Agency performance

Summary of key performance indicators

Key performance indicators assist CAHS to assess and monitor the extent to which State Government outcomes are being achieved and help inform the community about how CAHS is performing.

Effectiveness indicators assess the extent to which outcomes have been achieved through resourcing and delivery of services to the community.

Efficiency indicators monitor the relationship between the services delivered and the resources used to provide the service.

A summary of the CAHS key performance indicators and variation from the 2022–23 targets is given in Table 3.

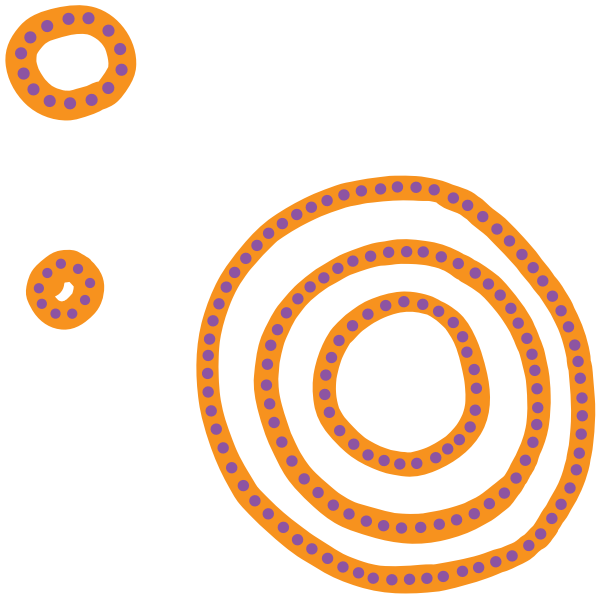
Actual results versus KPI targets

Table 3: Actual results versus KPI targets

Key performance indicator		2022–23 Target	2022–23 Actual
Unplanned hospital readmissions for patients within 28 days for selected surgical procedures	Tonsillectomy & Adenoidectomy	≤85.0	**50.6**
	Appendicectomy	≤25.7	**15.0**
Percentage of elective wait list patients waiting over boundary for reportable procedures	**Category 1** (≤30 days)	0%	**9.9%**
	Category 2 (≤90 days)	0%	**28.7%**
	Category 3 (≤365 days)	0%	**39.6%**
Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days		≤1.0	**0.92**
Percentage of admitted patients who discharged against medical advice (DAMA): a) Aboriginal patients; and b) non- Aboriginal patients	Aboriginal	≤2.78%	**0.25%**
	non-Aboriginal	≤0.99%	**0.05%**
Readmissions to acute specialised mental health inpatient services within 28 days of discharge		≤12.0%	**24.9%**
Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services		≥75%	**78.8%**
Average **admitted** cost per weighted activity unit		$7,314	**$8,007**
Average **Emergency Department** cost per weighted activity unit		$7,074	**$9,669**
Average **non-admitted** cost per weighted activity unit		$6,982	**$8,574**
Average cost per bed-day in **specialised mental health inpatient services**		$2,984	**$4,449**
Average cost per treatment day of **non-admitted care provided by mental health services**		$648	**$796**
Average cost per person of **delivering population health programs by population health units**		$226	**$262**

Financial summary

	2022–23 Target[1] $000	2022–23 Actual $000	Variation[7] $000
Total cost of services (expense limit) (sourced from Statement of Comprehensive Income)	901,755	1,034,556	132,801[2]
Net cost of services (sourced from Statement of Comprehensive Income)	828,189	936,805	108,616[3]
Total equity (sourced from Statement of Financial Position)	1,527,167	1,552,702	25,535[4]
Net decrease in cash held (sourced from Statement of Cash Flows)	(2,339)	(31,890)	(29,551)[5]
Approved salary expense level	622,589	702,324	79,735[6]



Notes

(1) As specified in the annual estimates approved under section 40 of the *Financial Management Act 2006*.

(2) The major cost drivers for the variation of $132.801 million in total cost of services are cost and demand pressures, pay increases and cost-of-living payments to employees under the State Government's enhanced wages policy, additional resourcing to address outcomes from the Independent Inquiry and Coronial Inquest, increased workforce capacity for additional patient beds and Emergency Department, and the associated increases in patient support costs, other supplies and services.

(3) As a result of the higher than expected reimbursements from the Australian Government under the Pharmaceutical Benefits Scheme for subsidised medicines, and increased grants and contributions from non-government sources, the variation in net cost of services is $24.185 million less than the variance in total cost of services.

