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

EMHS Annual Report
2025-2026

Statement of compliance

For year ended 30 June 2026

Hon Meredith Hammat
Minister for Health; Mental Health

In accordance with section 63 of the *Financial Management Act 2006*, we hereby submit for your information and presentation to Parliament, the Annual Report of East Metropolitan Health Service for the financial year ended 30 June 2026.

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

Sally Carbon OAM
Board Chair
East Metropolitan Health Service
11 September 2026

Melissa Grove
Chair, EMHS Board Audit and Risk Committee
East Metropolitan Health Service
11 September 2026

Acknowledgment of Country

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

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

We welcome all Aboriginal and non-Aboriginal people to our services.

Acknowledgment of Aboriginal people and communities

The voice of Aboriginal people and communities is reflected in the EMHS 2025-2026 Annual Report to ensure that cultural appropriateness and the health impacts on Aboriginal people have been considered and incorporated.

Cultural warning

The EMHS 2025-2026 Annual Report may contain articles that display names, images and artwork of Aboriginal persons who have passed away.

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

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

Celebrating 10 years of East Metropolitan Health Service

2016

2016-17
EMHS' first Strategic Intent (2017-20) released. The EMHS vision of healthy people, amazing care koorda moort, moorditj kwabadak and values of kindness, excellence, respect, integrity, collaboration and accountability still frame our health service today

2017-18
EMHS implemented the Aboriginal health Impact Statement and Declaration (ISD), to ensure the needs, interests and circumstances of Aboriginal people are incorporated into the development of new and revised policies, strategies, practices and procedures

2018-19
January 2019 – Inaugural Clinical Services Plan: Towards 2024 released, articulating how EMHS would plan for, and deliver, health care services to our community

2019-20
20 August 2019 – EMHS celebrated excellence across the health service at the inaugural Excellence Symposium – which has now become a key, inspirational staff event in EMHS' calendar

2019-20
December 2019 saw the release of EMHS' first digital strategy Smart EMHS: Design Digital. Create Health. Deliver Care – a plan that shaped many of the digital innovations used to provide care today

2019-20
EMHS joined the Global Green and Healthy Hospital network – a global community of hospitals, health care facilities and health services working to achieve measurable outcomes to improve sustainability

2019-20
December 2019 – EMHS prioritised 7 recommendations from the Sustainable Health Review, designed to bring a cultural and behavioural shift across the health system. In 2025-26, EMHS remains committed to implementing and enhancing services aligned with these recommendations

2020-21
November 2020 – EMHS Values in Action Awards were introduced to celebrate selected staff who consistently model the EMHS values and help to create a positive and healthy workplace

2020-21
In line with the WA Government's commitment for the protection of frontline staff, a new EMHS Security Unit was developed at Royal Perth Hospital, with a security control room that allows central CCTV monitoring across Armadale Hospital, Bentley Hospital and Kalamunda Hospital

2020-21
January 2021 – EMHS Multicultural Plan was launched, in line with the WA Multicultural Policy Framework, to promote cultural and linguistic diversity as an integral, valuable and positive feature of our health service

2020-21
December 2020 – EMHS launched Health in a Virtual Environment (HIVE) to remotely monitor patients and detect earliest signs of clinical deterioration - representing a significant milestone for digital healthcare in WA

2021-22
EMHS released its new Strategic Plan 2021-25, upholding the EMHS vision and values, and introducing new goals for consumers and community, the here and now, a better tomorrow and our people

2021-22
October 2021 – EMHS' existing care call system was rebranded as Aishwarya's CARE Call, as part of a WA Health system-wide collaboration to empower families and carers to alert hospital staff to deterioration in a patient's condition, prompting an escalation in care

2021-22
April 2022 – EMHS launched the Youth Community Assessment Treatment Team (YCATT) to complement the work of the East Metropolitan Youth Unit, and provide brief, targeted assessment and intervention for young people and their carers

2026

2022-23
Health in a Virtual Environment (HIVE) expanded its remote monitoring services to the community (Co-HIVE), empowering residential aged care facilities to look after their clients on their own premises, and providing virtual follow-up appointments for people discharged from hospital

2022-23
EMHS made major advances to harness virtual health and new technology to deliver efficient services. This included the introduction of electronic prescriptions, hi-tech automated dispensing cabinets and digital medical records, as well as further work on refining virtual patient consultations

2022-23
May 2023 – EMHS launched its Crisis Resolution Home Treatment Team (CRHTT) Marr Koodjal Mia to provide intensive mental health care in the home for people who would otherwise need a voluntary stay in hospital

2022-23
EMHS Environmental Sustainability Framework 2022-2026 was launched to set a course for a target of net zero emissions by 2050

2022-23
EMHS Board endorsed an Environmental, Social and Governance (ESG) Statement, reinforcing EMHS' commitment to minimising its environmental impact, focus on supporting healthy people and providing care to the community, and being accountable to the stakeholders we serve

2023-24
March 2024 – EMHS Board approved a refreshed Smart EMHS Digital Strategy, which calls on technologies that came to the fore during the COVID pandemic, when digital communication became a lifeline

2023-24
Oct 2023 – A Digital Medical Records (DMR) system came online at Armadale and Kalamunda Hospitals, as part of a statewide move to modernise patient care in public health services. Implementation at Bentley and Royal Perth Hospitals completed EMHS' DMR roll-out in 2025

2023-24
A refreshed EMHS Multicultural Plan 2024-27 was developed in consultation with internal and external stakeholders

2023-24
A revolutionary Home Hospital serviced commenced at Royal Perth Hospital, bringing a new era of healthcare delivery. Under the service, a virtual ward delivers hospital-level care in a patient's home with round-the-clock remote monitoring, daily ward rounds by medical staff, and daily or twice daily in-person visits by nurses and allied health professionals. Home Hospital expanded to Armadale Hospital in 2025

2023-24
EMHS established its new virtual hospital (East CareConnect), which harnesses technology to deliver hospital-quality treatment in the community. The service expanded in its first year of operations, with virtual services now being a core part of how EMHS delivers care

2024-25
A refreshed EMHS Clinical Services Plan Towards 2035 was released, defining the future state of a culturally safe, contemporary, tiered and integrated network of health services extending beyond the hospital walls

2025-26
The biggest growth in EMHS' 10-year history will reshape how we care for our growing community, including exciting new infrastructure projects funded by the State and Federal Governments

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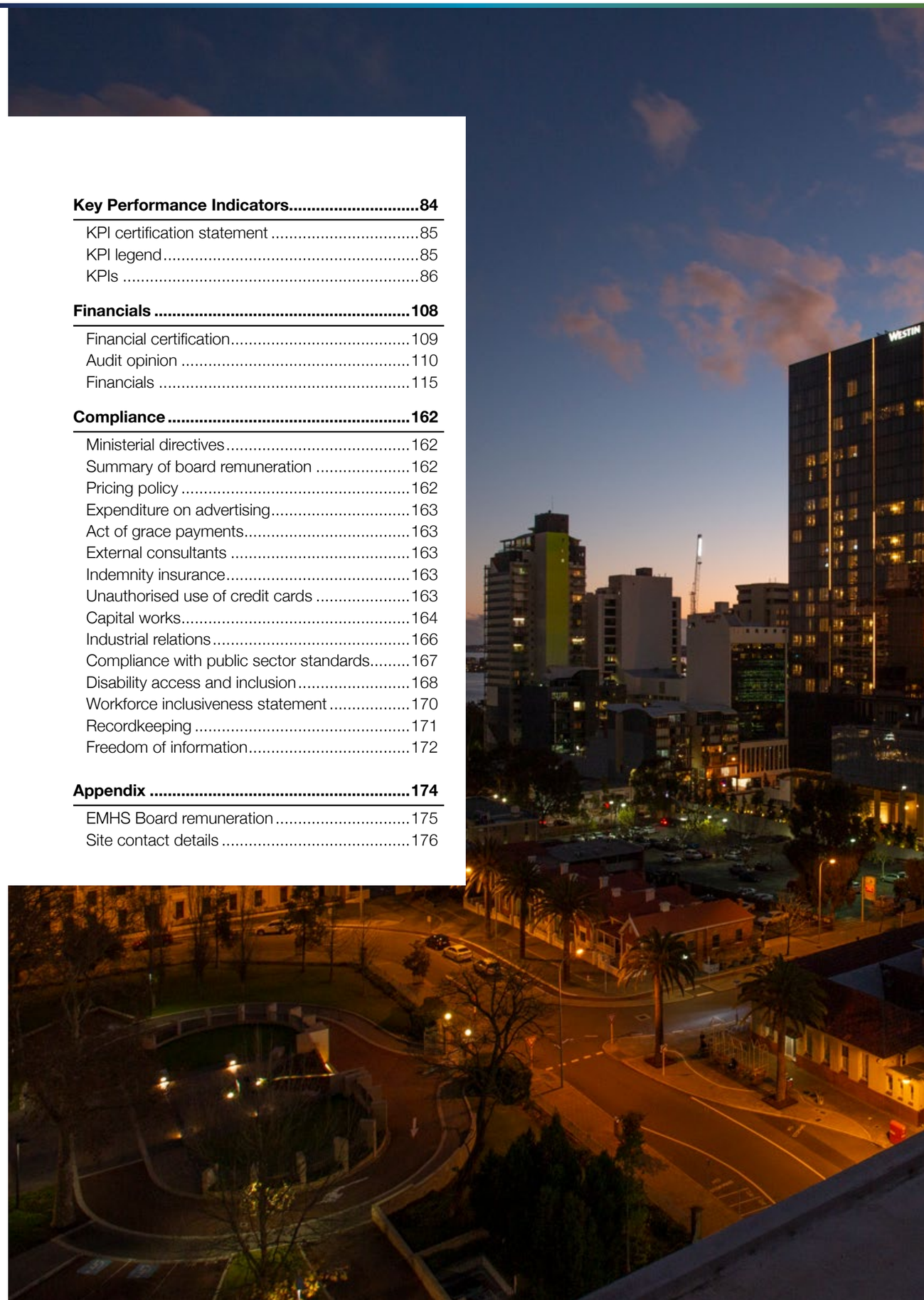


About EMHS

East Metropolitan Health Service

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

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

A range of community mental health, population health and Aboriginal health programs are also provided, along with expanding delivery of home hospital and virtual care services.

866,837
Total population within EMHS catchment
(2016-17 – 708,000)

3,647km^2
Catchment area

32,402
Total Aboriginal population within EMHS catchment
(2016-17 – 12,700)

Our hospital and community network

EMHS consists of:

Armadale Kalamunda Group (AKG), which includes **Armadale Hospital (AH)** Gangangarra and **Kalamunda Hospital (KH)**.

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

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

Royal Perth Bentley Group (RPBG) includes the inner-city **Royal Perth Hospital (RPH)** Walbirring Karlup**, Bentley Hospital (BH)**, and Bidi Wungen Kaat **St James Transitional Care Unit** for Mental Health.

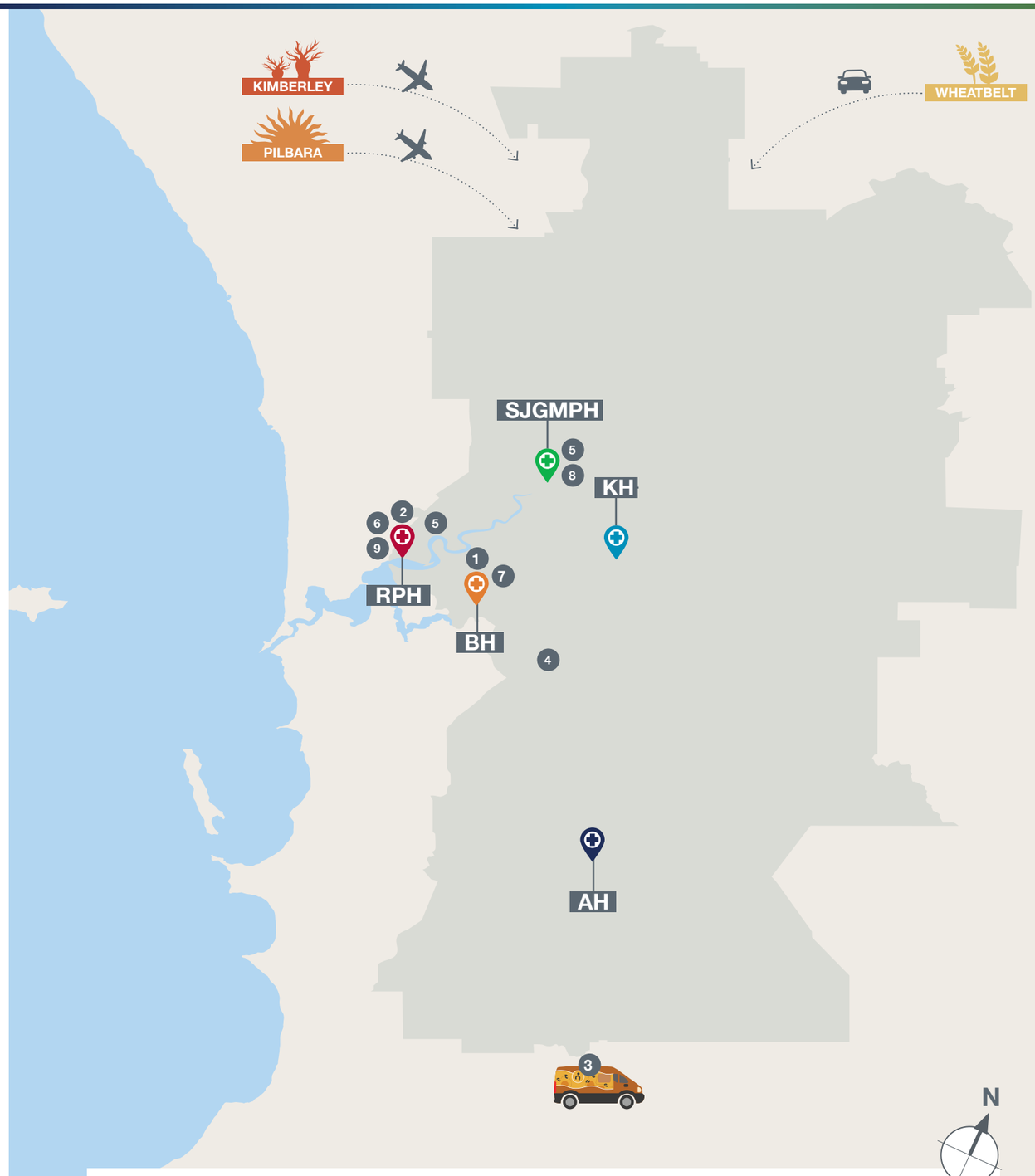
As a tertiary hospital, RPH provides an extensive range of healthcare including State adult major trauma, emergency and highly specialised services, as well as community and hospital-based mental health services.

BH is a specialist hospital with services including rehabilitation, elective and same-day surgery, maternity, older adults, and community and hospital-based mental health services.

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

From 1 September 2026, St John of God Mount Lawley will join the EMHS network as Mount Lawley Hospital (see page 59).

EMHS also delivers virtual hospital services to our community through **East CareConnect**.



Legend

Some of our community services and facilities

1. Bidi Wungen Kaat
2. Medical Respite Centre
3. Moorditj Djena (Healthy Feet) - mobile outreach across metro area
4. Orchard Ave Armadale MH Community Services
5. St John of God Mount Lawley (Ursula Frayne older adult inpatient unit)
6. City East Community MH
7. Bentley Community MH
8. Midland Community MH Service
9. Next Step Drug and Alcohol Service

Executive summary

2025-26 at a glance

	2025-26	2016-17
Emergency Department presentations	212,139 69,002 AH 78,527 RPH 64,610 SJGMPH	194,733
Inpatients - all	201,688 32,122 AH 10,819 BH 3,899 KH 111,405 RPH 571 SJGML 42,542 SJGMPH 330 Transitional Care Unit	135,477
Average length of stay (days)	6.10 5.09 AH 17.34 BH 17.17 KH 5.27 RPH 16.06 SJGML 4.98 SJGMPH 31.85 Transitional Care Unit	4.99
Outpatients	611,784 123,857 AH 35,030 BH 5,577 KH 322,733 RPH 12,557 SJGML 112,030 SJGMPH	480,322
Operations	60,628 11,724 AH 7,608 BH 3,302 KH 24,651 RPH 13,343 SJGMPH	47,904
No fixed address (inpatient and outpatient events)	6,726 382 AH 145 BH 1 KH 5,145 RPH 1 SJGML 1,042 SJGMPH 10 Transitional Care Unit	Unavailable
Births	4,451 2,293 Births (male) 2,158 Births (female)	5,025
Patients arrived by helicopter	217 217 RPH	278

EMHS 2025–26 financial summary

Total cost of services (expense limit)

Sourced from statement of comprehensive income

2025-26 target $000	2025-26 actual $000	Variation $000
$2,404,625	$2,645,991	$241,336

Net cost of services

Sourced from statement of comprehensive income

2025-26 target $000	2025-26 actual $000	Variation $000
$2,271,774	$2,493,575	$221,801

The total cost of services and the net cost of services variances reflect higher employee benefit expenses, and additional contract for services payments to private providers for the provision of extra general and mental health services.

Total equity

Sourced from statement of financial position

2025-26 target $000	2025-26 actual $000	Variation $000
$2,026,537	$2,125,243	$98,706

Total equity increased primarily because of a higher Landgate valuation for the Health Service's land and building assets. This higher valuation was partially offset by higher cost of services leading to a larger full year deficit relative to initial estimates.

Net increase in cash held

Sourced from statement of cash flow

2025-26 target $000	2025-26 actual $000	Variation $000
-$44,862	-$17,171	$27,691

The improvement in net cash position was primarily the result of additional cash funding provided to cover expenditure related to industrial award increases, inflation and indexation, and the delivery of heath activity above target. A greater focus on raising patient revenue and an improvement in cash collection performance also had an impact.

Approved salary expense level

Sourced from statement of comprehensive income

2025-26 target $000	2025-26 actual $000	Variation $000
$1,366,405	$1,485,160	$118,755

The primary drivers of the variance were the cost of award increases, the provision of new services, and additional staff needed to deliver quality and safe health care, together with associated flow-on effects (e.g. higher costs incurred for penalties, allowances, superannuation and worker's compensation premiums).

EMHS 2025–26 performance summary

Key Performance Indicators (KPIs) and KPI targets assist EMHS to assess and monitor achievement of the outcomes outlined in the Outcome Based Management Policy Framework (see page 23). Effectiveness indicators provide information on the extent to which outcomes were achieved through the funding and delivery of services to the community. Efficiency indicators monitor the relationship between the service delivered and the resources used to produce the service (i.e. activity and cost).

OUTCOME ONE: Public hospital-based services that enable effective treatment and restorative health care for Western Australians		
Effectiveness KPIs	**Target**	**Actual**
Unplanned hospital readmissions for patients within 28 days for selected surgical procedures (per 1,000 separations)		
(a) knee replacement	≤ 18.8	8.7
(b) hip replacement	≤ 18.3	10.5
(c) tonsillectomy & adenoidectomy	≤ 79.2	128.1
(d) hysterectomy	≤ 44.1	36.1
(e) prostatectomy	≤ 37.5	4.5
(f) cataract surgery	≤ 2.2	1.9
(g) appendicectomy	≤ 27.8	16.2
Percentage of elective wait list patients waiting over boundary for reportable procedures		
(a) category 1 over 30 days	0%	17.23%
(b) category 2 over 90 days	0%	39.72%
(c) category 3 over 365 days	0%	12.00%
Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days	**≤ 1.00**	0.71
Survival rates for sentinel conditions		
(a) Stroke		
0-49 years	≥ 95.3%	93.8%
50-59 years	≥ 94.7%	93.4%
60-69 years	≥ 94.3%	96.5%
70-79 years	≥ 92.4%	94.0%
80+ years	≥ 87.2%	91.1%
(b) Acute myocardial infarction (AMI)		
0-49 years	≥ 98.9%	100.0%
50-59 years	≥ 99.0%	99.6%
60-69 years	≥ 98.3%	97.8%
70-79 years	≥ 96.9%	97.3%
80+ years	≥ 93.1%	96.2%
(c) Fractured neck of femur (FNoF)		
70-79 years	≥ 98.9%	100.0%
80+ years	≥ 97.0%	97.2%

OUTCOME ONE: Public hospital-based services that enable effective treatment and restorative health care for Western Australians		
Effectiveness KPIs	**Target**	**Actual**
Percentage of admitted patients who discharged against medical advice		
a) Aboriginal patients	≤ 2.78%	7.94%
b) Non-Aboriginal patients	≤ 0.99%	1.31%
Percentage of live-born term infants with an Apgar score of less than 7 at 5 minutes post delivery	**≤ 1.90%**	1.10%
Readmissions to acute specialised mental health inpatient services within 28 days of discharge	**≤ 12.0%**	13.0%
Percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services	**≥ 75.0%**	84.9%
Efficiency KPIs	**Target**	**Actual**
Average admitted cost per weighted activity unit	**$8,183**	$8,497
Average Emergency Department cost per weighted activity unit	**$8,094**	$8,874
Average non-admitted cost per weighted activity unit	**$8,328**	$9,970
Average cost per bed-day in specialised mental health inpatient services	**$2,094**	$2,275
Average cost per treatment day of non-admitted care provided by mental health services	**$637**	$449

OUTCOME TWO: Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives		
Efficiency KPIs	**Target**	**Actual**
Average cost per person of delivering population health programs by population health units	**$31**	$7

EMHS 2025-26 focus areas

Managing expansion while maintaining and improving an already high-performing network of hospitals and health services was a key focus in 2025-26.

Through solid planning, coordination across operational teams, and prioritisation of staff and resources, we maintained high performance standards while progressing key expansion projects.

The EMHS Clinical Services Plan – Towards 2035 is a blueprint for the future state of a culturally safe, contemporary, tiered and integrated network of health services extending beyond the hospital walls.

Meeting rapid population growth

Our catchment is one of the fastest-growing areas in WA. As the population grows, demand for accessible and timely health services also rises.

To meet this demand, we have embarked on a series of major expansions. These will increase capacity in critical areas including emergency department (ED) care and access, operating theatres, public hospital beds, mental health services and health and community care.

Major projects include the new multi-storey building at Royal Perth Hospital (RPH) with 2 levels dedicated to a purpose-built ED, acquisition of St John of God Mount Lawley, expansion of St John of God Midland Public Hospital (a public-private partnership), Byford Health Hub and Bentley Surgicentre.

They follow the 2024-25 expansion of our East CareConnect community and virtual healthcare-at-home services such as Home Hospital, Health in a Virtual Environment (HIVE) and Community Hive (Co-HIVE).

Management of existing infrastructure

We are committed to balancing growth with investment in our current buildings, most of which are more than 70 years old.

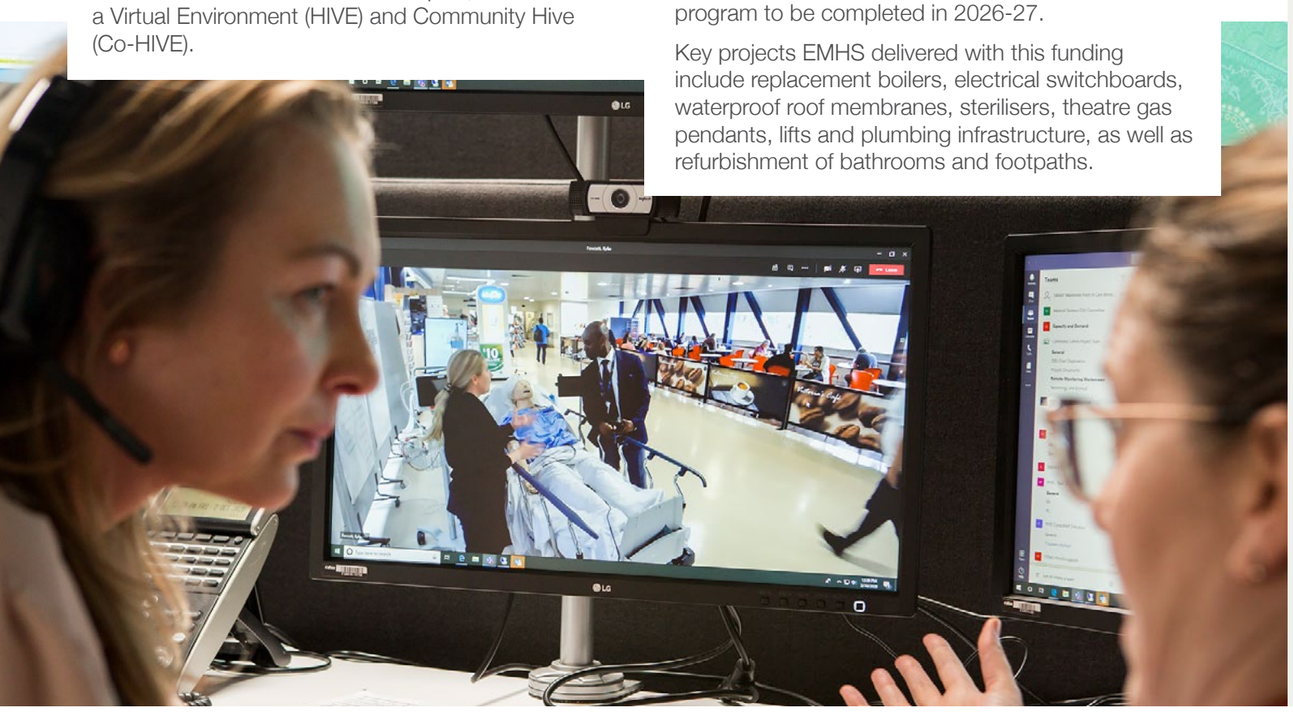
While we are in an active phase of infrastructure development, maintaining and upgrading our existing facilities to support service delivery remains a key priority.

The allocation of $7 million to undertake master planning of the RPH site will help identify an achievable and long-term path for redevelopment.

The WA Government's Health Asset Maintenance Fund (HAMF) was rolled out in 2025-26 to prioritise repairs and maintenance at older hospitals.

Our HAMF program consisted of 25 projects across RPH and Armadale Hospital (AH), with the full program to be completed in 2026-27.

Key projects EMHS delivered with this funding include replacement boilers, electrical switchboards, waterproof roof membranes, sterilisers, theatre gas pendants, lifts and plumbing infrastructure, as well as refurbishment of bathrooms and footpaths.



Serving our community

EMHS supports a diverse catchment with many priority populations as well as patients who have chronic disease and need more complex care.

Priority population groups experience health inequity and are at greater risk of poorer health outcomes.

We introduced a series of initiatives to help make our services more accessible to these community members.

RPH this year appointed its first Homeless Medicine Consultant. The role leads the Hospital's Homeless Team to improve healthcare outcomes for people experiencing homelessness.

We are strengthening our mental health initiatives on many fronts including developing a new Armadale Mental Health Emergency Centre and Bentley Secure Extended Care Unit.

An Older Adult Health Hub opened at a temporary location at Bentley Hospital for the physical, social and emotional needs of older adults, ahead of moving to new premises in Belmont.

We this year signed memorandums of understanding with 2 Aboriginal Community Controlled Health Services – Derbarl Yerrigan Health Service and Moorditj Koort Aboriginal Corporation – for health partnerships within our catchment (see page 53).

Improving outcomes for people experiencing homelessness

In 2025-26, EMHS provided 6,726 health care events to people of no fixed address. 5,145 of these were at RPH.

To improve healthcare outcomes for people experiencing homelessness, Daniel Hunt has been appointed as RPH Homeless Team's first Homeless Medicine Consultant.

Daniel was born in Three Springs to a mother of Jaru and Yindjibarndi descent and graduated in medicine from the University of Western Australia in 2010.

He took the team reins from founder Dr Amanda Stafford, whose invaluable work since its inception 10 years ago has set a strong foundation for the area's ongoing success.

Daniel joined the RPH team from the Derbarl Yerrigan Health Service, where he spent almost a decade working with Aboriginal and Torres Strait Islander people as a dentist, a general practitioner (GP) and, ultimately, as deputy medical director.

The RPH Homeless Team is an in-reach team, designed to link patients who present to the emergency department (ED) back into community GP care and community-based housing and support services.

"This is really groundbreaking, to have an Aboriginal Consultant working in our hospital and it demonstrates EMHS' commitment to pursuing better outcomes for our Aboriginal patients," Amanda said.

"It's an outstanding appointment and Daniel's years of experience with homelessness in the Aboriginal community will be easily extended to people of every background."

The 2025 NAIDOC Person of the Year and Australian Medical Association WA Advocate for the Year says he recognises the enormity of the work already done by his predecessor.

"Amanda has been a lead in this area for a decade. I've got quite impressive shoes to fill," Daniel said.

Building workforce capacity

Significant healthcare workforce challenges across the globe are compelling us to look at how we can have more agile and flexible systems to shape a fit-for-purpose healthcare workforce that will meet the needs of the WA community now and into the future.

A contemporary workforce goes beyond traditional workforce planning and looks at whole-of-health to redesign work, build capability, leverage technology, and enable new models of care to support the sustainable delivery of high-quality health care.

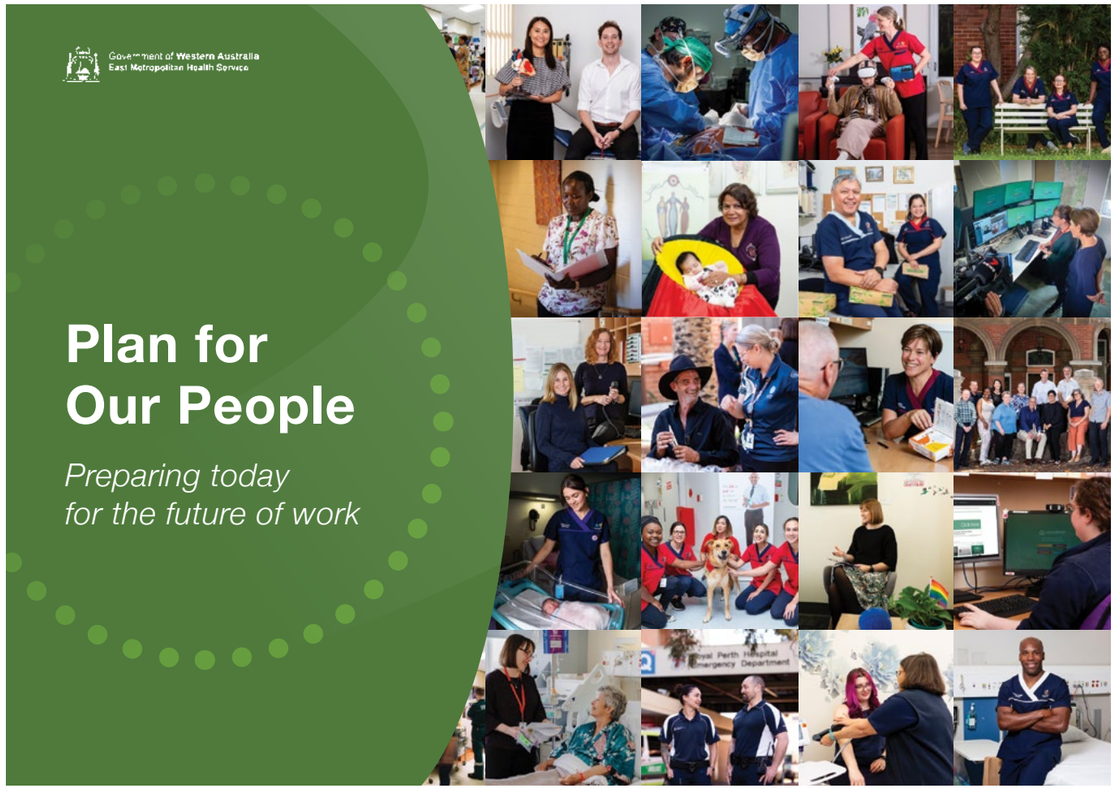
EMHS has been proactive in advancing contemporary workforce initiatives with innovative pilots, trials and programs.

Developed in response to critical workforce shortages and service gaps, these initiatives look at innovative ways of working to improve the way health care is delivered. They have provided valuable insights, lessons learnt and opportunities for expansion across EMHS and the wider health system.

Central to this is our commitment to our people. By engaging our workforce, investing in their development and creating a modern, flexible working environment, we enable our teams to deliver high-quality care.

One example is the growth of our nurse practitioner workforce, which has increased by 75 per cent since 2022. Nurse practitioners are advanced practice nurses who have extra education and clinical training.

Overall, EMHS' **Plan for Our People** is our blueprint for how we will continue to attract, support and grow a flexible, diverse and inclusive workforce.



Sustainable resources

EMHS remains focused on working together to reduce duplication and maximise the value of our resources.

Partnering with the broader WA Health system and external organisations supports more coordinated care and helps patients access the right services at the right time.

Responsible stewardship of public resources is central to our approach, helping us deliver safe, high-quality care while getting value for money.

We focus on utilising our people, facilities and funding efficiently, so resources are directed where they are needed most.

By reducing waste and improving efficiency, we maintain system capacity in a constrained financial environment.

This approach supports the long-term sustainability and resilience of our health services.

Strengthening cyber security

Health services continue to operate within an increasingly complex cyber threat environment with adversaries increasingly adopting new exploitation tools and services, and emerging artificial intelligence-enabled techniques.

Ensuring the security and resilience of our digital health systems remains a key priority. Continued investment in cyber security capabilities, virtual security infrastructure and workforce awareness initiatives maintains our ability to prevent, detect and respond to cyber threats.

In 2025-26, the EMHS Cyber Unit delivered a comprehensive program of cyber security activities and audits, including targeted staff engagement, physical security audits at Royal Perth and Armadale Hospitals, and incident response simulation exercises. The Cyber Unit also proactively identified and remediated vulnerabilities, resolving hundreds of critical and high-risk issues across enterprise, clinical and network-connected devices before they could impact service delivery and patient care.

EMHS continued to meet its obligations under the *Security of Critical Infrastructure Act*, by providing required information to the Department of Home Affairs and completing the WA Cyber Security Policy – Annual Implementation Report for the Department of Premier and Cabinet. Collectively, these activities strengthen and support cyber resilience of EMHS critical health infrastructure and ensures its ongoing compliance and organisational preparedness to safeguard our health services into the future.

Winter strategy and preparedness

The 2025 flu season was the worst and longest on record in WA, placing significant pressure on emergency departments, hospital beds and ambulance services.

In response, the WA Government released the 2026 Winter Strategy to prepare for increased seasonal demand.

Aligned with the strategy, EMHS introduced a coordinated suite of winter initiatives to improve patient flow and system resilience.

Alisha Thompson, substantive Executive Director Armadale Kalamunda Group (AKG), was seconded to a dedicated **Winter Commander** role to provide focused leadership of patient flow, capacity management and winter demand initiatives across the organisation. The role was established to strengthen system performance, coordinate winter strategy delivery, and support improved access to care during the peak winter period.

Bed Turnaround Teams, which last year operated at RPH, were expanded to AH and St John of God Midland Public Hospital to reduce delays between discharge and admission by making beds available faster.

A Winter Care Team was also introduced at RPH – one of 3 WA tertiary hospitals – to improve patient flow, support safe and timely discharge and reduce avoidable admissions. A geriatric in-reach team provided early assessment and coordinated care for older patients.

Governance

Enabling legislation

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

Responsible Minister

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

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

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

WA Department of Health (System Manager)

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

Accountable authority and Chief Executive

EMHS is a board-governed statutory authority. The EMHS Board is directly accountable to the public through the Minister for Health and works with the Director General (DG) of WA Department of Health.

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

Shared responsibilities with other agencies

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

Governance through risk management and audit

EMHS has adopted the Three Lines Model to clearly define roles and responsibilities in the management and oversight of risk. This model articulates the accountabilities across functions for those **owning, managing and overseeing** risks, including independent assurance providers.

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

- the continued high level of compliance with the WA Health Risk Management Policy and EMHS Risk Policy, including a full year of risk review and TAP compliance above the 90 per cent performance target
- approval by the EMHS Board of **10 new EMHS strategic risks**, including revision of the Board risk reporting process to enhance understanding and accountability by the Audit and Risk Committee over how these risks are managed
- progressing a complete revision of the EMHS Risk Appetite Statement, introducing risk tolerances and key risk indicators to improve Board direction to the EMHS risk management function
- revision of the EMHS Fraud and Corruption Control and Security of Critical Infrastructure risks to ensure contemporary and accurate reporting and management of critical risks.

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

The annual risk-based Internal Audit Plan was informed by key organisational risks and high-priority areas including outpatient management, informed consent and quality improvement audits, to identify opportunities for improvement to strengthen the safety and quality of EMHS' services delivered to patients.

In 2025-26, management was able to close **69 per cent** of the internal and external recommendations logged for the year, while 31 per cent were in progress at the time of this report.

Clinical governance

Clinical governance is the system through which organisations are accountable for continuously monitoring and seeking to improve the quality of their services and ensuring the safeguarding of these standards. This is achieved by creating an environment in which there is transparent responsibility and accountability for maintaining standards, and by allowing excellence in clinical care to flourish.

The **EMHS Clinical Governance Framework (CGF)** details how EMHS meets relevant statutory and policy requirements, aligns with WA's strategic goals for clinical care, and meets the National Safety and Quality Health Service (NSQHS) Standards for the provision of safe patient care.

Accountability

While all staff contribute to and support the delivery of safe patient care and consumer experience, the following 5 roles, based on the National Model Clinical Governance Framework, have specific responsibilities to ensure effective clinical governance systems:

- The **EMHS Board** has ultimate responsibility for the governance of patient safety and quality of care and is legally accountable (under the HSA 2016) for ensuring appropriate governance structures, processes and staff practices are in place.
- The **EMHS Chief Executive** is accountable to the Board for the effective management of all services involved in the provision of safe, effective, appropriate, timely and efficient patient care.
- **EMHS Area Executive Group (AEG) and senior managers (corporate and clinical)** are accountable for ensuring effective operational management, including implementation of strategic and operational directions set by the Board and Chief Executive.
- **Clinical staff** are responsible for the provision of safe and high-quality care and must hold the proper qualifications and skills, and work within their scope of practice.
- **Patients and consumers** are participating partners in their own care, and in organisational design and planning (see page 44).

Principles

The key principles that underpin the CGF are mandated via the WA Health Clinical Governance Safety and Quality Policy Framework and include:

- **Care is consumer and carer centred** – partnership is evident at all levels of the organisation.
- **Care is driven by information** – relevant, accurate information is available and used at all levels of EMHS to guide quality-improvement activities.
- **Organised for safety** – minimisation of clinical risks and incidents, with a systems approach to harm minimisation.
- **Led for high performance** – executive and clinical staff have the right qualifications and skills to provide safe, high-quality care and to foster a culture of openness, collaboration and continuous improvement.

Quality dimensions in health care

There are 7 quality dimensions incorporated in the EMHS CGF:

- **Access to services** - the degree to which people can access the healthcare they need, irrespective of geography, socio-economic group, ethnicity, age or sex. This includes availability of services such as waiting times for services and processes involved in accessing services.
- **Effectiveness** - the extent to which a treatment, intervention or service achieves the desired outcome (see page 84).
- **Efficiency** - the relationship between the cost of healthcare and its effectiveness and safety (see page 102).
- **Timeliness** - the relationship between the timing of an intervention, whereby people promptly obtain care, and its effectiveness.
- **Acceptability** - the extent to which the wishes, desires, expectations, cultural norms and religious beliefs of patients and families are met.
- **Appropriateness of care** - ensuring people receive health care relevant to their clinical needs and current best evidence.
- **Safety of care** - ensuring people receive health care without experiencing preventable harm (see page 54).

