use of our funding

Expenses incurred in the delivery of services

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

	Notes	2023 $'000	2022 $'000
Employee benefits expenses	3.1.1	1,379,122	1,242,176
Employee related provisions	3.1.2	350,478	329,615
Patient support costs	3.2	389,264	378,011
Contracts for services	3.3	140,756	141,592
Repairs, maintenance and consumable equipment	3.4	64,241	60,325
Other supplies and services	3.5	69,790	62,666
Other expenses	3.6	166,459	152,302

3.1.1 Employee benefits expenses

	2023 $'000	2022 $'000
Salaries and wages	1,255,157	1,135,660
Termination benefits	427	239
Superannuation - defined contributions plans [(a)]	123,534	106,272
Total employee benefits expenses	**1,379,118**	**1,242,171**
Add: AASB 16 Non-monetary benefits	26	33
Less: Employee Contribution	(22)	(28)
Net employee benefits	**1,379,122**	**1,242,176**

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

Salaries and wages include all costs related to employment including salaries and wages, fringe benefits tax (FBT), leave entitlements, paid sick leave, and non-monetary benefits for employees.

Termination benefits are payable when employment is terminated before normal retirement date, or when an employee accepts an offer of benefits in exchange for the termination of employment. Termination benefits are recognised when the Health Service is demonstrably committed to terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy. Benefits falling due more than 12 months after the end of the reporting period are discounted to present value.

Superannuation is the amount recognised in the statement of comprehensive income comprises employer contributions paid to the GSS (concurrent contributions), WSS, GESB, and other superannuation funds. The employer contribution paid to the GESB in respect of the GSS is paid back into the consolidated account by GESB.

GSS (concurrent contributions) is a defined benefit scheme for the purposes of employees and whole-of-government reporting. It is, however, a defined contribution plan for Health Service's purposes because the concurrent contributions (defined contributions) made by the Health Service to GESB extinguishes the Health Service's obligations to the related superannuation liability.

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

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3.1.1 Employee benefits expenses (continued)

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

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

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

3.1.2 Employee related provisions

Provision is made for benefits accruing to employees in respect of salaries and wages, annual leave, time off in lieu and long service leave for services rendered up to the reporting date and recorded as an expense during the period the services are delivered.

	2023 $'000	2022 $'000
Current		
Employee benefits provisions		
Annual leave	138,447	131,607
Time off in lieu	46,024	40,614
Long service leave	84,736	78,922
Deferred salary scheme	1,549	1,418
Provision for professional development (a)	-	2,244
	270,756	**254,805**
Non-Current		
Employee benefits provisions		
Long service leave	79,722	74,810
	79,722	**74,810**
Total employee related provisions	**350,478**	**329,615**

(a) Provision for professional development has been reported within payables for the current year. Refer to note 6.5 Payables for comparative figure.

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

Within 12 months of the end of the reporting period	101,220	89,886
More than 12 months after the end of the reporting period	83,251	84,579
	184,471	**174,465**

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

3.1.2 Employee related provisions (continued)

Long service leave liabilities are unconditional long service leave provisions and are classified as current liabilities as the Health Service does not have an unconditional right to defer settlement for at least 12 months after the end of the reporting period.

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

	2023 $'000	2022 $'000
Within 12 months of the end of the reporting period	20,886	19,782
More than 12 months after the end of the reporting period	143,572	133,950
	164,458	**153,732**

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

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

Within 12 months of the end of the reporting period	396	610
More than 12 months after the end of the reporting period	1,153	808
	1,549	**1,418**

Key sources of estimation uncertainty – long service leave

Key estimates and assumptions concerning the future are based on historical experience and various other factors that have significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year.

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

3.2 Patient support costs

Medical supplies and services	297,460	280,401
Domestic charges	28,259	34,137
Pathology services provided by PathWest [a] [b]	28,081	26,716
Fuel, light and power	13,805	12,266
Food supplies	10,480	9,480
Patient transport costs	9,973	8,612
Rapid antigen testing kits provided by HSS [b] [c]	1,188	6,363
Research, development and other grants	18	36
Total patient support costs	**389,264**	**378,011**

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

(b) See Note 4.1 Income from State Government.

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

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

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3.3 Contracts for services

	2023 $'000	2022 $'000
Public patients services [a]	136,718	139,390
Mental Health	1,739	637
Home and Comm Care (HACC)	1,521	688
Child, community and primary health	410	410
Blood & Organs	198	405
Patient transport service	158	58
Chronic diseases	-	1
Other contracts	12	3
Total contracts for services	**140,756**	**141,592**

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

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

3.4 Repairs, maintenance and consumable equipment

Repairs and maintenance	9,342	9,788
Consumable equipment	54,899	50,537
Total repairs, maintenance and consumable equipment	**64,241**	**60,325**

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

3.5 Other supplies and services

Sanitisation and waste removal services	2,634	2,453
Administration and management services	62,013	55,938
Interpreter services	2,059	2,125
Security services	1,824	1,306
Other	1,260	844
Total other supplies and services	**69,790**	**62,666**

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

3.6 Other expenses

	2023 $'000	2022 $'000
Communications	6,890	6,777
Computer services	25,464	26,704
Workers' compensation insurance	11,834	8,608
Lease expenses	2,588	2,063
Other insurances	13,019	10,538
Consultancy fees	6,723	4,666
Other employee related expenses	2,157	2,078
Printing and stationery	3,756	3,406
Expected credit losses	4,608	4,925
Freight and cartage	631	510
Periodical subscription	1,558	1,562
Services provided by HSS	79,623	72,496
Motor vehicle expenses	986	903
Audit fees	684	575
Waivers	373	537
Legal expenses	737	499
Legal services provided free of charge	211	400
Other	4,617	5,055
Total other expenses	**166,459**	**152,302**

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

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

Expected credit losses is an allowance for trade receivables, measured at the lifetime expected credit losses at each reporting date. The Health Service has established a provision matrix that is based on its historical credit loss experience, adjusted for forward looking factors specific to the debtors and the economic environment. Refer to note 6.1.1 Movement in the allowance for impairment of receivables.

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

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

Audit fees include the final audit fee for the previous year's audit and any interim audit fees (if any) for the current year's audit and an accrual for the current year's final audit fee. This is represented by external audit fees ($0.409M) and internal audit fees ($0.275M).

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

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4. Our funding sources

How we obtain our funding

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

	Notes	2023 $'000	2022 $'000
Income from State Government	4.1	2,064,829	1,969,058
Patient charges	4.2	94,823	80,200
Other fees for services	4.3	82,974	76,473
Grants and contributions	4.4	1,679	1,397
Commercial activities	4.5	154	563
Other revenue	4.6	19,768	19,162
Gains/(losses) on disposal	4.6	(137)	11,045

4.1 Income from State Government

Income received from other public sector entities during the period: [a]		
Department of Health - Service agreement	1,756,624	1,683,363
Mental Health - Service agreement	177,466	159,774
Income from other state government agencies	18,049	19,223
Total income received	**1,952,139**	**1,862,360**
Assets transferred from/(to) other State government agencies during the period: [b]		
- Transfer of medical equipment from Health Support Services	3,548	700
Total assets (transferred)/assumed	**3,548**	**700**
Services received free of charge from other State Government agencies during the period: [c]		
HSS Support Services (HSS)		
ICT Services	55,083	47,927
Supply chain services	11,471	13,642
Financial services	2,161	1,426
Human resources services	10,908	9,501
Rapid Antigen Test Kits	1,188	6,363
PathWest - Pathology Services	28,081	26,716
Department of Finance - Lease Management Services	39	23
Department of Justice - State Solicitors Office Legal Services	211	400
Total services received	**109,142**	**105,998**
Total income from State Government	**2,064,829**	**1,969,058**

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

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

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

4.1 Income from State Government (continued)

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

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

Pathology services provided by PathWest are in addition to the FFS charges already paid to PathWest included in Note 3.2 Patient support costs.

4.2 Patient charges

	2023 $'000	2022 $'000
Inpatient bed charges	74,745	61,745
Inpatient other charges	7,759	7,126
Outpatient charges	12,319	11,329
Total patient charges	**94,823**	**80,200**

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

4.3 Other fees for services

Recoveries from the Pharmaceutical Benefits Scheme (PBS)	75,220	74,072
Non-clinical services to other health organisations	7,754	2,401
Total other fees for services	**82,974**	**76,473**

(a) See note 9.2 Prior period restatements with respect to correction of accrued PBS revenue in prior years.

4.4 Grants and contributions

Commonwealth grants and contributions		
Recurrent grants:		
Community Health and Hospitals Program	6	129
Other grants and contributions		
Research Grant Revenue	1,673	1,268
Total grants and contributions	**1,679**	**1,397**

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

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

South Metropolitan Health Service
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4.5 Commercial activities

	2023 $'000	2022 $'000
Income from commercial activities		
Pharmacy clinical trials and research activity revenue	890	1,116
Research and development activity revenue	252	398
Ramsay Health Care Australia Pty Ltd (PHC) rent revenue	135	127
	1,277	**1,641**
Expenses from commercial activities		
Pharmacy clinical trials and research activity revenue	(852)	(876)
Research and development activity revenue	(172)	(34)
Ramsay Health Care Australia Pty Ltd (PHC) rent revenue	(99)	(168)
Profit/(loss) from commercial activities	**154**	**563**

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

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

4.6 Other revenue

Donation revenue

General public contributions	63	148
Total donation revenue	**63**	**148**

Other revenue

Use of hospital facilities	20	22
Rent from commercial properties	3,798	3,556
Rent from residential properties	52	45
Boarders' accommodation	7	7
Parking	6,889	6,480
Research and clinical trial revenue	7,991	8,124
Royalties	288	352
Course fees	200	96
Other	460	332
Total other revenue	**19,705**	**19,014**

Gains/(losses)

Net proceeds from disposal of non-current assets		
Property, plant and equipment	43	39
Carrying amount of non-current assets disposed		
Property, plant and equipment	(180)	(5)
Net gains/(losses) on disposal of non-current assets	**(137)**	**34**
Revaluation increments	-	11,011
Other gains/(losses) for the period	**-**	**11,011**

4.6 Other revenue (continued)

Realised and unrealised gains are usually recognised on a net basis. These include gains arising on the disposal of non-current assets and some revaluations of non-current assets.

Gains and losses on the disposal of non-current assets are presented by deducting from the proceeds on disposal the carrying amount of the asset and related selling expenses. Gains and losses are recognised in profit or loss in the statement of comprehensive income (from the proceeds of sale).

5. Key assets

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.

	Notes	2023 $'000	2022 $'000
Property, plant and equipment	5.1	2,122,722	1,879,459
Right-of-use assets	5.2	24,535	37,059
Service concession assets	5.3	67,182	62,473
Intangible assets	5.4	6,813	11,609
Total key assets		**2,221,252**	**1,990,600**

5.1 Property, plant and equipment

	Land $'000	Buildings $'000	Site infrastructure $'000	Computer equipment $'000	Furniture and fittings $'000	Medical equipment $'000	Other plant and equipment $'000	Artworks $'000	Work in progress $'000	Total $'000
1 July 2021										
Gross carrying amount	63,047	1,530,745	123,468	31,625	3,039	33,731	22,666	8	2,876	1,811,205
Accumulated depreciation	-	-	(14,564)	(6,383)	(912)	(16,660)	(8,639)	-	-	(47,158)
Carrying amount at start of year	**63,047**	**1,530,745**	**108,904**	**25,242**	**2,127**	**17,071**	**14,027**	**8**	**2,876**	**1,764,047**
Additions	-	9,265	195	1,449	1,148	6,984	1,800	-	7,527	28,368
Transfers	-	-	-	-	-	-	-	-	-	-
Transfer to Expense	-	-	-	(50)	-	-	(141)	-	(9)	(200)
Transfers to/(from) work in progress	-	2,416	306	23,143	-	-	-	-	(26,257)	(392)
Transfer from/(to) other reporting entities	-	-	-	-	-	-	-	-	-	-
Revaluation increments / (decrements)	10,994	141,894	-	-	-	-	-	-	-	152,888
Disposals	-	-	-	-	(5)	-	-	-	-	(5)
Depreciation	-	(43,816)	(2,923)	(12,573)	(314)	(3,653)	(1,968)	-	-	(65,247)
Transfers between asset classes	-	-	-	(23,863)	-	(505)	510	-	23,858	-
Carrying amount at 30 June 2022	**74,041**	**1,640,504**	**106,482**	**13,348**	**2,956**	**19,897**	**14,228**	**8**	**7,995**	**1,879,459**
Gross carrying amount	74,041	1,640,504	123,970	32,302	4,165	39,807	24,887	8	7,995	1,947,679
Accumulated depreciation	-	-	(17,488)	(18,954)	(1,209)	(19,910)	(10,659)	-	-	(68,220)
Accumulated impairment loss	-	-	-	-	-	-	-	-	-	-
1 July 2022										
Gross carrying amount	74,041	1,640,504	123,970	32,302	4,165	39,807	24,887	8	7,995	1,947,679
Accumulated depreciation	-	-	(17,488)	(18,954)	(1,209)	(19,910)	(10,659)	-	-	(68,220)
Carrying amount at start of year	**74,041**	**1,640,504**	**106,482**	**13,348**	**2,956**	**19,897**	**14,228**	**8**	**7,995**	**1,879,459**
Additions	-	14,434	-	2,415	1,642	14,969	2,109	-	3,120	38,689
Transfers	-	-	-	-	-	-	-	-	-	-
Transfer to Expense	-	-	-	-	-	-	-	-	(483)	(483)
Transfers to/(from) work in progress	-	5,718	-	312	-	-	-	-	(6,030)	-
Transfer from/(to) other reporting entities	-	29,716	1,074	-	161	2,202	-	-	1,264	34,417
Revaluation increments / (decrements)	1,430	239,715	-	-	-	-	-	-	-	241,145
Disposals	-	-	-	-	(54)	(100)	(26)	-	-	(180)
Depreciation	-	(50,960)	(2,951)	(7,306)	(487)	(6,315)	(2,306)	-	-	(70,325)
Transfers between asset classes	-	-	-	-	256	450	146	-	(852)	-
Carrying amount at 30 June 2023	**75,471**	**1,879,127**	**104,605**	**8,769**	**4,474**	**31,103**	**14,151**	**8**	**5,014**	**2,122,722**
Gross carrying amount	75,471	1,879,127	125,044	35,029	5,900	55,244	26,964	8	5,014	2,207,801
Accumulated depreciation	-	-	(20,439)	(26,260)	(1,426)	(24,141)	(12,813)	-	-	(85,079)
Accumulated impairment loss	-	-	-	-	-	-	-	-	-	-

5.1 Property, plant and equipment (continued)

Initial recognition

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

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

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

Subsequent measurement

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

- Land
- buildings

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

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

Land and buildings were revalued as at 1 July 2022 by the Western Australian Land Information Authority (Landgate). The valuations were performed during the year ended 30 June 2023 and recognised at 30 June 2023. In undertaking the revaluation, fair value was determined by reference to market values for land: $3.049 million (2022: $2.774 million) and buildings: $1.05 million (2022: $0.96 million). For the remaining balance, fair value of buildings was determined on the basis of depreciated replacement cost and fair value of land was determined on the basis of comparison with market evidence for land with low level utility (high restricted use land).

Revaluation model:

1. Fair Value where market-based evidence is available:

   The fair value of land and buildings (non-clinical sites) is determined on the basis of current market values determined by reference to recent market transactions. When buildings are revalued by reference to recent market transactions, the accumulated depreciation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount.

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

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

   Fair value for existing use buildings is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset, i.e. the depreciated replacement cost. Where the fair value of buildings is determined on the depreciated replacement costs basis, the accumulated depreciation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount.

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.

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5.1.2 Depreciation and impairment

	2023 $'000	2022 $'000
Charge for the period		
Buildings	50,960	43,816
Site infrastructure	2,951	2,923
Computer equipment	7,306	12,573
Furniture and fittings	487	314
Motor vehicles	-	-
Medical equipment	6,315	3,653
Other plant and equipment	2,306	1,968
Total depreciation for the period	**70,325**	**65,247**

Impairment

As at 30 June 2023 there were no indications of impairment to property, plant and equipment.

All surplus assets at 30 June 2023 have either been classified as assets held for sale or have been written-off.

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

Finite useful lives

All property, plant and equipment having limited useful life are systematically depreciated over their estimated useful lives in a manner that reflects the consumption of their future economic benefits. The exceptions to this rule include items under operating leases and land.

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

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

Asset	Useful life:
Buildings	50 years
Site infrastructure	50 years
Computer equipment	4 to 20 years
Furniture and fittings	2 to 20 years
Motor vehicles	3 to 10 years
Medical equipment	2 to 25 years
Other plant and equipment	3 to 25 years

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

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

Impairment

Non-financial assets, including items of property, plant and equipment, are tested for impairment whenever there is an indication that the asset may be impaired and at the end of each reporting period. Where there is an indication of impairment, the recoverable amount is estimated. Where the recoverable amount is less than the carrying amount, the asset is considered impaired and is written down to the recoverable amount and an impairment loss is recognised

5.1.2 Depreciation and impairment (continued)

Where an asset measured at cost is written down to its recoverable amount, an impairment loss is recognised through profit and loss in statement of comprehensive income.

Where a previously revalued asset is written down to recoverable amount, the loss is recognised as a revaluation decrement in other comprehensive income.

As the Health Service is a not-for-profit entity, unless a specialised asset has been identified as a surplus asset, the recoverable amount is the higher of an asset's fair value less costs to sell and depreciated replacement cost.

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

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

The recoverable amount of assets identified as surplus assets is the higher of fair value less costs to sell and the present value of future cash flows expected to be derived from the asset. Surplus assets carried at fair value have no risk of material impairment where fair value is determined by reference to market-based evidence. Where fair value is determined by reference to depreciated replacement cost, surplus assets are at risk of impairment and the recoverable amount is measured. Surplus assets at cost are tested for indications of impairment at the end of each reporting period.

