Government of **Western Australia**
Child and Adolescent Health Service

2020–2021

Annual Report

Acknowledgement of country

The Child and Adolescent Health Service acknowledges the traditional custodians of the land, the Whadjuk Noongar people and the Aboriginal people of the many traditional lands and language groups of Western Australia. We acknowledge the wisdom of Aboriginal Elders both past and present, and pay respect to them and Aboriginal communities of today.

Using the term Aboriginal

Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. Aboriginal and Torres Strait Islander may be referred to in the national context and Indigenous may be referred to in the international context. No disrespect is intended to our Torres Strait Islander colleagues and community.

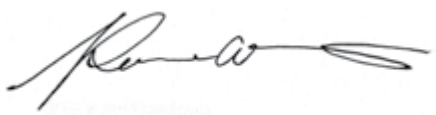
Statement of compliance

for the year ended 30 June 2021

HON ROGER COOK BA GradDipBus MBA MLA
DEPUTY PREMIER, MINISTER FOR 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 the Child and Adolescent Health Service for the reporting period ended 30 June 2021.

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



Dr Rosanna Capolingua

BOARD CHAIR
CHILD AND ADOLESCENT HEALTH SERVICE
21 September 2021

Prof Geoffrey Dobb

DEPUTY BOARD CHAIR
CHILD AND ADOLESCENT HEALTH SERVICE
21 September 2021

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Overview of agency

Locations and contact information

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Message from the Board Chair

Dr Rosanna Capolingua
Board Chair
Child and Adolescent Health Service

As the newly appointed Board Chair of CAHS, commencing in the role on 23 June 2021, my commentary on the 2020–21 financial year reflects on the efforts of others before me.

It is important to acknowledge the work of the entire CAHS Board throughout the year and formally note the resignation of Debbie Karasinski AM as Board Chair in May. I thank her for her valuable contribution over more than five years. I also recognise Professor Geoffrey Dobb for stepping into the role of Acting Board Chair.

It has been a very challenging year.

My priority and commitment is to continuously improve our health service in order to deliver the best care to children, young people and families. Children and young people are at the centre of all we do. We need to consider how the experience of being in our care is for them and their families. We need to be certain that we are providing clinical excellence; that we continuously learn, implement and improve our care, and that our priority is our patient and client. This requires everyone at CAHS to be on one team, together.

In returning, having served in the role of Chair of the CAHS Governing Council six years ago, I am reminded of the immense responsibility the Board carries in governing the health service.

I have maintained a keen interest in CAHS over the years and followed the evolution of the health service, both as a Medical Practitioner and advocate for healthcare, and as a member of the community.

I recognise the transformation that CAHS has made over recent years. Bringing Perth Children's Hospital (PCH) to life is a significant achievement, and more recently the addition of Neonatology to CAHS has broadened our focus to encompass the sickest newborn babies. Alongside our work in Community Health and Mental Health, we reach across all facets of health care from birth through to adolescence across the state.

As a health service that covers the journey from birth through adolescence, it is an incredible privilege to care for children, young people and their families. We hold the health and wellbeing of future generations in our

"We hold the health and wellbeing of future generations in our hands, and with that comes great reward but also an immense responsibility."

hands, and with that comes great reward but also an immense responsibility.

Every role across CAHS, both clinical and non-clinical, in community and hospital settings, has a direct effect on the services we provide to our patients and clients. Our focus as a Board continues to ensure that every member of staff is supported and able to do their very best every day, and contribute to the provision of safe, high quality care.

Without doubt, 2020–21 has been a pivotal year for CAHS. Alongside many notable achievements highlighted within this report, we cannot deny that there have been disappointments and challenges along the way. The tragic and unexpected deaths of our patients, Kate Savage last year, and Aishwarya Aswath in April this year are stark reminders of what is at stake. Our hearts go out to their families, and we acknowledge the ongoing pain and emptiness that becomes part of a family in the loss of a child.

These tragedies bring personal devastation to family and friends. I also know the significant impact they have had on staff across CAHS, and on the broader community.

There has been a clear acceptance of the need to learn from these tragedies and do better. Together with the Board, I am firmly focused on supporting CAHS through the processes that have emerged in response to these tragedies. This includes the Ministerial Taskforce into public mental health services for infants, children and adolescents, the implementation of recommendations arising from the Root Cause Analysis into Aishwarya's death, as well as the Commission of Quality and Safety in Health Care Independent Inquiry into PCH.

We are not waiting for recommendations from inquiries. We must always aim towards zero harm in our health care service, knowing that at times, factors will not enable this aim. The Board and Executive are focussed on all possible action to prevent further harm, and to ensure we use the opportunities to deliver excellence in health care across the organisation. We will maintain our focus on continuous improvement and an unwavering commitment to supporting staff to deliver safe, high quality care, always.

While these two tragedies and the associated response has rightly held much of our focus, it is important to reflect broadly on the events that have shaped the year for CAHS and for the wider community. I have witnessed the unprecedented demands that COVID-19 has brought in the last 18 months, and the fluctuating and somewhat unpredictable activity levels across our service. In response, our staff have shown remarkable resilience, flexibility and dedication, using their expertise and efforts to deliver the best possible service in challenging and changing circumstances. The need to increase our workforce and to drive valued based behaviour at all levels of our organisation is key.

The aspirations of our strategic plan have underlying measures and represent a long-term commitment to *healthy kids, healthy communities*. They focus our efforts on areas of critical importance to children and young people in Western Australia.

To support these endeavours, our Board members bring their personal experience

and expertise to CAHS as they work alongside Executive and senior staff to drive systems, processes and services that will generate long term and sustainable improvements at CAHS, with the focus on the patient or client.

I thank the Executive, and everyone, at every level, who are engaged in serving our Child and Adolescent Health Service in Western Australia. We collectively have responsibility for every child that comes into our care. We are not special in our roles in looking after children, but do carry a special responsibility and accountability to this vulnerable cohort. We know that across our community clinics, child health checks and immunisation programmes, we can deliver timely early intervention that can significantly improve long term health outcomes. Across CAMHS, where the needs of kids and adolescents constantly change with changing social impacts on individuals and families, we have an accountability to respond, be available, provide continuity of care and keep children safe. The challenges in Child and Adolescent Mental Health Services can seem daunting. Our role is to walk with the parents and children, no matter how difficult it may sometimes seem. I especially acknowledge the commitment of our people in this service.

We must be sensitive to all the journeys that come through our doors. We must respond to our Aboriginal families and those from CaLD communities in a way that does more than not discriminate, but is sensitive to their place and space in our community. We must never forget uniqueness and the individual circumstances of the children and families in our care.

> "Above all else, we will continue to place children, young people and families at the centre of our decision making."

Everyone with a role at CAHS, from support staff to clinicians, ward and reception clerks to security, Executive and management staff, volunteers to the members of Board, equally and collectively own this responsibility.

We will continue to work hard to ensure that CAHS has the right systems, tools, work environment, workforce and support to ensure the right decisions are made for every child and family we care for. We will respectfully and methodically look back at lessons learned, and work together to implement genuine and sustainable improvement.

Above all else, we will continue to place children, young people and families at the centre of our decision making.

Message from the Chief Executive

Dr Aresh Anwar
Chief Executive
Child and Adolescent Health Service

A sister children's hospital from across the globe has called its 2021 Annual Report "A Year of Bravery". These four words perfectly capture both the past year for CAHS and our position for the year ahead.

There is, of course, much to celebrate, however, it is the times where we have fallen short of expectations that have proven to be the most defining moments, prompting a renewed focus on both the "why" we are here and the direction we need to take going forward.

The tragic deaths of Kate Savage and Aishwarya Aswath during this year have caused immeasurable pain and distress that has been felt widely across the community.

Both incidents have triggered decisive and immediate actions and instigated longer term programs of work centred on enhancing the provision of safer, higher quality care. In the context of the scale of tragedy, this can appear no more than pithy words, however, we cannot shy away from the fact that we have not always delivered the outcomes we have aspired for, and we must acknowledge that the impact of these instances can be devastating. Indeed, every single clinical incident reflects a time when we could have and should have done better for the babies, children and young people in our care.

"...staff from across CAHS have demonstrated unwavering commitment to genuine and sustainable improvements.

So why the need to be brave? Because to be safer and better, we must acknowledge that we still have work to do. The why? The answer is of course simple – because we are here to ensure the very best for the children and families of WA. It is critical to continue to support a culture of safety, accountability, continuous improvement and child centred care at CAHS, with lessons shared across all levels of the organisation. We must ensure the first question we ask when any decision is made is: "what does this mean for children and families?"

There were some key pieces of work that have been delivered during 2020–21 that will serve as the basis for strengthening the foundations for ongoing improvements at CAHS. Whilst the efforts to realise positive change are not always immediate or obvious, staff from across CAHS have demonstrated unwavering commitment to genuine and sustainable improvements.

There has also been a clear impact on service delivery driven by demand, staffing challenges and the continuing impact of the COVID-19 pandemic.

We have, at the time of writing, been fortunate in managing the COVID pandemic in WA, however we have seen a very real impact on the children and families that we serve. In particular, there has been a significant and sustained increase in demand on mental health services, with work across CAMHS having focused on responding to urgent clinical and service issues. There has been a significant focus on the challenges facing children and families with eating disorders and gender dysphoria, and the need for enhanced provision of emergency mental health services. The capacity of these services to respond to demand has undoubtedly been challenged, and driven clinical teams to work intensely to reconfigure services to maximise access, for example through the introduction of the Emergency Telehealth Service to support children and young people experiencing episodes of more acute mental illness. Part of the CAMHS response has also included addressing recommendations from the Office of the Chief Psychiatrist review into the death of Kate Savage.

The ongoing impact of the COVID-19 pandemic provided an opportunity for CAHS to show leadership and support for the State's emergency management response. Throughout the year, the CAHS COVID-19 team has worked hard to ensure our health service was well prepared to manage community outbreaks and associated service impacts. We trained staff to support the WA's contact tracing and COVID testing efforts, and took a lead role in the rollout and ongoing management of the State delivered COVID-19 vaccination program.

In recognising that a healthy, skilled and well-equipped workforce plays a pivotal role in delivering child and family centred care, we took significant steps to expand and strengthen the People, Capability and Culture (PCC) portfolio at CAHS. The PCC strategy provides a clear roadmap to support our workforce with a multifaceted and person-centred approach, and is supplemented with aligned work programs and support systems. We must, however, also recognise that pivotal to the success of the organisation is ensuring that we have a staff base that is adequate to meet the changing and unpredictable nature of demand that has accompanied the pandemic. We have fundamentally changed the way in which we manage our hospital as a consequence. Not only have we increased the staff base to better capture the need for leave, but also provision for parental cover. Acknowledging the challenges that border closures have had on access to a specialist workforce, we have introduced a new support program allowing nursing staff with experience in the adult sector to transition their skills to caring for children. We have no doubt that this will enrich our organisation and help support provision of better, safer care for children and families.

The launch of the CAHS Multicultural Plan in March formalised the continuing work across CAHS to ensure we are providing services and support to meet the differing needs of the community we serve. There remains, however, much more to do if we are to truly demonstrate the CAHS values of compassion, respect and equity in our interactions with all children and families.

We established a dedicated innovation function to provide clear pathways to champion new and innovative ways of enhancing the work we do by fostering a spirit of innovation, curiosity and continuous

improvement. This is complemented by a Digital Transformation Program that provides clinical, digital and project expertise to drive 'clinically-led, co-designed' digital health transformation for CAHS.

Recognising the changing health landscape and value in delivering locally based services, work is continuing on the delivery of a community hub service model that will enhance access to community-based services in local communities.

Of course, some of these changes do have funding implications. The annual report clearly demonstrates that our end of year position was improved by the injection of $18.041M cash from the Department of Health on 30 June 2021. The increased funding will assist us to employ additional staff to meet increased service delivery demand. CAHS continues to undertake a recruitment program in a difficult employment market to attract the additional staff that are required.

On top of these specific highlights, I cannot express how exceptionally proud I am of our staff and volunteers who strive daily to provide high-quality care to our patients and clients. Every role in our health service plays a part in supporting children, young people and families, and I am honoured to lead a team of more than 5,000 people to support better health outcomes for children and young people.

While the date for accreditation against the National Safety and Quality Health Service Standards was postponed due to COVID-19, there has been consistent and ongoing work done to ensure we are prepared. Critically, rather than working towards accreditation as a point in time assessment, we are focused on using the Standards to guide the way we deliver the best care each and every day.

When bringing all of this together, the underlying message is an acknowledgement that the child and family must always remain at the centre of everything we do at CAHS. Changing and saving lives is central to our purpose, and our vision of *healthy kids, healthy communities* is underpinned by our commitment to continuous improvement, safe and high-quality systems, and a team that is highly trained and well supported to deliver exceptional and timely health care.

I have absolute belief that we have not, and will not, shy away from being brave, and we have and will continue to put the children, young people and families we serve at the heart of all we do.

The Health Service Board

The CAHS Board is the governing body of CAHS. Appointed by the Minister for Health, Board members have experience across the fields of medicine and health care, finance, law, and community and consumer engagement.

The Board meets on a monthly basis and met on 11 occasions during 2020–21. In this period, there were four standing committees of the Board: Finance, Audit and Risk, Safety and Quality, and People, Capability and Culture, all of which are made up of Board members with the Safety and Quality Committee also having a consumer representative. The Clinical Advisory Group, comprised of staff from across CAHS, also advises the Board on strategic issues.

During 2020– 21, the Board comprised the following members:

Board Chair, Dr Rosanna Capolingua MBBS FAMA FAICD

Dr Rosanna Capolingua is a General Practitioner with broad experience across health care delivery, serving as the Australian Medical Association (AMA) WA President and Federal AMA President. A member of the Federal AMA Executive for six years, she chaired the Ethics Medical Legal committee, Finance committee and Taskforce on Indigenous Health. She has extensive Board experience, including the Medical Board of WA, Professional Services Review Committee, Healthway and the Board of MercyCare. She was Chair of the Governing Council for the Child and Adolescent Health Service, Deputy Chair of the North Metropolitan Health Service, and a member of the WA Mental Health Commission's Alcohol and Other Drugs Advisory Board. She continues as Medical Director of the AMA (WA) Foundation, Chair of the Board of AMA (Ltd), Chair of the WA Immunisation Strategy Committee, and member of the AMA Indigenous Scholarship Foundation and St John of God Healthcare Australia Boards.

Former Board Chair, Ms Debbie Karasinski AM M.Sc., B.AppSc., OTR

Ms Debbie Karasinski was appointed to the CAHS Board as its inaugural Chair in 2016. She has worked in the health and disability sectors for the past 45 years. Her career has included Chief Executive Officer (CEO) of Senses Australia, CEO of the Multiple Sclerosis Society of WA, and Chief Occupational Therapist at Sir Charles Gairdner Hospital (SCGH). Ms Karasinski has extensive Board experience, most notably as a member of the National Disability Services Board, the WA Disability Services Commission Board and the Taxi Industry Board. She is currently a member of the Board of the Perth Clinic and Chair of the Curtin University, Health Sciences Faculty, Advisory Council. Debbie Karasinski was awarded the Member of the Order of Australia in 2019 for her contribution to people with disability and the Western Australian community and a Centenary Award in 2001 for her work with people with Multiple Sclerosis.

Deputy Board Chair, Professor Geoffrey Dobb
B.Sc.(Hons), MBBS, FRCP, FRCA, FANZCA, FCICM

Professor Geoffrey Dobb is a Consultant and former Head of the Intensive Care Unit at Royal Perth Hospital. In 2021, he was awarded honorary life membership of the Australian and New Zealand Intensive Care Society. A former Chair of the Southern Country Health Service Governing Council (WA), Professor Dobb has extensive clinical experience and knowledge of WA Health. He also has considerable experience on the Boards of healthcare organisations and professional associations, with an interest in organisational governance and safety and quality in healthcare, being a current Board member of the Australian Council on Healthcare Standards.

Board Member, Ms Miriam Bowen
LLB

Ms Bowen is currently self-employed as consultant health lawyer to private health, aged and community care clients. She was Senior Legal Counsel for St John of God Health Care from 2010–18 and previously worked as a lawyer for Mercy Care. Ms Bowen specialises in clinical risk and governance, which covers a range of legal issues arising in the health care sector. Prior to her legal work, she was a registered nurse with experience in acute clinical areas of private and public health. Ms Bowen holds a Bachelor of Laws and Diploma of Nursing qualifications. She has been a member of the CAHS Board since September 2018.

Board Member, Ms Kathleen Bozanic
B.Com., ACA, GAICD

Ms Kathleen Bozanic is a senior finance executive with over 25 years' experience and significant leadership roles as Partner of a leading professional services firm and as a Chief Financial Officer/General Manager of mining and construction companies. Ms Bozanic brings extensive experience in financial management, governance and compliance, risk management, business planning and strategic transformation, and a keen interest in WA Health. Ms Bozanic has significant Board experience in both not-for-profit and listed organisations, and is currently on the Boards of IGO Limited, DRA Global Sales Co Limited, Great Southern Mining Limited, Western Australian Rugby Union, and Future Force Foundations.

Board Member, Ms Linley (Anne) Donaldson
M.HMgt, B.AppSc., Postgrad Bus, GAICD

Ms Linley (Anne) Donaldson is a professional non-executive director with over 15 years' experience on government and not-for-profit boards, Government and tertiary education committees. Current board membership includes GP DownSouth, Mental Health Foundation Australia and ECU Human Research Ethics Committee. Ms Donaldson brings over 35 years' experience in Health and Human Services in metropolitan and regional Western Australia in senior Executive, and CEO positions. She is a former Director for the Health and Disability Service Complaints Office; a position that involved strategic leadership overseeing the management in effective resolution of health, disability and mental health complaints. During this time, Ms Donaldson was a member of the ACSQHC national committee to review the Open Disclosure Policy.

Board Member, Dr Alexius Julian
MBBS

Dr Alexius Julian is a highly-skilled clinician with significant experience in Information and Communications Technology (ICT) across health care. In particular, Dr Julian has previously served as the Chief Medical Information Officer at the St John of God Health Care Group, was a Clinical Lead in the commissioning of ICT at Fiona Stanley Hospital, and has also worked as a Medical Leadership Adviser for the Institute of Health Leadership. Alexius has a strong interest in technology, start-up and business, and is currently a self-employed clinician and works on several commercial interests.

Board Member, Dr Daniel McAullay
Ph.D, M AppEpi, B.Sc.

Dr Daniel McAullay is a health professional and a past member of the CAHS Governing Council, and has extensive experience as a member on health boards and committees. Dr McAullay currently works as the Director of Aboriginal Research at Edith Cowan University and is an Associate Professor with the Centre for Improving Health Services for Aboriginal Children and Families. Dr McAullay is a mid-career health services researcher with expertise in maternal, infant and child health, primary health care and Aboriginal health.

Board Member, Mr Peter Mott
Dip.HospAdmin, B.Bus, MIR, Grad Cert Lship

Mr Peter Mott has more than 35 years of health, executive management and CEO experience. Mr Mott is currently CEO of Hollywood Private Hospital, Vice President of the Australian Private Hospitals Association, a member of the University of Western Australia (UWA) Business School Ambassadorial Council and a member of the Young Lives Matter Foundation UWA Board. Peter is a past President of the Australian Institute of Management (AIM) WA, past Chairman of the AIM WA UWA Business School Executive Education Advisory Board, and past Chairman of Lifeline WA.

Board Member, Ms Maria Osman
M.Ed GAICD

Ms Maria Osman is an experienced Board Executive and Diversity Consultant with over 30 years' experience advising State and Federal government, private and public sectors, and universities on cultural diversity, human rights and gender equality. Ms Osman has held Executive Director roles in the Office of Multicultural Interests, Office for Women's Policy, and the Department Communities and Local Government. In 2015, she was an Australian delegate to the 59th Session of the United Nations Commission on the Status of Women in New York. Ms Osman currently serves as the Deputy Chair of Circle Green Community Legal, Advisory Board Member to the Public Policy Institute at the University of Western Australia, Member of the Premier's Supporting Communities Forum, Member of the Minister for Citizenship and Multicultural Interests Council and Council Member of the National Harmony Alliance for Migrant and Refugee Women.

Board Member, Professor Di Twigg AM
PhD, MBA, B.HlthSc. (Nsg) Hons,
RN, RM, FACN, FACHSM

Professor Di Twigg is Executive Dean of the School of Nursing and Midwifery at Edith Cowan University with research interests in patient outcomes, nursing workforce, and cost-effective care. Professor Twigg has worked in the health sector for over 35 years and held several senior health executive roles, most notably as Executive Director of Nursing Services at SCGH. She was awarded the Life Time Achievement Honour in 2017, and in 2019 was made a Member of the Order of Australia for significant service to nursing through a range of leadership, education and advisory roles.

Committee meeting attendance

July 2020 to June 2021

Name	Number of meetings	Meetings attended
CAHS Board		
Dr Rosanna Capolingua (Chair)	0	0
Ms Debbie Karasinski (Former Chair)	10	10
Professor Geoffrey Dobb (Deputy Chair)	11	11
Ms Miriam Bowen	11	11
Ms Kathleen Bozanic	11	11
Ms Anne Donaldson	11	11
Dr Alexius Julian	11	11
Dr Daniel McAullay	11	11
Mr Peter Mott	11	11
Ms Maria Osman	11	11
Professor Di Twigg	11	11
Finance Committee		
Dr Alexius Julian (Chair)	10	9
Ms Kathleen Bozanic	10	9
Professor Geoffrey Dobb	10	10
Ms Anne Donaldson	10	9
Ms Debbie Karasinski	8	7
Mr Peter Mott	10	10
Audit and Risk Committee		
Ms Kathleen Bozanic (Chair)	6	6
Professor Geoffrey Dobb	6	6
Ms Anne Donaldson	6	6
Dr Alexius Julian	6	6
Ms Debbie Karasinski	6	5
Professor Di Twigg	6	6

Name	Number of meetings	Meetings attended
Safety and Quality Committee		
Professor Geoffrey Dobb (Chair)	11	11
Ms Miriam Bowen	11	11
Ms Anne Donaldson	5	5
Dr Alexius Julian	4	2
Ms Debbie Karasinski	9	9
Dr Daniel McAullay	11	10
Ms Maria Osman	11	9
People, Capability and Culture Committee		
Professor Di Twigg (Chair)	5	5
Ms Miriam Bowen	5	5
Ms Anne Donaldson	2	1
Ms Debbie Karasinski	4	4
Dr Daniel McAullay	5	4
Mr Peter Mott	5	3
Ms Maria Osman	5	3

Our year at a glance

Neonatology

3,318
neonatal admissions

11
days average length of stay

1,065
neonatal emergency transports

383 pre-term infants received
826 litres of donor milk

Community Health

136,359
child health assessments

169,567
school health assessments (2020)

84,278
child development assessments

136,122
immunisations (2020)

CAMHS

140,337
service contacts

7,519
young people seen

493
inpatient unit separations

2,936
mental health ED presentations

PCH

67,759
Emergency Dept attendances

31,478
hospital admissions

15,999
surgeries performed

236,671 appointments for
61,281 outpatients

Vision, objectives, values

Our vision

Healthy kids, healthy communities

Our vision of 'healthy kids, healthy communities' sees that children and young people get the best start in life through health promotion, early identification and intervention, and patient centred, family focused care.

Our objectives

- Care for children, young people and families
- Provide high value healthcare
- Collaborate with our key support partners
- Value and respect our people
- Promote teaching, training and research

Our values drive us

Compassion

We treat others with empathy and kindness

Excellence

We take pride in what we do, strive to learn and ensure exceptional service every time

Collaboration

We work together with others to learn and continuously improve our service

Accountability

We take responsibility for our actions and do what we say we will

Equity

We are inclusive, respect diversity and aim to overcome disadvantage

Respect

We value others and treat others as we wish to be treated

Executive summary

The Child and Adolescent Health Service (CAHS) values of accountability, respect, compassion, equity, excellence and collaboration drive everything we do in our health service. We aspire to demonstrate these values each and every day in our interactions with children and families and with our colleagues.

This year has brought unprecedented challenges and opportunities to our health service and as we have navigated these, our values have never been more important.

Accountability

The tragic deaths of Kate Savage and Aishwarya Aswath during this year have brought into sharp focus the responsibility we have for children and young people. We have faced these very public tragedies head on and continue to focus on making ongoing improvements to how we care for, and support, the children and young people in our care.

The Chief Psychiatrist's Review into the care of Kate Savage and the resulting Ministerial

"The CAHS Board and Executive stand together in our absolute focus on continuous improvement and a commitment to supporting all staff to deliver safe, high quality care."

Taskforce have already brought change and will continue to focus attention on the support needed for children and young people. Our staff in Child and Adolescent Mental Health Services (CAMHS) have shown incredible fortitude in what has been another year of intense demand for our mental health services.

Following the unexpected death of Aishwarya Aswath in April 2021, the Root Cause Analysis provided a series of recommendations and we responded rapidly to start implementing these. The Independent Inquiry into Perth Children's Hospital was one recommendation and the report is expected in September 2021.

The CAHS Board and Executive stand together in our absolute focus on continuous improvement and a commitment to supporting all staff to deliver safe, high quality care.

Every clinical incident reflects a time when we could have and should have done better for the babies, children and young people in our care. We do not shy away from addressing the issues and challenges that lead to these incidents through comprehensive reviews and the development of multifaceted and broad reaching solutions. It is critical to continue to support a culture of safety, accountability, continuous improvement and child centred care at CAHS, with lessons shared across all levels of the organisation.

The CAHS Clinical Governance Framework continues to evolve and demonstrates our commitment to ongoing clinical safety and quality improvement. It outlines the role we all play in providing safe, high quality care with integrated corporate and clinical governance systems.

Respect

At CAHS, our biggest asset is our people, the dedicated staff and volunteers who support us. In 2020–21 we have strengthened our focus on providing a solid foundation to enable our staff to do their very best. The development of our People, Capability and Culture (PCC) directorate last year has been consolidated and we continue to build a team that focuses on supporting our staff. The development of the CAHS PCC Strategy and Framework has identified six key priorities to achieve the PCC vision of a solid foundation of leadership and partnering within a values-based environment that invests in our people and enables an agile healthy workforce that aspires towards excellence in performance over the next five years.

Staff safety, health and wellbeing continue to be a key focus of efforts and investment. This year, we maintained momentum with the development of our Work Health, Safety and Wellbeing Model which recognises the equal importance of physical and psychosocial safety, their interdependencies and the role that culture plays in these areas. This year PCC also commenced the development of an overarching wellbeing approach using consultative mechanisms along with a wellbeing communication strategy to improve staff wellbeing support.

The CAHS Learning and Development Strategy 2020–2025 has articulated our commitment to learning and development opportunities for all staff. By developing our staff, we can continue to improve the high-quality health care services for children and young people.

We also continue our journey towards becoming a values-based organisation and we maintain our commitment to invest in

our biggest asset so that we have a healthy workforce, supported and equipped to provide safe, high quality care.

Compassion

In September 2020, CAHS launched our Consumer Engagement Strategy 2020–2022 after an extended consumer and staff consultation process. This gives us a clear direction to ensure that the voice of children, young people and families is integral to how we plan, design and provide healthcare.

We have made great strides in this area, with the establishment of our new 'Engage' Online Consumer Network in December 2020, which gives consumers greater access to opportunities to be involved in the way we improve our services. In addition, our Consumer and Youth Advisory Councils continue to grow and they have had the opportunity to provide strategic advice and direction at the highest level, with the Chairs of the Councils being active members of the CAHS Executive Committee meetings.

This year, the CAHS Consumer Engagement team led the creation of a new consumer group supporting our mental health services. The Lived Experience Group, within Child and Adolescent Mental Health Services, is made up of young people, parents and carers who have experienced our mental health services in the hospital and community settings. The group provides an opportunity for consumers to play a part in shaping the provision of mental health services for children and young people.

We are incredibly grateful for the role so many children, young people and families play in sharing their experience of our health service so that we can continue to learn and improve the way our services are delivered.

Equity

We provide care to children and families from a diverse variety of cultural, religious and linguistic backgrounds and we are intently focused on improving the way we meet their needs.

This year we launched our inaugural Multicultural Plan, which supports our commitment to providing an inclusive, welcoming and equitable environment for all staff and families from WA's diverse communities. The Plan outlines a number of strategies that will be implemented during 2021 to ensure that everyone, no matter their background, feels that they belong, are respected, accepted and included, and receive equitable opportunities when using our services or as an employee.

This plan provides that focus and gives us a clear direction towards strengthening the cultural competencies of our staff. We are committed to understanding the systems that contribute to disadvantage and inequality and we are in a unique position to drive real change.

CAHS has also maintained an ongoing focus and a consolidation of the strategic goals and priorities needed to close the gap and improve the health and wellbeing of Aboriginal children.

At CAHS, Aboriginal health is everyone's business and we continue to strengthen our Aboriginal health programs while also focusing on building the capacity and capability of non-Aboriginal staff to work effectively with Aboriginal children, young people and families. We have made great strides this year in expanding our Aboriginal workforce and this will continue to be a priority.

"Our health service took a lead role in the WA COVID-19 vaccination program and our staff were agile to responding to the unique challenges and opportunities this presented."

Excellence

Our health service took a lead role in the WA COVID-19 vaccination program and our staff were agile to responding to the unique challenges and opportunities this presented. CAHS was designated in February 2021 as the lead agency for vaccination in the Perth metropolitan area, working in collaboration with the WA Country Health Service and the Department of Health to establish the WA COVID-19 Vaccination Program.

The CAHS COVID-19 Vaccination team was established to lead the initial phase of the program which saw the establishment of the first public clinics to vaccinate those most at-risk of exposure, including Australian Border Force, hotel quarantine and healthcare workers. The team worked rapidly to respond to the urgent need to establish clinics and deliver COVID-19 vaccinations to high risk workers. This included staff recruitment, induction and training of vaccinators and support staff as well as the transformation of the PCH Collegiate Lounge as the first hospital-based clinic.

The CAHS COVID-19 vaccination hub at PCH opened in February 2021 and by the time it closed in June, more than 25,000 vaccinations had been administered. The CAHS team also delivered vaccination clinics from hotel quarantine locations, Perth Airport, Perth Convention and Entertainment Centre, Claremont Showgrounds, Lakeside Joondalup Shopping Centre, Kwinana, Redcliffe and Midland.

The CAHS Vaccination team supported other Health Service Providers in the metropolitan area to establish clinics at all sites. This enabled ready access to vaccination for healthcare workers and assisted capacity building within the WA Health system to support vaccination of other vulnerable groups such as homeless and incarcerated.

Collaboration

Our non-government organisations and research partners provide additional support to the children and families we care for in a multitude of ways. We work with a range of NGOs across our health service and we are proud of the collaborative way we work together to support children and families.

Of note this year is our partnership with Perth Children's Hospital Foundation to build Western Australia's first children's hospice. This partnership will enable us to provide even better services for children with a life-limiting condition.

The Foundation has committed to funding the construction, fit out and ongoing non-operational costs of the hospice and CAHS will fund the ongoing clinical and support services and be responsible for governance, management and ongoing operational of the hospice.

The hospice will provide the clinical care of a hospital but the feel of a home in a beachside setting. This will include respite care and support for families.

Partnerships like this enable us to provide even better services for children and families and we are grateful to all our partner organisations for the role they play.

Operational structure

Legislation

Enabling legislation

The Child and Adolescent Health Service (CAHS) was established as a Board governed health service provider in the Health Services (Health Service Provider) Order 2016 made by the Minister for Health under section 32 of the *Health Services Act 2016*. CAHS is responsible to the Minister for Health and the Director General of the Department of Health (System Manager) for the efficient and effective management of the organisation.