(4) The asset revaluation increments of $72.956 million for buildings have contributed to the increase in total equity. Conversely, the equity increase has been lessened by the operating deficit of $49.007 million. The details are set out in Note 9.12 'Equity'.

(5) The higher than budgeted decrease (-$29.551 million) in cash held reflects the deficiency in service agreement funding from State and Commonwealth Governments in meeting the increased operating costs of the Health Service in the current financial year.

(6) Salaries and superannuation costs are above budget largely due to the pay increases and cost-of-living payments to employees under the State Government's enhanced wages policy and additional staff resources to address outcomes from the Independent Inquiry and Coronial Inquest and increased hospital activity.

(7) Further explanations are contained in Note 9.14 'Explanatory Statement' in the financial statements.

Emergency Department

The Perth Children's Hospital (PCH) Emergency Department (ED) provides a tertiary level emergency service for paediatric patients presenting with a range of conditions including trauma, medical, surgical and mental health issues. Urgent care and resuscitation, medical, surgical and mental health assessment, and treatment and diagnosis are all performed in the ED.

The 2022–23 financial year saw 70,131 patients presenting for assessment and treatment at the PCH ED. The number of patients needing inpatient admission following presentation to ED has remained steady at around 20 per cent.

Percentage of patients seen within recommended times

When patients first enter the ED they are assessed on how urgently treatment should be provided. A patient is allocated an Australasian Triage Score (ATS) between 1 (immediate) and 5 (less urgent) that indicates their clinical acuity. Treatment should commence within the recommended time of the triage category allocated (see Table 5).

Table 5: Triage categories

Triage category	Description	Response	Target
1	Immediately life-threatening	Immediate (≤2 minutes)	100%
2	Imminently life-threatening OR important time-critical treatment OR very severe pain	≤10 minutes	≥80%
3	Potentially life-threatening OR situational urgency	≤30 minutes	≥75%
4	Potentially serious OR situational urgency OR significant complexity or severity	≤60 minutes	≥70%
5	Less urgent	≤120 minutes	≥70%

During 2022–23 CAHS has continued to exceed performance expectations for triage categories 1, 2 and 5. Performance in triage categories 3 and 4, which make up the majority of presentations, has decreased compared to 2021–22.

Causes for reduced performance in seeing triage category 3 and 4 patients within recommended times are:

- Triage category 1 and 2 patients remain the absolute priority, needing clinical review and input for resuscitation and emergency care for life-threatening or time critical care.
- In 2022–23 the ED assessed and treated a significantly higher volume of patients in triage categories 1 and 2 with immediately or imminently life-threatening conditions, compared to the previous finance year 2021–22 (Table 6):
  - 32.08 per cent increase for category 1 patients seen
  - 36.32 per cent increase for category 2 patients seen.

Due to the criticality of patients in triage categories 1 and 2, a greater level of input and time from clinical staff is required to ensure thorough assessment and appropriate treatment is initiated.

Table 6: Increase in presentations for triage categories 1 and 2

Triage category	2020–21	2021–22	2022–23	% change from 2021–22
1	370	455	**601**	↑ 32.08%
2	6,203	7,703	**10,501**	↑ 36.32%

Strategies to improve target times

There are a number of strategies now in place to help improve triage category target performance:

- Collaboration with the PCH Patient Flow Unit which aims to improve timely transfers from the ED to the wards.
- ED workflow improvement using initiatives such as the pod-based care team and the use of triage and waiting room nurse support roles.
- Piloting an ED Handover tool which provides improved visibility of all triage category performance.
- Maximising use of Hospital in the Home including a new pathway for out-of-hours referral.
- Implementation of clinical pathways for specific presentations.

Table 7: Percentage of PCH ED patients seen within recommended times, by triage category, 2020–21 to 2022–23

Triage category	2020–21	2021–22	2022–23	Target
1	100%	100%	100%	100%
2	81%	84.3%	80.1%	≥80%
3	46.63%	51.8%	32.4%	≥75%
4	53.6%	62.6%	44.3%	≥70%
5	81%	93.9%	81.5%	≥70%

Data source: Emergency Department Data Collection

Improving Emergency Department access

To support the rapidly evolving staffing model in the ED, there has been a particular **focus on the education and training of nursing staff**. The expansion of an additional suite of training to provide increased exposure to clinical skills, consolidate learning and expedite clinical competence has enabled a more intensive learning pathway for nursing staff. The Paediatric Life Support and the Trauma Nursing Core Course have been key in supporting nurses' learning and development.