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5.2 Right-of-use assets

	Buildings non-accommodation $'000	Plant and equipment $'000	Motor vehicles $'000	Information, computer and telecommunications equipment $'000	Furniture fittings $'000	Medical equipment $'000	Total $'000
1 July 2021							
Gross carrying amount	**3,379**	**4,763**	**2,793**	**49,546**	**7,470**	**53,469**	121,420
Accumulated amortisation	**(174)**	**(2,858)**	**(1,127)**	**(29,781)**	**(4,495)**	**(32,174)**	(70,609)
Carrying amount at start of period	**3,205**	**1,905**	**1,666**	**19,765**	**2,975**	**21,295**	**50,811**
Additions	7,025	3,013	506	-	-	-	10,544
Disposals	(4,267)	-	(11)	-	-	-	(4,278)
Depreciation	(503)	(1,466)	(639)	(7,810)	(1,177)	(8,423)	(20,018)
Carrying amount at 30 June 2022	**5,460**	**3,452**	**1,522**	**11,955**	**1,798**	**12,872**	**37,059**
Gross carrying amount	5,726	7,775	3,198	49,482	7,470	53,469	127,120
Accumulated amortisation	(266)	(4,323)	(1,676)	(37,527)	(5,672)	(40,597)	(90,061)
1 July 2022							
Gross carrying amount	5,726	7,775	3,198	49,482	7,470	53,469	127,120
Accumulated amortisation	(266)	(4,323)	(1,676)	(37,527)	(5,672)	(40,597)	(90,061)
Carrying amount at start of period	**5,460**	**3,452**	**1,522**	**11,955**	**1,798**	**12,872**	**37,059**
Additions	6,236		470				6,706
Disposals	(3,739)		(10)				(3,749)
Depreciation	(750)	(1,682)	(728)	(5,531)	(833)	(5,957)	(15,481)
Carrying amount at 30 June 2023	**7,207**	**1,770**	**1,254**	**6,424**	**965**	**6,915**	**24,535**
Gross carrying amount	7,789	7,775	3,539	49,482	7,470	53,469	129,524
Accumulated amortisation	(582)	(6,005)	(2,285)	(43,058)	(6,505)	(46,554)	(104,989)

5.2 Right-of-use assets (continued)

Initial recognition

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

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

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

Subsequent measurement

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

Depreciation and impairment of right-of-use assets

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

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

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

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

	2023 $'000	2022 $'000
Depreciation expense of right-of-use assets	15,453	19,987
Lease interest expense	1,682	2,405
Expenses relating to variable lease payments not included in lease liabilities	-	
Lease maintenance expense	1,524	1,446
Short-term leases	1	-
Low-value leases	3	3
Gains or losses arising from sale and leaseback transactions	(179)	(32)
Total amount recognised in the statement of comprehensive income	**18,484**	**23,809**

The total cash outflow for leases in 2023 was $17.554 million (2022: $22.432 million).

As at 30 June 2022 there were no indications of impairment to right-of-use assets.

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

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

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

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

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

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5.3 Service concession assets

Year ended 30 June 2023

	Land $' 000	Buildings $' 000	Site infrastructure $' 000	Other plant and equipment $' 000	Medical equipment $' 000	Works in progress $' 000	Total $' 000
1 July 2021							
Gross carrying amount	6,070	47,363	5,386	763	487	-	60,069
Accumulated amortisation	-	-	(348)	(132)	(18)	-	(498)
Carrying amount at start of period	**6,070**	**47,363**	**5,038**	**631**	**469**	**-**	**59,571**
Additions	-	-	-	8	-	258	266
Revaluation increments / (decrements)	520	4,096	-	-	-	-	4,616
Depreciation	-	(1,672)	(180)	(67)	(61)	-	(1,980)
Carrying amount at 30 June 2022	**6,590**	**49,787**	**4,858**	**572**	**408**	**258**	**62,473**
Gross carrying amount	6,590	49,787	5,386	771	487	258	63,279
Accumulated amortisation	-	-	(528)	(199)	(79)	-	(806)
1 July 2022							
Gross carrying amount	6,590	49,787	5,386	771	487	258	63,279
Accumulated amortisation	-	-	(528)	(199)	(79)	-	(806)
Carrying amount at start of period	**6,590**	**49,787**	**4,858**	**572**	**408**	**258**	**62,473**
Additions			288				288
Transfers						(258)	(258)
Revaluation increments / (decrements)	310	6,510					6,820
Depreciation	-	(1,823)	(191)	(67)	(60)	-	(2,141)
Carrying amount at 30 June 2023	**6,900**	**54,474**	**4,955**	**505**	**348**	**-**	**67,182**
Gross carrying amount	6,900	54,474	5,672	771	487	-	68,304
Accumulated amortisation	-	-	(717)	(266)	(139)	-	(1,122)

Initial recognition

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

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

The health service as the grantor currently has one service concession arrangement in operation.

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

5.3 Service concession assets (continued)

The facility known as the Peel Health Campus was developed on the site and then sublet to the operator. Service concession assets identified within the service agreement are the facility and facility equipment. The facility and facility equipment are existing assets of the grantor, which the operator is given access to, to provide public services, as the basic purpose of the campus is to provide health services that are necessary or essential to the general public.

Where the Health Service has existing assets, which meet the conditions specified in the policy, these assets have been reclassified as service concession assets and have been measured based on the current replacement cost in accordance with the cost approach to fair value in AASB 13 as at the date of reclassification.

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

Subsequent measurement

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

- land
- buildings

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

Depreciation and impairment of service concession assets

	2023 $'000	2022 $'000
Charge for the period		
Buildings	1,823	1,673
Site infrastructure	191	180
Medical equipment	60	61
Other plant and equipment	67	67
Total depreciation for the period	**2,141**	**1,981**

Impairment

As at 30 June 2023 there were no indications of impairment to service concession assets.

Finite useful lives

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

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

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

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

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5.3 Service concession assets (continued)

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

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

Impairment

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

The policy in connection with testing for impairment is outlined in note 5.1.2 Depreciation and impairment.

5.4 Intangible assets

	Computer software $'000	Works in progress $'000	Total $'000
Year ended 30 June 2022			
1 July 2021			
Gross carrying amount	30,925	15	30,940
Accumulated amortisation	(17,080)	-	(17,080)
Accumulated impairment losses	-	-	-
Carrying amount at start of year	**13,845**	**15**	**13,860**
Additions	1,710	-	1,710
Transfers from work in progress	406	(15)	391
Transfers to expense	-	-	-
Amortisation expense	(4,352)		(4,352)
Carrying amount at 30 June 2022	**11,609**	**-**	**11,609**
Year ended 30 June 2023			
1 July 2022			
Gross carrying amount	33,041	-	33,041
Accumulated amortisation	(21,432)	-	(21,432)
Accumulated impairment losses			-
Carrying amount at start of year	**11,609**	**-**	**11,609**
Additions	190	-	190
Transfers from work in progress	-	-	-
Transfers between asset classes	(906)	-	(906)
Amortisation expense	(4,080)	-	(4,080)
Carrying amount at 30 June 2023	**6,813**	**-**	**6,813**

5.4 Intangible assets (continued)

Initial recognition

Intangible assets are initially recognised at cost. For assets acquired at no cost or for nominal cost, the cost is their fair value at the date of acquisition.

Acquisitions of intangible assets costing $5,000 or more and internally generated intangible assets costing $50,000 or more, that comply with the recognition criteria of AASB 138.57 Intangible Assets are capitalised.

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

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

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

Subsequent measurement

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

5.4.1 Amortisation and impairment

	2023 $'000	2022 $'000
Charge for the period		
Computer software	4,080	4,352
Total amortisation for the year	**4,080**	**4,352**

As at 30 June 2023 there were no indications of impairment to intangible assets.

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

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

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

Computer software	5 to 15 years

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

Impairment of intangible assets

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

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

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6. Other assets and liabilities

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

	Notes	2023 $'000	Restated (a) 2022 $'000
Receivables	6.1	55,502	38,244
Amounts receivable for services	6.2	1,218,166	1,126,623
Inventories	6.3	7,377	6,446
Other current assets	6.4	4,703	3,434
Payables	6.5	114,526	110,277
Contract liabilities	6.6	291	581
Grant liabilities	6.7	7,737	7,743
Other liabilities	6.8	280	269

6.1 Receivables

Current		
Patient fee debtors (b)	36,641	28,871
Other receivables	5,386	2,315
Less: Allowance for impairment of receivables	(15,147)	(12,808)
Accrued revenue (a)	24,350	15,507
GST receivable	4,272	4,359
Total current	**55,502**	**38,244**

(a) See note 9.2 Prior period restatements with respect to correction of accrued PBS revenue in prior years.

(b) Under the Private Patient Scheme approved by the State Government, the Department of Health provides ex-gratia payments towards private patient fees not paid in full by health insurance funds. The total amounts of ex-gratia payments is $2.27 million for 2023 ($1.77 million for 2022).

Receivables are initially recognised at their transaction price, or for those receivables that contain a significant financing component, at fair value. The Health Service holds the receivables with the objective to collect the contractual cashflows and therefore subsequently measured at the amortised cost using the effective interest method, less any allowance for impairment.

The Health Service recognises a loss allowance for expected credit losses (ECLs) on receivable not held at fair value through the profit and loss. The ECLs are based on the difference between the contractual cash flows and the cash flows that the entity expects to receive, discounted at the original effective interest rate. Individual receivables are written off when the Health Service has no reasonable expectations of recovering the contractual cashflows.

For receivables, the Health Service recognises an allowance for ECLs measured at the lifetime expected credit losses at each reporting date. The Health Service has established a provision matrix that is based on its historical credit loss experience, adjusted for forward-looking factors specific to the debtors and the economic environment. Refer to note 3.6 Other expenses for the amount expensed for ECLs during this financial year.

Accounting procedure for Goods and Services Tax (GST)

Rights to collect amounts receivable from the Australian Taxation Office (ATO) and responsibilities to make payments for GST have been assigned to the Department of Health. This accounting procedure was a result of application of the grouping provisions of A New Tax System (Goods and Services Tax) Act 1999 whereby the Department of Health became the Nominated Group Representative (NGR) for the GST group as from 1 July 2012. The entities in the GST group includes the Department of Health, Mental Health Commission, North Metropolitan Health Service, South Metropolitan Health Service, East Metropolitan Health Service, Health Support Services, PathWest Laboratory Medicine WA, WA Country Health Service, QE II Medical Centre Trust, and Health and Disability Services Complaints Office.

GST receivables on accrued expenses are recognised by the Health Service. Upon the receipt of tax invoices, GST receivables for the GST group are recorded in the accounts of the Department of Health.

6.1.1 Movement in the allowance for impairment of trade receivables

	2023 $'000	2022 $'000
Reconciliation of changes in the allowance for impairment of trade receivables		
Opening Balance	12,808	10,521
Expected credit losses expense	4,608	4,925
Amount written off during the period	(2,309)	(2,666)
Amount recovered during the period	40	28
Allowance for impairment at end of period	**15,147**	**12,808**

The maximum exposure to credit risk at the end of the reporting period for receivables is the carrying amount of the asset inclusive of any allowance for impairment as shown in the table at Note 8.1(c) Financial instruments disclosures.

The Health Service does not hold any collateral as security or other credit enhancements for receivables.

6.2 Amounts receivable for services (Holding Account)

Non-current	1,218,166	1,126,623
Total amounts receivable for services at the end of period	**1,218,166**	**1,126,623**

Amounts receivable for services represent the non-cash component of service appropriations. It is restricted in that it can only be used for asset replacement or payment of leave liability.

Amounts receivable for services are financial assets at amortised cost and are not considered impaired (i.e. there is no expected credit loss of the holding accounts).

6.3 Inventories

Current		
Pharmaceutical stores - at cost	7,215	6,350
Engineering stores - at cost	162	96
Total inventories end of period	**7,377**	**6,446**

Inventories are measured at the lower of cost or net realisable value. Costs are assigned on a weighted average cost basis.

Inventories not held for resale are measured at cost unless they are no longer required, in which case they are measured at net realisable value.

6.4 Other assets

Current		
Prepayments	4,694	3,237
Other	9	197
Total other assets at end of period	**4,703**	**3,434**

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

	2023 $'000	2022 $'000
Current		
Trade creditors	8,914	5,607
Other creditors [(a)]	46	45
Accrued expenses	62,361	63,391
Accrued salaries	40,914	41,234
Professional development payable	2,291	-
Total payables at end of period	**114,526**	**110,277**

(a) Includes $0.03 million Fringe Benefits Tax due to the ATO for 2023 Fringe Benefits Tax liability.

(b) Professional development payable was reported within note 3.1.2 Employee benefits expense as a provision for prior years. Refer to note for comparative figure.

Payables are recognised at the amounts payable when the Health Service becomes obliged to make future payments as a result of a purchase of assets or services. The carrying amount is equivalent to fair value, as settlement is generally within 15-20 days.

Accrued salaries represent the amount due to staff but unpaid at the end of the reporting period. Accrued salaries are settled within a fortnight of the reporting period end. The Health Service considers the carrying amount of accrued salaries to be equivalent to its fair value.

The accrued salaries suspense account (see note 7.3 Cash and cash equivalents) consists of amounts paid annually, from the Health Service's appropriations for salaries expense, into a Department of Treasury suspense account to meet the additional cash outflow for employee salary payments in reporting periods with 27 pay days instead of the normal 26. No interest is received on this account.

6.6 Contract liabilities

Current	291	581
Non-current	-	-
Total contract liabilities	**291**	**581**

The Health Services contract liabilities relate to revenue received in advance of contract obligations being satisfied, including rental contracts, prepaid patient revenue and salary funding.

6.6.1 Movement in contract liabilities

Reconciliation of changes in contract liabilities		
Opening balance	581	877
Additions	273	287
Revenue recognised in the reporting period	(563)	(583)
Total contract liabilities at end of period	**291**	**581**

The Health Service expects to satisfy the performance obligations unsatisfied at the end of the reporting period, within the next 12 months for all current contract liabilities.

6.7 Grant liabilities

	2023 $'000	2022 $'000
Current	7,737	7,743
Non-current	-	-
Total Grant liabilities	**7,737**	**7,743**

The Health Service's grant liabilities relate to grant revenue received in advance of the performance obligations being satisfied.

6.7.1 Movement in grant liabilities

Reconciliation of changes in grant liabilities		
Opening balance	7,743	379
Additions		7,500
Income recognised in the reporting period	(6)	(136)
Total grant liabilities at end of period	**7,737**	**7,743**

6.7.2 Expected satisfaction of grant liabilities

Income recognition		
1 year	-	7,743
1 to 5 years	7,737	-
Over 5 years	-	-
	7,737	**7,743**

6.8 Other liabilities

Current		
Refundable deposits	79	80
Paid parental leave scheme	260	250
Other	(59)	(61)
Total other liabilities at end of period	**280**	**269**

Revenue is recognised at the transactions price when the Health Service transfer controls of the services to customers.

Income received in advance relating to patient charges is disclosed in note 6.6 Contract liabilities. The performance obligations for patient charges are satisfied when the Health Service has treated and discharged the patient.

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7. Financing

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

	Notes	2023 $'000	2022 $'000
Lease liabilities	7.1	26,219	39,484
Finance costs	7.2	1,682	2,405
Cash and cash equivalents	7.3	113,847	169,354
Capital commitments	7.4.1	66,094	51,019
Private sector contracts	7.4.2	304,297	265,466
Other expenditure commitments	7.4.3	898,610	774,767

7.1 Lease liabilities

Current		
Finance lease - Fiona Stanley (a)	7,686	13,443
Leases - State Fleet	468	497
Leases - Other	1,897	1,861
Total current	**10,051**	**15,801**
Non-current		
Finance lease - Fiona Stanley (a)	8,729	16,416
Leases - State Fleet	669	883
Leases - Other	6,770	6,384
Total non-current	**16,168**	**23,683**
Total lease liabilities	**26,219**	**39,484**

Initial Measurement

The Health Service measures a lease liability, at the commencement date, at the present value of the lease payments to be made over the lease term. The lease payments are discounted using the interest rate implicit in the lease. If that rate cannot be readily determined, the Health Service uses the incremental borrowing rate provided by Western Australia Treasury Corporation.

Lease payments included by the Health Service as part of the present value calculation of lease liability include:

- fixed payments (including in-substance fixed payments), less any lease incentives receivable;
- variable lease payments that depend on an index or a rate initially measured using the index or rate as at the commencement date;
- amounts expected to be payable by the lessee under residual value guarantees;
- the exercise price of purchase options (where these are reasonably certain to be exercised);
- payments for penalties for terminating a lease, where the lease term reflects the Health Service exercising an option to terminate the lease.

The interest on the lease liability is recognised in profit or loss over the lease term so as to produce a constant periodic rate of interest on the remaining balance of the liability for each period. Lease liabilities do not include any future changes in variable lease payments (that depend on an index or rate) until they take effect, in which case the lease liability is reassessed and adjusted against the right-of-use asset.

Periods covered by extension or termination options are only included in the lease term by the Health Service if the lease is reasonably certain to be extended (or not terminated).

Variable lease payments, not included in the measurement of lease liability, that are dependent on sales are recognised by the Health Service in profit or loss in the period in which the condition that triggers those payments occurs.

This section should be read in conjunction with Note 5.2 Right-of-use assets.

7.1 Lease liabilities (continued)

Subsequent measurement

Lease liabilities are measured by increasing the carrying amount to reflect interest on the lease liabilities; reducing the carrying amount to reflect the lease payments made; and remeasuring the carrying amount at amortised cost, subject to adjustments to reflect any reassessment or lease modifications

(a) During the 2012 financial year, the 'Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals' entered into a facilities management contract for a minimum period of 10 years for FSH with Serco Limited, whereby, subject to approval by the Health Service, Serco is to acquire specified assets for use at the hospital. The specified assets are to be acquired under a lease facility with a bank. Under the terms of the Facilities Management Contract and the related agreements, an element of the fee paid to Serco is linked to the fixed lease payments detailed on each leasing schedule for each group of assets, and at the end of the lease period for each group of assets, the Health Service is required to take ownership directly or dispose of the asset.

Although the arrangement, that is under a Tripartite Agreement between the Minister for Health, the private sector provider and the bank, is not in the legal form of a lease, the Health Service concluded that the arrangement contains a lease of assets, because fulfilment of the arrangement is economically dependent on the use of the assets and the Health Service receives the full service potential from the assets through the services provided at FSH.

The Health Service is able to determine the fair value of the lease element of the Facilities Management Contract with direct reference to the underlying lease payments agreed on each leasing schedule between Serco and the bank, which has been authorised by the Health Service. Therefore, at lease inception, being the various dates on which the leasing schedules for the individual assets are entered into, the Health Service recognises the leased asset and liability at the lower of the fair value or present value of future lease payments. The imputed finance costs on the liability were determined based on the interest rate implicit in the lease.

	2023 $'000	2022 $'000
The carrying amounts of non-current assets pledged as security are:		
Right-of-use assets - Plant and equipment leased	613	1,141
Right-of-use assets - Motor vehicles leased	1	5
Right-of-use assets - Information, computer and telecommunications equipment (ICT) leased	6,391	11,894
Right-of-use assets - Furniture and fittings leased	965	1,797
Right-of-use assets - Medical equipment leased	6,915	12,873
Total assets pledged as security	**14,885**	**27,710**

7.2 Finance costs

Lease interest expense	1,682	2,405
Interest expense	-	-
Finance costs expensed	**1,682**	**2,405**

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

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7.3 Cash and cash equivalents

	2023 $'000	2022 $'000
Cash and cash equivalents	51,657	109,677
Restricted cash and cash equivalents	62,190	59,677
Balance at end of period	**113,847**	**169,354**

7.3.1 Reconciliation of cash

Cash assets at the end of the financial year as shown in the statement of cash flows are reconciled to the related items in the statement of financial position as follows:

Cash and cash equivalents		
Current [a]	**51,657**	**109,677**
Restricted cash and cash equivalents		
Current		
Restricted cash assets held for other specific purposes [b]	32,950	35,447
Fiona Stanley Hospital - Upgrade Works Account [c]	492	482
Total current	**33,442**	**35,929**
Non-current		
Accrued salaries suspense account [d]	28,748	23,748
Total non-current	**28,748**	**23,748**
Total restricted cash and cash equivalents	**62,190**	**59,677**
Balance at end of period	**113,847**	**169,354**

(a) Includes cash assigned to meet ongoing internal obligations arising from allocated donations, research program commitments, education and training grants, funds directed and quarantined under medical industrial agreement and funds directed and quarantined under previous Ministerial Directive.