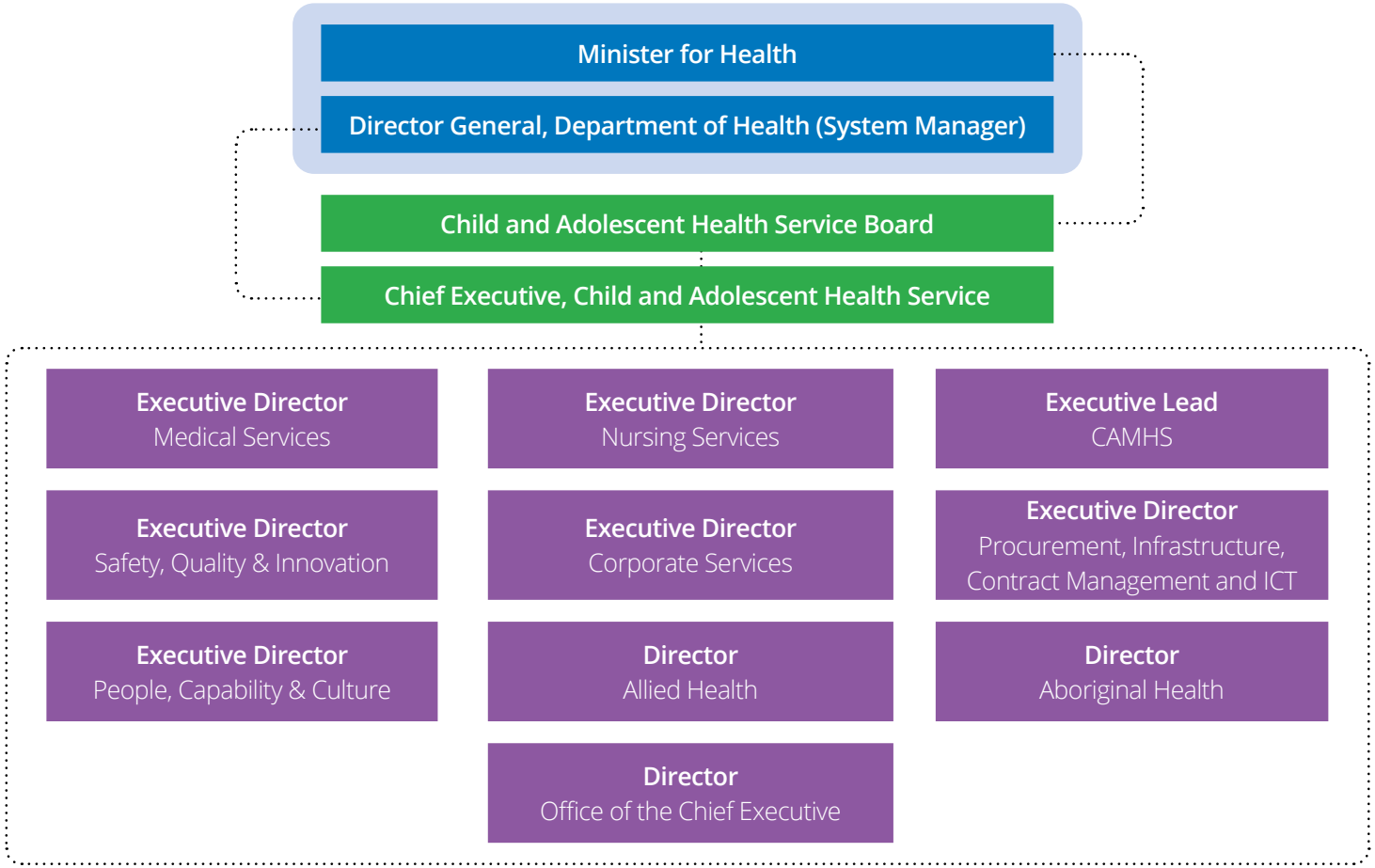
Accountable authority

The CAHS Board was the accountable authority for CAHS in 2020–21.

Responsible Minister

CAHS is responsible to the Minister for Health, the Hon Roger Cook MLA.

CAHS Management Structure 2020–21



Senior officers

Child and Adolescent Health Service
Chief Executive
Aresh Anwar
1 July 2020 – 14 February 2021
19 April 2021 – 30 June 2021

Child and Adolescent Health Service
Acting Chief Executive
Simon Wood
15 February 2021 – 18 April 2021

Medical Services
Executive Director
1 July 2020 – 14 February 2021
19 April 2021 – 30 June 2021

Medical Services
Acting Executive Director
Louise Houliston
15 February 2021 – 18 April 2021

CAMHS
Executive Lead
Katie McKenzie
15 February 2021 – 30 June 2021

Nursing Services
Executive Director
1 July 2020 – 14 February 2021

Nursing Services
Acting Executive Director
Terri Barrett
15 February 2021 – 30 June 2021

Safety, Quality and Innovation
Executive Director
Mary Miller
1 July 2020 – 30 June 2021

Corporate Services
Executive Director
Tony Loiacono
1 July 2020 – 30 June 2021

Procurement, Infrastructure, Contract Management and ICT
Executive Director
Danny Rogers
1 July 2020 – 30 June 2021

People, Capability and Culture
Executive Director
Valerie Jovanovic
1 July 2020 – 30 June 2021

Allied Health
Director
Emma Davidson
1 July 2020 – 30 June 2021

Aboriginal Health
Director
Mel Robinson
12 October 2020 – 30 June 2021

Office of the Chief Executive
Acting Director
Joanne Mizen
1 July 2020 – 30 June 2021

About CAHS

The Child and Adolescent Health Service (CAHS) is proud to be the leading service provider for paediatric healthcare in Western Australia, as the state's only dedicated health service for infants, children and young people. CAHS is made up four service areas: Neonatology, Community Health, Child and Adolescent Mental Health Services (CAMHS), and Perth Children's Hospital (PCH).

Our health service is uniquely positioned to ensure all children get the best start in life and receive the best possible care. Our services are delivered at PCH and across a network of more than 160 community clinics across the metropolitan area, ensuring the many aspects of care we provide are accessible close to where children and families live.

At CAHS, we strive to exemplify six core values: compassion, collaboration, respect, equity, accountability and excellence in all we do as we work toward our vision of *healthy kids, healthy communities*. Our strategic objectives provide a clear direction for our core services, and a focus for continuous quality improvement, excellence and innovation:

1. **Care for children, young people and families**
2. **Value and respect our people**
3. **Provide high-value healthcare**
4. **Promote teaching, training and research**
5. **Collaborate with our key support partners**

Neonatology provides Statewide tertiary neonatal services to the sickest newborn babies and infants in WA. Neonatology encompasses a range of services, including the Neonatal Intensive Care Unit (NICU), Special Care Nursery, Newborn Emergency Transport Service and Perron Rotary Express Milk Bank. Neonatology services are delivered at King Edward Memorial Hospital and PCH.

Community Health provides a comprehensive range of community-based early identification and intervention services, as well as health promotion, to infants, children, adolescents and families across the Perth metropolitan area; a region spanning 7,250 square kilometres. A key focus of Community Health is growth and development in the early years, and promoting wellbeing during childhood and adolescence. Service delivery is both universal and targeted, with services provided in a variety of settings, including homes, local community health centres, child and parent centres and schools. The service includes a number of specialist community based services, including immunisation, enuresis, and Aboriginal and refugee health.

Child and Adolescent Mental Health Services (CAMHS) provide mental health services to children, adolescents and their families across the Perth metropolitan area. Services include community-based programs as well as inpatient care and a range of specialised services for children with complex mental health conditions.

Perth Children's Hospital (PCH) is WA's only dedicated paediatric hospital and provides tertiary services for the State. The hospital provides inpatient, ambulatory and outpatient services. PCH is the home of WA's only paediatric trauma centre and the State's first intraoperative magnetic resonance imaging machine. PCH also houses the Stan Perron Immunisation Centre, which is available to all children and families attending the hospital to help them stay up-to-date with their scheduled immunisations.

Shared responsibilities with other agencies

CAHS partners with a large number of community and non-profit organisations that make significant contributions to support our patients, clients, families and carers. CAHS values these partnerships, as they are integral to the safe and high quality delivery of paediatric health care services.

CAHS works closely with numerous agencies, including, but not limited to the Mental Health and Disability Services Commissions and the Departments of Health, Education, Aboriginal Affairs, Child Protection and Family Support, and Justice, and the Health and Disability Service Complaints Office.

CAHS recognises the contribution of non-government organisations (NGOs) to the health service, with 'collaborate with key support partners' being one of the five objectives of the CAHS Strategic Plan 2018–2023. Strong partnerships with NGOs facilitate the transition of care from tertiary services to the community and not-for-profit sector, contributing to better health outcomes and a more sustainable health care system.

In 2020–21, CAHS partnered with over 75 NGOs through a range of contractual arrangements, including:

- Those who have a licence agreement for the occupancy of a dedicated space at PCH. These organisations provide services to patients and families without remuneration from CAHS.
- Visiting NGOs who have an access agreement with CAHS, enabling them to visit PCH to provide advocacy, support and education without remuneration from CAHS.
- Those with whom we have a formal contract, awarded after a procurement process, and are funded to provide a range of health-related services in the community.

Performance management framework

To comply with its legislative obligations, CAHS operates under the WA health system's Outcome Based Management Framework. This framework describes how outcomes, services and key performance indicators are used to measure agency performance towards achieving the relevant overarching whole-of-government goal. Key performance indicators measure the effectiveness and efficiency of services provided by the WA health system in achieving the stated desired outcomes.

All WA health system reporting entities contribute to achieving the outcomes through health services delivered either directly by the entities or indirectly through contracts with non-government organisations.

The WA health system's outcomes and key performance indicators for 2020–21 are aligned to the State Government goal of *strong communities: safe communities and supported families* (see Figure 1).

The outcomes for achievement in 2020–21 by CAHS are:

Outcome 1: Public hospital-based services that enable effective treatment and restorative health care for Western Australians.

Outcome 2: Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives.

Figure 2 shows how the different services CAHS provides align to Outcome 1 and 2.

Performance against activities and outcomes is summarised in the Agency Performance section, and described in detail under Key Performance Indicators in the Disclosures and Legal Compliance section commencing on page 122.

Figure 1: Outcomes and key effectiveness indicators aligned to the State Government goal for CAHS

WA STRATEGIC OUTCOME (WHOLE OF GOVERNMENT)

Strong Communities: Safe communities and supported families

CAHS VISION

Healthy kids, healthy communities

CAHS OBJECTIVES

1. Care for children, young people and families **2. Value and respect our people** **3. Provide high value healthcare**
4. Promote teaching, training and research **5. Collaborate with our key support partners**

Outcome 1

Public hospital based services that enable effective treatment and restorative health care for Western Australians.

Key effectiveness indicators contributing to Outcome 1

- Unplanned hospital readmissions for patients within 28 days for selected surgical procedures
- 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
- Percentage of admitted patients who discharged against medical advice: a) Aboriginal patients; and b) Non-Aboriginal patients
- Readmissions to acute specialised mental health inpatient services within 28 days of discharge
- Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services

Outcome 2

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

Key effectiveness indicators contributing to Outcome 2

These are reported by the Department of Health for the whole of the WA health system

Figure 2: Services delivered to achieve WA Health outcomes and key efficiency indicators for CAHS

Outcome 1

Public hospital based services that enable effective treatment and restorative health care for Western Australians.

Services delivered to achieve Outcome 1	KPIs measured
1. Public hospital admitted services	Average admitted cost per weighted activity unit
2. Public hospital emergency services	Average Emergency Department cost per weighted activity unit
3. Public hospital non-admitted services	Average non-admitted cost per weighted activity unit
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 2

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

Services delivered to achieve Outcome 2	KPIs measured
5. Aged and continuing care services	(none)
6. Public and community health services	Average cost per person of delivering population health programs by population health units

Changes to Outcome Based Management Framework

The WA health system Outcome Based Management (OBM) Framework received minor updates 2020–21. One surgical procedure within the key performance indicator *Unplanned hospital readmissions for patients within 28 days* was removed on the basis it was no longer appropriate.

Performance highlights

Neonatology

The Neonatology service provides a statewide tertiary neonatal service to the sickest newborns babies and infants in Western Australia.

The service includes two Neonatal Intensive Care Units (NICU) across two hospital sites: PCH and King Edward Memorial Hospital (KEMH). In 2020–21, there were 3,318 admissions to CAHS Neonatology inpatients services, with 50.6 per cent needing intensive care and 49.6 per cent requiring special care. The most common reasons for admission include respiratory conditions, prematurity and hypoglycaemia. The average length of stay for neonatal inpatients was 11 days, ranging from less than one day to as many as 156 days.

NICU Dad catch up group

Over 2,000 fathers come through the NICU every year. Statistics indicate that approximately 400 of them will experience post-natal depression due to the stress and trauma of their experience whilst their baby is in hospital. The focus of most post-natal support services are exclusively directed towards the mothers of NICU babies, with no structured services available for fathers. In September 2020, it became evident to Neonatology nursing, medical and social work staff that a number of fathers were suffering and required support. A meeting of NICU fathers further demonstrated their desire to have access to male orientated psychological and group support. In response, the *NICU Dad Catch Up* group was formed.

The NICU Dad Catch Up group meets fortnightly, and is usually facilitated by a male nurse, who has previously had a premature baby in NICU. The group is supported by volunteers, including a doctor, social workers, lactation consultant and ex-NICU parents. Fathers who attend the group are encouraged to talk about their experiences, ask questions about their babies' care and make connections that will offer them peer-to-peer support during their time in NICU and beyond. Future plans include applications for funds to support a project to engage a psychologist or mental health worker to be available for one-to-one counselling, to support group meetings therapeutically, and develop male-orientated parenting education.

Neonatology Post Discharge Support Service

Babies born prematurely or with a low birthweight require specialist care and support to facilitate the transition from hospital to home. The Neonatology Post Discharge Support Service provides specialist outreach care beyond the boundaries of the hospitals (both PCH and KEMH NICUs) to promote health in this extremely vulnerable population. The service aims to partner with parents to build capacity in caring for their baby at home and provide essential connection with key community services.

In February 2021, the Neonatology Post Discharge Support Service criteria expanded to include more

babies born prematurely or with a low birthweight, and to provide support to families post discharge regardless of where they live in WA. All infants born under 35 weeks gestational age at birth and/or under 1,800g birthweight are now eligible for support post discharge (previously <32 weeks and/or 1,500g). The Service bridges the gap between hospital and community provision from child health nursing services by monitoring progress via home visits for this at-risk cohort with specific care needs. The expanded service now offers support statewide for families living outside the metropolitan area via Telehealth.

Community Health

Child Health Nursing

CAHS Community Child Health Services comprise a range of primary prevention and early intervention programs focused on the health, development and wellbeing of children between birth and school entry. These services are offered at more than 160 sites across the Perth metropolitan area.

Child Health Services support the principle of progressive universalism, which aims to improve health equity and outcomes by providing support for all, with more support for those who need it most. The universal program comprises five high-quality health and developmental assessments at scheduled touch points, as well as a range of group-based and one support services.

During 2020–21, 26,465 new babies were welcomed into the Universal Child Health Program from birth, with 25,917 (98 per cent) accepting the offer of a postnatal home visit in the early postnatal period.

Community child health nurses provided a total of 131,549 individual child health contacts during the year, including 42,351 'Universal Plus' contacts for families needing additional support. This number includes both clinic and home visits. In response to COVID-19, child health nurse contacts were divided into two components: a phone call to discuss progress and concerns, followed by a short face-to-face visit for nurses to complete the physical component of the child health check. The face-to-face component has been recorded as Universal Plus contacts.

In addition to individual contacts, child health nurses delivered 3,683 parenting group sessions to 14,869 parents and saw 7,370 families at drop-in sessions throughout the year. Changes to service delivery as result of COVID-19 resulted in suspension of drop-in sessions between April and December 2020 and their resumption in January 2021.

School Health Nursing

Community school health nurses work with school staff and parents to deliver prevention and health promotion services, undertake health assessments, develop health care plans for students with complex or chronic health needs, and connect children and adolescents with other health services and supports as required.

Throughout 2020 and 2021, CAHS, in collaboration with the WA Country Health Service and the Department of Education, continued to implement the recommendations from the Review of School-aged Health Services. These recommendations relate to key aspects of the service delivery model, the role of community nurses working with children and young people, and workforce utilisation and supports. A number of initiatives have been progressed, including offering school entry health

NEW BABIES WELCOMED
26,465

SCHOOL AGED HEALTH REVIEW RECOMMENDATIONS
9

CHILD HEALTH CONTACTS
131,549

SCHOOL ENTRY HEALTH ASSESSMENTS
24,894

'UNIVERSAL PLUS' CONTACTS
42,351

SECONDARY STUDENT OCCASIONS OF SERVICE
68,409

GROUP SESSIONS
3,683

EDUCATION SUPPORT OCCASIONS OF SERVICE
62,957

VACCINATIONS ADMINISTERED (2020)
136,122

CHILDREN IMMUNISED (2020)
18,515

STUDENTS IMMUNISED (2020)
38,419

assessments during school holidays to enable parents to attend the appointment.

A core component of primary school health services is a universal School Entry Health Assessment (SEHA). During the 2020 school year, 24,894 (96 per cent) of children enrolled in kindergarten received a SEHA. In 2021, 148 SEHAs were provided during the January school holidays.

School health nurses also support children in secondary and education support schools, providing 68,409 occasions of service to secondary students and 62,957 occasions of service to students in education support facilities.

Nursing services in schools work within a primary health care role, i.e. in partnership with student services (where available) to support identification, first line support and referral for school aged children with psychosocial, mental health and wellbeing concerns.

Community Health also provides a community-based enuresis service for children experiencing nocturnal enuresis. This includes assessment, referral if needed, and provision of support, including alarm mats when appropriate.

Immunisation

Community Health provides free vaccinations as per the WA Immunisation Schedule, including immunisation and services for secondary students under the School Based Immunisation Program. Community Health also plays a key role in vaccination of complex clients, including humanitarian entrants, and seasonal influenza vaccination campaigns.

During 2020, community health nurses delivered a total of 136,122 vaccinations through the Childhood and School Based Immunisation Programs. Immunisations for 0–4 year-olds were provided from more than 50 community-based facilities across metropolitan Perth, with 61,991 vaccinations delivered to 18,515 children. Through the school-based program, Community Health delivered 74,131 vaccinations to 38,419 students at 196 schools across metropolitan Perth.

Child Development Service

The metropolitan Child Development Service (CDS) provides a range of assessment, early intervention and treatment services to children with developmental delay or

difficulty that impact on function, participation and/or parent-child relationship. The multidisciplinary teams work closely with families to plan and set goals based on their child's strengths and interests, and the parents' concerns and priorities for their child.

Demand for child development services continues to grow, with 30,594 discipline referrals[1] accepted during 2020–21, up 14 per cent on 2019–20 and 15 per cent in the past three years.

Families referred to the service are generally invited to attend a service planning appointment within eight weeks of referral. During this appointment, we discuss parents' concerns for their child, goals and priorities, and together we develop an agreed service plan. During 2020–21, 9,741 families received a service planning appointment. Depending on the child's needs, service options can include parent workshops, group interventions, home or school visits and individual treatments.

During 2020–21, 29,412 children received services from CDS, representing around 6 per cent of the 0–18 year old population.

1 *Some children with complex developmental difficulties are referred to multiple disciplines.*

Children aged 3–7 years account for the majority of children seen, in line with the focus on early intervention.

The demand for an autism assessment continues to grow, with 493 formal referrals received in 2020–21; a 22 per cent increase on the previous year. A total of 380 assessments were completed. The numbers cited do not reflect additional opportunistic diagnostic assessments completed for younger children at their local Child Development Service site.

CDS Telehealth

The delivery of telehealth services became increasingly important within the context of restrictions associated with COVID-19.

The Child Development Service, like many other health services, had to adapt its service model quickly, conducting appointments via telehealth in order to continue providing allied health and medical services to Western Australian children and families. Between July 2020 and June 2021, CDS provided a total of 9,229 individual telehealth appointments (telephone and video calls). Technology did not support the provision of group services. To understand how effective the provision of telehealth services was during the COVID-19 related restrictions and to identify areas for improvement, CDS undertook an extensive mixed method telehealth evaluation, analysing CDS appointment data and surveying 103 CDS staff and 663 consumers.

Telehealth was shown to be an acceptable form of service provision, with staff and consumers suggesting telehealth, in the form of both video and telephone calls, should continue to be offered as a service option that is selected based on clinical appropriateness and family preference. Although consumers viewed telehealth services positively, they overwhelmingly preferred the option of clinic-based appointments (93.4 per cent), followed by telephone (37 per cent) and video call (32 per cent) appointments.

DETECT COVID-19 Asymptomatic Testing

As part of the COVID-19 DETECT research Community Health supported the first module of a three module research project. This Telethon Kids Institute project collaborated with numerous partners, including Department of Education, Department of Health, CAHS, WA Country Health Service and PathWest.

Module One entailed testing asymptomatic metropolitan and regional school students

CDS REFERRALS ACCEPTED
30,594

CDS SERVICE PLANNING APPOINTMENTS
9,741 WITHIN 8 WEEKS

CHILDREN SEEN BY CDS
29,412

(aged 4 to 18) and staff across 40 schools. Three teams completed testing in schools across the metropolitan area, each consisting of a clinical nurse (team lead) recruited from Community Health and three registered nurses recruited from various areas of PCH.

The skill mix of nurses recruited from PCH and Community Health to make up the testing teams supported all aspects of the project. This has been a great opportunity for two areas of our health service to work together and achieve a great outcome.

Focused asymptomatic testing was a valuable part of ongoing monitoring for COVID-19 and DETECT complemented testing requirements for exempt travellers and other groups, such as transport, freight and logistics.

As part of recent COVID-19 community contact tracing, the DETECT team supported a pop-up testing clinic for children and families within the child care setting.

Child and Adolescent Mental Health Services

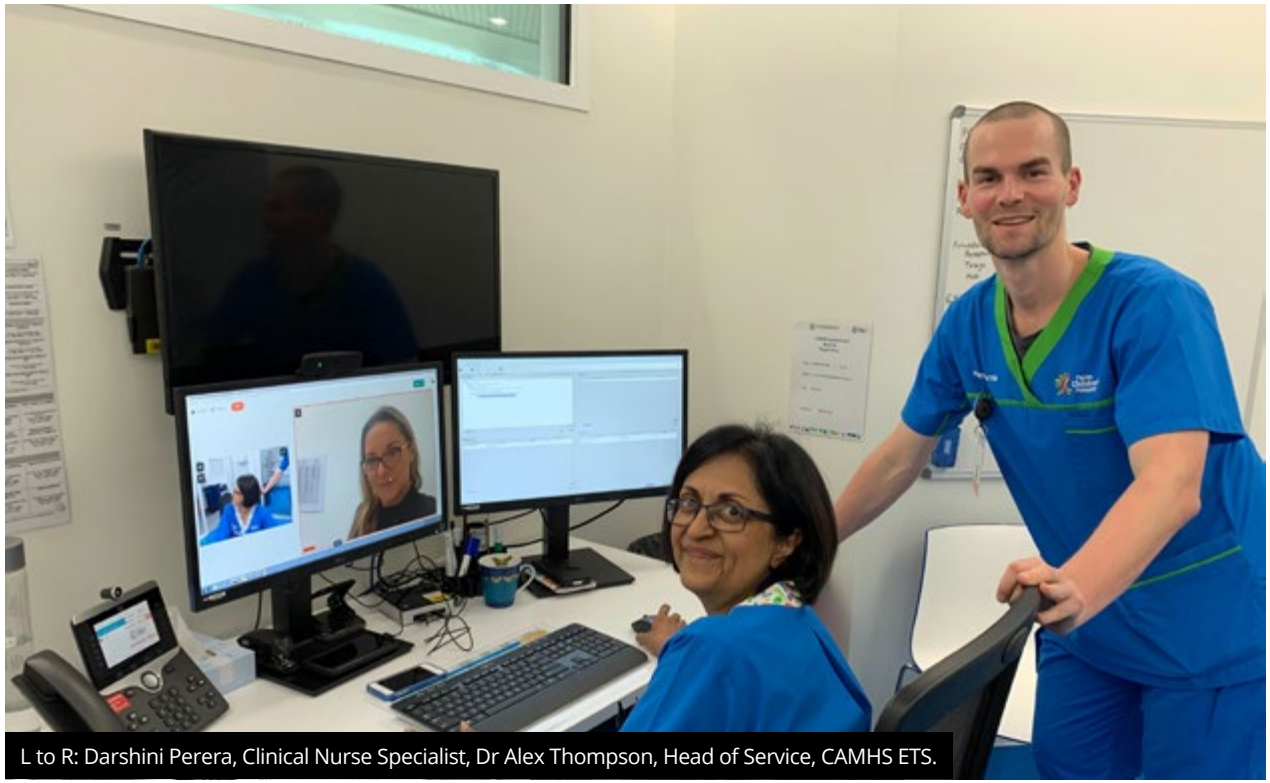
It has been busy year for all CAMHS teams, with many challenges and opportunities.

CAMHS Emergency Telehealth Service

The CAMHS Emergency Telehealth Service (ETS) opened on 13 July 2020, led by Consultant Psychiatrist Dr Alex Thompson. The CAMHS ETS provides telephone and video call support for children and young people experiencing a mental health crisis and to their families, educators and other health professionals. It aims to provide expert help to children and young people quickly, when they need it most. The CAMHS ETS also provides an 'in reach' service to other metropolitan emergency departments, ensuring children and young people have the opportunity to be assessed by child and adolescent trained staff, even if they are not available at the presenting hospital.

In 2020–21 CAMHS ETS received 4,095 triage calls. Of those callers who chose to provide their details, the majority of calls (65 per cent) were for young people 13–15 years of age. The next largest user groups were young people 10–12 years of age (15 per cent) and 16–18 years of age (14 per cent). Most calls received were from people within metropolitan Perth (91 per cent), and four per cent of callers reported identifying as being Aboriginal and/or Torres Strait Islander.

All callers receive a follow-up call from CAMHS ETS staff the following day. Children and young people discharged from the CAMHS inpatient unit also receive a follow up call within seven days of discharge to ensure they are receiving the support they need. In addition, CAMHS ETS staff also provide comprehensive mental health assessments in the PCH Emergency Department, with 398 of these completed by the team in 2020–21. The CAMHS ETS has received additional Mental Health Commission funding in 2021–22, and we look forward to reporting on an expanded version of the CAMHS ETS next year.



L to R: Darshini Perera, Clinical Nurse Specialist, Dr Alex Thompson, Head of Service, CAMHS ETS.

Members of the CAMHS Lived Experience Group before their first meeting.

CAMHS Lived Experience Group

Consumers, families and carers are the centre of all we do at CAMHS, so it is vital to ensure everything is driven by the needs of children, young people and families – our most important stakeholders. Introducing the CAMHS Lived Experience Group has been a logical next step in the growth of CAMHS, which was done in partnership with the CAHS Consumer Engagement team. The group is co-chaired by two young people and a carer representative, who work as a group to ensure a collaborative approach to meetings and actions. The group meets monthly and has input in a range of CAMHS initiatives.

Pathways renovation

The Pathways Therapeutic Day Program is an evidence-based specialist service providing children aged 6–12 years with co-occurring educational, behavioural and mental health conditions an intervention to address these issues as an alternative to traditional schooling. Each Pathways cohort attends for one school term, before 'graduating' and taking their learnings and strategies back to their usual school setting.

For most children attending Pathways, it is like starting at a new school. It is important the environment is as welcoming and friendly as our staff. The Pathways facility, located in Shenton Park, has had a major facelift to ensure it is fit for purpose and gives the best opportunities for children and staff to be their best. The improvements, funded by WA Health minor works funding and co-coordinated by the CAHS Infrastructure team and Pathways leadership, have been very well received by all. The outdoor play area has been converted into an undercover gym, which is excellent for the year-round Morning Movement and Fit for Play activity sessions children do daily with Pathways specialist exercise physiologists. The renovation is paving the way for even better outcomes for kids.

Zamia Pedro, Clinical Psychologist, and Yulia Furlong, Head of Service, Paediatric Consultation Liaison Service.

PCH EXPAAND Project

Clinicians in the Paediatric Consultation Liaison (PCL) CAMHS team work with children and young people with mental health concerns who are already being cared for by another PCH team. The PCH EXPAAND[2] project is a hospital-based research project that has been designed by the PCL team to help us understand Deliberate Self Harm (DSH) in children and young people. The study aims to understand the causal factors that increase the risk of DSH as a first step to preventing and treating DSH in children and young people.

The project will explore aspects of emotional functioning and attention spectrum disorders (including ADHD), each of which has been identified as elevating the risk of DSH. EXPAAND addresses the issue of repeated DSH presentations in three stages. Relevant PCH Emergency presentations will be assessed for a 12 month period, so the relationship between attentional disorders and DSH can be analysed. Finally, the project will use a Randomised Control Trial design to test the effectiveness of a brief psychological intervention tool on clinical presentation, service use and engagement in treatment, post-intervention. We look forward to reporting on the findings next year.

2 EXploring Psychiatric and Attentional risk factors in children and Adolescents Needing intervention for Deliberate self-harm.

The new Armadale CAMHS

After being required to vacate their previous premises in Armadale in 2020, the Armadale CAMHS team was temporarily relocated to PCH Clinic K. The team did a commendable job of maintaining services to the Armadale community during this period of time while also working closely with the CAHS Procurement and Infrastructure team to locate and fit out new premises in Fourth Road, Armadale. The new premises are located next to a headspace centre and in close proximity to both Armadale Shopping Centre and Armadale train station.

The facility has an open, spacious feel, with the colour scheme and artwork in each room inspired by Aboriginal healing motifs and the Noongar seasons. It is also equipped with the latest technology to enable services via telehealth and collaboration with other services, and bigger spaces to enable group activities and larger group therapies, such as Reflective Family Therapy. The facility officially opened on 9 June 2021.

Pictured (L - R): David Albanis (Service Manager), Sally-Anne Greengrass (Aboriginal Mental Health Worker), Anne Donaldson (CAHS Board Member) and Hon Stephen Dawson MLC (Minister for Mental Health) at the opening of the new Armadale CAMHS.

Perth Children's Hospital

Central Venous Access Device Service

The Department of Anaesthesia and Pain Medicine has worked collaboratively with senior nursing, radiology and surgical teams to establish a PCH Central Venous Access Device (CVAD) service. This service now coordinates the end-to-end care of children who need complex therapy via long term intravenous devices; from initial request through to device removal. Using evidence-based principles ensures the most appropriate device is used for each child to enable their therapy, which results in fewer complications and better outcomes. The CVAD service is coordinated by a nursing team that has had extensive training with insertion and care of CVAD devices, and which promotes research and education throughout CAHS to achieve the best outcomes for children needing long-term intravenous therapy.

Procedural Sedation Service

Many children are unable to tolerate simple procedures such as a blood tests, intravenous medications and even vaccinations. The Department of Anaesthesia and Pain Medicine has recently commenced the Procedural Sedation Service for children attending PCH that experience procedural anxiety. This service enables children to have procedures completed under sedation, creating a stress and anxiety reduced experience for both patients and their caregivers. The Procedural Sedation Service ensures patients are safely distracted, sedated with oral medication or, on some occasions, anaesthetised, in a monitored environment with the appropriately trained staff. The Procedural Sedation Service is a great example of PCH staff identifying an area of unmet need for patients and developing a model of care to provide for the most vulnerable children.

Elective Surgery Waitlist Recovery Project

The Elective Surgery Waitlist (ESWL) Recovery Project (July to December 2020) supported a reduction in the number of over-boundary reportable and non-reportable cases from 1,253 in June 2020 to 570 cases by end December 2020, largely reversing the COVID-related waitlist increase and returning the number of over-boundary cases to near pre-COVID levels. Throughout the duration of the project, approximately 9,000 elective surgical procedures were undertaken, reflecting a significant increase in theatre activity, which enabled a number of children to receive life changing surgical procedures. The increased effort has assisted in reducing the percentage of children waiting over-boundary from 32.9 per cent in June 2020 (reportable procedures) to 17.8 per cent in December 2020.

Inter-generational dental care at CAHS

Cate may be considered an 'old girl' of Princess Margaret Hospital, but not because of her age; she was treated for bilateral cleft lip and palate in the 1980s. Cate had various cleft-related surgeries, including lip and palate repair and an alveolar bone graft performed by Harold McComb, one of the founders of the Cleft Lip and Palate Unit.

Cate's children Phoebe and Oscar are both current patients of PCH. Phoebe has a unilateral cleft lip and palate and Oscar a bilateral cleft lip and palate. They are being treated by the multidisciplinary team of clinicians that makes up the Cleft Team, which includes the Department of Dental Medicine.

All the dental specialties collaborate to ensure the best possible outcome for the patient, both functionally and aesthetically. These include Paediatric Dentistry, Orthodontics, Periodontics, Prosthodontics, Maxillo-facial Surgery, Dental Medicine and Dental Hygiene/Therapy.

The Department of Dental Medicine currently has 3,200 patients with cleft lip and palate, and just like Cate, Phoebe and Oscar, they will receive care until growth maturity or transfer to adult services.

Orthopaedic surgery

Prior to the ESWL Recovery Project, PCH offered one spinal surgery operating list per month, which was increased to a weekly operating list throughout the duration of the project. The additional spinal surgery operating lists meant that children who had been waiting prolonged periods of time for their surgery were able to be operated on, thereby reducing the average wait time from three years to six months as of 31 December 2020. A collaborative multi-disciplinary team approach was required to facilitate the additional spinal operating lists, with the Paediatric Critical Care Unit, Neurology and Orthotics departments all playing an important role in supporting the surgical team.

Many of the children requiring spinal surgery have complex conditions and medical needs that have significant impact on their health, wellbeing and quality of life. In order to continue to treat this cohort of patients within a reduced timeframe, PCH has received funding to permanently increase the number of spinal operations to one list each week.

Treatment of children with cystic fibrosis

The 2019 Centre Comparisons for Australian Cystic Fibrosis Centres (published 16 March 2021) reported that PCH has the best lung function outcomes for children, and that lung function was higher for children in the PCH clinic than for children

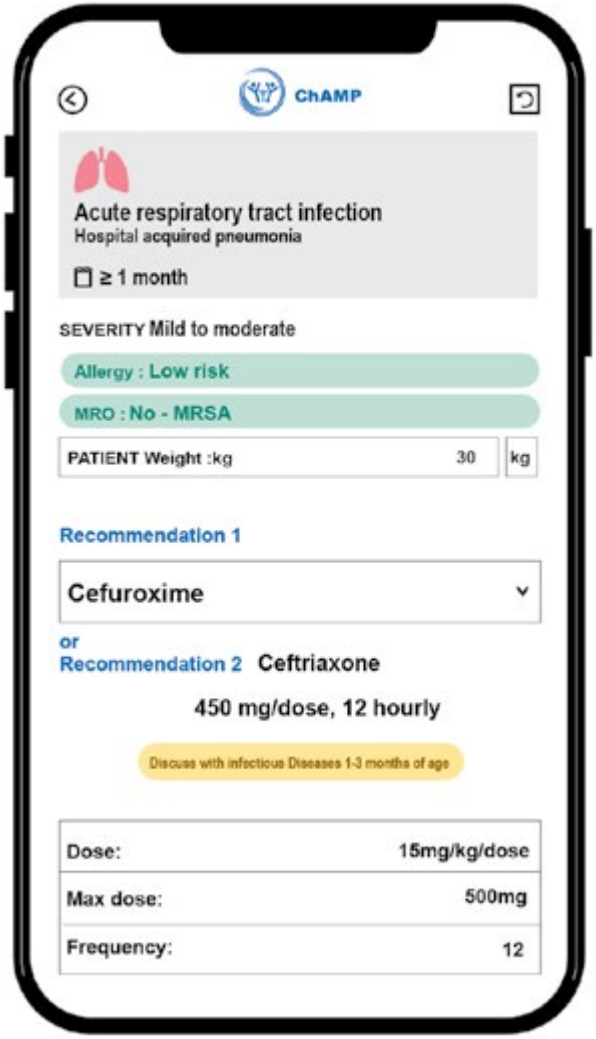
across Australia with cystic fibrosis. Every year, the Australian Cystic Fibrosis Data Registry reports key health related characteristics of people with cystic fibrosis living in Australia. The Cystic Fibrosis Service at PCH contributes data to the registry along with the 22 other Australian cystic fibrosis centres.