Governance and monitoring

The **EMHS Clinical Governance Committee Structure** governs the implementation of, and performance against, the CGF. Terms of Reference for each committee within the structure articulate accountability, purpose, roles and responsibilities and how patient care will be monitored.

The EMHS CGF is evaluated for effectiveness, staff awareness, implementation and compliance on a 2-yearly basis.

Sustainable Health Review

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

In 2025-26, EMHS continued to support prioritised recommendations, with a focus on outpatient access reform, digital health, management of complex chronic disease, workforce culture and capability, the health of the Aboriginal community, mental health and equitable access to health care.

- **Recommendation 2a** - Halt the rise in obesity in WA by July 2024 and have the highest percentage of population with a healthy weight of all states in Australia by July 2029.
- **Recommendation 3a** - Reduce inequity in health outcomes and access to care with a focus on Aboriginal people and families in line with the WA Aboriginal Health and Wellbeing Framework 2015-30.
- **Recommendation 5** - Reduce the health system's environmental footprint and ensure mitigation and adaption strategies are in place to respond to the health impacts and risks of climate change. Set ongoing targets and measures aligned with the established national and international goals.
- **Recommendation 11a** - Improve timely access to outpatient services through moving routine, non-urgent and less complex specialist outpatient services out of hospital settings in partnership with primary care.
- **Recommendation 11b** - Improve timely access to outpatient services through requiring all metropolitan HSPs to progressively provide telehealth consultations for 65 per cent of outpatient services for country patients by July 2022 (with Telehealth to become the regular mode of outpatient service delivery for most appointments in both country and metropolitan areas across all disciplines by July 2029).
- **Recommendation 13** - Implement models of care in the community for groups of people who are frequent presenters to hospital.
- **Recommendation 14** - Transform the approach to caring for older people by implementing models of care to support independence at home and other appropriate settings, in partnership with consumers, providers, primary care and the Commonwealth.
- **Recommendation 23** - Build a system-wide culture of courage, innovation and accountability that builds on the existing pride, compassion and professionalism of staff to support collaboration for change.

Keep a look out for the SHR icons throughout this Annual Report to see how EMHS is prioritising the SHR recommendations.

Links to government goals and outcomes

To comply with legislative obligations as a WA Government agency, EMHS is required to report financial and operational performance using an Outcome Based Management (OBM) framework (Department of Treasury requirement). This framework links outcomes, activities, services and Treasury approved Key Performance Indicators (KPIs) to State Government priorities and desired outcomes.

Targets for the OBM KPIs listed below are calculated and set by the System Manager.

Outcome one: Public hospital-based services that enable effective treatment and restorative health care for Western Australians	
Effectiveness KPIs	
Unplanned hospital readmissions for patients within 28 days for selected surgical procedures (per 1,000 separations)	
Percentage of elective wait list patients waiting over boundary for reportable procedures	
Healthcare-associated *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	
Percentage of live-born term infants with an Apgar score of less than 7 at 5 minutes post delivery	
Readmissions to acute specialised mental health inpatient services within 28 days of discharge	
Percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services	
Efficiency KPIs	
Service 1: Public hospital admitted services	Average admitted cost per weighted activity unit
Service 2: Public hospital emergency services	Average emergency department (ED) cost per weighted activity unit
Service 3: Public hospital non-admitted services	Average non-admitted cost per weighted activity unit
Service 4: Mental health services	Average cost per bed-day in specialised mental health inpatient services
	Average cost per treatment day of non-admitted care provided by mental health services

Outcome two: Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives	
Efficiency KPI	
Service 6: Public and community health services	Average cost per person of delivering population health programs by population health units

Governance – **Board**

Board (L-R)

Catherine Nottage, Glenn Murray, Tracey Moroney OAM, Denise Glennon, Clare Grieveson, Sally Carbon OAM (Chair)**, Andrew Whitechurch, Vanessa Elliott, Melissa Grove.**

From the Board Chair

Congratulations to all the people who have built EMHS into what it is today – for forging its unique culture, impacting people's lives, solving challenges and creating new services and structures together. This includes previous Chair Pia Turcinov AM, who served as Chair for nearly 3 years and on the Board for 6.

Now, 10 years in, with a steady population growth, in particular in EMHS locations, we enter a second decade, as a collective, with much on our plates. The EMHS catchment area is expected to have a population of 903,653 by 2031-32 – the largest of all the metropolitan health regions.

EMHS is benefiting from new funding from the State Government's $2 billion Building Hospitals Fund and the Federal Government, enabling transformative change through new projects such as:

- a new multi-storey building at Royal Perth Hospital (RPH), including 2 floors dedicated to the Emergency Department (ED)
- the addition of Mount Lawley Hospital, which has been purchased from the private sector
- a $355 million upgrade to St John of God Midland Public Hospital (SJGMPH), a joint State and Federal project
- a new, community-based $42.2 million Byford Health Hub
- an innovative new $167 million Bentley Surgicentre, also jointly funded by the State and Federal governments.

These developments will enable team members to strengthen the founding network of RPH, Armadale Hospital, Kalamunda Hospital, Bentley Hospital, SJGMPH and community services, which were brought together when EMHS was established as a board-governed statutory authority in July 2016. Each of these sites are still celebrating their own rich histories of service to the community.

The new developments also follow last year's expansion of EMHS' state-of-the-art East CareConnect virtual services, which were created to harness technology to take hospital quality care into people's homes and communities.

Looking ahead, the **EMHS 2036 Strategic Direction** frames a picture of:

- **person-centred services designed with and for people**
- **an optimised and engaged workforce**
- **sustainable high-value health care**
- **a service that is digitally driven and cyber aware**
- **transformation through innovation and research**
- **modern, integrated high-performing models of care.**

Around the board table there have been many new members including Clare Grieveson, Kane Blackman, Dr Cathy Nottage and Dr Glenn Murray. Although Board members come in and out, there is one who deserves high praise, and that is Dr Denise Glennon. Denise has served on the Board since July 2017 and has set high standards for patient experience and clinical excellence, as well as acting as Deputy Chair and Chair at times too. On behalf of everyone at EMHS, and as your time at EMHS comes to an end, thank you Denise for your service.

During this reporting period, EMHS also acknowledges the contribution of Dr Lesley Bennett as Chief Executive (CE), plus Acting CE Philip Aylward, and welcomes back former EMHS team member Joel Gurr into the substantive CE position. As Joel beds down succinctly in his role this year, the Board looks forward to committing with more clarity, sharpness and speed, to strategic priorities which will have the greatest impact, obligating to financial stewardship, and adding new value, to the people we serve.

On behalf of the EMHS Board, we extend our thanks to the EMHS executive team, clinicians, staff, government partners and community stakeholders for their contributions this year – with often fun personalities even among heavy or constrained moments. Board members also commit to their EMHS roles with discipline and accountability, and a serve of positivity.

While team members appreciate EMHS is in touching distance of a once-in-a-generation investment in built form, it's the caring and creative EMHS people who will deliver upon today's needs, as well as continue to evolve, innovate, challenge and deliver exceptional care for the future.

Ngala werda koorliny, koort-dan.
We go forward together, with heart – to keep our communities well.

Regards all,
Sally Carbon OAM
Board Chair

Accountable governance

As the employing and accountable authority of EMHS as a Health Service Provider (HSP), EMHS Board carefully monitors and directs EMHS' performance to ensure workforce capability and the provision of high-quality, safe health care.

The EMHS Board Committees enable accountable and transparent governance.

Board Finance Committee

Chair: Andrew Whitechurch

Meetings held: 8

The Board Finance Committee acts as the Board's primary mechanism for financial oversight, assurance and forward financial strategy, ensuring EMHS operates efficiently, compliantly and sustainably whilst supporting delivery of strategic objectives.

Core focus areas of the Committee are:

- financial stewardship and performance oversight
- budget and financial planning
- compliance and governance
- risk and assurance
- major investments and commercial decisions
- financial reporting and statutory obligations
- strategic financial insight.

Board Audit and Risk Committee

Chair: Melissa Grove

Meetings held: 5

The Board Audit and Risk Committee is the Board's primary mechanism for oversight of risk, audit and internal control environments, ensuring EMHS maintains strong governance, compliance and assurance frameworks to support safe, accountable and effective operations.

Core focus areas of the Committee are:

- risk oversight and enterprise risk management
- internal audit and control assurance
- external audit and assurance coordination
- compliance and governance integrity
- financial and performance reporting assurance
- risk culture and organisational resilience
- system-wide and cross-committee risk coordination.

Board Patient Experience and Clinical Excellence Committee

Chair: Denise Glennon

Meetings held: 6

The Board Patient Experience and Clinical Excellence Committee is the Board's primary mechanism for oversight of patient safety, clinical quality and experience, ensuring EMHS delivers safe, high-quality, patient-centred care with continuous improvement and strong clinical governance.

Core focus areas of the Committee are:

- clinical governance and safety and quality assurance
- patient experience and consumer engagement
- quality improvement and clinical excellence
- performance monitoring
- risk and clinical assurance
- strategic advice on care delivery
- system collaboration
- accreditation readiness.

Board Operational Performance and Strategy Committee

Chair: Tracey Moroney

Meetings held: 3

This Committee acted as the Board's primary forum for integrating performance oversight with strategic planning, ensuring EMHS delivers sustainable, high-performing and future focused health service aligned to community needs and system priorities.

Core focus areas of the Committee were:

- operational performance and system oversight
- strategic planning and alignment
- service planning and sustainability
- people, culture and workforce capability
- innovation and digital transformations
- strategic risk and system reform.

The Board Operational Performance and Strategy Committee was disbanded in 2025.

The EMHS Board now monitors these areas of focus via a newly implemented monthly (and larger quarterly) Chief Executive report to Board, and a new Board People and Wellbeing Committee.

Board People and Wellbeing Committee

Chair: Kane Blackman

Meetings held: 2

Established in 2026, the Board People and Wellbeing Committee acts as the Board's primary mechanism for oversight of workforce, culture and staff wellbeing, ensuring EMHS has a capable, safe, engaged and sustainable workforce that supports high-quality care and organisational performance.

Core focus areas of the Committee are:

- workforce strategy and sustainability
- diversity, equity and inclusion
- staff engagement
- capability and leadership
- staff safety and wellbeing
- performance, compliance and workforce governance
- integrity, risk and organisational culture
- strategic workforce insight and improvement
- equity and cultural lens.

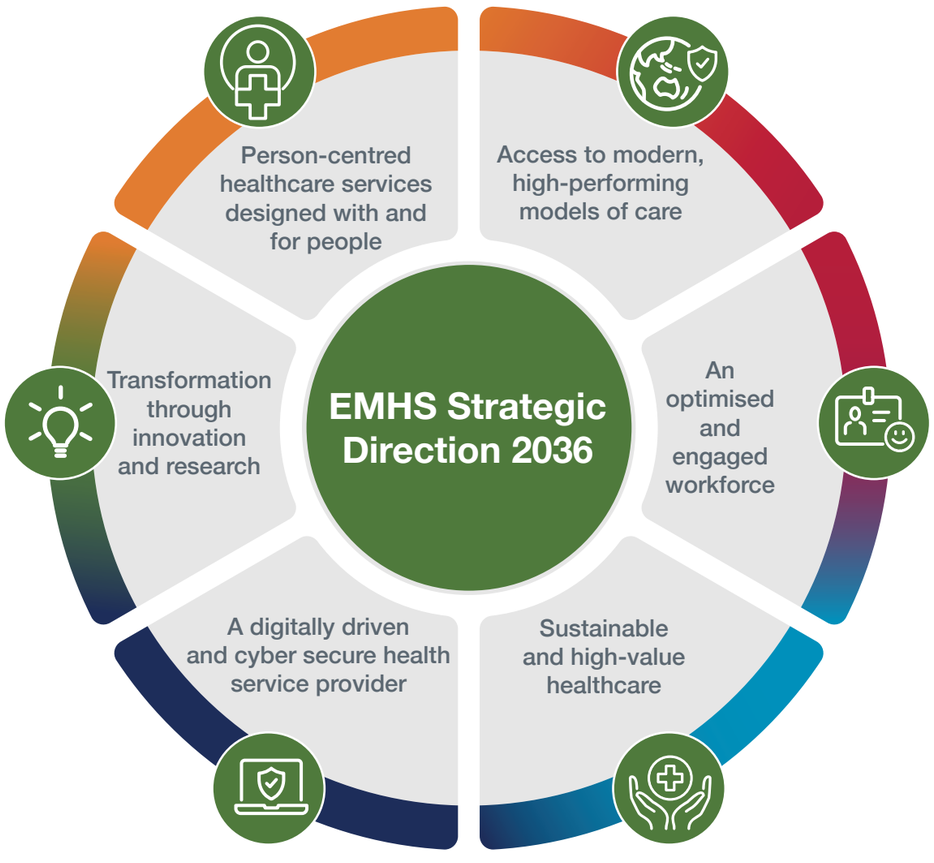
Setting the course for the future

The EMHS Board, as the accountable authority under the *Health Services Act 2016*, is responsible for setting the strategic direction of EMHS.

In 2025-26 the EMHS Board developed the **EMHS 2036 Strategic Direction**, which articulates the long-term strategic intent for the health service.

The Strategic Direction has been informed by contemporary health system priorities, including whole-of-system planning, sustainable service delivery, workforce capability and person-centred health care services. It focuses on 6 interdependent aspects which align with the WA Premier's health priorities, and will be used by the EMHS Board to guide decision-making and promote innovation across the organisation.

In 2026-27, the EMHS 2036 Strategic Direction will be supported by the development and delivery of new EMHS Chief Executive-led strategic and operational plans.



The Board continued its commitment to engagement through monthly leader rounding, giving staff and consumers the opportunity to discuss issues, challenges and celebrations with Board members.

Governance – **Area Executive Group**

Area Executive Group (L-R)

Professor Grant Waterer (Executive Director, Medical Services), **Sandra Miller** (Executive Director, Mental Health), **Chris Barton** (Chief Information Officer), **Ann Blunden** (A/Executive Director, Strategy, Planning and Performance), **Neil Cowan** (Executive Director, Finance and Business Performance), **Sarah-Louise Laing** (A/Executive Director, Armadale Kalamunda Group), **Wade Emmeluth** (A/Executive Director, Corporate Services and Contract Management), **Joel Gurr** (Chief Executive), **Dori Lombardi** (A/Executive Director, People and Culture), **Anne-Marie Presho** (Director, Office of the Chief Executive), **Lara Moltoni (**Executive Director, Patient Experience and Clinical Excellence)**, Ben Noteboom** (Executive Director, Royal Perth Bentley Group), **Chandima Hiyare-Hewage** (Executive Director, Infrastructure), **Danielle Kilmurray** (A/Area Director, Allied Health)

Absent: Kylie Fawcett (A/Executive Director, Nursing and Midwifery Services), **Francine Eades** (Area Director, Aboriginal Health)

From the Chief Executive

For 10 years, EMHS has been a cornerstone of clinical excellence, care and compassion for the community.

This anniversary is more than a milestone. It allows us to recognise the commitment of our people, and the trust placed in us by those we serve.

Our staff, leaders, community advisors and volunteers have shaped an organisation grounded in excellence, integrity, innovation and commitment to patient-centred care.

It is a strong foundation for our next phase.

In 2025-26 we embarked on a significant major infrastructure program to build on our current services and take us into the future.

We are looking forward to continuing to work with the Office of Major Infrastructure Delivery and the Department of Health's Central Commissioning Office on the delivery and commissioning of a number of new builds in EMHS in the coming years.

As you move about the cities or suburbs you may see our new projects taking shape, or, if you are using our services, new facilities or services opening.

One of the most visible additions will be a new multi-storey **Royal Perth Hospital Emergency Department (ED) expansion**, which will include 2-floors dedicated to a new ED with increased capacity to support current and future healthcare needs.

The vital extension has commenced construction.

Mount Lawley Hospital will join EMHS from September 1, adding 118 beds and 8 operating theatres to the public system.

The hospital has been in an active transition phase ahead of the transfer from St John of God Health Care. As many beds are already used for public patients, the operational change will be gradual for patients and staff rather than sudden.

EMHS was authorised to directly employ existing staff, and workforce planning has been well underway.

The State Government allocated $225 million in its 2026-27 State budget to buy, commission and begin Mount Lawley Hospital operations.

St John of God Midland Public Hospital (SJGMPH) will increase capability with the full transition of 60 private beds to public from August.

The **Byford Health Hub** will give people in the Shire of Serpentine-Jarrahdale access to specialist health and community care closer to home. Construction began in November 2025, with the facility due to be completed and opened in 2027.

Meanwhile, a **Bentley Surgicentre** with 6 operating theatres, 2 procedure rooms and a 24-bed surgical ward, is in a design and early works phase.

A lead architect was appointed in January 2026 and early site preparation began in May.

Progress has also been made on 2 new mental health facilities.

Main works is at tender for an **Armadale Mental Health Emergency Centre** at Armadale Hospital (AH).

A main works tender was also awarded in April 2026 for a **Bentley Secure Extended Care Unit** to provide mental health inpatient treatment and rehabilitation at Bentley Hospital (BH).

The scale of the new projects reflects the growing needs of our community and our determination to meet those needs with continued excellence.

Alongside our strategic expansion we are also prioritising our current infrastructure, investing in maintenance and upgrading to uphold the highest standards of care and safety for our patients.

This will ensure our existing sites – RPH, AH, Kalamunda Hospital, BH, SJGMPH and our network of community services – remain at the forefront of health care in WA.

Sector-wide challenges have shaped the environment in which we operate, and our organisation is responding.

Our focus on reducing ED wait times and avoidable ED presentations, moving care closer to home, and prevention and early intervention initiatives, confirm our commitment to collective advancement.

Importantly, we are positioning the organisation to continue delivering the high-quality care that has defined our first 10 years.

Joel Gurr
Chief Executive EMHS

Organisational structure

Joel Gurr
Chief Executive

Board
East Metropolitan Health Service

Chris Barton
Chief Information Officer

- Data Management
- Information Management
- Digital Innovation
- ICT Governance

Prof Grant Waterer
Executive Director Medical Services

- Research & Innovation
- East CareConnect

Kylie Fawcett
A/Executive Director Nursing & Midwifery Services

- Director of Nursing & Midwifery & Patient Support Services for Royal Perth Bentley Group
- Nursing & Midwifery Professional Standards
- Nursing & Midwifery Strategy

Wade Emmeluth
A/Executive Director Corporate Services & Contract Management

- Procurement & Contract Management
- Health Technology Management Unit
- Security
- General Services
- Clinical Coding
- Environmental Sustainability
- Cyber Security

Lara Moltoni
Executive Director Patient Experience & Clinical Excellence

- Clinical Governance
- Patient Experience
- Policy
- Audit & Risk

Ann Blunden
A/Executive Director Strategy, Planning & Performance

- Population Health
- Clinical Service Planning
- Operational Effectiveness
- Strategy & Enablement

Chandima Hiyare-Hewage
Executive Director Infrastructure

- Facilities Management
- Capital & Minor Works
- Fleet Management & Leasing
- Infrastructure

Neil Cowan
Executive Director Finance & Business Performance

- Financial Accounting
- Accounts Receivable
- Resource Management & Budgeting
- Revenue Collection

Anne-Marie Presho
Director Office of the Chief Executive

- Ministerial & Parliamentary Liaison
- Medical Treatment Liability Service and Coronial Matters
- Office of Chief Executive Support
- Board Support
- EMHS Freedom of Information
- Communications
- Travel
- Executive Administration

Sarah-Louise Laing
A/Executive Director Armadale Kalamunda Group (AKG)

- Armadale Hospital
- Kalamunda Hospital

Ben Noteboom
Executive Director Royal Perth Bentley Group (RPBG)

- Royal Perth Hospital
- Bentley Hospital

Sandra Miller
Executive Director Mental Health

- Mental Health Strategy
- Mental Health Operations

Dori Lombardi
A/Executive Director People & Culture

- Work Health & Safety
- Organisational Development
- Human Resources
- Industrial Relations
- Integrity & Ethics

Danielle Kilmurray
A/Area Director Allied Health & Health Sciences

- Director of Allied Health for Royal Perth Bentley Group
- Allied Health Strategy

Francine Eades
Area Director Aboriginal Health

- Aboriginal Health Strategy

We would like to acknowledge and thank former Chief Executive Lesley Bennett and A/Chief Executive Philip Aylward who both left EMHS in 2025-26.

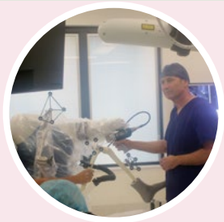
This year
10 years of EMHS

2016

1 July 2016
EMHS established as a Board-governed Health Service Provider under the Health Services Act 2016

November 2016
St John of God Midland Public Hospital (SJGMPH) celebrates its first birthday

April 2017
Bentley Hospital (BH) celebrates its 50th anniversary



2018-19
SJGMPH becomes the first public hospital in the Perth eastern region to use robotic technology (Mako Stryker orthopaedic robot)

May 2018
A dedicated Urgent Care Clinic (Toxicology) opened at Royal Perth Hospital (RPH) to provide specialised services for patients presenting with drug and alcohol issues or behavioural disturbances

June 2018
East Metropolitan Youth Unit (EMyU) opened at BH to provide dedicated inpatient mental health care for young people aged 16 to 24 years

October 2019
RPH opened a $1.15 million Mental Health Emergency Centre (MHEC) – a discrete, purpose built, short-stay unit adjacent to the Emergency Department

April 2020
Operations Hub launched at RPH to provide digital oversight of the entire hospital and real time bed capacity and demand

August 2020
EMHS new Medihotel - a WA Government election commitment and first of its kind in WA – opened at RPH. The Medihotel provides short-term accommodation for people (primarily from country areas) who have completed their hospital stay and are waiting for transport home, or who need to visit the hospital for an appointment, procedure or test

2019 -2023
The COVID years. See next page for more detail.

2019-2023 COVID - see detail next page

April 2021
EMHS opened the Safe Haven at RPH, to provide early intervention for people in distress through peer support

May 2022
RPH welcomed a new era of access to care for critically injured and sick patients with the opening of its new heliport

July 2022
Kalamunda Hospital (KH) opened a new Day Hospice for palliative care patients, the first of its kind in WA's public health system

June 2022
EMHS opened a new Mental Health Unit Dabakarn at RPH – a major addition to EMHS' suite of mental health services

December 2021
The Minister for Health, Hon Roger Cook MLA, officially opened the RPH Aboriginal Family Garden, which provides a culturally supportive space for family members

October 2022
A new 30-bed rehabilitation facility opened its doors at BH to provide care for older patients

October 2022
A new therapy garden was opened at the EMyU to provide a safe, welcoming space for patients to participate in activities, sensory modulation, mindfulness and social interaction, while enabling them to connect with nature

August 2022
EMHS officially opened WA's first mental health transitional care unit Bidi Wungen Kaat to support and accommodate people experiencing mental health issues and help them transition back into the community after hospital care

October 2023
KH celebrated its 50th anniversary, having recently undergone a $9.5 million upgrade

October 2023
RPH Emergency Department celebrated 50 years of providing emergency services to the community

November 2024
Minister for Medical Research officially opened the RPH Innovation Hub – designed to bring EMHS clinicians and innovators together with industry experts and the broader innovation community, to create opportunities to develop and grow ideas that improve the health and wellbeing of Western Australians

April 2024
Armadale Community Mental Health Services moved to a new purpose-built facility - the Orchard Avenue Centre

December 2024
EMHS opened a new Midwifery Birth Centre at BH providing a comfortable environment which supports natural, low-intervention birth

January 2026
Construction commenced on the WA Government's election commitment for a new $42.2 million Byford Health Hub, which will provide health and social care closer to home for Serpentine-Jarrahdale residents and reduce demand on Armadale Hospital

March 2026
Early works commenced for a new building at RPH, with 2 floors dedicated for a larger Emergency Department with additional triage rooms and ambulance bays. Construction commenced June 2026

May 2026
Early site preparation began for a new $167 million surgical centre at BH

2026

November 2025
SJGMPH celebrated its 10th anniversary

2019-2023 COVID

How COVID-19 made us stronger today

We celebrate our 10-year milestone a stronger health service for having met the challenge of the COVID-19 pandemic.

The pandemic reshaped health care delivery with new models and technologies that are now a core part of our everyday operations.

Three years on from its end, telehealth, digital health tools (such as remote monitoring devices) and early intervention and emergency preparedness continue to be central areas of focus.

2019

2019-20
In anticipation of a COVID-19 surge, the EMHS Telehealth Plan – Building and Embedding Telehealth in EMHS 2020-22 outlined requirements to ensure the EMHS community could access telehealth as part of normal health care practice

2019-20
In record time, EMHS Centre for Implant Technology and Retrieval Analysis (CITRA) developed and produced 10,000 face shields to help protect medical staff throughout WA during the pandemic

2019-20
COVID-19 became a significant challenge for health care services across the globe. In a rapidly evolving situation, EMHS quickly mobilised, adjusted and implemented initiatives for our community

2019-20
COVID clinics were established at rapid speed, and EMHS led the development of a system-wide pathway to manage the screening and testing of WA Health staff

2019-20
EMHS Data and Digital Innovation Team delivered initiatives to support the State's effort in responding to the pandemic, including a SMS system to automatically notify patients of negative COVID-19 test results. This was the first time such a system had been utilised in WA Health. By 30 June 2020, 86,600 SMS had been sent

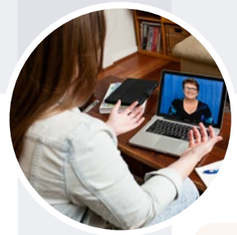
June 2020
EMHS' 24/7 Quarantine Outreach Service commenced at various Perth hotels, to provide clinical care for people undertaking mandatory quarantine and people who had acquired COVID-19 through local transmission

October 2020
EMHS commenced swabbing collection services at Perth Airport

2023

2021-22
For much of 2021-22, EMHS focussed on ensuring COVID readiness across hospital sites, in expectation of an influx of COVID patients

2021-22
Telehealth appointment activity peaked at 60 per cent (of all outpatient appointments) in March 2022, following the opening of the WA border

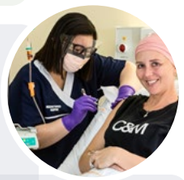


2021-22
Workforce wellbeing remained a key priority, as a surge in COVID-related absences placed significant demand on staff

November 2022
An allied health-led Post-COVID-19 Clinic opened at Bentley Hospital to help patients experiencing persistent symptoms of the virus

2022-23
Temporary COVID-19 patient screening tents were dismantled and COVID clinics ceased operations

2022-23
EMHS successfully managed and withstood several changes in the COVID-19 space, and moved to 'living with COVID'



This year
Optimised and engaged workforce

Building our workforce

Individual staff

12,093

11,526 in 2024-25 ▲
7,154 in 2016-17

Full time equivalent (FTE)

9,033

8,619 in 2024-25 ▲
5,776 in 2016-17

This included

122

Aboriginal staff members

110 in 2024-25 ▲

1,029
Hotel services*
1,003 in 2024-25 ▲
806 in 2016-17

1,389
Administration and clerical*
1,337 in 2024-25 ▲
904 in 2016-17

170
Maintenance*
172 in 2024-25 ▼
138 in 2016-17

3,684
Nursing*
3,505 in 2024-25 ▲
2,269 in 2016-17

1,310
Medical support*
1,239 in 2024-25 ▲
789 in 2016-17

1,416
Medical*
1,329 in 2024-25 ▲
845 in 2016-17

35
Other*
33 in 2024-25 ▲
25 in 2016-17

* FTE

Developing our people

The **EMHS Plan for Our People 2025-2030** is our workforce strategy which sets out the challenges of the future as we see them, articulates how we intend to respond, and identifies the capabilities we need to best position our workforce - our most valuable assets - to deliver the best care possible. The Plan summarises our people priorities into 4 people pillars:

Our Wellbeing
We support our staff to be well and thriving, so they can continue to deliver amazing care.

Our Culture
We cultivate a work culture that celebrates and embodies our values.

Our Capability
We embed the capabilities needed now and into the future by developing staff at all levels.

Our Future
We actively prepare for the future of work, including our future talent needs and the changing shape of the workforce.

Our Plan has a strong focus on building our workforce capability at all levels of the organisation. Over the past year, EMHS has progressed several development initiatives, including:

- design of new EMHS manager and leader development programs, ensuring our leaders are competent to tackle the opportunities and challenges in their roles, are adaptive with skills to mentor and develop others and foster positive workplace wellbeing
- introduction of our **Leading with Authenticity in Practice (LEAP) Clinician to Manager** program, supporting our clinicians who have aspiration for a management career
- development of our **Rising Clinical Leaders** program for our emerging clinical nurses and midwives, to build confidence and skills in readiness for career advancement
- building Aboriginal inclusive leadership in partnership with Garlett Group, to expand our cultural competence and foster cultural safety
- enabled a safe to speak up culture through implementation of our **Speak Up, Listen Up** program
- continuing our engagement in the **Public Sector Commission's Solid Futures Aboriginal Traineeship** program and Department of Health's **Aboriginal Cadets and Graduate** programs.

EMHS is committed to the development of our staff to ensure we have the capabilities needed today and into the future. We know the skills, capabilities and behaviours of our staff are integral to realising our vision of **Healthy People, Amazing Care**.

Work Health and Safety

EMHS is committed to understanding and managing its health, safety and wellbeing risks to proactively maintain worker wellbeing and prevent injuries. EMHS Work Health and Safety (WHS) systems are regularly audited, with the last systems audit completed in August 2024.

During 2025-26 EMHS was issued with **4** improvement notices from WorkSafe WA. All of those notices, together with **2** from the previous year, have been satisfactorily closed. **One** improvement notice (from Feb 2025) is currently open and work is ongoing to ensure it is finalised.

The potential for EMHS workers to be exposed to workplace aggression and violence persists and is the most reported category of workplace incidents. The Managing Aggression Proactively (MAP) strategy has continued to be rolled out. A key initiative has been the implementation of the Vocera communication system in some of our high-risk areas to support staff when responding to incidents of violence and aggression. The Behaviour Support Team (BeST) has been active at Royal Perth Hospital (RPH) since May 2025 and is in the process of being evaluated, with initial feedback from staff being very positive.

Although aggression is the most commonly reported incident type, more injuries are caused by manual tasks across EMHS, and these are trending downwards. Priority areas for intervention include availability and suitability of equipment, hazardous manual task risk assessments to develop standard operating procedures, work design and continued data collection and learning.

Governance, compliance and consultation

EMHS has active WHS committees covering all departments. These committees are made up of elected health and safety representatives (HSRs) and management representatives who facilitate consultation and communication and are an escalation point for WHS matters. As at the end of 2025-26, EMHS had of **228** elected HSRs, after holding elections under WHS legislation during March 2026. **189** of elected HSRs have completed a 5-day introductory course and **100** have completed a refresher, ensuring workers are represented on all issues relating to their health and safety in the workplace. EMHS WHS facilitates an education program providing opportunities for in-service training and support for all HSRs with an HSR Forum held in February 2026, which included a focus on psychosocial hazards as a key emerging risk.

WHS indicators

1. Number of fatalities

Base year*	0
Prior year	0
Target	0
Current year	**0**

2. Incidence of work-related injury or illness

Base year*	36.18
Prior year	31.32
Target	Reduce by 2% per year and 15% by 2033 compared with 2023
Current year	**30.53**

3. Incidence rate of serious claims with one or more weeks' lost time

Base year*	14.94
Prior year	17.18
Target	Reduce by 2.5% per year and 20% by 2033 compared with 2023
Current year	**15.15**

Although the target was not met compared to base year, improvement was seen compared to prior year. Initiatives to improve performance against this indicator include early intervention physiotherapy and psychology programs, focus on early return to, and recovery at work. EMHS liaises with the insurer and treating practitioners to ensure early clear diagnosis and treatment plans.

4. Incidence rate of claims resulting in permanent impairment

Base year*	4.45
Prior year	3.51
Target	Reduce by 2% per year and 15% by 2033 compared with 2023
Current year	**4.16**

Target met compared to base year, however a higher rate experienced compared to prior year. Initiatives to improve performance against this indicator include early intervention physiotherapy and psychology programs, focus on early return to, and recovery at work. EMHS has improved communication with parties through GP case conferences and claims reviews.

5. Incidence rate of work-related respiratory disease

Base year*	0.62
Prior year	0.12
Target	Reduce by 2.5% per year and 20% by 2033 compared with 2023
Current year	**0.12**

6. Managers and supervisors trained in:

i. WHS as relevant to the risk profile

Base year*	73.5%
Prior year	82%
Target	Greater than or equal to 80% of cohort trained within last 2 years
Current year	**71%**

Target not met due to transition from 3 yearly compliance to 2 yearly compliance for this mandatory skills training.

ii. Injury management

Base year*	73.5%
Prior year	82%
Target	Greater than or equal to 80% of cohort trained within last 5 years
Current year	**90%**

7. Percentage of workers returned to work on full duties and hours

i. Within 13 weeks

Base year*	48.2%
Prior year	47.2%
Target	No target
Current year	**38.4%**

ii. Within 26 weeks

Base year*	61.8%
Prior year	62.3%
Target	Greater than or equal to 70% returned to work within 26 weeks
Current year	**56%**

Targets not met. Multiple actions in place to improve return to work (RTW) rates including:

- RTW programs are discussed at lodgement of claims and are developed in consultation with the injured worker, line managers and treating practitioners, with a view to facilitating recovery at work and early return to duties
- RTW programs are compliant with the new regulatory requirements
- training has commenced for managers on the importance of early return to work and their support for the process
- claims reviews with managers and with the insurer are in place
- Injury Management team attend regular GP case conferences to discuss RTW goals, duties and progress.

Consultative systems:
EMHS has a number of WHS committees and sub-committees, including:

Armadale Kalamunda Group (AKG)
- AKG WHS Committee

Royal Perth Bentley Group (RPBG)
- Surgical Division WHS Committee
- Medical Division WHS Committee
- Hospital Logistics and Acute Access (HoLAA) Division WHS Committee
- Allied Health WHS Committee
- Clinical and Corporate Services WHS Committee
- Patient Support Services (PSS) WHS Committee
- Bentley & Mental Health WHS Committee

EMHS
- EMHS Group Services WHS Committee
- Facilities Management WHS Committee

Notes

*The performance reporting examines a 3-year trend and, as such, the comparison base year is to be 2 years prior to the current reporting year, where data is available.

Data source for mandatory WC/IM data reporting items is ICWA WHS and IM Report 2025-26.

Indicators 2, 3, 4, and 5 are calculated by number of claims divided by reported FTE for financial year, multiplied by 1,000.

Injury management

EMHS' systematic approach to workplace-based injury management services following work related injuries and illnesses fosters an environment where workers return safely to productive employment as soon as practicable.

EMHS has an Injury Management (IM) team within the Work Health and Safety department that supports managers, injured workers and treating practitioners to achieve the best outcomes for injured staff and the organisation in collaboration with the Insurance Commission of WA (ICWA). Additionally, the IM team works with EMHS Human Resources and managers to support employees with a personal illness or injury to remain safe and productive at work wherever possible.

A Psychological Early Intervention Program (PsychEIP) commenced in April 2026. The program aims to support staff at risk of a work-related psychological injury while staying in the workplace to support better outcomes and prevent the need to claim worker's compensation. If the staff member does need to move into the worker's compensation system, treatment is already underway and can continue under a claim leading to a higher likelihood of recovery.

The program will be reviewed in July to evaluate initial results and ensure the program is meeting the needs of EMHS before a full review in January 2027.

Critical to improving return to work is the engagement of line managers with the IM team to support early engagement with the employee, identification of suitable duties, participation in return to work (RTW) planning and reinforcing expectations of recovery at work and progression to full duties. EMHS has engaged ICWA to provide training for managers on their role in injury management and return to work. **64** leaders in high impact areas have attended training. Feedback from managers has been positive and therefore an ongoing schedule of sessions are being planned.

IM services were internally audited in 2024-25 with the final report received in February 2026. **Four of the 6 recommendations have been completed.** EMHS was also audited by the Office of the Auditor General as part of their Performance Audit: Management of injured workers in the public sector during 2025-26 with a final copy of the report pending. Proposed recommendations include seeking feedback from stakeholders about claim experience to guide future improvement opportunities, improving identifying and recording barriers to return to work, and establishing clear job analysis and capabilities including a centralised register for alternative duties to support early and proactive approach to injury management. EMHS is currently implementing these recommendations.

2025-26 workers' compensation claims by occupational category

4 Medical
3 in 2024-2025 ▲

108 Nursing
121 in 2024-2025 ▼

40 Medical support
19 in 2024-2025 ▲

21 Administration and clerical
26 in 2024-2025 ▼

29 Maintenance
27 in 2024-2025 ▲

62 Hotel services
75 in 2024-2025 ▼

Total claims **264**
271 in 2024-2025 ▼

Leading the way in caring for carers

In 2025-26, EMHS became the first hospital network in WA to achieve the highest level of carer-friendly workplace accreditation.

This achievement reflects our strong commitment to supporting employees with caring responsibilities through inclusive policies, flexible work practices and a supporting workplace culture.

Carers WA deliver the national Carers and Employers program in WA on behalf of Carers New South Wales.

Reaching **Level 3 – EXCEL** shows carer-friendly principles are embedded across our organisation and supported by our leadership, systems and everyday practice.

Our initiatives to recognise and support carers include flexible work arrangements, ongoing consultation, partnerships with Carers WA and active involvement in Carers Week.

These efforts are highlighted through executive-backed YouTube videos sharing personal carer stories across all levels of the organisation and a dedicated carer-friendly employer working group that champions inclusion and advocacy.

Achieving Level 3 accreditation reinforces our commitment to employee wellbeing and workforce sustainability and positions us as a sector leader.

It also reflects our values of kindness, respect and accountability by actively supporting staff in caring roles.

In 2025-26, EMHS became the first hospital network in WA to achieve the highest level of carer-friendly workplace accreditation.

This year
Person-centred services designed with and for people

In 2025-26, EMHS strengthened its commitment to engaging and partnering with our consumers and community to deliver person-centred services and optimise patient experience.

In Mental Health:

- EMHS has implemented a Work Development Program (WDP) to assist consumers who are having trouble paying court fines due to hardship. Under a WDP, eligible people can apply to complete approved activities though our community mental health services, in place of paying the amount owed.
- EMHS Mental Health Strategy team co-designed and developed language booklets with people with lived experience. These booklets are now available for staff to help guide the use of language that is most respectful and therapeutic for people with lived experience and their loved ones, as informed by them.
- EMHS has completed phase one of the implementation of the EMHS Lived Experience Strategy, designed with people with lived and living experience.