Restricted cash and cash equivalents are assets, the uses of which are restricted by specific legal or other externally imposed requirements.

(b) These include medical research grants, donations for the benefits of patients, medical education, scholarships, capital projects, employee contributions and staff benevolent funds.

(c) The moneys deposited to the Fiona Stanley Hospital Upgrade Works Account must be used for the purposes of the upgrade works in respect of the building and site services assets.

(d) Funds held in the suspense account at the Department of Treasury will be used only for the purpose of meeting the 27th pay in a financial year that occurs every 11 years. In a normal year there are 26 payroll periods where cash is outlaid. Every 11 years, however, there is an additional fortnightly payroll to the standard 26. This additional pay period is termed the '27th pay' and the next occurrence is in the year 2027/28. To ensure sufficient cash resources are available, it is prudent to reserve a portion of cash funds towards this event each year. The value reserved represents an estimated payroll amount for one day.

For the purpose of the statement of cash flows, cash and cash equivalent (and restricted cash and cash equivalent) assets comprise cash on hand, cash at bank and short-term deposits with original maturities of three months or less that are readily convertible to a known amount of cash and which are subject to insignificant risk of changes in value.

7.3.2 Reconciliation of net cost of services to net cash flows used in operating activities

	Notes	2023 $'000	Restated (a) 2022 $'000
Net cost of services		(2,116,129)	(1,954,499)
Non-cash items:			
Expected credit losses expense	3.6	4,608	4,925
Write off of receivables	6.1.1	(2,309)	(2,666)
Receivables amount recovered during the period	6.1.1	40	28
Depreciation and amortisation expense	5.1 - 5.4	91,999	91,567
WIP assets relating to prior years expensed	5.1 - 5.4	483	200
Net gain/(loss) from disposal of non-current assets	4.6	137	-
Capitalisation of finance lease charges	7.2	1,685	2,405
Net donation of non-current assets		22	-
Services received free of charge	4.1	109,142	105,998
Reversal of revaluation decrement - land	4.6	-	(11,011)
Recognition of revenue received in prior years.		6	-
Adjustment for other non-cash items		-	-
(Increase)/decrease in assets:			
GST receivable		87	(187)
Other current receivables		(19,685)	3,927
Inventories		(932)	(965)
Prepayments and other current assets		(1,270)	70
Increase/(decrease) in liabilities:			
Payables		2,005	1,363
Current provisions		18,195	28,848
Non-current provisions		4,912	(1,957)
Other current liabilities		11	(4)
Contract liabilities		(290)	(296)
Grant liabilities		(6)	7,364
Net cash used in operating activities		**(1,907,289)**	**(1,724,890)**
Cash flows from State Government			
Revenues from government agencies as per statement of comprehensive income		1,952,139	1,862,360
Capital contributions credited directly to Contributed equity (refer note 9.10 Equity)		45,864	52,093
		1,998,003	**1,914,453**
Less notional cash flows: Items paid directly by the Department of Health for the Health Service and are therefore not included in the statement of cash flows:			
Assets purchased via Department of Health		3,548	700
Accrual appropriations		(91,543)	(92,182)
Other non-cash adjustments to service appropriations		-	-
Cash flows from State Government as per statement of cash flows		**1,910,008**	**1,822,971**

At the end of the reporting period the Health Service had fully drawn on all financing facilities, details of which are disclosed in the financial statements.

(a) See note 9.2 Prior period restatements

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7.4 Commitments

The commitments below are inclusive of GST where relevant.

7.4.1 Capital expenditure commitments

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

	2023 $'000	2022 $'000
Capital expenditure commitments being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows:		
Within 1 year	31,207	33,441
Later than 1 year and not later than 5 years	34,887	17,578
Later than 5 years	-	-
	66,094	**51,019**

7.4.2 Private sector contracts for the provision of health services

Expenditure commitments in relation to private sector organisations contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:

Expenditure commitments in relation to private sector organisations contracted for at the end of the reporting period but not recognised as liabilities are payable as follows:		
Within 1 year	195,280	189,087
Later than 1 year and not later than 5 years	89,623	76,123
Later than 5 years	19,394	256
	304,297	**265,466**

7.4.3 Other expenditure commitments

Other expenditure commitments contracted for at the reporting period but not recognised as liabilities are payable as follows:

Other expenditure commitments contracted for at the reporting period but not recognised as liabilities are payable as follows:		
Within 1 year	192,138	7,704
Later than 1 year and not later than 5 years	659,544	703,282
Later than 5 years	46,928	63,781
	898,610	**774,767**

8. Risks and Contingencies

This section sets out the key risk management policies and measurement techniques of the Health Service.

	Notes
Financial risk management	8.1
Contingent assets	8.2
Contingent liabilities	8.2
Fair value measurements	8.3

8.1 Financial risk management

Financial instruments held by the Health Service are cash and cash equivalents, restricted cash and cash equivalents, receivables and payables. The Health Service has limited exposure to financial risks. The Health Service's overall risk management program focuses on managing the risks identified below.

(a) Summary of risks and risk management

Credit risk

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

Credit risk associated with the Health Service's financial assets is generally confined to patient fee debtors (see note 6.1 Receivables). The main receivable of the Health Service is the amounts receivable for services (holding account). For receivables other than government agencies and patient fee debtors, the Health Service trades only with recognised, creditworthy third parties. The Health Service has policies in place to ensure that sales of products and services are made to customers with an appropriate credit history. In addition, receivable balances are monitored on an ongoing basis with the result that the Health Service's exposure to bad debts is minimised. Debt will be written-off against the allowance account when it is improbable or uneconomical to recover the debt. At the end of the reporting period, there were no significant concentrations of credit risk.

Liquidity risk

Liquidity risk arises when the Health Service is unable to meet its financial obligations as they fall due. The Health Service is exposed to liquidity risk through its normal course of operations.

The Health Service has appropriate procedures to manage cash flows including drawdowns of appropriations by monitoring forecast cash flows to ensure that sufficient funds are available to meet its commitments.

Market risk

Market risk is the risk that changes in market prices such as foreign exchange rates and interest rates will affect the Health Service's income or the value of its holdings of financial instruments. The Health Service does not trade in foreign currency and is not materially exposed to other price risks.

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8.1 Financial risk management (continued)

(b) Categories of financial instruments

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

	2023 $'000	2022 $'000
Financial assets		
Cash and cash equivalents	51,657	109,677
Restricted cash and cash equivalents	62,190	59,677
Receivables [(a)]	1,269,396	1,160,508
Total financial assets	**1,383,243**	**1,329,862**
Financial liabilities		
Financial liabilities measured at amortised cost	140,745	149,761
Total financial liabilities	**140,745**	**149,761**

(a) The amount of receivables / financial assets at amortised cost excludes GST recoverable from the ATO (statutory receivable)

(b) The amount of financial liabilities at amortised cost excludes GST payable to the ATO (statutory payable).

(c) Credit risk exposure

The following table details the credit risk exposure on the Health Service's receivables using a provision matrix.

		Days past due				
	Total $'000	Current $'000	<30 days $'000	31-60 days $'000	61-90 days $'000	>91 days $'000
30 June 2023						
Expected credit loss rate	23%	2%	21%	20%	33%	50%
Estimated total gross carrying amount at default	66,378	32,332	5,542	2,089	1,288	25,127
Expected credit losses	15,147	511	1,175	425	421	12,615

		Days past due				
	Total $'000	Current $'000	<30 days $'000	31-60 days $'000	61-90 days $'000	>91 days $'000
30 June 2022						
Expected credit loss rate	27%	1%	24%	50%	35%	54%
Estimated total gross carrying amount at default	46,693	20,943	3,001	1,633	1,593	19,523
Expected credit losses	12,808	255	723	815	560	10,455

8.1 Financial risk management (continued)

(d) Liquidity risk and Interest rate exposure

The following table details the Health Service's interest rate exposure and the contractual maturity analysis of financial assets and financial liabilities. The maturity analysis section includes interest and principal cash flows. The interest rate exposure section analyses only the carrying amounts of each item.

Interest rate exposure and maturity analysis of financial assets and financial liabilities

			Interest rate exposure				Maturity dates			
	Weighted average effective interest rate %	Carrying amount $'000	Fixed interest rate $'000	Variable interest rate $'000	Non-interest bearing $'000	Nominal amount $'000	Up to 3 months $'000	3 months to 1 year $'000	1 to 5 years $'000	More than 5 years $'000
2023										
Financial Assets										
Cash and cash equivalents		51,657	-	-	51,657	51,657	51,657	-	-	-
Restricted cash and cash equivalents		62,190	-	-	62,190	62,190	62,190	-	-	-
Receivables [(c)]		51,230	-	-	51,230	51,230	51,230	-	-	-
Amounts receivable for services		1,218,166	-	-	1,218,166	1,218,166	-			1,218,166
		1,383,243	**-**	**-**	**1,383,243**	**1,383,243**	**165,077**	**-**	**-**	**1,218,166**
Financial Liabilities										
Payables		114,526	-	-	114,526	114,526	114,526	-	-	-
Finance lease - Fiona Stanley Hospital	6.35%	16,415	16,415	-	-	16,415	2,156	5,530	7,855	874
Leases - State Fleet	4.23%	1,137	1,137	-	-	1,137	122	346	653	16
Leases - Other	4.74%	8,667	8,667	-	-	8,667	412	1,485	3,383	3,387
		140,745	**26,219**	**-**	**114,526**	**140,745**	**117,216**	**7,361**	**11,891**	**4,277**
2022 Restated										
Financial Assets										
Cash and cash equivalents	-	109,677	-	-	109,677	109,677	109,677	-	-	-
Restricted cash and cash equivalents	-	59,677	-	-	59,677	59,677	59,677	-	-	-
Receivables [(c)]	-	33,885	-	-	33,885	33,885	33,885	-	-	- (a)
Amounts receivable for services	-	1,126,623	-	-	1,126,623	1,126,623	-	-	-	1,126,623
		1,329,862	**-**	**-**	**1,329,862**	**1,329,862**	**203,239**	**-**	**-**	**1,126,623**
Financial Liabilities										
Payables		110,277	-	-	110,277	110,277	110,277	-	-	-
Finance lease - Fiona Stanley Hospital	6.35%	29,857	29,857	-	-	29,857	3,592	9,850	14,445	1,970
Leases - State Fleet	3.47%	1,380	1,380	-	-	1,380	132	365	873	10
Leases - Other	3.11%	8,246	8,246	-	-	8,246	548	1,314	3,727	2,657
		149,760	**39,483**	**-**	**110,277**	**149,760**	**114,549**	**11,529**	**19,045**	**4,637**

(a) The amount reported for receivables excludes the GST recoverable from the ATO (statutory receivable).

(b) The amount of financial liabilities at amortised cost excludes GST payable to the ATO (statutory payable).

(c) Prior year receivables amount has been restated. See note 9.2 Prior period restatements with respect to correction of accrued PBS revenue in prior years.

8.2 Contingent assets and liabilities

Contingent assets and contingent liabilities are not recognised in the statement of financial position but are disclosed and, if quantifiable, are measured at the best estimate.

Contingent assets and liabilities are presented inclusive of GST receivable or payable retrospectively.

Contingent assets

In addition to the assets included in the financial statements, the Health Service has the following contingent assets:

	2023 $'000	2022 $'000
Other		
There are facilities management matters under negotiation that may or may not become assets. The negotiations are an ongoing part of contract management processes invoking formal contractual dispute mechanisms. These matters have not progressed to the 'litigation in process' stage.	-	171
Number of disputes	**-**	**2**

Contingent liabilities

In addition to the liabilities included in the financial statements, the Health Service has the following contingent liabilities:

	2023 $'000	2022 $'000
Other		
There are facilities management matters under negotiation that may or may not become liabilities. The negotiations are an ongoing part of contract management processes invoking formal contractual dispute mechanisms. These matters have not progressed to the 'litigation in process' stage.	17,896	18,295
Number of disputes	**11**	**22**

Contaminated sites

Under the Contaminated Sites Act 2003 the Health Service is required to report known and suspected contaminated sites to the Department of Water and Environmental Regulation. In accordance with the Act, the Department of Water and Environmental Regulation classifies these sites on the basis of the risk to human health, the environment and environmental values. Where sites are classified as contaminated – remediation required or possibly contaminated – investigation required, the Health Service may have a liability in respect of investigation or remediation expenses.

At the reporting date, the Health Service does not have any suspected contaminated sites reported under the Act.

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8.3 Fair value measurements

Fair value hierarchy

AASB 13 requires disclosure of fair value measurements by level of the following fair value measurement hierarchy:

1) quoted prices (unadjusted) in active markets for identical assets (level 1)
2) input other than quoted prices included within level 1 that are observable for the asset either directly or indirectly (level 2)
3) inputs for the asset that are not based on observable market data (unobservable input) (level 3).

	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
2023				
Assets measured and recognised at fair value:				
Land				
Specialised	-	3,049	79,322	82,371
Buildings				
Residential and commercial car park	-	-	65,167	65,167
Specialised	-	1,050	1,867,384	1,868,434
	-	**4,099**	**2,011,873**	**2,015,972**

	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
2022				
Assets measured and recognised at fair value:				
Land				
Specialised	-	2,774	77,857	80,631
Buildings				
Residential and commercial car park	-	-	58,570	58,570
Specialised	-	945	1,630,776	1,631,721
	-	**3,719**	**1,767,203**	**1,770,922**

Valuation techniques to derive Level 2 and Level 3 fair values

The Health Service obtains independent valuations of land and buildings from the Western Australian Land Information Authority (Landgate Valuation Services) annually. Two principal valuation techniques are applied to the measurement of fair values:

Market approach (comparable sales)

The Health Service's residential properties, commercial car park and vacant land are valued under the market approach. This approach provides an indication of value by comparing the asset with identical or similar properties for which price information is available. Analysis of comparable sales information and market data provides the basis for fair value measurement.

The best evidence of fair value is current prices in an active market for similar properties. Where such information is not available, Landgate Valuation Services considers current prices in an active market for properties of different nature or recent prices of similar properties in less active markets and adjusts the valuation for differences in property characteristics and market conditions.

For properties with buildings and other improvements, the land value is measured by comparison and analysis of open market transactions on the assumption that the land is in a vacant and marketable condition. The amount determined is deducted from the total property value and the residual amount represents the building value.

The Health Service's residential properties mainly consist of residential buildings that have been re-configured to be used as health centres or clinics.

8.3 Fair value measurements (continued)

Cost approach

Properties of a specialised nature that are rarely sold in an active market or are held to deliver public services are referred to as non-market or current use type assets. These properties do not normally have a feasible alternative use due to restrictions or limitations on their use and disposal. The existing use is their highest and best use.

For current use land assets, fair value is measured firstly by establishing the opportunity cost of public purpose land, which is termed the hypothetical alternate land use value. This approach assumes unencumbered land use based upon potential highest and best alternative use as represented by surrounding land uses and market analysis.

Fair value of the land is then determined on the assumption that the site is rehabilitated to a vacant marketable condition. This requires costs associated with rehabilitation to be deducted from the hypothetical alternate land use value of the land. Costs may include building demolition, clearing, planning approvals and time allowances associated with realising that potential.

In some instances, the legal, physical, economic and socio political restrictions on a land results in a minimal or negative current use land value. In this situation the land value adopted is the higher of the calculated rehabilitation amount or the amount determined on the basis of comparison to market corroborated evidence of land with low level utility. Land of low level utility is considered to be grazing land on the urban fringe of the metropolitan area with no economic farming potential or foreseeable development or redevelopment potential at the measurement date.

The Health Service's hospitals and medical centres are specialised buildings valued under the cost approach. Staff accommodation on hospital grounds is also considered as specialised buildings for valuation purpose.

This approach uses the depreciated replacement cost method which estimates the current cost of reproduction or replacement of the buildings, on its current site, less deduction for physical deterioration and relevant forms of obsolescence. Depreciated replacement cost is the current replacement cost of an asset less, where applicable, accumulated depreciation calculated on the basis of such cost to reflect the already consumed or expired future economic benefits of the asset.

The techniques involved in the determination of the current replacement costs include:

(a) review and updating of the 'as-constructed' drawing documentation

(b) categorisation of the drawings using the Building Utilisation Categories (BUC) which designate the functional areas typically provided by the following types of clinical facilities. Each BUC has different cost rates which are calculated from the historical construction costs of similar clinical facilities and are adjusted for the year-to-year change in building costs using building cost index

- nursing posts and medical centres
- metropolitan secondary hospitals

(c) measurement of the general floor areas

(d) application of the BUC cost rates per square meter of general floor areas

(e) application of the applicable regional cost indices, which are used throughout the construction industry to estimate the additional costs associated with building construction in locations outside of the Perth area.

The maximum effective age used in the valuation of specialised buildings is 50 years. The effective age of buildings is initially calculated from the commissioning date and is reviewed after the buildings have undergone substantial renewal, upgrade or expansion.

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8.3 Fair value measurements (continued)

The straight-line method of depreciation is applied to derive the depreciated replacement cost, assuming a uniform pattern of consumption over the initial 37 years of asset life (up to 75 per cent of current replacement costs). All specialised buildings are assumed to have a residual value of 25 per cent of their current replacement costs.

The valuations are prepared on a going concern basis until the year in which the current use is discontinued.

Buildings with definite demolition plan are not subject to annual revaluation. The depreciated replacement costs at the last valuation dates for these buildings are written down to the Statement of Comprehensive Income as depreciation expenses over their remaining useful life.

Fair value measurements using significant unobservable inputs (Level 3)

The following table represents the changes in level 3 items for the period ended 30 June 2023.