The **pod-based care** system was introduced in February 2023 for medical and nursing staff, and provides clinical supervision for junior medical officers to drive more efficient patient flow in the ED. A nursing pod leader helps junior staff with skill development and assists with patient and departmental flow. Since its implementation, there has been improved communication and collaboration between disciplines, resulting in improved clinical communication. Now this is established, there is a strong focus on using this model to help reduce review times for patients in triage categories 3 and 4.

ED research

Through the Paediatric Research in Emergency Departments International Collaborative group and internal projects, the research team is conducting and publishing high quality, clinically focused research on core paediatric presentations such as bronchiolitis, spinal injuries, sepsis, post-tonsillectomy haemorrhage and appendicitis.

The research team is currently running 11 prospective registries, interventional and prospective observational studies, with plans for an additional five studies in 2023–24.

With 32 publications in the last 24 months, as well as contributions to national guidelines on bronchiolitis and head injury, the PCH ED research team has been invited to present their research nationally and internationally.

Professor Meredith Borland, PCH ED Director of Emergency Medicine Research, was recognised on the Queen's Birthday 2022 Honours list as a Member of the Order of Australia (AM) in the General Division, for her significant service to emergency medicine, particularly paediatrics, and to medical research.

Patient safety at CAHS

CAHS is committed to the continual improvement of practice, care and service to ensure safe, high quality health care for our patients, clients and their families.

Learning from clinical incidents

Delivering high quality healthcare is complex and not without risk. CAHS is committed to ensuring that every clinical incident is an opportunity to learn, understand and make changes to improve care and reduce the likelihood of a similar occurrence in the future.

A good patient safety culture includes identifying and reporting clinical incidents and risks. CAHS is committed to providing an open and transparent environment that encourages staff to report incidents when something does not go as expected.

CAHS clinicians and support staff bring a high level of expertise and commitment to every patient and client at every moment of care. The overwhelming majority of interactions with our health service results in positive experiences and outcomes for the children, young people and their families. However, for a very small number of patients, regrettably, errors have occurred during their care, and in some cases, these errors may have contributed to a clinical incident or unintended harm.

The complexity of health care requires a robust program to identify and reduce the risk of harm to patients and clients. Staff learn about the purpose of identifying, reporting and investigating clinical incidents to assist with learning lessons and developing recommendations to prevent and manage the issues and risks.

All clinical incidents are categorised based on the severity and reviewed accordingly. A severity assessment code (SAC) 1 is the most significant clinical incident that has, or could have, contributed to serious harm or death.

In 2022–23 CAHS reported 25 clinical incidents with a SAC1 rating. Of the 25 serious incidents reported in 2022–23, the patient outcome* was noted as:

No harm	**2**
Minor harm	**8**
Moderate harm	**7**
Serious harm	**2**
Death	**6**

*It is important to note that the patient outcome does not necessarily arise as a direct cause of the incident. There are a number of factors other than healthcare-related that may contribute to a patient's outcome.

The number of SAC1 incidents is reflective of a strong culture of reporting. The most reported types of incidents are infection control incidents and medication incidents. All SAC1 clinical incidents are subject to a rigorous clinical incident investigation and the reports are reviewed by members of the CAHS Executive and the CAHS Board.

As a result of these investigations, a number of actions have been taken to improve patient safety.

- Updated decolonisation procedures to reduce the risk of infection for patients; and established auditing and surveillance programs for hand hygiene, aseptic technique and decolonisation practices to ensure a high standard of care is maintained. Where areas for improvement are identified, targeted action plans are implemented and monitored.
- Enhanced medication safety, with improved clarity of medication management guidance documents along with additional education and training to clinical teams. Targeted education has also been provided to strengthen the medication safety systems, including independent second checking and the six rights of safe medication administration.


Oncology Pharmacy
SEACOAST

Consumer Engagement

Working in partnership with our consumers and community

In 2022–23 CAHS continued to strengthen the way children, young people, parents and carers were involved in helping to make decisions on how CAHS delivers services and improves the experience for all consumers.

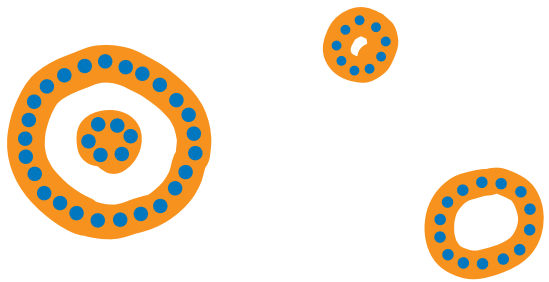
Examples are:

- undertaking a consumer-led audit to help make Child and Adolescent Mental Health Services (CAMHS) sites more welcoming and inclusive for all young people and families
- expanding the Engage online consumer network to over 700 members of the community
- working in partnership with consumers to develop an ED Parent Prompt Tool to help parents know what questions to ask clinical staff
- involving young people in developing a new children and youth consumer experience survey
- introducing the What Matters to Me poster in ward rooms, which helps staff to get to know the children and young people.

