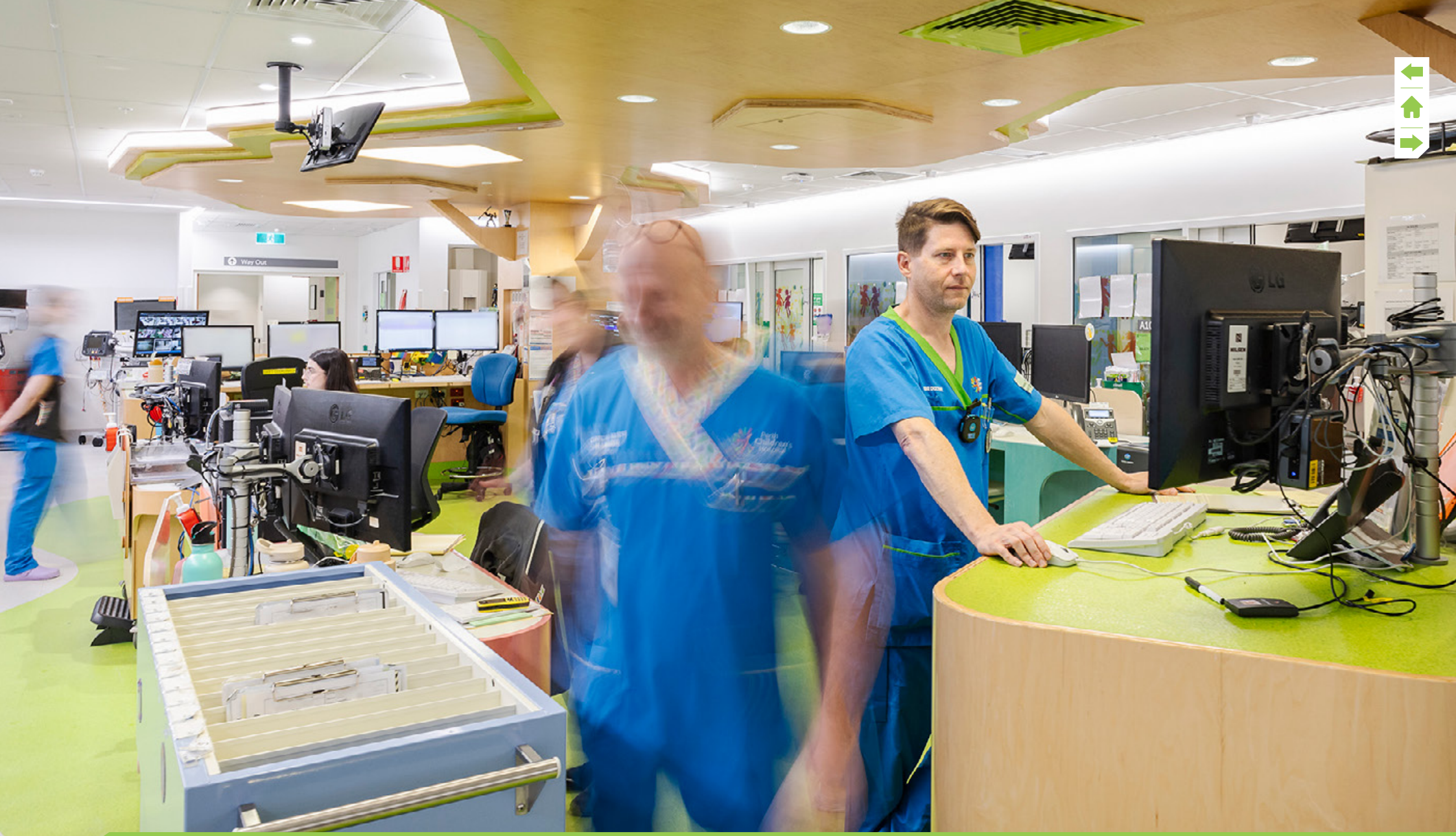


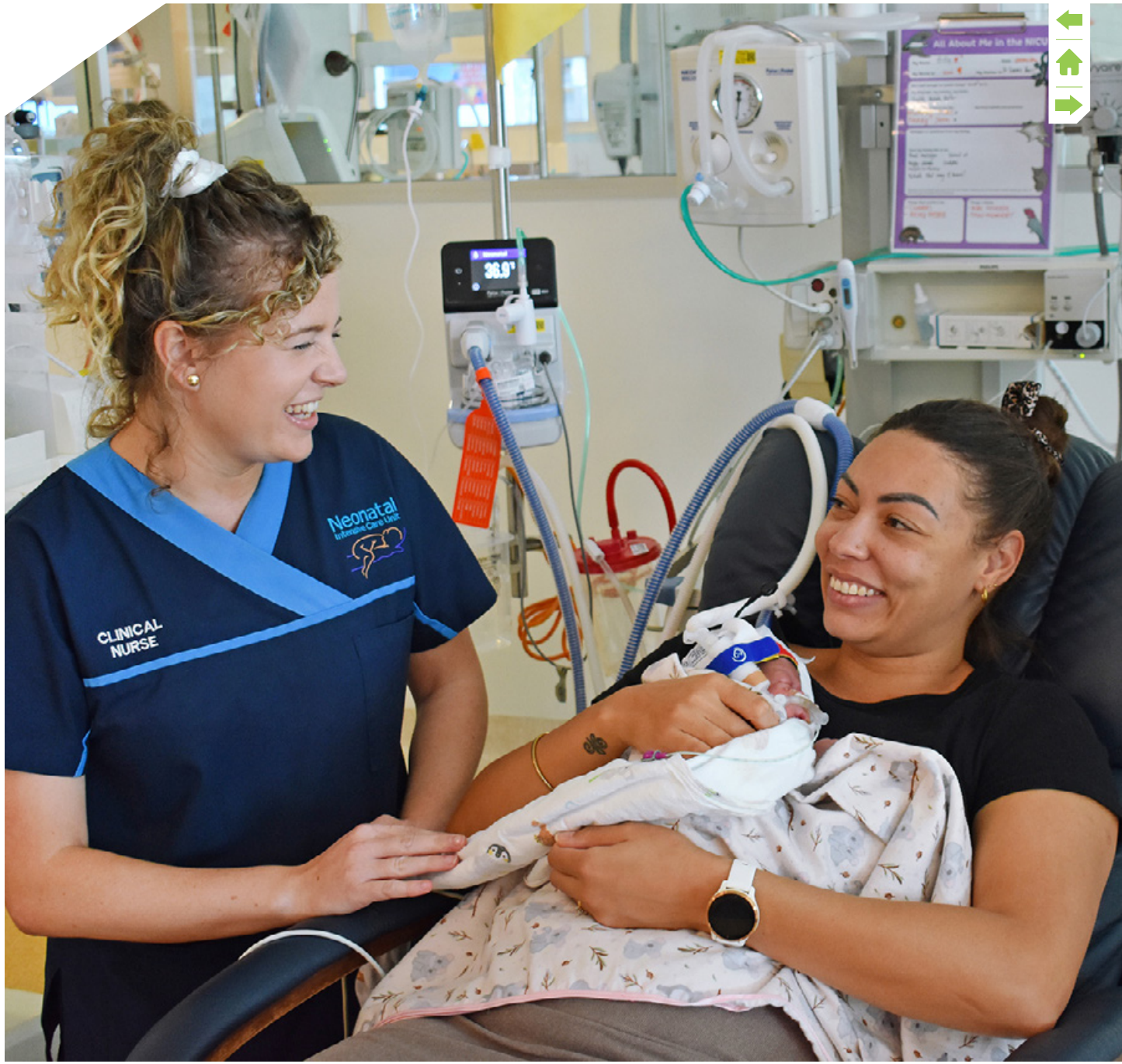
Agency performance

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, while 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 2023–24 targets are given in Table 1.



Actual results versus KPI targets

Table 1: 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	≤77.3	**56.6**
	Appendicectomy	≤23.9	**14.8**
Percentage of elective wait list patients waiting over boundary for reportable procedures	**Category 1** (≤30 days)	0%	**8.7%**
	Category 2 (≤90 days)	0%	**26.3%**
	Category 3 (≤365 days)	0%	**34.7%**
Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days		≤1.0	**0.70**
Percentage of admitted patients who discharged against medical advice (DAMA): a) Aboriginal patients; and b) non- Aboriginal patients	Aboriginal	≤2.78%	**0.24%**
	non-Aboriginal	≤0.99%	**0.10%**
Readmissions to acute specialised mental health inpatient services within 28 days of discharge		≤12.0%	**24.3%**
Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services		≥75%	**78.5%**
Average **admitted** cost per weighted activity unit		$7,461	**$9,335**
Average **Emergency Department** cost per weighted activity unit		$7,243	**$11,474**
Average **non-admitted** cost per weighted activity unit		$7,325	**$9,547**
Average cost per bed-day in **specialised mental health inpatient services**		$2,937	**$5,555**
Average cost per treatment day of **non-admitted care provided by mental health services**		$723	**$877**
Average cost per person of **delivering population health programs by population health units**		$247	**$282**