At Royal Perth and Bentley Hospitals:

- The annual Royal Perth Bentley Group (RPBG) Consumer and Carer Workshop continues to grow in both size and impact, with a record 19 attendees this year. The workshop offered an opportunity to reflect on progress, celebrate successes and consider future priorities. Consumers highlighted improvements in communication, representation and acknowledged their voices were being heard and that they could influence decision making.
- A warm welcome to an unfamiliar setting can make all the difference, especially for patients facing hospital stays alone. At Royal Perth Hospital (RPH), a new volunteer greeting service was a finalist in the WA Health Excellence Awards for its contribution to delivering person centred care.
- The RPBG Consumer Rounding Program expanded to provide 600 conversations across inpatient, Emergency Department, outpatient and general visiting areas, providing ears on the ground to better understand the contemporaneous patient experience and strengthen the consumer voice in advocacy across the organisation.

At Armadale and Kalamunda Hospitals:

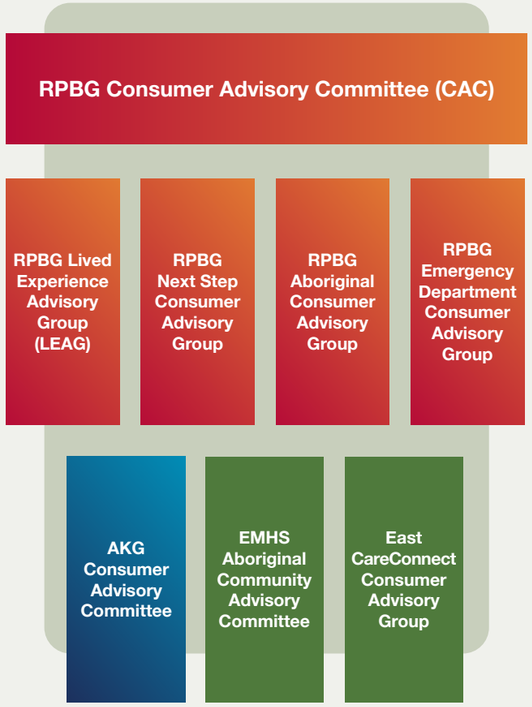
- EMHS has enhanced palliative care services across Armadale Kalamunda Group (AKG), with the Kalamunda Palliative Care Unit providing 30–31 inpatient beds and accepting referrals from tertiary hospitals, community palliative care teams and GPs. Weekend allied health and registrar coverage 7 days a week, 11:00am–7pm rostering, supports urgent late admissions from the community and other hospitals.
- At Armadale Hospital (AH), a palliative care consultant and nurse practitioner provide comprehensive care and identify patients requiring inpatient admission, facilitating timely referral to Kalamunda Hospital (KH) and optimising acute bed utilisation.
- Rehabilitation services implemented the transfer of care for all medical patients over 65 years of age to the geriatric team. This has increased consumer satisfaction by ensuring patients are managed by a single team, reducing wait times to be seen, improving communication with patients and between staff, and enabling faster implementation of clinical care.
- AH has implemented a GDMi (Gestational Diabetes Mellitus requiring insulin) service, enabling care for pregnant women who were previously required to travel to tertiary sites for management. This initiative brought specialised care closer to home for women and their families in the AKG catchment, improving access, continuity, and the overall patient experience.
- Implementation of an optimised short stay pathway for hip and knee joint replacements at AH is supporting earlier discharge and a more patient-centred model of care. The initiative improves flow, reduces late cancellations, and enables more patients to recover safely at home sooner.
- Enhanced paediatric services with improved access to oral food challenges for local children, support timely assessment and management of food allergies. These enhancements strengthen inpatient and outpatient paediatric pathways and improve care coordination, clinical outcomes and ward workflow efficiency.
- AKG established a Patient Experience and Clinical Excellence Committee as a mechanism to establish governance and oversight over patient experience metrics.

Consumer representative networks

Keeping consumers at the centre of everything we do, a network of 140 consumer representatives across EMHS sites supports and drives continuous improvement.

This network reflects a diverse range of backgrounds, including Aboriginal, culturally and linguistically diverse (CaLD), disability, LGBTIQ+, neurodiversity, mental health, chronic conditions and different generations. Consumer representatives partner with our staff across governance committees, project teams, and focus groups, and contribute to reviewing published patient information to ensure it meets the health literacy needs of our community.

Across EMHS, 8 consumer advisory groups provide a platform for meaningful engagement, helping to influence decision-making, guide service improvements, and ensure the perspectives and needs of the communities we serve are represented.



Consumer feedback

EMHS is committed to actively seeking out consumer feedback to support continuous service improvement and, ultimately, the experience of the community we serve.

MySay is a standardised state-wide Patient Reported Experience Measure (PREM) which allows for benchmarking across sites. MySay uses the Australian Commission on Safety and Quality in Health Care's Australian Hospital Patient Experience Question Set (AHPEQS) as a validated measure, sent to inpatients, ED patients and outpatients via SMS 48 hours after their interaction with our services. MySay inpatient results for 2025-26 were:

AHPEQS question	
My views and concerns were listened to	92
My individual needs were met	92
I felt cared for	93
I was involved as much as I wanted in making decisions about my treatment and care	90
I was kept informed as much as I wanted about my treatment and care	90
As far as I could tell the staff involved in my care communicated with each other about my treatment	91
I received pain relief that met my needs	92
I felt confident in the safety of my treatment and care	93
I experienced unexpected harm or distress as a result of my treatment or care (where a higher score reflects less harm)	90
Overall the quality of the treatment and care I received was very good	93

Net Promoter Score (NPS) is a widely used metric based on the response to **How likely would you be to recommend our service to a family member or friend? (0 to 10)** NPS 50-70 is considered excellent.

Net Promoter Score (NPS)			
Period	NPS	Responses	Response rate
2025-26	69.64	20,613	26.15%

Compliments and complaints

EMHS has robust processes for the management of compliments and complaints, consistent with the WA Health Complaints Management Policy. This includes set timeframes for complaints to be acknowledged, investigated and responded to, with quality improvement activities initiated to address identified issues as appropriate.

Recognising that some consumers may prefer to provide feedback anonymously, EMHS continues to subscribe to the use of Care Opinion, an independently controlled, online platform enabling members of the public to tell us about their experience with our services.

Whilst complaints are subjected to rigorous investigation processes with Executive level oversight, most feedback received is complimentary. Formal compliments of staff and teams are well received and celebrated across the organisation, recognising the positive impact that we have on many people's lives.

In 2025-26, through our formal processes, EMHS received:

- 2,553 compliments via formal feedback processes
- 59 entirely complimentary stories via Care Opinion

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

EMHS also received:

- 1,046 complaints via formal feedback processes
- 66 complaints via Care Opinion

Complaints data is submitted by EMHS each year to the independent Health and Disability Services Complaints Office (HaDSCO) and is published in the HaDSCO annual report.

For 2025-26, EMHS had very few complaints classified as grievances, which provides assurance that our complaints handling and management practices are sound, empathic and person-centred.

At a Care Opinion Forum on 21 April 2026, held to celebrate 10 years of Care Opinion in WA, EMHS was recognised for its work in strengthening the way patient feedback is captured, interpreted and translated into service improvement.

This recognition reflects a strong focus on ensuring patient voices are embedded within quality improvement processes and is a meaningful acknowledgment of EMHS' continued commitment to listening, responding, and using feedback to drive better outcomes for patients and families.

Putting community voices at the heart of care

EMHS strengthened its focus on patient care by appointing a Director of Patient Experience in September 2025.

This role is leading the development of a Patient Experience Strategic Framework, designed together with the community. This represents the first integrated approach to patient experience across EMHS sites and services.

Broad staff and consumer consultation has occurred to help understand what truly matters most to the community we serve. Work is now underway to co-design what these priorities look like across our diverse patient groups.

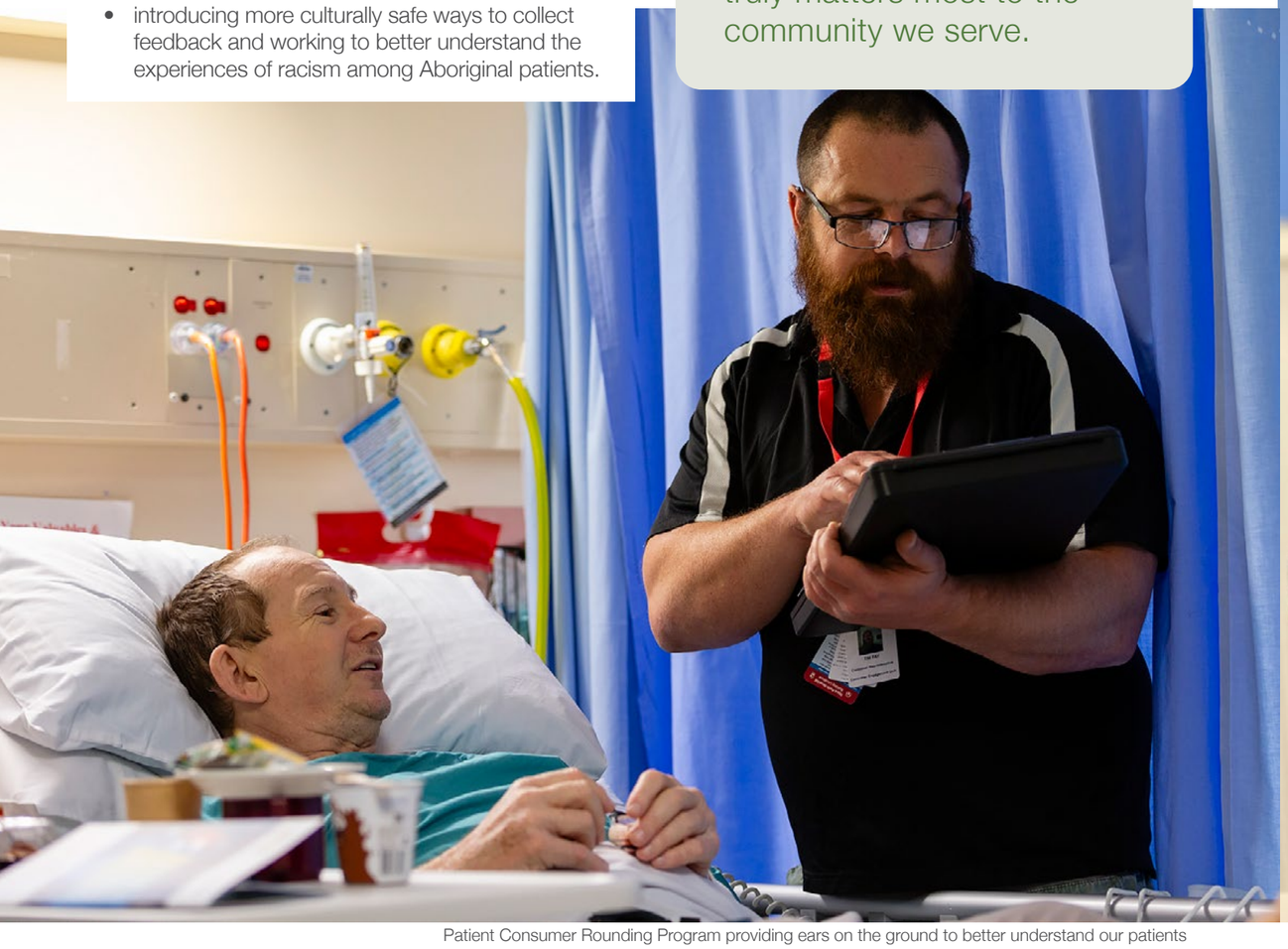
To support this work, we are reviewing how we collect patient feedback and testing new ways to improve it. This includes:

- using behavioural insights to better understand why people choose to give feedback, so we can make providing it easier and more accessible
- introducing more culturally safe ways to collect feedback and working to better understand the experiences of racism among Aboriginal patients.

An area-wide network of community representatives has also been created to ensure consumer voices remain at the centre of our work. We have made it easier for representatives to get started and developed a practical toolkit to support staff to engage effectively.

A key milestone has been reached, with our first consumer representatives now trained in Root Cause Analysis (RCA). This enables them to work alongside staff to investigate serious clinical incidents and develop recommendations for improvement.

> Working to understand what truly matters most to the community we serve.

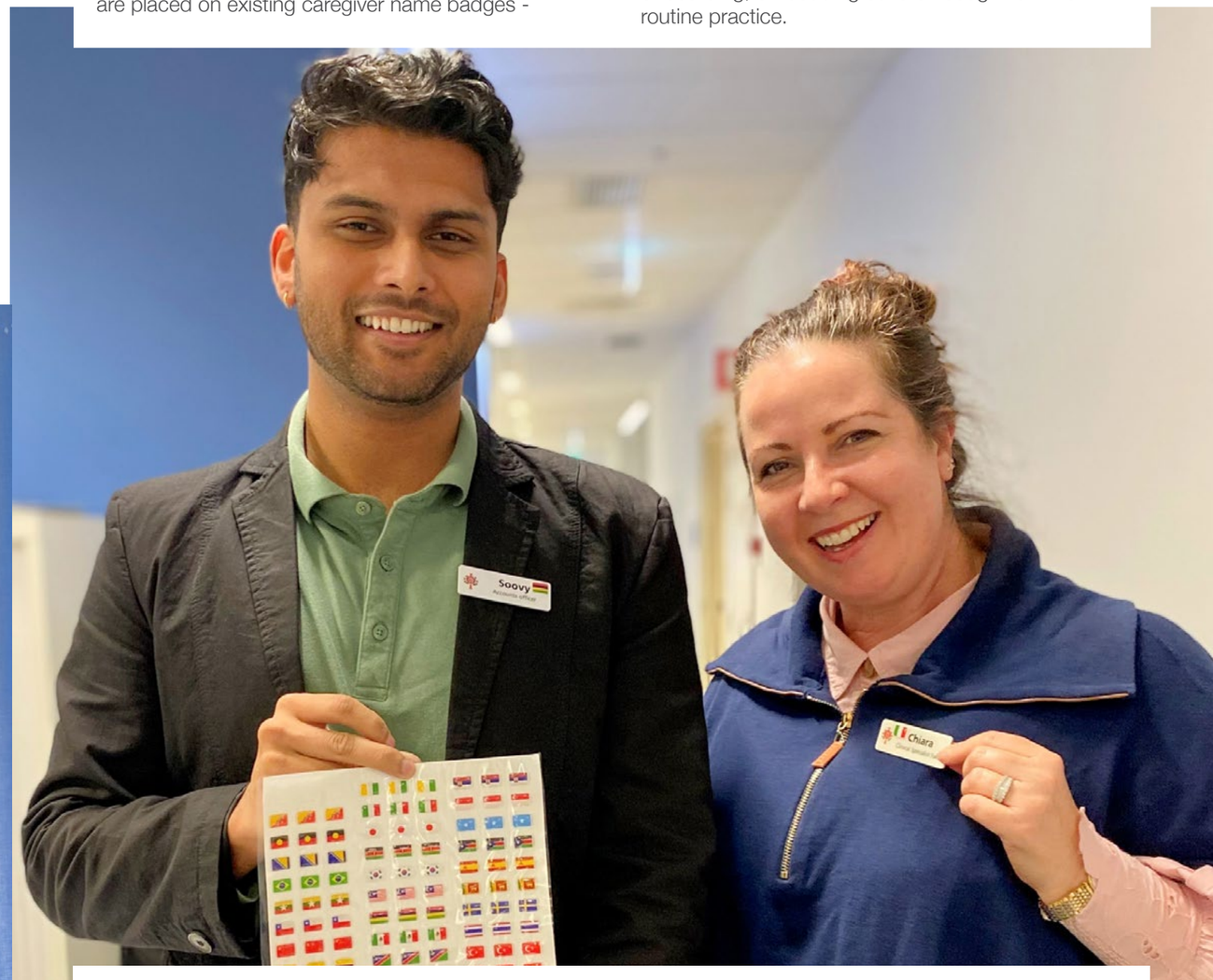


Patient Consumer Rounding Program providing ears on the ground to better understand our patients

Caregiver Language Badges initiative

The **Caregiver Language Badges** initiative was implemented at St John of God Midland Public Hospital as part of the 3Cs Program: **Connection, Compassion, Communication**, supporting culturally responsive care and improving patient comfort. The program highlights multilingual caregivers by providing long-life adhesive flags representing their country of origin. These identifiers are placed on existing caregiver name badges - positioned at the bottom right corner to ensure names and titles remain visible.

The initiative aims to strengthen rapport between caregivers and patients, particularly those who speak languages other than English, and serves as a practical conversation starter. New caregivers are offered the opportunity to add their flag during onboarding, embedding cultural recognition into routine practice.



EMHS patients - Top 5 countries of birth

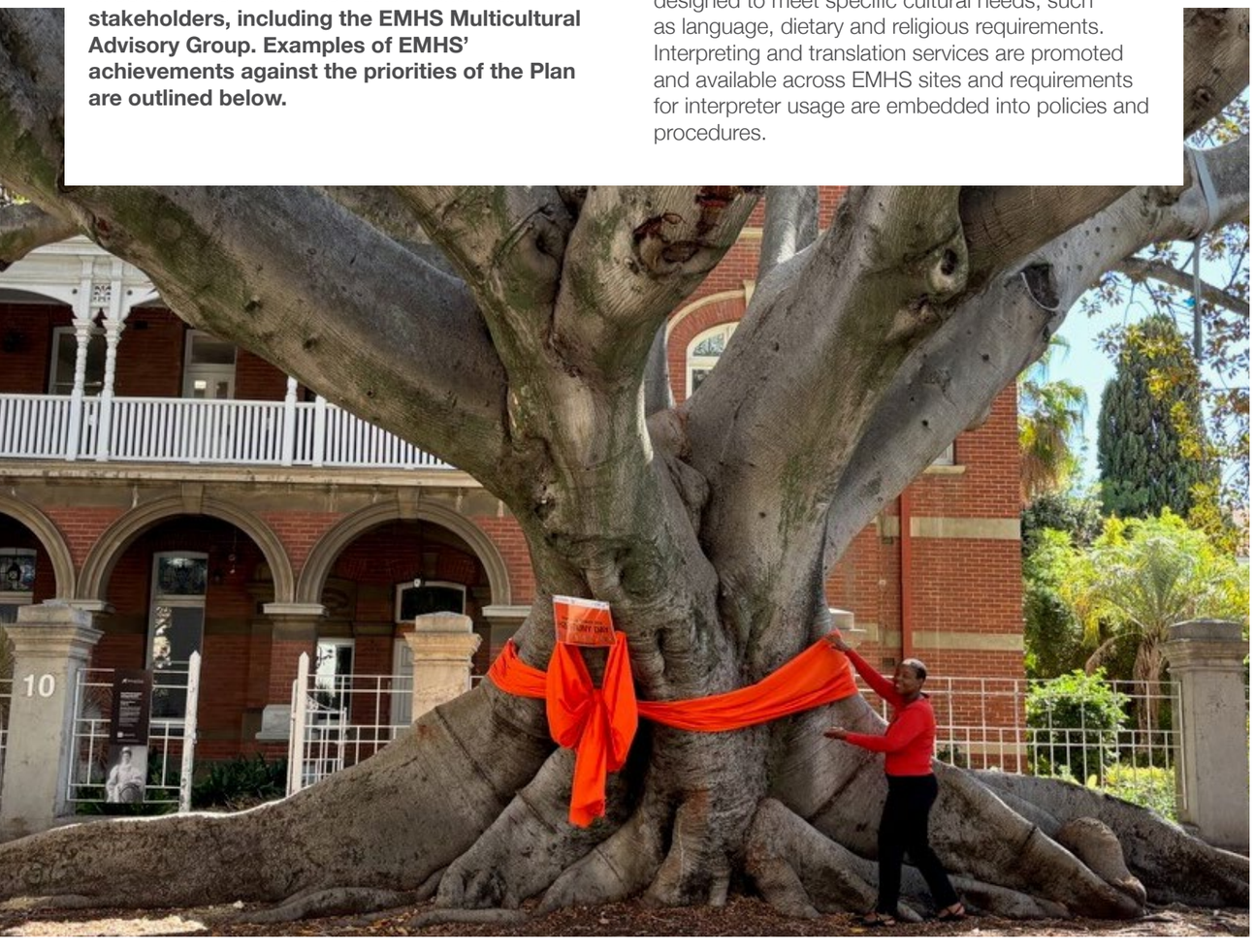
Australia	England	New Zealand	India	Phillipines
441,023	73,648	32,070	30,440	12,918

EMHS Multicultural Plan

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

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

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



Priority 1: Harmonious and inclusive communities

To support a strategic and sustainable approach, a new governance model has been developed, including establishment of an executive level Diversity, Equity and Inclusivity (DEI) Committee. The DEI Committee will have oversight and accountability for the ongoing delivery of the Plan.

EMHS celebrates cultural events including NAIDOC, Reconciliation Week and Harmony Week across sites and services. As part of Harmony Week 2026, staff participated in Wear Orange Day on Wednesday 25 March, where an orange ribbon was tied around the giant fig tree at the front of the historical Kirkman House.

EMHS has a range of services across its sites designed to meet specific cultural needs, such as language, dietary and religious requirements. Interpreting and translation services are promoted and available across EMHS sites and requirements for interpreter usage are embedded into policies and procedures.

Priority 2: Culturally responsive policies, programs, and services

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

Modesty Shawl Pilot Project was established in partnership with EMHS Community and Population Health, BreastScreen WA and Ishar to co-design a culturally appealing screening shawl for CaLD women to use while having a screening mammogram. The aim of this pilot is to increase regular participation in breast screening by addressing barriers associated with cost and modesty. A total of 550 shawls have been ordered as part of this project and women who are eligible to participate will be gifted the shawl after their mammogram.

The CaLD Women's Wellbeing Initiative (CWWI) was established in October 2025 as a partnership with EMHS Community and Population Health (CPH), Ishar, Muslim Women Support Centre (MWSC), Communicare and Multicultural Services Centre WA (MSCWA) to collectively address identified CaLD women's priority health needs, initially within the City of Canning and City of Gosnells. CWWI works collaboratively on initiatives within the Canning and Gosnells cities, which aim to address the priority health needs and strengthen access to health information and support services for CaLD women and their families in these communities.

The Strong Women Strong Families community event was held on 9 April 2026 for CaLD women promoting the message screening saves lives. This was a CWWI partnership event collaborated with national cancer screening services including Cancer Council, WA Bowel Cancer Screening, BreastScreen WA, Lung Cancer Screening Program and WA Cervical Cancer Prevention Program, as well as City of Canning and Town of Victoria Park.

Bilingual Health Educator Training conducted sessions to Ishar's bilingual health educators to deliver culturally sensitive and accurate cancer screening information.

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

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

EMHS CPH continues its partnership with Ishar, Communicare, MWSC and the CaLD Women's Health program in the City of Canning (launched 2024-25), which aims to provide culturally appropriate health education and physical activity opportunities to women from the Canning and Gosnells area. The full program has been delivered to approximately 117 participants across 18 sessions, including walking groups, Zumba and yoga. The program increases motivation to engage in daily movement.

In partnership with Youth Futures, EMHS CPH supported a Youth Week grant for the Young Chefs Big Stories project, based on a youth-led initiative at Altone Youth Centre (AYC) where 12 to 17-year-olds cooked and shared their cultural recipes. Many young people in the Altone/ Beechboro and surrounding areas struggle with cultural disconnection, identity issues, and food insecurity. This project aims to strengthen a sense of community, culture and belonging for these young people and celebrate the strength in their stories through the formulation of a recipe booklet.

Multicultural Community Garden City of Belmont supports fortnightly community garden sessions where CaLD communities can develop practical skills in gardening, healthy cooking, and self-care, contributing to improved food security. Sessions are coordinated by a nominated member, with WhatsApp as the preferred communication channel. This is a co-design partnership with EMHS CPH, City of Belmont and the city's CaLD community.

Tools and resources are available to all EMHS staff on a newly developed Sharepoint (intranet) page, including access to cultural competency training, resources to help engage with consumers, and resources for CaLD staff and managers.

SHR 3a

National Agreement on Closing the Gap

Priority reforms

EMHS continues to drive meaningful change through genuine collaboration with Aboriginal Community-Controlled Organisations (ACCOs).

Formal partnerships have been strengthened via a Memoranda of Understanding with Derbarl Yerrigan Health Service, Moorditj Aboriginal Corporation, local governments and 19 schools, alongside partnerships with Nganka Yira, Curtin University, Melbourne University, Nyoongar Outreach Service, Arche Health and 3 Aboriginal Community Advisory Groups.

EMHS is progressing new initiatives that place specialist staff within ACCO sites, ensuring timely, culturally safe care closer to home. Cultural safety remains a priority, supported by 5 strategic actions, including implementing Leave Events Action Plan, improved Aboriginal patient identification, reviewing the Aboriginal Health Champions Induction Program and strengthening policy compliance.

Delivering a strong, skilled and growing Aboriginal workforce, EMHS has developed 2 key documents to achieve this outcome - **EMHS Aboriginal Employment Action Plan**, with key actions to increase the Aboriginal workforce, and **EMHS Cultural Capability Framework - Towards Cultural Safety: Our Development Framework** to improve Aboriginal staff retention.

2024-25		2025-26
110 Aboriginal staff		122 Aboriginal staff

Socioeconomic outcomes and targets

EMHS reports against 8 of the 17 Closing the Gap targets, delivering targeted programs to improve life outcomes for Aboriginal people, families and communities. Cultural recognition has been embedded across EMHS sites through Noongar co-naming of Royal Perth Hospital (RPH) - **Walbirring Karlup** - and Armadale Hospital - **Gangangarra**. Numerous hospital wards, meeting rooms and Aboriginal programs also carry Noongar names, supporting cultural continuity and language revitalisation for future generations.

Tracking achieved outcomes

Outcome tracking reflects the diverse nature of EMHS services and programs. Clinical teams monitor performance through key performance indicators (KPIs), operational reporting, combined databases and service dashboards. Non-clinical Aboriginal Health Promotion programs collect qualitative feedback via participant forms, interviews and face-to-face surveys, with program outputs recorded in dedicated databases and monitored through service dashboards.

Assessing effectiveness of the achieved outcomes

EMHS maintains a strong commitment to integrity, excellence and continuous improvement.

Effectiveness is assessed through internal audits, robust data governance, specialised databases and the collection of both quantitative and qualitative evidence.

Consumer engagement remains central, ensuring programs evolve in response to community needs and experiences.

These processes uphold high-quality health outcomes for Aboriginal staff, patients and communities.

Partnering for Aboriginal health

We are proud to be leading the State with our working relationships with Aboriginal Community Controlled Health Organisations.

In February 2026, EMHS signed a Memorandum of Understanding with the Moorditj Koort Aboriginal Corporation, a not-for-profit organisation providing Aboriginal-led health and wellbeing support.

This followed the signing of a similar agreement with Derbarl Yerrigan Health Service Aboriginal Corporation in November 2025, a not-for-profit providing culturally safe primary and other health services.

Both agreements are for health partnerships within the EMHS catchment. Responsibilities include identifying opportunities to work together, supporting service delivery and creating two-way learning opportunities for staff.

The partnerships focus on listening to Aboriginal people, exploring better ways to work together and improving health outcomes by reviewing and sharing results.

They have evolved from our ground-breaking EMHS Aboriginal Health Joint Committee which began in 2024, bringing together EMHS, Derbarl Yerrigan and Moorditj Koort executives to raise and discuss issues, challenges and opportunities.

EMHS Area Director of Aboriginal Health, Francine Eades, said genuinely working together is a priority.

“The Closing the Gap approach is underpinned by the belief that when Aboriginal and Torres Strait Islander people have a genuine say in the design and delivery of policies, programs and services that affect them, better life outcomes are achieved,” Francine said.

“We acknowledge unprecedented shifts are needed to close the gap.

“Aboriginal and Torres Strait Islander people must determine, drive and own the desired outcomes, alongside all governments.”

“We acknowledge unprecedented shifts are needed to close the gap”

Continuing to deliver safe and high-quality care

Learning from clinical incidents

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

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

During 2025-26, there were 201,688 patient admissions to EMHS hospitals. In addition, 212,139 patients were seen in our emergency departments and another 611,784 patients were seen in an outpatient clinic or setting.

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

In the interests of transparency, we are sharing the number of serious clinical incidents that occurred in 2025-26 at our hospitals and health services.

During the reporting period, there were 138 clinical incidents reported with a Severity Assessment Code (SAC) rating of 1 (SAC1). A SAC1 incident is a clinical incident that has, or could have, caused serious harm or death, and which is attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.

The number of SAC1 incidents is attributed to an increase in activity and a strong culture of reporting. The most reported types of incidents include infection control, patient accidents/falls and delay in recognising/responding to physical clinical deterioration. All SAC1 clinical incidents are subject to a rigorous investigation with the reports being reviewed by members of the EMHS Executive, providing an opportunity for all EMHS hospitals to learn from incidents to improve the quality of care delivered across EMHS.

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

EMHS continues to actively participate in healthcare associated infection (HAIs) surveillance programs including the monitoring of hospital acquired blood stream infections (HABSI), enabling learning from current practice.

Of the 138 serious incidents reported in 2025-26, the patient outcome* was noted as:

- 11 **No harm** 3 in 2024-25 ▲
- 1 **Minor harm** 0 in 2024-25 ▲
- 3 **Moderate harm** 2 in 2024-25 ▲
- 87 **Serious harm** 72 in 2024-25 ▲
- 36 **Death** 26 in 2024-25 ▲

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

Note: excludes 'declassification approved' SAC1 incidents deemed not to be the fault of the health service.

A future with fewer falls – Safe Recovery Program

A new education program to reduce patient falls – a leading cause of injury-related hospitalisation – has been helping patients and staff at Royal Perth Hospital (RPH) better understand ways to prevent falls.

The **Safe Recovery Program** is a research project led by the University of Western Australia (UWA) and funded by the Federal Government's Medical Research Future Fund.

The project began at RPH in December 2025 and will run until October 2026. Wards in the trial include older adult medical wards 9A and 7A, and 3H, a surgical ward for orthopaedic and trauma care.

So far, more than 750 patients have received falls education from a physiotherapy assistant, guided by physiotherapy staff. Each session is tailored to the patient's needs and helps them understand their fall risk, mobility and personalised safety plan.

Around 150 staff members have also completed additional training based on World Falls Guidelines, focusing on early identification of risk and personalised care.

With falls prevention now a shared responsibility on the wards, there is better teamwork across nursing, allied health and medical staff. Prior research has shown that the program can reduce falls by up to 40 per cent when staff work together.

EMHS is one of 3 health services involved in the $1.4 million trial. The project is being led at RPH by UWA Professor Anne-Marie Hill, with support from a multidisciplinary team at RPH. It is delivered by Senior Physiotherapist Elisabeth Nolan and Clinical Nurse Vivian Liong.

Falls are the leading cause of injury hospitalisation in Australia, making up about 43 per cent of injury-related admissions, according to the Australian Institute of Health and Welfare.

Clinical Nurse Vivian Liong (left) and Senior Physiotherapist Liarna Ellis explain to patient Sue how she can reduce her risk of falls in hospital

SHR 2a

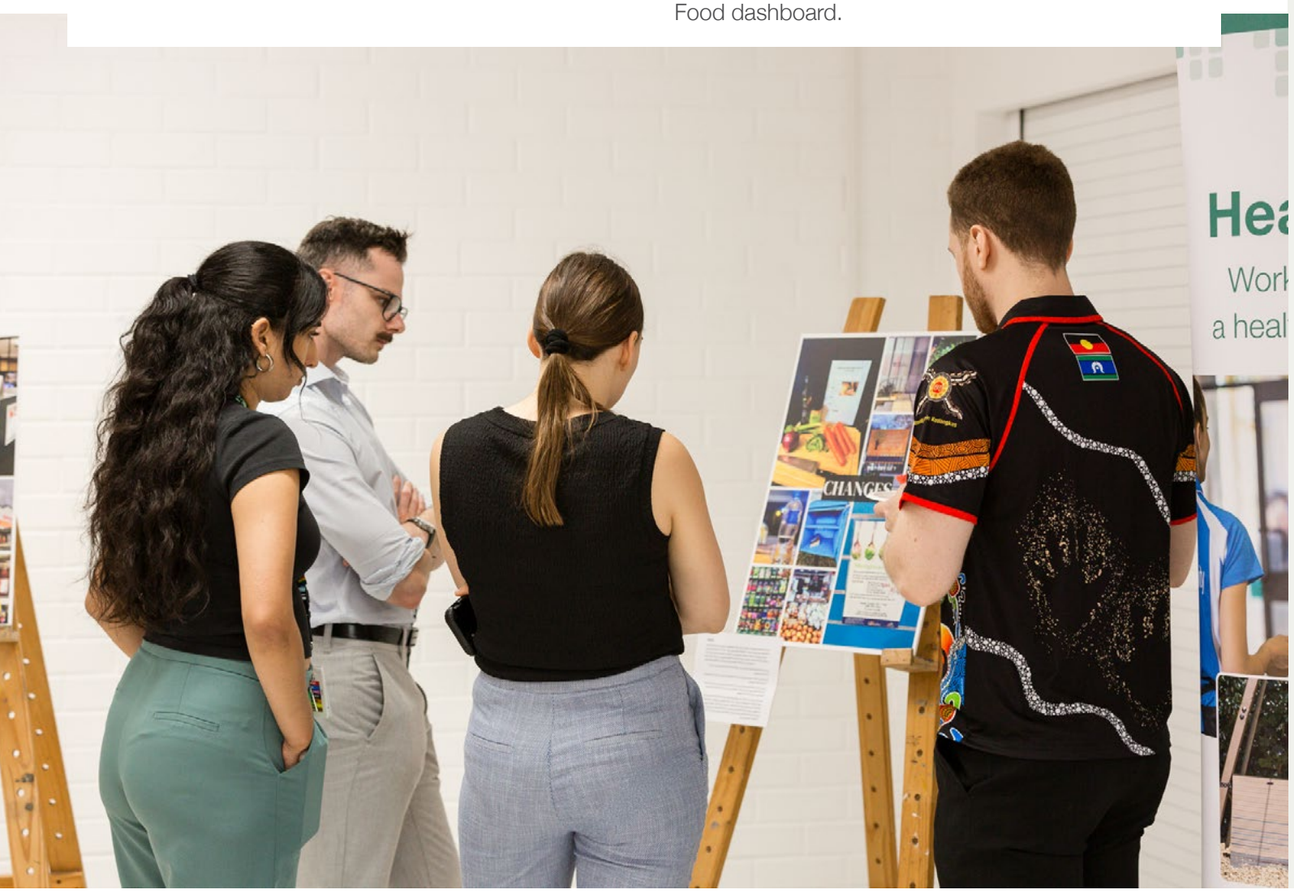
Promoting a healthy community

The EMHS Community and Population Health's **Obesity Prevention Strategy (OPS) 2020–2025** provided a coordinated, evidence-informed approach to address overweight and obesity across the EMHS catchment. Through partnerships with local governments, universities, community organisations and government agencies, the OPS progressed 28 actions across nutrition, physical activity, healthy weight and priority population groups.

Over the 5-year period, the OPS utilised a multifaceted approach to address overweight and obesity. A primary focus was strengthening the evidence base for prevention and supporting local public health planning through research, food environment mapping and surveillance activities. Notable achievements included contributions to the WA Food Atlas, development of the Food Outlet Dietary Risk Assessment (FoDR) and Menu Assessment Scoring Tool (MAST), and initiatives that improved understanding of local food environments, food security and opportunities to support physical activity.

Within health service settings, the OPS supported healthier environments for patients, visitors and staff. This included implementation of the Healthy Options WA Food and Nutrition Policy across EMHS sites, alongside initiatives promoting physical activity and active travel. Active travel infrastructure assessments and workplace wellbeing initiatives contributed to environments that make healthy choices easier. In addition, the OPS advanced respectful and evidence-based approaches to healthy weight through the development of the SHIFT Guide, workforce education initiatives and the Adult Nonsurgical Weight Management Clinical Model of Care.

The final OPS Report highlights several significant initiatives delivered during the 2025–26 financial year that contributed to health equity, strengthened community food security and supported healthy lifestyles. Key highlights included the co-design and launch of the Aboriginal Community Cookbook, progression of the Food Access and Affordability Basket survey, and development of the Charitable Food dashboard.



Priorities for 2026 and beyond

Building on the foundations established through the OPS, EMHS Community and Population Health will continue to focus on 3 key areas:

- addressing food insecurity
- creating environments that support healthy eating and physical activity
- strengthening community-led and culturally safe approaches to prevention.

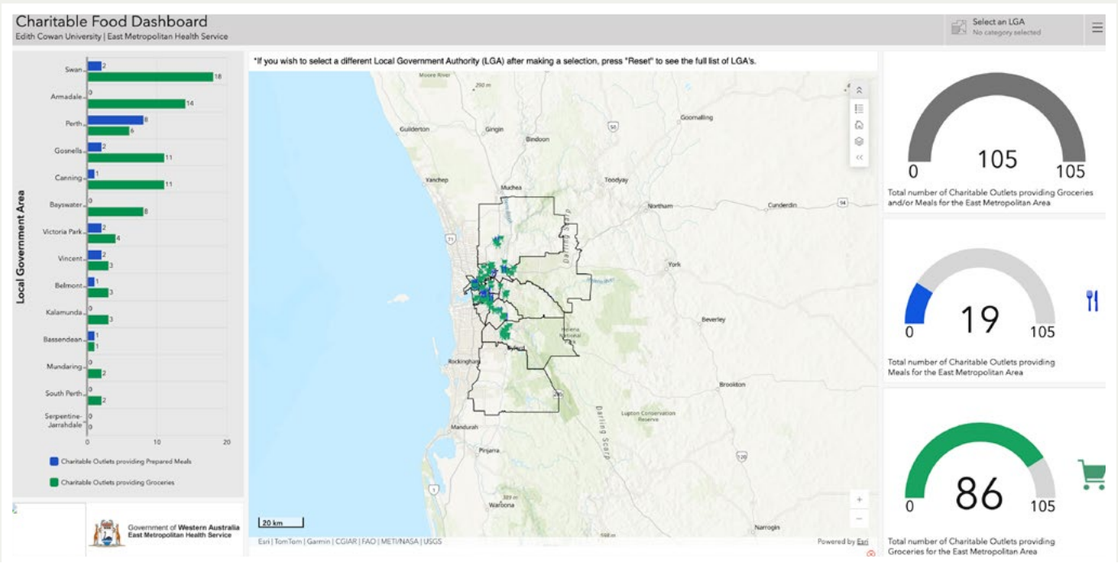
Future efforts will prioritise evidence-informed actions to improve food security, support healthier food and built environments, and reduce barriers experienced by priority populations, including Aboriginal peoples and culturally and linguistically diverse communities. Working with local governments, community organisations and research partners, EMHS will continue to strengthen prevention-focused initiatives that support health equity, improve wellbeing and long-term health outcomes across the EMHS catchment.

Charitable Food dashboard highlight

At the request of the food relief sector, and in response to increasing demand associated with ongoing cost-of-living pressures, EMHS Community and Population Health partnered with Edith Cowan University to develop an interactive Charitable Food dashboard. Supported by data collection undertaken in collaboration with the WA Council of Social Service (WACOSS), the project developed a prototype geospatial map to identify and categorise emergency food relief, meal services, and meal preparation and delivery programs across the EMHS region. The prototype was presented to local governments to gather feedback on usability and applications for planning and service delivery. This work provided the first comprehensive overview of charitable food services across the 13 local government areas within the EMHS catchment, strengthening understanding of service availability and distribution.