PCH is pleased to report that health outcomes of children and young people with cystic fibrosis cared for at PCH compare very favourably to other Australian centres. For all age groups lung function measures of PCH patients are higher than other centres. Lung function is an important marker of health in cystic fibrosis. Importantly, lung function in early life is strongly related to lung function in adulthood. The report also suggests PCH has greater engagement with families, as more patients attend the minimum four recommended annual clinic visits than other centres in Australia. PCH recognises the hard work by our cystic fibrosis team, but also the effort that parents and families put in every day to help their children stay healthy.

Children's Antimicrobial Management Program

The Children's Antimicrobial Management Program (ChAMP) application is a new and easy way for clinicians to access antimicrobial information while treating children at PCH. The Infectious Diseases team at PCH identified that access to clinical guidelines through the intranet and internet was time intensive and frustrating for clinical staff. The team pitched their idea of a ChAMP application at the inaugural CAHS innovation 'shark tank' and was one of the four teams selected to have their idea funded.

A prototype of the ChAMP application has been developed with and for the clinicians utilising a human-centred design thinking methodology to ensure the application meets the requirements of all clinicians at CAHS. Soon, all clinicians at CAHS will be able to access antimicrobial guidelines from a desktop or mobile device in a searchable and logical way. This digital innovation will reduce the time taken to locate medication guidelines for a variety of conditions, and ensure clinicians across PCH have access to this crucial information to help achieve our vision of *Healthy kids, healthy communities*.



The ChAMP application

Donations

This year, we have again been overwhelmed by the generosity of the West Australian public, having received over $150,000 of physical donations, including toys, toiletry packs, new clothes, quilts and blankets. All are used to support our goal of making the experience of visiting PCH as warm as possible for the children, families and carers who come through our doors.

A small toy can make all the difference to a child on a ward who may be away from their loved ones. A toiletry pack can help ease parental anxiety in the Emergency Department by permitting them to focus on their own needs for a few moments. New clothes are essential for the children who are supported by our Child Protection Unit and Social Work Department. A warm quilt may be given to a child or parent from the communities in northern WA who find Perth's climate cooler than they are used to.

CAHS sincerely appreciates the generosity of those individuals, craft clubs, not for profit organisations and companies whose donations provide a little extra comfort to our consumers as they face their health challenges.

Perth Children's Hospital hydrotherapy pool

Aboriginal Health at CAHS

Kaya,

'Aboriginal health is everyone's business' remains a key focus for CAHS, with ongoing work around Aboriginal programs and building the capacity and capability of non-Aboriginal staff to work effectively with Aboriginal children, young people and families.

The appointment of the Director of Aboriginal Health, Melanie Robinson, in October 2020, has ensured an ongoing focus and a re-setting of the strategic goals and priorities which are essential to close the gap and improve the health and wellbeing of Aboriginal kulungas (children).

Aboriginal workforce

Increasing the Aboriginal workforce has been a key priority for CAHS Aboriginal Health. Recently, several positions have been filled, with the commencement an Aboriginal Workforce Coordinator, Aboriginal Liaison Officer, and four new Aboriginal cadets. A priority has been the appointment of Aboriginal workers to vacant positions in accordance with section 50(d) of the *Equal Opportunity Act 1984*.

Kahlie Lockyer is one of four new Aboriginal cadets who joined CAHS during 2020–21.

An Aboriginal Health Strategy team has been established under the guidance of the Director Aboriginal Health with the creation and appointment of two project officers to assist in the development of approaches to address the gaps in immunisation rates and other priorities for Aboriginal Health.

The Aboriginal Health Team (Community Health) and Aboriginal Mental Health Workers (CAMHS) continue to contribute to improve the health and wellbeing of Aboriginal kulungas and their families. In late 2020, CAMHS appointed an Aboriginal Mental Health Coordinator to support and guide the Statewide Specialist Aboriginal Mental Health Workers (SSAMHS) and the non-Aboriginal staff at CAMHS.

Aboriginal health programs at CAHS

Aboriginal Health Team (Community Health)

The Community Health Aboriginal Health Team (AHT) delivers a culturally secure multidisciplinary service to Aboriginal families across the Perth Metropolitan region. The team consists of Aboriginal health workers, registered nurses, enrolled nurses, a medical officer, allied health and health promotion team. AHT delivers child health services to children 0–5 years, ear health screening for school-aged Aboriginal children, and medical officer clinics. Allied Health also deliver one-to-one assessments to alleviate any concerns the carer may have prior to being referred to the Child Development Service.

AHT also offers playgroups in Bentley, Hilton and Joondalup, ENT clinics in

SERVICES PROVIDED
22,397

FBH EAR HEALTH CLINIC ATTENDANCE
65%

SCHOOL EAR HEALTH SCREENING
2,262

Aboriginal Health Team celebrating the appointment of their 100th member.

Armadale and Padbury and immunisation clinics in Bentley and Maddington.

Aboriginal Mental Health Workers (CAMHS)

This team provide advocacy and Aboriginal cultural advice to the non-Aboriginal clinicians at CAMHS. The workers follow Aboriginal children and young people on their journey into CAMHS and link them to Aboriginal programs within the community. The Aboriginal mental health workers have greatly increased the engagement and attendance of Aboriginal children and young people into CAMHS through community engagement, including working closely with schools, workshops, presentations and participating in Aboriginal cultural events such as NAIDOC week. The Aboriginal Mental Health Coordinator role has been established to provide oversight and advocacy for the program in CAMHS.

Aboriginal liaison program (PCH)

At the end of 2020, a male Senior Aboriginal Liaison Officer commenced at PCH, which has been a great addition for Aboriginal families and the Aboriginal Liaison Program. The two existing Aboriginal liaison officers have been working with Aboriginal families for many years, which they support on the wards, in outpatient clinics and in the Emergency Department. They work alongside social workers, and advocate and educate clinicians about working with Aboriginal patients and families.

Koorliny Moort - 'Walking with Families'

The Koorliny Moort - 'Walking with Families' program provides care coordination for rural and metropolitan Aboriginal children and their families with complex needs. Paediatric outreach clinics are also conducted in the metropolitan area to allow families to access healthcare closer to home, with close collaboration with Aboriginal Community Controlled Health Services and other community agencies. The program employs an Aboriginal health worker and an Aboriginal enrolled nurse who work with a team of clinical nurses and doctors to provide holistic, culturally appropriate, family centred care.

Aboriginal community participation

Aboriginal consumers are integral and engagement with them is a priority for CAHS, including for infrastructure projects, such as the Midland Hub, the Children's Hospice, and the Kids' Bridge. The Aboriginal Health Strategy team is establishing an Aboriginal Community Advisory Group to provide opportunities for consultation and input from Aboriginal consumers and community members. Contributions from elders have been important, including the opening event during Living our Values week, when Sandra Harben shared her insights in Noongar culture. The Director Aboriginal Health attended a forum at East Metropolitan Health Service for Aboriginal youth, and has commenced building relationships with key Aboriginal organisations, including Yorgum, Moorditj Koort, David Wirrpanda Foundation and Derbarl Yerrigan Health Service.

Aboriginal cultural learning

Aboriginal cultural learning includes the education of CAHS staff about Aboriginal culture and how to engage and work effectively with Aboriginal people. Several Yarning Circle sessions focusing on communication and building relationships with Aboriginal kulungas have been held, with sessions on Ward 1A at PCH and at a palliative care workshop. We have established an Aboriginal Cultural Events Advisory Group and the Aboriginal calendar events, such as National Close the Gap Day have been utilised to highlight the priorities for CAHS, with a particular focus on increasing the Aboriginal workforce. Training sessions are being held with Health Information and

GROWTH IN CAHS ABORIGINAL WORKFORCE IN 2020–21

45%

CAHS STAFF COMPLETED ABORIGINAL CULTURAL LEARNING

90.7%

"Several Yarning Circle sessions focusing on communication and building relationships with Aboriginal kulungas have been held, with sessions on Ward 1A at PCH and at a palliative care workshop.

Administrative Services and administration staff at CAHS about asking families whether they identify as Aboriginal or Torres Strait Islander. This will ensure better access to support services, including the Aboriginal liaison officers and Aboriginal Health Team at Community Health.

Aboriginal health research

Aboriginal health research has been a focus, with partnerships formed with Telethon Kids Institute and CAHS researchers to begin discussions about the priorities and ensuring Aboriginal kulungas and families are involved in key research projects around immunisation for metropolitan Aboriginal kulungas, ear health, and management of wet cough and sepsis. CAHS Research and the Director Aboriginal Health are working closely to ensure cultural oversight on the development of projects to ensure sustainability and ongoing change for Aboriginal kulungas in the clinical context.

Creating a welcoming environment at PCH

On National Sorry Day, and to align with Reconciliation Week we relocated Koolung Wunjuning Kulark Wunjoo (Children Healing Place Welcome); the Aboriginal welcome artwork by Richard Walley, Olman Walley and John Walley, into a more prominent position at PCH on Level 1 near the yellow lifts and food court. This coincided with a series of lunchtime Aboriginal art tours hosted by Belinda Cobby, CAHS Art Curator, and Mel Robinson, Director Aboriginal Health Strategy, which were very successful.

Aboriginal Health Action Plan

Aligned to the *WA Aboriginal Health and Wellbeing Framework 2015–2030,* the *Aboriginal Health Action Plan* has been completed and approved by the CAHS Board. Implementation of the priorities has commenced, with the development of an Aboriginal health dashboard and focus on monitoring of key targets, including discharge against medical advice, did not attend (non-attendance) at outpatient clinics, immunisation rates, rates of attendance for mental health appointments and child health checks. A five year review is currently underway to assess performance of health service providers against the framework.

Keynote presentations

The Director Aboriginal Health presented at the Living Child event held on International Midwives Day (5 May) to highlight the importance of a child's first 1,000 days. This event showcased the importance of cultural safety, increasing the Aboriginal workforce in the child and maternal health space, and better engagement and communication with Aboriginal kulungas and families. A presentation was delivered to nursing students at the University of Notre Dame about Aboriginal child health in Western Australia. A video message[1] from the Director Aboriginal Health was showcased around National Close the Gap Day to highlight the key priorities for Aboriginal Health at CAHS.

1 https://www.youtube.com/watch?v=Zzw5NGKc740

Vale Leah Bonson

Early in 2021, CAHS learned of the passing a long-term Aboriginal staff member Leah Bonson, who was the inaugural Director Aboriginal Health from 2011–19. Leah made a sustained contribution to CAHS with the development of programs including Koorliny Moort, Aboriginal Health Team (Community Health) and the Aboriginal Mental Health Workers (CAMHS). Leah was integral in growing the Aboriginal workforce and providing education about Aboriginal health to non-Aboriginal employees at CAHS. Leah will be sadly missed by CAHS staff and her family, including Gemma, Krista, Dana, and Harley. CAHS will continue to honour Leah's legacy and sustain the work she did to improve the lives of kulungas and families.

(Photo used with permission from Leah's family)

Refugee health at CAHS

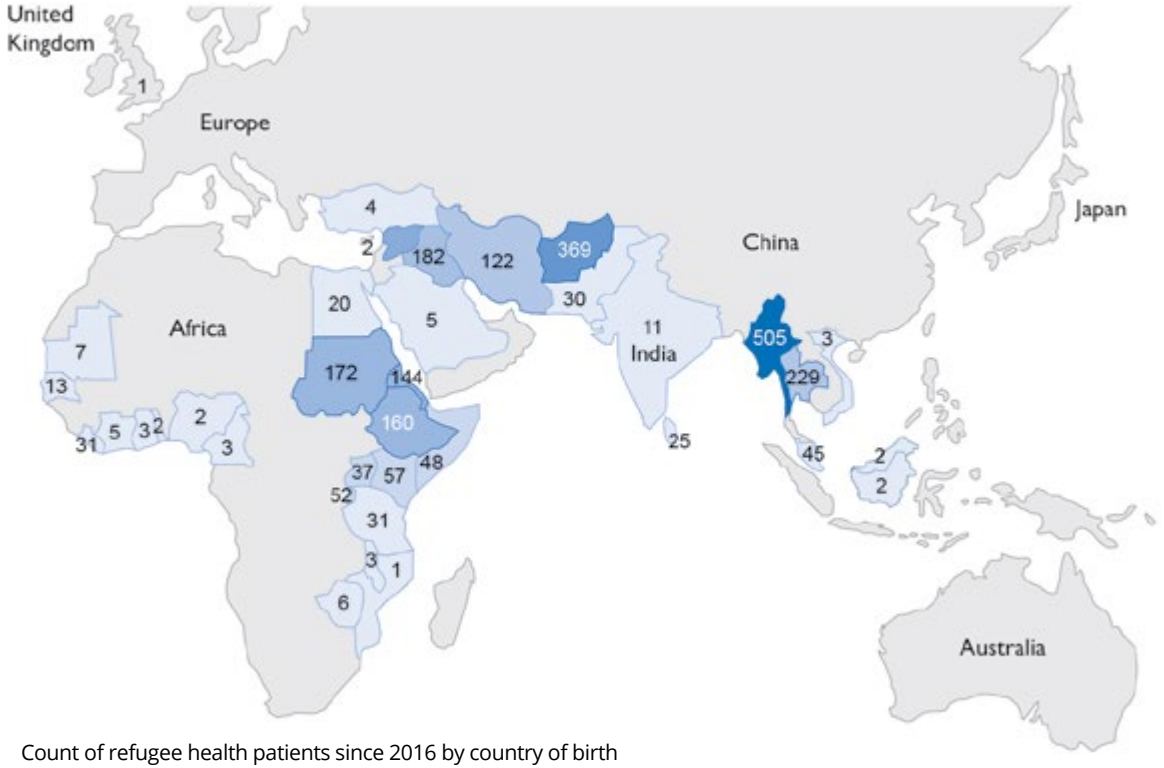
The CAHS Refugee Health Service (RHS) is celebrating the ongoing endeavours related to integrating the Community Refugee Health Team and Perth Children's Hospital multidisciplinary RHS team.

RHS works collaboratively to support the health needs of Western Australian children and adolescents from refugee-like backgrounds and their families as they settle in our local communities and empower transition over time into mainstream health services. RHS care is culturally-safe and trauma-informed, as well as nuanced for families with limited English proficiency, variable health literacy or broader socio-economic disadvantage.

The services provided by RHS include nurse-led home and school visiting by Community Health nurses, multidisciplinary outpatient clinics, inpatient consultation and urgent outpatient assessment for children arriving in WA with Federal health undertakings or complex care needs. The PCH multidisciplinary team comprises medical, nursing, dietetic, social work, clinical psychology and dental staff, assisted by a School of Special Educational Needs liaison teacher. The team is supported by professional interpreters (via CAHS Language Services), clinical researchers and PCH Foundation volunteers. RHS patients and families also have regular contact with mainstream services across CAHS through the breadth of Community Health, CAMHS, Neonatology and other PCH subspecialties. CAHS RHS staff assist patients and families navigate the complexities of our health system using a family-centred approach. Liaison, advocacy, care coordination and flexibility are underpinned by the CAHS values of compassion, equity and excellence.

Impact of COVID-19

Smaller numbers of families are being resettled in Western Australia, with annual numbers impacted by restrictions on international arrivals. Increased numbers of refugee families are relocating to Perth from interstate and or regional WA, requiring linkages across CAHS, WA Health and other community services and supports. Ongoing risks pertaining to COVID-related vulnerabilities are present, with the RHS team continuing to undertake COVID Wellbeing Checks during clinical interactions, with increasing emphasis on COVID and influenza vaccination. These reviews provide targeted coronavirus education to parents (including language-specific resources) who are additionally vulnerable due to socio-economic impoverishment, language, literacy, education and/or trauma barriers. Identification of specific COVID-related educational risks (e.g. lack of resources, internet barriers, parental illiteracy), chronic health concerns and social isolation are also being identified, allowing development of support strategies in partnership with key non-health organisations.



Count of refugee health patients since 2016 by country of birth

Refugee Health Service clinical activity

More than 20 different ethnic backgrounds are represented in the patient cohort, similar to previous years. The most prevalent countries of origin were Myanmar (Burma), Afghanistan, Syria and Iraq, with the most predominant languages spoken being Arabic,

Karen, Dari, Farsi and Burmese. Very high levels of relative disadvantage exist, with 80 per cent residing in the lowest national socio-economic deciles.

The RHS team has focused on waitlist reduction during the last 12 months, with improvement in follow up profiles and transition planning for complex patients. RHS has also transitioned to a multidisciplinary clinics format that aims to improve clinical efficiency for families moving through CAHS.

Increasing numbers of patients with disability and neurocognitive concerns continue to be assessed. Positive outcomes have been noted from the new RHS-Neurosciences Unit outreach pilot program, which is also improving collaborative practice across organisations.

Community Refugee Health Team

CAHS Community Health provides a comprehensive range of health promotion and early identification and intervention community-based services to newly arrived refugee children under 18 years and their primary carers with a focus on growth and development in the early years. The nursing team provides best practice child-centered service delivery, clinical expertise, and specialist advanced complex client care within the community setting, collaborating and advocating with key community-based stakeholders and integrating their practice with the PCH RHS staff. The team actively supports families to access the health services in their local community and assist them in finding community cultural links.

The team provides services across the Perth metropolitan area, with staff dispersed across various locations. The team consists of senior community nurses who help families orientate and learn to navigate the health system, complete catch-up immunisations, identify their health concerns and priorities, learn to manage chronic and complex conditions, and link in to appropriate providers for continuing health care. The majority of contacts provided by the team are home visits (82 per cent), with additional occasions of service provided by telephone and at Community Health sites. The team provides COVID related education at all contacts and assists families to access WA Health approved translated information in clients' language.

Advocacy, education, research and policy

The RHS team contributes to education, policy, research and advocacy for refugees and asylum seekers, but has a broader cross-cultural lens reflecting the ethnolinguistic diversity of the WA population. RHS paediatricians continue to represent CAHS and WA on various state and national committees, including the WA Refugee Health Advisory Group, WA Forced Marriage Network, Refugee Health Network of Australia (Executive), Australian Paediatric Refugee Health Network and Royal Australasian College of Physicians (RACP) Health of Refugee and Asylum Seeker Working Group. RHS staff are also members of the CAHS Consumer Engagement Reference Group, CAHS Research Reference Group, Mental Health Commission Multicultural Subnetwork and Heart Kids National Working Group for Priority Populations for the Standards of Care for Childhood-onset Heart Disease (CALD/refugee input). Staff have also provided input into the CAHS Multicultural Framework and the Refugee Health Network of Australia National Disability Insurance Scheme consultation related to Independent Assessments.

The team consists of senior community nurses who help families orientate and learn to navigate the health system, complete catch-up immunisations, identify their health concerns and priorities, learn to manage chronic and complex conditions, and link in to appropriate providers for continuing health care

Substantive equality

The PCH Refugee Health Service (RHS) and Community Refugee Health Team (CRHT) are committed to identifying, modifying and eliminating barriers to enable better health outcomes for refugee and asylum-seeker patients. Refugee health staff across RHS and CHRT undertake quality assurance processes and clinical research, as well as working in partnership with key non-government organisations providing services to refugees. Identification of system or clinical service gaps allows improvements strategies to be developed to achieve health equity. RHS continuous quality assurance and clinical research themes strongly align with the 2019 WA Sustainable Health Review priority populations and key strategic recommendations. The positive impact of integrating mental health staff within school hubs (CAMHS Parkwood and Koondola Integrated Service Centre) as well as within the PCH RHS highlights a culturally responsive approach to removing access barriers, which is not currently reflected in mainstream mental health services.

The collaborative RHS *New Beginnings: healthy teeth, healthy lives* refugee health dental program continues to gain momentum. Over 210 RHS patients have been successfully recruited into the RHS Arresting Dental Caries randomised controlled trial, overcoming research enrolment barriers in patients with limited English proficiency. RHS has also collaborated with the *Clinics to Communities* oral health promotion program. The program facilitates provision of oral hygiene kits alongside tailored oral health education as part of a holistic prevention and health promotion strategy for all new RHS families.

Similarly, the targeted RHS dietary health education program allows culturally-specific tailored health education to be provided to families. Through an innovative PCH Foundation Education and Training Grant, the RHS team has developed and translated culturally appropriate paediatric dietary resources that have been successfully trialled in group settings at PCH and in community outreach sessions.

CAHS RHS has worked with the Office of Population Health Genomics and Royal Children's Hospital to update and translate local haemoglobinopathy and G6PD patient information resources, which are now available to use across WA Health.

Quality and safety improvements

RHS has undertaken quality improvement audits in order to identify health delivery gaps and improve utilisation of interpreters for PCH patients with limited English proficiency. The team worked with Dr Shani Law-Davis, who undertook a Medical Service Improvement Rotation. Dr Law-Davis' project, titled *INTER-great* reviewed the PCH process of booking and utilising interpreters for inpatients with limited English proficiency, with positive staff engagement across departments and recommendations to increase visibility and accessibility to interpreters, thus improve safety and quality of cross-cultural communication within our ward settings.

Clinical A/Prof Sarah Cherian was also shortlisted as one of the inaugural 2020 CAHS Patient Safety Champions for her endeavours to improve safety of clinical care within CAHS for patients with socio-economic vulnerabilities; especially those with limited English proficiency or trauma backgrounds.

Improving cultural competence

RHS continues to provide interdisciplinary health education to improve cross-cultural competence within CAHS. RHS staff teach medical, dental, nursing and allied health students and staff. A pilot cross-cultural RHS training module for junior doctors has been evaluated, with demonstrated positive shift in cross-cultural awareness related to health care needs of patients from refugee-like backgrounds. The University of Western Australia Crossing Borders 4 Health RHS Cultural Competence attachment continues to be well-regarded, and has now expanded to include medical students from Curtin University.

Research

The status of research and research support is a key focus area for our health service.

The CAHS Research Strategy was released in early 2021, providing clear objectives to measure our aspirations to build research capacity and culture, while ensuring maximum impact and translation into clinical care. Increased efforts and focus in the research space over the past year demonstrate our ongoing efforts to be a world-class paediatric research focused health service.

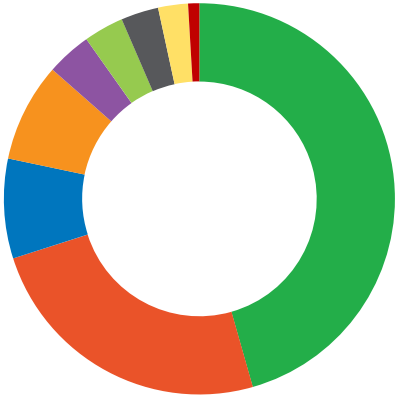
Funding for CAHS-based research activity is held across our child health research partners. This summary represents funding awarded for 2020 from local funders to CAHS and within the Centre for Child Health Research.

CAHS Research summary

Please note that figures represent the 2020 calendar year unless otherwise indicated. This is based on the current reporting system for research data and the entries made by researchers. The data may not fully capture all research activity at CAHS.

New studies with CAHS site approval	98
New studies approved by CAHS Human Research Ethics Committee (HREC)	67
Total number of active research studies	519
Active studies at PCH	488
Active studies at Community Heath	19
Active studies at CAMHS	12
Total number of clinical trials	180
Total number of commercial studies	34

Funding for Centre of Child Health Research activity



Total: $42.51M

International funding	$19.38M
Commonwealth gov't	$10.40M
Telethon Trust	$3.50M
WA Dept of Health	$3.47M
Perron Foundation	$1.58M
Local NGOs	$1.41M
National NGOs	$1.32M
PCH Foundation	$1.05M
Cancer charities	$0.39M

"The fact that CAHS staff are involved in close to half of the 60 COVID-19 research projects underway in WA is one outstanding achievement that reflects the strength and adaptability of our researchers."

– Professor Peter Richmond, Director of Research

Support for research

The CAHS Department of Research offers specialised support services to assist in the development, governance and implementation of effective research across our health service. The team supports CAHS researchers as well as our partners who engage in research at our sites or with our patients or clients.

Support is available at any stage of the research pipeline; from project design, review and feasibility through to access of research facilities, education and training, ethics and site approval and the ongoing monitoring of research activity. There is also support for biostatistical analysis, data management, communications, and funding or grant development and management.

Emily Bell, Research Assistant with the Anaesthesia and Pain Medicine research team.

CAHS Research case studies

Physiotherapist Dr Noula Gibson with Jo Vernon with her son Ashton, who welcomed the consensus statement.

Collaborative research group leads international efforts to reduce respiratory risks for cerebral palsy patients

Researchers from the Physiotherapy Department, KidsRehab WA and Respiratory Medicine at PCH, in partnership with the Ability Centre and researchers at four of the major paediatric hospitals in Australia, are leading work internationally to help better manage the respiratory risks faced by children living with cerebral palsy (CP).

The group published a 'consensus statement' last year, a precursor to clinical guidelines, to raise awareness about respiratory risks, which is the leading cause of death in children with CP.

The statement helps clinicians and allied health practitioners recognise the early warning signs of respiratory disease that are often missed.

Longer term, the team is aiming to reduce hospital admissions, improve the quality of life and the survival rates of these children.

Testing the recommendations from the consensus statement and training general practitioners and allied health professionals who work with CP kids is the next research project the group will tackle thanks to a WA Department of Health research grant.

Exercise physiologist Kat Fortnum with some of her young participants in the Fit for Play program.

Supporting early researchers through PhD research studies: Fit for Play activates and motivates Pathways participants

The Fit for Play program, based on the 'exercise is medicine' concept, was established by exercise physiologist Kat Fortnum, in collaboration with the University of Western Australia and Pathways, a specialised CAMHS program, as part of her PhD project in 2019.

Ms Fortnum set out to cater for the physical activity-based needs of primary school-aged children with disorders including post-traumatic stress disorder, severe anxiety and Attention Deficit Hyperactivity Disorder.

The project showed that Fit for Play helped provide the first positive physical active experience for many of the participants.

Ms Fortnum said one of the big drivers of this research was knowing higher activity is often linked to better outcomes from a mental health perspective.

As a result of the findings, an exercise physiologist will remain in the multidisciplinary CAMHS team and the program will remain part of the treatment model at Pathways.

Community Health researchers who presented at the Child Health Symposium.

Community Health research showcase attracts strong support

A special showcase session at the 2020 Child Health Research Symposium provided Community Health researchers with an opportunity to step into the limelight.

The session, which generated strong attendance and engagement, was a pivotal step for the Community Health leadership team, who aim to drive and collaborate on research that improves health and service delivery outcomes for their clients and community.

Senior Coordinator Information and Performance at Community Health, Dr Meredith Green, said there are obvious challenges that arise from working offsite, so the event was a valuable boost for the Community Health research team on a number of fronts.

"It provided an excellent opportunity to facilitate a stakeholder-led discussion on research priority areas for Community Health. It also gave us a platform to showcase the breadth and depth of our research projects and also to forge connections with other researchers and departments at CAHS" said Ms Green.

Ms Green said she looks forward to celebrating research success from Community Health as research activity and output grows.

"Longer term, the collaborations initiated are expected to strengthen research output from Community Health and broaden the capacity of sustainable research activity in areas where it is needed most" said Ms Green.

Dr Shripada Rao (pictured left) with Fiona Reale and her baby daughter Hali who was recovering from surgery in the Perth Children's Hospital Neonatal Intensive Care Unit.

Neonatal research helps unlock important insights into gut health

A neonatal study has provided vital clues about how gut bacteria might influence the health of newborn babies requiring gut surgery.

The study found that babies with surgical conditions in the Neonatal Intensive Care Unit (NICU) developed more harmful bacteria and lesser amounts of beneficial bacteria in their gut compared with the healthy group of babies.

Lead author and Consultant Neonatologist in the NICU, Dr Shripada Rao said the findings provided an insight into why these babies often suffer adverse health following their surgery, such as infections and facing difficulties in tolerating milk feeds.

The research findings have paved the way for a pilot study to investigate whether probiotics could be used in the future to reduce the risk of infections in babies with surgical conditions.

"I hope longer term, our work will help these babies recover faster from their surgery and decrease the amount of time they need to spend in the NICU, which would ease stress for their parents" Dr Rao said.

Neurologist Dr Maina Kava, Clinical nurse Jodi Mann with Mitchell and Aiden Hillyard, who were the first patients enrolled on this trial.

Neurology clinical trial offers hope to patients with a rare genetic disease

For the first time in WA, an international clinical trial run by the Neurology Department is offering hope to families of boys with a rare genetic disease called Duchenne Muscular Dystrophy (DMD).

The trial is testing the effectiveness of a new drug 'Ataluren' targeting a specific genetic mutation in patients with DMD, a devastating disease that not only causes significant musculoskeletal disability and cardiorespiratory failure, but also a shortened life expectancy.

No treatment or trial could previously be offered to these patients in WA.

Neurologist and Principal Investigator on the trial, Dr Maina Kava, said the trial will help pave the way towards potential treatment options in the future.

"We are passionate about providing the best possible care to our patients with this debilitating disease. Our research team has worked hard to establish this trial and we are keen to ensure all our patients have access to clinical trials if they are eligible" Dr Kava said.

Neurologist Dr Maina Kava, Clinical Nurse Jodi Mann with Mitchell and Aiden Hillyard, who were the first patients enrolled on this trial.

Telethon funding continues to boost overall CAHS research

Enhanced research support

Funding from Telethon Trust awarded in 2020 will continue to facilitate high-quality research activity at CAHS. Support services will now encapsulate data management expertise, assisting researchers organise the many different pieces of data they use from study participants and across clinical information. Awarded funding will also be used to support researchers navigate setting up their projects within CAHS and the Telethon Clinical Research Centre.

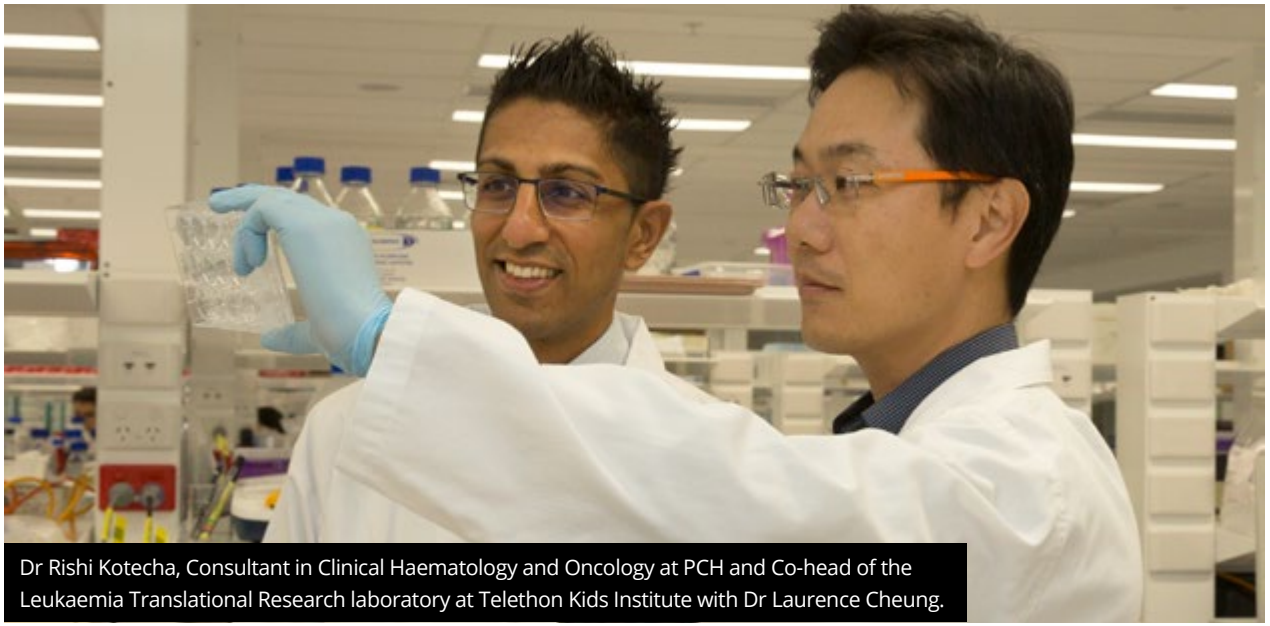
Telethon Clinical Research Centre: Research outpatient clinic

The Telethon Clinical Research Centre is a dedicated clinical research area located at PCH. This is a unique space with modern facilities that enables CAHS, Telethon Kids Institute and university researchers to work together in one specialised area to undertake clinical research appointments.

Celebrating research activity at CAHS: Child Health Research Symposium

The 2020 Child Health Research Symposium, run in partnership with Telethon Kids Institute, achieved record-breaking success thanks to strong support from researchers across CAHS.