Financial summary

Table 2: Financial summary

	2023–24 Target[1] $000	2023–24 Actual $000	Variation[7] $000
Total cost of services (expense limit) (sourced from Statement of Comprehensive Income)	956,431	1,087,521	131,090[2]
Net cost of services (sourced from Statement of Comprehensive Income)	874,168	984,239	110,071[3]
Total equity (sourced from Statement of Financial Position)	1,570,121	1,628,793	58,672[4]
Net increase in cash held (sourced from Statement of Cash Flows)	(7,419)	8,332	15,751[5]
Approved salary expense level	656,480	753,206	96,726[6]

Notes

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

(2) The major causes for the variation of $131.090 million in total cost of services are the reduced funding base in the initial budget estimates, cost escalations, increased workforce capacity for Emergency Department and improved nurse-to-patient ratio, and the associated increases in patient support costs, other supplies and services.

(3) As a result of the unexpected asset revaluation increments for land ($2.375 million), higher than budgeted grants and contributions from charitable organisations ($10.567 million), other fees for services ($3.870 million) and other income ($3.317 million), the variation in net cost of services is $21.019 million less than the variance in total cost of services.

(4) The asset revaluation increments of $74.488 million for buildings have contributed to the increase in total equity. Conversely, the equity increase has been lessened by the operating deficit of $14.633 million. The details are set out in Note 9.12 'Equity'.

(5) The higher than budgeted cash held (+$15,751 million) is mainly caused by the rescheduling of capital project completion to the 2024–25 financial year for the Ward 5A reconfiguration, Midland Community Hub and Murdoch Community Hub, and the deferment of payment to accrued salaries account to 2024–25.

(6) Salaries and superannuation costs are above budget partly because of the reduced funding base in the initial estimates and partly as a result of additional staffing resourcing engaged to address essential service needs, to enhance the service capability of the Emergency Department, to improve nurse-to-patient ratio and to maintain safety and quality measures within the Perth Children's Hospital.

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

Emergency Department (ED)

The 2023–24 financial year saw 67,638 patients attend the PCH ED for assessment and treatment. Consistent with previous years, about 20 per cent required inpatient admission following initial treatment in the ED.

Percentage of emergency department patients seen within recommended times

The Australasian Triage Scale (ATS) category review time targets are supportive indicators. They measure the time to first review by an ED doctor or nurse practitioner, or the start of treatment. The triage system aims to provide a balance between the need to provide immediate care to those at highest risk with clinical resources in the ED.

Table 3: Triage categories

Triage category	Description	Response	Target	Achieved
1	Immediately life-threatening	Immediate (≤ 2 minutes)	100%	100%
2	Imminently life-threatening OR time-critical treatment OR very severe pain	≤ 10 minutes	≥ 80%	85%
3	Potentially life-threatening OR situational urgency	≤ 30 minutes	≥ 75%	30.7%
4	Potentially serious OR situational urgency OR significant complexity or severity	≤ 60 minutes	≥ 70%	46.3%
5	Less urgent	≤ 120 minutes	≥ 70%	85.6%

ATS category 1 and 2 patients remain the absolute priority for clinical assessment to ensure they receive resuscitation and emergency care for life-threatening presentations. The ED recorded a 6.25 per cent improvement (5 percentage points) for review times for ATS category 2 patients over the previous year (see Table 3).

The focus on treating the more urgent category patients, as well as an overall increase in the number of ATS category 3 patients presenting to the ED, has led to relatively static performance in meeting ATS category 3 patient review time targets.

There has been some improvement for ATS category 4 and 5 patients compared to the previous financial year.

Strategies have been introduced to help improve the ATS category 3 and 4 patient review times without affecting the performance of the more urgent categories, however it is too early to see results.

These strategies include:

- an increase in medical staff rostered in the evening and night shifts to address seasonal surges in activity and reduce the volume of patients later in the day
- additional problem-specific clinical pathways to initiate clinical care, ahead of winter 2024
- planned use of additional clinical areas to maximise clinical space for assessment and treatment during peak demand in the ED

Table 4: Percentage of PCH ED patients seen within recommended times, by triage category, 2021–22 to 2023–24

Triage category	2021–22	2022–23	2023–24	Target
1	100%	100%	100%	100%
2	84.3%	80.1%	85.3%	≥ 80%
3	51.8%	32.4%	30.7%	≥ 75%
4	62.62%	44.3%	46.3%	≥ 70%
5	93.9%	81.5%	85.6%	≥ 70%

Achievements

The Net Promoter Score (NPS) provides a snapshot of overall customer experience via exit surveys of patients who were discharged from the ED. The department has seen a significant improvement in the NPS over 2023–24, averaging 59.6 per cent for the year, with a world class score greater than 70 per cent being achieved over a 3-month period.