The project highlighted the potential of geospatial mapping to support evidence-informed planning, identify service gaps and underserved communities, improve awareness of available supports, and inform action to address food insecurity. The data also has practical value for food relief organisations, enabling targeted service planning, better resource allocation, and improved access to food relief for communities experiencing the greatest need.

Future work will focus on further developing the Charitable Food dashboard, supporting its uptake across the EMHS region, and working with local governments and community partners to translate insights into actions that strengthen food security, improve service accessibility, and support equitable access to food relief services.



This year
Modern, integrated, high performing models of care

Boost to beds and facilities at Midland

St John of God Midland Public Hospital (SJGMPH) is an important part of our expansion.

SJGMPH has been operated by St John of God Health Care (SJGHC) on behalf of the State since the hospital opened in 2015. A St John of God Midland Private Hospital is co-located on site with the public hospital.

All 60 private beds and 3 surgical theatres will transfer to the public system, coinciding with SJGHC opening a new private hospital nearby.

There will be an immediate boost to our bed and surgical capacity when it becomes a 367-bed solely public hospital in August, under a continuing public-private partnership.

SJGHC will continue to run the expanded public hospital for EMHS and the State.

Further major benefits will flow from a staged $355 million redevelopment of the site, including a major upgrade of its emergency department (ED).

The ED expansion will increase capacity to meet growing demand in the Swan and Hills area, where emergency visits are expected to rise by 38 per cent by 2031-32.

Both levels of government have made significant election commitments – the Federal Government $200 million and the State Government $155 million.

Mount Lawley Transition Program

EMHS is supporting the transition of St John of God Mount Lawley Hospital into the WA public health system from 1 September 2026. Announced by the State Government in November 2025, the transition will bring additional beds and operating theatre capacity online for public patients, helping to strengthen access to hospital care across the community.

Led by Executive Director Mount Lawley Transition Program, Susan Mylne (substantive Executive Director Strategy, Planning and Performance), the dedicated EMHS team is preparing the hospital to operate safely and effectively as part of the public health system, under the governance of Royal Perth Bentley Mount Lawley Group. Work in preparation for the transition spans clinical, non-clinical and support services, workforce, integration and governance, facilities management and infrastructure, ICT, equipment, commercial, procurement and finance, with each area focused on supporting a smooth and well-coordinated transition.

At the heart of the program is a commitment to patients, staff and the community. EMHS is working closely with St John of God Health Care, the Department of Health and other key partners to prepare the hospital for its role in caring for public patients, while keeping patient experience and safety at the centre of planning. Sales and Transition Agreements have been completed, with detailed planning and operational readiness work continuing ahead of the 1 September transition date.

The transition also recognises the long and valued history of the Mount Lawley site. Since opening as St Anne's Nursing Home in 1937, the hospital has cared for generations of families and played an important role in the lives of many people across the local community. EMHS is committed to honouring this legacy while supporting the hospital's next chapter as part of the WA public health system.

As planning continues, the focus remains on creating a safe, welcoming and well-prepared hospital environment from day one. This includes bringing people, systems, services and processes together in a way that supports high-quality care and gives patients, families, staff and volunteers confidence in the transition.

The Mount Lawley Hospital Transition represents an important milestone for EMHS and the wider WA health system. It reflects a shared commitment to expanding access to public healthcare while respecting the history, relationships and sense of community that have shaped Mount Lawley Hospital over many decades.

It reflects a shared commitment to expanding access to public healthcare while respecting the history, relationships and sense of community that have shaped Mount Lawley Hospital over many decades.

SHR 13

Connected care after discharge

In 2025-26, Royal Perth Hospital (RPH) became the first trial site in WA to commence an **Aftercare Service**, providing a short-term, recovery-oriented support pathway for individuals who present to an Emergency Department (ED) following a suicidal crisis or attempt.

In partnership with Neami National, the EMHS Aftercare Service provides an integrated model of care which recognises the heightened risk of suicide in the immediate period following a crisis and aims to bridge the critical transition gap between hospital and community settings. The service focuses on delivering brief, targeted interventions that promote safety, autonomy, and meaningful connection to longer-term treatment and support services.

In a shift from traditional medically-led models, the Nurse Practitioner-led EMHS Aftercare Team works alongside the ED Mental Health Liaison Team to support fast tracking of appropriate assessments and provides phone follow-up for up to 72-hours post discharge.

An EMHS Aftercare Outpatient Clinic operates 3 days per week to provide Nurse Practitioner follow-up for care planning, prescribing and deprescribing, and brief therapeutic intervention, while partner Neami National provides a proactive Aftercare program for up to 90 days, inclusive of wrap-around psychosocial support and care coordination.

> Consumers of the Aftercare Service have said that they felt valued and heard, and that the caring Team explained things thoughtfully and provided valuable next steps

Setting new standards in suicide prevention

The suicide prevention program at our **Bidi Wungen Kaat** Transitional Care Unit has once again been recognised, reflecting its continued excellence and meaningful impact.

The unit won an Innovative Practice and Research Award at Suicide Australia's 2026 WA LiFE (Living is for Everyone) Awards in March, recognising exceptional efforts in suicide prevention across Australia.

This follows earlier recognition in 2025, when Bidi Wungen Kaat, which means journey to a healthy mind, received an Excellence in Injury Recovery Award for the same program at the Injury Prevention and Safety Promotion Awards.

Located in St James, the 40-bed Bidi Wungen Kaat Centre provides an evidence-based and innovative approach to mental health care for long and short-stay patients in partnership with Mind Australia, creating a multidisciplinary team of clinical and allied health and peer practitioners.

Its Suicide Intervention Group was developed by Consultant Psychiatrist Dr Madhavan Seshadri, Mind Australia Manager Susan Greenhatch and Senior Social Worker Chelsea Gray.

The 3-session program supports people experiencing suicidal thoughts by breaking down stigma, building practical skills to manage symptoms and developing safety plans for in the community. It also encourages their active involvement in their own recovery.

"What makes this group a success is the partnership between clinicians and peer practitioners, where professional guidance is enriched by the honesty and credibility of lived experience," Chelsea says.

"Our data shows a very positive trend between starting and finishing the course, in participants being able to identify early stages of risk and knowing how to reach out for help."

> "What makes this group a success is the partnership between clinicians and peer practitioners..."

(L-R) Program founders, Senior Social Worker Chelsea Gray, Consultant Psychiatrist Dr Madhavan Seshadri and Mind Peer Manager Susan Greenhatch

Providing emergency care

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

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

The 2025-2026 targets for percentage of emergency department patients seen within recommended times are outlined below. Improved or maintained performance is demonstrated by a result equal to or above target.

Triage category	Seen within	Target
1	≤ 2 minutes	100%
2	≤ 10 minutes	80%
3	≤ 30 minutes	75%
4	≤ 60 minutes	70%
5	≤ 120 minutes	70%

Targets are based on national best practice recommendations proposed by the Australasian College of Emergency Medicine. These recommended times and categories are used both locally by the WA Department of Health and nationally by the Department of Health and Ageing, and the Australian Institute of Health and Welfare.

Results

Triage category 1

YEAR	TARGET	ACTUAL
2025-26	**100%**	**100%**
2024-25		99.9%
2023-24		98.3%
2022-23		99.0%

Triage category 2

YEAR	TARGET	ACTUAL
2025-26	**80%**	**56.8%**
2024-25		61.3%
2023-24		71.7%
2022-23		69.0%

Triage category 3

YEAR	TARGET	ACTUAL
2025-26	**75%**	**12.3%**
2024-25		13.1%
2023-24		18.8%
2022-23		17.1%

Triage category 4

YEAR	TARGET	ACTUAL
2025-26	**70%**	**26.5%**
2024-25		28.9%
2023-24		37.3%
2022-23		38.7%

Triage category 5

YEAR	TARGET	ACTUAL
2025-26	**70%**	**61.3%**
2024-25		64.6%
2023-24		72.4%
2022-23		73.3%

Hospital sites across EMHS faced sustained pressure on patient flow throughout the year, despite periods which saw a decrease in demand in ED volume.

As a result, this is reflected in ambulance transfer delays, access block, and deteriorating length of stay performance. Factors such as high volume of mental health presentations, high-acuity demand (sustained increase in average ATS 1 and 2 presentations), and outward pressure at the back of the pathway, such as high numbers of patients medically cleared for discharge and waiting transitional aged care services, contributed to ongoing rises in ED length of episodes as well as inpatient length of stay.

Performance against ATS category 2-5 targets in 2025-26 reflects continued deterioration across all 3 sites, with performance significantly under target. Sites continued to experience ongoing demand pressures, both on their EDs as well as inpatient beds.

EMHS continued to experience high volumes in the complexity and acuity of patient presentations, with ATS category 1 always seen on time.

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

Increased bed capacity

EMHS has undertaken several initiatives to increase bed capacity to improve patient flow and relieve pressure on tertiary hospitals, such as Royal Perth Hospital (RPH). These initiatives include the expansion of Home Hospital, the buy-back of St John of God Midland Public Hospital (SJGMPH) and the purchase of St John of God Mount Lawley Hospital (SJGML), as well as repurposed beds at Bentley Hospital (BH) for Older Adults.

- Expansion of Home Hospital
  - Home Hospital (HH) allows patients to safely return to their normal place of residence and receive the right care at the right place. Following the launch of HH in 2024, EMHS is expanding its capacity to 70 beds.
  - In mid June 2026 there were 55 beds in operation, with HH commencing at SJGMPH in December 2025 and plans to increase from 10 to 15 beds by mid year.
  - In addition to the beds at SJGMPH, there are 30 beds operating in RPH and 15 beds at Armadale Hospital (AH).
- Increased capacity at SJGMPH
  - From late August 2026 EMHS will purchase the private capacity at St John of God Midland Hospital for public use, which includes 60 beds, 3 operating theatres and a procedure room.
- Purchase of SJGML
  - In November 2025, the WA State Government announced its intention to purchase the SJGML hospital. This hospital includes 196 beds, 8 operating theatres and 2 procedure rooms, and will help relieve pressure on public tertiary hospitals such as RPH. EMHS is currently contracting additional beds at SJGML with the hospital becoming an EMHS site from September 2026.
- Increased capacity for older adults at Royal Perth Bentley Group (RPBG)
  - As at the end of July 2025, 20 repurposed beds on BH Ward 2 were open for older adults awaiting aged care placement to provide the right environment for older adults awaiting placement.

Period: 2022-2023 to 2025-2026 financial years
Contributing sites: Armadale Hospital, Royal Perth Hospital, St John of God Midland Public Hospital
Data source: Emergency Department Data Collection


Winter Care Team

Winter strategy initiatives

There have been several key initiatives implemented across the hospitals within EMHS during the winter period to reduce Emergency Department (ED) congestion and improve patient flow. Some initiatives were implemented due to success in the winter of 2025, while others are new initiatives. Key initiatives for 2026 winter include:

- Winter Care Teams
  - In June 2026, Royal Perth Hospital (RPH) introduced the implementation of a multidisciplinary Winter Care Team to improve patient flow and accelerate discharge processes to reduce ED congestion.
- Bed Turnaround Teams
  - Bed Turnaround Teams deployed at Armadale Hospital (AH), St John of God Midland Public Hospital (SJGMPH) and RPH, with the goal of reducing the time between one patient leaving and the next one arriving. Working alongside clinical teams, Bed Turnaround Teams are embracing new ways to provide timely support through cleaning rooms and patient transfers, thereby reducing delays between discharge and admission.
- Additional hospital transport
  - From June 2026 RPH added additional transport crews at peak times to assist with transferring patients to other sites so that they can commence their specialist care and avoid any unnecessary additional overnight stays in a tertiary setting.
- Expansion of Transit Lounge hours
  - The expansion of Transit Lounge hours is to facilitate early movement of discharges and transfers to free up beds on inpatient wards to ease pressure on patient flow.
    - RPH and AH introduced increased operational hours from June 2025.
    - SJGMPH commenced utilising a Transit Lounge in May and is now operating 7-days a week to improve flow.
- Introduction of a 7-Day Acute Geriatric Multidisiplinary Team at Armadale Kalamunda Group
  - The goal of the service is to enable direct admissions from ED into geriatric care pathways and avoid interim general medicine admissions. The service will address current weekend service gaps which have historically limited discharge activity and contributed to avoidable bed days and poor patient flow.

Expansion of ambulatory care

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

- The Ambulatory Unit at RPH was extended from 5 to 7 days per week in June 2025.

Our 15-minute path to faster diagnosis

A new program at AH has transformed how respiratory illness is diagnosed and managed in the ED, leading the way across the State and nationally.

The **BIOFIRE SPOTFIRE** program provides rapid, point-of-care molecular testing, identifying up to 15 viral and bacterial pathogens in around 15 minutes – compared to traditional laboratory testing that could take up to 6 hours.

The program was initially trialled in winter 2025 and is now fully integrated into routine care, with testing occurring at triage and results available early in the clinical pathway.

It has had a major impact on patient care and flow at AH. Clinicians can now diagnose and begin treatment during the patient's ED visit, improving decision-making, reducing delays and enhancing the patient experience – particularly during peak winter demand.

The success of the AH pilot directly informed a WA government-funded rollout to other hospitals, positioning it as a model for improving ED efficiency and preparedness.

It is also an Australian first in embedding rapid molecular respiratory testing within ED workflows.

EMHS Winter Commander Alisha Thompson says the program has been a game-changer.

"What this means, particularly for parents of young children, is that we can give them reassurance about their diagnosis, which has dropped our re-presentation rate significantly," she says.

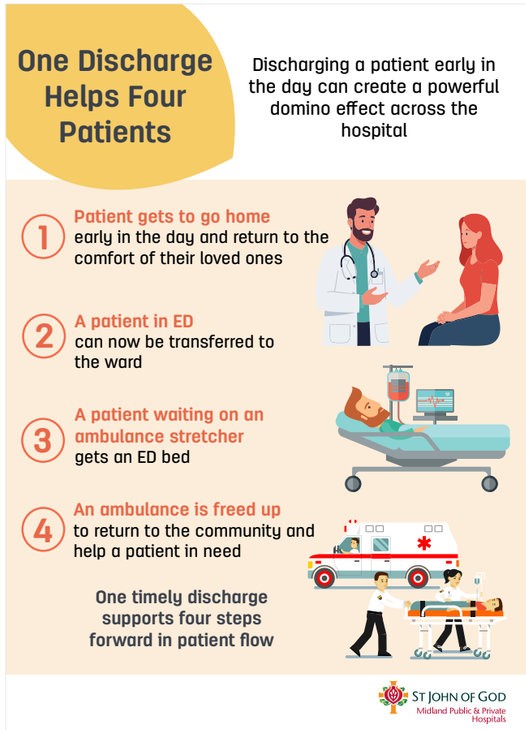
The SPOTFIRE program is part of the WA Government's Winter Strategy, aimed at improving patient flow and reducing pressure on hospitals during periods of peak respiratory illness.

One Discharge Helps Four Patients initiative

The **One Discharge Helps Four Patients** initiative at **St John of God Midland Public Hospital** developed under the Access to Care program, reinforces the critical role of timely discharge in optimising patient flow. Discharge is one of the few patient-related variables that caregivers can directly influence, and early discharge generates a 4-step positive impact across the hospital and broader health system:

1. The discharged patient returns home earlier, improving comfort and continuity of care.
2. A patient in the Emergency Department (ED) can be transferred to a ward bed.
3. A patient waiting on an ambulance stretcher can be moved into the ED.
4. An ambulance is released back into the community to respond to new emergencies.

Caregivers are encouraged to reinforce this message through team meetings, huddles and other communication channels to support consistent, organisation-wide commitment to patient-flow improvement.



This year
Digitally driven and cyber secure

Implementation of the eReferral Digital Outpatient Referral System

St John of God Midland Public Hospital (SJGMPH), in partnership with EMHS, implemented the eReferral digital outpatient referral system to modernise referral processes and improve interoperability with WA Health sites. The initiative replaces manual, email and fax-based workflows with a structured, secure digital platform that enhances referral quality, visibility and efficiency.

A phased rollout commenced in October 2025, with physiotherapy and podiatry piloting inbound digital referrals. The pilot delivered immediate improvements in data accuracy, triage efficiency and transparency of referral status for both referring and receiving sites.

Following its success, all SJGMPH public outpatient services transitioned to eReferrals in February 2026, receiving 362 digital referrals in April alone. Outbound referrals commenced shortly after, with podiatry sending referrals to WA Health sites from April 2026. Expansion to the Emergency Department is planned, supporting one of the hospital's highest-volume referring areas.

The initiative strengthens alignment between SJGMPH and WA Health, improves information security, reduces administrative burden and enhances coordination of care across EMHS.

Keeping EMHS cyber secure

During 2025-26, the EMHS Cyber Security Unit continued to strengthen organisational resilience and maturity, with a strong focus on protecting patient safety, ensuring service continuity, and aligning with State and Commonwealth cyber security obligations. Cyber security remains a recognised enterprise risk for EMHS, with ongoing uplift activities progressing to address vulnerabilities within a complex and highly interconnected clinical and digital environment.

Key achievements across the year included the advancement of governance, risk, and compliance practices, including the completion of the Essential Eight Annual Implementation Report for 2025, and continued alignment to the WA Government Cyber Security Policy and Security of Critical Infrastructure (SOCI) obligations. EMHS maintained foundational maturity across several Essential Eight controls, while progressing broader 'Further Five' capabilities which include:

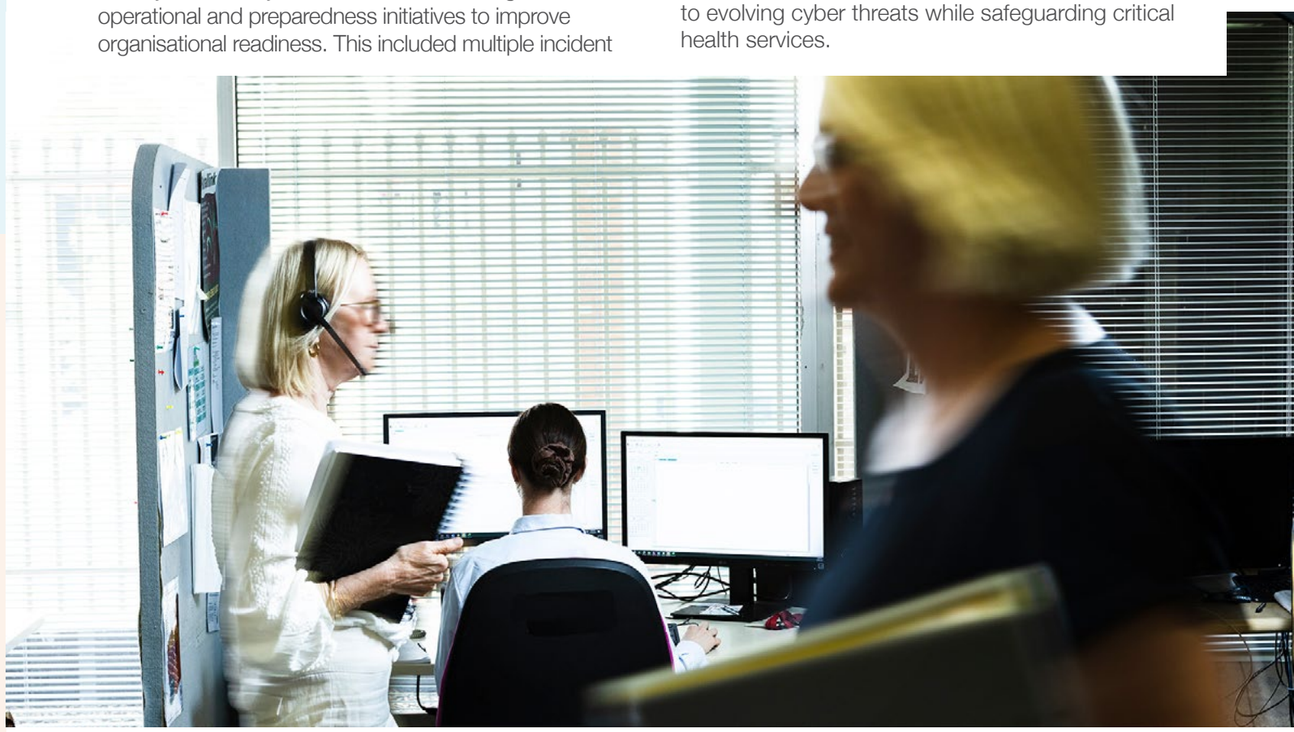
- server application hardening
- block spoofed emails
- network segmentation
- continuous incident detection and response
- personnel management.

The Cyber Security Unit also delivered a range of operational and preparedness initiatives to improve organisational readiness. This included multiple incident response tabletop exercises across business areas, strengthening coordination and response capability for significant cyber events. Targeted cyber security awareness programs were delivered across the organisation, including leadership-focused workshops and Cyber Security Month activities, supporting improved cyber hygiene practices and workforce awareness of threats to sensitive health information.

From an operational perspective, the team continued to actively triage and respond to cyber security incidents and events, while enhancing visibility across the environment through improved access to security monitoring platforms. Vulnerability management remained a priority area, with measurable progress in server patching and reduction of legacy vulnerabilities, supported by structured risk-based exemption and remediation processes to minimise disruption to critical clinical services.

Importantly, EMHS Cyber continued to work collaboratively with Health Support Services (HSS), the Department of Health, and internal stakeholders to strengthen shared-service delivery models and support system-wide cyber resilience initiatives.

Collectively, these activities represent a continued uplift in EMHS' cyber security posture, positioning the organisation to better prevent, detect and respond to evolving cyber threats while safeguarding critical health services.



Expanding East CareConnect services

East CareConnect, our ‘hospital without walls’, expanded services across the EMHS catchment in its first year of operations.

Launched in June 2025, East CareConnect unified our virtual, in-home and community-based services under a single model. These included the groundbreaking virtual services, **Health in a Virtual Environment (HIVE)** and **Community Health in a Virtual Environment (Co-HIVE)**, and hospital-at-home service, **Home Hospital**.

Over the past year, East CareConnect has continued to grow and evolve. Existing services have expanded, while new services have strengthened our reach across the community.

Home Hospital is now available through St John of God Midland Hospital, following earlier rollouts at Royal Perth Hospital (2 years ago) and Armadale Hospital (one year ago).

Co-HIVE, which delivers specialist geriatrician-led virtual care and support, has strengthened partnerships across metropolitan, regional and aged care settings, and is progressing towards a statewide model.

A virtual **Older Adult Community Integrated Care Hub** has complemented a physical hub currently operating from Bentley Hospital. Together, they support coordinated care for older adults – particularly in managing complex conditions – to avoid hospital admissions.

Innovation remains a key focus. **HIVE** has been trialling new wireless monitoring devices, while our data science teams are developing artificial intelligence tools to support discharge planning for the Royal Perth Hospital trial.

Several additional services have also joined East CareConnect, including the **Voluntary Assisted Dying Service**, **Aged Care Assessment Team** and **GP Liaison Service**. These services help deliver and coordinate care beyond traditional hospital settings through a mix of virtual, in-home and community-based approaches.

Virtual services are now a core part of how EMHS delivers care, building on a solid foundation of accessibility and equity. East CareConnect continues to support a more connected, future-focused healthcare system.

Digital controlled drug register delivers better oversight and efficiency

A digital system was implemented over 10 months commencing in April 2025, to record and track controlled medications across our hospital network. The system significantly improves governance and oversight, streamlines workflows, and enhances the efficiency in the management of controlled Schedule 8 (S8) and Schedule 4 Restricted (S4R) medications.

Our rollout of the **MedX Electronic Controlled Substance Register (ECSR)** was completed in February 2026. We became the first WA Health Service Provider to fully manage controlled S8 and S4R medications electronically.

This also marked Australia’s first closed-loop system to track medications from Pharmacy distribution to ward receipt, with full tracking back to Pharmacy.

Key features and benefits include real time medication tracking, secure user logins, audit trails, automated scheduled ordering, and reduced administrative burden on staff.

EMHS Executive Director of Nursing, Midwifery and Patient Support Services, Dori Lombardi said, “The achievement is about more than technology. It’s about strengthening governance, improving safety and supporting our staff with systems that make their work easier and more reliable.”

The ECSR was introduced after sector-wide Corruption and Crime Commission audits in 2017 and 2018 identified the need for electronic management of S8 and S4R medications.

It is also part of a broader WA Health shift towards modern, paperless medication management systems and processes.

> “The achievement is about more than technology. It’s about strengthening governance, improving safety and supporting our staff with systems that make their work easier and more reliable.”

This year
Transformation through innovation and research

Without medical research, advances in diagnosis and treatment would not occur. At EMHS, we are unlocking new discoveries to improve the quality of healthcare available to all Western Australians, with exciting implications for patients across the world.

2025-26 research and innovation at a glance

84
New research projects

5
Research projects conducted with WA universities

20
Investigator-initiated research projects conducted by local staff and sites within WA Health

24
Events (excluding meetings) held in the Innovation Hub space with 362 total attendees (38% of attendees were external to EMHS)

24
Research projects conducted with not-for-profit organisations and institutions

26
Projects supported through EMHS Innovation project management services

35
Clinical trials commenced

3
Innovation interns completed their internship project

Robotics and AI power RPH innovation

A new robotic system has been introduced at Royal Perth Hospital (RPH) to assist surgeons with complex general and urology surgery – with significant benefits for patients.

The da Vinci Surgical System – the latest step in our surgical innovation – came into use in April 2026.

The state-of-the-art equipment allows RPH's highly skilled surgeons to perform minimally invasive procedures through tiny incisions with enhanced precision, dexterity and control.

For patients, it means smaller scars, less time under anaesthesia and a quicker recovery.

Royal Perth Bentley Group Medical Co-Director, Surgical Division, Dr Eva Denholm, says the system is a fabulous addition to the RPH surgical service.

"It has been a seamless commissioning thanks to the commitment of our multidisciplinary working group," Eva says.

"Bringing this program online for our patients at East Metropolitan Health Service will provide significant benefits for many years to come."

Partly funded by the RPH Research Foundation, the da Vinci system is the latest technological advance to enhance our health care.

It follows last year's addition of the ROSA Knee System to assist surgeons with knee surgery.

As well as robotic advances, RPH also this year began trialling the use of an artificial intelligence (AI) system to optimise patient flow.

Under the $700,000 pilot, funded by the State Government, the logistics and planning system aims to predict length of stay and streamline hospital workflows to improve bed availability.

Software flags critical tasks required for discharge such as laboratory tests, imaging, allied health clearance, pharmacy medication preparation and discharge summaries, helping coordinate care more efficiently.

The pilot began in June 2026 and is planned to run for a year.

For patients, it means smaller scars, less time under anaesthesia and a quicker recovery.

Giving patients a voice

The Communication and Assistive Technology Service (CATS) is a team within EMHS' Health Technology Management Unit (HTMU) that provides specialist multidisciplinary assessment and loan equipment to inpatients and outpatients who need access to assistive and communication technology to improve independence and overcome limitations in speech and mobility.

This year, CATS and the EMHS Innovation team have collaborated on an internship project, run by Senior Speech Pathologist, Libby Sinclair, to set up a pilot **Voice Banking Clinic** for WA patients at risk of losing their natural speech. This new service was co-designed with patients and referrers.

Voice cloning has emerged as a product of increasing interest to patients, where patients can generate a highly realistic AI digital copy of their voice that can speak on communication devices and mobile phones. This helps preserve identity and a sense of self when they are no longer able to speak. While the technology has existed commercially for several years, patients were struggling to access these products due to a range of technical and knowledge barriers.

Through collaboration with the Scientific Computing team in HTMU, the Voice Banking Clinic has developed an in-house AI audio cleaning and voice cloning tool, which will vastly improve staff efficiency when editing patient voice recordings for cloning and ensure all patient voice data is stored and processed within EMHS.

This cloning tool will offer patients increased control and choice when voice cloning in the future.

The clinic has established patient pathways for recording and cloning their voices in clinic, at home and remotely using a range of supported processes that provide the necessary equipment and support.

The pilot received 23 referrals over 4 months, with 9 patients successfully preserving their voice, and 12 in progress. All consumers have indicated satisfaction with their completed voice.

Landmark partnership in healthcare innovation

EMHS is leading the way in healthcare innovation, with the signing of a Memorandum of Understanding (MoU) with The University of Western Australia (UWA).

The MoU was enacted through Perth Biodesign – marking an exciting new chapter in a partnership already delivering real results for our clinicians and patients.

The MoU was celebrated on 22 May 2026 at the EMHS Innovation Hub at Royal Perth Hospital (RPH), which welcomed an international Perth Biodesign delegation as part of the organisation's 10-year anniversary celebrations.

Representatives from leading innovation and MedTech organisations were in attendance – including Stanford University, the New England Medical Innovation Centre, the University of Galway, and BioInnovate Ireland – placing EMHS firmly on the global stage of healthcare innovation.

The partnership formalises a collaboration growing since 2023 through the UWA Biomedical Engineering Capstone Program, which pairs final-year engineering students with EMHS clinicians to tackle real clinical challenges. Working over 9-months, using the Biodesign methodology, student teams develop innovative solutions that EMHS can assess for real-world implementation.

Our clinicians gain fresh perspectives and exposure to structured innovation thinking, while students benefit from working on problems that genuinely matter.

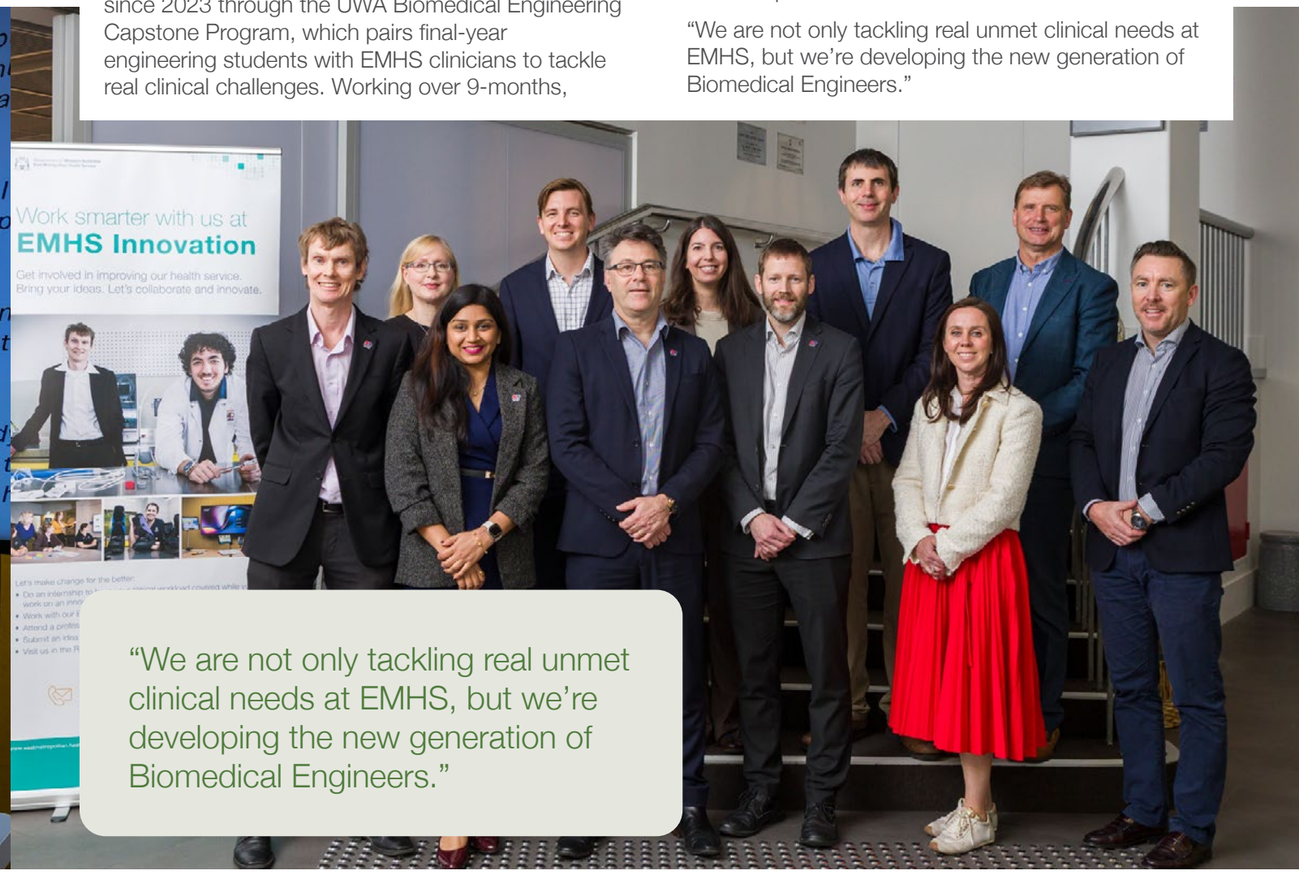
With the MoU running through to 2029, EMHS and UWA are committed to deepening this partnership – continuing to lead the way in building a culture of innovation that benefits our staff, our students, and our community.

Dr David Morrison, Innovation Technical Lead at the RPH Innovation Hub, has overseen the growth of the collaboration.

"The students grow so much over the 9-month program," David explained.

"They are exposed for the first time to the challenges of a large and complex health system and have to innovate possible solutions.

"We are not only tackling real unmet clinical needs at EMHS, but we're developing the new generation of Biomedical Engineers."



"We are not only tackling real unmet clinical needs at EMHS, but we're developing the new generation of Biomedical Engineers."

EMHS team helps in Staphylococcus treatment

Two EMHS hospitals are involved in a worldwide trial which has found that the broad-spectrum antibiotic Cefazolin is the best first option for treating all susceptible Staphylococcus cases.

The finding has been submitted for publication in the prestigious New England Journal of Medicine.

Staphylococcus aureus, commonly known as golden Staph, is one of the most serious bloodstream bacterial conditions, with about 5,000 infections a year in Australia.

Associate Professor Owen Robinson said the SNAP trial (Staphylococcus aureus Network Adaptive Platform) has, so far, involved 265 patients at Royal Perth Hospital (RPH) and 33 patients at Armadale Hospital (AH) – as well as patients from 2 other WA hospitals – and its findings have dramatically changed clinical practice.

“Our main aim has been to establish which ‘backbone’ antibiotic is the best,” Owen said.

“Data analysis has discovered that Cefazolin is superior to Flucloxacillin and now Cefazolin has become the preferred agent to prescribe,” he said.

Joining Owen in the research team are doctors David New, Tim Whitmore and Katherine Norton from Royal Perth and Armadale Hospitals.

Since it started in 2022, more than 12,000 patients across 15 countries and 150 hospitals - including Fiona Stanley Hospital and Perth Children’s Hospital - have joined the study.

Their combined interest is based on the seriousness of Staphylococcus and the fact that little progress has been made on improving treatment options in recent decades.

When the bacteria enters the bloodstream, it can cause an overwhelming immune response, called sepsis, leading to possible organ failure and, in 15 to 20 per cent of cases, death.

Patients are hospitalised and typically receive intravenous antibiotics for at least 2 weeks.

For information about the SNAP Trial, visit SNAP Trial – Staphylococcus aureus Network Adaptive Platform Trial

“Our main aim has been to establish which ‘backbone’ antibiotic is the best”

Associate Professor Owen Robinson (inset), Dr David New, Dr Katherine Norton and Dr Tim Whitmore

Snakebite study helps define antivenom use

A long-term snakebite study involving hundreds of patients in emergency departments across Australia has radically changed the treatment for victims, according to RPH Clinical Toxicologist and Researcher Dr Jessamine Soderstrom.

By collecting clinical details and blood serum from patients over the past 20 years, Jessamine said researchers had answered many questions about how venom works, the need to administer early antivenom and the doses required.

The Australian Snakebite Project (shortened to ASP – the same name as a species of snake) is being coordinated with Dr Geoff Isbister at the Calvary Mater Newcastle Hospital in New South Wales, along with Jessamine from the RPH Centre for Clinical Research in Emergency Medicine.

The latest research paper from ASP describes the cohort of patients who have early cardiovascular collapse from snake venom – primarily from brown snakes.

Collapse occurs within an hour of the bite and, sadly, 16 per cent of these patients do not survive.

“The participation of hospitals across Australia has been invaluable in determining the mechanism of how venom works,” Jessamine said

“We still have many questions to answer about the effects of different venoms and refining the treatment required,” she added.

In WA, the research involves RPH, Sir Charles Gairdner, Fiona Stanley and Rockingham General hospitals, Armadale Hospital and regional hospitals under the WA Country Health Service.

Between 2005 and 2020, about 2,180 people with snakebites around the country were recruited to ASP. This included 1,259 who had been envenomed and 182 from WA, mainly from brown snakes and tiger snakes.

The project, initially funded by the National Health and Medical Research Council, aimed to:

- understand the clinical picture produced by different snakes
- define how much antivenom is needed and the timing to administer it
- determine the use and role of blood products in reversing some of the toxicity from snake bites
- understand how venom works.

“The ASP study has changed the way we manage snake bites, in particular the dose and timing of antivenom. We now know that the early use of antivenom prevents some of the damage from venom to muscles and nerves,” Jessamine said.

“The participation of hospitals across Australia has been invaluable in determining the mechanism of how venom works”

RPH researcher and Clinical Toxicologist Dr Jessamine Soderstrom holds lifesaving antivenom

RPH Research Foundation

In 2025, the RPH Research Foundation launched its inaugural **Ignition Grants Program**, investing $500,000 to support bold, early-stage research with strong potential to improve patient care.

The program awarded up to $100,000 per project to 5 projects led by early and mid-career researchers across EMHS in cardiac care, intensive care and advanced therapies, enabling them to test innovative ideas, generate critical preliminary data, and accelerate pathways to real-world clinical impact.

The RPH Research Foundation also awarded $99,694 across 5 innovative projects led by nursing and allied health professionals with the **2026 Nursing and Allied Health Grants**. These grants support practical, patient-focused research that address everyday challenges in healthcare, from improving communication and cultural understanding, to testing new models of care.

On Friday 31 October 2025, the RPH Research Foundation held its annual Research Awards Day.

Dr Chris Lim and Dr Courtney Weber were co-winners of the Professor Lyn Beazley AO **Emerging Leader Award**, while Rebecca Crellin was the recipient of the **Doreen McCarthy Nursing Research Award**. Amada Quek received the **Early Career Publication Award**, and the **Mentorship Award** went to Consultant Haematologist Professor Wendy Erber.

Dr Sarah Hug, Coordinating Principal Investigator of RPH Research Foundation Nursing and Allied Health Grant-funded project **What does good chronic obstructive pulmonary disease (COPD) care look like? Improving everyday conversations between clinicians and people with COPD**

Telethon backs groundbreaking CAR T-Cell research for children with neuroblastoma

The RPH Research Foundation also received funding from Telethon to support an innovative research project aimed at advancing a potentially life-saving treatment for children with one of the most aggressive forms of cancer.

Led by Associate Professor Zlatibor Velickovic, this project is laying the groundwork for a new immunotherapy approach using GD2-directed CAR T-cell therapy. Neuroblastoma is the most common solid tumour in early childhood and remains one of the deadliest paediatric cancers, with children who relapse facing survival rates of less than 10 per cent.

With Telethon's support, the team at Cell and Tissue Therapies WA will undertake a pilot study to establish the manufacturing processes needed to produce these specialised CAR T-cells in WA. This includes developing Good Manufacturing Practice (GMP) protocols, validating production methods and assessing scalability to enable future clinical trials.