	Land $'000	Buildings $'000	Total $'000
2023			
Fair value at start of period	77,857	1,689,346	1,767,203
Additions	-	49,869	49,869
Revaluation increments/(decrements) recognised in profit or loss	-	-	-
Revaluation increments/(decrements)	1,465	246,100	247,565
Depreciation	-	(52,764)	(52,764)
Fair value at end of period	**79,322**	**1,932,551**	**2,011,873**
2022			
Fair value at start of period	66,487	1,577,238	1,643,725
Additions	-	11,681	11,681
Revaluation increments/(decrements) recognised in profit or loss	10,867	-	10,867
Revaluation increments/(decrements)	503	145,898	146,401
Depreciation	-	(45,471)	(45,471)
Fair value at end of period	**77,857**	**1,689,346**	**1,767,203**

Valuation processes

The Health Service manages its own valuation processes. This includes the provision of property information to a quantity surveyor, Landgate, and the review of valuation reports. Valuation processes and results are discussed with the chief finance officer at least once every year.

Landgate determines the fair values of the Health Service's land and building. A quantity surveyor is engaged by the Health Service to provide an update of the current replacement costs for specialised buildings. Landgate endorses the current replacement costs calculated by the quantity surveyor for specialised buildings and calculates the depreciated replacement costs.

9. Other disclosures

This section includes additional material disclosures required by accounting standards or other pronouncements, for the understanding of this financial report.

	Notes
Events occurring after the end of the reporting period	9.1
Future impact of Australian Accounting Standards not yet operative	9.3
Key management personnel	9.4
Related party transactions	9.5
Related bodies	9.6
Affiliated bodies	9.7
Special purpose accounts	9.8
Remuneration of auditor	9.9
Equity	9.10
Supplementary financial information	9.11

9.1 Events occurring after the end of the reporting period

There were no events occurring after the reporting period which had significant financial effects on these financial statements.

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9.2 Prior period restatements

Recoveries from the Pharmaceutical Benefits Scheme (PBS):

During the financial year a review was conducted to confirm the validity of the iPharmacy data used to calculate the accrued PBS rebates. It was identified that the accruals were overstated by amounts related to patient contributions. This impacted the Other fees for services and Accrued revenue for 2021-22 which were overstated by $2.247M. In addition, the Accumulated surplus as at 1 July 2021 was overstated by $9.773M, reflecting the cumulative effects of excess accrual of PBS recoveries in previous financial years.

9.3 Future impact of Australian Accounting Standards not yet operative

The Health Service cannot early adopt an Australian Accounting Standard unless specifically permitted by TI 1101 *Application of Australian Accounting Standards and Other Pronouncements* or by an exemption from TI 1101. Where applicable, the Health Service plans to apply the following Australian Accounting Standards from their application date.

		Operative for reporting periods beginning on/after
Operative for reporting periods beginning on/after 1 Jan 2023		
AASB 17	*Insurance Contracts* This Standard establishes principles for the recognition, measurement, presentation and disclosure of insurance contracts. The Health Service has not assessed the impact of the Standard.	1 Jan 2023
AASB 2020-1	*Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-current* This Standard amends AASB 101 to clarify requirements for the presentation of liabilities in the statement of financial position as current or non-current. These is no financial impact.	1 Jan 2023
AASB 2021-2	*Amendments to Australian Accounting Standards – Disclosure of Accounting Policies and Definition of Accounting Estimates* This Standard amends: (a) AASB 7, to clarify that information about measurement bases for financial instruments is expected to be material to an entity's financial statements; (b) AASB 101, to require entities to disclose their material accounting policy information rather than their significant accounting policies; (c) AASB 108, to clarify how entities should distinguish changes in accounting policies and changes in accounting estimates; (d) AASB 134, to identify material accounting policy information as a component of a complete set of financial statements; and (e) AASB Practice Statement 2, to provide guidance on how to apply the concept of materiality to accounting policy disclosures. There is no financial impact.	1 Jan 2023

9.3 Future impact of Australian Accounting Standards not yet operative (continued)

Operative for reporting periods beginning on/after 1 Jan 2023 (continued)

AASB 2021-6	*Amendments to Australian Accounting Standards – Disclosure of Accounting Policies: Tier 2 and Other Australian Accounting Standards* This standard amends This standard amends: (a) AASB 1049, to require entities to disclose their material accounting policy information rather than their significant accounting policies; (b) AASB 1054 to reflect the updated accounting policy terminology used in AASB 101 Presentation of Financial Statements; and (c) AASB 1060 to required entities to disclose their material accounting policy information rather than their significant accounting policy and to clarify that information about measurement bases for financial instruments is expected to be material to an entity's financial statements. There is no financial impact.	1 Jan 2023
AASB 2022-7	*Editorial Corrections to Australian Accounting Standards and Repeal of Superseded and Redundant Standards* This Standard makes editorial corrections to various Australian Accounting Standards and AASB Practice Statement 2 Making Materiality Judgements. There is no financial impact.	1 Jan 2023
AASB 2022-8	*Amendments to Australian Accounting Standards – Insurance Contracts: Consequential Amendments* This Standard amends: (a) AASB 1; (b) AASB 3; (c) AASB 5; (d) AASB 7; (e) AASB 9; (f) AASB 15; (g) AASB 17; (h) AASB 119; (i) AASB 132; (j) AASB 136; (k) AASB 137; (l) AASB 138; (m) AASB 1057; and (n) AASB 1058, to permit public sector entities to continue applying AASB 4 and AASB 1023 to annual periods beginning on or after 1 January 2023 but before 1 July 2026. There is no financial impact.	1 Jan 2023

Operative for reporting periods beginning on/after 1 Jan 2024

AASB 2021-7C	*Amendments to Australian Accounting Standards – Effective Date of Amendments to AASB 10 and AASB 128 and Editorial Corrections* This Standard further defers (to 1 January 2025) the amendments to AASB 10 and AASB 128 relating to the sale or contribution of assets between an investor and its associate or joint venture. The standard also includes editorial corrections. There is no financial impact.	1 Jan 2025
AASB 2022-5	*Amendments to Australian Accounting Standards – Lease Liability in a Sale and Leaseback* This Standard amends AASB 16 to add measurement requirements for sale and leaseback transactions that satisfy the requirements in AASB 15 to be accounted for as a sale. There is no financial impact.	1 Jan 2024

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9.3 Future impact of Australian Accounting Standards not yet operative (continued)

Operative for reporting periods beginning on/after 1 Jan 2024 (continued)

AASB 2022-6	*Amendments to Australian Accounting Standards – Non-current Liabilities with Covenants* This Standard amends AASB 101 to improve the information an entity provides in its financial statements about liabilities arising from loan arrangements for which the entity's right to defer settlement of those liabilities for at least twelve months after the reporting period is subject to the entity complying with conditions specified in the loan arrangement. The Standard also amends an example in Practice Statement 2 regarding assessing whether information about covenants is material for disclosure. There is no financial impact.	1 Jan 2024
AASB 2022-9	*Amendments to Australian Accounting Standards – Insurance Contracts in the Public Sector* This Standard amends AASB 17 and AASB 1050 to include modifications with respect to the application of AASB 17 by public sector entities. This Standard also amends the following Standards to remove the temporary consequential amendments set out in AASB 2022-8 since AASB 4 and AASB 1023 do not apply to public sector entities for periods beginning on or after 1 July 2026: (a) AASB 1; (b) AASB 3; (c) AASB 5; (d) AASB 7; (e) AASB 9; (f) AASB 15; (g) AASB 119; (h) AASB 132; (i) AASB 136; (j) AASB 137; (k) AASB 138; (l) AASB 1057; and (m) AASB 1058 There is no financial impact.	1 Jan 2026
AASB 2022-10	*Amendments to Australian Accounting Standards – Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities.* 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. The financial impact has not been assessed.	1 Jan 2024

9.4 Key management personnel

The Health Service has determined that key management personnel include ministers, members and senior officers of the Authority. However, the Health Service is not obligated to compensate ministers and therefore disclosures in relation to ministers' compensation may be found in the Annual Report on State Finances.

The total fees, salaries, superannuation, non-monetary benefits and other benefits for senior officers of the for the reporting period are presented within the following bands:

	2023	2022
Compensation of members of the accountable authority		
Compensation band ($)		
50,001 - 100,000	2	1
0 - 50,000	8	9

Compensation of senior officers		
Compensation band ($)		
450,001 - 500,000	-	1
400,001 - 450,000	1	-
300,001 - 350,000	1	3
250,001 - 300,000	3	1
200,001 - 250,000	4	7
150,001 - 200,000	4	1
100,001 - 150,000	2	-
50,001 - 100,000	-	2
0 - 50,000	1	1

	2023 $'000	2022 $'000
Short-term employee benefits	3,500	3,494
Post-employment benefits	368	338
Other long-term benefits	105	315
Termination benefits	-	83
Total compensation of key management personnel	**3,973**	**4,230**

Total compensation includes the superannuation expense incurred by the Health Service in respect of senior officers.

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9.5 Related party transactions

The Health Service is a wholly owned and controlled entity of the State of Western Australia. In conducting its activities, the Health Service is required to pay various taxes and levies to the State and entities related to the State. The payment of these taxes and levies, is based on the standard terms and conditions that apply to all tax and levy payers.

Related parties of the Health Service include:

- all senior officers and their close family members, and their controlled or jointly controlled entities
- all cabinet ministers and their close family members, and their controlled or jointly controlled entities
- other departments and public sector entities, including related bodies included in the whole of government consolidated financial statements
- associates and joint ventures, that are included in the whole of government consolidated financial statements
- the Government Employees Superannuation Board (GESB).

All related party transactions have been entered into on an arm's length basis.

Significant transactions with government related entities

In conducting its activities, the Health Service is required to transact with the State and entities related to the State. These transactions are generally based on the standard terms and conditions that apply to all agencies. Such transactions include:

- income from State Government (note 4.1)
- capital appropriations (note 9.10)
- superannuation payments to GESB (note 3.1.1)
- lease rentals payments for accommodation and fleet leasing to the Department of Finance (note 3.6)
- commitments for future lease payments to the Department of Finance (note 7.4)
- insurance transactions with the Insurance Commission (note 3.6)
- remuneration for services provided by the Office of the Auditor General (note 9.9)
- utility payments to Water Corporation (note 3.2)
- utility payments to Electricity Generation and Retail Corporation (Synergy) (note 3.2)
- payments for legal advice to Department of the Attorney General (note 3.6)
- maintenance transactions with the Department of Fire and Emergency Services (note 3.4 and note 3.5)
- funding agreement with Disability Services Commision (note 3.3)
- transactions with the Department of Health and other Metropolitan and Country Health Services (note 4.1).

Material transactions with related parties

The Health Service had no material related party transaction with Ministers/senior officers or their close family members or their controlled (or jointly controlled) entities for disclosure.

9.6 Related bodies

A related body is a body which receives more than half its funding and resources from the Health Service and is subject to operational control by the Health Service.

The Health Service had no related bodies during the financial year.

9.7 Affiliated bodies

An affiliated body is a body which receives more than half its funding and resources from the Health Service but is not subject to operational control by the Health Service.

The Health Service had no affiliated bodies during the financial year.

9.8 Special purpose accounts

Mental Health Commission Fund (South Metropolitan Health Service) Account

The purpose of the special purpose account is to receive funds from the Mental Health Commission, to fund the provision of mental health services as jointly endorsed by the Department of Health and the Mental Health Commission, in the South Metropolitan Health Service, in accordance with the annual Service Agreement and subsequent agreements.

	2023 $'000	2022 $'000
Balance at start of period	-	-
Add receipts		
Service delivery arrangement:		
Commonwealth contributions	(57,959)	(55,543)
State contributions	(121,710)	(104,231)
	(179,669)	**(159,774)**
Payments	177,465	159,774
Balance at end of period	**(2,204)**	**-**

9.9 Remuneration of auditors

Remuneration paid or payable to the Auditor General in respect of the audit is as follows:

Auditing the accounts, controls, financial statements and key performance indicators	375	335
	375	**335**

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9.10 Equity

Contributed equity

The Western Australian Government holds the equity interest in the Health Service on behalf of the community. Equity represents the residual interest in the net assets of the Health Service. The asset revaluation reserve represents that portion of equity resulting from the revaluation of non current assets.

	2023 $'000	2022 $'000
Balance at start of period	2,586,996	2,534,903
Contribution by owners [b]		
Capital Appropriations administered by Department of Health	45,864	52,093
Transfer of net assets (other than cash) from other agencies	32,055	-
	77,919	**52,093**
Distributions to owners [b] [c] [d] [e]		
Transfer of net assets (other than cash) to other agencies [d]		-
Total contribution by owners	**-**	**-**
Balance at end of period	**2,664,915**	**2,586,996**

(a) TI 955 'Contributions by Owners Made to Wholly Owned Public Sector Entities' designates capital appropriations as contributions by owners in accordance with AASB Interpretation 1038 'Contributions by Owners Made to Wholly Owned Public Sector Entities'.

(b) AASB 1004 'Contributions' requires transfers of net assets as a result of a restructure of administrative arrangements to be accounted for as contributions by owners and distributions to owners.

TI 955 designates non-discretionary and non-reciprocal transfers of net assets between state government agencies as contributions by owners in accordance with AASB Interpretation 1038. Where the transferee agency accounts for a non-discretionary and non-reciprocal transfer of net assets as a contribution by owners, the transferor agency accounts for the transfer as a distribution to owners.

(c) TI 955 requires non-reciprocal transfers of net assets to Government to be accounted for as distribution to owners in accordance with AASB Interpretation 1038.

(d) Transfer of net assets (other than cash) to other agencies is made up of the following items:

Reserves

Asset revaluation reserve [a]		
Balance at the start of period	225,235	78,742
Net revaluation increments/(decrements) [b]*:*		
Land	1,740	503
Buildings	246,225	145,990
Balance at end of period	**473,200**	**225,235**

(a) The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets.

(b) Any increment is credited directly to the asset revaluation reserve, except to the extent that any increment reverses a revaluation decrement previously recognised as an expense.

9.10 Equity (continued)

Accumulated surplus

	2023 $'000	2022 $'000
Accumulated surplus/(deficit)		
Balance at start of period	34,501	29,715
Prior years' restatement (a)		(9,773)
Restated balance at the start of the period	**34,501**	**19,942**
Result for the period	(51,300)	14,559
Balance at end of period	**(16,799)**	**34,501**

(a) See note 9.2 Prior period restatements with respect to correction of accrued PBS revenue in prior years.

9.11 Supplementary financial information

(a) Revenue, public and other property written off

Revenue and debts written off under the authority of the Accountable Authority	1,980	2,666
Revenue and debts written off under the authority of the Minister	362	-
Public and other property written off under the authority of the Accountable Authority	41	33
Public and other property written off under the authority of the Minister	182	-
	2,565	**2,699**

(b) Losses of public monies and other property

Losses of public monies and public or other property through theft or default	**-**	-
Less amount recovered	**-**	-
Net losses	**-**	**-**

(c) Gifts of public property

Gifts of public property provided by the Health Service	**-**	-
	-	**-**

10. Explanatory statement

This section explains variations in the financial performance of the Health Service undertaking transactions under its own control, as represented in the primary financial statements.

	Notes
Explanatory statement for controlled operations	10.1

All variances between annual estimates (original budget) and actual results for 2023, and between the actual results for 2023 and 2022 are shown below. Narratives are provided for key major variances which vary more than 10 per cent from their comparative and that the variation is more than 1 per cent of the following variance analyses for the:

1. Estimate and actual results for the current year
   - Total cost of services of the estimate for the Statements of comprehensive income and Statement of cash flows (i.e. 1% of $22.035M)
   - Total assets of the estimate for the Statement of Financial Position (i.e. 1% of $34.283M)

2. Actual results for the current year and the prior year actual
   - Total cost of services of the previous year for the Statements of comprehensive income and Statement of cash flows (i.e. 1%of $21.433M)
   - Total assets of the previous year for the Statement of Financial Position (i.e. 1% of $33.347M)

10.1.1 Statement of Comprehensive Income Variances

	Variance Notes	Estimate 2023 $'000	Actual 2023 $'000	Restated Actual (a) 2022 $'000	Variance between actual and estimate $'000	Variance between actual results for 2022 and 2023 $'000
COST OF SERVICES						
Expenses						
Employee benefits expense	1	1,260,902	1,379,122	1,242,176	118,220	136,946
Fees for contracted medical practitioners		12,592	12,087	12,297	(505)	(210)
Contracts for services		145,760	140,756	141,592	(5,004)	(836)
Patient support costs		416,659	389,264	378,011	(27,395)	11,253
Finance costs		1,466	1,682	2,405	216	(723)
Depreciation and amortisation expense		88,478	91,999	91,567	3,521	432
Loss on disposal of non-current assets		-	137	-	137	137
Repairs, maintenance and consumable equipment		56,974	64,241	60,325	7,267	3,916
Other supplies and services		61,695	69,790	62,666	8,095	7,124
Other expenses		158,980	166,459	152,302	7,479	14,157
Total cost of services		**2,203,506**	**2,315,537**	**2,143,341**	**112,031**	**172,196**
INCOME						
Revenue						
Patient charges		80,461	94,823	80,200	14,362	14,623
Other fees for services		88,807	82,974	76,473	(5,833)	6,501
Commonwealth grants and contributions		6,918	6	129	(6,912)	(123)
Other grants and contributions		378	1,673	1,268	1,295	405
Donation revenue		58	63	148	5	(85)
Interest revenue		-	10	2	10	8
Commercial activities		-	154	563	154	(409)
Other revenue		23,273	19,705	19,014	(3,568)	691
Total revenue		**199,895**	**199,408**	**177,797**	**(487)**	**21,611**
Gains						
Gain on disposal of non-current assets		-	-	34	-	(34)
Gain on revaluation		-	-	11,011	-	(11,011)
Total gains		**-**	**-**	**11,045**	**-**	**(11,045)**
Total income other than income from State Government		**199,895**	**199,408**	**188,842**	**(487)**	**10,566**
NET COST OF SERVICES		**2,003,611**	**2,116,129**	**1,954,499**	**112,518**	**161,630**
INCOME FROM STATE GOVERNMENT						
Department of Health - Service agreement		1,724,508	1,756,624	1,683,363	32,116	73,261
Mental Health - Service agreement		172,658	177,466	159,774	4,808	17,692
Grants from other state government agencies		19,547	18,049	19,223	(1,498)	(1,174)
Assets (transferred)/assumed		-	3,548	700	3,548	2,848
Services received free of charge		93,698	109,142	105,998	15,444	3,144
Total income from State Government		**2,010,411**	**2,064,829**	**1,969,058**	**54,418**	**95,771**
Surplus/(deficit) for the period		**6,800**	**(51,300)**	**14,559**	**(58,100)**	**(65,859)**
Other comprehensive income						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve		-	247,965	146,493	247,965	101,472
Total other comprehensive income		**-**	**247,965**	**146,493**	**247,965**	**101,472**
Total comprehensive income for the period		**6,800**	**196,665**	**161,052**	**189,865**	**35,613**

(a) See note 9.2 Prior years' restatements.