- 96 per cent of respondents reported they were treated with respect by staff.
- 93 per cent felt their views and concerns were listened to.
- 96 per cent reported they felt hospital staff respected their cultural values and practices.

This outstanding result reflects the commitment of the ED staff to deliver high-quality, patient and family-focused care.

More information about the NPS is available on page 29.

Quality improvements

Handover and rostering project

The handover project aimed to improve junior medical officer and registrar rosters and the medical handover process.

Two key improvements since implementation:

- Medical staff are clinically available for up to an extra 90 minutes per day because the medical handover occurs in the clinical area.
- The incorporated safety huddle has resulted in improved visibility of staffing and collaboration. It is expected this will also assist with patient flow within the department.

Clinical pathways

The use of clinical pathways aims to improve safety, patient experience and reduce the recordable wait times for eligible patients. The following clinical pathways have been created and were implemented in June 2024:

- Wheeze – start salbutamol and corticosteroids
- Croup – start Dexamethasone
- Gastrointestinal Illness – start oral fluid trial
- Minor wounds requiring suturing – apply topical anaesthesia (Laceraine).

Screening tool for teens

A new screening tool is enabling young people aged 13 and over to share important information with their clinicians to support their health and wellbeing.

The e-HEADSSS is an electronic screening tool that asks questions about home, education and employment, activities, drugs and depression, sexuality, spirituality and safety.

We started to use the tool in the ED in April 2024 and it has been received positively by patients.

The tool has given medical staff more information about their patients' mental and sexual health, wellbeing and concerns before starting their clinical assessment. This maximises the opportunity to provide optimal holistic care and equitable access to information and support for their patients and aligns with the WA Youth Health Policy vision of optimising health and wellbeing of young people in WA.

For more information on e-HEADSSS see page 57.

Research

The CAHS ED research team, led by Professor Meredith Borland AM, continues to develop evidence in paediatric emergency presentations through national and international collaborations.

The team is leading the update of the Australasian Bronchiolitis Guideline, which will continue to set the standards of care for babies with bronchiolitis across the nation.

During the reporting period the research team started or completed 13 studies into therapies for bronchiolitis, challenging behavioural disorders, post-tonsillectomy bleeds, development of clinical scores for appendicitis assessment (see page 51), recognition of sepsis and spinal injuries.
This research work is supported by competitive grants from the WA Child Research Fund, the Perth Children's Hospital Foundation, the National Health and Medical Research Council and the Medical Research Future Fund.

There have been 11 publications, with further new studies starting on management options for febrile convulsions, asthma therapies and asthma scoring systems.

ED research coordinator Dr Sharon O'Brien was a finalist in the 2024 WA Nursing and Midwifery Excellence Awards (see page 55) for her research work.

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

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 children, young people and their families. However, there are instances that may have contributed to a clinical incident or unintended harm. We take this very seriously and, with the utmost resolve, learn from these incidents to inform our journey of continual improvement.

The complexity of health care requires a robust program to identify and reduce the risk of harm to patients and clients. A good patient safety culture includes identifying and reporting clinical incidents and risks.

We are 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. Our open and transparent environment encourages staff to report incidents when something does not go as expected.

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.

CAHS takes its responsibility for children, young people, their families and the broader community seriously. The program that CAHS has in place for the investigation, learning and improvement from clinical incidents aims to build and maintain trust with the community.

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

The number of SAC 1 incidents reflects our strong culture of reporting. All SAC 1 clinical incidents are subject to a rigorous clinical incident investigation and the reports are reviewed by the CAHS Executive and the CAHS Board.

Through the SAC 1 clinical incident review, the range of factors that contribute to a patient's outcome are considered, including healthcare-related factors. It is important to note that the patient outcome does not necessarily arise as a direct cause of the incident.

In 2023–24 CAHS reported and reviewed 24 clinical incidents with a SAC1 rating.

At the time of Certification of this Annual Report, 17 reviews from the 2023–24 year have been completed. Of these, 5 incidents were approved for declassification by the Patient Safety Surveillance Unit based on findings that there were no healthcare factors that contributed to the adverse patient outcome. Seven SAC 1 incident reviews are still in progress and are not yet complete.

Table 5: Of the SAC 1 investigations that were completed or remain in progress[#], the patient outcome was noted as:

No Harm	2
Minor Harm	4
Moderate Harm	4
Serious Harm	4
Death	5

[#] Note: the table includes SAC 1 clinical incidents where the investigation is ongoing at the time of reporting. These numbers are subject to change following the completion of the investigations and any subsequent declassifications that may occur.