This project is believed to be the first initiative in Australia to establish GMP manufacturing capability for GD2-targeted CAR T-cell therapy for paediatric neuroblastoma. By building this capability locally, WA children and their families may one day have access to cutting-edge treatment closer to home, reducing the need to travel interstate or overseas during an already challenging time.

Bringing advanced therapy closer to home

In 2025–26, Cell and Tissue Therapies WA (CTTWA), located at Royal Perth Hospital (RPH), secured a variation to its Therapeutic Goods Administration (TGA) manufacturing licence, enabling it to produce Chimeric Antigen Receptor (CAR) T-cell and tumour-infiltrating lymphocytes (TILs) therapies for clinical use.

CTTWA is WA's only hospital-based TGA-licensed manufacturer of these advanced living medicines, and one of only a few facilities of its kind in Australia. This strengthens EMHS' role in a capability of national significance.

For EMHS and the patients it serves, the impact is immediate. CAR T-cell therapies treat blood cancers, including leukaemia, lymphoma and multiple myeloma, while TIL therapy offers new hope for people with advanced melanoma.

Until now, these treatments have largely been available only through costly, time-consuming international supply. Being able to manufacture them locally, at the place of care and within the public health system, improves access and affordability for Western Australians who need them, and shows EMHS bringing some of the world's most advanced therapies directly to patients.

This year
Sustainable and high-value healthcare

Environment, Social and Governance statement

EMHS is dedicated to contributing to the sustainability of our communities. We have the responsibility to minimise our environmental impact, focusing on supporting healthy people and providing care to the communities we operate in, and being accountable to the stakeholders we serve. As part of the public health system, we will play a key role in supporting measures to build a more adaptive, resilient, and environmentally friendly future. Through every aspect of our care business, sustainability is a value that guides our operations across 3 pillars of Environment, Social and Governance (ESG).

Environment

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

Social

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

Governance

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

SHR 5

Strengthening our path to net zero

Diverting waste from landfill, climate literacy scholarships and national research exploring the benefits of green spaces in health care – these are just some of the initiatives we supported this year on the path to net-zero emissions by 2050.

A series of exciting measures has continued to strengthen our workplace culture and advance sustainable ways of working and reducing our environmental impact.

For the second year, EMHS staff were able to apply for 25 scholarships for a 2-day climate literacy training course in May 2026. After completing the course, the attendees created action plans to improve sustainability at work, including reducing waste, promoting renewable energy and switching to energy-efficient lighting.

Green spaces in the health workplace was a topic explored in a national Greenspace 4 Hospital Staff survey in early 2026 – EMHS is a partner in the research and staff were invited to take part.

Across EMHS, we have also worked to reduce emissions by fixing nitrous oxide pipelines, upgrading to LED lighting, installing energy-saving boilers and reducing waste through waste-to-energy programs.

Other initiatives this year included expanding the WA Health Corporate SmartRider scheme to encourage public transport use, improved bike storage facilities and a Buy Nothing working group promoting re-use and landfill diversion.

For the last 2 years our sustainable practices have been guided by the EMHS Environmental Sustainability Strategic Approach 2024-26.

As this concludes, our Environmental Sustainability Unit is preparing a new plan to take us through to 2030, aligned closely to the strategic direction developed by the EMHS Board.

EMHS Environmental Sustainability Framework 2022-2026

Major new infrastructure takes us into the future

The biggest growth in our 10-year history will reshape our health service and how we care for our growing community.

It includes exciting new infrastructure projects funded by the State Government's $2 billion Building Hospitals Fund, and the Federal Government.

Royal Perth Hospital (RPH)

Construction has commenced on a new, multi-storey building which will be constructed on the north-western end of the existing hospital site (S Block), with 2 levels dedicated to a purpose-built Emergency Department (ED).

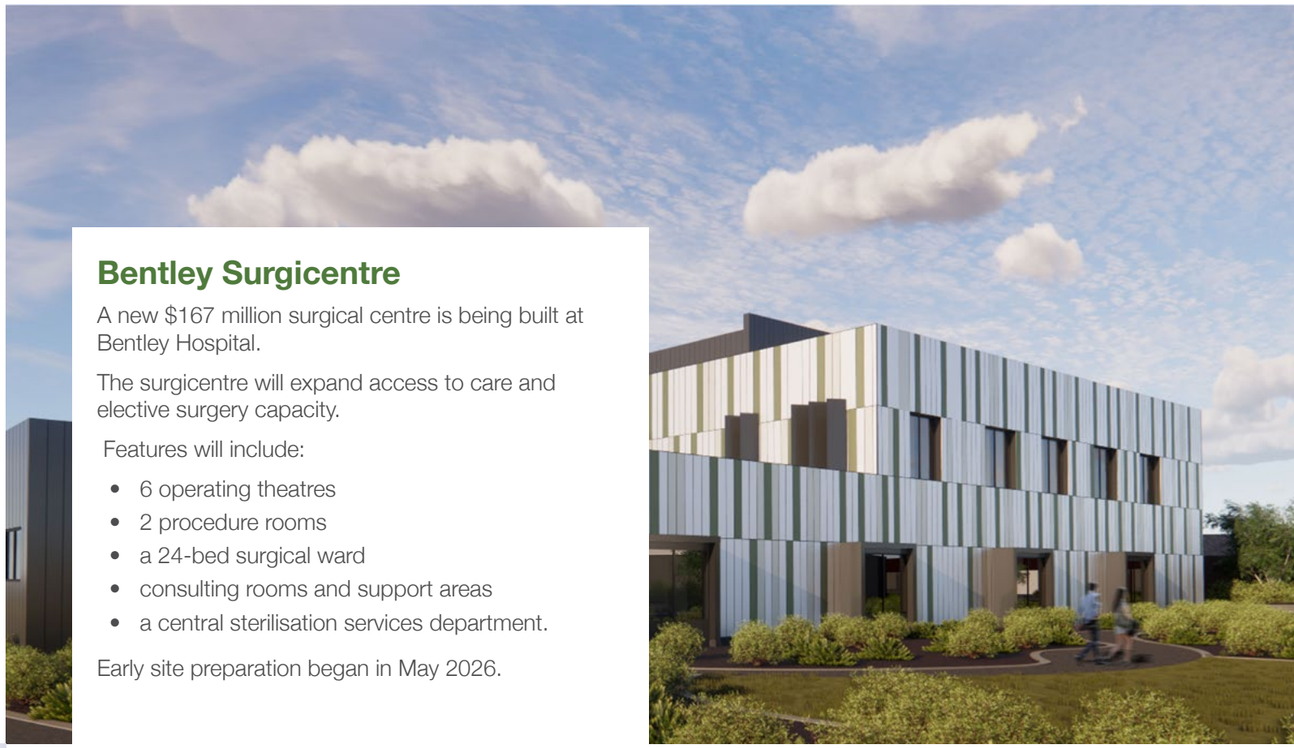
The new building will meet current and future healthcare needs and will be connected to the existing hospital via a link to integrate care and hospital operations.

The new building will feature:

- increased acute care and fast tracked capacity
- additional ambulance bays and improved patient flow
- more inpatient capacity to support future growth
- connection to the existing hospital via a link, to integrate care and operations.

This is the first stage of the RPH redevelopment, with construction expected to reach practical completion in late 2028. RPH will remain fully operational during construction, with careful monitoring to minimise impacts as much as possible.

For further information about the RPH ED expansion visit www. buildingfortomorrow.wa.gov.au/projects/royal-perth-hospital/



Bentley Surgicentre

A new $167 million surgical centre is being built at Bentley Hospital.

The surgicentre will expand access to care and elective surgery capacity.

Features will include:

- 6 operating theatres
- 2 procedure rooms
- a 24-bed surgical ward
- consulting rooms and support areas
- a central sterilisation services department.

Early site preparation began in May 2026.

Bentley Secured Extended Care Unit (SECU)

In April 2026, construction commenced on a new 24-bed SECU which will provide specialised care for involuntary mental health patients aged 18 to 64 years who experience severe mental illness - including those with intellectual disability, and who present a significant risk to themselves or others.

Designed to support longer-term treatment and rehabilitation, the facility will accommodate patients for periods ranging from 6-months to 3-years, with an expected average stay of around one year.

The key driver is the ability to provide optimal long-term clinical care and rehabilitation experience for the intended patients. The new facility will create a calm, respectful, inclusive and genuinely hopeful therapeutic 'home' that facilitates recovery and rehabilitation, with a high standard of care and treatment.

The recovery goal is to build links with community service providers and transition the individual to living back in community inpatient rehabilitation units.

Construction is planned for completion in mid-2028.

Byford Health Hub

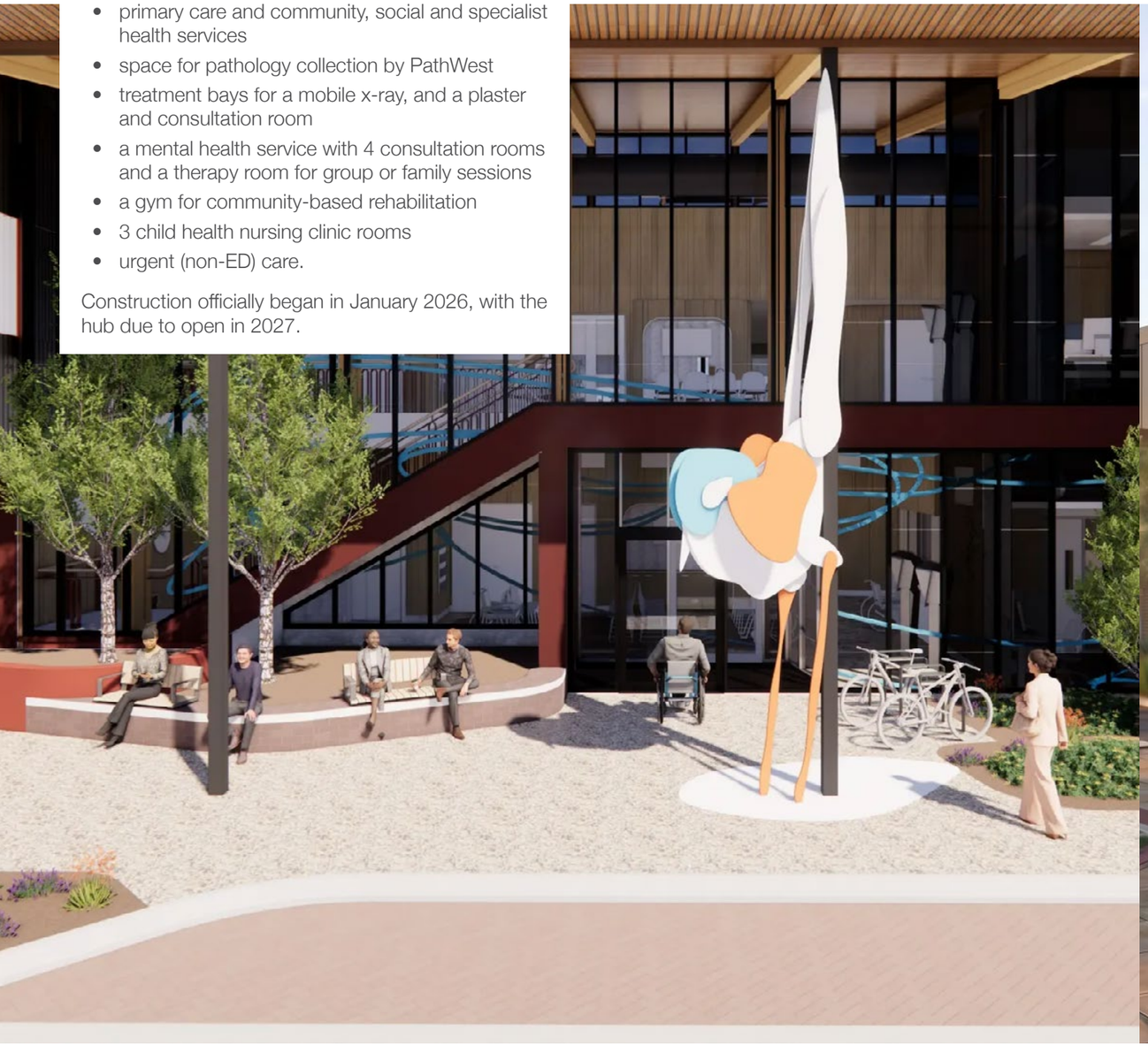
A new $42.2 million community health and urgent care hub is being built at Bushman Glade in Byford.

The 2-storey hub will provide health and social care closer to home for Serpentine-Jarrahdale residents and reduce pressure on Armadale Hospital (AH).

Features will include:

- 28 first-floor consultation and therapy rooms for in-person and telehealth appointments with WA Health outpatient services and non-WA Health providers
- primary care and community, social and specialist health services
- space for pathology collection by PathWest
- treatment bays for a mobile x-ray, and a plaster and consultation room
- a mental health service with 4 consultation rooms and a therapy room for group or family sessions
- a gym for community-based rehabilitation
- 3 child health nursing clinic rooms
- urgent (non-ED) care.

Construction officially began in January 2026, with the hub due to open in 2027.



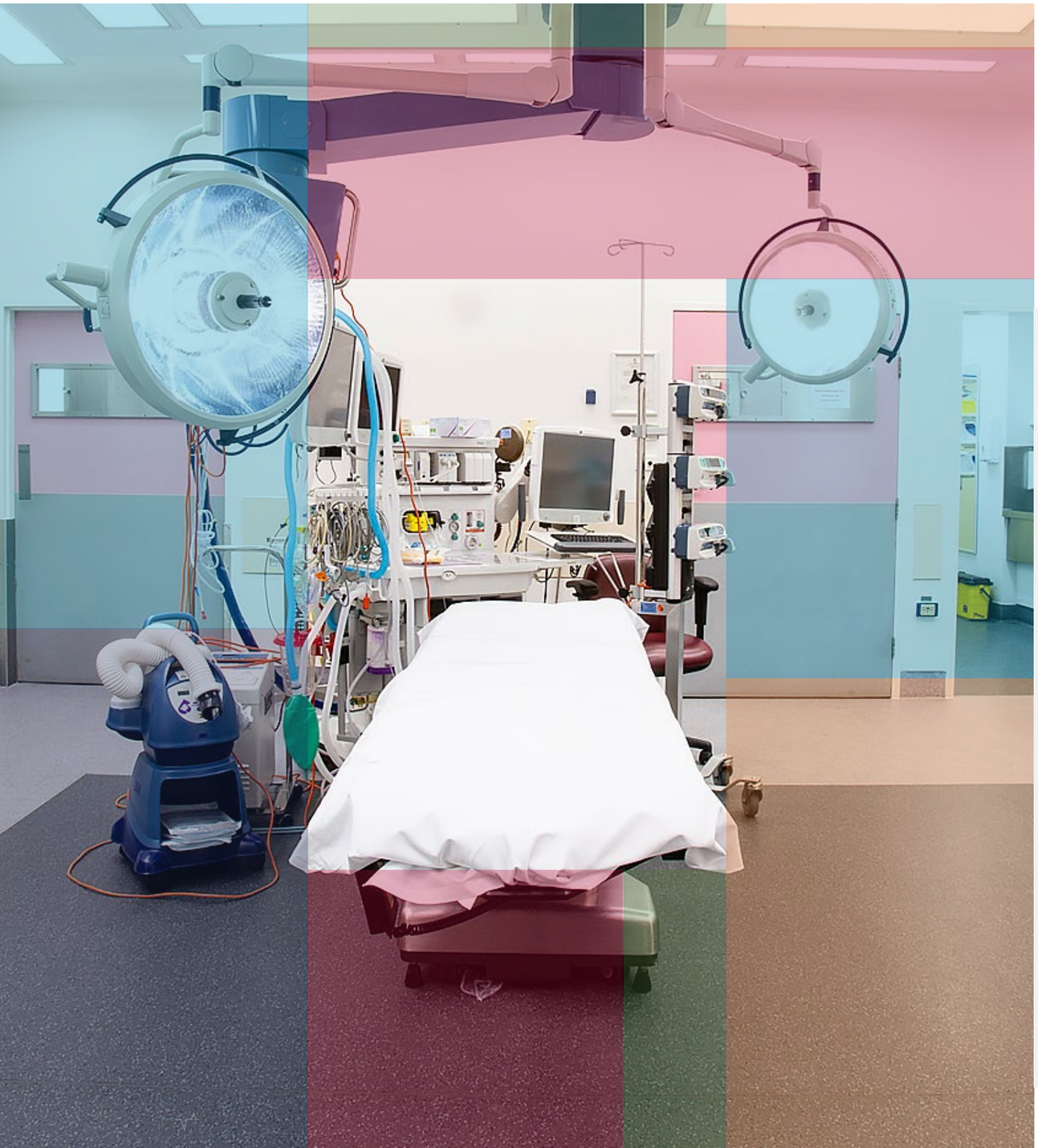
Armadale Mental Health Emergency Centre

A purpose-built Mental Health Emergency Centre (MHEC) is planned for AH. It will sit alongside existing inpatient mental health units and community services already on site.

An election commitment by the WA Government, the MHEC will be designed to improve outcomes for people in acute mental health crisis.

The MHEC is due to be completed in 2028.

Key Performance Indicators



Certification of Key Performance Indicators

East Metropolitan Health Service

Certification of Key Performance Indicators for the year ended 30 June 2026

We hereby certify the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess East Metropolitan Health Service's performance, and fairly represent the performance of the East Metropolitan Health Service for the financial year ended 30 June 2026.

Sally Carbon OAM

Board Chair
East Metropolitan Health Service

11 September 2026

Melissa Grove

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

11 September 2026

KPIs

Outcomes

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

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

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

KPI data legend

TARGET

DESIRED RESULT

UNDESIRED RESULT

Introduction

EMHS remains committed to delivering safe, high-quality care with robust processes in place to identify variations in care and outcomes, fostering system-wide learning, improving service delivery, and driving clinical improvement. The health service continues to focus on improving efficiency and sustainability without compromising the safety and wellbeing of patients and the workforce.

Overall, the 2025-26 Key Performance Indicators reflect the impact of the workforce growth required to meet this service demand and the associated workforce-related costs.

The methodology used to calculate the KPIs has also been revised for 2025-26, using an Activity Based Costing approach as the basis of the financial calculations.

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

Outcome one // Effectiveness KPI

Rationale

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

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

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

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

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

Target

The 2025 targets for unplanned readmissions for each procedure (per 1,000 separations) are outlined below. Improved or maintained performance is demonstrated by a result below or equal to target.

(a) knee replacement .....≤ 18.8
(b) hip replacement .....≤ 18.3
(c) tonsillectomy & adenoidectomy .....≤ 79.2
(d) hysterectomy .....≤ 44.1
(e) prostatectomy .....≤ 37.5
(f) cataract surgery .....≤ 2.2
(g) appendicectomy.....≤ 27.8

Results

(a) Knee replacement:

YEAR	TARGET	ACTUAL
2025	**18.8**	**8.7**
2024		14.4
2023		14.3
2022		10.4

(b) Hip replacement:

YEAR	TARGET	ACTUAL
2025	**18.3**	**10.5**
2024		7.9
2023		16.4
2022		11.1

c) Tonsillectomy & adenoidectomy:

YEAR	TARGET	ACTUAL
2025	**79.2**	**128.1**
2024		147.1
2023		58.8
2022		84.7

(d) Hysterectomy:

YEAR	TARGET	ACTUAL
2025	**44.1**	**36.1**
2024		31.3
2023		47.9
2022		25.9

(e) Prostatectomy:

YEAR	TARGET	ACTUAL
2025	**37.5**	**4.5**
2024		42.6
2023		69.4
2022		54.5

(f) Cataract surgery:

YEAR	TARGET	ACTUAL
2025	**2.2**	**1.9**
2024		1.5
2023		2.6
2022		2.3

(g) Appendicectomy:

YEAR	TARGET	ACTUAL
2025	**27.8**	**16.2**
2024		26.0
2023		22.3
2022		25.8

Commentary

EMHS strives to provide safe, high-quality care to its patients at all times. In 2025 improved performance can be seen across the majority of indicators relating to hospital readmission. EMHS continues to perform case reviews to drive clinical improvement across these cohorts. These reviews can identify variations in care and outcomes, fostering system-wide learning and service improvement.

In 2025 unplanned readmissions following tonsillectomy and adenoidectomy exceeded target. These results are based on a small number of cases where individual case reviews noted a high degree of patient complexity contributing to the need for readmission, as well as some opportunities for quality improvement to streamline care delivery including standardised delivery of patient information, ensuring consistent discharge advice and optimising pain management protocols.

EMHS will continue to monitor performance of these indicators.

Period: 2022 to 2025 calendar years
Contributing sites: Armadale Hospital, Bentley Hospital, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital (public patients)
Data source: Hospital Morbidity Data Collection (HMDC); WA Data Linkage System

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

Outcome one // Effectiveness KPI

Rationale

Elective surgery refers to planned surgery that can be booked in advance following specialist assessment, resulting in placement of the patient on an elective surgery waiting list.

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

Patients are prioritised based on their assigned clinical urgency category:

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

Target

The 2025-26 target for patients waiting over boundary for all urgency categories is 0 per cent. A result equal to target is desired.

Results

Category 1:

YEAR	TARGET	ACTUAL
2025-26	**0%**	**17.23%**
2024-25		8.7%
2023-24		7.3%
2022-23		11.9%

Category 2:

YEAR	TARGET	ACTUAL
2025-26	**0%**	**39.72%**
2024-25		35.9%
2023-24		33.4%
2022-23		38.5%

Category 3:

YEAR	TARGET	ACTUAL
2025-26	**0%**	**12.00%**
2024-25		11.4%
2023-24		10.8%
2022-23		15.8%

Commentary

In 2025-26, EMHS did not meet the elective surgery recommended target for any urgency category.

Challenges impeding EMHS' ability to meet the elective surgery targets include a growing and ageing population requiring more complex care. Additionally, availability of elective surgery is impacted by theatre availability, surgical and Intensive Care Unit (ICU) bed capacity, and ongoing workforce constraints.

Several actions were progressed to improve the elective surgery waitlist in the 2025-26 financial year:

- procurement and commissioning of a non-orthopaedic surgical robot, for use in the general surgery and urology specialties
- outsourcing surgical services privately to support meeting high demand, with a focus on orthopaedics, general surgery and urology
- additional theatre lists, including weekend elective operating lists
- revision of service models to support more efficient service allocation across the EMHS hospital network
- piloting and implementing a digital platform at Royal Perth Hospital (RPH) to support pre-surgical patient screening and preparation processes for endoscopy procedures to improve efficiency and visibility of the patient pathway.

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

- progressing a tiered service network for EMHS elective surgical services, allowing sites to operate as an integrated network with formal referral, escalation, and transfer pathways, enabling the collective delivery of care
- multi-site recruitment strategies, supporting improved patient flow between hospital sites
- expanding the contemporary workforce model across particular specialties, which supports non-medical staff to work to their full or extended scope. This can divert patients away from the elective surgery waitlist via conservative non-surgical management, and frees up capacity of medical specialists to manage more complex cases
- expanding use of the digital platform for pre-surgical patient screening and preparation to other sites and procedures
- the addition of theatres and surgical bed capacity as a result of the acquisition of St John of God Mount Lawley from 1 September 2026, the transfer of private beds at St John of God Midland to public from late August 2026, and Bentley Surgicentre from 2029.

Period:	2022-23 to 2025-2026 financial years (average of weekly census data)
Contributing sites:	Armadale Hospital, Bentley Hospital, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital (public patients)
Data source:	Elective Services Wait List Data Collection

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

Outcome one // Effectiveness KPI

Rationale

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

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

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

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

Target

The 2025 target for HA-SABSI is ≤1.00 per 10,000 occupied bed-days. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2025	**1.00**	**0.71**
2024		0.63
2023		0.82
2022		0.69

Commentary

During 2025, EMHS achieved the target for HA-SABSI, with a result equating to 29 infections from 410,957 bed-days.

EMHS participates in a state-wide surveillance program and has robust processes in place that involve the review of all cases of HA-SABSI by infection control specialists and treating clinicians. These processes are designed to identify the factors that contributed to the individual cases and closely monitor infection rates.

EMHS remains committed to minimising the occurrence of HA-SABSI as demonstrated by the following initiatives:

- continued focus of the Vascular Access Service which provides expert and specialist care in the insertion and management of invasive devices
- specialist vascular access training in the Emergency Department to enhance the skills of clinicians, particularly in handling patients with difficult intravenous access
- regular hand hygiene audits.

Period:	2022 to 2025 calendar years
Contributing sites:	Armadale Hospital, Bentley Hospital, Kalamunda Hospital, Royal Perth Bentley Group Transitional Care Unit (Bidi Wungen Kaat Centre), Royal Perth Hospital
Data source:	Healthcare Infection Surveillance Western Australia (HISWA) Data Collection

Survival rates for sentinel conditions

Outcome one // Effectiveness KPI

Rationale

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

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

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

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

Target

Please see the 2025 target for each condition noted in the results per age group. Improved or maintained performance is demonstrated by a result equal to or exceeding target.

Results

(a) Stroke

0 – 49 years:

YEAR	TARGET	ACTUAL
2025	**95.3%**	**93.8%**
2024		94.9%
2023		95.2%
2022		94.7%

50 – 59 years:

YEAR	TARGET	ACTUAL
2025	**94.7%**	**93.4%**
2024		94.6%
2023		94.0%
2022		99.0%

60 – 69 years:

YEAR	TARGET	ACTUAL
2025	**94.3%**	**96.5%**
2024		97.1%
2023		94.7%
2022		97.2%

70 - 79 years:

YEAR	TARGET	ACTUAL
2025	**92.4%**	**94.0%**
2024		94.7%
2023		92.2%
2022		94.4%

80+ years:

YEAR	TARGET	ACTUAL
2025	**87.2%**	**91.1%**
2024		93.0%
2023		89.5%
2022		89.8%

Commentary

EMHS' performance in the survival rate for stroke was slightly below target across 2 age ranges, representing a small number of patients whose severity of stroke was catastrophic or significant and unfortunately not amenable to active clinical intervention.

(b) Acute myocardial infarction (AMI)

0 – 49 years:

YEAR	TARGET	ACTUAL
2025	**98.9%**	**100.0%**
2024		98.9%
2023		98.4%
2022		99.4%

50 – 59 years:

YEAR	TARGET	ACTUAL
2025	**99.0%**	**99.6%**
2024		99.0%
2023		99.7%
2022		99.0%

60 – 69 years:

YEAR	TARGET	ACTUAL
2025	**98.3%**	**97.8%**
2024		99.4%
2023		98.6%
2022		99.4%

70 - 79 years:

YEAR	TARGET	ACTUAL
2025	**96.9%**	**97.3%**
2024		95.5%
2023		97.6%
2022		96.7%

80+ years:

YEAR	TARGET	ACTUAL
2025	**93.1%**	**96.2%**
2024		93.4%
2023		92.6%
2022		96.0%

Commentary

EMHS' performance in the survival rate for acute myocardial infarction remained within the acceptable target range, or exceeded target, for most groups. This result can be largely attributed to patients sustaining timely access to invasive coronary diagnostic and interventional procedures, as well as effective inter-hospital transfer arrangements of patients from Armadale Hospital and St John of God Midland Public Hospital to Royal Perth Hospital.

The 60-69 years age group was slightly below target, representing a small number of complex cases, with most patients in this range experiencing co-morbidities.

(c) Fractured neck of femur (FNoF)

70 - 79 years:

YEAR	TARGET	ACTUAL
2025	**98.9%**	**100.0%**
2024		99.2%
2023		99.4%
2022		99.3%

80+ years:

YEAR	TARGET	ACTUAL
2025	**97.0%**	**97.2%**
2024		97.7%
2023		97.0%
2022		97.6%

Commentary

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

Monitoring of this KPI will continue throughout 2026 to actively identify any opportunities for improvement. All inpatient deaths are further subject to peer review as part of a morbidity and mortality review process. Actions taken to address issues and lessons learnt are shared with clinical teams.

Period: 2022 to 2025 calendar years
Contributing sites: Armadale Hospital, Bentley Hospital, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital
Data source: HMDC

Percentage of admitted patients who discharged against medical advice

Outcome one // Effectiveness KPI

Rationale

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

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

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

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

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

Target

The 2025 targets for admitted patients who discharged against medical advice are:

a) Aboriginal patients ≤ 2.78%

b) Non-Aboriginal patients ≤ 0.99%

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

Results

Aboriginal patients:

YEAR	TARGET	ACTUAL
2025	**2.78%**	**7.94%**
2024		6.90%
2023		6.17%
2022		5.98%

Non-Aboriginal patients:

YEAR	TARGET	ACTUAL
2025	**0.99%**	**1.31%**
2024		1.29%
2023		1.14%
2022		1.09%

Commentary

While EMHS did not achieve DAMA performance targets in 2025, several key strategies were implemented across sites to support improvement. EMHS:

- established the Royal Perth Bentley Group (RPBG) Aboriginal Consumer Advisory Group to formally embed Aboriginal consumer partnerships and strengthen culturally informed care
- enhanced patient experience by enabling Aboriginal Health Liaison Officers (AHLOs) to provide free television access for Aboriginal patients in areas at higher-risk of leaving
- continued implementation of the EMHS Aboriginal Cultural Competency Learning Framework, including expansion of the Aboriginal Health Champions Program, to build cultural capability across the EMHS workforce
- established the DAMA and Did Not Wait (DNW) Strategy and Performance Committee (DSPC) in October 2025 to lead EMHS' strategic and system-wide efforts to improve performance.

EMHS refers to the KPIs of DAMA and Did Not Wait/ Left at own Risk for Emergency Department patients collectively as 'leave events'.

Through the EMHS Leave Events Action Plan 2026, EMHS is prioritising culturally secure safety-netting, enhanced follow-up and strengthened transitions between hospital and community-based services, in partnership with Aboriginal Community Controlled Health Services.

This work is being progressed in parallel with broader initiatives to strengthen and grow the EMHS Aboriginal Health workforce.

Period: 2022 to 2025 calendar years

Contributing sites: Armadale Hospital, Bentley Hospital, Kalamunda Hospital, Royal Perth Bentley Group Transitional Care Unit (Bidi Wungen Kaat Centre)[1], Royal Perth Hospital, St John of God Midland Public Hospital

Data source: HMDC

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

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

Outcome one // Effectiveness KPI

Rationale

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

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

This outcome measure can lead to the development and delivery of improved care pathways and interventions to improve the health outcomes of Western Australian infants and aligns to the National Core Maternity Indicators (2025) Health, Standard 04/12/2024.

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

Results

YEAR	TARGET	ACTUAL
2025	**1.90%**	**1.10%**
2024		1.47%
2023		0.99%
2022		1.05%

Commentary

EMHS achieved performance for this KPI, which is indicative of the quality of care and skilled workforce providing maternity and neonatal services in EMHS hospitals.

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

Target

The 2025 target for the percentage of live-born term infants with an Apgar score of less than 7 at 5 minutes post-delivery is ≤ 1.90 per cent. Improved or maintained performance is demonstrated by a result below or equal to target.

Period: 2022 to 2025 calendar years
Contributing sites: Armadale Hospital, Bentley Hospital[2], St John of God Midland Public Hospital (public patients only)
Data source: Midwives Notification System

[2]Bentley Hospital has only been included since the Midwifery Birth Centre opened in late 2024.

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

Outcome one // Effectiveness KPI

Rationale

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

While multiple hospital admissions over a lifetime may be necessary for someone with ongoing illness, a high proportion of readmissions shortly after discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was not adequate to maintain the patient's recovery out of hospital. Rapid readmissions place pressure on finite beds and may reduce access to care for other consumers in need.

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

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

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

Target

The 2025 target for readmissions to acute specialised mental health inpatient services within 28 days of discharge is ≤ 12.0 per cent. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2025	**12.0%**	**13.0%**
2024		14.2%
2023		14.6%
2022		14.4%

Commentary

Demand for acute mental health beds and patient complexity remains high. EMHS has demonstrated an improvement in readmission rate reducing from previous year of 14.2 per cent to 13.0 per cent.

EMHS continues to prioritise the provision of responsive and person-centred community-based services to better support patients following discharge. Recent developments include:

- Commissioning of the Aftercare Service in Royal Perth Hospital in February 2026. This is a pilot service jointly funded by the Mental Health Commission (MHC) and the WA Primary Health Alliance (WAPHA). Aftercare is designed to strengthen post-crisis support and reduce suicide risk through timely and coordinated follow-up care and is a collaborative partnership between EMHS and Non-govt organisation (NGO) partner NEAMI.
- The GP Shared Care Program for mental health consumers commenced 2025, providing a practical pathway to improve patient flow and support discharge planning. A key strength of the program has been dedicated focus on GP liaison and engagement and many GPs are now actively engaged and participating in shared care arrangements.

Period: 2022 to 2025 calendar years

Contributing sites: Armadale Hospital and Health Service, Bentley Hospital and Health Service, Royal Perth Bentley Group Transitional Care Unit (Bidi Wungen Kaat Centre)[3], Royal Perth Hospital, St John of God Midland Public Hospital

Data source: HMDC (inpatient separations)

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

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

Outcome one // Effectiveness KPI

Rationale

In 2022, one in four (6.6 million) Australians reported having a mental or behavioural condition. Therefore, it is crucial to ensure effective and appropriate care is provided not only in a hospital setting but also in the community.

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

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

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

Target

The 2025 target for percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services is ≥ 75.0 per cent. Improved or maintained performance is demonstrated by a result equal to or above target.

Results

YEAR	TARGET	ACTUAL
2025	**75.0%**	**84.9%**
2024		86.7%
2023		84.2%
2022		86.8%

Commentary

Over the past 4 years, EMHS has consistently exceeded the target for this key performance indicator.

This result demonstrates our commitment to connecting with our mental health consumers within a week of being discharged from hospital, to assist them through a key period of transition of care. EMHS 7-day follow-up dashboard continues to support compliance, data quality and accurate recording of follow-up contacts by staff.

Period: 2022 to 2025 calendar years

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

Data source: Mental Health Information Data Collection (MIND) (ambulatory mental health service contacts); HMDC (inpatient separations)

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

Average admitted cost per weighted activity unit

Outcome one // Efficiency KPI
Service one: Public hospital admitted services

Rationale

This indicator is a measure of the cost per weighted activity unit (WAU) compared with the State target, as approved by the Department of Treasury and published in the 2025-26 Budget Paper No. 2, Volume 1.

The measure ensures a consistent methodology is applied to calculating and reporting the cost of delivering inpatient activity against the state's funding allocation. As admitted services received nearly half of the overall 2025-26 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

Target

The 2025-26 target for average admitted cost per WAU is $8,183. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2025-26	**$8,183**	**$8,497**
2024-25		$8,148
2023-24		$7,871
2022-23		$7,524

Commentary

The 2025-26 financial year recorded a 5.3 per cent increase in activity and service delivery compared with the previous year.

EMHS continued to build on its virtual care strength, including significant growth in the Home Hospital (HH) program, where clinicians had increased access to virtual operational beds to provide care for patients in their homes where clinically appropriate (HH services expanded from an average of 7.2 beds per utilised day throughout 2024-25, to 29.5 beds per utilised day throughout 2025-26).

Rising workforce-related costs continued to be the primary driver of expenditure growth, alongside increased costs for medical and surgical supplies and pharmaceuticals.

Balancing cost pressures while maintaining operational efficiency and delivering high standards of patient care remain a key challenge for the health service, which has resulted in EMHS being very slightly (4 per cent) over the target value.

Period:	2022-23 to 2025-26 financial years
Contributing sites:	Armadale Hospital, Bentley Hospital, Kalamunda Hospital, Royal Perth Bentley Group Transitional Care Unit (Bidi Wungen Kaat Centre), Royal Perth Hospital, St John of God Midland Public Hospital, St John of God Mount Lawley (contracted services)
Data source:	OBM allocation application; Oracle 11i financial system; HMDC extracts; webPAS; Contracted Health Entities (CHE) discharge extracts

Average Emergency Department cost per weighted activity unit

Outcome one // Efficiency KPI
Service two: Public hospital emergency services

Rationale

This indicator is a measure of the cost per WAU compared with the State target as approved by the Department of Treasury, which is published in the 2025-26 Budget Paper No. 2, Volume 1.

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

Target

The 2025-26 target for average ED cost per WAU is $8,094. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2025-26	**$8,094**	**$8,874**
2024-25		$8,753
2023-24		$8,405
2022-23		$7,630

Commentary

Whilst the 2025-26 financial year observed a slight decline in emergency presentations (1.4 per cent), the cost of providing care within EDs rose to support the acuity and complexity of those presentations, alongside an overall increase in workforce-related costs.

The emergency area remained a priority focus area to improve operational efficiency whilst maintaining care 24/7, with examples including increased point of care testing and increased nursing rosters.

Period:	2022-23 to 2025-26 financial years
Contributing sites:	Armadale Hospital, Royal Perth Hospital, St John of God Midland Public Hospital
Data source:	OBM allocation application; Oracle 11i financial system; Emergency Department Data Collection (EDDC)

Average non-admitted cost per weighted activity unit

Outcome one // Efficiency KPI
Service three: Public hospital non-admitted services

Rationale

This indicator is a measure of the cost per WAU compared with the State (aggregated) target, as approved by the Department of Treasury, which is published in the 2025-26 Budget Paper No. 2, Volume 1.

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

Target

The 2025-26 target for average non-admitted cost per WAU is $8,328. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2025-26	**$8,328**	**$9,970**
2024-25		$8,902
2023-24		$8,297
2022-23		$7,778

Commentary

The average non-admitted cost per WAU of $9,970 is $1,642 above the 2025-26 target of $8,328. The current year's cost is also $1,068 higher than the actual cost of $8,902 when compared to the cost per unit in 2024-25.

The 2025-26 financial year saw a 3.5 per cent increase in non-admitted activity across all sites as EMHS focused on providing additional appointments.

These increases included:

- midwifery-led care at Bentley Hospital
- increased physiotherapy appointments at Bentley Hospital
- increased nurse practitioner-led specialist palliative care appointments at Kalamunda Hospital
- increased cardiology, gastroenterology, gerontology and ophthalmology services at Royal Perth Hospital.

Period: 2022-23 to 2025-26 financial years
Contributing sites: Armadale Hospital, Bentley Hospital, Kalamunda Hospital, Royal Perth Hospital, St John of God Midland Public Hospital, St John of God Mount Lawley (contracted services)
Data source: OBM allocation application; Oracle 11i financial system; Non Admitted Data Collection (NADC)

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

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

Rationale

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

Target

The 2025-26 target for average cost per bed-day in specialised mental health inpatient services is $2,094. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2025-26	**$2,094**	**$2,275**
2024-25		$2,223
2023-24		$1,867
2022-23		$2,156

Commentary

EMHS delivered specialised mental health inpatient services at a cost per bed-day of $2,275, which is higher by $181 compared to the target rate $2,094, and it is also $52 higher when compared to the 2024-25 actual result of $2,223.

EMHS saw a 4.5 per cent increase in demand for specialised mental health beds based on last year's performance, with the fully refurbished Ward 2K at RPH re-opening on 24 July 2025. The re-opening of this Mental Health ward to its full capacity has contributed to increased demand.