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Major variance narratives

Variances between actual results for 2023 and 2022

1. Employee benefits expense

The 2023 actual result is $137M higher than the 2022 outcome. This is due to a significant increase in the workforce capacity during the year to address additional operational demand from several areas to accommodate the Living with COVID strategy. This included activity increases, opening new wards/bed expansion and additional mental health services. Inflationary pressures as part of public sector wages policy, cost of living payments and the superannuation guarantee levy increase, all contributed to the increased costs in this area.

10.1.2 Statement of Financial Position Variances

	Variance Notes	Estimate 2023 $'000	Actual 2023 $'000	Restated Actual (a) 2022 $'000	Variance between actual and estimate $'000	Variance between actual results for 2023 and 2022 $'000
ASSETS						
Current assets						
Cash and cash equivalents		134,960	51,657	109,677	(83,303)	(58,020)
Restricted cash and cash equivalents		35,929	33,442	35,929	(2,487)	(2,487)
Receivables		42,263	55,502	38,244	13,239	17,258
Inventories		6,446	7,377	6,446	931	931
Other current assets		3,434	4,703	3,434	1,269	1,269
Total Current Assets		**223,032**	**152,681**	**193,730**	**(70,351)**	**(41,049)**
Non-current assets						
Restricted cash and cash equivalents		28,748	28,748	23,748	-	5,000
Amounts receivable for services		1,215,101	1,218,166	1,126,623	3,065	91,543
Property, plant and equipment	2	1,875,391	2,122,722	1,879,459	247,331	243,263
Service concession assets		60,494	67,182	62,473	6,688	4,709
Right-of-use assets		21,170	24,535	37,059	3,365	(12,524)
Intangible assets		4,378	6,813	11,609	2,435	(4,796)
Total non-current assets		**3,205,282**	**3,468,166**	**3,140,971**	**262,884**	**327,195**
Total assets		**3,428,314**	**3,620,847**	**3,334,701**	**192,533**	**286,146**
LIABILITIES						
Current liabilities						
Payables		110,276	114,526	110,277	4,250	4,249
Contract liabilities		574	291	581	(283)	(290)
Grant liabilities		7,750	7,737	7,743	(13)	(6)
Lease liabilities		9,847	10,051	15,801	204	(5,750)
Provisions		270,431	270,756	254,805	325	15,951
Other current liabilities		269	280	269	11	11
Total current liabilities		**399,147**	**403,641**	**389,476**	**4,494**	**14,165**
Non-current liabilities						
Contract liabilities		-	-	-	-	-
Lease liabilities		13,249	16,168	23,683	2,919	(7,515)
Provisions		78,051	79,722	74,810	1,671	4,912
Total non-current liabilities		**91,300**	**95,890**	**98,493**	**4,590**	**(2,603)**
Total liabilities		**490,447**	**499,531**	**487,969**	**9,084**	**11,562**
NET ASSETS		**2,937,867**	**3,121,316**	**2,846,732**	**183,449**	**274,584**
EQUITY						
Contributed equity		2,656,176	2,664,915	2,586,996	8,739	77,919
Reserves		225,236	473,200	225,235	247,964	247,965
Accumulated surplus/(deficit)		56,455	(16,799)	34,501	(73,254)	(51,300)
TOTAL EQUITY		**2,937,867**	**3,121,316**	**2,846,732**	**183,449**	**274,584**

(a) See note 9.2 Prior years' restatements.

South Metropolitan Health Service
Notes to the Financial Statements
For the year ended 30 June 2023

Major variance narratives

Variances between estimate and actual results for 2023

2. Property, plant and equipment

The Landgate valuation services assesses the fair values of all land and buildings assets on an annual basis for government property assets. For this year the value of the land and buildings asset reserves increased by $236M. Also refer to Note 5.1 Property, Plant and Equipment.

Variances between actual results for 2023 and 2022

2. Property, plant and equipment

The Landgate valuation services assesses the fair values of all land and buildings assets on an annual basis for government property assets. For this year the value of the land and buildings asset reserves increased by $236M. Also refer to Note 5.1 Property, Plant and Equipment.

10.1.3 Statement of Cash Flows Variances

	Variance Notes	Estimate 2023 $'000	Actual 2023 $'000	Restated Actual (a) 2022 $'000	Variance between estimate and actual $'000	Variance between actual results for 2023 and 2022 $'000
CASH FLOWS FROM STATE GOVERNMENT						
Revenues from State Government Agencies		1,828,234	1,864,144	1,770,878	35,910	93,266
Capital appropriations administered by Department of Health	3	69,180	45,864	52,093	(23,316)	(6,229)
Net cash provided by State Government		**1,897,414**	**1,910,008**	**1,822,971**	**12,594**	**87,037**
Utilised as follows:						
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits	4	(1,238,902)	(1,355,516)	(1,210,299)	(116,614)	(145,217)
Supplies and services		(750,962)	(731,197)	(703,419)	19,765	(27,778)
Finance costs		(1,465)	-	-	1,465	-
Receipts						
Receipts from customers		80,461	82,789	81,596	2,328	1,193
Commonwealth grants and contributions		6,918	-	7,500	(6,918)	(7,500)
Other grants and contributions		378	1,673	1,268	1,295	405
Donations received		58	63	148	5	(85)
Interest received			10	2	10	8
Other receipts		112,080	94,889	98,314	(17,191)	(3,425)
Net cash used in operating activities		**(1,791,434)**	**(1,907,289)**	**(1,724,890)**	**(115,855)**	**(182,399)**
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Payment for purchase of non-current physical and intangible assets		(59,309)	(40,365)	(30,344)	18,944	(10,021)
Receipts						
Proceeds from sale of non-current physical assets		-	43	39	43	4
Net cash used in investing activities		**(59,309)**	**(40,322)**	**(30,305)**	**18,987**	**(10,017)**
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Repayment of lease liabilities		(16,388)	(17,904)	(22,402)	(1,516)	4,498
Net cash used in financing activities		**(16,388)**	**(17,904)**	**(22,402)**	**(1,516)**	**4,498**
Net increase/(decrease) in cash and cash equivalents	5	30,283	(55,507)	45,374	(85,790)	(100,881)
Cash and cash equivalents at the beginning of the year	6	169,354	169,354	123,980	-	45,374
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**199,637**	**113,847**	**169,354**	**(85,790)**	**(55,507)**

(a) See note 9.2 Prior years' restatements.

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Major variance narratives

Variances between estimate and actual results for 2023

3. Capital appropriations administered by Department of Health

The $23M variation results from changes in the capital project deliverables and outlays which have occurred since the preparation and release of the initial estimates. These changes stemmed from the refinement in the project timelines and complications in tendering processes delaying progress.

5. Net increase/(decrease) in cash and cash equivalents

The decrease in the cash position is largely due to inflationary pressures in employee costs and service delivery requirements not supported by government and other funding sources. Refer to explanation provided for variances in Employee Benefits.

Variances between actual results for 2023 and 2022

4. Employee benefits

The 2023 actual result is $145M higher than the 2022 outcome. This is due to a significant increase in the workforce capacity during the year to address additional operational demand from several areas to accomodate Living with COVID strategy. This included activity increases, opening new wards/bed expansion and additional mental health services. Inflationary pressures as part of public sector wages policy, cost of living payments and the superannuation guarantee levy increase, all contributed to the increased costs in this area.

5. Net increase/(decrease) in cash and cash equivalents

The decrease in the cash position is largely due to inflationary pressures in employee costs and service delivery requirements not supported by government and other funding sources. Refer to explanation provided for variances in Employee Benefits.

6. Cash and cash equivalents at the beginning of the year

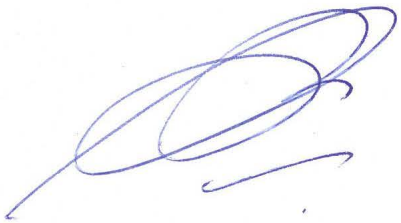
The improved opening cash position reflects a combination of sustained operational efficiencies, increased revenue recoveries and the carryover of funds for commitments where outlays were expected during financial year.

Certification of key performance indicators

South Metropolitan Health Service

Certification of key performance indicators
for the year ended 30 June 2023

We hereby certify that the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess South Metropolitan Health Service's performance and fairly represent the performance of South Metropolitan Health Service for the financial year ended 30 June 2023.



Adjunct Associate Professor Robyn Collins
Board Chair
South Metropolitan Health Service
14 September 2023

Mr Liam Roche
Board member
South Metropolitan Health Service
14 September 2023

Key performance indicators

Unplanned hospital readmissions for patients within 28 days for selected surgical procedures: (a) knee replacement; (b) hip replacement; (c) tonsillectomy and adenoidectomy; (d) hysterectomy; (e) prostatectomy; (f) cataract surgery; (g) appendicectomy

Percentage of elective wait list patients waiting over boundary for reportable procedures (a) % Category 1 over 30 days (b) % Category 2 over 90 days (c) % Category 3 over 365 days

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

Survival rates for sentinel conditions

Percentage of admitted patients who discharged against medical advice: a) Aboriginal patients; and b) Non-Aboriginal patients

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

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

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

Average admitted cost per weighted activity unit

Average Emergency Department cost per weighted activity unit

Average non-admitted cost per weighted activity unit

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

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

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

Unplanned hospital readmissions for patients within 28 days for selected surgical procedures: (a) knee replacement; (b) hip replacement; (c) tonsillectomy and adenoidectomy; (d) hysterectomy; (e) prostatectomy; (f) cataract surgery; (g) appendicectomy

Rationale

Unplanned hospital readmissions may reflect less than optimal patient management and ineffective care pre-discharge, post-discharge and/or during the transition between acute and community-based care[1]. These readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

Readmission reduction is a common focus of health systems worldwide as they seek to improve the quality and efficiency of healthcare delivery, in the face of rising healthcare costs and increasing prevalence of chronic disease.[2]

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

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

Target

The target is represented as the upper limit per 1,000 separations. Improved or maintained performance is demonstrated by a result below or equal to the target.

Results

For the period January to December 2022, SMHS unplanned readmission rates for selected surgical procedures are presented in Table 8.

Unplanned readmissions are monitored at monthly safety and quality performance meetings. For procedures where the target is not met, case reviews are undertaken with the outcomes discussed at the meetings in order to identify any system issues that may require improvement.

Knee replacement

The readmission rate for knee replacement has remained within the target for the past three years.

Hip replacement

The readmission rate for hip replacement was above the target and represents a deterioration in performance from the previous year. The readmissions were for a low number of cases and were related to known complications with no system issues identified.

Tonsillectomy and adenoidectomy

The readmission rate for tonsillectomy and adenoidectomy was above the target. Individual case reviews were undertaken for readmissions, with the majority related to known complications including post-operative bleeding and pain management. Improvements have been made in the provision of written discharge information to patients on pain management post tonsillectomy and adenoidectomy.

1 Australian Institute of Health and Welfare (2009). Towards national indicators of safety and quality in health care. Cat. no. HSE 75. Canberra: AIHW. Available at: https://www.aihw.gov.au/reports/health-care-quality-performance/towards-national-indicators-of-safety-and-quality/contents/table-of-contents

2 Australian Commission on Safety and Quality in Health Care. Avoidable Hospital Readmissions: Report on Australian and International indicators, their use and the efficacy of interventions to reduce readmissions. Sydney: ACSQHC; 2019. Available at: https://www.safetyandquality.gov.au/publications-and-resources/resource-library/avoidable-hospital-readmission-literature-review-australian-and-international-indicators

Hysterectomy

The readmission rate for hysterectomy was within the target and represents an improvement on the previous year's performance.

Prostatectomy

The readmission rate for patients undergoing prostatectomy was within target and represents a continued improvement, with the lowest rate for the past five years.

Cataract

The readmission rate for cataract surgery remains above target but represents an improvement on last year. This involved a small number of cases related to known complications of surgery, with no system issues identified with the clinical care.

Appendicectomy

The readmission rate for appendicectomy remained within target, with the lowest readmission rate for the past five years.

Table 8: Rate of unplanned readmissions within 28 days for selected surgical procedures

	Calendar year					
Surgical procedure	**2018 actual (per 1,000)**	**2019 actual (per 1,000)**	**2020 actual (per 1,000)**	**2021 actual (per 1,000)**	**2022 actual (per 1,000)**	**Target (per 1,000)**
Knee replacement	25.5	21.7	7.9	10.7	10.7	≤19.6
Hip replacement	18.3	27.2	21.8	12.6	20.9	≤17.1
Tonsillectomy and adenoidectomy	109.4	84.5	93.3	69.8	91.4	≤85.0
Hysterectomy	69.0	61.5	47.1	24.8	23.3	≤42.3
Prostatectomy	40.2	28.9	44.9	29.3	16.9	≤36.1
Cataract surgery	3.7	2.7	0.5	2.8	2.4	≤1.5
Appendicectomy	26.0	25.9	30.9	19.0	16.9	≤25.7

Data source: Hospital Morbidity Data Collection.
Note: As these are calendar KPIs, the latest and most up to date information reported refers to the 2022 calendar year results.

Percentage of elective wait list patients waiting over boundary for reportable procedures (a) % Category 1 over 30 days (b) % Category 2 over 90 days (c) % Category 3 over 365 days

Rationale

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

Elective surgical services delivered in the WA health system are those deemed to be clinically necessary. Excessive waiting times for these services can lead to deterioration of the patient's condition and/or quality of life, or even death[3]. Waiting lists must be actively managed by hospitals to ensure fair and equitable access to limited services, and that all patients are treated within clinically appropriate timeframes.

Patients are prioritised based on their assigned clinical urgency category:

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

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

Target

The target requires that no patients (0 per cent) on elective waiting lists for reportable procedures wait longer than the clinically recommended time, according to their urgency category.

Results

During 2022–23, SMHS continued to work towards reducing over boundary cases and improve the timeliness of treatment for elective surgery waitlisted patients.

Improvement on previous years' results towards the target of treating all patients within clinically recommended times was not achieved in any urgency category. Progress was inhibited by the large waitlist that grew during COVID lockdowns, and the lingering COVID impacts on SMHS ability to return to full theatre capacity due to staff furloughing and patients cancelling surgery.

SMHS continues to proactively manage elective waitlists and implement initiatives to reduce over boundary case numbers across all urgency categories

Table 9: Percentage of elective wait list patients waiting over boundary for reportable procedures

	2018–19 actual (%)	2019–20 actual (%)	2020–21 actual (%)	2021–22 actual (%)	2022–23 actual (%)	Target (%)
Urgency category 1	17.6	11.5	11.2	30.5	37.9	0
Urgency category 2	16.4	14.8	10.9	29.2	38.5	0
Urgency category 3	2.9	3.9	4.6	10.7	24.4	0

Data source: Elective Services Wait List Data Collection.

3 Derrett, S., Paul, C., Morris, J.M. (1999). Waiting for Elective Surgery: Effects on Health-Related Quality of Life, International Journal of Quality in Health Care, Vol 11 No. 1, 47-57.

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

Rationale

Staphylococcus aureus bloodstream infection is a serious infection that may be associated with the provision of health care. *Staphylococcus aureus* is a highly pathogenic organism and even with advanced medical care, infection is associated with prolonged hospital stays, increased healthcare costs and a marked increase in morbidity and mortality. (SABSI mortality rates are estimated at 20–25 per cent[4].)

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

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

Target

The target is an infection rate of ≤1.0 per 10,000 occupied bed days in public hospitals.

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

Results

The rate of HA-SABSI decreased to 1.0 per 10,000 occupied bed days in 2022, and within the target for the first time in three years.

SMHS is focussed on continued improvements in HA-SABSI and in March 2023, the Zero Preventable Healthcare Associated Infections Project commenced. By applying quality improvement methodology and engaging frontline staff in identifying issues and solutions, it is anticipated that this approach will result in sustained improvement in HA-SABSI rates. Areas of focus include hand hygiene, aseptic technique and clean and tidy wards.

Table 10: Hospital infection rate

	Calendar year					
	2018	2019	2020	2021	2022	Target
Infection rate per 10,000 bed days	0.7	0.7	1.1	1.3	1.0	≤1.0

Data source: Healthcare Infections Surveillance WA Data Collection (HISWA).
Note: As these are calendar KPIs, the latest and most up to date information reported refers to the 2022 calendar year results.

4 van Hal, S. J., Jensen, S. O., Vaska, V. L., Espedido, B. A., Paterson, D. L., & Gosbell, I. B. (2012). Predictors of mortality in Staphylococcus aureus Bacteremia. *Clinical microbiology reviews,* 25(2), 362–386. doi:10.1128/CMR.05022-11

Survival rates for sentinel conditions

Rationale

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

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

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

Target

The target is based on the state average result for the previous five calendar years excluding the most recent calendar year.

An improved or maintained performance is demonstrated by a result exceeding or equal to the target.

Table 11 illustrates the target for each condition by age group.

Table 11: Survival target rates for sentinel conditions, by age group

	Sentinel conditions		
Age group (years)	**Stroke (%)**	**AMI (%)**	**FNOF (%)**
0–49	≥95.2	≥99.0	Not reported
50–59	≥95.3	≥98.9	Not reported
60–69	≥94.4	≥98.1	Not reported
70–79	≥92.5	≥97.0	≥99.0
80+	≥87.1	≥92.2	≥97.4

Results

A review is undertaken of all in-hospital deaths resulting from stroke, AMI or FNOF in order to determine if the care delivered to patients was appropriate or could have been delivered differently, and to identify any areas for improvement.

The survival rate for patients diagnosed with stroke was above the target indicating good performance in each age group.

Table 12: Survival rate for stroke, by age group

	Calendar year					
Age group (years)	**2018 (%)**	**2019 (%)**	**2020 (%)**	**2021 (%)**	**2022 (%)**	**Target (%)**
0–49	97.1	100.0	97.7	98.4	97.7	≥95.2
50–59	98.7	97.3	96.8	97.6	96.3	≥95.3
60–69	96.5	96.9	95.6	97.1	97.0	≥94.4
70–79	92.4	93.8	91.7	95.3	94.8	≥92.5
80+	87.9	86.7	88.6	86.1	88.5	≥87.1

Data source: Hospital Morbidity Data Collection.
Note: As these are calendar KPIs, the latest and most up to date information reported refers to the 2022 calendar year results.

The survival rate for patients diagnosed with AMI was at or above target for each age group apart from the 50–59 and the 60–69 age groups, with a number of these patients suffering out-of-hospital cardiac arrests. Despite in-hospital interventions, the majority of patients that did not survive had known co-morbidities including advanced heart disease, respiratory disease, diabetes and cancer, further complicating their AMI outcome.

Table 13: Survival rate for acute myocardial infarction, by age group

	Calendar year					
Age group (years)	**2018 (%)**	**2019 (%)**	**2020 (%)**	**2021 (%)**	**2022 (%)**	**Target (%)**
0–49	97.9	97.5	98.6	98.3	99.1	≥99.0
50–59	97.0	98.8	99.3	98.8	97.2	≥98.9
60–69	97.8	97.3	97.3	97.8	97.5	≥98.1
70–79	97.4	96.6	97.6	97.5	97.1	≥97.0
80+	96.0	91.7	93.7	94.8	96.9	≥92.2

Data source: Hospital Morbidity Data Collection.
Note: As these are calendar KPIs, the latest and most up to date information reported refers to the 2022 calendar year results.