From Professor Fiona Wood's challenge, issued in her opening plenary address, to catch a bubble of innovation to a thought provoking panel discussion titled 'Towards a digital health vision for WA', presentations were enthusiastically received.



Dr Rishi Kotecha, Consultant in Clinical Haematology and Oncology at PCH and Co-head of the Leukaemia Translational Research laboratory at Telethon Kids Institute with Dr Laurence Cheung.

The symposium was the biggest ever staged, with:

- 186 abstracts submitted
- close to 1,000 registrations for face to face and virtual sessions
- 70 posters displayed and
- 18 presentations delivered.

A focus on collaboration and inspiring others to get involved in research - staff, students and the community emerged as important themes across the symposium.

Consumer Engagement Strategy update

The CAHS Consumer Engagement Strategy 2020-2022 was launched in September 2020. The Strategy has been a key driving force in ensuring that the consumer voice shapes the design and delivery of our services. Engaging children, young people, families and carers helps us better meet their diverse needs.

A number of key actions have already been achieved, including the establishment of a comprehensive consumer engagement intranet hub, equipping staff with the necessary guidelines and toolkits to implement meaningful consumer engagement.

The MySay Healthcare Survey was rolled out to inpatients at Perth Children's Hospital during 2020–21. The Survey is texted to parents to seek their feedback on the quality of their experiences during their child's hospital stay. The survey is a validated tool created in partnership between CAHS and the Australian Commission on Safety and Quality in Health Care. With over 3,000 responses received from parents and carers so far, this tool will continue to grow as an important source of consumer feedback.

In December 2020, the 'Engage Consumer Network' was established to expand the ways consumers can:

- help CAHS to improve health services for infants, children and young people
- become a consumer representative at CAHS
- attend consumer events to have their say
- make sure the information provided to children, young people and families is easily understood
- have their say or take part in research.

The Network already has over 600 members and will continue to be promoted throughout services.

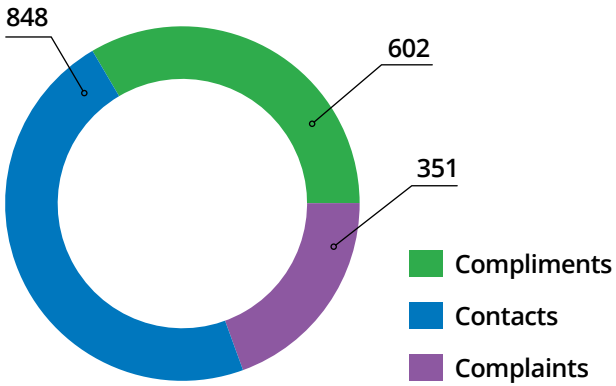
The CAHS Consumer Engagement team led the formation of the new Lived Experience Group within the Child and Adolescent Mental Health Service. Membership includes young people, parents and carers, and complements the existing CAHS Consumer Advisory Council (Parent and Carer) and Youth Advisory Council. This group enables consumers to shape mental health services for children and young people in WA.

CAHS continues to strengthen consumer awareness of feedback mechanisms, including development of tools for children and young people to share their experience, so we can continue to learn and improve the way services are delivered.

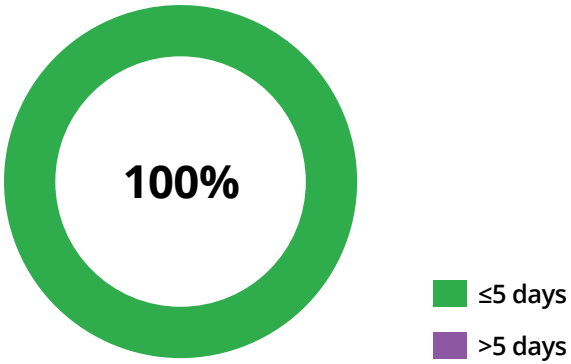
Consumer feedback

Listening to our consumers is central to improving the safety and quality of our health service. We encourage feedback from children, young people, their families and carers, as it helps us identify where we have done

Feedback type



Complaints acknowledged within 5 working days



well and where there are opportunities to improve their healthcare experiences. Consumers are welcome to provide their feedback directly to CAHS in person, by telephone, by post, email or online form.[3]

While 100 per cent of complaints were acknowledged within five days, CAHS regrets that the increased volume of consumer feedback it received during the year affected response times. CAHS is dedicated to improving this aspect of its complaints handling performance, and actions are being implemented to ensure more consumers are provided with timely responses to their feedback in future.

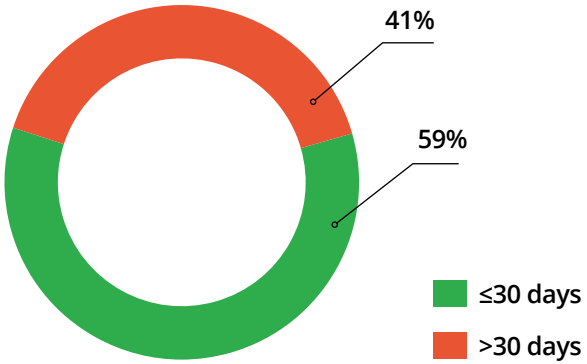
3 https://cahs.health.wa.gov.au/For-families-and-carers/Compliments-and-complaints

Care Opinion

Care Opinion is another mechanism for consumers to provide anonymous feedback, both positive and negative, via an online platform.[4] This allows a timely response from the Executive at CAHS, and can be viewed by other consumers and staff.

4 https://www.careopinion.org.au

Complaint response timeframes



Statement from the Consumer Advisory Council

The Consumer Advisory Council has risen to the challenges posed in the last 12 months.

Starting with recruiting six new members that bring a wealth of diversity, we have successfully established a Council that truly represents all of CAHS services.

In October, we said farewell to long standing member and Chair, Margaret Wood, and welcomed existing member Tania Harris as the new Chair. Tania has brought her experience as a mother, advocate and Aboriginal woman into her leadership role.

Over the last year, we have provided significant support to the Consumer Engagement team and are proud of the significant progress made to achieving key outcomes in *National Safety and Quality Health Service Standard 2: Partnering with Consumers*. This included developing and launching the 'Engage' network that enables consumers to register their interest in helping to improve services.

We are proud to have helped shape the Consumer Experience Survey for patients admitted to Perth Children's Hospital, which is planned to be adopted by other health services. We have also been key in helping to develop a community health consumer experience question set that will be implemented in 2021–22.

We provided feedback on a number of policies and documents, including providing a parent and carers perspective of the revised Admission Care Plan for use at Perth Children's Hospital, Consent to Treatment Policy, the Sharing of Patient Information Policy, and the Neonatal Guideline - Transition and Transfer from Neonatology to PCH Inpatient Unit.

Of particular note was the opportunity to provide input into the development of consumer engagement plans for Child and Adolescent Mental Health Services, which has introduced more robust structures to support consumer participation into such an important area of child health.

We have always felt strongly about the need for new staff joining CAHS to understand how they can improve consumer experience. This year, we saw our suggestion adopted, with members filming their own experience of the Child and Adolescent Health Service to include as part of the staff induction program.

As we move forward, we look forward to hosting consumer events, supporting the implementation of Child and Family Centred Care, increasing our engagement in consumer communications, and providing ongoing support to the expansion of patient experience surveys.

Statement from the Youth Advisory Council

The Youth Advisory Council (YAC) started this year with a bang! We achieved full recruitment and greater diversity of our membership, which in turn has brought fresh energy and new perspectives.

Our members range from 13–23 years old and we are particularly proud that we have been able to bring Aboriginal perspectives to the feedback we provide.

YAC increased its focus on community health services this year. Two projects in which we are particularly proud to be involved are the psycho-social assessment tool for kids transitioning to high school and the HEADSS[5] handbook. We worked with Community Health to improve the accessibility, appeal, and delivery of these projects to assist with youth engagement.

YAC has also been increasing our presence around Perth Children's Hospital and out in the community. Our Chair was invited as a guest speaker on Radio Lollipop to discuss the importance of involving and educating our young people in their health care. Additionally, we rewrote the health care rights of children in a way our youth can relate to and understand. Today these youth-friendly health rights are displayed on the Patient Entertainment System.

The WA Department of Health engaged our members in developing the 'My health in my hands' animation[6]. It was an exciting initiative that allowed us to influence the creative direction of the animation development. Launched in April 2021, the animation has helped educate and increase health awareness in youth across WA.

We farewelled longstanding members Neve, Daniel and Kai, thank them for their outstanding contribution and commitment over the years, and wish them well with their studies. We aim to start 2021–22 with a group that further embodies our goals of diverse culture, age and gender. We want to make health services within CAHS as equitable and personable as possible, and believe a diverse group will make this goal more achievable.

We are excited for upcoming YAC-driven events that will focus on consumer engagement and cultural awareness. Another long-term goal is to increase the awareness and identity of Youth Advisory Council, including producing a slogan and graphic design unique to YAC.

Our continued focus is to develop our members to be great consumer representatives for young consumers by *sharing our voices to shape your care.*

5 HEADSS - home, education (i.e. school), activities/employment, drugs, suicidality, and sex

6 https://www.healthywa.wa.gov.au/News/2021/My-Health-in-My-Hands


JUACK

Statement from the Disability Access and Inclusion Committee Chair

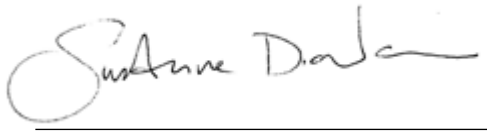
The Disability Access and Inclusion Committee has continued the work of advocating for people with disability accessing CAHS services.

The committee also has responsibility for monitoring, evaluating and reporting on the CAHS Disability Access and Inclusion Plan. This work has been progressed strategically and operationally with capable assistance from the CAHS Consumer Engagement team, and the Committee thanks them for their continued support.

This year has seen stronger engagement with the CAHS People Capability and Culture Executive Committee, which has increased our profile and reach across CAHS. We aim to increase people's knowledge and skills, in addition to providing practical advice to improve disability access and inclusion for all CAHS employees and consumers.

We look forward to commissioning the Changing Places accessible bathroom at PCH in October 2021, which has been driven by consumer feedback and supported by persistent advocacy from Committee members. The Committee will be developing a new five year plan during 2021–22. Please look out for the consumer and workforce surveys, which will help inform development of the new plan.

I would like to thank all members for their continued support and active engagement in the work of the Committee.



Sue-Anne Davidson
Chair
Disability Access and Inclusion Committee

Agency performance

Delivering safe, high-quality care

Communicating for safety

CAHS has a commitment to providing care that is safe, high-quality and meets the needs of our children, adolescents and their families. We do this by ensuring that our children and young people are at the centre of everything we do, and we invite our consumers to partner with us in care that meets their individual, spiritual, psychological, and socio-cultural needs.

CAHS has a continual improvement focus on care and treatment, and demonstrates this through internal and external programs to evaluate and improve safe systems and practice. The National Safety and Quality Health Service (NSQHS) Standards (2nd Edition) provide a roadmap for the eight standards that define expected actions for a range of requirements to demonstrate and drive safe practices and quality improvement activities.

Communicating for Safety (Standard 6) is critical to provide the foundation for communicating with each other, our patients and clients, their families and carers, and other healthcare providers. Communicating for Safety aims to ensure timely, focused and effective communication and documentation that support continuous, coordinated and safe care for patients[7]. The need to communicate effectively at every critical point of patient or client care is recognised in this Standard and Partnering with Consumers (Standard 2).

Critical points of care that require comprehensive and accurate communication centred on the needs of the child and family include admission, transfer and discharge from our health service. CAHS has well established systems and processes that align with this Standard. These include discharge summaries that can be sent to the patient's general practitioner, handover between clinical staff at CAHS and other health services, and bedside handovers where we involve the patient and their family.

Another important requirement of this Standard is the need to correctly identify the patient or client to ensure we are providing them with the correct medication or procedure, and giving them the correct test. Communicating critical information is imperative to keep our patients and client safe. Critical information can include alerts and risks like drug and food allergies that staff and families need to know about to prevent harm.

Other practices to enhance timely and effective communication include 'ward safety huddles' where staff can meet to discuss emerging issues, using 'critical language' to enhance the collective understanding of concern and urgency of an issue, and our commitment to the Speaking Up for Safety™ program. This program provides a framework for all staff to understand the importance of speaking up and to and raising concerns that may impact on patient safety in real time. This program enables staff to communicate and escalate clinical concerns in real time.

At PCH, we provide a consumer focused program to allow families and carers to call a senior clinician if they have attempted to share their concerns about the clinical condition of their child but are still concerned. The CARE Call program allows families to escalate their concerns if they are worried about their child. This program has been recently implemented in the emergency department. We monitor and evaluate each CARE Call to apply lessons learned to our practice.

We continue to strive to improve what we communicate to each other, our patients, clients and their families, and how we communicate. We remain committed to Partnering with Consumers, and putting the patient, client and family at the centre of clinical communication.

7 *https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard*

Learning from clinical incidents

It is difficult to talk about learning in the context of the tragic death of a young child or young adolescent knowing the profound impacts on their families, hospital and community. Acknowledging these tragic events in a healthcare setting and more critically learning and instituting change as a consequence is, however, critical to improving the safety and quality of care.

Similarly to other adverse events, critical reflections after the deaths of Aishwarya Aswath and Kate Savage have led to us to re-examine many aspects of our organisation, including staffing numbers, staff training and support, reporting and monitoring processes and equipment, as well as sharing and learning processes.

There are of course solutions that can support improved care that have been easier to implement than others – for example the provision of additional equipment. Others are more complex and can never be considered complete in their implementation – for example the need to support staff to ensure that they are up to date with latest treatments. Acknowledging child and family centred care as the critical guiding element has provided additional focus and impetus to ensure we are able to meet the diverse needs of the children and families we serve. Central to this of course has been the recognition of the critical role parents and guardians play in alerting us to when their child is deteriorating and a more rapid response is required. CARE Call has provided one mechanism through which this is facilitated, and its introduction into our emergency department represents the start of the journey to better enable escalation.

A key focus for CAHS is on working with our staff to ensure children and families from culturally and linguistically diverse (CALD) backgrounds receive care that is safe and appropriate to their cultural needs. We are conducting this work in partnership with our consumers, who have provided valuable insights into the challenges faced by families from diverse cultural backgrounds to ensure they can communicate their child's needs with support from staff and interpreters where required.

CAHS has clear processes in place to investigate clinical incidents in order to understand factors that may have contributed. After a rapid review, adverse events are categorised and investigated accordingly. We ask staff to highlight anything they feel may adversely impact on care of a child. This can range from the use of a wrong name sticker to omission of a medication. For the most significant events (Severity Assessment Code 1 – SAC1), a critical analysis by a panel of experts results in a report with clear recommendations the implementation of which are carefully tracked. This forms part of the 'Clinical Governance' overseeing safety and quality.

"The best way to reduce harm … is to embrace wholeheartedly a culture of learning."

A promise to learn – a commitment to act, The National Advisory Group on the Safety of Patients in England, chaired by Don Berwick, August 2013

Table 1: SAC 1 incidents 2020–21

SAC 1 Incident	
Total notified:	28
Investigated	21
Ongoing investigation	5
Declassified*	2
Total confirmed:	26
Confirmed with patient outcome of death	6
Confirmed with patient outcome of serious harm	9
Confirmed with patient outcome of moderate harm	8
Confirmed with patient outcome of minor harm	3
Confirmed with patient outcome of no harm	0

** Declassified incidents have been investigated and found not to have resulted from health care delivery.*

Sepsis

Sepsis remains a leading cause of childhood morbidity and mortality in Australia. Despite this diagnosis can be challenging as there is no single clinical finding or test that is diagnostic. As part of the work to improve our recognition and management of children we have been working on tools that will enhance recognition and education packages that support staff. We have introduced a paediatric acute recognition and response observation chart that has clear prompts and escalation processes to assist our staff to identify the signs of sepsis early and take action to treat it.

Reducing hospital-acquired complications

In Australia, approximately one in nine patients who are admitted to hospital develops a complication, or one in four patients who are admitted overnight. Complications developed as a result of hospital care can cause patients discomfort, delay recoveries, and extend hospital stays. The most serious complications can cause permanent injury or death.

The Australian Commission on Safety and Quality in Health Care defines a hospital-acquired complication (HAC) as 'a complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring'.

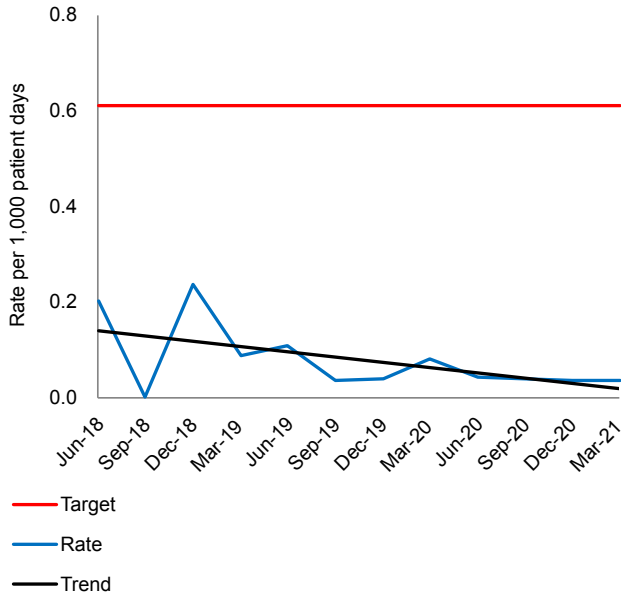
CAHS monitors HACs to identify and explore issues relating to the quality of care, and to implement strategies to minimise them.

Pressure injuries

A pressure injury, also known as a pressure ulcer or sore, occurs when an area of skin is damaged due to unrelieved pressure, dragging or pulling on the skin. Pressure injuries can develop quickly and take a long time to heal, which has consequences for patients' quality of life. Such injuries are susceptible to infection, can cause severe pain, and lead to sleep and mood disturbance. They can also lead to increased length of stay in hospital, and adversely affect rehabilitation, mobility and long-term quality of life. Preventing pressure injuries is therefore an important challenge for hospitals.

Figure 3 shows the success CAHS has had keeping the rate of the most serious Stage III and IV pressure injuries below the target set by the WA Department of Health and reducing the rate over time. This is attributed to frequent review of data and incidents by the Comprehensive Care Committee, and completing rounds, whereby various medical disciplines come together to discuss the patient's condition and coordinate care.

Figure 3: Rate of Stage III & IV pressure injury

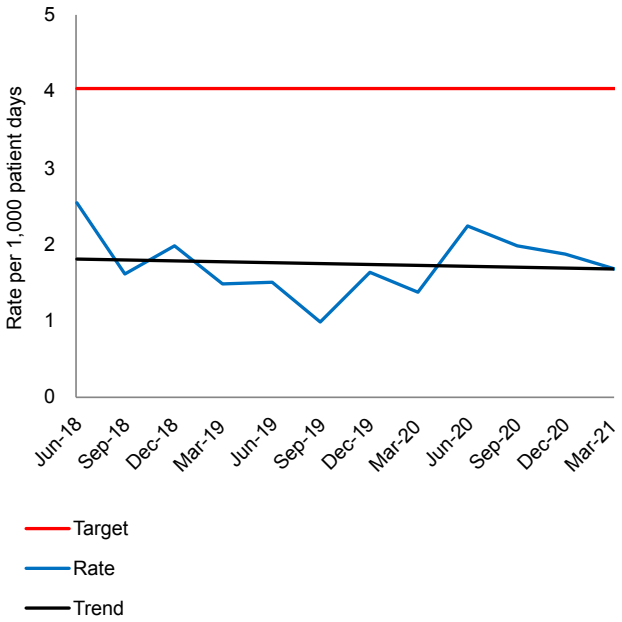


Healthcare-associated infections

Healthcare-associated infections (HAIs) are those infections that are acquired as a direct or indirect result of healthcare. HAIs are one of the most common hospital-acquired complications, can cause unnecessary pain and suffering for patients and families, prolong a patient's stay in hospital and increase the cost of their care. As such, healthcare-associated infections are identified as the highest reported category of SAC 1 incidents.

To reduce HAIs, CAHS implemented an action plan focused on key areas of clinical guidelines and policies, hand hygiene auditing, aseptic technique competencies for central venous access devices for clinical staff, antibiotics prophylaxis, and education regarding documentation of peripheral intravenous devices. The work is monitored and reported regularly via the Preventing and Controlling Healthcare Acquired Infections Committee. Figure 4 indicates the plan has proven successful, with the average rate of HAIs over the past three years remaining steady at below half the target set by the WA Department of Health.

Figure 4: Rate of healthcare associated infection



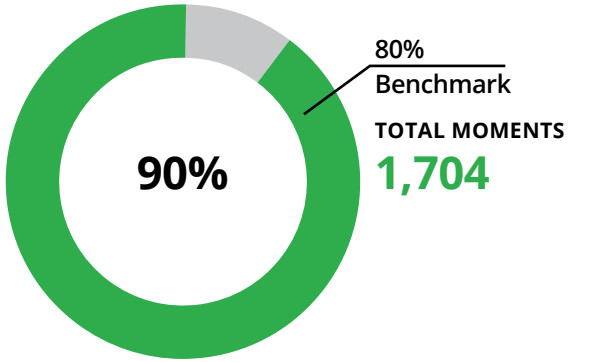
Hand hygiene

Effective health care worker hand hygiene is a core strategy in the prevention of healthcare-associated infections and the transmission of antimicrobial resistance. Strategies include provision of alcohol-based hand rub at the point-of-care, health care worker education, and regular auditing, with performance feedback of hand hygiene compliance according to the '*5 Moments for Hand Hygiene*' approach. The five moments are:

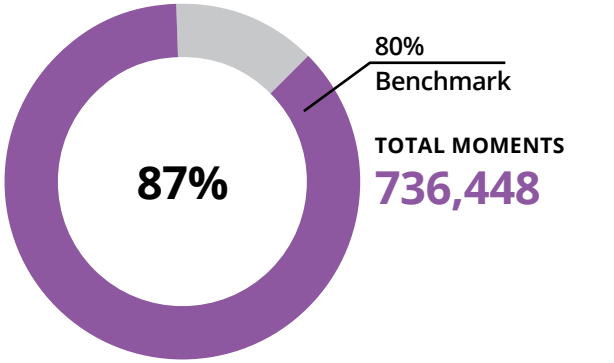
1. before touching a patient
2. before a procedure
3. after a procedure or body fluid exposure risk
4. after touching a patient
5. after touching a patient's surroundings.

Audits are conducted three times each year, and the most recent audit of 2020–21 shows PCH continues to exceed the benchmark of 80 per cent and perform better than the national average.

Perth Children's Hospital



National



Emergency Department access

Emergency Departments (EDs) are specialist multidisciplinary units with expertise in managing acutely unwell patients for their first few hours in hospital.

The Perth Children's Hospital (PCH) Emergency Department provides a tertiary level emergency service for paediatric patients including resuscitation, assessment, diagnosis and treatment for patients with a range of conditions including trauma, medical, surgical and psychiatric presentations. The ED typically sees over 66,000 patients per year, with a hospital admission rate of 20 per cent. It has three resuscitation bays, a 23 bed acute pod area, an eight cubicle low acuity area, a fast track (minor injuries) area, a psychiatric assessment pod and an 11 bed short stay unit.

When patients first enter ED, they are assessed on how urgently treatment should be provided. A patient is allocated a triage category between 1 (immediate) and 5 (less urgent) that indicates their treatment acuity. Treatment should commence within the recommended time of the triage category allocated (see Table 2). The purpose of this process is to ensure treatment is given in the appropriate time, with the aim of preventing deterioration in the patient's condition.

Table 2: Triage category, description and WA performance targets

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%

With increasing demand on emergency departments, it is important to monitor performance to help develop strategies to manage this demand and assess the effectiveness of service provision.

Percentage of Emergency Department patients seen within recommended times

This indicator measures how effective emergency departments are at the starting point of patient care. It captures the percentage of patients treated within the timeframes recommended by the Australasian College for Emergency Medicine. A higher percentage indicates better performance.

CAHS strives to treat all Emergency Department patients within the recommended period, but places most emphasis on the sickest and most time critical patients assigned to Categories 1 and 2. In 2020–21, CAHS continued to exceed performance expectations for Categories 1 and 2, although performance in Categories 3 and 4 declined slightly compared with last year (Table 3). Category 5 access sits above target, and comprises low acuity cases that represent a small percentage of presentations that can either be treated by a wider multi-disciplinary team or be directed to other providers through the triage process.

In 2020–21, the 12-month Graduate Nurse Program run by the CAHS Department of Paediatric Nursing Education was expanded to include specialist paediatric Emergency Department training, with Dejana Jovanovic (L) and Megan Winter (R) being the first graduates. The Professional Development Progression Pathway assists and supports new graduates transition to the acute care area of an Emergency Department. Over 12 months they learn and develop the specialist skills required by an Emergency nurse including nursing assessments, procedural sedation, and resuscitation room responsibilities.

Annual results are affected by factors such as high winter demand, the total number of cases and the timing of presentations. For instance, patients mostly arrive at the Emergency Department at intervals between zero and five minutes for several hours in a row, particularly in the evening, which can make it difficult to achieve the targets consistently. Wait times for Categories 3 and 4 have been negatively impacted in 2020–21; first by an unseasonal increase in presentations October 2020 to February 2021 due to respiratory syncitial virus, and subsequent impact of hospital capacity and access block. Access block affects waiting times by reducing the number of treatment spaces available to assess and manage patients within ED. COVID-19 precautions continue to be a factor impacting waiting times. In order to protect staff, patients and families, significant changes were made to workflows and personal protective equipment (PPE) recommendations at PCH ED in light of COVID-19. The delays attributable to the sharp rise in the use of PPE, in conjunction with increased cleaning requirements, are reflected in the slight deterioration in performance in the Category 3 and 4 figures for 2020–21. The Emergency Department is looking at various strategies to improve the Category 3 and 4 performance and has implemented some changes, such as the Triage Rapid Assessment Model team.

Table 3: Percentage of Child and Adolescent Health Service Emergency Department patients seen within recommended times, by triage category, 2018–19 to 2020–21

Triage category	2018–19	2019–20	2020–21	Target
1	100%	100%	**100%**	**100%**
2	88.5%	87.6%	**81.0%**	**≥80%**
3	66.3%	61.5%	**46.6%**	**≥75%**
4	65.8%	64.7%	**53.6%**	**≥70%**
5	97.5%	95.0%	**81.0%**	**≥70%**

Favourable performance **Unfavourable performance**

Early into the COVID-19 pandemic, CAHS recognised that personal protective equipment intended to prevent its spread could increase anxiety in young patients to the Emergency Department. Life-sized posters were placed in waiting areas to assure patients that despite these precautions, it was the same caring doctors and nurses beneath.


Way Out

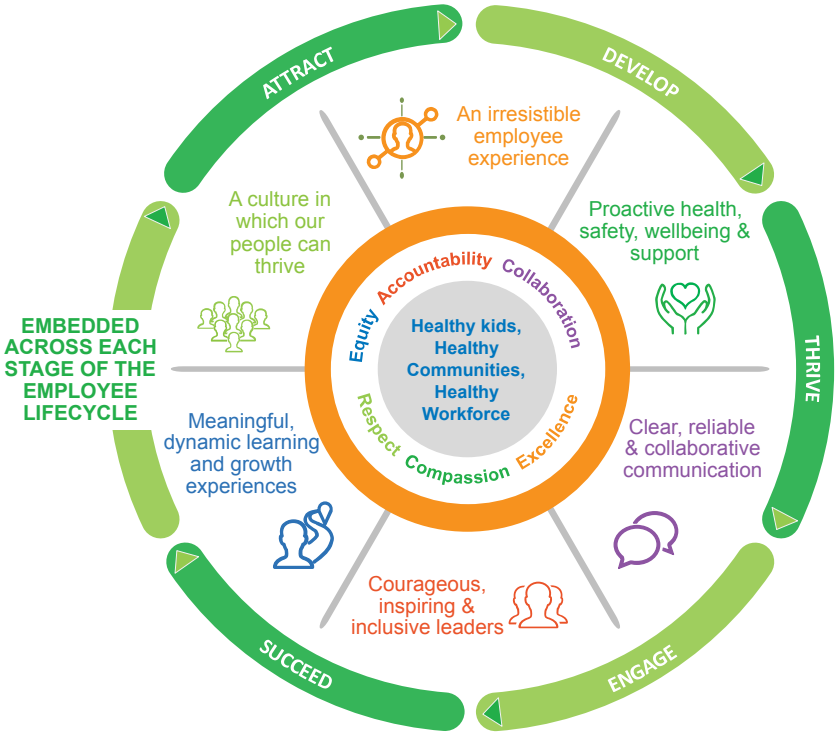
People, capability and culture

Year in Review

Valuing and respecting our employees continues to be a strategic priority for CAHS, with a strong focus on supporting the culture and wellbeing of the workforce. During the reporting period, the People, Capability and Culture (PCC) directorate continued with progressing the maturity of the directorate to effectively support the organisation to achieve its strategic priorities and to meet its future needs. Key to this was the development of PCC's vision, strategy and framework to guide the directorate's purpose, objectives and initiatives for the next 5 years. This work was undertaken in partnership with key stakeholders through evaluation surveys, workshops and consultative processes to ensure the vision of the directorate aligned to the needs of the organisation. It was carried out over several months, with workshops initially held in July 2020, and the final PCC vision and strategy being presented to and endorsed by the CAHS Board in February 2021.

The PCC vision is to lead and partner in a values-based environment that invests in our people and enables an agile, healthy workforce that aspires to excellence in performance. To identify the priorities of this vision, all work was aligned to six key themes:

1. An irresistible employee experience
2. Proactive health, safety, wellbeing and support
3. Clear, reliable and collaborative communication
4. Courageous, inspiring and inclusive leaders
5. Meaningful, dynamic learning and growth experiences
6. A culture in which our people can thrive.



Core activities have been identified to achieve these priorities, with a key focus on using evidence-based people management theory and practice to enable a solutions focused approach to current and future workforce challenges. PCC aims to lead and drive initiatives through partnership with CAHS service areas to elevate our position as an 'employer of choice' by working with business units to create a positive workplace environment that values, respects, engages and supports individual contributions and collective strength.

Our people – employee profile

CAHS employs over 5,000 staff who perform a wide variety of roles in service of WA children and their families and carers. Many are part-time employees, but when measured as full-time equivalents, our Service grew in 2020–21 (Table 4). The majority of growth relates to Neonatology staff transferred from the North Metropolitan Health Service in February 2020 and the impact of staff resources regarding COVID-19 and the COVID-19 vaccination program. CAHS also delivered more activity this year, which required more staff.

MEDIAN AGE
41

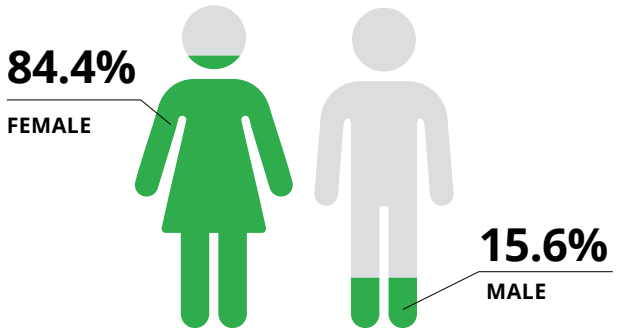
ABORIGINAL EMPLOYEES
1.6%

CALD EMPLOYEES
13.7%

EMPLOYEES WITH A DISABILITY
1.2%

AVERAGE LENGTH OF SERVICE
9.1 YEARS

CAHS EMPLOYEES BY GENDER



AVERAGE HOURS WORKED PER FORTNIGHT
59.5 HOURS

Leasa Ashton is a teacher with the School of Special Educational Needs: Medical and Mental Health. She works at PCH within inter-disciplinary teams to support the educational needs of long-term patients within the Complex Pain Service and Rheumatology department. Leasa was awarded a Churchill Fellowship and is undertaking research into increasing the quality of life and educational outcomes for young people with chronic pain and fatigue. Her research will also take her overseas once international borders reopen.

Table 4: Total full-time employees of CAHS, by category

Category	Definition	2019–20	2020–21
Administration & clerical	All clerical-based occupations together with patient-facing (ward) clerical support staff	686.3	742.4
Agency	Administration and clerical, medical support, hotel services, site services, medical salaried (excludes visiting medical practitioners) and medical sessional	29.0	41.7
Agency nursing	Workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest	3.6	1.6
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care	16.0	29.5
Dental nursing	Dental nurses and dental clinic assistants	6.6	7.5
Hotel services	Catering, cleaning, stores/supply laundry and transport occupations	175.3	187.4
Medical salaried	All salary-based medical occupations including interns, registrars and specialist medical practitioners	384.0	459.5
Medical sessional	Specialist medical practitioners that are engaged on a sessional basis	69.3	90.1
Medical support	All Allied Health and scientific/technical related occupations	631.6	649.0
Nursing	All nursing occupations. Does not include agency nurses	1,415.4	1,673.0
Site services	Engineering, garden and security-based occupations	2.2	1.3
Other occupations	Aboriginal and ethnic health employees	25.6	28.0
	Total	**3,444.8**	**3,911.0**

Workforce planning

During 2020–21, CAHS undertook a baseline assessment of the workforce as part of developing a strategy to ensure the composition and supply of the future workforce meets expected requirements.

The purpose of the workforce assessment was to provide granular detail of the current workforce composition, including the identification of factors and influences potentially impacting on future planning while identifying strategic workforce risks.