Period: 2022-23 to 2025-26 financial years
Contributing sites: Armadale Hospital and Health Service, Bentley Hospital and Health Service, Royal Perth Bentley Group Transitional Care Unit (Bidi Wungen Kaat Centre)[5], Royal Perth Hospital, St John of God Midland Public Hospital
Data source: OBM allocation application; Oracle 11i financial system; BedState

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

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

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

Rationale

Public community mental health services consist of a range of community-based services such as emergency assessment and treatment, case management, day programs, rehabilitation, psychosocial, residential services and continuing care. The aim of these services is to provide the best health outcomes for the individual through the provision of accessible and appropriate community mental health care.

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

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

Target

The 2025-26 target for average cost per treatment day of non-admitted care provided by mental health services is $637. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2025-26	**$637**	**$449**
2024-25		$447
2023-24		$494
2022-23		$451

Commentary

Community Mental Health services continue to transition to activity based funding with a 9.3 per cent increase in recorded treatment episodes, which supported EMHS' provision of these services at a cost significantly below target.

Period: 2022-23 to 2025-26 financial years
Contributing sites: Armadale Mental Health Service, Bentley Mental Health Service, Midland Mental Health Service, Royal Perth Hospital Mental Health Service, St John of God Midland Public Hospital Mental Health Services
Data source: OBM allocation application; Oracle 11i financial system; Mental Health Information Data Collection

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

Outcome two // Efficiency KPI
Service six: Public and community health services

Rationale

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

Population health aims to improve health by integrating all activities of the health sector and linking them with broader social and economic services and resources as described in the WA Health Promotion Strategic Framework 2022-2026. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

The 2025-26 target for average cost per person of delivering population health programs by population health units is $31. Improved or maintained performance is demonstrated by a result below or equal to target.

Results

YEAR	TARGET	ACTUAL
2025-26	**$31**	**$7**
2024-25		$15 *
2023-24		$18
2022-23		$55

*The 2024-25 original result ($20) has been re-stated using the 2025-26 costing methodology, with no change to the reported performance against the target for that year. While the costing system was in place during 2022-23 and 2023-24, the costing framework and methodology applied in those years was not compatible with the current methodology and therefore could not be reliably re-stated.

Please note:

- 2022-23 is based on the 2017-21 estimates
- 2023-24 is based on the 2018-22 estimates
- 2024-25 is based on the 2019-23 estimates
- 2025-26 is based on the 2020-24 estimates

Commentary

The methodology used to calculate this indicator was fully reviewed and updated to improve accuracy, which included some services previously classified as population health now being more accurately reported within general hospital services.

Consequently, the reported performance demonstrates a change in methodology rather than underlying change in performance.

Period: 2022-23 to 2025-26 financial years
Contributing sites: East Metropolitan Health Service health region
Data source: OBM allocation application; Oracle 11i financial system; Estimated Resident Populations for 2020-2024 and projection of 2025 population provided by the Epidemiology Directorate, Public and Aboriginal Health Division, WA Department of Health

Financials

Certification of Financial Statements

For the financial year ended 30 June 2026

The accompanying financial statements of the East Metropolitan Health Service have been prepared in compliance with the provisions of the *Financial Management Act 2006* from proper accounts and records to present fairly the financial transactions for the financial year ended 30 June 2026 and the financial position as at 30 June 2026.

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

Sally Carbon OAM
Board Chair
East Metropolitan Health Service

11 September 2026

Melissa Grove
Chair, EMHS Board Audit and Risk Committee
East Metropolitan Health Service

11 September 2026

Neil Cowan
Chief Finance Officer
East Metropolitan Health Service

11 September 2026

Auditor General

INDEPENDENT AUDITOR'S REPORT

2026

East Metropolitan Health Service

To the Parliament of Western Australia

Report on the audit of the financial statements

Opinion

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

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

In my opinion, the financial statements are:

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

Basis for opinion

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

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

Responsibilities of the Board for the financial statements

The Board is responsible for:

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

7th Floor Albert Facey House 469 Wellington Street Perth MAIL TO: Perth BC PO Box 8489 Perth WA 6849 TEL: 08 6557 7500

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

Report on the audit of controls

Opinion

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

In my opinion, in all material respects, the controls exercised by the Health Service are sufficiently adequate to provide reasonable assurance that the controls within the system were suitably designed to achieve the overall control objectives identified as at 30 June 2026, and the controls were implemented as designed as at 30 June 2026.

The Board's responsibilities

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

Auditor General's responsibilities

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

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

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

Limitations of controls

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

Report on the audit of the key performance indicators

Opinion

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

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

The Board's responsibilities for the key performance indicators

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

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

Auditor General's responsibilities

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

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

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

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

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

Other information

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

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

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

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

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

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

A. Morrissey

Aloha Morrissey
Acting Auditor General
Perth, Western Australia
11 September 2026

East Metropolitan Health Service
Statement of comprehensive income
For the year ended 30 June 2026

	Note	2026 $000	2025 $000
Cost of services			
Expenses			
Employee benefits expense	3.1.1	1,485,160	1,375,658
Contracts for services	3.2	462,090	420,078
Patient support costs	3.3	346,854	317,888
Fees for contracted medical practitioners	3.4	34,859	34,995
Finance costs	7.2	732	738
Depreciation and amortisation expense	5.5	81,425	61,430
Repairs, maintenance and consumable equipment	3.5	44,916	43,096
Other supplies and services	3.6	17,923	16,003
Cost of sales	4.6	8,885	4,691
Other expenses	3.7	163,147	149,196
Total cost of services		2,645,991	2,423,773
Income			
Patient charges	4.3	77,174	66,215
Other fees for services	4.4	131	543
Commonwealth grants and contributions	4.2	-	15,600
Other grants and contributions	4.2	2,966	2,667
Donation income	4.5	557	567
Sales and service revenue	4.6	9,120	4,205
Other income and recoveries	4.7	62,468	60,854
Total income other than income from State Government		152,416	150,651
Net cost of services		2,493,575	2,273,122
Income from State Government			
Department of Health - Service Agreement:			
- State component	4.1	1,305,247	1,198,728
- Commonwealth component	4.1	675,521	601,711
Mental Health Commission - Service Agreement	4.1	320,784	295,968
Income from other state government agencies	4.1	39,439	49,010
Resources received	4.1	99,097	93,971
Total income from State Government		2,440,088	2,239,388
Deficit for the period		(53,487)	(33,734)
Other comprehensive income			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.9	146,716	323,588
Total other comprehensive income		146,716	323,588
Total comprehensive income for the period		93,229	289,854

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

See also note 2.2 'Schedule of income and expenses by service'.

East Metropolitan Health Service
Statement of financial position
As at 30 June 2026

	Note	2026 $000	2025 $000
Assets			
Current assets			
Cash and cash equivalents	7.3.1	66,813	96,527
Restricted cash and cash equivalents	7.3.1	63,011	50,468
Receivables	6.1	46,895	49,337
Inventories	6.3	7,615	7,184
Other current assets	6.4	1,511	1,750
Total current assets		185,845	205,266
Non-current assets			
Receivables	6.1	52,994	42,732
Amounts receivable for services	6.2	842,529	781,637
Property, plant and equipment	5.1	1,137,335	1,027,472
Intangible assets	5.2	130	79
Right-of-use assets	5.3	11,695	14,523
Service concession assets	5.4	441,800	405,056
Total non-current assets		2,486,483	2,271,499
Total assets		2,672,328	2,476,765
Liabilities			
Current liabilities			
Payables	6.5	172,789	157,251
Grant liabilities	6.6	955	955
Lease liabilities	7.1	6,444	4,641
Employee benefits provisions	3.1.2	307,019	287,567
Other current liabilities	6.7	1,902	1,271
Total current liabilities		489,109	451,685
Non-current liabilities			
Employee benefits provisions	3.1.2	48,717	45,564
Lease liabilities	7.1	9,259	12,805
Total non-current liabilities		57,976	58,369
Total liabilities		547,085	510,054
Net assets		2,125,243	1,966,711
Equity			
Contributed equity	9.9	1,425,015	1,359,712
Reserves	9.9	787,455	640,739
Accumulated deficit		(87,227)	(33,740)
Total equity		2,125,243	1,966,711

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

East Metropolitan Health Service
Statement of changes in equity
For the year ended 30 June 2026

	Note	2026 $000	2025 $000
Contributed equity	9.9		
Balance at start of period		1,359,712	1,312,747
Transactions with owners in their capacity as owners:			
Contribution by Owners – Capital appropriations administered by Department of Health		65,303	35,453
Other contributions by owners		-	11,512
Balance at end of period		1,425,015	1,359,712
Reserves	9.9		
Asset revaluation reserve			
Balance at start of period		640,739	317,151
Other comprehensive income for the period		146,716	323,588
Balance at end of period		787,455	640,739
Accumulated surplus			
Balance at start of period		(33,740)	(6)
Deficit for the period		(53,487)	(33,734)
Balance at end of period		(87,227)	(33,740)
Total equity			
Balance at start of period		1,966,711	1,629,892
Total comprehensive income for the period		93,229	289,854
Transactions with owners in their capacity as owners		65,303	46,965
Balance at end of period		2,125,243	1,966,711

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

East Metropolitan Health Service
Statement of cash flows
For the year ended 30 June 2026

	Note	2026 $000 Inflows/(Outflows)	2025 $000 Inflows/(Outflows)
Cash flows from State Government			
Contribution by Owners – Capital Appropriations administered by Department of Health		65,303	36,112
Service agreement - Department of Health		1,919,876	1,741,055
Service agreement - Mental Health Commission		320,784	295,968
Funds received from other state government agencies		39,439	49,010
Net cash provided by State Government		2,345,402	2,122,145
Utilised as follows:			
Cash flows from operating activities			
Payments			
Employee benefits		(1,453,928)	(1,318,273)
Supplies and services		(955,912)	(871,651)
Finance costs		(732)	(738)
Receipts			
Receipts from customers		68,933	76,917
Other grants and contributions		2,966	2,667
Donations received		288	95
Other receipts		68,850	59,961
Net cash used in operating activities	7.3.2	(2,269,535)	(2,051,021)
Cash flows from investing activities			
Payments			
Purchase of non-current assets		(79,875)	(48,787)
Receipts			
Proceeds from sale of non-current assets		-	(41)
Net cash used in investing activities		(79,875)	(48,828)
Cash flows from financing activities			
Payments			
Principal elements of lease payments		(2,901)	(2,752)
Payment to accrued salaries account		(10,262)	(7,843)
Net cash used in financing activities		(13,163)	(10,595)
Net increase/(decrease) in cash and cash equivalents		(17,171)	11,701
Cash and cash equivalents at the beginning of the period		146,995	135,294
Total cash and cash equivalents at the end of the period	7.3.1	129,824	146,995

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

East Metropolitan Health Service
Notes to the financial statements
As at 30 June 2026

Note 1 Basis of preparation

East Metropolitan Health Service (the Health Service) is a Government not-for-profit entity controlled by the State of Western Australia, which is the ultimate parent.

A description of the nature of its operations and its principal activities have been included in the 'Governance/Overview' which does not form part of these financial statements.

These annual financial statements were authorised for issue by the Accountable Authority of the Health Service on 11 September 2026.

Statement of compliance

The financial statements constitute general purpose financial statements that have been prepared in accordance with Australian Accounting Standards (AASs), the Financial Management Act 2006 (FMA), the Treasurer's Instructions (TIs) and other authoritative pronouncements of the Australian Accounting Standards Board (AASB) as applied by TIs. Several of these are modified by TIs to vary application, disclosure, format and wording.

The FMA and TIs take precedence over AASs and other authoritative pronouncements of the AASB. Where modification is required and has a material or significant financial effect upon the reported results, details of that modification and the resulting financial effect are disclosed in the notes to the financial statements.

Basis of preparation

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

Judgements and estimates

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

Contributed equity

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

Note 2 Health Service outputs

How the Health Service operates

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

	Note
Health Service objectives	2.1
Schedule of income and expenses by service	2.2

2.1 Health Service objectives

Services

To comply with its legislative obligation as a WA Government agency, the Health Service operates under an Outcome Based Management framework (OBM). The OBM framework is determined by WA Health and replaces the former activity based costing framework for annual reporting from 2017-18 and beyond. This framework describes how outcomes, activities, services and key performance indicators (KPIs) are used to measure agency performance towards achieving the relevant overarching whole of government goal of strong communities, safe communities and supported families and the WA health system agency goal of delivery of safe, quality, financially sustainable and accountable healthcare for all Western Australians. The Health Service is predominantly funded by Parliamentary appropriations.

East Metropolitan Health Service
Notes to the financial statements
As at 30 June 2026

2.1 Health Service objectives (continued)

The Health Service provides the following services:

Public hospital admitted services

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

Public hospital emergency services

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

Public hospital non-admitted services

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

Mental health services

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

Aged and continuing care services

The provision of aged and continuing care services. Aged and continuing care services include programs that assess the care needs of older people, provide functional interim care or support for older, frail, aged and younger people with disabilities to continue living independently in the community and maintain independence.

Public and community health services

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2026

2.2 Schedule of income and expenses by service

	Public hospital admitted	Public hospital emergency	Public hospital non-admitted	Mental health	Aged and continuing care	Public and community health	Total
	2026 $000	2026 $000	2026 $000	2026 $000	2026 $000	2026 $000	2026 $000
Cost of services							
Expenses							
Employee benefits expense	902,010	152,221	180,745	212,752	12,014	25,418	1,485,160
Contracts for services	295,738	85,065	42,211	37,969	962	145	462,090
Patient support costs	237,752	33,929	54,422	11,944	4,394	4,413	346,854
Fees for contracted medical practitioners	26,979	3,193	4,654	33	-	-	34,859
Finance costs	30	4	11	655	14	18	732
Depreciation and amortisation expense	49,495	8,587	11,081	11,644	156	462	81,425
Repairs, maintenance and consumable equipment	24,998	4,026	6,197	5,113	199	4,383	44,916
Other supplies and services	8,531	1,507	2,053	5,516	65	251	17,923
Cost of sales	7,272	433	706	445	4	25	8,885
Other expenses	98,979	16,456	19,681	23,753	1,255	3,023	163,147
Total cost of services	1,651,784	305,421	321,761	309,824	19,063	38,138	2,645,991
Income							
Patient charges	60,383	8,833	5,908	2,016	3	31	77,174
Other fees for services	72	25	19	10	-	5	131
Other grants and contributions	5	2	2	-	-	2,957	2,966
Donation income	198	35	53	10	1	260	557
Sales and service revenue	7,412	464	755	457	5	27	9,120
Other income and recoveries	32,839	802	20,646	735	4	7,442	62,468
Total income other than income from State Government	100,909	10,161	27,383	3,228	13	10,722	152,416
Net cost of services	**1,550,875**	**295,260**	**294,378**	**306,596**	**19,050**	**27,416**	**2,493,575**
Income from State Government							
Department of Health - Service Agreement:							
- State component	902,192	161,451	204,561	13,052	13,407	10,584	1,305,247
- Commonwealth component	465,831	82,174	104,115	-	6,824	16,577	675,521
Mental Health Commission - Service Agreement	6,537	10,126	14	304,107	-	-	320,784
Income from other state government agencies	18,214	3,203	6,401	3,335	60	8,226	39,439
Resources received	57,348	13,073	16,559	11,141	676	300	99,097
Total income from State Government	1,450,122	270,027	331,650	331,635	20,967	35,687	2,440,088
Surplus/(deficit) for the period	**(100,753)**	**(25,233)**	**37,272**	**25,039**	**1,917**	**8,271**	**(53,487)**

During 2025–26, the Health Service revised the methodology used to prepare the Schedule of Income and Expenses by Service. The updated methodology adopts an activity-based costing approach, whereby costs are allocated to services based on the extent to which resources are consumed in delivering Outcome Based Management (OBM) outputs and services. Comparative figures for 2024–25 have been restated, where applicable, to ensure consistency and comparability with the current year presentation.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2026

2.2 Schedule of income and expenses by service (continued)

	Public hospital admitted	Public hospital emergency	Public hospital non-admitted	Mental health	Aged and continuing care	Public and community health	Total
	2025 $000	2025 $000	2025 $000	2025 $000	2025 $000	2025 $000	2025 $000
Cost of services							
Expenses							
Employee benefits expense	822,825	147,567	171,402	194,372	10,923	28,569	1,375,658
Contracts for services	264,560	80,404	37,800	36,370	782	162	420,078
Patient support costs	204,397	33,005	57,698	10,765	1,381	10,642	317,888
Fees for contracted medical practitioners	26,613	3,392	4,869	121	-	-	34,995
Finance costs	15	2	7	681	11	22	738
Depreciation and amortisation expense	36,919	6,771	7,594	9,258	252	636	61,430
Repairs, maintenance and consumable equipment	23,417	4,111	5,269	4,767	428	5,104	43,096
Other supplies and services	6,940	1,395	1,502	5,773	60	333	16,003
Cost of sales	4,451	5	28	207	-	-	4,691
Other expenses	88,282	15,891	18,321	22,878	970	2,854	149,196
Total cost of services	1,478,419	292,543	304,490	285,192	14,807	48,322	2,423,773
Income							
Patient charges	46,904	9,375	8,400	1,496	1	39	66,215
Other fees for services	73	14	18	6	-	432	543
Commonwealth grants and contributions	7,240	-	488	7,872	-	-	15,600
Other grants and contributions	2	2	2	-	-	2,661	2,667
Donation income	327	67	77	23	2	71	567
Sales and service revenue	4,000	-	19	186	-	-	4,205
Other income and recoveries	24,598	870	23,986	1,266	35	10,099	60,854
Total income other than income from State Government	83,144	10,328	32,990	10,849	38	13,302	150,651
Net cost of services	**1,395,275**	**282,215**	**271,500**	**274,343**	**14,769**	**35,020**	**2,273,122**
Income from State Government							
Department of Health - Service Agreement:							
- State component	829,369	149,558	183,723	11,987	9,063	15,028	1,198,728
- Commonwealth component	415,670	73,889	90,767	1	4,477	16,907	601,711
Mental Health Commission - Service Agreement	7,649	8,686	551	279,082	-	-	295,968
Income from other state government agencies	29,010	4,889	6,363	1,790	88	6,870	49,010
Resources received	54,549	12,669	15,301	10,432	330	690	93,971
Total income from State Government	1,336,247	249,691	296,705	303,292	13,958	39,495	2,239,388
Surplus/(deficit) for the period	**(59,028)**	**(32,524)**	**25,205**	**28,949**	**(811)**	**4,475**	**(33,734)**

During 2025–26, the Health Service revised the methodology used to prepare the Schedule of Income and Expenses by Service. The updated methodology adopts an activity-based costing approach, whereby costs are allocated to services based on the extent to which resources are consumed in delivering Outcome Based Management (OBM) outputs and services. Comparative figures for 2024–25 have been restated, where applicable, to ensure consistency and comparability with the current year presentation.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2026

	2026 $000	2025 $000

Note 3 Use of our funding

Expenses incurred in the delivery of services

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

	Note
Employee benefits expense	3.1.1
Employee benefits provisions	3.1.2
Contracts for services	3.2
Patient support costs	3.3
Fees for contracted medical practitioners (CMP)	3.4
Repairs, maintenance and consumable equipment	3.5
Other supplies and services	3.6
Other expenses	3.7

3.1.1 Employee benefits expense

Employee benefits	1,331,911	1,242,827
Termination benefits	615	867
Superannuation - defined contribution plans (a)	152,634	131,929
Total employee benefits expense	1,485,160	1,375,623
Add: AASB 16 Non-monetary benefits (b)	-	35
Net employee benefits	1,485,160	1,375,658

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

(b) Non-monetary employee benefits that are predominantly relating to the provision of vehicle benefits recognised under AASB 16.

Employee benefits include salaries and wages, fringe benefits plus the fringe benefits tax component and leave entitlements including superannuation contribution components.

Workers' compensation insurance expense is excluded here but included in note 3.7 'Other expenses'.

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

Superannuation is the amount recognised in profit or loss of the statement of comprehensive income comprises employer contributions paid to the GSS (concurrent contributions), the WSS, other GESB schemes or other superannuation funds. The employer contribution paid to the Government Employees Superannuation Board (GESB) in respect of the GSS is paid back into the Consolidated Account by the GESB.

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

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

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2026

	2026 $000	2025 $000

3.1.2 Employee benefits provisions

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

Current		
Annual leave (a)	149,323	136,038
Time off in lieu leave (a)	43,570	40,812
Long service leave (b)	112,659	109,760
Deferred salary scheme (c)	1,467	957
	307,019	287,567
Non-current		
Long service leave (b)	48,717	45,564
Total employee benefits provisions	355,736	333,131

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

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

Within 12 months of the end of the reporting period	110,496	100,438
More than 12 months after the end of the reporting period	82,397	76,412
	192,893	176,850

Annual leave and time off in lieu leave are not expected to be settled wholly within 12 months after the end of the reporting period and therefore considered to be 'other long-term employee benefits'. The leave liability is recognised and measured at the present value of amounts expected to be paid when the liabilities are settled using the remuneration rate expected to apply at the time of settlement.

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

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

Within 12 months of the end of the reporting period	34,760	37,536
More than 12 months after the end of the reporting period	126,616	117,788
	161,376	155,324

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

Under the advice of Government Sector Labour Relations (GSLR), casual employees of the Health Service are entitled to long service leave even if the applicable awards provide casual loading in lieu of long service leave. The provision for casual employees who are currently employed by the Health Service has been included in the long service leave balance: $10.9 million. The amount of obligation for the casual employees who are no longer employed by the Health Service has been included in the Payables (note 6.5): $1.8 million.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2026

	2026 $000	2025 $000

3.1.2 Employee benefits provisions (continued)

(c) The deferred salary scheme liabilities relate to Health Service employees who have entered into an agreement to self-fund an additional twelve months leave in the fifth year of the agreement. The provision recognises the value of salary set aside for employees to be used in the fifth year. The liability is measured on the same basis as annual leave. It is classified as a current provision as employees can leave the scheme at their discretion at any time.

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

Within 12 months of the end of the reporting period	296	273
More than 12 months after the end of the reporting period	1,171	684
	1,467	957

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

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

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

3.2 Contracts for services

Public patient services (a)	422,613	378,497
Mental health services (a)	36,981	36,321
Home and community care (a)	923	783
Other contracts	1,573	4,477
Total contracts for services	462,090	420,078

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

3.3 Patient support costs

Drug supplies	85,910	78,972
Pathology	63,112	58,508
Prosthesis	35,446	33,672
Other medical supplies and services	113,204	98,530
Domestic charges	21,746	21,060
Fuel, light and power	10,163	9,570
Food supplies	10,657	10,219
Patient transport costs	6,502	6,528
Research, development and other grants	114	829
Total patient support costs	346,854	317,888

3.4 Fees for contracted medical practitioners (CMP)

Fees for contracted medical practitioners (CMP)		
Clinical	26,423	26,250
Radiology	8,436	8,745
Total fees for contracted medical practitioners	34,859	34,995

CMP, both general practitioners and specialists, are contracted to provide medical services to a hospital via a Medical Services Agreement. CMP are independent contractors operating medical businesses and are not Health Service employees. CMP were previously known as visiting medical practitioners (VMP).

East Metropolitan Health Service
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For the year ended 30 June 2026

	2026 $000	2025 $000
3.5 Repairs, maintenance and consumable equipment		
Repairs, maintenance and consumable equipment		
Repairs and maintenance	33,444	31,140
Consumable equipment	11,472	11,956
Total repairs, maintenance and consumable equipment	44,916	43,096

Repairs and maintenance costs are recognised as expenses as incurred, except where they relate to the replacement of a significant component of an asset. In that case the costs are capitalised and depreciated. Consumable equipment costing less than $5,000 is recognised as an expense (see note 5.1 'Property, plant and equipment').

3.6 Other supplies and services		
Other supplies and services (recognised as an expense as incurred)		
Sanitisation and waste removal services	2,383	2,524
Administration and management services	5,192	3,766
Interpreter services	2,397	2,011
Security services	7,310	6,888
Outsourced health promotion	83	189
Outsourced engineering	60	177
Employee assistance	220	215
Other	278	233
Total other supplies and services	17,923	16,003

3.7 Other expenses		
Other expenses		
Services provided by Health Support Services: (a)		
ICT services	52,051	48,705
Supply chain services	9,055	8,357
Financial services	1,951	2,940
Human resources services	10,955	11,532
Workers compensation insurance	30,944	31,599
Lease expenses (b)	911	1,119
Other insurances	21,597	19,159
Legal services	675	299
Audit fees	934	1,321
Consultancy fees	6,030	5,229
Printing and stationery	3,680	3,886
Library subscription	1,780	1,616
Expected credit losses expense (c)	6,356	929
Communications	2,603	1,966
Freight, cartage and manual handling fees	889	919
Other employee related expenses	3,144	2,995
Loss on disposal of non-current assets	1,556	198
Motor vehicle expenses	767	653
Computer services	4,161	2,856
Accommodation (d)	490	435
Other	2,618	2,483
Total other expenses	163,147	149,196

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

(b) See note 5.3 'Right-of-use assets' and 7.1 'Lease liabilities'. Included within lease expenses are short-term leases with lease terms of up to 12 months and low-value leases with identified assets of up to $5,000. The lease expenses also include variable lease payments and maintenance expenses related to the leased assets.

(c) Expected credit losses expense is recognised as the movement in the allowance for expected credit losses. The allowance for expected credit losses of trade receivables is measured at the lifetime expected credit losses at each reporting date. The Health Service has established a provision matrix that is based on its historical credit loss experience. (See note 6.1.1 'Movement of the allowance for impairment of receivables').

(d) Lease payments to the Department of Housing and Works for the Government Office Accommodation.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2026

	2026 $000	2025 $000
Note 4 Our funding sources		

How we obtain our funding

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

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

4.1 Income from State Government		
Service Agreement received (a):		
Department of Health - Service Agreement - State component (b)	1,305,247	1,198,728
Department of Health - Service Agreement - Commonwealth component	675,521	601,711
Total service agreement received from Department of Health	1,980,768	1,800,439
Mental Health Commission - Service Agreement	320,784	295,968
Income from other state government agencies (c):		
Insurance Commission of Western Australia - patient fees (motor vehicle injuries)	21,599	32,301
Insurance Commission of Western Australia - non patient (other recoveries)	1,132	3,069
Road Safety Commission - Road Trauma Program (Injury Prevention)	1,576	577
South Metropolitan Health Service - Health Technology Management Services	10,521	8,365
South Metropolitan Health Service - Business Intelligence Services	1,852	2,795
Child and Adolescent Health Service - Data Services	67	-
North Metropolitan Health Service - Data Services	210	-
Other Health Service Providers	2,482	1,903
Total income from other state government agencies	39,439	49,010
Resources received from other state government agencies during the year (d):		
Services received free of charge:		
Health Support Services - shared services		
ICT services	52,051	48,705
Supply chain services	9,055	8,357
Financial services	1,951	2,940
Human resources services	10,955	11,532
PathWest - indirect costs	24,658	21,855
Department of Justice - legal services	456	200
Department of Housing and Works - rental lease management	14	13
Assets transferred in (out):	(43)	369
Total resources received	99,097	93,971
Total income from State Government	2,440,088	2,239,388

(a) Service agreement income is recognised at fair value in the period in which the Health Service gains control of the funds. The Health Service gains control of the funds at the time those funds are deposited in the bank account. If the service agreement specifies specific performance obligation(s), the income is recognised when the Health Service has satisfied its performance obligation(s).

(b) Service agreement from Department of Health comprises a cash component and a receivable (asset) component. The receivable which is the Holding Account (see note 6.2 'Amounts receivable for services (Holding Account)') comprises the budgeted depreciation expense for the year and any agreed increase in leave liabilities.

(c) Income from other state government agencies include amounts paid by other government agencies on a charge out basis (fee for service model).

(d) Resources received from other state government agencies are recognised as income (and assets or expenses) equivalent to the fair value of the assets, or the fair value of those services that can be reliably determined and which would have been purchased if not donated.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2026

	2026 $000	2025 $000
4.2 Commonwealth and other grants and contributions		
Capital grants	-	15,600
Total commonwealth grants and contributions	-	15,600
Research and other grants	2,966	2,667
Total other grants and contributions	2,966	2,667
4.3 Patient charges		
Inpatient bed charges	57,619	50,058
Inpatient other charges	6,914	5,036
Outpatient charges	12,641	11,121
Total patient charges	77,174	66,215
4.4 Other fees for services		
Non-clinical services to other health organisations	131	543
Total other fees for services	131	543
4.5 Donation income		
General public donations	557	567
Total donations	557	567
4.6 Commercial activities - sales and service revenue		
Sales:		
Cafeteria sales	4,775	4,205
Car parking fees	4,345	-
Total sales	9,120	4,205
Cost of sales:		
Cafeteria	(4,832)	(4,691)
Car parking	(4,053)	-
Total cost of sales	(8,885)	(4,691)
Gross profit/(loss)	235	(486)
4.7 Other income and recoveries		
Abatements	-	35
Rent from commercial properties	918	905
Parking	622	331
Commissions	204	173
Sponsorship	158	640
Training and education	440	35
Clinical trial income	7,055	5,032
Medical reports and certificates	69	75
Pharmaceutical Benefits Scheme (PBS)	52,364	50,247
Reversal asset revaluation decrement - land	-	2,487
Other	638	894
Total other income and recoveries	62,468	60,854

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

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

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

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2026

	2026 $000	2025 $000
Note 5 Key assets		

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

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

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

5.1 Property, plant and equipment

Land		
Carrying amount	114,472	97,524
Reconciliation:		
Carrying amount at start of period	97,524	83,441
Additions	-	1,278
Transfers from/(to) other reporting entities	-	4,760
Revaluation increments/(decrements)	16,948	8,045
Carrying amount at end of period	114,472	97,524
Buildings		
Carrying amount	847,106	802,670
Reconciliation:		
Carrying amount at start of period	802,670	551,088
Additions	11,804	2,480
Transfers from/(to) other reporting entities	-	4,857
Transfers from works in progress	2,416	20,159
Disposals	(8,937)	-
Revaluation increments/(decrements) (b)	89,921	256,786
Write-down of assets	-	-
Depreciation	(50,768)	(32,700)
Carrying amount at end of period	847,106	802,670
Site infrastructure		
Gross carrying amount	27,459	27,459
Accumulated depreciation	(15,361)	(13,825)
Carrying amount	12,098	13,634
Reconciliation:		
Gross carrying amount at start of period	27,459	27,459
Accumulated depreciation	(13,825)	(12,289)
Carrying amount at start of period	13,634	15,170
Depreciation	(1,536)	(1,536)
Carrying amount at end of period	12,098	13,634
Leasehold improvements		
Gross carrying amount	3,921	3,762
Accumulated depreciation	(3,167)	(2,891)
Carrying amount	754	871
Reconciliation:		
Gross carrying amount at start of period	3,762	3,308
Accumulated depreciation	(2,891)	(2,542)
Carrying amount at start of period	871	766
Additions	159	454
Depreciation	(276)	(349)
Carrying amount at end of period	754	871

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2026

5.1 Property, plant and equipment (continued)	2026 $000	2025 $000
Computer equipment		
Gross carrying amount	16,339	12,010
Accumulated depreciation	(8,090)	(5,818)
Carrying amount	8,249	6,192
Reconciliation:		
Gross carrying amount at start of period	12,010	7,673
Accumulated depreciation	(5,818)	(3,976)
Carrying amount at start of period	6,192	3,697
Additions	4,297	4,061
Transfers from works in progress	-	341
Transfers between asset classes	32	(40)
Depreciation	(2,272)	(1,867)
Carrying amount at end of period	8,249	6,192
Furniture and fittings		
Gross carrying amount	1,947	1,932
Accumulated depreciation	(1,513)	(1,424)
Carrying amount	434	508
Reconciliation:		
Gross carrying amount at start of period	1,932	1,913
Accumulated depreciation	(1,424)	(1,386)
Carrying amount at start of period	508	527
Additions	116	169
Disposals	-	(15)
Transfers between asset classes	(58)	(52)
Write-down of assets (a)	(34)	-
Write-off of assets	-	(12)
Depreciation	(98)	(109)
Carrying amount at end of period	434	508
Motor vehicles		
Gross carrying amount	688	688
Accumulated depreciation	(500)	(462)
Carrying amount	188	226
Reconciliation:		
Gross carrying amount at start of period	688	375
Accumulated depreciation	(462)	(113)
Carrying amount at start of period	226	262
Transfers between asset classes	-	18
Depreciation	(38)	(54)
Carrying amount at end of period	188	226

East Metropolitan Health Service
Notes to the financial statements
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5.1 Property, plant and equipment (continued)	2026 $000	2025 $000
Medical equipment		
Gross carrying amount	118,902	104,899
Accumulated depreciation	(65,507)	(57,695)
Carrying amount	53,395	47,204
Reconciliation:		
Gross carrying amount at start of period	104,899	96,346
Accumulated depreciation	(57,695)	(52,003)
Carrying amount at start of period	47,204	44,343
Additions	16,560	10,571
Transfers from/(to) other reporting entities	(48)	1,143
Transfers from works in progress	13	141
Disposals	(268)	(118)
Transfers between asset classes	47	276
Write-down of assets (a)	(288)	(64)
Write-off of assets	-	(22)
Depreciation	(9,825)	(9,066)
Carrying amount at end of period	53,395	47,204
Other plant and equipment		
Gross carrying amount	32,838	28,009
Accumulated depreciation	(11,954)	(9,992)
Carrying amount	20,884	18,017
Reconciliation:		
Gross carrying amount at start of period	28,009	22,627
Accumulated depreciation	(9,992)	(8,581)
Carrying amount at start of period	18,017	14,046
Additions	4,218	2,709
Transfers from/(to) other reporting entities	-	82
Transfers from works in progress	725	3,283
Disposals	-	(5)
Transfers between asset classes	(21)	(202)
Write-down of assets (a)	(40)	-
Write-off of assets	-	(5)
Depreciation	(2,015)	(1,891)
Carrying amount at end of period	20,884	18,017
Artworks		
Carrying amount	1,103	1,096
Reconciliation:		
Carrying amount at start of period	1,096	1,080
Additions	7	16
Carrying amount at end of period	1,103	1,096
Works in progress		
Carrying amount	78,652	39,530
Reconciliation:		
Carrying amount at start of period	39,530	37,456
Additions	43,668	28,119
Capitalised to asset classes	(3,154)	(23,925)
Write-down of assets (a)	(1,392)	(2,120)
Carrying amount at end of period	78,652	39,530

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Notes to the financial statements
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	2026 $000	2025 $000
5.1 Property, plant and equipment (continued)		
Total property, plant and equipment		
Gross carrying amount	1,243,427	1,119,579
Accumulated depreciation	(106,092)	(92,107)
Carrying amount	1,137,335	1,027,472
Reconciliation:		
Gross carrying amount at start of period	1,119,579	832,766
Accumulated depreciation	(92,107)	(80,890)
Carrying amount at start of period	1,027,472	751,876
Additions	80,829	49,857
Transfers from/(to) other reporting entities	(48)	10,842
Disposals	(9,206)	(138)
Revaluation increments/(decrements) (b)	106,869	264,830
Write-down of assets (a)	(1,753)	(2,184)
Write-off of assets	-	(39)
Depreciation	(66,828)	(47,572)
Carrying amount at end of period	1,137,335	1,027,472

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

(b) This amount includes professional and project management fees and one-off cost allowances. These amounts are included in the value of current use building assets under the current replacement cost basis.

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

The cost of a leasehold improvement is capitalised and depreciated over the shorter of the remaining term of the lease or the estimated useful life of the leasehold improvement.

Subsequent measurement
Subsequent to initial recognition as an asset, the revaluation model is used for the measurement of land and buildings and historical cost for all other property, plant and equipment. Land is carried at fair value and buildings are carried at fair value less accumulated depreciation (buildings) and accumulated impairment losses. All other items of property, plant and equipment are carried at historical cost less accumulated depreciation and accumulated impairment losses.

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

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

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

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

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

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2026 $000 2025 $000
5.1 Property, plant and equipment (continued)

Land and buildings were revalued as at 1 July 2025 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2026 and recognised at 30 June 2026. In undertaking the revaluation, fair value was determined by reference to market values for land: $5.6 million (2025: $5.5 million) and buildings: $0.9 million (2025: $0.2 million). For the remaining balance, fair value of buildings was determined on the basis of current replacement cost and fair value of land was determined on the basis of comparison with market evidence for land with low level utility (high restricted use land).

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

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

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

Significant assumptions and judgements
The most significant assumptions and judgements in estimating fair value are made in assessing whether to apply the existing use basis to assets and in determining estimated economic life. Professional judgement by the valuer is required where the evidence does not provide a clear distinction between market type assets and existing use assets. In order to estimate fair value on the basis of existing use, the current replacement costs are determined on the assumption that the buildings will be used for the same functions in the future. A major change in utilisation of the buildings may result in material adjustment to the carrying amounts.

Derecognition
Upon disposal or derecognition of an item of property, plant and equipment, any revaluation surplus relating to that asset is retained in the asset revaluation reserve.

Impairment of assets
Property, plant and equipment and intangible assets are tested for any indication of impairment at the end of each reporting period. Where there is an indication of impairment, the recoverable amount is estimated. Where the recoverable amount is less than the carrying amount, the asset is considered impaired and is written down to the recoverable amount and an impairment loss is recognised. Where an asset measured at cost is written down to recoverable amount, an impairment loss is recognised in profit or loss. Where a previously revalued asset is written down to recoverable amount, the loss is recognised as a revaluation decrement in other comprehensive income. As the Health Service is a not-for-profit entity, unless a specialised asset has been identified as a surplus asset, the recoverable amount is the higher of an asset's fair value less costs to sell and depreciated replacement cost.

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

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

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

As at 30 June 2026 there were no indications of impairment to property, plant and equipment and intangible assets.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2026

5.2 Intangible assets

	2026 $000	2025 $000
Computer software		
Gross carrying amount	503	469
Accumulated amortisation	(415)	(390)
Carrying amount	88	79
Reconciliation:		
Gross carrying amount at start of the period	469	443
Accumulated amortisation	(390)	(360)
Carrying amount at start of the period	79	83
Additions	34	20
Amortisation	(25)	(24)
Carrying amount at end of the period	88	79
Works in progress		
Carrying amount	42	-
Reconciliation:		
Carrying amount at start of period	-	-
Additions	42	-
Carrying amount at end of period	42	-
Total intangible assets		
Gross carrying amount	545	469
Accumulated amortisation	(415)	(390)
Carrying amount	130	79
Reconciliation:		
Gross carrying amount at start of period	469	443
Accumulated amortisation	(390)	(360)
Carrying amount at start of period	79	83
Additions	76	20
Amortisation	(25)	(24)
Carrying amount at end of period	130	79

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

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

Acquisitions of intangible assets costing $5,000 or more and internally generated intangible assets costing $50,000 or more are capitalised and measured at cost. Costs incurred below these thresholds are immediately expensed directly to the statement of comprehensive income.

Costs incurred in the research phase of a project are immediately expensed.