The survival rates for patients admitted with FNOF was above the target for the 80+ age group, and just below target for the 70–79 age group. The patients that did not survive in the 80+ age group had other co-morbidities impacting their outcome, including advanced dementia and cancer.

Table 14: Survival rate for fractured neck of femur, by age group

	Calendar year					
Age group (years)	**2018 (%)**	**2019 (%)**	**2020 (%)**	**2021 (%)**	**2022 (%)**	**Target (%)**
70–79	99.1	100.0	99.4	98.1	98.5	≥99.0
80+	98.3	96.8	99.4	97.6	98.2	≥97.4

Data source: Hospital Morbidity Data Collection.
Note: As these are calendar KPIs, the latest and most up to date information reported refers to the 2022 calendar year results.

Percentage of admitted patients who discharged against medical advice: a) Aboriginal patients; and b) Non-Aboriginal patients

Rationale

Discharge against medical advice (DAMA) refers to patients leaving hospital against the advice of their treating medical team or without advising hospital staff, e.g. absconding or missing and not found. Patients who do so have a higher risk of readmission and mortality[5] and have been found to cost the health system 50 per cent more than patients who are discharged by their physician.[6]

Between July 2015 and June 2017 Aboriginal patients (3.4 per cent) in WA were almost 11 times more likely than non-Aboriginal patients (0.3 per cent) to discharge against medical advice, compared with 6.2 times nationally (3.1 per cent and 0.5 per cent respectively)[7]. This statistic indicates a need for improved responses by the health system to the needs of Aboriginal patients.

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

Discharge against medical advice performance measure is also one of the key contextual indicators of Outcome 1 “Aboriginal and Torres Strait Islander people enjoy long and healthy lives” under the new National Agreement on Closing the Gap, which was agreed to by the Coalition of Aboriginal and Torres Strait Islander Peak Organisations, and all Australian Governments in July 2020[8].

Target

The target for Aboriginal patients is less than or equal to 2.78 per cent. This target is based on a 50 per cent reduction in the gap between performance for WA Aboriginal and non-Aboriginal patients from the period of 2016–17 to 2017–18.

The target for non-Aboriginal patients is less than or equal to 0.99 per cent and is based on the national performance for non-Aboriginal patients over the 2016–17 to 2017–18 period, as provided by the Australian Institute of Health and Welfare.

An improved or maintained performance is demonstrated by a result below or equal to the target.

5 Yong et al. Characteristics and outcomes of discharges against medical advice among hospitalised patients. Internal medicine journal 2013:43(7):798-802.
6 Aliyu ZY. Discharge against medical advice: sociodemographic, clinical and financial perspectives. International journal of clinical practice 2002:56(5):325-27.
7 Australia Institute of Health and Welfare 2020. Aboriginal and Torres Strait Islander Health Performance Framework 2020 summary report. Cat. No. IHPF. Canberra: AIHW. Available at: https://www.indigenoushpf.gov.au/measures/3-09-discharge-against-medical-advice
8 https://www.closingthegap.gov.au/national-agreement

Results

The rate of non-Aboriginal DAMA remained within target at 0.80 per cent.

The rate of DAMA for Aboriginal patients for 2022 was 3.80 per cent, which is above target and an increase on the previous year. A number of strategies have been implemented to address the Aboriginal DAMA rate including the review of all DAMA cases to identify contributing factors and related areas of service improvement, as well as the increasing involvement of Aboriginal liaison officers. The SMHS Patient Initiated Early Discharge Policy has also been implemented across all sites, in order to support individual patient discharge decisions and processes and ensure that patients requesting early discharge have the appropriate services in place prior to discharge.

Table 15: Percentage of patients who discharge against medical advice

	Calendar year					
Discharge against medical advice	**2018 (%)**	**2019 (%)**	**2020 (%)**	**2021 (%)**	**2022 (%)**	**Target (%)**
Aboriginal	2.73	3.50	3.59	3.07	3.80	≤2.78
Non-Aboriginal	0.74	0.73	0.71	0.72	0.80	≤0.99

Data source: Hospital Morbidity Data Collection.

Note: As these are calendar KPIs, the latest and most up to date information reported refers to the 2022 calendar year results.

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

Rationale

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

The Apgar score is an assessment of an infant's health at birth based on breathing, heart rate, colour, muscle tone and reflex irritability. An Apgar score is applied at one, five and (if required by the protocol) ten minutes after 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 (2021) Health, Standard 17/12/2021.

Target

An Apgar score of less than seven at five minutes after birth is considered to be an indicator of complications and compromise for the infant.

The target for live born infants with an Apgar score of seven or less at five minutes post-delivery is less than or equal to 1.9 per cent and is based on the national average from the Australian Institute of Health and Welfare publication 'Australian's mothers and babies – in brief'. In 2022–23 the target is the 2019 national figure.

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

Results

An Apgar score of less than seven at five minutes after birth is considered to be an indicator of complications and compromise of the infant.

SMHS continues to perform well, with the percentage of live born term infants with an Apgar score below 7 remaining within target at 1.2 per cent.

Table 16: Percentage of live-born term infants with an Apgar score of less than seven, five minutes post-delivery

	Calendar year					
	2018 (%)	2019 (%)	2020 (%)	2021 (%)	2022 (%)	Target (%)
Percentage of live born infants	1.4	0.8	1.0	1.0	1.2	≤1.9

Data source: Midwives Notification System.
Note: As these are calendar KPIs, the latest and most up to date information reported refers to the 2022 calendar year results.

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

Rationale

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

While multiple hospital admissions over a lifetime may be necessary for someone with ongoing illness, a high proportion of readmissions shortly after discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was not adequate to maintain the patient's recovery out-of-hospital[9].

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

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

Target

The target is less than or equal to 12 per cent. The source of the target is the Fourth National Mental Health Plan Measurement Strategy (May 2011) produced by the Mental Health Information Strategy Subcommittee, AHMAC, Mental Health Standing Committee.

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

Results

In 2022 the rate of readmissions within 28 days to an acute specialised mental health inpatient unit was 16 per cent. Whilst the readmission rate is above target, SMHS performance has seen overall improvement since 2018.

SMHS is maintaining a focus on building mental health community care services and has established a seven day per week Addiction Medicine Outpatient Service to better support patients to remain within the community.

Table 17: Rate of readmissions to acute specialised mental health inpatient services within 28 days of discharge

	Calendar year					
	2018 (%)	2019 (%)	2020 (%)	2021 (%)	2022 (%)	Target (%)
Readmissions rate	19	17	16	15	16	≤12

Data source: Hospital Morbidity Data System.

Note: As these are calendar KPIs, the latest and most up to date information reported refers to the 2022 calendar year results.

9 Australian Health Ministers Advisory Council Mental Health Standing Committee (2011). Fourth National Mental Health Plan Measurement Strategy. Available at: https://www.aihw.gov.au/getmedia/d8e52c84-a53f-4eef-a7e6-f81a5af94764/Fourth-national-mental-health-plan-measurement-strategy-2011.pdf.aspx

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

Rationale

In 2017–18, one in five (4.8 million) Australians reported having a mental or behavioural condition[10]. Therefore, it is crucial to ensure effective and appropriate care is provided not only in a hospital setting but also in the community.

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

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

Target

The target is ≥75 per cent.

The target is an endorsed value from the Australian Health Minister's Advisory Council Mental Health Standing Committee, in May 2011.

Improved or maintained performance is demonstrated by a result greater than or equal to the target.

Results

SMHS performance in relation to mental health patients receiving community follow up within seven days of discharge from hospital has continued to improve. SMHS result of 86 per cent is well above the target and the highest level of performance for the past five years.

Table 18: Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services

	Calendar year					
	2018 (%)	2019 (%)	2020 (%)	2021 (%)	2022 (%)	Target (%)
Post discharge community-based contact	79	78	82	82	86	≥75

Data sources: Mental Health Information Data Collection, Hospital Morbidity Data Collection.
Note: As these are calendar KPIs, the latest and most up to date information reported refers to the 2022 calendar year results.

10 National Health Survey 2017–18

Service 1: Public Hospital Admitted
Average admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per WAU compared with the State target, as approved by the Department of Treasury and published in the 2022–23 Budget Paper No. 2, Volume 1.

The measure ensures that a consistent methodology is applied to calculating and reporting the cost of delivering inpatient activity against the State's funding allocation. As admitted services received nearly half of the overall 2022–23 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

Target

The target is $7,314 per WAU.

A result on or below the target is desirable.

Results

SMHS delivered admitted activity at $7,619 per WAU which was higher than 2021–22 and above the target rate.

The 2022–23 financial year saw increased activity compared to the prior year. The impact of the COVID-19 response on service delivery continued to drive higher costs in 2022–23. In addition to this, inflationary cost pressures in goods and services as well as employment cost pressures as part of public sector wages policy, cost of living payments and the superannuation guarantee levy increase, all contributed to the increased unit cost.

Elective surgery activity improved due to less frequent restrictions in 2022–23 compared to 2021–22 however it has not returned to pre-COVID levels. Bed expansion as part of the 'living with COVID' strategy allowed for additional capacity to deliver admitted activity, but has contributed to additional costs, whilst this capacity is being added. The completion of the Fremantle Hospital air conditioning replacement project meant that more theatres were operational which assisted in delivering additional activity.

Table 19: Average admitted cost per WAU

	2018–19 ($)	2019–20 ($)	2020–21 ($)	2021–22 ($)	2022–23 ($)	Target ($)
Average cost	6,597	6,766	6,638	7,399	7,619	7,314

Data source: Hospital Morbidity Data Collection, Oracle 11i financial system, Outcome Based Management Allocation Application.
Note: This key performance indicator includes Peel Health Campus.

Service 2: Public Hospital Emergency Services
Average Emergency Department cost per weighted activity unit

Rationale

This indicator is a measure of the cost per WAU compared with the State target as approved by the Department of Treasury, which is published in the 2022–23 Budget Paper No. 2, Volume 1.

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

Target

The target is $7,074 per WAU.

A result on or below the target is desirable.

Results

An improved cost per WAU at $7,509 was achieved in 2022–23 compared to the prior year, however the outcome remains above the targeted rate.

COVID-19 continued to have an impact on the delivery of services in 2022–23, though to a lesser degree compared to 2021–22. In the second part of 2022–23 a reduction in 'bed blockage' was achieved that led to some improvement in the ED activity levels. Whilst this was encouraging, the full year throughput had not yet returned to the pre-pandemic levels.

For 2022–23 significant resource investment continued around ensuring accessible and safe delivery of ED services. Additional medical and nursing staff were recruited to address response priorities, manage increased patient complexities and to ensure that sufficient coverage of personnel was maintained during periods of high staff furloughing and elevated sick leave.

The ED activity levels delivered during the year were unable to compensate for the growth in resourcing costs, therefore resulting in the higher variance against target for 2022–23.

Table 20: Average Emergency Department cost per WAU

	2018–19 ($)	2019–20 ($)	2020–21 ($)	2021–22 ($)	2022–23 ($)	Target ($)
Average cost	6,069	6,546	6,520	7,534	7,509	7,074

Data sources: Emergency Department Data Collection, Oracle 11i financial system, Outcome Based Management Allocation Application.
Note: This key performance indicator includes Peel Health Campus.

Service 3: Public Hospital Non-Admitted Services
Average non-admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per WAU compared with the State (aggregated) target, as approved by the Department of Treasury, which is published in the 2022–23 Budget Paper No. 2, Volume 1.

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

Target

The target is $6,982 per WAU.

A result on or below the target is desirable.

Results

The non-admitted activity cost per WAU is below the target due strong activity growth, however, due to inflationary cost pressures the cost per WAU still increased over the 2021–22 result.

Non-admitted activity remained consistently high in 2022–23. With elective surgeries having increased over the period, this also led to increased non-admitted activity in the outpatient clinics. The increase in activity was offset by the lowered need for COVID-19 related services as part of the pandemic response.

In addition, there were fewer COVID-19 disruptions in 2022–23 compared to previous years which enabled volumes to be maintained throughout the year and assisted in SMHS achieving activity targets.

Table 21: Average non-admitted cost per WAU

	2018–19 ($)	2019–20 ($)	2020–21 ($)	2021–22 ($)	2022–23 ($)	Target ($)
Average cost	6,559	7,297	6,233	6,126	6,908	6,982

Data sources: Non-Admitted Patient Activity Data Collection, Oracle 11i financial system, Outcome Based Management Allocation Application.
Note: This key performance indicator includes Peel Health Campus

Service 4: Mental Health Services
Average cost per bed-day in specialised mental health inpatient services

Rationale

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

Target

The target is 1,776 per bed-day in specialised mental health inpatient services.

A result on or below the target is desirable.

Results

SMHS delivered specialised mental health inpatient services at a cost per bed-day which was lower than 2021–22 but higher than the target rate.

High occupancy rates continued in specialised mental health wards throughout 2022–23 and were at similar levels to 2021–22. Whilst the number of bed days within these specialised mental health wards remained constant, the patient complexity increased when compared to the 2021–22 period. Patient complexity can increase costs in service delivery, but this impact is not reflected in the bed-day measure used in this KPI.

SMHS supplements the delivery of mental health activity outside of the specialist inpatient wards via Hospital in the Home (HITH) services. In 2022–23 SMHS further expanded the mental health HITH service which was established in 2021–22. The increase enabled additional mental health bed days to be provided in a cost-effective manner. The delivery of these additional mental health bed days led to a decrease in the average cost per bed day despite inflationary cost pressures and wage indexation growth of more than 3 per cent.

Table 22: Average cost per bed-day in specialised mental health inpatient units

	2018–19 ($)	2019–20 ($)	2020–21 ($)	2021–22 ($)	2022–23 ($)	Target ($)
Average cost	1,529	1,552	1,637	1,853	1,813	1,776

Data sources: Bed State, Oracle 11i financial system, Outcome Based Management Allocation Application.

Service 4: Mental Health Services
Average cost per treatment day of non-admitted care provided by mental health services

Rationale

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

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

Target

The target is 591 per treatment day of non-admitted care provided by mental health services.

A result on or below the target is desirable.

Results

The average cost per treatment day of non-admitted mental health care increased in 2022–23 and was higher than the target rate.

Whilst SMHS delivered 4.4 per cent more treatment days, the average cost per unit increased over 2021–22. The cost increases resulted from wage inflationary pressures and increased funding for the expansion of community mental health services.

As treatment days are not adjusted for patient complexity, this measure is less reliable with regards to benchmarking against targets or across time.

Table 23: Average cost per treatment day of non-admitted care provided by mental health services

	2018–19 ($)	2019–20 ($)	2020–21 ($)	2021–22 ($)	2022–23 ($)	Target ($)
Average cost	480	458	476	581	660	591

Data sources: Mental Health Information Data Collection, Oracle 11i financial system, Outcome Based Management Allocation Application.

Service 6: Public and Community Health Services
Average cost per person of delivering population health programs by population health units

Rationale

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

Population health aims to improve health by integrating all activities of the health sector and linking them with broader social and economic services and resources as described in the *WA Health Promotion Strategic Framework 2017–2021*.[11] This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

The target is $16 per person of delivering health programs by population health units.

A result below the target is desirable.

Results

The cost per person of delivering health programs by population health units has decreased compared to 2021–22 and remains above the target rate. Whilst expenditure in population health is seen as a cost-effective way of reducing health expenditure growth over time, reduced program funding was provided in 2022–23 compared to 2021–22. Funding for the Training Centre for Sub-acute Care WA and Home First program ceased for 2022–23, lowering the cost within this indicator.

Table 24: Average cost per person of delivering programs by Population Health Units

	2018–19 ($)	2019–20 ($)	2020–21 ($)	2021–22 ($)	2022–23 ($)	Target ($)
Average cost per person	17	21	23	25	18	16

Data sources: 2022 calendar year population projected by the Epidemiology Branch, Oracle 11i financial system, OBM Allocation Application.

11 A draft WA Health Promotion Strategic Framework 2022-2026 was released for public consultation on 7 December 2021 and closed on 18 February 2022. A final copy has not been released. See https://consultation.health.wa.gov.au/chronic-disease-prevention-directorate/draft-wa-healthpromotion-strategic-framework-2022/ for further information


DOCTOR

Governance and legal compliance

Ministerial directives

There were no ministerial directives received by SMHS during 2022–23.

Pricing policy

The National Health Reform Agreement sets the policy framework for the charging of public hospital fees and charges. Under the agreement, an eligible person who receives public hospital services as a public patient in a public hospital or a publicly contracted bed in a private hospital is treated 'free of charge'. This arrangement is consistent with the Medicare principles which are embedded in the *Health Services Act 2016 (WA)*. The majority of hospital fees and charges for public hospitals are set under Schedule 1 of the Health Services (Fees and Charges) Order 2016 and are reviewed annually.

The following informs WA public hospital patients' fees and charges for:

Nursing home type patients

The State charges public patients who require nursing care and/or accommodation after the 35th day of their stay in hospital, providing they no longer need acute care and they are deemed to be nursing home type patients. The total daily amount charged is no greater than 87.5 per cent of the current daily rate of the single aged pension and the maximum daily rate of rental assistance.

Compensable or Medicare ineligible patients

Patients who are either 'private' or 'compensable' and Medicare ineligible (overseas residents) may be charged an amount for public hospital services as determined by the State. The setting of compensable and Medicare ineligible hospital accommodation fees is set close to, or at, full cost recovery.

Private patients (Medicare eligible Australian residents)

The Commonwealth Department of Health regulates the minimum benefit payable by health funds to privately insured patients for private shared ward and same day accommodation. The Commonwealth also regulates the nursing home type patient 'contribution' based on March and September pension increases. To achieve consistency with the *Commonwealth Private Health Insurance Act 2007*, the State sets these fees at a level equivalent to the Commonwealth minimum benefit.

Veterans

Hospital charges of eligible war service veterans are determined under a separate Commonwealth-State agreement with the Department of Veterans' Affairs. Under this agreement, DoH does not charge medical treatment to eligible war service veteran patients; instead medical charges are fully recouped from the Department of Veterans' Affairs.

The following fees and charges also apply:

1. The Pharmaceutical Benefits Scheme (PBS) regulates and sets the price of pharmaceuticals supplied to outpatients, patients on discharge and for day admitted chemotherapy patients. Inpatient medications are supplied free of charge.
2. The Dental Health Service charges to eligible patients for dental treatment are based on the Department of Veterans' Affairs Fee Schedule of dental services for dentists and dental specialists.

Eligible patients are charged the following co-payment rates:

- 50 per cent of the treatment fee if the patient holds a current Health Care Card or Pensioner Concession Card
- 25 per cent of the treatment fee if the patient is the current holder of one of the above cards and receives a near full pension or an allowance from Centrelink or the Department of Veterans' Affairs.