This baseline assessment will be used to inform People Capability and Culture strategies and actions.

Volunteers

The 'team in tangerine' consists of over 400 volunteers who support CAHS to provide a warm and welcoming environment for children, their families and carers. They are a diverse group of people from 18 to 86 years old, speaking over 60 different languages. Our longest serving volunteer has completed 41 years of service.

Our volunteers operate in the following areas of Perth Children's Hospital:

- All entrances – welcoming visitors, screening, assisting outpatients check in, directing and escorting where necessary
- Emergency Department
- Wards

- Outpatient clinics
- Admissions, pre-op and recovery in the theatre area
- Refugee clinic
- Stitches shuttle
- Refugee bus
- School of Special Educational Needs
- Supporting delivery of PCH play and wait strategy
- Archives
- Aboriginal health

Ad hoc support is provided to projects across the hospital including:

- Research
- Pastoral care service
- Diabetes clinic
- Play, leisure and engagement
- Paediatric exams

CAHS also provides volunteers to work collaboratively with our NGO partners including:

- Telethon Kids Institute Discovery Centre
- Animal Companions
- Starlight Foundation
- Perth Children's Hospital Foundation
- Scholastic Book Bunker

Since the COVID-19 pandemic, CAHS has seen a huge demand for volunteers providing support for visitor screening and in the vaccination clinic.

Our culture

Led by Professor David Forbes and Dr Asha Bowen, the Shape our Future Steering Team continued to provide multi-disciplinary input into making CAHS a great place to work. The team continued to meet monthly throughout the year to guide the cultural transformation of CAHS, either via MS Teams or in person depending on COVID-19 restrictions. The enthusiasm and commitment of the Shape our Future Steering Team has continued, with activities that focus our attention on Living our Values of collaboration, compassion, accountability, respect, equity and excellence at CAHS.

In November 2020, CAHS celebrated World Kindness Day, a Shape our Future initiative aimed at highlighting good deeds and providing an opportunity for staff to let each other know how much they are appreciated and valued. CAHS Kindness Cards were available in print and digital versions for staff to share messages of kindness to others. The cards featured the colouring in from Living our Values week by Melissa Miro in Community Health.

The tradition of *Living our Values* Week continued across CAHS from 22 to 26 February 2021. A working group of Shape our Future members organised and promoted activities, including an official Welcome to Country and opening from the CAHS Board and Executive, meditation and mindfulness sessions, long table lunches and a values colour dress up day.

The bi-annual Barrett's Cultural Values Assessment will be completed again in November 2021, with Neonatology included for the first time since joining CAHS. The 2019 cultural values assessment highlighted that CAMHS required a specific focus and action to address employee engagement. CAMHS undertook a Shape our Future process in 2020 to enable staff to contribute to a CAMHS Culture Action Plan. A total of 229 participants (over 50 per cent of CAMHS staff) provided feedback in a series of 29 focus groups, eight individual interviews and online feedback, with representation from all teams and disciplines. Feedback was analysed using an iterative process by working group members, ambassadors and staff, including "Your Said, We Heard" sessions in December 2020. Recommendations for action to improve workplace culture and the experience of staff have been developed for consideration by CAHS and CAMHS leadership. In 2021–22, we will focus on CAMHS nursing staff as a key activity of our cultural transformation.

CAHS is continuing its 5–10 year process towards becoming a values based organisation. Now in our fourth year, we have renewed our commitment with the launch of the Culture Action Strategy 2.0 (2021–2023) and recently welcomed new members to the Shape our Future Steering Team.


Certificate of Appreciation


World Kindness Day
CAHS Kindness Card
In honour of
World Kindness Day,
I want to say....

2021 WA Sonographer of the Year

Over the past year, WA Sonographer of the Year Leanne Lamborn, her team and her radiologist colleagues implemented several new examinations that eliminated the need for paediatric patients to undergo a general anaesthetic. Leanne and her professor also provide a new option for assessing liver lesions using ultrasound contrast instead of a liver biopsy. In response to COVID-19, Leanne produced short videos for doctors to help them with machine covers and cleaning procedures to ensure staff and patients were safe.

Recognising our people

Stars of CAHS

The Stars of CAHS Awards recognise individual employees or teams who provide exceptional care and service in line with the CAHS values of compassion, collaboration, equity, respect, excellence and accountability. There are three categories of awards:

1. Stars of CAHS Award – nominated by staff
2. Stars of CAHS Consumer Award – nominated by consumers
3. Stars of CAHS Chief Executive's Award – selected by the Chief Executive from all nominations

In 2020–21, there were 13 winners from 131 nominations. CAHS is grateful for the ongoing support of award sponsors HESTA and Perth Children's Hospital Foundation.

WA Nursing and Midwifery Excellence Awards

CAHS is very proud of the following staff who were finalists for the 2020 WA Nursing and Midwifery Excellence Awards:

Graduate of the Year
Alexandra Brindley – Community Health

Excellence in Primary, Public and Community Care
Lisa Palchak – Community Health

Excellence in Registered Nursing
Jeremy Johnson – Neonatology

(L-R) Pania Falconer, Elaine Taaffe, Dr Robina Redknap (Chief Nursing and Midwifery Officer), Jane Lake, Kate Addiscott, Terri Barrett (Acting Executive Director, Nursing Services). Absent Kate McLaughlan and Dianna Tanian

CAHS International Nurses Day Nursing Awards

Six nurses were recognised by CAHS on International Nurses Day 2021 for exemplifying CAHS values of compassion, excellence or being an inspiration to others.

Australasian College of Health Service Management (WA) – Stars of COVID-19

The Stars of COVID-19 campaign was launched by ACHSM to acknowledge and celebrate staff from all over WA's health care, aged care and community care sectors who demonstrated compassion and exceptional leadership during the pandemic. CAHS nominees were:

- Elizabeth Harding (Clinical Nurse Manager, Community Health)
- Gillian Charlwood (Clinical Nurse Specialist, Infection Prevention and Control)
- Kate McKenzie (Occupational Therapist, Community Health)
- Julie Branley (Nurse Educator, Community Health)
- Victoria Stone and Talitha Halliday (Emergency Management Unit)
- Child and Adolescent Mental Health Service Extended Leadership Group
- Samara Gardiner and Samantha Barba (Procurement, Infrastructure and Contract Management)
- Nicola Palmer (Clinical Nurse Specialist, Community Health)
- Carrie Dunbar (Nurse Co-Director, Surgical, Perth Children's Hospital)
- Newborn Hearing Screening Team

Highlights in workplace relations 2020–21

Planning and preparations to react in a timely manner to the ongoing COVID-19 threat presented challenges throughout the year. Structures were reconfigured both to improve services and respond promptly to any contingencies that could have arisen. Rapid recruitment processes ensured staffing levels could be maintained or increased in the event of community spread. Additionally, CAHS played a pivotal role in staffing vaccination centres throughout the metropolitan area.

Another area of key focus was addressing insecure employment contracts (with a continued drive to fill all vacancies on a permanent basis). This occurred through both standard recruitment and conversion processes to enable permanent contracts to be issued to fixed term and casual employees.

The requirement to provide accurate and timely advice to line managers on new and emerging workplace issues in this changed environment placed significant demand on workplace relations advisory services. Activity levels for individual employee issues requiring ongoing management and workplace relations advice rose again during the year. There was also an increase in the number of disputes or appeals in 2020–21, mostly related to individual employee matters. All the disputes or appeals were successfully resolved without the need for arbitration, but increased use of formal conciliation or meditation and use of formal internal dispute resolution procedures was evident.

Throughout the year, the unions have run a number of campaigns for their membership, such as the *S.A.F.E.*[8] *Mental Health Campaign*. In terms of employees raising issues at the workplace level, this campaign activity had some impact, with CAHS management, in a number of instances, taking immediate positive steps to engage with the employees and consider potential resolutions.

Compliance with public sector standards and ethical codes

As part of CAHS' ongoing commitment to engaging and developing an ethical, transparent and accountable health service we:

- focus on building an ethical culture by continuing to strengthen communication and promotion of employee responsibilities across the organisation. This included the implementation of an Integrity Policy Framework.
- actively participate as a member of the WA Health Integrity Working Group in support of a consistent approach to integrity and ethics across the WA health system.
- publish expected standards of conduct on the CAHS website and inform the public about how to give compliments or complaints, and notify us about misconduct and Public Interest Disclosures.
- partner with the Corruption Crime Commission to

8 Sustainable, Accessible, Funded, Excellent.

support misconduct resistance and prevention, along with the Public Sector Commission to entrench the integrity-focused partnership.

To ensure our employees are aware of their rights and responsibilities in accordance with the Public Sector Standards and ethical codes, CAHS ensures:

- resources, expectations, and accountabilities are communicated to employees through online and face-to-face forums, inductions, orientations, and learning programs.
- policies, procedures and associated guidelines are regularly reviewed and made accessible electronically via external-facing websites and local intranet sites.
- information about the Standards and their application is communicated via the CAHS intranet.
- matters raised by employees are tracked via regular reporting to support equitable and timely resolution.
- Human Resources and Integrity and Ethics Officers are available to advise managers and staff.

Compliance monitoring

During 2020–21, there were five claims lodged against the employment standard. No claims were resolved internally, with all five referred to the Public Sector Commission (PSC) for review. Two were subsequently declined by the PSC, two were withdrawn by the claimant following referral, and one outcome is still pending. There was one claim lodged against the grievance standard in 2020–21.

A total of 55 reports or complaints alleging non-compliance with the Code of Conduct (breaches of discipline) were lodged (Table 5). Suspected breaches of discipline, including matters of reportable misconduct, were dealt with through the WA Health Disciplinary processes, and where appropriate, reported to the Public Sector Commission (4) or the Corruption Crime Commission (8) as required under the *Corruption, Crime and Misconduct Act 2003*. Where breaches were substantiated, the decision maker determined the appropriate action in accordance with the *Health Services Act 2016*.

Table 5: Complaints alleging non-compliance with the Code of Conduct, by area of compliance

Type	
Communication and official information	7
Conflict of interest	0
Fraud and corrupt behaviour	17
Personal behaviour	29
Record keeping and use of information	1
Use of public resources	1
Total	**55**

Fraud and corruption prevention

CAHS has zero tolerance of fraud and corruption. Reporting suspected fraud or corruption is strongly encouraged, and will be investigated and resolved in accordance with the *Corruption, Crime and Misconduct Act 2003* and internal policies and procedures.

In 2020–21, CAHS commenced the development of an assurance map relating to fraud and corruption prevention controls, gaps and red flags across key areas of CAHS.

Our commitment to integrity is supported through:

- increased resourcing in the Integrity and Ethics Unit
- ongoing review and monitoring of integrity and ethics internal and external reporting
- internal audits focused on hot spots, including additional hours and overtime
- reviewing and updating the communication plan to target and align key messages with global awareness dates.

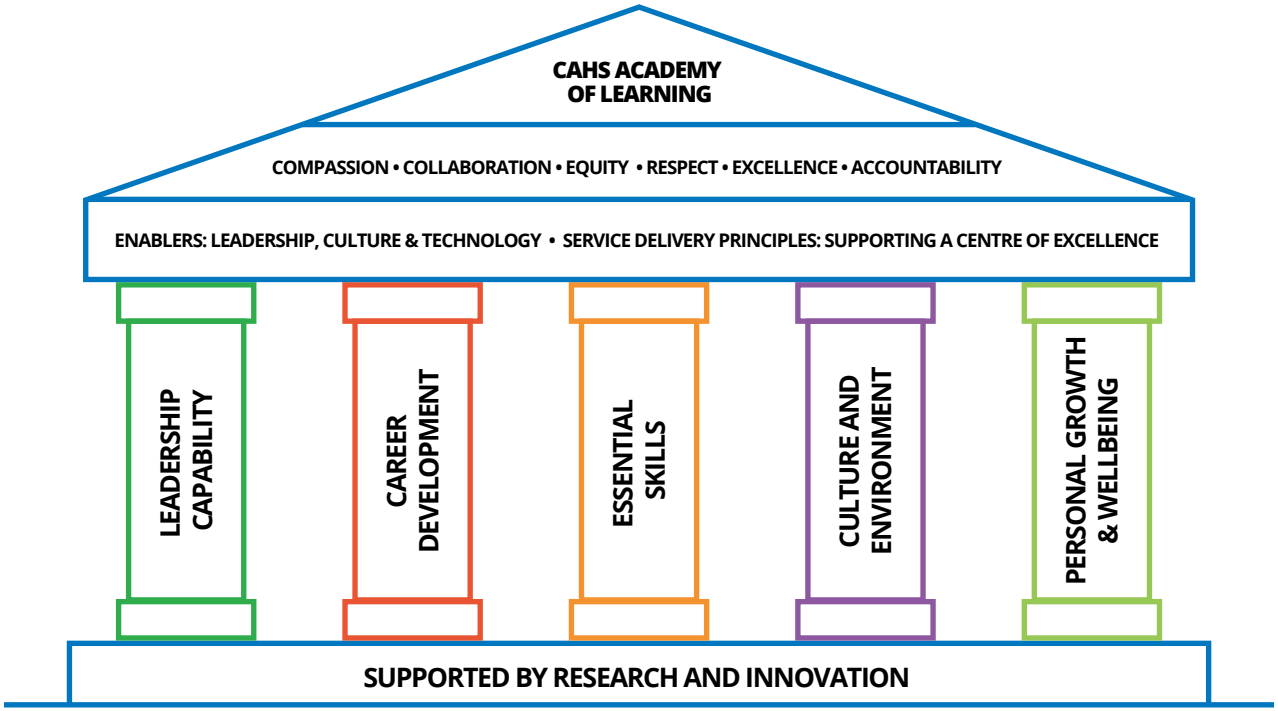
Our capability

In March 2021, People, Capability and Culture (PCC) launched the CAHS Learning and Development Strategy and Model 2020–2025 to support its strategic objective of achieving high-impact learning and development in the workplace. The notion of high-impact learning acknowledges the need to ensure the knowledge, capability and performance of the workforce supports the delivery of excellence in health care.

The strategy also aligns with the broader PCC framework which aspires to offer 'meaningful, dynamic learning and growth experiences'.

The strategy aims to support our employees through a sustainable and future-focused learning and development vision that centers on collaboration, communication and improved alignment across CAHS. It will shape and enhance development of every individual to inspire learning and excellence in health care delivery.

Going forward, the delivery of learning and development activities at CAHS will be supported by the establishment of an Action In Learning hub. The hub will support CAHS Learning and Development teams and subject matter experts by embracing fresh thinking, consider the learner's experience and be solution focused. The hub function includes leadership and governance, learner experience, organisational development and service support.



Workforce development

CAHS encourages a culture of life-long learning and professional development across the organisation through provision of ongoing education, training and development of employees. In-house training programs are facilitated by a number of areas within CAHS, and employees are supported to access external opportunities through a number of corporate partnerships.

During 2020–21, the People, Capability and Culture team worked with a number of internal stakeholders to develop the overarching learning and development

vision for CAHS that will guide the organisation over the next five years. This vision aims to develop an outcome focused, high impact and dynamic learning culture that supports its people to drive excellence in the delivery of health care and is supported by a roadmap to build capability within the workforce by developing leadership and management programs, introducing capability frameworks, capitalising on technology and supporting communities of practice. This model will be supported by an Action In Learning hub that will be established during the next financial year.

Some highlights for the year included:

- Development of a new hub page to bring together a collection of training and resources for staff
- Development of a new escalation system based on research – Paediatric Acute Recognition and Response Observation Tool (PARROT).

This entailed significant collaboration across the health service and CAHS has a number of initiatives in the pipeline for the next financial year.

Leadership Capability

Leadership capability has been identified as a key focus area within the strategic Learning and Development vision of establishing a CAHS Academy of Learning.

In 2020–21, a third cohort of participants completed the Leading CCAREE[9] program, a tailored program focusing on leading with the CAHS values to contribute to a unified and collaborative culture across CAHS.

At the start of 2021, the PCC team launched some important initiatives to support leadership development at CAHS in line with the Learning and Development Strategy:

9 The Leading CCAREE program is named after the CAHS values of Compassion, Collaboration, Accountability, Respect, Excellence and Equity.

- The Medical Head Development Program is an in-house program delivered by those CAHS staff with subject matter expertise in areas considered to be fundamentals of management.
- The CAHS Mentoring Program, facilitated by Leadership Development Consultant Dee Roche, is underway with paired mentors and mentees from various occupational groups across CAHS, completing their orientation in April 2021.
- Work has commenced in determining the preferred structure for a new tailored CAHS Leadership Development Program that will be offered in 2022.
- CAHS is also strengthening partnerships with the WA Health Institute of Health Leadership in supporting employees to participate in programs such as Coach as Leaders Programs, Aboriginal LEAD Program and the First Step Aboriginal Emerging Leaders Program.

Work health, safety and wellbeing

CAHS is committed to providing employees, contractors, volunteers, patients/consumers/clients, families, carers, elders and visitors with a healthy and safe working environment. This is done in accordance with the *Occupational Safety and Health Act 1984* by taking a proactive approach to prevention and risk management for all.

Harmonisation of new legislation expected in early 2022 prompted a review of current functions and capacity of the Occupational Safety and Health department within CAHS. The review highlighted a need for a work health, safety and wellbeing model that recognises both physical and psychosocial safety and their interdependence, and shows the relationship culture has on both.

Consultation on Work Health and Safety (WHS) issues is a management responsibility, but is supported through elected employee safety representatives across all departments and service areas. Dedicated WHS Committees coordinated by the CAHS WHS team meet bi-monthly to:

- Monitor workplace hazards
- Review WHS policies and procedures
- Make recommendations to CAHS about workplace activities affecting safety and health.

Wellbeing

A Health and Wellness Coordinator joined CAHS in June 2020 to support the development of health and wellness initiatives across the organisation. Initially, time was spent developing CAHS' approach to wellbeing, including an overarching wellbeing strategy, wellbeing communication strategy, intranet page and wellness advocates across the multiple sites. The strategy outlines two aims:

1. creating a work environment where CAHS provides the same kindness, compassion and care for the wellbeing of ourselves and colleagues as we do for our patients
2. creating an engaged and empowered workforce where staff look after their wellbeing and are physically and psychologically safe in our workplaces, and are supported to maximise their health and wellbeing.

Initiatives implemented since June 2020 include:

- establishing a wellbeing intranet hub providing information and initiatives across the pillars of health (physical, mental, social, spiritual and financial)
- psychological support for staff, including internal psychological support for staff after critical incidents, mental health education, development of wellbeing and staff support resources, review of EAP services
- implementation of a fitness passport
- financial education workshops, and
- collaborating and listening to the wellbeing needs of staff through the wellbeing survey and other surveys.

We are committed to building on and further embedding initiatives identified during this time to ensure readiness for the future.

Pastoral care services

Dedicated pastoral care services form part of the new WHSW department. It is integral to the development of the Wellbeing Centre, providing support for the emotional, psychosocial and spiritual health and wellbeing of families and staff.

Having a child in hospital is a confronting, difficult and dislocating time that may cause feelings of uncertainty or apprehension. Pastoral care services are therefore available to all, offering a no-cost, confidential, supportive service to patients and their families, as well as staff at PCH.

Injury management

The CAHS Board and Executive have formal consultation mechanisms in place to fulfil their legislative role. Compliance against the requirements under the *Workers' Compensation and Injury Management Act 1981*. The Injury Management Code of Practice (WorkCover WA) is monitored through the CAHS PCC Executive Committee, which is accountable for the safety of all CAHS staff, visitors, patients/clients, carers and contractors. Through values based leadership, CAHS supports injured workers through a comprehensive injury management service provided by professional injury management staff.

Workers' compensation

When employees sustain a work-related injury, CAHS aims to support their return to work in a safe and timely manner. This is done in consultation and agreement with the injured worker, management and treating medical practitioner.

A total of 74 workers' compensation claims were made in 2020–21 (Table 6).

Work health, safety and wellbeing performance

Recent work health and safety and injury performance for CAHS is summarised in Table 7.

Table 6: Number of workers' compensation claims in 2020-21

Category	Claims
Nursing Services / Dental Care Assistants	31
Administration and Clerical	14
Medical Support	6
Hotel Services	22
Maintenance	0
Medical (salaried)	1
Total	**74**

Table 7: Occupational safety, health and injury performance, 2018–19 to 2020–21

Measure	2018–19	2019–20	2020–21	Target	Comment
Fatalities (number of deaths)	0	0	**0**	0	Target met
Lost time injury/diseases (LTI/D) incidence rate (per 100)	2.0%	1.9%	**1.6%**	0 or 10% improvement on the previous 3 years	Target met
Lost time injury severity rate (per 100, i.e. percentage of all LTI/D)	36.4%	47.8%	**59.7%**	0 or 10% improvement on the previous 3 years	Target not met
Percentage of injured workers returned to work within 13 weeks	77%	75%	**80%**	No target	
Percentage of injured workers returned to work within 26 weeks	77%	88%	**90%**	≥80%	Target met
Percentage of managers trained in occupational safety, health and injury management responsibilities	48%	80%	**54%**	≥80%	+37% in progress

PCH Food Services ensure patients and eligible parents receive nutritious, appetising and satisfying meals and snacks that help meet their clinical, nutritional, social and cultural needs. This service is supported by Dietetics and the Food and Nutrition Working Group.

Financial targets

	2020-21 TARGET [1] $000	2020-21 ACTUAL $000	VARIATION [7] $000
Total cost of services (expense limit) (sourced from Statement of Comprehensive Income)	797,935	834,777	36,842[2]
Net cost of services (sourced from Statement of Comprehensive Income)	732,728	759,772	27,044[3]
Total equity (sourced from Statement of Financial Position)	1,453,283	1,466,919	13,636[4]
Net increase / (decrease) in cash held (sourced from Statement of Cash Flows)	(6,360)	11,532	17,892[5]
Approved salary expense level	549,124	558,987	9,863[6]

Note

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

(2) The major cost drivers for the variation of $36.842 million in total cost of services are the unexpectedly higher drug costs ($10.473 million), increased employee benefits expenses ($9.863 million) for delivering additional activities at the Perth Children's Hospital (PCH) and Neonatology, and the costs incurred for the COVID-19 pandemic.

(3) As a result of additional funding ($4.413 million) for the higher drug costs from the Pharmaceutical Benefits Scheme, and increases in patient charges ($2.713 million) and donation revenue ($1.586 million), the variation in net cost of services is less than the variance in total cost of services.

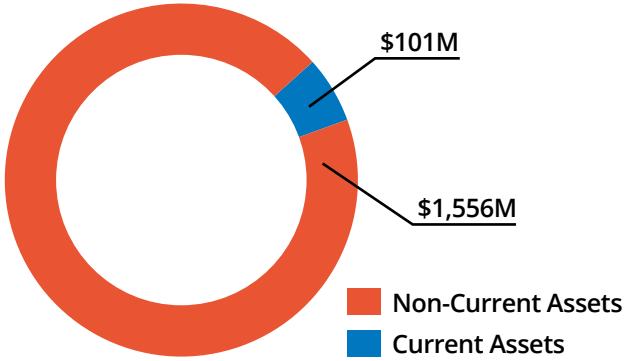
(4) The operating surplus of $8.867 million and the transfer of Crown land amounting to $15.700 million for the Perth Children's Hospice have contributed to the increase in total equity. Conversely, the equity increase has been lessened by the reduction of $10.931 million in State Government's appropriations for capital works program. The details are set out in Note 9.13 'Equity' to the financial statements.

(5) The unexpected increase ($17.892 million) in cash held was mainly caused by the $18.041 million of service agreement funding being received from the Department of Health on the last day of the financial year.

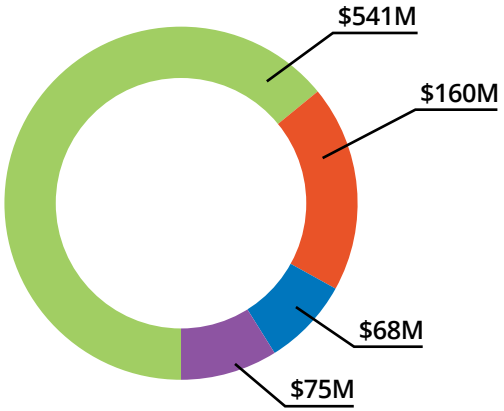
(6) The amounts for salary expense level include superannuation.

(7) Further explanations are contained in Note 9.15 'Explanatory Statement' to the financial statements.

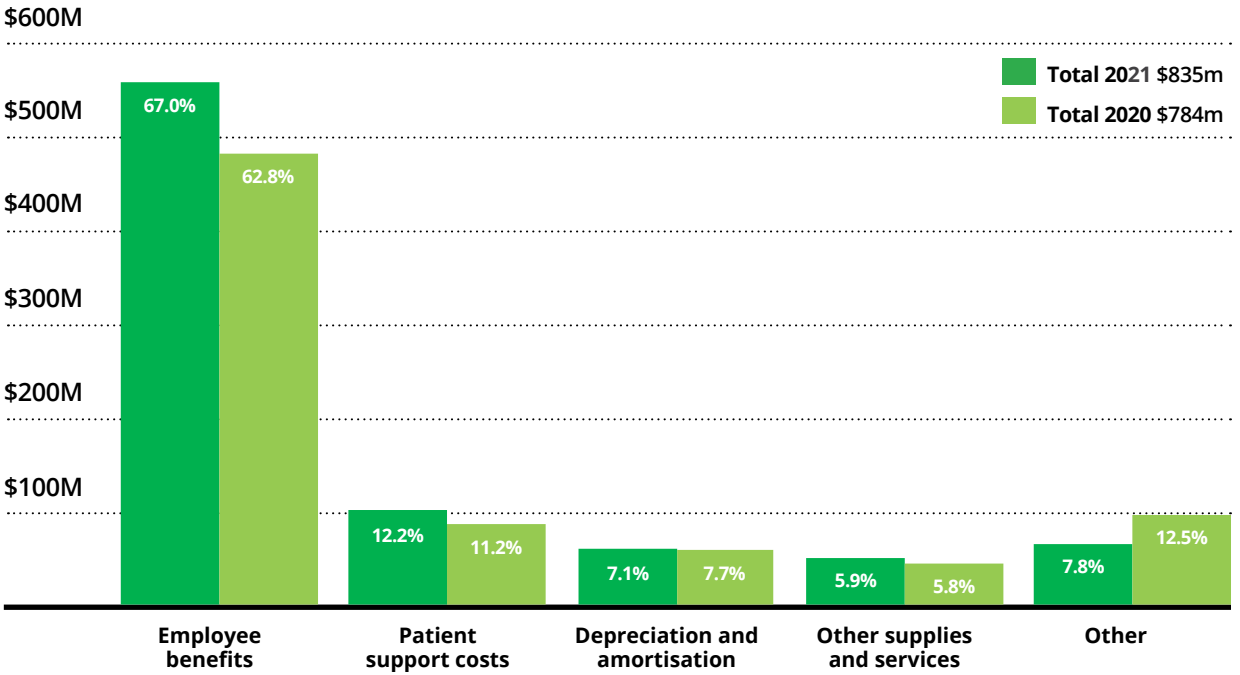
Total assets



Income



Expenditure by type



Total assets

The Child and Adolescent Health Service finished the 2021 year with a total asset value of $1,657 million, which represents an increase of $40 million over the previous year. The major components of assets are Property plant and equipment totalling $1,098 million and Cash and cash equivalents totalling $95 million. Further details of the breakdown by asset category can be found within the statement of financial position in the annual financial statements presented as at 30 June 2021.

Income

The Child and Adolescent Health Service receives the majority of its income via the service agreement funding from the Department of Health. This totalled $653 million comprising the State component of $493 million and the Commonwealth component of $160 million for the 2021 year. A further $42 million in income was received via services received free of charge from State Government entities and $68 million from the Mental Health Commission towards the cost of providing child and adolescent mental health services. Further details of the breakdown by income category and comparison to the previous year can be found within the statement of comprehensive income in the annual financial statements presented for the year ended 30 June 2021.

Expenditure by type

Employee benefits capture the costs of staff providing services within the Child and Adolescent Health Service and represent the major component of expenditure for the 2021 year. Further details of the breakdown by expense category and comparison to the previous year can be found within the statement of comprehensive income in the annual financial statements presented for the year ended 30 June 2021.

Summary of key performance indicators

Key performance indicators assist the Child and Adolescent Health Service (CAHS) assess and monitor the extent to which State Government outcomes are being achieved.

Effectiveness indicators provide information that 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. Key performance indicators also provide a means to communicate to the community how CAHS is performing.

A summary of the CAHS key performance indicators and variation from the 2020–21 targets is given in Table 8.

Note: It is essential that Table 8 be read in conjunction with detailed information on each key performance indicator found in the Disclosures and Legal Compliance section of this report.

Table 8: Actual results versus KPI targets

Key performance indicator		2020–21 Target[1]	2020–21 Actual	Variation	Further info
Unplanned hospital readmissions for patients within 28 days for selected surgical procedures	Appendicectomy	25.7	**16.5**	9.2	p.218
	Tonsillectomy & Adenoidectomy	81.8	**65.5**	16.3	
Percentage of elective wait list patients waiting over boundary for reportable procedures	Cat 1 (≤30 days)	0	**1.6**	1.6	p.220
	Cat 2 (≤90 days)	0	**29.1**	29.1	
	Cat 3 (≤365 days)	0	**21.2**	21.2	
Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days		1.0	**0.48**	0.52	p.221
Percentage of admitted patients who discharged against medical advice	Aboriginal	2.78	**0.14**	2.64	p.222
	Non-Aboriginal	0.99	**0.06**	0.93	
Readmissions to acute specialised mental health inpatient services within 28 days of discharge		12%	**23.3%**	11.3%	p.223
Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services		75	**94.1**	19.1	p.224
Average admitted cost per weighted activity unit		$7,073	**$7,547**	$473	p.225
Average Emergency Department cost per weighted activity unit		$6,853	**$8,013**	$1,160	p.226
Average non-admitted cost per weighted activity unit		$7,025	**$6,877**	-$147	p.227
Average cost per bed-day in specialised mental health inpatient services		$3,815	**$3,408**	-$407	p.228
Average cost per treatment day of non-admitted care provided by mental health services		$617	**$598**	-$18	p.229
Average cost per person of delivering population health programs by population health units		$255	**$250**	-$4	p.230

The Service Agreement with the Department of Health effectively sets CAHS-specific financial performance expectations that in most cases are higher than the Annual Report targets. Refer to the discussion of Key Performance Indicator results for further information.

Favourable performance **Unfavourable performance**

Significant issues

Caring for children, young people and families

CAHS Multicultural Plan

The inaugural CAHS Multicultural Plan was launched in March 2021 and outlines CAHS' commitment to delivering health services that are inclusive, welcoming and equitable for staff and for the children, young people and families from WA's diverse communities.

A number of initiatives have been put in place, including establishing a Diversity and Inclusion Intranet Hub, providing staff with resources on cultural diversity, cultural competence, equal opportunity and health literacy. CAHS also secured membership for all health service staff to Diversity Council Australia, providing access to a range of resources, research, training and information on improving diversity and inclusion in the workplace.

As part of Refugee Week 2021, the Refugee Residence Perth Photographic Display was made available to staff via monitors at Perth Children's Hospital and on social media platforms. The vivid digital display, created by a Clinical Nurse from the CAHS Community Health Refugee Health Team, consisted of photos reflecting the unique interior environments that refugee families live in and how they integrate their customs and beliefs into the Australian context.

Supported by the CAHS Language Services Team, over 32 health information documents were translated into different languages, with the team also providing 15 staff education and training sessions on accessing and effectively using interpreters. A review of the CAHS volunteer workforce showed that 30 per cent spoke a language other than English (with 48 languages identified), opening opportunities for CAHS to explore how families could be better supported by volunteers who come from similar cultural backgrounds.

Priority initiatives planned over the coming months include developing welcome signage at CAHS sites in various languages, more translated information in the PCH Emergency Department, broadening of the range of cultural competency training available to staff, increased visibility of the National Interpreter Symbol, and formal consumer consultation with multicultural families to better understand their experience of our services.

Child Safe Organisations

As Western Australia's only dedicated paediatric health service, we want children and young people to be safe, feel safe and be treated with respect whenever they access CAHS services.

The Australian Human Rights Commission defines a child safe organisation as one that:

- creates an environment where children's safety and well-being is at the centre of thoughts, values and actions
- places emphasis on genuine engagement with and valuing of children and young people
- creates conditions that reduce the likelihood of harm to children and young people
- creates conditions that increase the likelihood of identifying any harm, and
- responds to any concerns, disclosures, allegations or suspicions of harm.

CAHS is leading the way in implementing the National Principles for Child Safe Organisations (National Principles). These Principles are intentionally broad, and include a combination of policy and other strategies that aim to create and support a child safe culture in which everyone recognises their role in promoting and protecting the safety and well-being of all children.

Significant progress has been made to create the foundation for a child safe approach in CAHS by implementing the first phase of the Child Safe Organisation Action Plan. A major undertaking was a review of all CAHS facilities to identify and quantify areas of risk that required action to increase the safety and well-being of children and young people.

Moving forward, phase two of the action plan will build the child safe capacity of CAHS with work streams targeting education, governance and communication and engagement to further align CAHS with the national principles and the broader health system policies and procedures. This will strengthen CAHS child safe culture, which is central to the broader goal of developing and sustaining a child safe environment.

Value and respect our people

People Capability and Culture

Development of the vision and strategy was a key step in establishing the People Capability and Culture (PCC) directorate undertaken this year, and will guide CAHS purpose, objectives and initiatives forward over the next five years.