CAHS has now completed the 2020–22 Consumer Engagement Strategy, which saw us make great strides in creating a strong foundation for meaningful partnerships with consumers.

Key achievements this year included:

- implementing a new policy framework for consumer engagement
- incorporating consumer involvement planning into project management templates
- co-delivering consumer induction training with consumer representatives to ensure all new representatives feel supported in their role
- making a diverse range of educational resources available to consumers to raise awareness and understanding of their healthcare rights
- starting work on CAHS' new Consumer Engagement Strategy in collaboration with our consumers.



Consumer feedback

During the 2022–23 period, the following consumer feedback was received:

475
compliments received via formal feedback processes

853
contacts received via formal feedback processes

231
complaints received via formal feedback processes (of these, 50 were complaints received as a ministerial)

43.5%
of complaints were resolved within 30 working days

What we are doing to improve

Complaint response times varied over the past year and showed a declining trend, attributable to several factors including a strong focus on improving the quality of investigations and responses, complex complaints across clinical divisions, staff absence and positions unfilled.

CAHS has prioritised improving the quality of complaint investigations and written responses and increasing the number of family meetings with the relevant staff to resolve complaints more effectively. CAHS has found that these family meetings lead to a better-quality outcome for the family but does mean longer timeframes past 30 working days.

How we measure the consumer experience

CAHS uses a range of surveys using a Net Promoter Score (NPS) which is a measure of overall patient experience, a consumer's willingness to use a service again, and whether they would promote the service to others.

What is a good NPS score?

- below 0 is poor
- 0 and 50 is good
- 50 and 70 is excellent
- 70 or greater is world class

Perth Children's Hospital

A link to the MyVisit or MySay survey is sent to families of patients who visit the PCH ED, Outpatients or are admitted, and the Neonatology wards at PCH and King Edward Memorial Hospital.

Overall patient experience

67	66	52
Inpatient	**Outpatient**	**Emergency Department**

Community Health

The Community Health Consumer Experience Survey is sent via text message to parents and carers of children five days after attending the four-month child health nurse appointment, and five days after attending a Child Development Service appointment.

Overall patient experience

82	82
Nursing	**Child Development Service**

CAMHS

The Your Experience of Service survey and Carer Experience Survey were implemented in 2020. CAMHS staff offer the surveys at key points of assessment and review at all inpatient, outpatient and community sites.

71%	66%
of consumers reported a positive experience of service	**of carers** reported a positive experience of service

Compliments

Perth Children's Hospital

My son sustained a traumatic injury to his face whilst playing basketball at school. From a patient care perspective, **our experience at PCH ranks as the most comprehensive, professional, empathetic, and compassionate care that I have observed**, anywhere, outranking all other experiences from my time in the military and the fire service.

We arrived at PCH at approximately 15:45. The triage nurse was polite, professional, and rapidly had us in a bay in ED within 5 minutes of arrival. In under a minute, observations were being taken, multiple personnel were obtaining histories, checking on my son's condition and well-being, and prepping him for any blood work or drug administration that may need to occur. In extremely short order, and I'm estimating it was less than 15 minutes since we presented at the triage point, we were on the move to the Dental department where we were seen by what I'll describe as the all-star team of five or six personnel, who by some weird scheduling anomaly, were all there at the same time, instead of just one person.

The standard of care there was nothing short of exceptional, with everyone working as a team to ensure the best possible outcome for my son. Reassurance was ongoing, personnel slipped seamlessly between roles, no egos, just getting the job done, a lot of concurrent activity whilst still taking the time to explain various elements of his treatment. So, I just want to say, THANK YOU to everyone involved, but particularly the Dental department. Your actions made a bad experience much more tolerable, and although he needs further treatment, my son is back to being his happy, cheerful self, and it reflects great credit on yourselves, and PCH.

My son and I came down from the Kimberley. The city can be a frightening place for people like us, that were born and bred in small towns or communities. Upon arriving at the Ronald McDonald House and PCH, **we were treated with kindness and respect** and were given a lot of support when needed.