There are other categories of fees specified under Health Regulations through Determinations, which include the supply of surgically implanted prostheses, magnetic resonance imaging services and pathology services. The pricing for these hospital services is determined according to their cost of service.

Capital works

SMHS continues to facilitate re-modelling and development of health infrastructure within its area of responsibility.

Table 25. Capital works completed in 2022–23 financial year

Project	Total cost in 2022–23 ($ '000)
FH reconfiguration stage 1	250
FSH birthing centre	1,828
RGH cladding	3,280
FH theatre upgrade	8,702
COVID-19 medical equipment	1,332
FSH transition project capital purchases	1,263
RGH four x 30 modular bed (120 bed modular)	340

Table 26. Capital works in progress

Project	Estimated total cost in 2022–23 ($ '000)	Reported in 2020–21 ($ '000)	Variance ($ '000)	Expected completion date	Variation to cost explanation (>=10%)
FSH critical works	5,897	4,475	1,422	2024	Funding revised
FSH – facilities management services contract asset solution [refer note (d)]	15,188	15,188		2024	
FSH ICT capital replacement [refer note (d)]	39,300	39,300		2024	
FSH ICT commissioning	32,264	32,264		2023	
FSH ICT – intensive care clinical information systems [refer note (d)]	4,200	4,200		2024	
FSH ICT – pharmacy automation	9,600	9,600		2023	
FH acute mental health beds [refer note (d)]	45,500	40,000	5,500	2026	Funding revised
FH bed optimisation [refer note (d)]	5,000	5,000		2024	
COVID-19 SMHS 24 beds [refer note (d)]	13,150	11,400	1,750	2024	Funding revised
PHC development stage 1	7,261	6,761	500	2025	Funding revised
PHC reconfiguration of emergency department	4,927	4,927		2025	
PHC redevelopment	152,047	152,047		To be determined	
SMHS water saving initiative	366	366		To be determined	
RGH mental health emergency centre	12,037	10,321	1,716	To be determined	Funding revised
FSH cladding	3,780		3,780	To be determined	New Project
Electronic Medical Record (EMR)	3,000		3,000	2024	New Project
AS4187 sterilisation	760		760	2024	New Project
Virtual Emergency Medicine	200		200	2024	New Project

Notes of relevance as footnote to tabular information above:

(a) The above information includes the Budgeted Expense Capital allocation.
(b) The allocation from the medical equipment and minor works programs are not included as these are reported by the DOH.
(c) The timeframe for the 'Expected completion date' is updated for the latest information at the time of reporting.
(d) The expected completion date was revised due to the impacts of product availability risks and supply chain impediments.

Employee profile

WA Government agencies are required to report a summary of the number of employees, by category, compared to the previous financial year.

Table 27: SMHS total full time equivalent (FTE) by category

Administration and clerical	Agency nursing	Assistants in nursing	Dental nursing	Hotel services
1,394.68 ▲ FTE 2022–23	**20.49 ▲** FTE 2022–23	**183.44 ▼** FTE 2022–23	**2.02 ▲** FTE 2022–23	**916.38 ▲** FTE 2022–23
1,316.32 (2021/2022)	**16.71** (2021–22)	**239.65** (2021–22)	**1.78** (2021–22)	**797.69** (2021–22)
Includes all clerical-based occupations together with patient-facing (ward) clerical support staff.	Includes workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest.	Support registered nurses and enrolled nurses in delivery of general patient care.	Includes dental nurses and dental clinic assistants.	Includes catering, cleaning, stores/supply laundry and transport occupations.

Maintenance services	Medical	Medical support	Nursing and Midwifery	Other occupations
72.92 ▲ FTE 2022–23	**1,540.65 ▲** FTE 2022–23	**1,369.96 ▲** FTE 2022–23	**3,684.23 ▲** FTE 2022–23	**10.30 ▲** FTE 2022–23
68.49 (2021–22)	**1,443.38** (2021–22)	**1,278.56** (2021–22)	**3,484.10** (2021–22)	**9.82** (2021–22)
Includes engineering, garden and security-based occupations.	Includes all salary-based medical occupations including interns, registrars and specialist medical practitioners.	Includes all allied health and scientific/technical related occupations.	Includes all nursing occupations including enrolled, registered and clinical nurses, and midwives. Does not include agency nurses.	Not limited to but primarily includes Aboriginal and ethnic health specialist positions.

Notes:

Data source: HR Data Warehouse

Year-to-date FTE True divides the total FTE paid in every pay fortnight to date by the number of periods possible during the financial year up to the date specified.

FTE includes ordinary hours, overtime, all paid leave categories, public holidays, time-off-in-lieu and workers compensation. Penalties, allowances, unpaid leave, leave cash-outs and terminations do not incur FTE.

Industrial relations

The Industrial Relations Policy MP 0025/16 established under the DoH Employment Policy Framework defines the service delivery responsibilities of SMHS for industrial relations.

DoH is responsible for systemwide industrial relations matters including negotiation and registration of industrial instruments. SMHS is responsible for:

- the application of the WA public sector legislative and regulatory frameworks regulating employment and industrial relations
- management of misconduct matters
- representation and advocacy in industrial tribunals and courts
- engagement with unions and other external stakeholders in industrial matters.

Key activities for 2022–23 included:

- continued coordination and advice on the implementation of conversion to permanency provisions introduced into industrial agreements, including ongoing management and monitoring of reviews, as required within the industrial agreements
- advice on DoH industrial policies in relation to COVID-19 vaccination requirements
- coordination of submissions informing DoH of upcoming enterprise bargaining negotiations affecting SMHS allied health and support worker employment groups
- representation on five matters before various industrial tribunals and courts
- education of managers regarding substandard performance and appointment of fixed-term contract and casual staff to permanent employment
- continued monitoring and coordination of measures in relation to retirement on grounds of ill health policies
- negotiation with unions and other relevant external stakeholders in response to workplace industrial disputes and workplace change initiatives
- advice and assistance to managers and HR relating to change management
- drafting, quality assurance, liaison and advice on contracting and associated matters relating to the PHC transition.

Staff development

The SMHS Organisational Development Strategy 2021–25 aims to develop team and inter-team trust, respect and effective collaboration and communication, leading to a psychologically safe organisation. Developing staff capability is a key pillar of the strategy and further detail on the strategy and associated initiatives is included earlier in this report.

Courses available on MyLearning continue to grow and provide clinical and corporate staff with access to online, face-to-face and blended learning. The top five courses accessed in 2022–23 were:

- Essential cyber security training
- Personal protective equipment: donning and doffing
- Hand hygiene
- WA Health open disclosure
- Emergency awareness.

Workers' compensation

SMHS is committed to providing staff with a safe and healthy work environment, and recognises this is essential to attracting and retaining the workforce needed to deliver effective and efficient healthcare services.

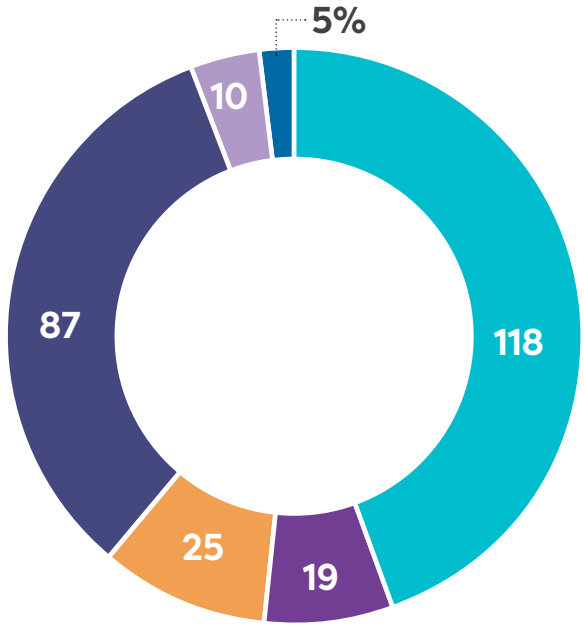
A total of 264 workers' compensation claims were made in 2022–23.

For further details on the work health and safety and injury management processes within SMHS, please refer to the Work Health and Safety section of this report.

For the purposes of this section, employee categories are defined as:

- **administration and clerical** – includes administration staff and executives, ward clerks, receptionists and clerical staff
- **medical support** – includes physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dietitians and social workers
- **hotel services** – includes cleaners, caterers and patient service assistants.

Workers' compensation claims profile



*Note: Data includes all claims lodged in 2022–23 regardless of liability. Data excludes non-WA health staff, e.g. Serco staff at FSH.

Work health and safety

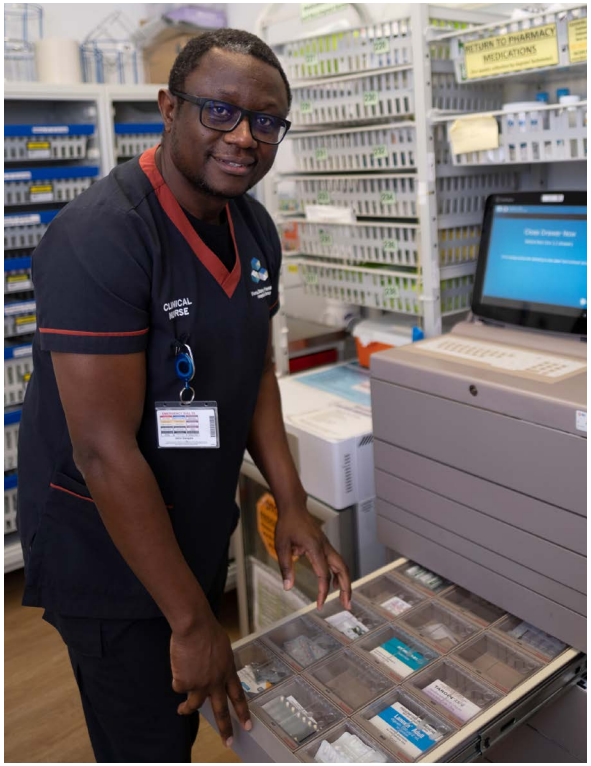
(Previously referred to as occupational safety and health)

Fundamental to delivering quality healthcare services, SMHS is committed to ensuring the health, safety and wellbeing of our staff, volunteers, students, contractors and visitors. This commitment is outlined in the SMHS Work Health and Safety Commitment Statement and is achieved by:

- building and maintaining a workplace culture that cares for one another and always prioritises safety
- leading by example and demonstrating a visible commitment to health, safety and wellbeing in the workplace and delivering on SMHS responsibilities
- supporting managers in assessing risks, and developing and implementing strategies to improve safety in the workplace
- continuously improving the health and safety management system to ensure it meets the needs of SMHS staff, complies with legislation and relevant standards, and focuses on reduction of incidents and injuries
- embedding a WHS reporting culture to ensure SMHS continues to learn and improve, can measure our WHS performance, and meet our targets
- not tolerating aggression, physical or verbal, against SMHS staff and supporting them in seeking police action against those who threaten or commit violence
- providing early intervention and support for staff with injury or illness, to optimise recovery and enable safe and sustainable return to work or stay at work.

This commitment is reviewed annually by the Work Health and Safety Executive Committee and endorsed by the SMHS Area Executive Group. It is communicated to staff, volunteers, students, contractors and visitors through the SMHS intranet and visual displays throughout SMHS hospitals and community locations.

Consultation with the SMHS workforce occurs through a three-level WHS committee structure covering our departments and workplaces, hospital groups and SMHS-wide. The committees provide strategic oversight and direction on WHS matters and issues and address broad aspects of work health and safety affecting the area represented.



SMHS has 287 health and safety representatives who are vital to consultation in SMHS workplaces. All health and safety representatives have access to a WHS committee which meets at least quarterly and supports them with opportunities to raise, discuss, resolve, and, where appropriate in line with our WHS issue resolution process, escalate WHS matters for further action.

Workforce consultation on our WHS Management System is undertaken through our WHS committees and departments, and on the SMHS intranet during consultation periods.

SMHS remains committed to assisting injured workers back to gainful employment.

The SMHS WHS management system complies with the *Workers' Compensation and Injury Management Act 1981*. An injury management system is in place, documented in the SMHS Injury Management Policy and Procedure and available on the intranet.

Injured workers across SMHS are supported with access to a workplace injury Early Intervention Program (EIP) including medical review, and physiotherapy treatment. The program places injured workers first, with an emphasis on immediate care advice and injury assessment, ensuring optimal management to expedite a safe and sustainable return to work following a workplace injury or illness.

SMHS managers are active participants in the management and workplace rehabilitation of injured workers providing opportunities, based on medically indicated restrictions, for full and modified return to work programs.

SMHS continues to review and improve our practices focusing on strategies to reduce frequency, severity, and volume of compensable injuries.

During 2022 an external audit of the SMHS WHS management system was undertaken to ensure compliance with the *Work Health and Safety Act 2020 (WA)*. Actions taken to address the findings were finalised in late 2022.

SMHS has an internal WHS audit system in place. WHS departments continue to verify the activities of each SMHS site to ensure compliance with the requirements of our WHS Management System at the local level. The WHS audit system includes regular chemical stocktakes, and system-wide chemical reviews.

Table 28: 2022–23 work health and safety performance

Measure	2021–22	2022–23	Target	Comment on result
Number of fatalities	0	**0**	0	Achieved.
Lost time injury and/or disease incident rate	2.60	**3.06**	0 or 10% reduction	Negative increase in incident rate from 2021–22 to 2022–23 against target of <2.75%. Improvement strategies are identified and included in the 2023–25 WHS Plan. These strategies include actions related to injury prevention, injury management, wellbeing, safety leadership and governance.
Lost time injury and/or disease severity rate	47.2	**43.64**	0 or 10% reduction	Positive reduction in severity rate from 2021–22 to 2022–23 against target of <39.27%. A key improvement strategy is the monthly review of worker compensation claim severity rates and estimates between the insurer and Injury management teams.
Percentage of injured workers returned to work within 13 weeks	39.0	**44.2**	Greater than or equal to 80%	Positive increase in 13 week return to work rate from 2021–22 to 2022–23.
Percentage of injured workers returned to work within 26 weeks	51.3	**55.6**	Greater than or equal to 80%	Positive increase in 26 week return to work rate from 2021–22 to 2022–23.
Percentage of managers trained in occupational, health and injury management responsibilities	71.7	**64.8**	Greater than or equal to 80%	Negative decrease in compliance of managers with health and safety training from 2021–22 to 2022–23. In line with increased accountabilities under the *Work Health and Safety Act 2020*, and to promote the importance of WHS and improve engagement, SMHS Area Executive Group approved annual compliance with WHS training for SMHS managers. Improvement strategies include a review to confirm cohorts required to complete training.

Unauthorised use of credit card

Relevant SMHS staff are authorised and issued with a corporate credit (purchasing) card if their job function requires usage of this facility. Credit cards are not for personal use by the cardholder. Should a cardholder use a credit card for personal purposes, they must give written notice to SMHS within five working days and refund the total amount of expenditure.

Despite being made aware of obligations pertaining to the use of the credit cards, one SMHS cardholder used their card for personal purposes. The full amount $64.00 was refunded before the end of the reporting period.

Table 29: Credit card personal use expenditure

Expenditure	Amount ($)
Aggregate amount of personal use expenditure for the reporting period	64.00
Aggregate amount of personal use expenditure settled by the due date (within 5 working days)	nil
Aggregate amount of personal use expenditure settled after the period (after 5 working days)	64.00
Aggregate amount of personal use expenditure outstanding at the end of the reporting period	nil

Advertising

SMHS incurred a total advertising expenditure of $254,940 for 2022–23 period:

Table 30: Advertising by class of expenditure

Expenditure	Amount ($)
Advertising agencies	nil
Market research organisations	nil
Polling organisations	nil
Direct mail organisations	nil
Media advertising organisations	254,940

Table 31: Breakdown of advertising expenditure by agency

Agency	Amount ($)
HG Leadership Pty Ltd	101,541
Initiative Media Australia Pty Ltd	99,352
BMJ Publishing Group Ltd	27,227
Carat Australia Media Services Pty Ltd	18,003
Good News Broadcasters Inc	3,964
Government Education and Business Directories Pty Ltd	2,419
Directories of Australia Pty Ltd	1,073
Other*	1,361

*__Note__: Three organisations equating to an additional advertising spend of under $1,000 each.

Act of Grace, ex-gratia payments

SMHS did not make any charitable gifts or ex-gratia payments over $100,000 in 2022–23.

Pecuniary interests

Senior officers of government are required to declare any interest in or proposed contract that has, or could result in, the member receiving a financial benefit.

SMHS Board member, Karen Brown declared her position as Chair of Cannings Purple, in which she has a one per cent share. Cannings Purple held contracts with DoH, SMHS and the Child and Adolescent Health Service in 2022–23. This interest is declared and managed through the conflict of interest process.

External member of the SMHS Safety and Quality Committee, Phillip Della declared his position as an independent consultant contracted to DoH up to August 2022 to conduct an independent review of nursing hours per patient day.

SMHS Executive member, Neil Doverty declared his position as Board member of the Health Roundtable of Australia and New Zealand. The Health Roundtable has a contract with DoH.

Summary of board and committee remuneration

The total remuneration for the SMHS Board and each SMHS committee is listed in table 32. For details of individual board or committee members' remuneration refer to appendix 1.

Table 32: Total remuneration for SMHS Board and committees

Board/committee name	Total remuneration ($)
South Metropolitan Health Service Provider Board	502,378
Community Advisory Council, Rockingham General Hospital	19,693
Community Advisory Council, Fiona Stanley and Fremantle Hospitals Group	7,575
Fiona Stanley Hospital Emergency Department Consumer Advisory Group	6,660
Peel Mental Health Consumer Advisory Group	5,775
Rockingham Mental Health Consumer Advisory Group	5,050
Fremantle Hospital Mental Health Consumer Advisory Group	2,535
Fiona Stanley Hospital Mental Health Consumer Advisory Group	2,250
Fiona Stanley Hospital Maternity Advisory Group	2,025

Multicultural framework

The SMHS Multicultural Plan 2021–2025 demonstrates the health service's commitment to supporting equal opportunities for consumers and staff. A key initiative of the SMHS Multicultural Plan was the development of an Equity, Diversity and Inclusion Plan (EDIP), which aims to provide sustainable employment outcomes for all diversity groups. SMHS is proud of its diverse workforce, with 34 per cent of staff indicating they are from a cultural or linguistically diverse background.