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

See note 5.1 'Property, plant and equipment' for testing assets for impairment.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2026

5.3 Right-of-use assets

	2026 $000	2025 $000
Buildings		
Gross carrying amount	20,308	20,377
Accumulated depreciation	(10,902)	(7,877)
Carrying amount	9,406	12,500
Reconciliation:		
Opening net carrying amount	12,500	13,851
Additions	196	1,969
Depreciation	(3,290)	(3,320)
Carrying amount at end of the period	9,406	12,500
Vehicles		
Gross carrying amount	3,516	2,666
Accumulated depreciation	(1,227)	(643)
Carrying amount	2,289	2,023
Reconciliation:		
Opening net carrying amount	2,023	1,044
Additions	921	1,570
Disposals (leases expired)	(4)	(49)
Depreciation	(651)	(542)
Carrying amount at end of the period	2,289	2,023
Total Right-of-use assets		
Gross carrying amount	23,824	23,043
Accumulated depreciation	(12,129)	(8,520)
Carrying amount	11,695	14,523
Reconciliation:		
Opening carrying amount	14,523	14,895
Additions	1,117	3,539
Disposals (leases expired)	(4)	(49)
Depreciation	(3,941)	(3,862)
Carrying amount at end of the period	11,695	14,523

Initial Recognition
Right-of-use assets are measured at cost which include the following:
- the net present value of the future minimum payments
- any lease payments made at or before the commencement date less any lease incentives received
- any initial direct costs, and
- restoration costs, including dismantling and removing the underlying asset (make good provision)

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

Subsequent Measurement

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

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

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

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2026

	2026 $000	2025 $000
5.3 Right-of-use assets (continued)		
The following amounts relating to leases have been recognised in the statement of comprehensive income.		
Depreciation expense of right-of-use assets		
Buildings	3,290	3,320
Vehicles	651	542
Total right-of-use asset depreciation	3,941	3,862
Lease interest expense (included in Finance cost)	732	738
Short-term leases (included in Other Expenses)	8	-
The statement of cash flows shows the following amounts relating to leases:		
Finance costs	732	738
Principal elements of lease payments	2,901	2,752

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

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

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

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

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

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

5.4 Service concession assets (SCA)		
Land SCA		
Carrying amount	17,300	14,500
Reconciliation:		
Carrying amount at start of period	14,500	12,000
Revaluation increments/(decrements)	2,800	2,500
Carrying amount at end of period	17,300	14,500
Buildings SCA		
Carrying amount	403,930	368,554
Reconciliation:		
Carrying amount at start of period	368,554	317,555
Revaluation increments/(decrements)	44,590	58,744
Depreciation	(9,214)	(7,745)
Carrying amount at end of period	403,930	368,554
Site infrastructure SCA		
Gross carrying amount	16,831	16,831
Accumulated depreciation	(2,561)	(2,195)
Carrying amount	14,270	14,636
Reconciliation:		
Gross carrying amount at start of period	16,831	16,831
Accumulated depreciation	(2,195)	(1,829)
Carrying amount at start of period	14,636	15,002
Depreciation	(366)	(366)
Carrying amount at end of period	14,270	14,636

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	2026 $000	2025 $000
5.4 Service concession assets (SCA) (continued)		
Computer equipment SCA		
Gross carrying amount	207	207
Accumulated depreciation	(207)	(207)
Carrying amount	-	-
Reconciliation:		
Gross carrying amount at start of period	207	211
Accumulated depreciation	(207)	(211)
Carrying amount at end of period	-	-
Furniture and fittings SCA		
Gross carrying amount	763	776
Accumulated depreciation	(739)	(731)
Carrying amount	24	45
Reconciliation:		
Gross carrying amount at start of period	776	776
Accumulated depreciation	(731)	(679)
Carrying amount at start of period	45	97
Depreciation	(21)	(52)
Carrying amount at end of period	24	45
Medical equipment SCA		
Gross carrying amount	6,056	6,856
Accumulated depreciation	(5,408)	(5,908)
Carrying amount	648	948
Reconciliation:		
Gross carrying amount at start of period	6,856	7,242
Accumulated depreciation	(5,908)	(5,638)
Carrying amount at start of period	948	1,604
Disposals	-	(14)
Transfers between asset classes	-	-
Write-off of assets	-	(8)
Depreciation	(300)	(634)
Carrying amount at end of period	648	948
Other plant and equipment SCA		
Gross carrying amount	12,520	12,804
Accumulated depreciation	(7,892)	(7,431)
Carrying amount	4,628	5,373
Reconciliation:		
Gross carrying amount at start of period	12,804	12,870
Accumulated depreciation	(7,431)	(6,281)
Carrying amount at start of period	5,373	6,589
Disposals	(15)	(4)
Depreciation	(730)	(1,212)
Carrying amount at end of period	4,628	5,373
Artworks SCA		
Carrying amount	1,000	1,000
Reconciliation:		
Carrying amount at start of period	1,000	1,000
Carrying amount at end of period	1,000	1,000
Computer software SCA		
Gross carrying amount	1,068	1,068
Accumulated amortisation	(1,068)	(1,068)
Carrying amount	-	-
Reconciliation:		
Gross carrying amount at start of period	1,068	1,068
Accumulated amortisation	(1,068)	(1,068)
Carrying amount at end of period	-	-

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	2026 $000	2025 $000
5.4 Service concession assets (SCA) (continued)		
Total service concession assets		
Gross carrying amount	459,675	422,596
Accumulated depreciation	(17,875)	(17,540)
Carrying amount	441,800	405,056
Reconciliation:		
Gross carrying amount at start of period	422,596	369,553
Accumulated depreciation	(17,540)	(15,706)
Carrying amount at start of period	405,056	353,847
Disposals	(15)	(18)
Revaluation increments/(decrements) (a)	47,390	61,244
Transfers between asset classes	-	-
Write-off of assets	-	(8)
Depreciation	(10,631)	(10,009)
Carrying amount at end of period	441,800	405,056

(a) This amount includes professional and project management fees and one-off cost allowances. These amounts are included in the value of current use building assets under the current replacement cost basis.

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

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

The Health Service manages a contract in relation to a 20-year public-private partnership agreement between St John of God Health Care and the State of Western Australia that was signed in 2012, to operate a hospital for public patients in Midland - St John of God Midland Public Hospital (SJOGMPH).

Where the Health Service identified existing assets which meet the conditions as set under AASB 1059, these assets have been reclassified as service concession assets and measured initially at current replacement cost in accordance with the cost approach to fair value in AASB 13 Fair Value Measurement.

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

5.5 Depreciation and amortisation expense

Depreciation and amortisation charge for the period:		
Buildings	50,768	32,700
Medical equipment	9,825	9,066
Site infrastructure	1,536	1,536
Leasehold improvements	276	349
Computer equipment	2,272	1,867
Furniture and fittings	98	109
Motor vehicles	38	54
Other plant and equipment	2,015	1,890
Right-of-use asset	3,941	3,827
Service concession asset	10,631	10,009
Total depreciation for the period	81,400	61,407
Total amortisation for the period - Computer software	25	23
Total depreciation and amortisation for the period	81,425	61,430

Useful lives
All property, plant and equipment having a limited useful life are systematically depreciated over their estimated useful lives in a manner that reflects the consumption of their future economic benefits. The exceptions to this rule include assets held for sale, land and works of art. Amortisation of finite life intangible assets is calculated on a straight-line basis at rates that allocate the asset's value over its estimated useful life. All intangible assets controlled by the Health Service have a finite useful life and zero residual value.

East Metropolitan Health Service
Notes to the financial statements
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	2026 $000	2025 $000
5.5 Depreciation and amortisation expense (continued)		

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

Buildings	50 years
Site infrastructure	50 years
Leasehold improvements	Term of the lease
Computer equipment	3 to 10 years
Furniture and fittings	2 to 20 years
Motor vehicles	3 to 10 years
Medical equipment	2 to 25 years
Other plant and equipment	3 to 50 years
Computer software	5 to15 years

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

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

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

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

Note 6 Other assets and liabilities

This section sets out the Health Service's other assets utilised for economic benefits and liabilities incurred during normal operations.

Assets	Note
Receivables	6.1
Amounts receivable for services (Holding Account)	6.2
Inventories	6.3
Other current assets	6.4
Liabilities	
Payables	6.5
Grant liabilities	6.6
Other current liabilities	6.7

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	2026 $000	2025 $000
6.1 Receivables		
Current		
Patient fee debtors (a)	29,154	24,139
Other receivables	8,924	6,991
Less: Allowance for impairment of receivables	(17,286)	(13,991)
Accrued income	19,374	25,507
GST receivable (b)	6,729	6,691
Total current	46,895	49,337
Non-current		
Accrued salaries suspense account (c)	52,994	42,732
Total receivables	99,889	92,069

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

(a) Under the Private Patient Scheme approved by the State Government, the Department of Health provides ex-gratia payments towards private patient fees not paid in full by health insurance funds. The Health Service has received $1.07 million in ex-gratia payments for the 2025-26 period (2024-25: $1.19 million). Receipt of ex-gratia payments from the Department have been applied by the Health Service against the patient fee invoices reducing the debtors balance.

Receivables are recognised at original invoice amount less any allowances for uncollectible amounts (i.e. impairment). The carrying amount is equivalent to fair value as it is due for settlement within 30 days.

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

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

(c) Accrued salaries suspense account contains amounts paid annually into the Treasurer's special purpose account. It is restricted for meeting the additional cash outflow for employee salary payments in reporting periods with 27 pay days instead of the normal 26. No interest is received on this account. This account is classified as non-current for 10 out of the 11 years.

6.1.1 Movement of the allowance for impairment of receivables		
Balance at start of period	13,991	16,151
Expected credit losses (note 3.7 'Other expenses')	6,356	929
Amounts written off during the period	(1,989)	(2,407)
Amount recovered during the period	117	1
Debt waivers during the period (a)	(1,189)	(683)
Balance at end of period	17,286	13,991

(a) Debt waivers are discretionary in nature and under justifiable and reasonable circumstances, can be used by the Accountable Authority to permanently forgive a debt.

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

Key sources of estimation uncertainty - Provision for doubtful debt
Historical debt collection trends are used to estimate impairment of receivables. Changes in the economic, political and legislative environment can affect debt collection rates. These changes may impact the carrying amount of receivables.

East Metropolitan Health Service
Notes to the financial statements
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	2026 $000	2025 $000
6.2 Amounts receivable for services (Holding Account)		
Non-current	842,529	781,637
Total amounts receivable for services	842,529	781,637

Amounts receivable for services represent the non-cash component of service appropriations. It is restricted in that it can only be used for asset replacement or payment of leave liability.
Amounts receivable for services are considered not impaired (i.e. there is no expected credit loss of the holding accounts).

6.3 Inventories		
Current		
Pharmaceutical stores - at cost	6,702	6,253
Engineering stores - at cost	913	931
Total inventories	7,615	7,184

Inventories are measured at the lower of cost and net realisable value. Costs are assigned on a weighted average cost basis. Inventories not held for resale are measured at cost unless they are no longer required, in which case they are measured at net realisable value.

6.4 Other current assets		
Current		
Prepayments	1,511	1,750
Total other assets	1,511	1,750

Other non-financial assets include prepayments which represent payments in advance of receipt of goods or services or that part of expenditure made in one accounting period covering a term extending beyond that period.

6.5 Payables		
Current		
Accrued expenses	93,407	89,772
Trade creditors	16,672	13,803
Accrued salaries	58,724	50,153
Other creditors	3,986	3,523
Total current	172,789	157,251

Payables are recognised at the amounts payable when the Health Service becomes obliged to make future payments as a result of a purchase of assets or services. The carrying amount is equivalent to fair value, as settlement is generally within 7-30 days.

TI 5.3 Timely Payment of Accounts requires payments for goods, services and construction works valued at less than $1 million, and not subject to an exemption, to be paid within 20 calendar days of the receipt of an invoice or the provision of goods or services whichever is later. Payments of over $1 million are required to be settled within 30 calendar days of the receipt of a correctly rendered invoice, or provision of goods or services whichever is later unless alternative payment terms are specified in the contract or as agreed with the vendor.

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

6.6 Grant liabilities		
Current	955	955
	955	955
Expected satisfaction of grant liabilities		
Later than 1 year, and not later than 5 years	955	955
Balance at end of period	955	955

The Health Service received funding from the Community Health and Hospital Program for the construction of Mental Health Emergency Centre at the St John of God Midland Public Hospital. The grant liabilities represent the amount unspent at the reporting date.

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Notes to the financial statements
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	2026 $000	2025 $000
6.7 Other current liabilities		
Current		
Refundable deposits	283	266
Paid parental leave scheme	185	23
Unearned income	1,018	603
Other	416	379
Total current	1,902	1,271

Note 7 Financing

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

	Note
Lease liabilities	7.1
Finance costs	7.2
Cash and cash equivalents	7.3
Reconciliation of cash	7.3.1
Reconciliation of net cost of services to net cash flows used in operating activities	7.3.2
Capital commitments	7.4

7.1 Lease liabilities

Current	6,444	4,641
Non-current	9,259	12,805
	15,703	17,446

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

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

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

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

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

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

This section should be read in conjunction with note 5.3 Right-of-use assets.

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

7.2 Finance costs

Finance costs		
Finance lease charges	732	738

Finance costs include the interest component of lease liability repayments.

East Metropolitan Health Service
Notes to the financial statements
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		2026 $000	2025 $000
7.3 Cash and cash equivalents			
7.3.1 Reconciliation of cash			
Current			
Cash and cash equivalents		66,813	96,527
Restricted cash and cash equivalents (a)		63,011	50,468
Total cash and cash equivalents at end of period		129,824	146,995

(a) Restricted cash and cash equivalents are assets, the uses of which are restricted by specific legal or other externally imposed requirements. These include medical research grants, donations for the benefits of patients, medical education, scholarships, capital projects, employee contributions and staff benevolent funds.

For the purpose of the statement of cash flows, cash and cash equivalent (and restricted cash and cash equivalent) assets comprise of cash on hand and cash at bank.

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

	Note		
Net cost of services (statement of comprehensive income)		(2,493,575)	(2,273,122)
Non-cash items			
Depreciation and amortisation expense	5.5	81,425	61,430
Expected credit loss expense	3.7	6,356	929
Services received free of charge	4.1	99,140	93,602
Net (gain)/loss on disposal of non-current assets	3.7	1,556	198
Donation of non-current assets		(270)	(473)
Write down of property, plant and equipment	3.7	1,753	2,184
Reversal asset revaluation decrement - land	4.7	-	(2,487)
Write-off of receivables	6.1.1	(3,178)	(3,090)
Adjustment for other non-cash items		(471)	(663)
(Increase)/decrease in assets			
GST receivable	6.1	(38)	(1,248)
Other current receivables	6.1	(815)	179
Inventories	6.3	(431)	(872)
Prepayments and other current assets	6.4	239	(673)
Increase/(decrease) in liabilities			
Current payables	6.5	15,538	23,383
Current employee benefits provisions	3.1.2	19,452	46,169
Other current liabilities	6.7	631	244
Non-current employee benefits provisions	3.1.2	3,153	3,288
Net cash used in operating activities (statement of cash flows)		(2,269,535)	(2,051,021)

7.4 Capital commitments

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

Within 1 year	68,132	23,977
Later than 1 year, and not later than 5 years	1,698	341
Balance at end of period	69,830	24,318

The totals presented for capital commitments are inclusive of GST.

Capital commitments of $69.8 million primarily comprise $26.3 million associated with the Byford Health Hub, a State Government election commitment to establish a health facility in the southern region; $9.7 million for capital works and equipment replacement associated with the acquisition of St John of God Mt Lawley Hospital, supporting the State Government's objective of increasing public health bed capacity; and $3.1 million for capital works and professional fees associated with the Bentley Secure Extended Care Unit, a State Government initiative to provide an additional 24 specialised mental health beds. The balance includes $12.1 million of major and minor capital works across the Health Service hospital sites relating to refurbishment, maintenance and works to sustain or increase service capacity.

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2026

Note 8 Risks and contingencies

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

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

8.1 Financial risk management

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

All financial assets and liabilities recognised in the statement of financial position, whether they are carried at cost or fair value, are recognised at amounts that represent a reasonable approximation of fair value unless otherwise stated in the applicable notes.

a) Summary of risks and risk management

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

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

In circumstances where a third party is responsible for payment, or there are legal considerations, payment of accounts can be delayed considerably. Unpaid debts are referred to an external debt collection service on a case-by-case basis, considering financial election and reasons for non-payment.

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

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

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

b) Categories of financial instruments

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

	2026 $000	2025 $000
Financial assets		
Cash and cash equivalents	66,813	96,527
Restricted cash and cash equivalents	63,011	50,468
Financial assets at amortised cost (1)	93,160	85,378
Amounts receivable for services	842,529	781,637
Total financial assets	1,065,513	1,014,010
Financial liabilities		
Financial liabilities measured at amortised cost	189,376	175,365
Total financial liabilities	189,376	175,365

(1) The amount of receivables and financial assets at amortised cost excludes GST recoverable from ATO (statutory receivable).

East Metropolitan Health Service
Notes to the financial statements
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8.1 Financial risk management (continued)

c) Credit risk exposure

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

		Days past due				
	Total	Current	< 30 days	31-60 days	61-90 days	>91 days*
	$000	$000	$000	$000	$000	$000
30 June 2026						
Expected credit loss rate		4%	11%	33%	32%	73%
Estimated total gross carrying amount at default	57,452	29,009	5,469	1,338	1,660	19,976
Expected credit losses	(17,286)	(1,152)	(628)	(438)	(535)	(14,533)
30 June 2025						
Expected credit loss rate		2%	7%	24%	32%	73%
Estimated total gross carrying amount at default	56,637	30,541	6,690	1,623	1,518	16,265
Expected credit losses	(13,991)	(744)	(500)	(387)	(491)	(11,869)

*Includes receivables with maturity dates greater than 2 years.

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

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

		Interest rate exposure				Maturity dates				
	Weighted average effective interest rate	Carrying amount	Fixed interest rate	Variable interest rate	Non-interest bearing	Nominal amount	Up to 3 months	3 months to 1 year	1 - 5 years	More than 5 years
	%	$000	$000	$000	$000	$000	$000	$000	$000	$000
2026										
Financial Assets										
Cash and cash equivalents		66,813	-	-	66,813	66,813	66,813	-	-	-
Restricted cash and cash equivalents		63,011	-	-	63,011	63,011	63,011	-	-	-
Receivables - non-interest bearing (1)		93,160	-	-	93,160	93,160	40,166	-	52,994	-
Amounts receivable for services		842,529	-	-	842,529	842,529	-	-	-	842,529
		1,065,513	-	-	1,065,513	1,065,513	169,990	-	52,994	842,529
Financial Liabilities										
Payables	-	172,789	-	-	172,789	172,789	172,789	-	-	-
Lease liabilities	4.62%	15,703	15,703	-	-	15,703	-	6,444	4,585	4,673
Other current liabilities		884			884	884	884			
		189,376	15,703	-	173,673	189,376	173,673	6,444	4,585	4,673
2025										
Financial Assets										
Cash and cash equivalents		96,527	-	-	96,527	96,527	96,527	-	-	-
Restricted cash and cash equivalents		50,468	-	-	50,468	50,468	50,468	-	-	-
Receivables - non-interest bearing (1)		85,378	-	-	85,378	85,378	42,646	-	42,732	-
Amounts receivable for services		781,637	-	-	781,637	781,637	-	-	-	781,637
		1,014,010	-	-	1,014,010	1,014,010	189,641	-	42,732	781,637
Financial Liabilities										
Payables	-	157,251	-	-	157,251	157,251	157,251	-	-	-
Lease liabilities	4.38%	17,446	17,446	-	-	17,446	-	4,641	7,700	5,105
Other current liabilities		668	-	-	668	668	668			
		175,365	17,446	-	157,919	175,365	157,919	4,641	7,700	5,105

(1) The amount of receivables excludes the GST recoverable from ATO (statutory receivable).

e) Interest rate sensitivity analysis

The Health Service does not have exposure on changes to the interest rate environment as it does not have financial instrument which depends on variable interest rates.

East Metropolitan Health Service
Notes to the financial statements
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8.2 Contingent assets and liabilities

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

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

8.2.1 Contingent assets

At the reporting date, the Health Service is not aware of any contingent assets.

8.2.2 Contingent liabilities

At the reporting date, the Health Service is not aware of any material contingent liabilities.

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

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

8.3 Fair value measurements

Assets measured at fair value **2026**	**Level 1 $000**	**Level 2 $000**	**Level 3 $000**	**Total $000**
Land (notes 5.1 'Property, plant and equipment' and 5.4 'Service concession assets (SCA)')				
Vacant land	-	-	-	-
Specialised land	-	5,613	126,159	131,772
Buildings (notes 5.1 'Property, plant and equipment' and 5.4 'Service concession assets (SCA)')				
Residential and commercial carpark	-	944	-	944
Specialised buildings	-	-	1,250,092	1,250,092
	-	6,557	1,376,251	1,382,808

Assets measured at fair value **2025**	**Level 1 $000**	**Level 2 $000**	**Level 3 $000**	**Total $000**
Land (notes 5.1 'Property, plant and equipment' and 5.4 'Service concession assets (SCA)')				
Vacant land	-	-	-	-
Specialised land	-	5,490	106,534	112,024
Buildings (notes 5.1 'Property, plant and equipment' and 5.4 'Service concession assets (SCA)')				
Residential and commercial carpark	-	234	-	234
Specialised buildings	-	-	1,170,991	1,170,991
	-	5,724	1,277,525	1,283,249

There were no transfers between Level 1 and 2 during the current and the previous period.

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

Level 1 inputs - quoted prices (unadjusted) in active markets for identical assets.

Level 2 inputs - input other than quoted prices included within level 1 that are observable for the asset, either directly or indirectly.

Level 3 inputs - input not based on observable market data.

East Metropolitan Health Service
Notes to the financial statements
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8.3 Fair value measurements (continued)

Valuation techniques to derive level 2 and level 3 fair values

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

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

The best evidence of fair value is current prices in an active market for similar properties. Where such information is not available, Western Australian Land Information Authority (Valuations and Property Analytics) considers current prices in an active market for properties of different nature or recent prices of similar properties in less active markets and adjusts the valuation for differences in property characteristics and market conditions.

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

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

For current use land assets, high utility land values are measured by drawing comparison between the subject asset as a going concern and market pricing data of assets having similar utility and service capacity.

The assessed highest and best use value is based upon comparable utility transactions and is adjusted for valuation deferment recognition. Valuation deferment is the practice of delaying the recognition or calculation of an asset's value until a future date, primarily used to manage uncertainty, account for value over time, restrictions on ownership and current use considerations. The value of the land reflects differences between public and private sector market associated with title conversion, time deferments, and other factors including encumbrances, title status, management orders or lease conditions.

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

The Health Service's hospitals and community centres are specialised buildings and their fair value is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset (i.e. current replacement cost). Current replacement cost is generally determined by estimating the current cost of reproduction or replacement of the building, on its current site, adjusted for physical deterioration and all relevant forms of obsolescence and optimisation. Obsolescence encompasses physical deterioration, functional (technological) obsolescence and economic (external) obsolescence. Current replacement cost is unlikely to be materially different from depreciated replacement cost as a measure of value in use of specialised assets that are rarely sold.

In addition, professional and project management fees estimated and added to the current replacement costs provided by Landgate for current use buildings represent significant Level 3 inputs used in the valuation process. The fair value of these assets will increase with a higher level of professional and project management fees.

East Metropolitan Health Service
Notes to the financial statements
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8.3 Fair value measurements (continued)

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

a) Review and updating of the 'as-constructed' drawing documentation.

b) Categorisation of the drawings using the Building Utilisation Categories (BUC's) which designate the functional areas typically provided by the following types of clinical facilities. Each BUC has different cost rates which are calculated from the historical construction costs of similar clinical facilities and are adjusted for the year-to-year change in building costs using building cost index.
- Nursing Posts and Medical Centres
- Metropolitan Secondary, Specialist and General Hospitals
- Tertiary Hospitals

c) Measurement of the general floor areas.

d) Application of the BUC cost rates per square metre of general floor areas.

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

The straight-line method of depreciation is applied and assumes a uniform pattern of consumption over the initial 37.5 years of asset life (up to 75% of current replacement costs). All specialised buildings are assumed to have a residual value of 25% of their current replacement costs.

The valuations are prepared on a going concern basis until the year in which the current use is discontinued. Buildings with definite demolition plan are not subject to annual revaluation. The current replacement costs at the last valuation dates for these buildings are written down to the statement of comprehensive income as depreciation expenses over their remaining useful life.

Fair value measurements using significant unobservable inputs (Level 3)

	Land	Buildings
	$000	$000
2026		
Fair value at beginning of period	106,534	1,170,991
Additions	-	14,220
Revaluation increments/(decrements) recognised in profit or loss	-	-
Revaluation increments/(decrements) recognised in other comprehensive income	19,625	133,781
Disposals	-	(8,937)
Depreciation	-	(59,963)
Fair value at end of period	126,159	1,250,092
2025		
Fair value at beginning of period	73,461	866,543
Additions	23,657	29,275
Revaluation increments/(decrements) recognised in profit or loss	1,360	-
Revaluation increments/(decrements) recognised in other comprehensive income	8,056	315,560
Depreciation	-	(40,387)
Fair value at end of period	106,534	1,170,991

Valuation processes

Western Australian Land Information Authority (Valuation and Property Analytics) determines the fair values of the Health Service's land and buildings. A quantity surveyor is engaged by the Health Service to provide an update of the current construction costs for specialised buildings. Western Australian Land Information Authority (Valuation and Property Analytics) may endorse the current construction costs calculated by the quantity surveyor for specialised buildings and calculates the current replacement costs.

East Metropolitan Health Service
Notes to the financial statements
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Note 9 Other disclosures

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

	Note
Events occurring after the end of the reporting period	9.1
Future impact of Australian Accounting Standards not yet operative	9.2
Key management personnel	9.3
Related party transactions	9.4
Related bodies	9.5
Affiliated bodies	9.6
Special purpose accounts	9.7
Remuneration of auditors	9.8
Equity	9.9
Supplementary financial information	9.10
Administered trust accounts	9.11

9.1 Events occurring after the end of the reporting period

The WA Government has acquired Mount Lawley Hospital from St John of God Health Care. The 196-bed facility will deliver additional beds into the public health system, and will be fully transitioned as a public hospital within the East Metropolitan Health Service on 31 August 2026.

Effective 26 August 2026, the 60-bed private hospital co-located within the St John of God Midland Public Hospital site, will transition into public hospital beds. This will make the Midland Public Hospital campus, a fully public hospital campus of 367 beds. The facility will continue to be operated by St John of God Health Care under the Public Private Partnership between the State and St John of God Health Care until 2035.

9.2 Future impact of Australian Accounting Standards not yet operative

The Health Service cannot early adopt an Australian Accounting Standard unless specifically permitted by TI 9 *Application of Australian Accounting Standards and Other Pronouncements* or by an exemption from TI 9. Where applicable, the Health Service plans to apply the following Australian Accounting Standards from their application date.

Title	Operative for reporting periods beginning on/after
AASB 2024-2 Amendments to Australian Accounting Standards – Classification and Measurement of Financial Instruments	1 Jan 2026
This Standard amends AASB 7 and AASB 9 as a consequence of the issuance of Amendments to the Classification and Measurement of Financial Instruments (Amendments to IFRS 9 and IFRS 7) by the International Accounting Standards Board in May 2024. The Health Service has not assessed the impact of the Standard.	
AASB 2024-3 Amendments to Australian Accounting Standards – Annual Improvements Volume 11	1 Jan 2026
This Standard amends AASB 1, AASB 7, AASB 9, AASB 10 and AASB 107 as a consequence of the issuance of Annual Improvements to IFRS Standards – Volume 11 by the International Accounting Standards Board in July 2024. The Health Service has not assessed the impact of the Standard.	
AASB 18 (NFP) Presentation and Disclosure in Financial Statements (Appendix D)	1 Jan 2028
This Standard replaces AASB 101 with respect to the presentation and disclosure requirements in financial statements applicable to not-for-profit entities. This Standard is a consequence of the issuance of IFRS 18 Presentation and Disclosure in financial Statements by the International Accounting Standards Board in April 2024. This Standard also makes amendments to other Australian Accounting Standards set out in Appendix D of this Standard. The Health Service has not assessed the impact of the Standard.	

East Metropolitan Health Service
Notes to the financial statements
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9.3 Key management personnel

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

The Board of East Metropolitan Health Service is the Accountable Authority for the Health Service.

Total compensation (includes the superannuation expense incurred by the Health Service) for key management personnel, comprising members and senior officers of the Accountable Authority for the period are presented within the following bands:

	2026	2025
Compensation of members of the Accountable Authority		
Compensation band		
$ 0 - $ 10,000	2	-
$ 10,001 - $ 20,000	2	-
$ 20,001 - $ 30,000	1	-
$ 30,001 - $ 40,000	4	1
$ 40,001 - $ 50,000	4	8
$ 50,001 - $ 60,000	2	-
$ 80,001 - $ 90,000	-	1
Total	15	10
Compensation of senior officers		
Compensation band		
$ 0 - $ 50,000	-	2
$ 50,001 - $ 100,000	3	2
$ 100,001 - $ 150,000	1	-
$ 150,001 - $ 200,000	3	-
$ 200,001 - $ 250,000	5	9
$ 250,001 - $ 300,000	7	5
$ 350,001 - $ 400,000	2	-
$ 400,001 - $ 450,000	-	1
$ 500,001 - $ 550,000	-	1
$ 550,001 - $ 600,000	1	-
Total	22	20
Short-term employee benefits (a)	5,023	4,269
Post-employment benefits	599	532
Other long-term benefits	147	89
Total compensation of key management personnel	5,769	4,890

(a) The short-term employee benefits include salary, motor vehicle benefits, district and travel allowances incurred by the Health Service in respect of senior officers.

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9.4 Related party transactions

The Health Service is a wholly-owned public sector entity that is controlled by the State of Western Australia.

Related parties of the Health Service include:

- all senior officers and their close family members, and their controlled or jointly controlled entities
- all members of the Accountable Authority, and their close family members, and their controlled or jointly controlled entities
- all cabinet ministers and their close family members, and their controlled or jointly controlled entities
- other departments and statutory authorities, including related bodies, that are included in the whole of government consolidated financial statements (i.e. wholly-owned public sector entities)
- the Government Employees Superannuation Board (GESB)

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

	Note
Income from State Government	4.1
Capital contributions from Department of Health	9.9
Superannuation payments to GESB	3.1.1
Remuneration for services provided by Office of the Auditor General	9.8
Lease payments to the Department of Finance (Government Office Accommodation and State Fleet motor vehicles)	3.7, 7.1

Material transactions with other related parties
Outside of normal citizen type transactions with the Health Service, there were no other related party transactions that involved key management personnel and/or their close family members and/or their controlled (or jointly controlled) entities.

9.5 Related bodies

A related body is a body that receives more than half of its funding and resources from an agency and is subject to operational control by that agency.

The Health Service had no related bodies during the reporting period.

9.6 Affiliated bodies

An affiliated body is a body that receives more than half its funding and resources from an agency but is not subject to operational control by that agency.

The Health Service had no affiliated bodies during the reporting period.

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	2026 $000	2025 $000

9.7 Special purpose accounts

Mental Health Commission Fund (East Metropolitan Health Service) Account

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

Balance at start of period	14,953	8,475
Receipts		
Commonwealth contributions (note 4.1)	104,611	90,456
State contributions (note 4.1)	214,821	204,972
Other	1,352	540
	335,737	304,443
Payments	(316,664)	(289,490)
Balance at end of period	19,073	14,953

H&LB Fund

The account was established on 26 May 2026 to receive royalty income from William Cook Australia Pty Ltd, donations and interest revenue. Funds held in the account are used to support research and the advancement of public health vascular surgery and medical imaging in Western Australia.

Balance at start of period	12,300	-
Receipts		
Interest	53	-
	12,353	-
Payments	-	-
Balance at end of period	12,353	-

The special purpose accounts are established under section 16(1)(d) of the *Financial Management Act 2006*.

9.8 Remuneration of auditors

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

Auditing the accounts, financial statements, controls, and key performance indicators	485	469

East Metropolitan Health Service
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	2026 $000	2025 $000

9.9 Equity

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

Contributed equity		
Balance at start of the period	1,359,712	1,312,747
Contributions by owners (a)		
Contribution by Owners – Capital Appropriations administered by Department of Health (b)	65,303	35,453
Transfer of net assets from Mental Health Commission (c)	-	11,512
Total contributions by owners	1,425,015	1,359,712
Total contributed equity at end of period	1,425,015	1,359,712

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

TI 8.8 designates non-discretionary and non-reciprocal transfers of net assets between State government agencies as contributions by owners in accordance with *AASB Interpretation 1038*. Where the transferee agency accounts for a non-discretionary and non-reciprocal transfer of net assets as a contribution by owners, the transferor agency accounts for the transfer as a distribution to owners.

(b) *TI 8.8 'Contributions by Owners Made to Wholly-Owned Public Sector Entities'* designates capital appropriations as contributions by owners in accordance with *AASB Interpretation 1038 'Contributions by Owners Made to Wholly-Owned Public Sector Entities'*.

(c) *In accordance with the Minister's direction, the assets and liabilities relating to the Next Step Drug and Alcohol Services were transferred from the Mental Health Commission to the Health Service on 18 November 2024. This transfer of assets and liabilities was formally designated as contribution by owner under AASB 1004 and forms part of the contributed equity of the Health Service.*

Breakdown of assets and liabilities transferred to the Health Service relating to the Next Step Drug and Alcohol Services is provided below. Income and expenditure attributable to the transferred activities of the Next Step Drug and Alcohol Services are not separately shown due to immateriality.

Assets	
Cash	2,969
Receivables (27th Pay)	507
Land	4,760
Buildings	4,858
Medical equipment	1,097
Plant and equipment	82
Right-of-use assets - Motor Vehicles leased	28
Other assets	225
Total assets	14,526
Liabilities	
Employee benefits provisions	(2,986)
Lease liabilities	(28)
Total liabilities	(3,014)
Net assets	11,512
Equity	
Contributed equity	11,512

Asset revaluation reserve		
Balance at start of the period	640,739	317,151
Changes in asset revaluation surplus:		
Land	19,749	8,056
Buildings	126,967	315,532
Total asset revaluation reserve at end of period	787,455	640,739

The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets on a class of assets basis. Any increment is credited directly to the asset revaluation reserve, except to the extent that the increment reverses a revaluation decrement previously recognised as an expense (see note 5.1 'Property, plant and equipment').

For land revaluation decrement recognised as an expense, see note 3.7 'Other expenses'.

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	2026 $000	2025 $000
9.10 Supplementary financial information		
a) Write-offs		
Debts written off under the authority of the Accountable Authority	1,989	2,154
Public and other property written off under the authority of the Minister	-	-
Debts written off under the authority of the Minister	-	253
	1,989	2,407
See also Note 6.1.1 Movement of the allowance for impairment of receivables		
b) Debt waivers		
Debts waived under the authority of the Accountable Authority	1,189	683
	1,189	683
9.10 Supplementary financial information (continued)		
Debt waivers are discretionary in nature and under justifiable and reasonable circumstances, can be used by the Accountable Authority to permanently forgive a debt.		
See also Note 6.1.1 Movement of the allowance for impairment of receivables		
Losses of public money, and public and other property through theft or default	-	563
Amounts recovered	-	(43)
	-	520
9.11 Administered trust accounts		

Funds held in these trust accounts are not controlled by the Health Service and are therefore not recognised in the financial statements.

The Health Service administers trust accounts for the purpose of holding patients' private moneys.

A summary of the transactions for these trust accounts are as follows:

Balance at start of period	12	19
Add receipts	46	62
	58	81
Less payments	(48)	(69)
Balance at end of period	10	12

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Note 10 Explanatory statement

All variances between 2026 actual results and 2026 estimates (original budget) are shown below. Narratives are provided for key major variances, which are greater than 10% and $24.05 million for the statement of comprehensive income, statement of cash flows and $24.9 million for the statement of financial position.

Statement of comprehensive income	Note	Estimates 2026 $000	Actuals 2026 $000	Variance between 2026 actuals and 2026 estimates $000
Expenses				
Employee benefits expense		1,366,405	1,485,160	118,755
Contracts for services		421,063	462,090	41,027
Patient support costs		316,394	346,854	30,460
Fees for contracted medical practitioners		34,850	34,859	9
Finance costs		739	732	(7)
Depreciation and amortisation expense		61,112	81,425	20,313
Repairs, maintenance and consumable equipment		37,929	44,916	6,987
Other supplies and services		15,892	17,923	2,031
Cost of sales		4,671	8,885	4,214
Other expenses		145,570	163,147	17,577
Total cost of services		2,404,625	2,645,991	241,366
Income				
Patient charges		67,247	77,174	9,927
Other fees for services		518	131	(387)
Other grants and contributions		2,708	2,966	258
Donation income		576	557	(19)
Sales and service revenue		4,671	9,120	4,449
Other income and recoveries		57,131	62,468	5,337
Total income other than income from State Government		132,851	152,416	19,565
Net cost of services		2,271,774	2,493,575	221,801
Income from State Government				
Department of Health - Service Agreement:				
- State component		1,217,398	1,305,247	87,849
- Commonwealth component	1	611,082	675,521	64,439
Mental Health Commission - Service Agreement		300,578	320,784	20,206
Income from other state government agencies		49,439	39,439	(10,000)
Resources received		95,232	99,097	3,865
Total income from State Government		2,273,729	2,440,088	166,359
Surplus/(deficit) for the period		1,955	(53,487)	(55,442)
Other comprehensive income				
Items not reclassified subsequently to profit or loss				
Changes in asset revaluation reserve		-	146,716	146,716
Total other comprehensive income		-	146,716	146,716
Total comprehensive income/(loss) for the period		1,955	93,229	91,274

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2026

Note 10 Explanatory statement (continued)

Statement of financial position	Note	Estimates 2026 $000	Actuals 2026 $000	Variance between 2026 actuals and 2026 estimates $000
Assets				
Current assets				
Cash and cash equivalents		51,665	66,813	15,148
Restricted cash and cash equivalents		50,468	63,011	12,543
Receivables		42,155	46,895	4,740
Inventories		7,184	7,615	431
Other current assets		1,751	1,511	(240)
Total current assets		153,223	185,845	32,622
Non-current assets				
Receivables		52,923	52,994	71
Amounts receivable for services		842,749	842,529	(220)
Property, plant and equipment		1,035,318	1,137,335	102,017
Intangible assets		79	130	51
Right-of-use assets		10,677	11,695	1,018
Service concession assets	2	395,090	441,800	46,710
Total non-current assets		2,336,836	2,486,483	149,647
Total assets		2,490,059	2,672,328	182,269
Liabilities				
Current liabilities				
Payables	3	120,163	172,789	52,626
Grant liabilities		955	955	-
Lease liabilities		3,975	6,444	2,469
Employee benefits provisions	4	275,595	307,019	31,424
Other current liabilities		1,271	1,902	631
Total current liabilities		401,959	489,109	87,150
Non-current liabilities				
Employee benefits provisions		50,816	48,717	(2,099)
Lease liabilities		10,746	9,259	(1,487)
Total non-current liabilities		61,562	57,976	(3,586)
Total liabilities		463,521	547,085	83,564
Net assets		2,026,538	2,125,243	98,705
Equity				
Contributed equity		1,417,584	1,425,015	7,431
Reserves		640,739	787,455	146,716
Accumulated deficit		(31,785)	(87,227)	(55,442)
Total equity		2,026,538	2,125,243	98,705

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2026

Note 10 Explanatory statement (continued)

Statement of cash flows	Note	Estimates 2026 $000	Actuals 2026 $000	Variance between 2026 actuals and 2026 estimates $000
Cash flows from State Government				
Contribution by Owners – Capital Appropriations administered by Department of Health		57,871	65,303	7,432
Service agreement - Department of Health		1,767,367	1,919,876	152,509
Service agreement - Mental Health Commission		300,578	320,784	20,206
Funds received from other state government agencies		49,440	39,439	(10,001)
Net cash provided by State Government		2,175,256	2,345,402	170,146
Utilised as follows:				
Cash flows from operating activities				
Payments				
Employee benefits		(1,373,125)	(1,453,928)	(80,803)
Supplies and services		(917,300)	(955,912)	(38,612)
Finance costs		(739)	(732)	7
Receipts				
Receipts from customers		66,525	68,933	2,408
Other grants and contributions		2,708	2,966	258
Donations received		576	288	(288)
Other receipts		69,299	68,850	(449)
Net cash used in operating activities		(2,152,056)	(2,269,535)	(117,479)
Cash flows from investing activities				
Payments				
Purchase of non-current assets	5	(55,146)	(79,875)	(24,729)
Receipts				
Proceeds from sale of non-current assets		-	-	-
Net cash used in investing activities		(55,146)	(79,875)	(24,729)
Cash flows from financing activities				
Payments				
Principal elements of lease payments		(2,725)	(2,901)	(176)
Payment to accrued salaries account		(10,191)	(10,262)	(71)
Net cash used in financing activities		(12,916)	(13,163)	(247)
Net increase (decrease) in cash and cash equivalents		(44,862)	(17,171)	27,691
Cash and cash equivalents at the beginning of the period		146,995	146,995	-
Total cash and cash equivalents at the end of the period		102,133	129,824	27,691

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2026

Note 10 Explanatory statement (continued)

All variances between actual results for 2026 and 2025 are shown below. Narratives are provided for key major variances, which are greater than 10% and $24.24 million for the statement of comprehensive income and statement of cash flows and $24.77 million for the statement of financial position.