Community Health

I would like to express my gratitude to our child health nurse. I brought my four week-old son in for a standard check-up and weigh in. The child health nurse noticed the narrow shape and ridging of my son's head, along with a very small fontanelle. She calmly advised me that she highly recommend I get this checked, either by a doctor or PCH. I said yes, I definitely will straight away, and she went the extra mile for me, calling PCH and arranged for me to bring my son in to get checked.

Doctors at the hospital confirmed he needed at CT scan and the scan confirmed that he had sagittal craniosynostosis. I am so grateful that the child health nurse advocated for my son and did all she could to have him seen straight away. The condition is very time sensitive – as the spring assisted cranioplasty surgery must be done prior to four months old.

My son has now had his surgery and now one year later is absolutely thriving. **If it wasn't for the child health nurse, we may not have found out about my son's condition until much later**, when the only option is the much more invasive and scarier cranio vault reconstruction surgery.

The child health nurse has such a lovely kind and calming nature and really helped me through this scary time, she even gave me follow up calls to see how we were all doing. I just wanted to give my appreciation and commend her for all she has done for our family.

Neonatology

Dear Neonatal Intensive Care Unit (NICU), I just wanted to say the biggest thank you for the incredible care you gave to my daughter and I during our time in NICU. I am so grateful for your kindness, support and expertise.

She is now doing really well and that is largely because of all the wonderful people who work in NICU. You are incredible from the bottom of our hearts. Thank you.

Child and Adolescent Mental Health Services

5A thank you so much for helping me get better.

Thank you for spending your time to choose the right medication for me that has helped with almost all my problems and taking me off unhelpful medications.... **Thank you for being kind to me** and chatting to me. I'll miss you when I'm back at home.

Care Opinion

Care Opinion is an independent, online consumer feedback platform that enables members of the public to share stories about their healthcare experience.

The platform is independently moderated and supplements existing feedback and complaints systems by providing a real-time, anonymous process for consumers to be heard and for health services to respond.

Stories received during 2022–23

20	26
what was good	what could be improved

Here is an example of a story received via Care Opinion:

> I attended PCH Emergency with my child who at the time was 15 months old. I had received a call from daycare that my child was breathing funnily and had been to urgent care who referred us onto Emergency. When we attended PCH we were seen to very quickly. I was so grateful for the efforts of the nursing staff who were patient, kind, compassionate and creative in their engagement with a very poorly and overtired toddler.
>
> **I was also grateful for the excellent care of both the nursing and medical teams** who came up with a plan to stay overnight on the short stay ward for monitoring. The following day, having made massive improvement, we were discharged early and able to return home with clear care instructions.

Message from our consumer representatives

Amber Bates
Chair - CAHS Consumer Advisory Council

Amelie Farrell
Chair - CAHS Youth Advisory Council

We were privileged again this year to represent the young people and families using CAHS services at an Executive level, within our respective councils, and on the CAHS Executive Committee.

It has been a busy 12 months for the Consumer Advisory Council (CAC) and the Youth Advisory Council (YAC). We have focused on strengthening our committee structures and connecting with other consumer committees in CAHS to identify common consumer issues and jointly advocate for them at Executive and CAHS Board levels, where we regularly have opportunities to present.

We have provided feedback on how the health service has addressed difficulties experienced by consumers, given insight into several organisation-wide strategies such as the Consumer Engagement Strategy and the Disability Access and Inclusion Plan, and provided advice on a wide range of quality improvement projects.

The YAC has provided feedback on the What Matters to Me poster, and the welcome signage introduced at PCH that highlights the importance of access and inclusion for consumers from Aboriginal or culturally and linguistically diverse backgrounds, LGBTQIA+ consumers and people with disability. The YAC's advocacy has extended into reviewing staff training run at CAHS and even virtually touring the Gender Diversity Service at PCH to ensure the safety needs of our LGBTQIA+ consumers are being met.

We also had the opportunity to influence the newly launched Neurodiversity Care Program in the PCH ED, which helps children and young people feel more comfortable in stressful situations. We enjoyed making videos for Neurodiversity Celebration Week which we shared on social media to strengthen general awareness.

The CAC worked on several initiatives, including with the PCH Emergency Department to develop the ED Parent Prompt Tool which is sent to parents and carers once they have been triaged to help them prepare for conversations with the clinical team. We have also had input into some major projects, including the design of the Children's Hospice and the plans for the new Women and Babies Hospital. The CAC has also been advocating for strengthening the way the health service communicates and manages cancellations of surgeries and appointments.

Both councils have said goodbye to some longstanding members and welcomed eager new members who have brought fresh perspectives and a range of experiences. Over the next year, we will continue to work in partnership with CAHS towards a safe and accessible health service for all children and young people by *sharing our voices to shape your care.*