- During **Harmony Week 2023**, SMHS reflected on Australia's cultural diversity, promoting inclusivity, respect and a sense of belonging for all, from the traditional owners of the land to those who have come from countries around the world. Displays were set up at FSH, FH and RGH with daily updates about Harmony Week circulated across the health service. Throughout Harmony Week, staff were encouraged to wear orange to signify social communication, meaningful conversations, the freedom of ideas and encouragement of mutual respect. Education opportunities were promoted to develop cultural competency and help make SMHS a vibrant, respectful and inclusive place to work.
- The launch of the SMHS online community engagement platform, **Put it to the People**, provides greater opportunities for members of the south metropolitan community from culturally and linguistically diverse (CALD) backgrounds to have a voice in the design and delivery of the healthcare that SMHS provides. Put it to the People features a translation tool that enables content to be translated into the top ten languages for the most commonly used interpreter services.
- **SMHS Inclusivity and People Experience Working Group** was established to coordinate, implement and support initiatives to create an open and inclusive workplace culture where diversity is valued and consumers feel confident that when they attend sites as a patient or visitor, they will be treated with respect and looked after in a culturally safe manner.

Substantive equality

Substantive equality seeks to address inequalities that stem from an individual's circumstances. At SMHS, our commitment is to ensure equitable access for our patients and workforce by not creating disadvantage for minority groups. SMHS continues to make significant progress in ensuring its services are responsive to the needs of different people and groups of people, and this includes workforce initiatives.

The SMHS EDIP 2021–2025 demonstrates SMHS' commitment to an equitable, diverse and inclusive workforce, and one reflective of the diversity of the community which we serve. The plan recognises the need for an open and inclusive workplace culture that values diversity and respects the social and cultural backgrounds of all employees. In 2022–23, SMHS continued to work towards:

- delivering sustainable, culturally safe and responsive healthcare services
- improving access to healthcare services for Aboriginal peoples
- ensuring policy and service structures and processes do not inadvertently disadvantage Aboriginal and minority groups
- partnering with Aboriginal peoples, communities and organisations to design, deliver, monitor and review health services.

The Aboriginal population remains one of the most disadvantaged groups within the SMHS catchment. It is therefore important for SMHS to maintain its focus on achieving health equity for Aboriginal peoples and communities by working in partnership with Aboriginal peoples, communities and organisations.

Workforce initiatives

SMHS continued to facilitate career pathways and increase the Aboriginal workforce to support improved health outcomes for Aboriginal people in 2022–23. Initiatives included:

- continued participation in WA Health's Aboriginal Cadet Program which provides tertiary students an opportunity to gain work experience while completing their undergraduate degree
- addressing recruitment process gaps through development of a new eLearning module specifically on section 51 of the *Equal Opportunity Act (1984)*
- creation of two new Aboriginal health practitioner positions
- establishment of the first training psychiatric registrar in Aboriginal Mental Health at Rockingham Peel Group.

Culture awareness and security

Ensuring Aboriginal patients in SMHS care feel secure and safe is important to improving Aboriginal health outcomes. The SMHS Aboriginal Health Champions program continues to grow and develop with 262 Aboriginal Health Champions in SMHS, including 60 staff members inducted into the program in 2022–23.

Other cultural education programs delivered in 2022–23 included:

- training for medical staff from emergency departments, anaesthesia and physiotherapy. SMHS emergency department teams have actively worked with Aboriginal staff and consumers to reduce discharge against medical advice and did not wait rates
- regular toolbox sessions and participation in medical grand rounds on Aboriginal cultural awareness
- cultural awareness sessions provided to medical students at The University of Notre Dame, Curtin University and new doctors at the beginning of their internship at SMHS
- the Aboriginal Person-Centred Care training program, which moved under the governance of SMHS in 2022–23 and is delivered across all sites.

Other initiatives to support cultural safety across SMHS sites included:

- the use of Aboriginal art and language throughout SMHS hospitals. In the RGH emergency department, Aboriginal art was installed throughout the department. Aboriginal names have been incorporated into the development of the new services including mental health beds at Fremantle Hospital and the SMHS Specialist Eating Disorders Service.
- the Aboriginal Health Strategy team worked closely with one of the clinical service improvement resident medical officers to increase identification of Aboriginal and Torres Strait Islander patients to increase the referral process to Aboriginal Hospital Liaison services and improve the patient experience.

Community engagement

In 2022–23, consumer participation activities included:

- the Aboriginal Consumer and Community Engagement Framework was updated
- local Aboriginal community members were engaged in service development through monthly Rockingham Aboriginal Health Advisory Group (Moorditj Kwoparding Mia) meetings
- monthly FSFHG Partnering with Consumers group meetings
- Fremantle Hospital Mental Health Services consulted with local Aboriginal community members to provide Noongar names for new mental health wards and common areas and to decide on artwork and furnishings for the new 40 bed mental health unit
- local Noongar language experts provided advice on an appropriate name that captured the spirit of the service for the new SMHS Eating Disorders Service
- a walking path was created at RGH acknowledging local flora and fauna translated into Noongar language
- local Peel Aboriginal community members were consulted on the naming of PHC as it transitions to SMHS
- developing posters to promote the Aboriginal Health Liaison Service and encourage feedback from patients, family and carers.

Patient experience feedback

Providing a great patient experience is a strategic priority for SMHS and listening to our patients through feedback is critical to the health service understanding what we are doing well and where we can improve when delivering care. Consumer feedback also allows us to recognise when staff and teams deliver compassionate care and exceed our patients' expectations.

MySay surveys provide patients an opportunity to complete questions on their experience with the aggregated survey data available to all staff and used to celebrate great care and identify areas for improvement. The surveys have been extended to include outpatients, emergency department patients and community patients, as well as in additional languages.

In 2022–23, SMHS heard from 36,458 patients, including:

- 18,100 people regarding their overnight or same day admission. Of these, 92 per cent rated their overall quality of care as very good or good.
- 3,000 people provided feedback regarding their care in SMHS emergency departments with 81 per cent of these rating their quality of care as very good or good.
- 14,350 people provided feedback regarding their visits to SMHS outpatient departments. Of these, 95 per cent rated their overall quality of care as very good or good.
- In January 2023, SMHS launched the MySay Healthcare survey – REACH to capture feedback from patients who have received care from community services. More than 1,000 people completed the survey. Of these, 98 per cent rated their overall quality of care as very good or good.
- In 2022–23, SMHS received a total of 127 stories via Care Opinion, an online platform that allows members of the public to tell us about their experience with our services. Of these, 52 stories were positive and 75 included suggested areas for improvement.

Some of the positive feedback shared via **Care Opinion**:

Fremantle Hospital

"My family member got fantastic care for a serious mental illness that they've had for most of their life, but recently got worse. I found them very respectful and welcoming of family feedback and they have wraparound community care moving forward. A great outcome and what a relief, I felt, to know this service is there."

Rottnest Island Nursing Post

"I would like to extend the greatest of thanks to the clinical nurse who supported us, not once but twice while on a day trip to Rottnest Island.
I am a clinical nurse myself and the care provided to my travelling companion was exceptional. The clinic was busy and we were able to witness not only exceptional care to ourselves but quick, appropriate and decisive care to a young boy presenting with burns during our stay."

Fiona Stanley Hospital

"I had gallbladder surgery at Fiona Stanley Hospital. I am from remote WA and was very nervous about attending to have surgery in unfamiliar environment. The size of the hospital is overwhelming, including the number of people working there. However, everyone I encountered, greeted me with a smile and friendly conversation. The care I received was truly impressive and very knowledgeable. A big thanks to Dr Mo, Dr Michela, the theatre team and the short stay nursing and medical team. Even the afternoon orderly was a delight, she came to my bedside to have a chat and made me feel very comfortable. It's a credit to the organisation."

Rehabilitation in the home

"When discharged from hospital I was still quite unwell and had wondered how I was going to manage as I live alone. An immediate response from rehabilitation in the home (RITH) reassured me that all would be dealt with. It could not have been a smoother transition from hospital to home with the services put in place and meeting my needs. A special mention to the physiotherapists, Kris and Kelly who got me back on my feet. The care given at each visit assured me that I wasn't just a number on a file. I feel they are an asset to the Health Department. My experience with RITH has been excellent. Keep up the good work and grateful thanks to all concerned."

Rockingham General Hospital

"I would like to acknowledge all of the amazing staff at Rockingham Hospital recently who I felt went above and beyond with the care they took for my husband on a weekend morning. From the moment we entered the emergency department the staff we saw from the triage and reception points were exceptional. Within a short time my husband was seen by a nurse who then organised blood tests which were done very quickly. While waiting for the results they were organising a bed in a ward. He was then put on an intravenous antibiotics while a bed was sorted. I felt the ongoing care while on the ward from the doctors, nurses, pharmacist and the lovely team with the meals was also exceptional from the beginning until he was discharged. We would love to thank them sincerely for their wonderful care."

In 2022–23, SMHS received 3,191 compliments, 2,839 contacts and concerns and 809 complaints via formal feedback processes.

Complaint is defined as an expression of dissatisfaction by an individual regarding any aspect of a service provided by the health service.

Contact/concern is defined as feedback from an individual regarding an aspect of service where:

- they state they do not wish to lodge a formal complaint
- the issues can be resolved without going through the formal complaint management process.

The WA Health Complaints Management Policy 2020

Disability access and inclusion

The SMHS Disability Access and Inclusion Plan (DAIP) 2022–2027 supports the delivery of services to consumers and staff with disability to ensure equitable access to health services, information and facilities.

SMHS reports annually on progress towards the seven desired outcomes outlined in the Disability Services Regulations 2004. In 2022–23, positive progress was seen across the health service, particularly with respect to the coordination of care and access for people with disability.

Outcome 1

People with disabilities have the same opportunities as other people to access the services of, and events organised by, a public authority.

FSFHG and RkPG disability access and inclusion committees have developed site-specific implementation plans to deliver the strategies in the SMHS DAIP 2022–2027. These include ensuring processes are in place to consider the access needs of people with disability during the creation or development of health services.

The RGH concierge service has increased the number of mobility devices for patients and visitors on arrival at the hospital. These devices, which include powered wheelchairs, have improved access and assisted in the transportation of patients and visitors around the hospital.

The WA Health Hospital Stay Guidelines were implemented across SMHS. The guidelines aim to improve the hospital experience for people with disability by providing information on ways to support patients them during their hospital admission.

Outcome 2

People with disabilities have the same opportunities as other people to access the buildings and other facilities of a public authority.

During the development of a new outpatient clinic at RGH, a comprehensive review of the clinic space was undertaken to ensure rooms were accessible. An alternative clinic bay has been created for use by patients who may have difficulties accessing smaller clinic rooms.

Access to ACROD bays within certain car parks across the FSH site has been highlighted as a concern by patients attending the hospital. While FSH complies with the required number of ACROD bays across the site, an audit identified underutilised bays in some areas. Reallocation of these bays to car parks with higher ACROD bay demand is underway.

Outcome 3

People with disabilities receive information from a public authority in a format that will enable them to access the information as readily as other people are able to access it.

SMHS identified the need to support staff to provide relevant health information in alternative formats for people with disability. A selection of consumer resources has been prioritised for conversion to easy-read format as part of a project to produce consumer information in this way. This will make it easier to present information for people with intellectual disabilities.

As part of the development of printed consumer information for use across SMHS, all new forms and patient information handouts are reviewed by members of consumer advisory councils prior to final print approval. Each council includes a range of consumers and carers with lived experience, including those with disability. The councils provide feedback on accessibility, with consideration of the needs of people with disability.

An intranet page to support staff caring for consumers with cognitive impairment was launched in November 2022. The information features resources for staff that they can share with patients, with the goal of providing the right support at the right time to ensure that patients with cognitive impairment feel comfortable and safe in hospital.

Outcome 4

People with disabilities receive the same level and quality of service from the staff of a public authority as other people receive from the staff of that public authority.

A trial to support people with non-visible disabilities to access the support they need while they receive healthcare is underway at FSH. The use of the globally recognised Hidden Disabilities Sunflower logo acts as a prompt for someone to choose to let people around them know they have a non-visible disability, and that they may need additional support.

The FSFHG NDIS linkage team includes four staff members who are experts at understanding the NDIS pathways to support hospital discharge. The multidisciplinary team works closely with clinical staff to facilitate timely discharge.

At RGH, a NDIS project officer has been recruited to improve education and access to support services for patients with disability. This has included the development of an education strategy for all staff.

Outcome 5

People with disabilities have the same opportunities as other people to make complaints to a public authority.

SMHS consumers with disability and their families are supported to provide feedback via a range of methods. Feedback is reviewed by site disability access and inclusion committees.

As a result of feedback received at FSFHG, wayfinding signage is being reviewed in several areas including the emergency department, common use corridors and visitor car parks.

Improvements include upgrades to wheelchair friendly disability toilets at RGH and FSH. Positive feedback has been received from a consumer, who noted the independence these facilities afforded them.

Outcome 6

People with disabilities have the same opportunities as other people to participate in any public consultation by a public authority.

A consumer survey was undertaken inviting people with disability, their families, and carers to comment on their experiences with SMHS services. The survey was launched to coincide with International Day of People with Disability in December 2022. The results will be used to inform work to improve the accessibility and inclusiveness of SMHS and the broader community for people with disability.

Outcome 7

People with disability have the same opportunities as other people to obtain and maintain employment.

SMHS has engaged in a partnership with BIZLINK, a Perth not-for-profit organisation which provides disability employment support services and connects people with disabilities with employers. This is helping SMHS facilitate opportunities for people with all types of disabilities, barriers and backgrounds to secure and maintain employment.

The first face-to-face disability awareness training for managers and colleagues of employees with disability was held in March 2023. The training, which will continue over the next 12 months, aims to develop a disability confident employment workforce.

To assist managers, supervisors, and employees, SMHS has developed the SMHS Reasonable Adjustment Guidelines. Reasonable adjustment refers to the administrative, environmental or procedural changes required to carry out their duties effectively.

Compliance with Public Sector Standards

Public Sector Standards

The Public Sector Standards in HR management set out the minimum standards of merit, equity and probity required of all WA public sector bodies and their employees. SMHS is committed to ensuring ongoing compliance through:

- supplying new employees with information about the standards and HR policies and procedures as part of their induction
- managing breach of standard claims in accordance with the Public Sector Management (Breaches of Public Sector Standards) Regulations 2005
- regularly developing, reviewing and implementing HR policies, procedures and practices that are consistent with the standards
- providing HR and industrial relations consultants to assist managers and staff in HR activities
- providing HR recruitment teams at RGH and FH and ensuring recruitment activities are performed in accordance with the standards
- training employee support officers, who are available to all staff
- informing staff via SMHS intranet and electronic newsletter on the need for staff to comply with the standards
- managing staff redeployment in accordance with the Public Sector Commission's (PSC) Employment and Redeployment Standards, the PSC Instructions and the Public Sector Management (Redeployment and Redundancy) Regulations 2014
- providing equitable and timely resolution of employee grievances and promoting a commitment to providing a safe and positive workplace.

Examples of SMHS compliance include:

- SMHS Workforce reviewed recruitment selection and appointment processes and resources including recruitment quick guides. These are made available on the SMHS Rethinking Recruitment intranet page.
- The SMHS Discipline Guidelines were updated following consultation with stakeholders. This includes information on performance and conduct reporting, non-disciplinary processes and reporting on performance or conduct.

During 2022–23:

9	**claims were lodged against the employment standard:**
4	claims were resolved by SMHS and did not result in a breach of standard
3	claims were sent to the PSC for review and were dismissed with no breach of standard found
1	claim was sent to the PSC for review and declined as SMHS had taken agreed action
1	claim was sent to the PSC for review and declined as it did not meet 11A of the *Public Sector Management (Breaches of Public Sector Standards) Regulations 2005*

There were no breach claims against any other Public Sector Standards in HR management.

Recordkeeping plan

SMHS continues to develop and implement good record keeping practices in accordance with the *State Records Act 2000*. The SMHS recordkeeping plan underwent a significant review in 2022–23 in consultation with the WA State Records Commission. The plan was endorsed by the State Records Commission in May 2023.

Record management training sessions continued to be offered to all staff, supported by a dedicated intranet site and resources.

Code of Conduct

SMHS works within the DoH's Code of Conduct, with an expectation that all employees, volunteers and contractors adhere to the Code of Conduct and the WA Public Sector Code of Ethics.

SMHS has a vision of **excellent health care, every time**, which is supported by the values of Care, Integrity, Respect, Excellence and Teamwork.

There is a clear expectation that all staff adhere to the SMHS values and Code of Conduct at all times, no matter where they are employed.

The SMHS Integrity and Ethical Governance Framework was endorsed in April 2023 and incorporates the principles and accountability mechanisms used to monitor compliance with ethics, integrity and accountability. The Integrity and Ethical Governance Framework aligns with the WA PSC's principles and is supported by the formal disciplinary and reporting mechanisms to ensure oversight, appropriate decision making and reporting to external agencies.

SMHS ensures ongoing compliance with the ethical codes by:

- supplying new staff with information about the SMHS values, standards, Code of Conduct and HR policies and procedures during induction
- ensuring policies are updated and reviewed to support all staff in operating within their delegations
- providing education sessions to staff on a range of ethical conduct matters including additional employment, conflicts of interest and gifts
- ensuring training in recruitment processes is provided to staff to ensure processes reflect contemporary HR practices and public sector requirements
- developing a culture where staff feel able to speak up when they see behaviours that may not be aligned with SMHS values and ethical principles
- informing staff through articles within SMHS electronic newsletters and intranet sites.

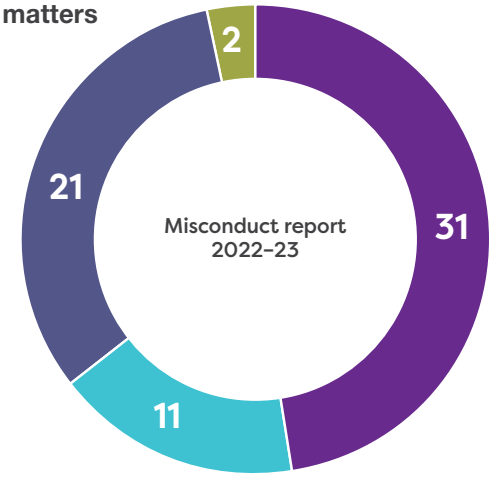
Staff compliance with ethical codes is monitored through reports of breaches of discipline which can be reported through consumer complaints, staff or manager complaints and the public interest disclosure process.

Disciplinary outcomes often require staff to undertake additional training in respect to the Code of Ethics as an improvement action resulting from their conduct.

When required, investigations are undertaken by either a delegated SMHS staff member or by an investigator sourced through the common use arrangements.

During 2022–23, **65 misconduct matters** were recorded and of these:

- 31 matters were assessed as **serious misconduct** and reported to the Corruption and Crime Commission
- 11 matters were assessed as **minor misconduct** and reported to the PSC
- 21 matters were assessed as **not reportable**
- two matters were **pending assessment**.



Of the **65 matters reported**, following consideration by a decision maker, and/or investigations:

- 39 matters were **substantiated**
- 9 matters were **not substantiated**
- 15 matters are **in progress**
- two matters were **withdrawn**