Statement of comprehensive income	Note	Actuals 2026 $000	Actuals 2025 $000	Variance between 2026 and 2025 actual results $000
Expenses				
Employee benefits expense		1,485,160	1,375,658	109,502
Contracts for services	6	462,090	420,078	42,012
Patient support costs		346,854	317,888	28,966
Fees for contracted medical practitioners		34,859	34,995	(136)
Finance costs		732	738	(6)
Depreciation and amortisation expense		81,425	61,430	19,995
Repairs, maintenance and consumable equipment		44,916	43,096	1,820
Other supplies and services		17,923	16,003	1,920
Cost of sales		8,885	4,691	4,194
Other expenses		163,147	149,196	13,951
Total cost of services		2,645,991	2,423,773	222,218
Income				
Patient charges		77,174	66,215	10,959
Other fees for services		131	543	(412)
Commonwealth grants and contributions		-	15,600	(15,600)
Other grants and contributions		2,966	2,667	299
Donation income		557	567	(10)
Sales and service revenue		9,120	4,205	4,915
Other income and recoveries		62,468	60,854	1,614
Total income other than income from State Government		152,416	150,651	1,765
Net cost of services		2,493,575	2,273,122	220,453
Income from State Government				
Department of Health - Service Agreement:				
- State component	7	1,305,247	1,198,728	106,519
- Commonwealth component	7	675,521	601,711	73,810
Mental Health Commission - Service Agreement		320,784	295,968	24,816
Income from other state government agencies		39,439	49,010	(9,571)
Resources received		99,097	93,971	5,126
Total income from State Government		2,440,088	2,239,388	200,700
Surplus/(deficit) for the period		(53,487)	(33,734)	(19,753)
Other comprehensive income				
Items not reclassified subsequently to profit or loss				
Changes in asset revaluation reserve		146,716	323,588	(176,872)
Total other comprehensive income		146,716	323,588	(176,872)
Total comprehensive income/(loss) for the period		93,229	289,854	(196,625)

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2026
Note 10 Explanatory statement (continued)

Statement of financial position	Note	Actuals 2026 $000	Actuals 2025 $000	Variance between 2026 and 2025 actual results $000
Assets				
Current assets				
Cash and cash equivalents		66,813	96,527	(29,714)
Restricted cash and cash equivalents		63,011	50,468	12,543
Receivables		46,895	49,337	(2,442)
Inventories		7,615	7,184	431
Other current assets		1,511	1,750	(239)
Total current assets		185,845	205,266	(19,421)
Non-current assets				
Receivables		52,994	42,732	10,262
Amounts receivable for services		842,529	781,637	60,892
Property, plant and equipment	9	1,137,335	1,027,472	109,863
Intangible assets		130	79	51
Right-of-use assets		11,695	14,523	(2,828)
Service concession assets	2	441,800	405,056	36,744
Total non-current assets		2,486,483	2,271,499	214,984
Total assets		2,672,328	2,476,765	195,563
Liabilities				
Current liabilities				
Payables		172,789	157,251	15,538
Grant liabilities		955	955	-
Lease liabilities		6,444	4,641	1,803
Employee benefits provisions		307,019	287,567	19,452
Other current liabilities		1,902	1,271	631
Total current liabilities		489,109	451,685	37,424
Non-current liabilities				
Employee benefits provisions		48,717	45,564	3,153
Lease liabilities		9,259	12,805	(3,546)
Total non-current liabilities		57,976	58,369	(393)
Total liabilities		547,085	510,054	37,031
Net assets		2,125,243	1,966,711	158,532
Equity				
Contributed equity		1,425,015	1,359,712	65,303
Reserves		787,455	640,739	146,716
Accumulated deficit		(87,227)	(33,740)	(53,487)
Total equity		2,125,243	1,966,711	158,532

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2026

Note 10 Explanatory statement (continued)

Statement of cash flows	Note	Actuals 2026 $000	Actuals 2025 $000	Variance between 2026 and 2025 actual results $000
Cash flows from State Government				
Contribution by Owners – Capital Appropriations administered by Department of Health	5	65,303	36,112	29,191
Service agreement - Department of Health	7	1,919,876	1,741,055	178,821
Service agreement - Mental Health Commission		320,784	295,968	24,816
Funds received from other state government agencies		39,439	49,010	(9,571)
Net cash provided by State Government		2,345,402	2,122,145	223,257
Utilised as follows:				
Cash flows from operating activities				
Payments				
Employee benefits	8	(1,453,928)	(1,318,273)	(135,655)
Supplies and services		(955,912)	(871,651)	(84,261)
Finance costs		(732)	(738)	6
Receipts				
Receipts from customers		68,933	76,917	(7,984)
Other grants and contributions		2,966	2,667	299
Donations received		288	95	193
Other receipts		68,850	59,961	8,889
Net cash used in operating activities		(2,269,535)	(2,051,022)	(218,513)
Cash flows from investing activities				
Payments				
Purchase of non-current assets	5	(79,875)	(48,787)	(31,088)
Receipts				
Proceeds from sale of non-current assets		-	(41)	41
Net cash used in investing activities		(79,875)	(48,828)	(31,047)
Cash flows from financing activities				
Payments				
Principal elements of lease payments		(2,901)	(2,752)	(149)
Payment to accrued salaries account		(10,262)	(7,843)	(2,419)
Net cash used in financing activities		(13,163)	(10,595)	(2,568)
Net increase/(decrease) in cash and cash equivalents		(17,171)	11,700	(28,872)
Cash and cash equivalents at the beginning of the period		146,995	135,294	11,701
Total cash and cash equivalents at the end of the period		129,824	146,994	(17,170)

East Metropolitan Health Service
Notes to the financial statements
For the year ended 30 June 2026

Note 10 Explanatory statement (continued)

Explanation of significant variances between 2026 estimates and 2026 actuals and between 2026 and 2025 actual results

1. **Income from State Government – Department of Health - Service Agreement - Commonwealth Component.**
The Health Service received additional funding under its 2025-26 Service Agreement with the Department of Health from the Commonwealth for:
$47 million to deliver additional health services and address cost pressures arising from award wage increases, price escalation, and other operational expenses.
$17 million for specific funded initiatives, including Co-Hive, Dialysis Clinics and HIV Treatment program.

2. **Service concession assets**
The Health Service has a Public Private Partnership (PPP) arrangement with St John of God Healthcare operating the St John of God Midland Public Hospital. In 2025-26, the value of the land and buildings associated with the hospital increased by $2.8 million and $44.6 million respectively.

3. **Payables**
The increase in payables is consistent with the growth in the Health Service's activities during the year, including the provision of new services as explained in note 6 and 8 of these explanatory notes. The higher level of activity resulted in increased expenditure, which in turn led to a corresponding increase in payables at the end of the financial year.

4. **Employee benefits provisions**
The increase in employee benefits provisions is consistent with the increase in employee benefits expense, as outlined under note 8 of these explanatory notes.

5. **Purchase of non-current assets**
The increase in acquisitions of non-current assets is primarily attributable to the progression of major capital projects, including the Royal Perth Hospital Emergency Department expansion and other infrastructure projects. Some of these projects are managed by Office of Major Infrastructure Delivery (OMID) on behalf of the Health Service.

6. **Contracts for services**
In 2025-26, additional payments of $42 million were made under the Public Private Partnership (PPP) arrangement with St John of God Healthcare to support the provision of additional general and mental health services.

7. **Income from State Government – State and Commonwealth**
The Health Service received additional funding under its 2025-26 Service Agreement with the Department of Health, comprising:
$130 million to address cost pressures associated with award wage increases, price escalation, and other operational expenses;
$27 million to support the delivery of additional health activity, including increased activity in Hospital in the Home services;
$15 million to facilitate the transition of Mount Lawley Hospital; and
$9 million for specific funded initiatives.

8. **Employee benefits**
The variance is primarily attributable to the following factors:
$90 million increase resulting from award wage increases, the provision of new services, and the recruitment of additional staff to support the delivery of healthcare services;
$47 million increase arising from the flow-on effects of these workforce-related costs, including higher penalty rates, allowances, superannuation contributions, and workers' compensation insurance premiums;
$23 million decrease attributable to a reduction in leave liabilities.

9. **Property, plant and equipment**
The increase in the property, plant and equipment was primarily driven by the revaluation of land and buildings. In 2025-26, the value of the Health Service's land increase by $16.9 million and the value of its buildings increased by $89.9 million.

Compliance

Ministerial directives

Treasurer's Instructions 8(3.1) require disclosure of information on any written ministerial directives relevant to the setting or achievement of desired outcomes or operational objectives, investment activities and financing activities.

On 9 September 2025, the Minister for Health announced in Parliament that she had issued a direction to the Director General of the Department of Health to implement a requirement for Health Service Providers to regularly report the results of their water testing regimes to the Department of Health, and to immediately notify the Chief Health Officer, in writing, when any exceedance of the Australian Drinking Water Guidelines is detected.

On 16 September 2025, the Director General wrote to EMHS to convey this, and EMHS has fully implemented the requirements of this directive.

Summary of board/ committee remuneration

Board/committee	Total remuneration ($)
EMHS Board	501,500

Pricing policy

EMHS charges for goods and services rendered on a partial or full cost recovery basis and complies with the *Health Insurance Act 1973*, the Addendum to National Health Reform Agreement (NHRA) 2026-31, the WA Health Procurement and Contract Management Policy MP 0161/21, and the *Health Services Act 2016* (WA) (HSA 2016). These fees and charges are determined though the WA Health costing and pricing authorities and approved by the Minister for Health.

Guidelines for rules in relation to fees and charges are outlined in the WA Health Fees and Charges Manual. This is a mandatory document in the WA Health Financial Management Policy Framework and binding to all Health Service Providers under the HSA 2016, s27(1).

Expenditure on advertising

In 2025-26, in accordance with section 175ZE of the *Electoral Act 1907*, EMHS incurred a total advertising expenditure of **$102,529.06**, as per the table below:

	Total
Promotion and education materials	**$41,921.49**
Cubic Promote	$18,446.50
Express Promo	$1,964.00
Initiative Media Australia Pty Ltd	$1,590.50
Kwik Kopy Printing Centre – Perth City East	$442.47
Promotion Products Pty Ltd	$19,478.02
Public and staff awareness	**$25,420.52**
Creativa Pty Ltd	$22,587.50
Crystal Creative	$2,250.00
Kwik Kopy Printing Centre – Perth City East	$583.02
Public notice	**$5,952.05**
Initiative Media Australia Pty Ltd	$5,952.05
Recruitment advertising	**$29,235.00**
Australasian College of Physical Scientists and Engineers in Medicine	$460.00
LinkedIn Singapore Pte Ltd	$28,775.00
TOTAL	**$102,529.06**

Act of grace payments

In 2025-26, no act of grace or ex-gratia payments were made by EMHS under the *Financial Management Act 2006*.

External consultants

EMHS did not engage any external consultants to provide strategic advice in the 2025-26 financial year.

Indemnity insurance

In 2025-26, the amount of the insurance premium paid to indemnify directors of the EMHS Board [with 'director' defined as per Part 3 of the *Statutory Corporations (Liability of Directors) Act 1996*] against a liability incurred under sections 13 or 14 of that Act was **$94,050** (including GST).

Unauthorised use of credit cards

WA Government purchasing cards can be issued by EMHS to employees where their functions warrant usage of this facility. These credit cards are not to be used for personal (unauthorised) purposes (i.e. a purpose that is not directly related to performing functions for the agency).

All credit card purchases are reviewed by someone other than the cardholder to monitor compliance. If during a review it is determined that the credit card was used for unauthorised purchases, written notice must be given to the cardholder and EMHS Board.

EMHS had 6 instances (total amount of $94.38) where a purchasing card was used for personal purposes in 2025-26. A review of these transactions confirmed they were immaterial and the result of genuine and honest mistakes, and no further action was deemed necessary as prompt notification and full restitution was made by the individuals concerned. These were not referred for disciplinary action.

	Total
Instances of use for personal purposes	6
Aggregate amount of personal use expenditure	$94.38
Aggregate amount of personal use expenditure settled by a due date	$94.38
Aggregate amount of personal use expenditure settled after a due date	0
Aggregate amount of personal use expenditure remaining unpaid at end of financial year	0
Number of referrals for disciplinary action instigated by the notifiable authority	0

Capital works

Incomplete capital works

	Expected year of completion	Estimated remaining cost to complete ($'000)	Estimated total cost reported in 2024-25 ($'000))	Estimated total cost 2025-26 ($'000)	Total cost variation 2024-25 to 2025-26 ($'000)	Explanation for variation (≥ 10%)
Anti-Ligature Remediation Program – Statewide	2026-27	1,192	5,552	5,552	0	
Election commitment – Royal Perth Hospital (RPH) Aseptic Unit	2026-27	381	9,632	9,632	0	
EMHS Anti-Ligature Remediation Program	2026-27	438	5,000	5,000	0	
RPH A Block Window Replacement	2026-27	762	1,500	1,500	0	
RPH Innovation Hub	2026-27	40	2,828	3,595	767	Approved injection of additional capital funding.
St John of God Midland Public Hospital expansion (bed buy-back)	2026-27	79,648	81,059	81,059	0	
EMHS Electrical Plant Replacement Program	2027-28	6,131	n/a	6,519	n/a	
EMHS fire safety upgrades	2027-28	391	7,000	7,000	0	
EMHS Health In a Virtual Environment (HIVE)	2027-28	1,570	22,893	22,893	0	
EMHS mechanical plant replacement	2027-28	7,771	n/a	7,947	n/a	
Byford Health Hub	2028-29	31,628	42,150	42,150	0	
Fire risk – RPH	2028-29	3,767	9,963	9,963	0	
Mental Health Emergency Centre (MHEC) – Armadale Hospital	2028-29	18,591	15,766	21,135	5,369	Approved injection of additional capital funding.
Secure Extended Care Unit (SECU) – Bentley Hospital	2028-29	58,992	56,640	67,114	10,474	Approved injection of additional capital funding.
Surgicentre – Bentley Hospital	2029-30	160,887	167,002	167,002	0	
MHEC – St John of God Midland	To be determined		6,021			This is being held over until commencement of the expansion of the St John of God Midland Public Hospital Emergency Department.

Complete capital works

	Estimated total cost in 2024-25 ($'000)	Total cost to complete in 2025-26 ($'000)	Total cost variation 2024-25 to 2025-26 ($'000)	Explanation for variation (≥ 10%)
Election commitment – RPH Intensive Care Unit	28,254	27,854	-400	
Medical Respite Centre	1,843	1,668	-175	
Refurbishment of RPH ward 2K	7,000	7,000	0	
Chiller - RPH	881	881	0	
High voltage switchgear - RPH	3,000	3,000	0	
St John of God Midland Health Campus – master planning project	3,000	490	-2,510	Lower than anticipated site and facility audits as they were funded as part of separate project.
Electronic Medical Record (EMR)	14,545	15,245	700	The Department of Health approved $700,000 in funding to support dual processing activities associated with project implementation.
Urgent Mental Health anti-ligature works - Bentley Hospital	3,898	3,898	0	

Notes:

1. The above information is based upon the:
   i. 2024–25 EMHS published Annual Report
   ii. 2026–27 published State Budget Papers and 2025-26 Service Agreement for EMHS.
2. Completion timeframes are based upon a combination of the approved delivery schedule, scope and budget at the time of reporting, and reflect the financial completion of the project.
3. Only capital projects that were administered by EMHS are reflected in the table.
4. Incomplete capital works is defined to be financially incomplete projects, and Completed is defined to be financially completed or fully expended projects.
5. Estimated total cost of project and Estimated remaining cost to complete are reflected as per the 2026-27 Service Agreement and are subject to changes following outcomes of future Mid-Year review and budget process.
6. Variance represents the difference between the estimated total cost of the project in the 2026-27 published Budget Papers in comparison to the total cost or estimated total cost of the project as reported in the 2024–25 EMHS Annual Report. An explanation is provided where a variance is greater than or equal to 10 per cent.

(L-R) Ben Noteboom, Joel Gurr, Sally Carbon OAM, Minister Meredith Hammat, Zaneta Mascarenhas, Minister John Carey and Chandima Hiyare-Hewage.

Industrial relations

EMHS engaged with the WA Health System in contributing to negotiations for new Industrial Agreements for 2025-26 including:

- WA Health System Engineering and Building Services Industrial Agreement 2025
- WA Health System – Medical Practitioners (Clinical Academics) AMA Industrial Agreement 2026.

EMHS is now implementing new and modified conditions of employment contained in these Industrial Agreements, including implementation of improved career pathways for allied health professionals and anaesthetic technicians.

EMHS continued with its commitment to a permanent workforce and to reducing its reliance on agency workers and a casual workforce.

Employment and staff development

See page 39.

Work health and safety management

See page 40.

Workers compensation

See page 42.

WA multicultural policy framework

See page 50.

Closing the gap

See page 52.

Compliance with public sector standards and ethical codes

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

The Department of Health and EMHS maintain HR policies and guidelines that are consistent with the standards. These are available to all employees on the EMHS intranet and/or the Department of Health policy frameworks internet pages.

Information about the Public Sector Standards is promoted and available to employees via:

- notification of the breach claim rights processes, including relevant deadlines applicable to the standards
- information, fact sheets, policies and guidelines on the EMHS intranet
- recruitment, selection and appointment training for recruiting managers and panel members
- EMHS peak performance training for line managers.

The HR Directorate provides information, guidance and support to all managers to promote best practice and application of these policies and procedures, and also manages any claims made against the Public Sector Standards. Advice is also provided, where appropriate, in order to reach a prompt, satisfactory outcome at the most appropriate level.

During 2025-26, there were:

16 breach of standard claims lodged against the employment standards:

- **5** were resolved internally and withdrawn
- **0** are currently being managed by HR
- **11** were referred to the Public Sector Commission

0 breach of standard claims for grievance resolution, performance management, termination or redeployment standards.

Code of Conduct

Integrity and ethical behaviour are integral to EMHS' core business. EMHS reminds and encourages staff to reflect on the EMHS values (including accountability, integrity and respect) and to incorporate these into their daily work.

To support awareness of their responsibilities, new staff receive and acknowledge the Code of Conduct as a part of their offer of employment to work with EMHS. Responsibility for workplace behaviours and conduct is reinforced at formal induction, and through completion of mandatory training.

In addition to mandatory training, EMHS proactively provides training to staff where appropriate, covering areas such as conflicts of interest, medicine discrepancies and investigations.

In order to ensure its effectiveness, EMHS has recently conducted an audit into its Fraud and Corruption Control System. The audit concluded that EMHS has a strong commitment to fraud and corruption control through established governance frameworks aligned with Department of Health policy, a values-based culture and a clearly articulated Code of Conduct. The audit identified a number of areas for improvement, for which EMHS has developed and implemented actions to address.

The EMHS Ethical Conduct Advisory Committee (ECAC) was established in 2023-24, comprising of a group of senior executive stakeholders. The ECAC has met regularly throughout 2025-26, with its main functions being the development and management of strategies to improve integrity awareness, compliance and culture. This financial year, this included the full review of EMHS' integrity environment using the Public Sector Commission's Integrity Maturity self-assessment tool. This process identified some areas for improvement, for which actions were put in place.

EMHS commenced **63** disciplinary processes in relation to potential breaches of policy and/or the Code of Conduct in 2025-26. All suspected breaches of discipline, including reportable misconduct, were managed in accordance with the requirements of the WA Health Discipline Policy and where appropriate, reported to external oversight agencies as required by legislation.

Disability Access and Inclusion

Aligned with the social model of disability, EMHS acknowledges that we all share a responsibility to address systemic barriers, limiting attitudes and environmental obstacles that lead to inequity.

We continue to develop and implement strategies that empower people experiencing disability, their families and carers, to engage with EMHS through equitable access to services, facilities, information, employment and feedback mechanisms.

The EMHS Disability Access and Inclusion Plan guides all our hospitals and services to contribute to 7 key outcomes. Progress in 2025-26 includes:

Outcome 1

People with disability have the same opportunities as other people to access the services of, and any events organised by, EMHS

EMHS published the Disability Access and Inclusion Plan 2025-2030. A new committee was formed to coordinate its implementation and ensure a service-wide focus on accessibility. The committee comprises key stakeholders from each hospital group as well as consumer representation, elevating the voices of people with lived experience.

To improve access to services and events by people with invisible disabilities, EMHS has joined the internationally recognised Hidden Disabilities Sunflower initiative. A working group has been established to build awareness and enhance staff capabilities to enable a roll-out over 2026-27.

Consumers and staff were invited to join in an accessible and inclusive program of events to recognise International Day of People with Disability. This included an interactive 'Unity in Inclusion Story Wall' display at Royal Perth Hospital (RPH), and participation in the Disability Health Network event was offered both online and in person.

Outcome 2

People with disability have the same opportunities as other people to access the buildings and other facilities of EMHS

Through regular and ongoing maintenance of EMHS buildings, grounds, car parks and facilities, we ensure compliance with relevant building codes and work to continuously improve accessibility of facilities. Enhancements include:

- installation of 2 rest stations on Level 3 at RPH, catering for bariatric and disabled patients
- updates to bathroom signage during refurbishments and developments across EMHS sites, to support our dementia plan and other inclusion aims
- construction of a disability compliant footpath at Armadale Hospital (AH), connecting the Mental Health Unit to overflow parking
- modification of the entry to occupational therapy facilities at Ward 10 at Bentley Hospital (BH) to accommodate wheelchairs and mobility aids.

Outcome 3

People with disability receive information from EMHS in a format that will enable them to access the information as readily as other people are able to access it

EMHS publications and patient information are regularly reviewed to ensure it meets the needs of healthcare users, includes adequate information, is available in different formats and uses appropriate language. Our website and digital products are designed to comply with the WA Government's Accessibility and Inclusivity Standard and meet Web Content Accessibility Guidelines 2.2 Level AA standards.

In 2025-26, we responded to different audience information needs by:

- providing multimedia displays with subtitling in physiotherapy waiting rooms to provide consumers with information on what to expect during appointments
- ensuring ophthalmology resources use larger print, with an audit underway to ensure older resources are brought up to standard
- developing the Mental health care in hospital booklet into an easy read format and supplementing the digital version of the booklet with a spoken voice option. The voice recordings are also linked to the print version via a QR code.

Outcome 4

People with disability receive the same level and quality of service from the staff of EMHS as other people receive from the staff of EMHS

EMHS continued to offer flexible services that respond to the needs of our varied consumers, such as through the expansion of the Home Hospital initiative at RPH. This initiative provides access for treatment and follow-up for patients, including those with a disability, by a multidisciplinary team in their own home.

Additionally, Royal Perth Bentley Group (RPBG) commenced the NDIS and Long Stay Project to proactively identify, advocate and support people with disability at the intersection of health and disability systems. The project promotes early, coordinated, person-centred discharge planning with patients and their support networks, to improve patient outcomes and reduce length of stay associated with disability support barriers.

Bentley Hospital's Older Adult Mental Health Unit has developed an accessible occupational therapy program, including seated physical exercise, horticultural therapy using new accessible raised garden beds, and sensory interventions to reduce patient distress through 'animal therapy' from an advanced interactive robot seal (PARO).

Outcome 5

People with disability have the same opportunities as other people to make complaints to EMHS

EMHS regularly reviews compliance with complaints management processes to maximise the way feedback and complaints are received and to ensure they meet the accessibility needs of consumers.

A variety of methods are available for providing feedback and lodging complaints, including via paper-based forms, web submissions, e-mail, phone, in person and via staff/volunteers assisting to compile complaints. Patient feedback is monitored, including quarterly review at Disability Access and Inclusion Plan Committee meetings.

Across EMHS hospitals (and particularly in emergency departments) visual aids and telecommunications equipment have been installed to ensure that consumers are aware of consumer-initiated care escalation pathways, such as 'Aishwarya's CARE call'.

Outcome 6

People with disability have the same opportunities as other people to participate in any public consultation by EMHS

Consumers with lived experience of physical, mental and hidden disability are consistently involved in shaping services through regular participation in planning, evaluation, and improvement activities across EMHS. Consumer representatives actively participate on governance committees and advisory groups. Staff and consumers with a lived experience of disability are members of the EMHS Disability Access and Inclusion Committee and are involved in the review of services, policies and programs.

Outcome 7

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

EMHS is committed to removing barriers for people with a disability to obtain and maintain employment within the organisation. The newly formed Disability Access and Inclusion Plan committee established 2 working groups focussed on employment. One is developing recruitment programs targeted at people with disability, and the other is developing streamlined processes to provide workplace adjustments for both new and existing employees. Both initiatives are expected to be implemented in 2026-27.

Workforce inclusiveness statement

EMHS is committed to becoming a leader in the health sector by striving for inclusion targets that reflect the diversity of the communities we serve. We are dedicated to fostering a workplace culture that values diversity and inclusion, recognising that staff who feel safe, supported and engaged contribute to better health outcomes and stronger organisational performance.

EMHS **Plan for Our People 2025-2030**, launched in August 2025, was informed through the voice of our people gathered through feedback from our annual staff survey, including on diversity and inclusiveness in the workplace. The EMHS Plan for Our People outlines our commitment to inclusion through specific actions and outcomes over the life of the Plan.

Over the past year, EMHS has progressed several key diversity and inclusion initiatives, including:

- piloted inclusive recruitment campaigns such as **Join Our Mob at East!** using storytelling and community engagement to encourage Aboriginal people to explore employment opportunities with EMHS
- continuing to host our Aboriginal employee forums, to provide a dedicated space for our Aboriginal employees to connect, share cultural experiences, and focus on wellbeing and self-care. We work with Aboriginal controlled organisations, such as, Garlett Group, Corroboree for Life and Red Dust Healing, and are guided by their cultural knowledge to empower our Aboriginal workforce
- celebrating Harmony Week through our staff sharing stories of their culture and wrapping an orange ribbon, the Harmony Week colour, around the big Moreton Bay fig tree outside Kirkman House to publicly share our commitment to multiculturalism (see page 50)
- celebrated the International Day of People with Disability with the official launch of **EMHS Disability Access and Inclusion Plan 2025-2030** (see page 168)
- proudly took part in the 2025 Pride Parade, demonstrating our ongoing commitment to inclusion and support for the LGBTQIA+ community for both staff and consumers
- continuing our commitment to better support our staff with carer responsibilities, earning EMHS a Level 3 EXCEL carers accreditation, making us the first health service provider to have achieved this level of recognition (see page 43).

We aim to remain a valued employer in the health sector and better reflect the diverse communities we serve. EMHS acknowledges there are areas that can be improved, so we are committed to continuing to work towards a culture of inclusion.

Recordkeeping

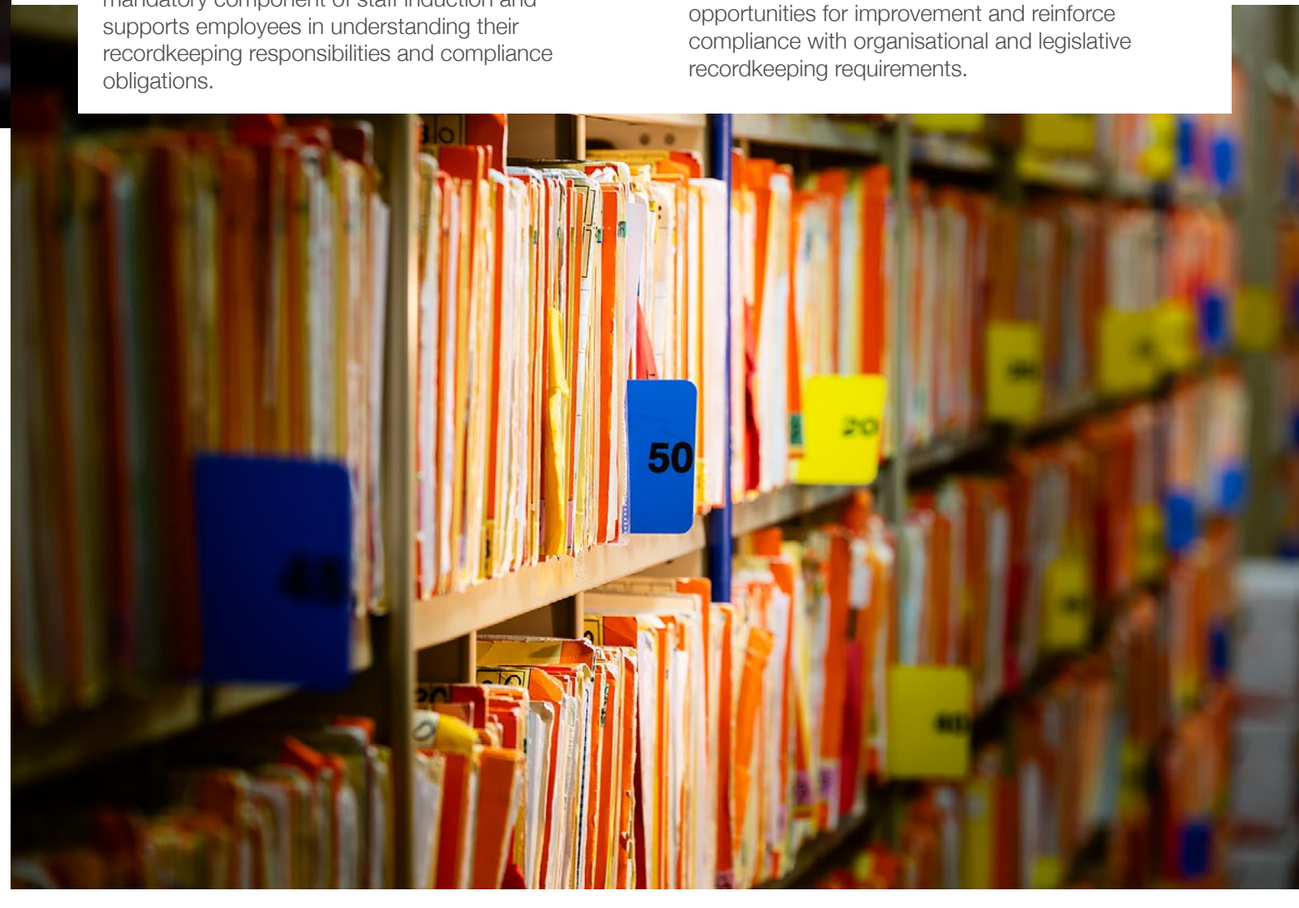
During 2025-26, EMHS continued to strengthen its information governance and recordkeeping practices in accordance with the *State Records Act 2000* and its approved Recordkeeping Plan. Corporate Records Management, within the Office of the Chief Information Officer, plays a key role in supporting the creation, management and preservation of corporate records to ensure they remain accessible, reliable and compliant with legislative requirements.

Corporate records are maintained in both physical and electronic formats, with electronic records managed through Content Manager, EMHS' Electronic Document and Records Management System (EDRMS). The system supports the secure capture, storage and retrieval of corporate information. As of 30 June 2026, almost 700 staff were active in the system, which contained more than 1.7 million documents and emails created since its implementation in 2019.

Recordkeeping Awareness Training remains a mandatory component of staff induction and supports employees in understanding their recordkeeping responsibilities and compliance obligations.

During 2025–26, Corporate Records Management continued to support the adoption of Content Manager through a range of education, personalised engagement and awareness initiatives. User-friendly online training resources, guidance materials and targeted communications were developed to strengthen staff understanding of their recordkeeping responsibilities and support the consistent creation and management of corporate records across EMHS.

Corporate Records Management also continued to progress actions arising from previous internal audit recommendations to further strengthen recordkeeping governance and practices across EMHS. During 2025–26, the team enhanced reporting capabilities through the development of Power BI dashboards, providing increased transparency of corporate recordkeeping activities and Content Manager usage across EMHS. These dashboards will support managers and business areas to monitor recordkeeping activity, identify opportunities for improvement and reinforce compliance with organisational and legislative recordkeeping requirements.



Freedom of information

The *Freedom of Information Act 1992* (WA) (FOI Act) gives all Western Australians a right of access to information held by EMHS. Access to information can be made through a Freedom of Information (FOI) application, which should be addressed to the FOI contact for the appropriate EMHS site.

FOI applications can be granted full access, partial access or access may be refused in accordance with the FOI Act.

FOI applications

In 2025-26, EMHS sites collectively received **2,495** new applications under FOI legislation (includes Swan Districts Hospital and Midland Community Mental Health – mental health records).

800 Non-personal applications

1,695 Personal applications

Contacts

EMHS, FOI

EMHS.FOI@health.wa.gov.au

For records relating to:

- Armadale Hospital
- Bentley Hospital
- CCTV/body worn camera footage
- City East Mental Health Service
- Community Midland Mental Health Service
- EMHS corporate
- Kalamunda Hospital
- Mental Health – Armadale, Bentley, and Royal Perth Hospitals
- Next Step Drug and Alcohol Service
- Orchard Ave Mental Health Service
- Royal Perth Hospital
- St James Transitional Care Unit (Bidi Wungen Kaat/TCU)

For former records relating to:

- Bentley Adolescent Unit
- Heathcote Hospital
- Hillview Hospital
- Mount Lawley Annexe
- Shenton Park Hospital
- Swan Districts Hospital

St John of God Midland Public and Private Hospitals - Health Information Services (not governed by EMHS)

MI.ROI@sjog.org.au

For records relating to:

- St John of God Midland Public Hospital
- St John of God Mount Lawley - contracted services

For more information, visit:

EMHS Freedom of Information

New information and official enquiries department

A new centralised EMHS Release of Information Department opened this year, reflecting our commitment to transparency and accountability.

The department comes under the EMHS Office of the Chief Executive and manages requests under the *Freedom of Information Act 1992* for our network.

Before the department was established in October 2025, Freedom of Information (FOI) requests were handled by separate Royal Perth Bentley and Armadale Kalamunda Group teams. Other EMHS-wide corporate requests previously went through the EMHS Office of the Chief Executive.

In 2025-26, the Release of Information Department collectively received 2,495 new FOI applications.

By bringing official patient and corporate requests together, the new department has streamlined information services, improved oversight and visibility, and reduced application response times.

EMHS Office of the Chief Executive Director Anne-Marie Presho says enquiries are now handled by one coordinated, expert team.

“By centralising our FOI function, we’re strengthening good governance across the organisation through consistent decision-making, greater accountability, and a more streamlined, transparent approach to managing information requests,” Anne-Marie says.

“...consistent decision-making, greater accountability, and a more streamlined, transparent approach to managing information requests”

Appendix

EMHS Board remuneration

EMHS Board			
Position	**Name**	**Period of membership (days)**	**Total remuneration for 2025-26 ($)***
Chair	Pia Turcinov	92	21,931
Chair	Sally Carbon	245	56,554
Deputy Chair	Denise Glennon	365	51,962
Member	Clare Grieveson	310	39,606
Member	Kane Blackman	240	30,605
Member	Cathy Nottage	282	36,005
Member	Glenn Murray	310	39,606
Member	Tracey Moroney	365	47,544
Member	Vanessa Elliott	365	46,807
Member	Melissa Grove	365	46,807
Member	Andrew Whitechurch	365	46,807
Member	Peter Forbes	92	12,062
Member	Steven Patchett	83	10,802
Member	Elizabeth Koff	55	7,201
Member	Ross Keesing	55	7,201
Total			**$501,500.00**

*Includes superannuation

Hospital site contact details

Royal Perth Bentley Group

Royal Perth Hospital
Address
197 Wellington Street,
Perth WA 6000

Postal address
GPO Box X2213,
Perth WA 6847

Telephone (08) 9224 2244
Fax (08) 9224 3511

rph.health.wa.gov.au

Bentley Hospital
Address
18 – 56 Mills Street,
Bentley WA 6102

Postal address
PO Box 158,
Bentley WA 6982

Telephone (08) 9416 3666
Fax (08) 9416 3711

bhs.health.wa.gov.au

Armadale Kalamunda Group

Armadale Hospital
Address
3056 Albany Highway,
Mount Nasura WA 6112

Postal address
PO Box 460,
Armadale WA 6992

Telephone (08) 9391 2000
Fax (08) 9391 2149

ahs.health.wa.gov.au

Kalamunda Hospital
Address
Elizabeth Street,
Kalamunda WA 6076

Postal address
PO Box 243,
Kalamunda WA 6926

Telephone (08) 9257 8100
Fax (08) 9293 2488

https://emhs.health.wa.gov.au/Hospitals-and-Services/Hospitals/Kalamunda-Hospital

St John of God Health Care

St John of God Mt Lawley (contracted services)
Address
Corner Ellesmere Rd
and Thirlmere Road,
Mt Lawley 6050

Postal address
Thirlmere Road,
Mt Lawley 6050

Telephone (08) 9370 9222
Fax (08) 9272 1229
Email info.mtlawley@sjog.org.au

sjog.org.au/mtlawley

St John of God Midland Public Hospital
Address
1 Clayton Street,
Midland WA 6056

Postal address
GPO Box 1254,
Midland WA 6936

Telephone (08) 9462 4000
Fax (08) 9462 4050
Email info.midland@sjog.org.au

sjog.org.au/midland

East Metropolitan Health Service (area office)

Address:
10 Murray Street, Perth WA 6000
Postal address:
GPO box X2213, Perth WA 6847

Telephone: (08) 9224 2244
Fax: (08) 9224 3511

Email: EMHS.GeneralEnquiries@health.wa.gov.au
Website: www.emhs.health.wa.gov.au