The vision is to lead and partner in a values-based environment that invests in our people and enables an agile, healthy workforce that aspires to excellence in performance. To identify the priorities of this vision, all work was aligned into six key themes of:

1. An irresistible employee experience
2. Proactive health, safety, wellbeing and support
3. Clear, reliable and collaborative communication
4. Courageous, inspiring and inclusive leaders
5. Meaningful, dynamic learning and growth experiences
6. A culture in which our people can thrive.

Given the level of change required, the first 12 months has focused on strengthening foundations and building momentum for change in order to achieve future aspirations. Much work has been done to date to identify requirements and commenced the 'core' activities for the future and to grow a strong and sustainable team within the directorate to support this change.

A selection of key milestones and highlights are:

April 2020	PCC Executive Committee established
September 2020	WH&S and Wellbeing Model endorsed
December 2020	CAHS Strategic Workforce Plan finalised
January 2021	PCC Framework and strategy endorsed by CAHS Board
March 2021	Commenced official membership on Disability Access and Inclusion Committee to support inclusive workplaces
	PCC Aboriginal Workforce Coordinator commenced
June 2021	CAHS Learning and Development Strategy endorsed
	CAHS Wellbeing approach endorsed by Executive

Culture Action Strategy 2.0 (2021 – 2023)

Two years ago, CAHS committed to becoming a values-based organisation as well as a great place to work. We conducted the first Cultural Values Assessment which set forth our 5 – 10 year plan of cultural transformation.

Our cultural transformation now continues with development of the Culture Action Strategy 2.0. This updated version of the Strategy has been prepared jointly by the Shape our Future Steering Team together with the PCC directorate

The Culture Action Strategy 2.0 builds upon organisational vision, values and strategic objectives, to focus on the organisational commitment to respect and value staff, to provide excellence in health care and to collaborate across our services. In addition, the PCC directorate and the Shape our Future Steering Team have been jointly supporting the attraction of new members, and engaging in workshops to focus on the next stage of cultural transformation, beyond the initial setting the foundations and monitoring of the Culture Action Strategy 1.0 and Culture Action Work Plan.

Results of the second Cultural Values Assessment saw 39 per cent of staff respond with feedback on how CAHS is tracking on its goal to becoming a values-based organisation. This result indicated that we have made progress and highlighted areas where there is still room for improvement.

Having achieved significant progress, the stage is set to focus on building up from the foundations to ensure the workforce feels valued, culturally secure, engaged and supported.

The third Cultural Values Assessment will be conducted in November 2021 to measure progress achieved. This will be an exciting time, as it will be the first time that Neonatology staff will be included.

Congratulations to Prof Helen Milroy – Western Australian 2021 Australian of the Year.

Professor Helen Milroy was named Western Australia's 2021 Australian of the Year in February 2021 in recognition of her extensive contributions to child and adolescent psychiatry. CAHS is privileged to benefit from Helen's passion and extensive contributions to supporting improvement in the lives of Western Australian children, young people and their families.

Professor Milroy was also named as the joint winner of the 2020 Australian Mental Health Prize. These prestigious awards provide a valuable platform from which Professor Milroy may continue to highlight, on the national stage, the importance of child and adolescent mental health.

These accolades are well-deserved recognition of Professor Milroy's lifetime of achievements; from being Australia's first Indigenous doctor, to her research and educational work in Aboriginal and child mental health and recovery from grief and trauma. In all of her work, Professor Milroy emphasises the strength and resilience of Indigenous communities.

Western Australian 2021 Australian of the Year
Prof. Helen Milroy

Provide high value health care

CAHS Community Hubs – Midland and Murdoch

In alignment with our Strategic Asset Plan, CAHS is establishing integrated and coordinated community-based health services for children and families in both the Midland and Murdoch regions. These hubs will offer families the convenience of accessing multiple CAHS services from a single, contemporary, safe and fit-for-purpose site that will provide care closer to home.

The service delivery framework for community hubs has been designed to optimise communication, connectivity, relationships and coordination between CAHS health professionals and services. This will enhance responsiveness to health needs in the region, improve health outcomes and enhance the care experience for children and their families.

Development of the hubs is aligned to key WA State Government and WA Health strategic directions, including the WA Health Sustainable Health Review (SHR) and the Department of Treasury Strategic Asset Management Framework. These recommend the provision of high-quality healthcare from a co-located site that incorporates child health, development and mental health services, emphasising the first 1,000 days of a child's life (SHR Strategy 3, Recommendation 8).

Midland and Murdoch are the initial two CAHS hub sites that have been selected, based on consumer demand for CAHS community-based services and population growth.

CAHS was allocated $7.2 million in funding via the SHR to establish the Midland Community Hub. Comprehensive land and property searches are being conducted in collaboration with the Department of Finance and Development WA, with a site to be finalised.

A business case was submitted to the Department of Treasury in 2020 regarding funding of the Murdoch Community Hub. Treasury approved capital funding of $2.6 million and operational funding of $35.6 million (for lease costs over 15 years).

A preferred site in the Murdoch area has been identified and lease negotiations are currently underway at the time of writing.

Innovation

The term 'healthcare innovation' has gained widespread global attention and adoption with innovation often synonymous with technology,

commercialisation, translation, game changing, invention, creativity, and problem solving.

Our definition of innovation at CAHS is 'doing something new, different, or better that results in a positive difference for CAHS and the children, young people and families we serve.'

At CAHS, we are focusing on cultural transformation to enable and promote a spirit of innovation, curiosity and continuous improvement to unlock the potential of our workforce to achieve our vision of *healthy kids, healthy communities.*

CAHS has made a commitment to innovation through our strategic objectives of 'provide high value healthcare by providing excellence in safety, quality, innovation and improvement' and 'promote teaching, training and research by promoting and celebrating innovation, teaching and research excellence'. Innovation at CAHS is driven by one of our guiding principles of 'a spirit of innovation, curiosity and continuous improvement'.

We have made significant progress this year to achieve our strategic objectives through the establishment of the innovation function and the appointment of the inaugural Innovation Manager.

To kick-off the innovation function, a 'shark-tank' event saw 99 staff submit ideas for funding with four projects selected for funding and progressed to implementation.

Other keys achievements include:

- Delivery of an Australian first digital health innovation training program.
- Establishment of a CAHS Innovation Champions Network.
- Delivery of various design thinking and pitch coaching sessions to scope and externally fund innovation projects.

Digital Transformation

The CAHS digital transformation that began in March 2019 continues with the program leveraging new and emerging healthcare technologies that support contemporary models of care and improve health outcomes. Modern digital health technology enables safer, higher quality, integrated care and provides transparent, real-time information to clinicians. This includes leveraging the lessons learned in response to the COVID-19 pandemic and expanding telehealth capabilities into new service areas and further into the community, while exploring the possibilities of wearable technologies on the wards and in the home. With the rise of mainstream video-conferencing, consumer-led expectations are driving rapid development and adoption in this space.

As a foundation-level project that enables many other digital health solutions, and as part of a state-wide initiative, CAHS has commenced the introduction of an Electronic Medical Record (EMR) system. This multi-year program will transition clinical service areas from paper-based workflows, improve and streamline processes, and help create a more efficient and sustainable health system for children, their families and the community.

Better access to patient information means better health outcomes for patients through targeted prevention, early diagnosis, and effective interventions. This program will be clinically led and co-designed to ensure that patient needs are the focus, and that the technology is robust, reliable, and based on contemporary architecture.

Work continues in the community health and mental health services to catalogue and improve the quality of infrastructure at more than 160 clinics around the metropolitan region. This infrastructure is critical to the successful delivery of current healthcare services, as well as the growing digital health capabilities and expectations being deployed into these sites. Existing technology and services fall short of the requirements of modern healthcare and many clinics are overdue for a technology refresh. New community hubs are now being developed and planning is underway to ensure that these are designed with contemporary digital health solutions.

Promote teaching, training and research

CAHS Research Strategy 2021 – 2023

There is a strong legacy of research excellence across CAHS, with established researchers and centres of research. Building on past achievements and the passion of existing researchers, and capitalising on an engaged workforce with a commitment to the health and well-being of children and young people, CAHS has the opportunity to expand research platforms and partnerships to drive future success.

The CAHS Research Strategy 2021 – 2023, launched in February 2021, provides a three-year roadmap to strengthen research across four strategic pillars:

People

Enhance research capacity and build a strong research culture that encourages research participation and excellence across all service areas and the clinical workforce.

Platforms

Improve our research infrastructure, governance and support systems.

Partnerships

Embrace collaborative research opportunities and strengthen partnerships with various stakeholders to enhance research excellence and capacity.

Priorities

Define and manage our research priorities to ensure maximum research impact.

Research plays a key role in CAHS achieving its bold aspirational targets in striving toward its vision of *healthy kids, healthy communities*.

Our strategic intent is for CAHS to be celebrated for a culture of research excellence that continually improves the health and wellbeing of children and young people.

Save and change lives, improve clinical care, enhance our health service

Children, young people and families drive our passion for research excellence. Our research focus is centred on children and young people. By establishing opportunities for meaningful consumer participation in all stages of the research process, genuine improvements in health and wellbeing will be realised for children and young people now and in future generations.

Launch of the Wal-yan Respiratory Research Centre

A partnership between the Telethon Kids Institute, Perth Children's Hospital and Perth Children's Hospital Foundation saw the launch of the Wal-yan Respiratory Research Centre in August 2020. The Centre is a global epicentre for paediatric respiratory research, informing clinical practice and unites all respiratory-focussed projects to drive a new research agenda for childhood lung health.

A focus on identification and intervention in early life to prevent life-long problems and lung damage underpins all research taking place.

The Centre comprises more than 140 laboratory scientists, epidemiologists, clinical researchers, computational biologists, bioinformaticians, PhD students and research assistants, working in partnership with a core leadership team. The team is based at the Telethon Kids Institute, co-located within PCH.

There is an integrated, multidisciplinary approach between the Telethon Kids Institute and PCH, and close collaborations with local universities, King Edward Memorial Hospital, the Royal Children's Hospital in Melbourne, and centres of research excellence in paediatric respiratory health around the world.

Child Health Symposium – November 2020

The annual Child Health Research Symposium, co-hosted by CAHS and the Telethon Kids Institute, showcases a vibrant child health research community, and provides an opportunity to acknowledge and celebrate the achievements of researchers from both organisations.

The 2020 symposium achieved record-breaking success in receiving 186 abstracts, almost 1,000 registrations for face-to-face and virtual attendance at plenary sessions, 70 posters were displayed and 18 presentations were delivered.

A focus on collaboration and inspiring others to become involved in research - staff, students and the community emerged as an important theme across the symposium.

The symposium was streamed online for the first time due to COVID-19 limitations, enabling attendance from a broad audience. The panel of one plenary session received a question that was texted to them from an audience member located in Seattle USA, which demonstrates an international interest in our world-class research endeavours.

(L-R) Members from the 'Digital health vision' panel: Catherine Resnick, Dr Carlo Bellini, Professor Desiree Silva, Professor Radhouane Aniba, Liz Dallimore, Associate Professor Chris Blyth, Dr Sarah Doyle.

Collaborate with our key support partners

The Kids' (Koolangka) Bridge

A colourful pedestrian bridge linking PCH and the wider Queen Elizabeth II Medical Centre campus with Kings Park and Botanic Gardens across Winthrop Avenue took shape rapidly in the latter half of this financial year.

The bridge has been a collaborative effort, with a range of partners working together with Main Roads WA, including the QEIIMC Trust, Child and Adolescent Health Service, Kings Park and Botanic Gardens and the City of Perth.

Aptly named 'the Kids' Bridge' this unique infrastructure will provide direct and safe access for patients, families and staff to bushland in Kings Park, allowing opportunities for improved health and wellbeing through a closer connection to nature.

The project was able to proceed thanks to the generous support of Perth Children's Hospital Foundation with a $6.3 million funding commitment.

WA Children's Hospice Project

The Child and Adolescent Health Service is partnering with Perth Children's Hospital Foundation to build Western Australia's first children's hospice.

The Foundation will provide funding for the construction, fit out and ongoing non-operational costs of the hospice, while CAHS will be responsible for governance, management and ongoing operational clinical and support services funding. While practical completion of the facility is anticipated in 2023, there has been a significant focus on the design and the development of the model of care.

Specialist paediatric palliative care is known to improve the quality of life for a child with a life-limiting condition, and their family and carers from the time of diagnosis and over the course of the illness. This facility will provide the care of a hospital and the feel of a home for children living with life-limiting conditions. Respite care and support will also be provided for the families. The hospice will provide an opportunity for families to come together, to celebrate life and to connect with others in similar circumstances, while being supported by a clinical team.

Development of this state of the art facility aligns with Recommendation 9 of the Sustainable Health Review to 'achieve respectful and appropriate end of life care and choices'.

Supporting children and young people experiencing mental health issues

There have been a number of reports developed since 2015 that have highlighted mental illness as a priority and emphasised the need to improve services available to support children and young people.

Amidst a backdrop of increasing demand, the COVID-19 pandemic has created a surge in demand across all child and adolescent mental health services, with particularly strong demand for inpatient beds at Perth Children's Hospital. The 10 Community CAMHS clinics across the metropolitan area have seen a large increase in demand, clinical complexity, risk and acuity over the last five years. Referrals to the Eating Disorders Service have significantly increased during the pandemic, including an unprecedented readmission rate. Referrals for the CAMHS Gender Diversity Service have more than tripled in the last two years; from six per month in June 2018 to 21 per month in August 2020.

The CAMHS Emergency Telehealth Service, introduced in July 2020, provides a much-needed alternative to a visit to the Emergency Department for young people experiencing a mental health crisis. However, there are no community-based intensive services for children and adolescents experiencing a mental health crisis, with admission to a mental health inpatient unit often the only option available. CAMHS services were also impacted by the closure or limiting of many services in the early stages of the COVID-19 pandemic. Many primary care mental health services and private providers also closed or limited services to phone or telehealth.

These systemic challenges were brought tragically and sharply into focus in July 2020, with the death of 13-year-old Kate Savage, a young person actively engaged in CAMHS services. Kate's death triggered an outpouring of community grief and intensive focus on mental health services for children and young people, with the then Minister for Health and Mental Health, the Honourable Roger Cook, initiating a targeted review by the Chief Psychiatrist, Dr Nathan Gibson, into Kate's treatment, with a final report released in December 2020.

The Chief Psychiatrist's report highlights that mental health services are under persistent considerable strain, reflecting a nationwide increase in demand. It made seven recommendations that focus on strengthening mental health services to support children and young people up to the age of 18.

CAHS recognised the opportunity to move quickly to implement some of the recommendations to immediately enhance the care available through CAMHS, and committed to some immediate actions. Implementation of the full scope of the recommendations reflects a substantial program to deliver the systemic changes required. CAHS is committed to working closely with the Department of Health, Mental Health Commission, CAMHS staff and consumers to ensure every opportunity is taken to enhance services for children, young people and their families, and has remained intensely focused on this throughout the year.

"CAHS recognised the opportunity to move quickly to implement some of the recommendations to immediately enhance the care available through CAMHS, and committed to some immediate actions."

Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0–18 in Western Australia

In December 2020, the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0–18 in Western Australia (the ICA Taskforce) commenced, as a key recommendation arising from the Chief Psychiatrist's review into the treatment of Kate Savage.

The Taskforce, chaired by Robyn Kruk, started in February 2021 with the goal to clearly articulate a

vision for public specialist mental health services for children and adolescents across WA, including infants aged from 0 years and up to 18 years.

The ICA Taskforce is developing a whole of system plan for State Government funded specialist infant, child and adolescent mental health services in both metropolitan and country areas. It is supported by three expert advisory groups (clinical, lived experience and interagency) and is actively engaging children, adolescents, families, clinicians and other key stakeholders. The Taskforce's final report is expected to be delivered in late 2021.

COVID-19 update

The COVID-19 pandemic was an ever-present issue throughout the year, with ongoing planning and preparedness activities interchanged with managing outbreak response and associated restrictions.

A CAHS COVID-19 Executive Oversight Committee was established to ensure the CAHS response to the COVID-19 pandemic is contemporary, strategic and responsive to the risk levels within Western Australia and nationally. To support the targeted work requirements, the dedicated multidisciplinary COVID-19 team continued to evolve to ensure a coordinated and expert-led health service response to the global pandemic.

There were three full lockdowns during the year, which included rapid changes to surgical cases and outpatient appointments at PCH, as well as clinical services in community settings. Despite the challenges associated with these urgent changes, teams of staff worked extremely hard to manage communications with families as well as switching appointments to telehealth or alternative formats where safe and appropriate.

The times of increasing or easing of restrictions were managed through the collaboration and extensive efforts of staff from patient flow, administrative services, community health nurses as well as PCH volunteers who assisted with visitor management and screening. Personal protective equipment supplies were well managed by Clinical Supplies and Patient Support Services to ensure stable holdings of stock and rapid availability when required.

Members of the CAHS COVID-19 team

CAHS took a lead role in the COVID-19 vaccination rollout in Western Australia. The CAHS COVID-19 Vaccination Team continues to manage the vaccination workforce that administers the vaccination program at the major State managed clinics in Perth.

Preparedness

The CAHS COVID-19 Education and Training program has been developed and implemented. It is a risk based approach developed for individuals to understand their own level of risk and enrol in education modules that contain training relevant to the individual's likelihood of exposure.

During the year, a more comprehensive communications strategy was implemented to ensure ongoing COVID safe messages were available across all CAHS sites and assisted with support for physical distancing and capacity requirements.

In addition, extensive work was done to support staff and consumer information in response to lockdowns and restrictions that impacted on health service delivery and visitor management.

To be more prepared for potential staff outbreaks, an electronic Staff Health Survey was developed to help identify clusters of staff with COVID-19 symptoms. It provides a more cohesive approach to identification, management and communication with staff about potential COVID-19 cases. The survey has been tested and is ready to implement should there be widespread community transmission or the risk is determined to be significant enough to warrant this approach.

CAHS has also established and trained a team of nursing staff who can coordinate COVID-19 contact tracing as required. This allows for a rapid response to any positive COVID swabs of staff to better manage potential spread in the workplace. These staff also supported requests from the State Health Incident Command Centre (SHICC) for rapid deployment of contact tracing teams during COVID outbreaks. A number of CAHS community health nurses were also seconded to Public Health Emergency Operations Centre (PHEOC) to support state-wide contact tracing requirements.

To prepare for managing quarantine patients in a paediatric environment, guidelines were developed to support staff and families in navigating the legislative requirements and infection prevention and control principles relating to COVID-19. Algorithms were created to ensure consistency in creating individualised risk mitigation plans for cases ranging from transfers from interstate and overseas to exemptions on compassionate grounds. They support our family-centred approach to healthcare, ensure the safety of staff, patients and families, and maintain compliance with legislative requirements.

COVID-19 lock downs or increased public restrictions (such as mask wearing) impact how CAHS manages its patients and visitors, which is dependent on the latest health advice and enforceable by WA Government legislation. CAHS visitor management is adaptable to rapidly changing COVID-19 restrictions as it aligns with the CAHS Pandemic Response phases rather than government recovery phases. This approach was particularly useful during transition out of lock down restrictions, where health service activity was at pre-COVID-19 levels yet visitor restrictions to health care sites were still mandated. CAHS also supported the implementation of the SafeWA app to all CAHS sites, ensuring compliance with mandatory contact tracing registers.

Volunteers have been a valuable resource, assisting with visitor screening and supporting consumers to use the SafeWA app. Volunteers also supported the visitor management for the COVID-19 vaccination clinics at PCH. During times of lockdown however, volunteers were asked to remain off site in accordance with WA Health recommendations.

CAHS Vaccination Team in the PCH Vaccination hub in the Collegiate Lounge.

COVID-19 vaccination program

CAHS worked closely with WA Health to support COVID-19 vaccination program rollout in WA, including the temporary secondment of the CAHS Chief Executive, Aresh Anwar, to the Department of Health. The CAHS COVID Vaccination Team was set up to lead the initial phase of the program, including rapid establishment of the first clinics to vaccinate the most at high risk workers, such as border force, hotel quarantine and healthcare workers.

The CAHS COVID-19 vaccination hub at Perth Children's Hospital opened in February 2021, starting with staff categorised in Phase 1a of the program. Within weeks, the hub was vaccinating Phase 1b staff from the health service and wider community. By the time it closed in June, the clinic at PCH had administered over 25,000 vaccinations.

The rapid introduction of the program; from staff recruitment, induction and training through to the transformation of the PCH Collegiate Lounge and in-reach clinics into fully functioning vaccination hubs was possible due to the hard work, skill and cooperation of many people in the CAHS team. This includes pharmacists, nurses and educators, as well as corporate staff from procurement and contract management, ICT, facilities and communications. They have also been well supported by project and administration staff.

CAHS also ran vaccination clinics from hotel quarantine locations, Perth airport, Perth Convention and Entertainment Centre, Claremont Showgrounds, Lakeside Joondalup Shopping Centre, Kwinana, Redcliffe and Midland.

STAFF COVID-19 VACCINATIONS (AT 30 JUNE 2021)

Dose 1:
3,623

Dose 2:
3,358

CAHS staff at the pop-up COVID testing clinic in Landsdale on Sunday, 25 April.

Sonya Egan, Registered Nurse in the CAHS COVID team overseeing the fit testing of a nurse.

Supporting a pop-up COVID testing clinic

In an outstanding collaborative effort, Community Health, the CAHS COVID Team, CAMHS and PCH staff came together to form the CAHS contingent of the pop-up COVID testing clinic at Landsdale on Sunday, 25 April 2021.

Working alongside representatives from the COVID-19 Public Health Emergency Operations Centre and PathWest, and coordinated by the CAHS Community Health clinical nurse specialist, the expertise and assistance provided by CAHS staff led to around 270 children and their parents being rapidly tested.

Mask fit testing

CAHS commenced the roll out of a fit testing program supported SHICC. The Fit Testing program is a specialist component of a comprehensive Respiratory Protection Program (RRP) for healthcare workers.

A fit testing team was convened and trained to support the rapid roll out the program. A risk matrix was developed by SHICC and staff deemed high risk for COVID-19 exposure (Categories 1 and 2) were identified and tested as a priority from January 2021. By February, CAHS had obtained second device to increase testing capabilities and commenced testing for Neonatology staff based at King Edward Memorial Hospital. Risk Category 3 and 4 staff were included in the program from March 2021. Training for donning and doffing personal protective equipment was also expanded for staff to support COVID-19 preparation.

STAFF FITTED FOR MASKS (AT 30 JUNE 2021)

1,575

Disclosures and legal compliance

Auditor General

INDEPENDENT AUDITOR'S OPINION
2021
Child and Adolescent 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 Child and Adolescent Health Service (Health Service) which comprise:

- the Statement of Financial Position at 30 June 2021, and the Statement of Comprehensive Income, Statement of Changes in Equity, Statement of Cash Flows and Schedule of Income and Expense by Service for the year then ended
- Notes comprising a summary of significant accounting policies and other explanatory information.

In my opinion, the financial statements are:

- based on proper accounts and present fairly, in all material respects, the operating results and cash flows of the Child and Adolescent Health Service for the year ended 30 June 2021 and the financial position at the end of that period
- in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions.

Basis for opinion

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

I am independent of the Health Service in accordance with the *Auditor General Act 2006* and the relevant ethical requirements of the Accounting Professional & Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants (including Independence Standards)* (the Code) that are relevant to my audit of the financial statements. I have also fulfilled my other ethical responsibilities in accordance with the Code.

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.

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 Child and Adolescent Health Service. The controls exercised by the Health Service are those policies and procedures established by the Board 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 legislative provisions (the overall control objectives).

My opinion has been formed on the basis of the matters outlined in this report.

In my opinion, in all material respects, the controls exercised by the Child and Adolescent Health Service are sufficiently adequate to provide reasonable assurance that the receipt, expenditure and investment of money, the acquisition and disposal of property and the incurring of liabilities have been in accordance with legislative provisions during the year ended 30 June 2021.

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 Child and Adolescent Health Service for the year ended 30 June 2021. The key performance indicators are the Under Treasurer-approved key effectiveness indicators and key efficiency indicators that provide performance information about achieving outcomes and delivering services.

In my opinion, in all material respects, the key performance indicators of the Child and Adolescent Health Service are relevant and appropriate to assist users to assess the Health Service's performance and fairly represent indicated performance for the year ended 30 June 2021.

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 control it determines necessary to enable the preparation of key performance indicators that are free from material misstatement, whether due to fraud or error.

In preparing the key performance indicators, the Board is responsible for identifying key performance indicators that are relevant and appropriate, having regard to their purpose in accordance with Treasurer's Instruction 904 *Key Performance Indicators*.

Auditor General's responsibilities

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

An assurance engagement involves performing procedures to obtain evidence about the amounts and disclosures in the key performance indicators. It also involves evaluating the relevance and appropriateness of the key performance indicators against the criteria and guidance in Treasurer's Instruction 904 for measuring the extent of outcome achievement and the efficiency of service delivery. The procedures selected

depend on my judgement, including the assessment of the risks of material misstatement of the key performance indicators. In making these risk assessments I obtain an understanding of internal control relevant to the engagement in order to design procedures that are appropriate in the circumstances.

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

My independence and quality control relating to the reports on 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 ASQC 1 *Quality Control for Firms that Perform Audits and Reviews of Financial Reports and Other Financial Information, and Other Assurance Engagements*, the Office of the Auditor General maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Other information

The Board responsible for the other information. The other information is the information in the entity's annual report for the year ended 30 June 2021, but not the financial statements, key performance indicators and my auditor's report.

My opinions do not cover the other information and, accordingly, I do not express any form of assurance conclusion thereon.

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

This auditor's report relates to the financial statements, controls and key performance indicators of the Child and Adolescent Health Service for the year ended 30 June 2021 included 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 these financial statements, controls or key performance indicators. If users of the financial statements, controls and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to contact the entity to confirm the information contained in the website version of the financial statements, controls and key performance indicators.

Caroline Spencer
Auditor General for Western Australia
Perth, Western Australia

3 September 2021

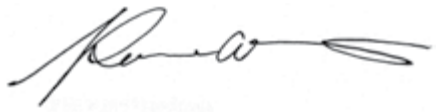
Certification of financial statements

Child and Adolescent Health Service

Certification of Financial Statements for the year ended 30 June 2021

The accompanying financial statements of the Child and Adolescent Health Service have been prepared in compliance with the provisions of the *Financial Management Act 2006* from proper accounts and records to present fairly the financial transactions for the reporting period ended 30 June 2021 and the financial position as at 30 June 2021.

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

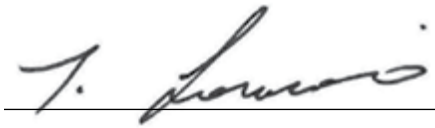


Dr Rosanna Capolingua

BOARD CHAIR
CHILD AND ADOLESCENT HEALTH SERVICE
2 September 2021

Prof Geoffrey Dobb

DEPUTY BOARD CHAIR
CHILD AND ADOLESCENT HEALTH SERVICE
2 September 2021



Mr Tony Loiacono

CHIEF FINANCE OFFICER
CHILD AND ADOLESCENT HEALTH SERVICE
2 September 2021

Child and Adolescent Health Service
Statement of comprehensive income
For the year ended 30 June 2021

	Notes	2021 $000	2020 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	3.1(a)	558,987	492,561
Fees for visiting medical practitioners		2,693	2,679
Contracts for services	3.2	9,453	52,558
Patient support costs	3.3	101,975	87,602
Finance costs	7.2	255	185
Depreciation and amortisation expense	5	59,601	60,192
Asset revaluation decrements	5.1	3,723	709
Loss on disposal of non-current assets	5.1.2	141	63
Repairs, maintenance and consumable equipment	3.4	23,214	20,065
Other supplies and services	3.5	49,390	45,521
Other expenses	3.6	25,345	22,124
Total cost of services		**834,777**	**784,259**
INCOME			
Patient charges	4.2	21,787	17,661
Other fees for services	4.2	30,470	25,872
Grants and contributions	4.3	13,828	14,239
Donation revenue	4.4	2,096	1,978
Asset revaluation increments	5.1	605	-
Other revenue	4.5	6,219	5,330
Total income other than income from State Government		**75,005**	**65,080**
NET COST OF SERVICES		**759,772**	**719,179**

	Notes	2021 $000	2020 $000
INCOME FROM STATE GOVERNMENT			
Service agreement funding - State	4.1	492,775	451,059
Service agreement funding - Commonwealth	4.1	159,824	140,252
Grants from other state government agencies	4.1	68,828	65,044
Services provided to other government agencies	4.1	3,981	1,383
Assets (transferred)/assumed	4.1	863	-
Services received free of charge	4.1	42,368	39,262
Total income from State Government		**768,639**	**697,000**
SURPLUS / (DEFICIT) FOR THE PERIOD		**8,867**	**(22,179)**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve		-	-
Total other comprehensive income		-	-
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**8,867**	**(22,179)**

The Statement of Comprehensive Income should be read in conjunction with the accompanying notes.

Child and Adolescent Health Service
Statement of financial position
For the year ended 30 June 2021

	Notes	2021 $000	2020 $000
ASSETS			
Current Assets			
Cash and cash equivalents	7.3	67,836	60,743
Restricted cash and cash equivalents	7.3	17,374	15,435
Receivables	6.1	11,490	10,403
Inventories	6.3	3,580	2,962
Other current assets	6.4	909	669
Total Current Assets		101,189	90,212
Non-Current Assets			
Restricted cash and cash equivalents	7.3	9,972	7,472
Amounts receivable for services	6.2	408,937	346,357
Property, plant and equipment	5.1	1,097,608	1,124,827
Right-of-use assets	5.2	9,768	10,256
Intangible assets	5.3	29,370	37,889
Total Non-Current Assets		1,555,655	1,526,801
TOTAL ASSETS		**1,656,844**	**1,617,013**
LIABILITIES			
Current Liabilities			
Payables	6.5	29,999	35,882
Contract liabilities	6.6	89	53
Grant liabilities	6.7	-	945
Lease liabilities	7.1	1,858	1,790
Employee benefits provisions	3.1 (b)	123,317	107,686
Other current liabilities	6.8	83	89
Total Current Liabilities		155,346	146,445
Non-Current Liabilities			
Lease liabilities	7.1	8,214	8,645
Employee benefits provisions	3.1 (b)	26,365	31,340
Total Non-Current Liabilities		34,579	39,985
TOTAL LIABILITIES		**189,925**	**186,430**
NET ASSETS		**1,466,919**	**1,430,583**
EQUITY			
Contributed equity	9.13	1,466,826	1,439,357
Reserves		-	-
Accumulated surplus/(deficit)		93	(8,774)
TOTAL EQUITY		**1,466,919**	**1,430,583**

The Statement of Financial Position should be read in conjunction with the accompanying notes.

Child and Adolescent Health Service
Statement of cash flows
For the year ended 30 June 2021

	Notes	2021 $000	2020 $000
CASH FLOWS FROM STATE GOVERNMENT			
Service agreement funding - State		430,195	384,570
Service agreement funding - Commonwealth		159,824	140,252
Grants from other state government agencies		68,828	65,044
Services provided to other government agencies		3,981	1,383
Capital appropriations administered by Department of Health		11,769	7,592
Net cash provided by State Government	7.3.3	**674,597**	**598,841**
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(544,132)	(476,710)
Supplies and services		(178,529)	(181,055)
Finance costs		(253)	(151)
Receipts			
Receipts from customers		21,451	15,493
Grants and contributions		12,919	15,237
Donations received		123	677
Other receipts		35,437	32,903
Net cash used in operating activities	7.3.2	**(652,984)**	**(593,606)**

	Notes	2021 $000	2020 $000
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Purchase of non-current assets		(8,239)	(3,713)
Receipts			
Proceeds from sale of non-current assets	5.1.2	11	132
Net cash used in investing activities		**(8,228)**	**(3,581)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Principal elements of lease payments		(1,853)	(1,380)
Net cash used in financing activities		**(1,853)**	**(1,380)**
Net increase / (decrease) in cash and cash equivalents		11,532	274
Cash and cash equivalents at the beginning of the period		83,650	65,425
Cash and cash equivalents transferred from North Metropolitan Health Service	9.13	-	17,951
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.3	**95,182**	**83,650**

The Statement of Cash Flows should be read in conjunction with the accompanying notes.

Child and Adolescent Health Service
Statement of changes in equity
For the year ended 30 June 2021

	Notes	Contributed equity $000	Reserves $000	Accumulated surplus/(deficit) $000	Total equity $000
Balance at 1 July 2019		1,412,087	-	13,405	1,425,492
Deficit		-	-	(22,179)	(22,179)
Total comprehensive income for the period		-	-	(22,179)	(22,179)
Transactions with owners in their capacity as owners:					
Capital appropriations administered by Department of Health	9.13	7,335	-	-	7,335
Other contributions by owners	9.13	19,935	-	-	19,935
Total		27,270	-	-	27,270
Balance at 30 June 2020		**1,439,357**	**-**	**(8,774)**	**1,430,583**
Balance at 1 July 2020		1,439,357	-	(8,774)	1,430,583
Deficit		-	-	8,867	8,867
Other comprehensive income	9.13	-	-	-	-
Total comprehensive income for the period		-	-	8,867	8,867
Transactions with owners in their capacity as owners:					
Capital appropriations administered by Department of Health	9.13	11,769	-	-	11,769
Other contributions by owners	9.13	15,700	-	-	15,700
Total		27,469	-	-	27,469
Balance at 30 June 2021		**1,466,826**	**-**	**93**	**1,466,919**

The Statement of Changes in Equity should be read in conjunction with the accompanying notes.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2021

1. Basis of preparation

The Child and Adolescent Health Service (The Health Service) is a statutory authority established under the *Health Services Act 2016* and governed by a Board. The Health Service is controlled by the State of Western Australia, which is the ultimate parent. The Health Service is a not-for-profit entity (as profit is not its principal objective).

A description of the nature of the Health Service's operations and its principal activities has been included in the 'Overview' section of the annual report which does not form part of these financial statements.

These annual financial statements were authorised for issue by the Accountable Authority (the Board) of the Health Service on 2 September 2021.

Statement of compliance

These general purpose financial statements have been prepared in accordance with:

1) The Financial Management Act 2006;

2) The Treasurer's Instructions;

3) Australian Accounting Standards including applicable interpretations;

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

The *Financial Management Act 2006* and the Treasurer's Instructions (TI) take precedence over Australian Accounting Standards (AAS). Several AAS are modified by the TI to vary application, disclosure, format and wording. 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).

Notwithstanding the Health Service's deficiency of working capital (total current assets being less than total current liabilities), the financial statements have been prepared on the going concern basis. This basis has been adopted because, with continuing funding from the State Government, the Health Service is able to pay its liabilities as and when they fall due.

The neonatal services at the King Edward Memorial Hospital (KEMH) have formally become part of the Child and Adolescent Health Service, after being operated as part of the North Metropolitan Health Service up to January 2020. In the first seven months of the 2019-20 financial year, the KEMH neonatal services were

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2021

operated under a purchasing arrangement whereby the Child and Adolescent Health Service was the purchaser and the North Metropolitan Health Service was the service provider.

Pursuant to the order made by the Minister for Health under section 194 of the *Health Services Act 2016*, the assets, rights and liabilities in connection with the KEMH neonatal services were transferred from the North Metropolitan Health Service to the Child and Adolescent Health Service on 1 February 2020. Note 9.13 (d) 'Equity' provides the details of the assets and liabilities transferred from NMHS.

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 955 *Contributions by Owners made to Wholly Owned Public Sector Entities* and will be credited directly to Contributed Equity.

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

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2021

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. This note also provides the distinction between controlled funding and administered funding:

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

2.1 Health Service objectives

Mission

The Health Service's mission is to deliver high quality health care in hospital and in the community by placing children, young people, families and carers at the centre of everything, as well as build partnerships to advocate and delivery care to those who need it most, advance internationally recognised research focuses on health outcomes and attract exceptional staff by offering continued education, training, support and career development.

The Health Service is predominantly funded by Parliamentary appropriations.

Services

The key services of the Health Service are:

Public Hospital Admitted Services

Public hospital admitted patient services describe the care services provided to inpatients in the hospital (excluding specialised mental health wards). An admission to hospital can be for a period of one or more days and includes medical and surgical treatment, and oncology services.

Public Hospital Emergency Services

Emergency department services describe the treatment provided to those people with sudden onset of illness or injury of such severity and urgency that they need immediate medical help which is either not available from their general practitioner, or for which their general practitioner has referred them for treatment. An emergency department can provide a range of services and may result in admission to hospital or in treatment without admission.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2021

2.1 Health Service objectives (cont.)

Public Hospital Non-admitted Services

Medical officers, nurses and allied health staff provide non-admitted (out-patient) care services and include clinics for pre- and post-surgical care, allied health care and medical care.

Mental Health Services

Contracted mental health services describe inpatient care in an authorised ward and community mental health services provided by the Health Service under an agreement with the Mental Health Commission for specialised admitted and community mental health.

Aged and Continuing Care Services

The provision of continuing care services includes the programs that provide functional interim care or support for children with disabilities to continue living with their families.

Public and Community Health Services

Community Health provides services and programs delivered to increase optimal health and wellbeing, encourage healthy lifestyle, 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. These include child health services, school health services, child development services, public health programs and Aboriginal health programs.

2.2 Schedule of income and expenses by service

The Schedule of Income and Expenses by Service should be read in conjunction with the accompany notes.

(a) Under the service category of Aged and Continuing Care, only the Continuing Care Service component is applicable to the Health Service.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2021

2.2 Schedule of income and expenses by service (cont.)

	Public Hospital Admitted Services		Public Hospital Emergency Services		Public Hospital Non-Admitted Services		Mental Health Services	
	2021	2020	2021	2020	2021	2020	2021	2020
COST OF SERVICES	$000	$000	$000	$000	$000	$000	$000	$000
Expenses								
Employee benefits expense	259,816	209,930	40,355	39,079	81,022	75,381	64,865	57,660
Fees for visiting medical practitioners	1,839	1,831	280	284	562	551	-	-
Contracts for services	6,651	48,577	31	164	127	797	14	35
Patient support costs	65,046	55,863	10,265	9,796	19,597	17,124	1,917	1,484
Finance costs	48	32	7	5	14	9	86	60
Depreciation and amortisation expense	36,875	37,424	5,613	5,805	11,276	11,261	3,954	3,688
Asset revaluation decrements	-	783	-	122	-	236	40	-
Loss on disposal of non-current assets	95	43	14	7	29	13	-	-
Repairs, maintenance and consumable equipment	10,062	9,355	1,593	1,480	3,196	2,869	3,106	1,582
Other supplies and services	24,381	22,149	3,730	3,566	7,492	6,909	4,849	4,073
Other expenses	9,028	8,405	1,393	1,308	2,797	2,536	3,596	2,724
Total cost of services	413,841	394,392	63,281	61,616	126,112	117,686	82,427	71,306
Income								
Patient charges	18,449	14,759	581	715	1,940	1,765	817	422
Other fees for services	20,652	17,449	3,143	2,706	6,315	5,250	168	140
Grants and contributions	9,197	9,551	1,400	1,482	2,812	2,874	337	214
Donation revenue	1,431	1,318	218	205	438	397	-	-
Asset revaluation increments	(7)	-	(1)	-	(2)	-	138	-
Other revenue	4,140	3,419	630	530	1,267	1,029	21	22
Total income other than income from State Government	53,862	46,496	5,971	5,638	12,770	11,315	1,481	798
NET COST OF SERVICES	**359,979**	**347,896**	**57,310**	**55,978**	**113,342**	**106,371**	**80,946**	**70,508**
INCOME FROM STATE GOVERNMENT								
Service agreement funding - State	239,622	227,898	37,146	34,273	75,597	61,093	3,954	3,688
Service agreement funding - Commonwealth	97,295	84,963	17,793	16,410	39,040	38,122	3,665	-
Grants from other state government agencies	458	146	69	23	139	44	68,097	64,643
Services provided to other government agencies	3,652	879	92	136	216	264	-	61
Assets (transferred)/assumed	589	-	90	-	180	-	-	-
Services received free of charge	21,036	20,039	3,495	3,559	5,997	5,069	4,232	3,630
Total income from State Government	362,652	333,925	58,685	54,401	121,169	104,592	79,948	72,022
SURPLUS / (DEFICIT) FOR THE PERIOD	**2,673**	**(13,971)**	**1,375**	**(1,577)**	**7,827**	**(1,779)**	**(998)**	**1,514**

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2021

2.2 Schedule of income and expenses by service (cont.)

	Aged and Continuing Care Services [a]		Public and Community Health Services		Total	
	2021	2020	2021	2020	2021	2020
COST OF SERVICES	$000	$000	$000	$000	$000	$000
Expenses						
Employee benefits expense	1,734	1,815	111,195	108,696	558,987	492,561
Fees for visiting medical practitioners	12	13	-	-	2,693	2,679
Contracts for services	1	7	2,629	2,978	9,453	52,558
Patient support costs	384	400	4,766	2,935	101,975	87,602
Finance costs	-	-	100	79	255	185
Depreciation and amortisation expense	239	266	1,644	1,748	59,601	60,192
Asset revaluation decrements	-	-	3,683	(432)	3,723	709
Loss on disposal of non-current assets	-	-	3	-	141	63
Repairs, maintenance and consumable equipment	71	69	5,186	4,710	23,214	20,065
Other supplies and services	132	138	8,806	8,686	49,390	45,521
Other expenses	53	59	8,478	7,092	25,345	22,124
Total cost of services	2,626	2,767	146,490	136,492	834,777	784,259
Income						
Patient charges	-	-	-	-	21,787	17,661
Other fees for services	134	124	58	203	30,470	25,872
Grants and contributions	59	68	23	50	13,828	14,239
Donation revenue	9	9	-	49	2,096	1,978
Asset revaluation increments	-	-	477	-	605	-
Other revenue	27	24	134	306	6,219	5,330
Total income other than income from State Government	229	225	692	608	75,005	65,080
NET COST OF SERVICES	**2,397**	**2,542**	**145,798**	**135,884**	**759,772**	**719,179**
INCOME FROM STATE GOVERNMENT						
Service agreement funding - State	2,339	2,296	134,117	121,811	492,775	451,059
Service agreement funding - Commonwealth	-	-	2,031	757	159,824	140,252
Grants from other state government agencies	2	1	63	187	68,828	65,044
Services provided to other government agencies	5	7	16	36	3,981	1,383
Assets (transferred)/assumed	4	-	-	-	863	-
Services received free of charge	113	114	7,495	6,851	42,368	39,262
Total income from State Government	2,463	2,418	143,722	129,642	768,639	697,000
SURPLUS / (DEFICIT) FOR THE PERIOD	**66**	**(124)**	**(2,076)**	**(6,242)**	**8,867**	**(22,179)**

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2021

3. Use of our funding

This section provides 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.

Expenses incurred in the delivery of services

The primary expenses incurred by the Health Service in achieving its objectives are:

	Notes	2021 $000	2020 $000
Employee benefits expense	3.1(a)	558,987	492,561
Contracts for services	3.2	9,453	52,558
Patient support costs	3.3	101,975	87,602
Repairs, maintenance and consumable equipment	3.4	23,214	20,065
Other supplies and services	3.5	49,390	45,521
Other expenses	3.6	25,345	22,124

Liabilities incurred in the delivery of services

The primary employee related liabilities incurred by the Health Service in achieving its objectives are:

	Notes	2021 $000	2020 $000
Employee benefits provision	3.1(b)	149,682	139,026

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2021

3.1(a) Employee benefits expense

	2021 $000	2020 $000
Employee benefits	511,994	451,337
Termination benefits	470	224
Superannuation - defined contribution plans	46,523	41,000
	558,987	492,561

Employee benefits: Include salaries, wages, accrued and paid leave entitlements, paid sick leave and non-monetary benefits for employees.

Termination benefits: 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: The amounts recognised in the Statement of Comprehensive Income comprise employer contributions paid to the Gold State Superannuation Scheme (GSS), the West State Superannuation Scheme (WSS), the GESB Super Scheme (GESBS), or other superannuation funds.

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 the Health Service's purposes because the concurrent contributions (defined contributions) made by the Health Service to the Government Employees Superannuation Board (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.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2021

3.1(b) Employee benefits provisions

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

	2021 $000	2020 $000
Current		
Employee benefits provisions		
Annual leave [(a)]	60,603	55,370
Time off in lieu leave [(a)]	12,839	11,715
Long service leave [(b)]	48,664	39,369
Deferred salary scheme [(c)]	1,211	1,232
	123,317	107,686
Non-Current		
Employee benefits provisions		
Long service leave [(b)]	26,365	31,340
	26,365	31,340
	149,682	139,026

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

	2021 $000	2020 $000
Within 12 months of the end of the reporting period	51,302	46,837
More than 12 months after the end of the reporting period	22,140	20,248
	73,442	67,085

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

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2021

3.1(b) Employee benefits provisions (cont.)

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

Pre-conditional and conditional long service leave provisions are classified as non-current liabilities because the Health Service has an unconditional right to defer the settlement of the liability until the employee has completed the requisite years of service.

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

	2021 $000	2020 $000
Within 12 months of the end of the reporting period	11,126	9,759
More than 12 months after the end of the reporting period	63,903	60,950
	75,029	70,709

The provision of the long service leave liabilities 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. These payments are estimated using the remuneration rate expected to apply at the time of settlement, discounted using market yields at the end of the reporting period on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

(c) **Deferred salary scheme liabilities:** Classified as current where there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

	2021 $000	2020 $000
Within 12 months of the end of the reporting period	176	274
More than 12 months after the end of the reporting period	1,035	958
	1,211	1,232

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2021

3.1(b) Employee benefits provisions (cont.)

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 retention rates; and
- Expected future payments

Changes in these estimations and assumptions may impact on the carrying amount of the long service leave provision.

In estimating the non-current long service leave liabilities, employees are assumed to leave the Health Service each year on account of resignation or retirement at 7.2%. This assumption was based on an analysis of the historical turnover rates exhibited by employees in the Health Service. Employees with leave benefits to which they are fully entitled are assumed to take all available leave uniformly over the following five years or to age 65 if earlier.

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

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Notes to the financial statements
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3.2 Contracts for services

	2021 $000	2020 $000
Neonatal services [(a)]	6,512	48,001
Community and primary health	2,604	4,065
Other contracts	337	492
	9,453	52,558

Contracts for services include the costs related to the provision of health care services by external organisations. Expenses are recognised in the reporting period in which they are incurred.

(a) In the first seven months of the 2019-20 financial year, the neonatal services and the related support services were purchased from the North Metropolitan Health Service for the Perth Children's Hospital (PCH) and the King Edward Memorial Hospital (KEMH). After the neonatal services at the KEMH site formally became part of the Child and Adolescent Health Service on 1 February 2020, a new purchasing arrangement has been in place with the North Metropolitan Health Service to continue the provision of support services.

3.3 Patient support costs

	2021 $000	2020 $000
Medical supplies and services [(a)]	83,787	73,489
Domestic charges	10,249	6,202
Food supplies	1,356	1,410
Power and water charges	5,385	5,287
Patient transport costs	985	698
Research, development and other grants	213	516
	101,975	87,602

Patient support costs are recognised in the reporting period in which expenses are incurred.

(a) Medical supplies and services include the pathology services received free of charge amounting to $5.627 million from PathWest Laboratory Medicine WA (2020: $5.319 million). See Note 4.1 'Income from State Government'.

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Notes to the financial statements
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3.4 Repairs, maintenance and consumable equipment

	2021 $000	2020 $000
Repairs and maintenance	18,724	15,503
Consumable equipment	4,490	4,562
	23,214	20,065

Repairs and maintenance expenses include the day-to-day servicing and minor replacement parts of property, plant and equipment. The cost of replacing a significant part of an item of property, plant and equipment is recognised in its carrying amount, if the recognition criteria are met.

3.5 Other supplies and services

	2021 $000	2020 $000
Facility management services	6,065	5,288
Administrative services	3,866	3,549
Interpreter services	847	839
Shared services for accounting [(a)]	932	937
Shared services for human resources [(a)]	3,270	4,062
Shared services for information technology [(a)]	30,009	26,513
Shared services for supply [(a)]	2,500	2,386
Other	1,901	1,947
	49,390	45,521

Other supplies and services are recognised in the reporting period in which expenses are incurred.

(a) The Health Service receives the shared services free of charge from the Health Support Services. See Note 4.1 ‘Income from State Government’

Child and Adolescent Health Service
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3.6 Other expenses

	2021 $000	2020 $000
Workers compensation insurance	3,927	3,748
Other insurances	3,302	2,800
Other employee related expenses	1,033	1,330
Communications	1,743	1,626
Computer services	1,877	1,123
Consultancy fees	2,138	2,231
Expected credit losses expense [(a)]	513	172
Freight and cartage	426	302
Motor vehicle expenses	521	513
Rental expenses [(b)]	1,392	1,325
Other accommodation expenses [(c)]	1,257	1,130
Periodical subscription	537	490
Printing and stationery	2,662	2,196
Write-down of assets [(d)]	991	244
Asset write off - stock take [(d)]	407	-
Other	2,619	2,894
	25,345	22,124

Other expenses generally represent the administrative costs incurred by the Health Service.

(a) **Expected credit losses expense** is recognised as the movement in the allowance for impairment of receivables, measured at the lifetime expected credit losses at each reporting date. The Health Service has established a provision matrix that is based on its historical credit loss experience, adjusted for forward-looking factors specific to the debtors and the economic environment. See Note 6.1.1 Movement of the allowance for impairment of receivables.

(b) **Rental expenses** include:
- (i) Short-term leases with a lease term of 12 months of less;
- (ii) Low-value leases with an underlying value of $5,000 or less; and
- (iii) Variable lease payments, recognised in the period in which the event or condition that triggers those payments occurs.

(c) **Other accommodation expenses** are for outgoing expenses only.

(d) See Note 5.1 ‘Property, plant and equipment’.

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4. Our funding sources

How we obtain our funding

This section provides 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 are:

	Notes	2021 $000	2020 $000
Income from State Government	4.1	768,639	697,000
Patient charges and other fees for services	4.2	52,257	43,533
Grants and contributions	4.3	13,828	14,239
Donations	4.4	2,096	1,978
Other revenue	4.5	6,219	5,330

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4.1 Income from State Government

	2021 $000	2020 $000
Service agreement funding received during the period:		
Department of Health - Service agreement - State component	492,775	451,059
Department of Health - Service agreement - Commonwealth component [(i)]	159,824	140,252
Total service agreement funding	652,599	591,311
Grants from other state government agencies during the period:		
Mental Health Commission - Service delivery agreement	68,097	64,643
Department of Health - Research development grant	598	366
Department of Health - COVID-19 vaccination	94	-
Department of Health - Aboriginal Cadetship Program	39	35
Total grants from other state government agencies	68,828	65,044
Services provided to other state government agencies during the period:		
North Metropolitan Health Service - various clinical services	3,187	494
WA Country Health Service - various clinical services	752	786
South Metropolitan Health Service - training for radiology registrars	18	18
Other	24	85
Total services provided to other state government agencies	3,981	1,383
Assets transferred from/(to) other State government agencies during the period:		
Transfer of medical equipment from other Health Services	893	-
Transfer of plant & equipment to other Health Services	(30)	-
Net assets transferred	863	-
Services received free of charge from other State government agencies during the period:		
Health Support Services - accounting, human resources, information technology and supply services	36,711	33,899
Department of Finance - leasing of accommodation	30	45
PathWest Laboratory Medicine WA - pathology services	5,627	5,319
Total services received free of charge	42,368	39,262
Total income from State Government	768,639	697,000

Child and Adolescent Health Service
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For the year ended 30 June 2021

4.1 Income from State Government (cont.)

(a) **Service agreement funding** is recognised as income at fair value in the period in which the Health Service gains control of the funds as appropriated under the Service Agreement with the Department of Health. The Health Service gains control of appropriated funds at the time those funds are deposited in the bank account or credited to the 'Amounts receivable for services' (holding account) held at the Department of Treasury.

Being the major income source to fund the net cost of services delivered (as set out in Note 2.2), service agreement funding comprises the following:

- Cash component; and
- A receivable (asset).

The receivable (holding account – Note 6.2) comprises the following:

- The budgeted depreciation expense; and
- Any agreed increase in leave liabilities.

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

(b) **Grants from other state government agencies** are recognised as revenue when the Health Service has satisfied its performance obligations under the grants agreement. If there is no performance obligation, revenue will be recognised when the grant is received or receivable.

(c) **Transfer of assets:** Discretionary transfers of assets (including grants) and liabilities between State government agencies are reported under Income from State Government. Transfers of assets and liabilities in relation to a restructure of administrative arrangements are recognised as distribution to owners by the transferor and contribution by owners by the transferee under AASB 1004. Other non-discretionary non-reciprocal transfers of assets and liabilities designated as contributions by owners under TI 955 are also recognised directly to equity.

(d) **Services received free of charge** or for nominal cost, are recognised as revenue at the fair value of those services that can be reliably measured and which would have been purchased if not received as free services. A corresponding expense is recognised for services received (Note 3.3 'Patient support costs' and Note 3.5 'Other supplies and services').

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4.2 Patient charges and other fees for services

	2021 $000	2020 $000
Patient charges [(a)]		
Inpatient charges	19,254	15,181
Outpatient charges	2,533	2,480
	21,787	17,661
Other fees for services		
Recoveries from the Pharmaceutical Benefits Scheme [(b)]	27,287	22,789
Clinical services to other health organisations [(c)]	2,923	2,888
Non clinical services to other health organisations [(c)]	260	195
	30,470	25,872
	52,257	43,533

(a) Patient charges are recognised at a point in time (or over a relatively short period of time) when the services have been provided to patients. As the Health Service is a not-for-profit entity, patient charges have not been determined on a full cost recovery basis.

(b) Under the Pharmaceutical Benefits Scheme (PBS), the Health Service receives reimbursements from Medicare Australia for PBS-listed medicines dispensed to patients at the Perth Children's Hospital. Reimbursements are mostly received within the month of claims.

(c) Revenue is recognised over time for services provided to other health organisations. The Health Service typically satisfies its performance obligations in relation to the fees and charges when the services are performed. The progress towards performance obligations is measured on the basis of an input method.

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Notes to the financial statements
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4.3 Grants and contributions

	2021 $000	2020 $000
Perth Children's Hospital Foundation	3,599	3,866
Telethon Kids Institute	1,289	1,921
Channel 7 Telethon Trust	4,690	4,817
Stan Perron Charitable Trust	578	540
Medtronic Foundation	81	80
Angela Wright Bennett Foundation	400	400
University of Western Australia	505	179
Cystic Fibrosis clinical research	120	117
Raine Medical Research Foundation	294	253
Royal Australasian College of Physicians	473	395
ANZCHOG	179	31
The Children's Hospital of Philadelphia	156	88
Rural Health West	107	32
University of Queensland	86	215
WA Health Translation Network	88	206
Redkite	100	198
Royal Australian & NZ College of Radiologists	53	131
Other	1,030	770
	13,828	14,239

Where the arrangements are not classified as contract with customers, operational grants are recognised as income when the Health Service obtains control over the assets comprising the contribution, usually when cash is received. For contracts with customers, operational grants are recognised as revenue either over time or at a point in time, when the specific performance obligations are satisfied. Capital grants are recognised as income when the Health Service achieves milestones specified in the grant agreements.

Key judgements under AASB 15 *Revenue from Contracts with Customers* include determining the timing of revenue from contracts with customers in terms of timing of satisfaction of performance obligations and determining the transaction price and the amounts allocated to performance obligations.

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4.4 Donation revenue

	2021 $000	2020 $000
Perth Children's Hospital Foundation - donations of equipment	1,883	1,242
Humpty Dumpty Foundation - donations of medical equipment	90	-
City of Stirling - Donation of building	-	50
Paul Moncrieff - Donation of artwork	-	9
Deceased Estate	77	648
Other	46	29
	2,096	1,978

Donations and other bequests are recognised as revenue when cash or assets are received.

4.5 Other revenue

	2021 $000	2020 $000
Pharmaceutical manufacturing activities	1,749	2,099
Rent from commercial tenants	407	325
Expense recoupment from tenants	2,134	2,149
RiskCover insurance premium rebate	1,008	97
Immunisation services	138	160
Use of hospital facilities by medical practitioners	88	20
Other	695	480
	6,219	5,330

Revenue from pharmaceutical manufacturing activities, immunisation services and other services is recognised when the goods or services are delivered to the customers.

Rent and recoupment of outgoing expenses are received in accordance with the agreements with tenants, and are recognised as revenue on a monthly basis. Insurance premium rebate is recognised as revenue, when the cash is received from RiskCover.

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5. Key assets

Assets the Health Service utilises for economic benefit or service potential

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

	Notes	2021 $000	2020 $000
Property, plant and equipment	5.1	1,097,608	1,124,827
Right-of-use assets	5.2	9,768	10,256
Intangible assets	5.3	29,370	37,889
Total key assets		1,136,746	1,172,972

Depreciation and amortisation expense	Notes	2021 $000	2020 $000
Property, plant and equipment	5.1.1	49,081	50,140
Right-of-use assets	5.2	2,001	1,532
Intangible assets	5.3.1	8,519	8,520
		59,601	60,192

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5.1 Property, plant and equipment

Year ended 30 June 2020	Land	Build-ings	Site infra-struc-ture	Lease-hold improve-ments	Com-puter equip-ment	Furni-ture & fittings	Medical equip-ment	Motor vehicles, other plant & equip-ment	Work in pro-gress	Art-works	Total
	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
Carrying amount at start of period	**23,363**	**941,113**	**19,656**	**145**	**64,185**	**10,505**	**82,845**	**20,148**	**373**	**5,035**	**1,167,368**
Additions	-	-	-	106	18	95	4,012	-	408	17	4,656
Transfer of Neonatal assets from North Metropolitan Health Service (Note 9.13) [(a)]	-	-	-	-	18	-	2,851	62	-	-	2,931
Transfer from other agencies [(c)]	1,110	50	-	-	-	-	-	-	-	-	1,160
Disposals (Note 5.1.2)	-	-	-	-	-	-	(195)	-	-	-	(195)
Revaluation increments / (decrements) [(b)]	(150)	(559)	-	-	-	-	-	-	-	-	(709)
Depreciation (Note 5.1.1)	-	(19,915)	(479)	(43)	(14,299)	(731)	(12,187)	(2,486)	-	-	(50,140)
Write-down of assets (Note 3.6)	-	-	-	-	-	-	(240)	-	(4)	-	(244)
Carrying amount at 30 June 2020	**24,323**	**920,689**	**19,177**	**208**	**49,922**	**9,869**	**77,086**	**17,724**	**777**	**5,052**	**1,124,827**

(a) Assets were transferred from the North Metropolitan Health Service on 1 February 2020 following the handover of management control over the Neonatal Services operated at the King Edward Memorial Hospital.

(b) Revaluation increment is recorded in the asset revaluation reserve, except to the extent that any increment reverses a revaluation decrement of the same class of assets previously recognised as an expense. Revaluation decrement is recognised as an expense, except to the extent of any balance existing in the asset revaluation reserve in respect of that classes of assets. In 2019-20, revaluation decrement of $0.709 million consisting of $0.559 million for buildings and $0.150 million for land was recognised as an expense.

(c) This included the crown land ($1.110 million) transferred from the Department of Planning, Lands and Heritage for the Karrinyup Child Health Centre and the Hilton Child Health Centre. The transfer was accounted for as contributions by owners (Note 9.13 Equity).

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5.1 Property, plant and equipment (cont.)

Year ended 30 June 2021	Land $000	Build-ings $000	Site infra-struc-ture $000	Lease-hold improve-ments $000	Com-puter equip-ment $000	Furni-ture & fittings $000	Medical equip-ment $000	Motor vehicles, other plant & equip-ment $000	Work in pro-gress $000	Art-works $000	Total $000
1 July 2020											
Gross carrying amount	24,323	920,689	20,380	598	77,089	11,454	106,271	22,982	777	5,052	1,189,615
Accumulated depreciation	-	-	(1,203)	(390)	(27,167)	(1,585)	(29,185)	(5,258)	-	-	(64,788)
Carrying amount at start of period	**24,323**	**920,689**	**19,177**	**208**	**49,922**	**9,869**	**77,086**	**17,724**	**777**	**5,052**	**1,124,827**
Additions	-	711	-	1,225	6	100	3,813	290	3,822	-	9,967
Transfer from other agencies [(a)]	15,700	-	-	-	-	-	-	-	-	-	15,700
Transfer from/(to) other Health Services (Note 4.1)	-	-	-	-	-	-	893	(30)	-	-	863
Disposals (Note 5.1.2)	-	-	-	-	-	-	(149)	(3)	-	-	(152)
Revaluation increments / (decrements) [(b)]	(3,723)	605	-	-	-	-	-	-	-	-	(3,118)
Depreciation (Note 5.1.1)	-	(19,871)	(479)	(137)	(12,835)	(726)	(12,556)	(2,477)	-	-	(49,081)
Asset write offs - stock take (Note 3.6)	-	-	-	-	-	(5)	(372)	(30)	-	-	(407)
Write-down of assets (Note 3.6)	-	-	-	(26)	-	(1)	(867)	(97)	-	-	(991)
Carrying amount at 30 June 2021	**36,300**	**902,134**	**18,698**	**1,270**	**37,093**	**9,237**	**67,848**	**15,377**	**4,599**	**5,052**	**1,097,608**
Gross carrying amount	36,300	902,134	20,380	1,797	76,656	11,545	108,680	23,003	4,599	5,052	1,190,146
Accumulated depreciation	-	-	(1,682)	(527)	(39,563)	(2,308)	(40,832)	(7,626)	-	-	(92,538)

(a) A crown land was transferred from the Department of Planning, Lands and Heritage for the Perth Children's Hospice. The transfer was accounted for as contributions by owners (Note 9.13 Equity).

(b) Revaluation increment is recorded in the asset revaluation reserve, except to the extent that any increment reverses a revaluation decrement of the same class of assets previously recognised as an expense. Revaluation decrement is recognised as an expense, except to the extent of any balance existing in the asset revaluation reserve in respect of that classes of assets. In 2020-21, revaluation decrement of $3.723 million for land is recognised as an expense and revaluation increment of $0.605 million for buildings is recognised as an other revenue.

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5.1 Property, plant and equipment (cont.)

Initial recognition

Items of property, plant and equipment, costing $5,000 or more are measured initially at cost. Where an asset is acquired for no 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 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 of an asset, the revaluation model is used for the measurement of land and buildings.

Land is carried at fair value. Buildings are carried at fair value less accumulated depreciation and accumulated impairment losses.

All other property, plant and equipment are stated at historical cost less accumulated depreciation and accumulated impairment losses.

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 (Landgate 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.

Land and buildings were revalued as at 1 July 2020 by the Western Australian Land Information Authority (Landgate Valuation Services). The valuations were performed during the year ended 30 June 2021 and recognised at 30 June 2021. In undertaking the revaluation, fair value was determined by reference to market values for land: $0.625 million (2020: $0.603 million) and buildings: $0.080 million (2020: $0.102 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:

(a) Fair Value where market-based evidence is available:

The fair value of land and buildings is determined on the basis of current market values determined by reference to recent market transactions.

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5.1 Property, plant and equipment (cont.)

(b) Fair value in the absence of market-based evidence:

Fair value of land and buildings is determined on the basis of existing use where buildings are specialised or where land is restricted.

Existing use buildings: Fair value is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset, i.e. the current replacement cost.

Restricted use land: Fair value 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).

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.

A number of buildings that are located on the land of local government agencies have been recognised in the financial statements. The Health Service believes that, based on past experience, its occupancy in these buildings will continue to the end of their useful lives.

5.1.1 Depreciation and impairment charges for the period

	Notes	2021 $000	2020 $000
Depreciation			
Buildings	5.1	19,871	19,915
Site infrastructure	5.1	479	479
Leasehold improvement	5.1	137	43
Medical equipment	5.1	12,556	12,187
Computer equipment	5.1	12,835	14,299
Furniture and fittings	5.1	726	731
Motor vehicles, other plant and equipment	5.1	2,477	2,486
Total depreciation for the period		**49,081**	**50,140**

As at 30 June 2021 there were no indications of impairment to property, plant and equipment.

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Notes to the financial statements
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5.1.1 Depreciation and impairment (cont.)

Finite 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 and land.

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

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

Buildings	50 years
Site infrastructure	50 years
Leasehold improvements	Term of the lease
Computer equipment	2 to 10 years
Furniture and fittings	3 to 20 years
Motor vehicles	4 to 10 years
Medical equipment	2 to 20 years
Other plant and equipment	2 to 20 years

Land and artworks, which are considered to have an indefinite useful life, are not depreciated. 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 estimated useful lives, residual values and depreciation method are reviewed at the end of each annual reporting period, and adjustments are made where appropriate.

Impairment

Non-financial assets, including items of plant and equipment, are tested for impairment whenever there is an indication that the asset may be impaired. 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 its recoverable amount, an impairment loss is recognised through profit or loss.

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

Child and Adolescent Health Service
Notes to the financial statements
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5.1.1 Depreciation and impairment (cont.)

Impairment (cont.)

As the Health Service is a not-for-profit entity, the recoverable amount of regularly revalued specialised assets is anticipated to be materially the same as fair value.

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.

5.1.2 Gain/(loss) on disposal of non-current assets

The Health Service recognised the following gains on disposal of non-current assets:

	2021 $000	2020 $000
Carrying amount of non-current assets disposed:		
Property, plant and equipment	(152)	(195)
Proceeds from disposal of non-current assets:		
Property, plant and equipment	11	132
Net gain/(loss) on disposal of non-current assets	(141)	(63)

Realised and unrealised gains are usually recognised on a net basis.

Gains and losses on the disposal of non-current assets are presented by deducting from the proceeds on disposal the carrying amount of the asset and related selling expenses.

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5.2 Right-of-use assets

	Buildings $000	Vehicles $000	Total $000
Year ended 30 June 2020			
Carrying amount at start of period	4,304	1,238	5,542
Additions	5,443	348	5,791
Adjustments	469	7	476
Disposals	-	(21)	(21)
Depreciation	(1,049)	(483)	(1,532)
Carrying amount at 30 June 2020	9,167	1,089	10,256
Year ended 30 June 2021			
1 July 2020			
Gross carrying amount	9,996	1,535	11,531
Accumulated depreciation	(829)	(446)	(1,275)
Carrying amount at start of period	9,167	1,089	10,256
Additions	847	246	1,093
Adjustments	412	19	431
Disposals	-	(11)	(11)
Depreciation	(1,534)	(467)	(2,001)
Carrying amount at 30 June 2021	8,892	876	9,768
Gross carrying amount	10,966	1,714	12,680
Accumulated depreciation	(2,074)	(838)	(2,912)

The Health Service has leases for vehicles, office and clinical accommodations.

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

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

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

Child and Adolescent Health Service
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5.2 Right-of-use assets (cont.)

Initial recognition

Right-of-use assets are measured at cost including the following:
- the amount of the initial measurement of lease liability
- any lease payments made at or before the commencement date less any lease incentives received
- any initial direct costs, and
- restoration costs, including dismantling and removing the underlying asset

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

Subsequent Measurement

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

Depreciation and impairment of right-of-use assets

Right-of-use assets are depreciated on a straight-line basis over the shorter of the lease term and the estimated useful lives of the underlying assets. If ownership of the leased asset transfers to the Health Service at the end of the lease term or the cost reflects the exercise of a purchase option, depreciation is calculated using the estimated useful life of the asset.

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

The following amounts relating to leases have been recognised in the Statement of Comprehensive Income:

	Notes	2021 $000	2020 $000
Depreciation expense of right-of-use assets	5.2	2,001	1,532
Lease interest expense	7.2	255	173
Short-term leases		30	382
Low-value leases		12	7
Total amount recognised in the Statement of Comprehensive Income		2,298	2,094

The total cash outflow for leases in 2021 was $2.091 million (2020: $1.422 million).

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5.3 Intangible assets

	Computer software
	$000
Carrying amount at 1 July 2019	46,409
Amortisation expense (Note 5.3.1)	(8,520)
Carrying amount at 30 June 2020	37,889
Amortisation expense (Note 5.3.1)	(8,519)
Carrying amount at 30 June 2021	29,370
Gross carrying amount	55,638
Accumulated amortisation	(26,268)
	29,370

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 $5,000 or more, that comply with the recognition criteria (as noted below), are capitalised.

Costs incurred below these thresholds are immediately expensed directly to the Statement of Comprehensive Income.

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5.3 Intangible assets (cont.)

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

(a) The technical feasibility of completing the intangible asset so that it will be available for use;

(b) An intention to complete the intangible asset and use it;

(c) The ability to use the intangible asset;

(d) The intangible asset will generate probable future economic benefit;

(e) The availability of adequate technical, financial and other resources to complete the development and to use the intangible asset;

(f) The ability to measure reliably the expenditure attributable to the intangible asset during its development.

Costs incurred in the research phase of a project are immediately expensed.

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.

Subsequent measurement

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

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5.3.1 Amortisation and impairment

Charges for the period

	2021 $000	2020 $000
Amortisation		
Computer software	8,519	8,520
Total amortisation for the period	**8,519**	**8,520**

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

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

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

Computer software [(a)]	5 to 10 years

(a) Software that is not integral to the operation of any related hardware.

Impairment

Intangible assets with finite useful lives are tested for impairment annually or when an indication of impairment is identified. The policy in connection with testing for impairment is outlined in Note 5.1.1.

As at 30 June 2021 there were no indications of impairment to intangible assets.

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6. Other assets and liabilities

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

	Notes	2021 $000	2020 $000
Receivables	6.1	11,490	10,403
Amount receivable for services	6.2	408,937	346,357
Inventories	6.3	3,580	2,962
Other current assets	6.4	909	669
Payables	6.5	29,999	35,882
Contract liabilities	6.6	89	53
Grant liabilities	6.7	-	945
Other liabilities	6.8	83	89

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6.1 Receivables

	2021 $000	2020 $000
Current		
Patient fee debtors	5,410	6,567
GST receivable	761	536
Receivable from North Metropolitan Health Service	-	1,281
Other receivables	3,996	3,430
Allowance for impairment of receivables	(2,581)	(3,729)
Accrued revenue	3,904	2,318
	11,490	**10,403**

Patient fee debtors and other receivables are recognised at original invoice amount less any allowances for uncollectible amounts (i.e. impairment). The carrying amounts of net patient fee debtors and other receivables are equivalent to fair value as it is due for settlement within 30 days.

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

Accounting procedure for Goods and Services Tax

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

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6.1.1 Movement of the allowance for impairment of receivables

	2021 $000	2020 $000
Reconciliation of changes in the allowance for impairment of receivables:		
Balance at start of period	3,729	4,333
Transfer from North Metropolitan Health Service (Note 9.13(d))	-	255
Expected credit losses expense	513	172
Amount written off during the period	(1,661)	(1,031)
Balance at end of period	2,581	3,729

The collectability of receivables is reviewed on an ongoing basis and any receivables identified as uncollectible are written-off against the allowance account.

6.2 Amounts receivable for services (Holding Account)

	2021 $000	2020 $000
Current	-	-
Non-Current	408,937	346,357
	408,937	**346,357**

The Health Service receives service appropriations from the State Government via the Department of Health, partly in cash and partly as a non-cash asset. Amounts receivable for services represent the non-cash component and 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 for the holding account).

Subject to the State Government's approval, the receivable is accessible on the emergence of the cash funding requirement to cover the payments for leave entitlements and asset replacement.

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6.3 Inventories

	2021 $000	2020 $000
Current		
Pharmaceutical stores - at cost	3,580	2,962

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 assets

	2021 $000	2020 $000
Current		
Prepayments	850	599
Unearned patient charges	56	68
Others	3	2
	909	669

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.

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6.5 Payables

	2021 $000	2020 $000
Current		
Trade payables	6,458	5,465
Payable for purchase of neonatal services [(a)]	-	8,796
Payable - return of capital appropriations [(b)]	-	996
Other payables	52	25
Accrued expenses	8,464	8,946
Accrued salaries	15,025	11,654
	29,999	35,882

(a) A final payment amounting to $8.796 million for neonatal services was not made to the North Metropolitan Health Service (NMHS) within the 2019-20 financial year. See Note 3.2 for the details of neonatal services purchased from NMHS.

(b) $0.996 million was payable to the Department of Health as the return of capital appropriations in excess of funding requirement for the principal repayments of lease liabilities (see Note 9.13).

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 30 days.

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

The accrued salaries suspense account (See 'Restricted cash and cash equivalents' in Note 7.3.1) consists of amounts paid annually into a Treasury suspense account to meet the additional cash outflow for employee salary payments in the reporting periods with 27 pay days instead of the normal 26. No interest is received on this account.

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6.6 Contract liabilities

	2021 $000	2020 $000
Current	89	53
Non-current	-	-
	89	53

Contract liabilities are the values of payments received for services yet to be provided to the customers at the reporting date. Refer to Note 4.3 for details of the revenue recognition policy.

6.6.1 Movement in contract liabilities

	2021 $000	2020 $000
Reconciliation of changes in contract liabilities		
Opening balance	53	-
Additions	89	108
Revenue recognised in the reporting period	(53)	(55)
Balance at end of period	89	53

The Health Service expects to satisfy the performance obligations within the next 12 months.

6.7 Grant liabilities

	2021 $000	2020 $000
Current	-	945
Non-current	-	-
	-	945

Income is recognised when the Health Service achieves milestones specified in the grant agreement.

The Health Service's grant liabilities for 2020 related to capital grants received from the Channel 7 Telethon Trust for purchases of equipment.

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6.7 Grant liabilities (cont.)

6.7.1 Movement in grant liabilities

	2021 $000	2020 $000
Reconciliation of changes in grant liabilities		
Opening balance	945	-
Additions	-	945
Revenue recognised in the reporting period	(945)	-
Balance at end of period	-	945

6.7.2 Expected satisfaction of grant liabilities

	2021 $000	2020 $000
Income recognition is expected to occur within:		
1 year	-	945
1 to 5 years	-	-
Over 5 years	-	-
	-	945

6.8 Other liabilities

	2021 $000	2020 $000
Current		
Paid parental leave scheme	83	89
	83	89

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7. Financing

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

	Notes
Lease liabilities	7.1
Finance costs	7.2
Cash and cash equivalents	7.3
Reconciliation of cash	7.3.1
Reconciliation of cash flows used in operating activities	7.3.2
Reconciliation of cash flows from State Government	7.3.3
Capital commitments	7.4

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7.1 Lease liabilities

	2021 $000	2020 $000
Current	1,858	1,790
Non-current	8,214	8,645
Total lease liabilities	10,072	10,435

The Health Service measures a lease liability, at the commencement date, at the present value of the lease payments that are not paid at that date. 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 lessee 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, are recognised by the Health Service in profit or loss in the period in which the condition that triggers the payment occurs.

This section should be read in conjunction with Note 5.2.

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7.1 Lease liabilities (cont.)

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.

Significant assumptions and judgements

Judgements have been made in the identification of leases within contracts, assessment of lease terms by considering the reasonable certainty in exercising extension or termination options, and identification of appropriate rate to discount the lease payments.

7.2 Finance costs

	2021 $000	2020 $000
Interest expense on borrowings [(a)]	-	12
Lease interest expense	255	173
	255	**185**

Finance costs are recognised as expenses in the period in which they are incurred.

Lease interest expense is the interest component of lease liability repayments.

(a) Finance costs for 2020 included the interest on the Department of Treasury loans which was fully repaid prior to 30 June 2020.

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7.3 Cash and cash equivalents

7.3.1 Reconciliation of cash

	2021 $000	2020 $000
Cash and cash equivalents	67,836	60,743
Restricted cash and cash equivalents		
Current		
Capital work projects	2,584	808
Mental Health Commission Funding [(a)]	2,006	2,175
Restricted cash assets held for other specific purposes [(b)]	12,784	12,452
	17,374	15,435
Non-current		
Accrued Salaries Suspense Account [(c)]	9,972	7,472
Total restricted cash and cash equivalents	27,346	22,907
Balance at end of period	**95,182**	**83,650**

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

(a) The unspent funds from the Mental Health Commission are committed to the provision of mental health services.

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

(c) The Accrued Salaries Suspense Account has been established for the Health Service at the Department of Treasury for the purpose of meeting the 27th pay which occurs in each eleventh year. This account is classified as non-current for 10 out of 11 years.

For the purpose of the Statement of Cash Flows, cash and cash equivalents and restricted cash and cash equivalents assets comprise cash on hand and short-term deposits with original maturities of three months or less that are readily convertible to a known amount of cash and which are subject to insignificant risk of changes in value.

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

	Notes	2021 $000	2020 $000
Net cost of services (Statement of Comprehensive Income)		(759,772)	(719,179)
Non-cash items:			
Expected credit losses expense	3.6	513	172
Write off of inventory		8	(8)
Depreciation and amortisation expense	5	59,601	60,192
Asset revaluation decrement	5.1	3,723	709
Asset revaluation increment	5.1	(605)	-
Net gain/(loss) from disposal of non-current assets	5.1.2	141	63
Write down of assets	3.6	991	244
Asset write off	3.6	407	-
Interest expense paid by the Department of Health	7.2	-	12
Interest capitalised		2	22
Donations of assets	4.4	(1,636)	(1,003)
Services received free of charge	4.1	42,368	39,262
(Increase)/decrease in assets:			
Receivables		(1,600)	(399)
Inventories		(626)	(394)
Other current assets		(264)	(47)
Increase/(Decrease) in liabilities:			
Payables		(5,976)	14,238
Current provisions		15,631	7,276
Non-current provisions		(4,975)	4,216
Grant liabilities		(945)	945
Contract liabilities		36	53
Other current liabilities		(6)	20
Net cash used in operating activities (Statement of Cash Flows)		**(652,984)**	**(593,606)**

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7.3.3 Reconciliation of cash flows from State Government

	2021 $000	2020 $000
Notional cash flows		
Service agreement funding - State	492,775	451,059
Service agreement funding - Commonwealth	159,824	140,252
Grants from other state government agencies	68,828	65,044
Services provided to other government agencies	3,981	1,383
Capital appropriation credited directly to Contributed equity (refer Note 9.13)	11,769	7,335
	737,177	665,073
Return of capital appropriations to the Department of Health (refer Note 6.5)	-	996
Less notional cash flows:		
Items paid directly by the Department of Health for the Health Service and are therefore not included in the Statement of Cash Flows:		
Interest payments to the Department of Treasury	-	(14)
Repayment of borrowings to the Department of Treasury	-	(739)
Accrual appropriations	(62,580)	(66,475)
	(62,580)	(67,228)
Cash Flows from State Government as per Statement of Cash Flows	674,597	598,841

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

7.4 Capital commitments

	2021 $000	2020 $000
Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows:		
Within 1 year	211	3,304
Later than 1 year, and not later than 5 years	-	45
	211	3,349

Amounts presented for capital expenditure commitments are GST inclusive.

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8. Risks and Contingencies

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

	Notes
Financial risk management	8.1
Contingent assets	8.2.1
Contingent liabilities	8.2.2
Fair value measurements	8.3

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8.1 Financial risk management

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

(a) Summary of risks and risk management

Credit risk

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

The maximum exposure to credit risk at the end of the reporting period in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any allowance for impairment as shown in the tables at Note 8.1(c) 'Credit risk exposure' and Note 6.1 'Receivables'.

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

All debts are individually reviewed, on a timely basis at 30, 60, 90 and 120 days. In a circumstance 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 within six months of the accounts being raised.

Allowance for impairment of financial assets is calculated based on objective evidence such as observable data indicating changes in client credit ratings.

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's exposure to market risk for changes in interest rates relates primarily to the long-term debt obligations.

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8.1 Financial risk management (cont.)

(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:

	2021 $000	2020 $000
Financial Assets		
Cash and cash equivalents	67,836	60,743
Restricted cash and cash equivalents	27,346	22,907
Financial assets at amortised cost [(a)]	419,666	356,224
	514,848	**439,874**
Financial Liabilities		
Financial liabilities measured at amortised cost	40,160	47,315
	40,160	**47,315**

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

(c) Credit risk exposure

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

		Days past due					
	Total $000	Current $000	31-60 days $000	61-90 days $000	91-180 days $000	181-365 days $000	>1 year $000
30 June 2021							
Expected credit loss rate		3%	7%	17%	23%	55%	69%
Estimated total gross carrying amount at default	9,874	4,571	626	360	1,127	1,015	2,175
Expected credit losses	(2,582)	(149)	(46)	(60)	(263)	(554)	(1,510)
30 June 2020							
Expected credit loss rate		3%	7%	22%	29%	45%	77%
Estimated total gross carrying amount at default	9,690	3,242	779	220	633	1,130	3,686
Expected credit losses	(3,728)	(101)	(53)	(49)	(182)	(508)	(2,835)

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8.1 Financial risk management (cont.)

(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

	Weighted average effective interest rate	Interest rate exposure				Maturity dates			
		Carrying amount	Fixed interest rate	Variable interest rate	Non-interest bearing	Nominal Amount	Up to 3 months	3 months to 1 year	1-5 years	More than 5 years
	%	$000	$000	$000	$000	$000	$000	$000	$000	$000
2021										
Financial Assets										
Cash and cash equivalents		67,836	-	-	67,836	67,836	67,836	-	-	-
Restricted cash and cash equivalents		27,346	-	-	27,346	27,346	17,374	-	-	9,972
Receivables [(a)]		10,729	-	-	10,729	10,729	10,729	-	-	-
Amounts receivable for services		408,937	-	-	408,937	408,937	-	-	-	408,937
		514,848	-	-	514,848	514,848	95,939	-	-	418,909
Financial Liabilities										
Payables		29,999	-	-	29,999	29,999	29,999	-	-	-
Contract liabilities		89	-	-	89	89	89	-	-	-
Grant liabilities		-	-	-	-	-	-	-	-	-
Lease liabilities	2.49%	10,072	10,072	-	-	11,424	542	1,521	4,744	4,617
		40,160	10,072	-	30,088	41,512	30,630	1,521	4,744	4,617

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

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8.1 Financial risk management (cont.)

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

	Weighted average effective interest rate %	Carrying amount $000	Interest rate exposure: Fixed interest rate $000	Interest rate exposure: Variable interest rate $000	Interest rate exposure: Non-interest bearing $000	Nominal Amount $000	Maturity dates: Up to 3 months $000	Maturity dates: 3 months to 1 year $000	Maturity dates: 1-5 years $000	Maturity dates: More than 5 years $000
2020										
Financial Assets										
Cash and cash equivalents		60,743	-	-	60,743	60,743	60,743	-	-	-
Restricted cash and cash equivalents		22,907	-	-	22,907	22,907	15,435	-	-	7,472
Receivables [(a)]		9,867	-	-	9,867	9,867	9,867	-	-	-
Amounts receivable for services		346,357	-	-	346,357	346,357	-	-	-	346,357
		439,874	-	-	439,874	439,874	86,045	-	-	353,829
Financial Liabilities										
Payables		35,882	-	-	35,882	35,882	35,882	-	-	-
Contract liabilities		53	-	-	53	53	32	21	-	-
Grant liabilities		945	-	-	945	945	945	-	-	-
Lease liabilities	2.17%	10,435	10,435	-	-	11,876	518	1,474	5,180	4,704
		47,315	10,435	-	36,880	48,756	37,377	1,495	5,180	4,704

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

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8.1 Financial risk management (cont.)

(e) Interest rate sensitivity analysis

The following table represents a summary of the interest rate sensitivity of the Health Service's financial assets and liabilities at the end of the reporting period on the surplus for the period and equity for a 1% change in interest rates. It is assumed that the change in interest rates is held constant throughout the reporting period.

		-100 basis points		+100 basis points	
	Carrying amount $000	Surplus $000	Equity $000	Surplus $000	Equity $000
2021					
Financial Liabilities					
Lease liabilities	10,072	101	101	(101)	(101)
Total Increase/(Decrease)		**101**	**101**	**(101)**	**(101)**
2020					
Financial Liabilities					
Lease liabilities	10,435	104	104	(104)	(104)
Total Increase/(Decrease)		**104**	**104**	**(104)**	**(104)**

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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

Under the *Long Service Leave Act 1958* (LSL Act), casual employees who have been employed for more than 10 years and meet continuous service requirements may be entitled to long service leave. Whilst a provision for casual employees, who are currently still employed by WA Health and who meet the criteria, has been recognised in the financial statements, the amount of the obligation for those casual employees who are no longer employed by WA Health cannot be measured with sufficient reliability at reporting date. We are currently assessing the impact of the LSL Act for those casual employees.

At the reporting date, the Health Service is not aware of other contingent liabilities.

Litigation in progress

The Health Service does not have any pending litigation that are not recoverable from RiskCover insurance at the reporting date.

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.

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8.3 Fair value measurements

AASB 13 '*Fair Value Measurement*' requires disclosure of fair value measurement by level of the following fair value measurement hierarchy:

a) quoted prices (unadjusted) in active markets for identical assets (level 1);

b) input other than quoted prices included within level 1 that are observable for the asset either directly or indirectly (level 2); and

c) inputs for the asset that are not based on observable market data (unobservable input) (level 3).

The following table represents the Health Service's assets measured at fair value:

2021	Notes	Level 1 $000	Level 2 $000	Level 3 $000	Fair value at end of period $000
Land	5.1				
Residential		-	625	-	625
Specialised		-	-	35,675	35,675
Buildings	5.1				
Residential		-	80	-	80
Specialised		-	-	902,054	902,054
		-	705	937,729	938,434
2020					
Land	5.1				
Residential		-	603	-	603
Specialised		-	-	23,720	23,720
Buildings	5.1				
Residential		-	102	-	102
Specialised		-	-	920,587	920,587
		-	705	944,307	945,012

There were no transfers between Levels 1, 2 or 3 during the current and previous periods.

Child and Adolescent Health Service
Notes to the financial statements
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8.3 Fair value measurements (cont.)

Valuation processes

The Health Service obtains independent valuations of land and buildings from the Western Australian Land Information Authority (Landgate Valuation Services) annually.

There were no changes in valuation techniques during the period.

Transfers in and out of a fair value level are recognised on the date of the event or change in circumstances that caused the transfer. Transfers are generally limited to assets newly classified as non-current assets held for sale as Treasurer's instructions require valuations of land and buildings to be categorised within Level 3 where the valuations will utilise significant Level 3 inputs on a recurring basis.

Valuation techniques to derive Level 2 fair values

Level 2 fair values of land and buildings (converted residential properties) are derived using the market approach. This approach provides an indication of value by comparing the asset with identical or similar properties for which price information is available. Analysis of comparable sales information and market data provides the basis for fair value measurement.

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

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

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

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8.3 Fair value measurements (cont.)

Fair value measurements using significant unobservable inputs (Level 3)

2021	Land $000	Buildings $000
Fair value at start of period	23,720	920,587
Transfer from other agencies	15,700	-
Additions	-	711
Revaluation increments/(decrements) recognised in Profit or Loss	(3,745)	625
Depreciation expense	-	(19,869)
Fair Value at end of period	**35,675**	**902,054**
2020		
Fair value at start of period	22,740	941,006
Transfer from other agencies	1,110	50
Revaluation increments/(decrements) recognised in Profit or Loss	(130)	(556)
Depreciation expense	-	(19,913)
Fair Value at end of period	**23,720**	**920,587**

Valuation techniques to derive Level 3 fair values

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.

Land (Level 3 fair values)

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

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8.3 Fair value measurements (cont.)

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

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

Buildings (Level 3 fair values)

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

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

a) Review and updating of the 'as-constructed' drawing documentation;

b) Categorisation of the drawings using the Building Utilisation Categories (BUC's) which designate the functional areas within the 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;

c) Measurement of the general floor areas;

d) Application of the BUC cost rates per square meter 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 to derive the depreciated replacement cost, assuming a uniform pattern of consumption over the initial 37 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 depreciated replacement costs at the last valuation dates for these buildings are written down to the Statement of Comprehensive Income as depreciation expenses over their remaining useful life.

Child and Adolescent Health Service
Notes to the financial statements
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9. Other disclosures

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

Child and Adolescent Health Service
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9.1 Events occurring after the end of the reporting period

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

9.2 Initial application of Australian Accounting Standards

AASB 1059 *Service Concession Arrangements: Grantors* is effective from 1 July 2020. This Standard addresses the accounting for a service concession arrangement (a type of public private partnership) by a grantor that is a public sector agency by prescribing the accounting for the arrangement from the grantor's perspective. Timing and measurement for the recognition of a specific asset class occurs on commencement of the arrangement and the accounting for associated liabilities is determined by whether the grantee is paid by the grantor or users of the public service provided.

The Health Service does not manage any public private partnership that is within the scope of the Standard. Hence, there is no financial impact on the 2020-21 financial statements.

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9.3 Future impact of Australian Accounting Standards not yet operative

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

		Operative for reporting periods beginning on/after
AASB 2020-1	*Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-current* This Standard amends AASB 101 to clarify requirements for the presentation of liabilities in the statement of financial position as current or non-current. There is no financial impact.	1 Jan 2023
AASB 2020-3	*Amendments to Australian Accounting Standards – Annual Improvements 2018–2020 and Other Amendments* This Standard amends: (a) AASB 1 to simplify the application of AASB 1; (b) AASB 3 to update a reference to the Conceptual Framework for Financial Reporting; (c) AASB 9 to clarify the fees an entity includes when assessing whether the terms of a new or modified financial liability are substantially different from the terms of the original financial liability; (d) AASB 116 to require an entity to recognise the sales proceeds from selling items produced while preparing property, plant and equipment for its intended use and the related cost in profit or loss, instead of deducting the amounts received from the cost of the asset; (e) AASB 137 to specify the costs that an entity includes when assessing whether a contract will be loss-making; and (f) AASB 141 to remove the requirement to exclude cash flows from taxation when measuring fair value. There is no financial impact.	1 Jan 2022
AASB 2020-6	*Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-current – Deferral of Effective Date* This Standard amends AASB 101 to defer requirements for the presentation of liabilities in the statement of financial position as current or non-current that were added to AASB 101 in AASB 2020-1. There is no financial impact.	1 Jan 2022
AASB 2020-7	*Amendments to Australian Accounting Standards – Covid-19-Related Rent Concessions: Tier 2 Disclosures* This Standard adds new disclosure requirements to AASB 1060. There is no financial impact.	1 Jul 2021

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

AASB 2021-2	*Amendments to Australian Accounting Standards – Disclosure of Accounting Policies and Definition of Accounting Estimates* This Standard amends: (a) AASB 7, to clarify that information about measurement bases for financial instruments is expected to be material to an entity's financial statements; (b) AASB 101, to require entities to disclose their material accounting policy information rather than their significant accounting policies; (c) AASB 108, to clarify how entities should distinguish changes in accounting policies and changes in accounting estimates; (d) AASB 134, to identify material accounting policy information as a component of a complete set of financial statements; and (e) AASB Practice Statement 2, to provide guidance on how to apply the concept of materiality to accounting policy disclosures. There is no financial impact.	1 Jan 2023
AASB 2021-3	*Amendments to Australian Accounting Standards – Covid-19-Related Rent Concessions beyond 30 June 2021* This Standard amends AASB 16 to extend by one year the application period of the practical expedient added to AASB 16 by AASB 2020-4. There is no financial impact.	1 Apr 2021

9.4 Remuneration of auditors

Remuneration payable to the Auditor General in respect of the audit for the current financial year is as follows:

	2021 $000	2020 $000
Auditing the accounts, financial statements, controls, and key performance indicators	220	221

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9.5 Key management personnel

The key management personnel include Ministers, board members, and senior officers of the Health Service. The Health Service does not incur expenditures to compensate Ministers and those disclosures may be found in the *Annual Report on State Finances*.

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

Compensation band ($)	**2021**	**2020**
$0	1	1
$1 - $10,000	1	-
$40,001 - $50,000	8	8
$70,001 - $80,000	1	-
$80,001 - $90,000	-	1
Total number of members of the Accountable Authority	11	10

	2021 $000	**2020 $000**
Short-term employee benefits	404	410
Post-employment benefits	38	39
Total compensation of members of the Accountable Authority	**442**	**449**

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9.5 Key management personnel (cont.)

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

Compensation band ($)	2021	2020
$80,001 - $90,000	-	1
$170,001 - $180,000	-	1
$190,001 - $200,000	-	2
$200,001 - $210,000	1	-
$210,001 - $220,000	1	-
$220,001 - $230,000	1	1
$230,001 - $240,000	1	1
$240,001 - $250,000	1	-
$310,001 - $320,000	-	1
$500,001 - $510,000	1	-
$530,001 - $540,000	-	1
$540,001 - $550,000	1	1
$580,001 - $590,000	1	-
Total number of senior officers	8	9

	2021 $000	2020 $000
Short-term employee benefits	1,841	2,052
Post-employment benefits	216	235
Other long-term benefits	198	218
Termination benefits	470	-
Ex-gratia payment	55	-
Total compensation of senior officers	**2,780**	**2,505**

The short-term employee benefits include salaries, motor vehicle benefits and travel allowances incurred by the Health Service in respect of senior officers.

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9.6 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 Ministers and their close family members, and their controlled or jointly controlled entities;
- all board members, senior officers and their close family members, and their controlled or jointly controlled entities;
- Wholly owned public sector entities (departments and statutory authorities), including their related bodies, that are included in the whole of government consolidated financial statements;
- Associates and joint ventures of a wholly-owned public sector entity; and
- Government Employees Superannuation Board (GESB).

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9.6 Related party transactions (cont.)

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:

	Notes	2021 $000	2020 $000
Income			
Service agreement funding - State	4.1	492,775	451,059
Service agreement funding - Commonwealth	4.1	159,824	140,252
Mental Health Commission - Service delivery agreement	4.1	68,097	64,643
Department of Health - Research development grant	4.1	598	366
Department of Health grant - COVID-19 vaccination	4.1	94	-
Department of Health grant - Aboriginal Cadetship Program	4.1	39	35
North Metropolitan Health Service - various clinical services	4.1	3,187	494
WA Country Health Service - various clinical services	4.1	752	786
South Metropolitan Health Service - training for radiology registrars	4.1	18	18
Assets assumed/(transferred)	4.1	863	-
Services received free of charge	4.1	42,368	39,262
Expenses			
Contracts for services - Department of Communities [(a)]		522	515
Insurance payments - Insurance Commission (RiskCover)	3.6	7,229	6,548
Rental and other accommodation expenses - Department of Finance [(a)]		1,125	1,085
Interest expense on loan - Department of Treasury	7.2	-	12
Lease interest expense - State Fleet	7.2	31	29
Remuneration for audit services - Office of the Auditor General	9.4	220	221

(a) These transactions are included at Note 3.2 ‘Contracts for services’ and Note 3.6 ‘Other expenses’.

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9.6 Related party transactions (cont.)

Significant transactions with Government-related entities (cont.)

	Notes	2021 $000	2020 $000
Assets			
Receivables at 30 June - North Metropolitan Health Service	6.1	-	1,281
Liabilities			
Payables at 30 June - North Metropolitan Health Service	6.5	180	8,796
Payables at 30 June - Department of Health	6.5	-	996
Lease liabilities at 30 June - State Fleet	7.1	935	1,142
Repayments of lease liabilities - State Fleet		461	432
Contributed Equity			
Capital appropriations administered by Department of Health	9.13	11,769	7,335
Transfer of assets from/(to) state government agencies	9.13	15,700	19,935

Material transactions with other related parties

Details of significant transactions between the Health Service and other related parties are as follows:

	2021 $000	2020 $000
Superannuation payments to GESB	37,532	34,425
Payable to GESB	1,169	921

All other transactions (including normal citizen type transactions) between the Health Service and Ministers, or board members, or senior officers, or their close family members, or their controlled (or jointly controlled) entities are not material for disclosure.

9.7 Related bodies

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

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

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9.8 Affiliated bodies

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

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

9.9 Services provided free of charge

During the reporting period, the following services were provided to other agencies free of charge:

	2021 $000	2020 $000
Department for Communities - health assessments for children in care	275	293
Disability Services Commission - paediatric services for children with disability	3,243	3,197
Department of Education - school health services	15,118	16,543
	18,636	20,033

9.10 Other statement of receipts and payments

	2021 $000	2020 $000
Commonwealth Grant - Christmas and Cocos Island		
Balance at the start of period	(30)	-
Receipts		
Commonwealth grant - provision of paediatric services	69	35
Payments		
Costs of visiting specialists	(91)	(65)
Balance at the end of period	**(52)**	**(30)**

A grant amount of $29,673 for 2019-20 was received from Commonwealth in the 2020-21 financial year.

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9.11 Special purpose accounts

Mental Health Commission Fund (Child and Adolescent Health Service) Account

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

The special purpose account has been established under section 16(1)(d) of *the Financial Management Act 2006.*

	2021 $000	2020 $000
Balance at the start of period	2,175	1,356
Receipts		
Service delivery agreement - Commonwealth contributions	11,222	9,881
Service delivery agreement - State contributions	56,456	54,352
Other	419	410
	68,097	64,643
Payments	(68,266)	(63,824)
	(169)	819
Balance at the end of period	**2,006**	**2,175**

9.12 Administered trust accounts

Trust Accounts are used by the Health Service to account for funds that they may be holding on behalf of another party. The Health Service does not have control of the use of these funds, and cannot deploy them to meet its objectives. Trust Accounts do not form part of the resources available to the Health Service, and are not reported as assets in the financial statements.

The Health Service administers a trust account for the purpose of holding patients' private moneys.

The trust account did not have any receipts or payments during the financial year.

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9.13 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.

	2021 $000	2020 $000
Contributed equity		
Balance at start of period	1,439,357	1,412,087
Contributions by owners		
Capital appropriations administered by Department of Health [(a)]	11,769	7,335
Transfer of net assets from other agencies [(b)]		
Neonatal assets and liabilities from North Metropolitan Health Service [(c)]	-	18,825
Crown land from the Department of Planning, Lands and Heritage [(d)]	15,700	1,110
Total contributions by owners	**27,469**	**27,270**
Distributions to owners	**-**	**-**
Balance at end of period	**1,466,826**	**1,439,357**

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

	2021 $000	2020 $000
Capital appropriations received in cash	11,769	7,592
Plus: Capital appropriations received notionally	-	739
Less: Payable - return of capital appropriations	-	(996)
	11,769	7,335

(b) AASB 1004 '*Contributions*' requires transfers of net assets as a result of a restructure of administrative arrangements to be accounted for as contributions by owners and distributions to owners. TI 955 designates non-discretionary and non-reciprocal transfers of net assets between state government agencies as contributions by owners in accordance with AASB Interpretation 1038. Where the transferee agency accounts for a non-discretionary and non-reciprocal transfer of net assets as a contribution by owners, the transferor agency accounts for the transfer as a distribution to owners.

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9.13 Equity (cont.)

(c) Assets and liabilities for Neonatal Services were transferred from North Metropolitan Health Service (NMHS) to the Health Service:

	2020 $000
Property, plant and equipment	2,931
Right-of-use assets	30
Cash and cash equivalent	17,423
Restricted cash and cash equivalent	528
Patient fee debtors (i)	1,136
Amount receivable for services	14,922
Payables	(1,724)
Lease liabilities	(30)
Employee benefits provision	(16,391)
Total Neonatal service assets and liabilities transferred	18,825

(i) The transfer of patient fee debtors included the allowance for impairment of receivables amounting to $0.254 million.

(d) Crown land for the Karrinyup Child Health Centre and Hilton Child Health Centre were transferred from the Department of Planning, Lands and Heritage during the 2019-20 financial year. In the 2020-21 financial year, a crown land was transferred from the Department of Planning, Lands and Heritage for the Perth Children's Hospice.

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9.14 Supplementary financial information

(a) Revenue, public and other property written off

	2021 $000	2020 $000
Revenue and debts written off under the authority of the Accountable Authority	1,745	1,418
Public and other property written off under the authority of the Accountable Authority	-	-
	1,745	1,418

(b) Losses through theft, defaults and other causes

There were no losses of public money and public and other property through theft or default during the period.

(c) Gifts of public property

There were no gifts of public property provided by the Health Service during the period.

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9.15 Explanatory statement

All variances between annual estimates (original budget) and actual results for 2021 and between the actual results for 2021 and 2020 are shown below. Narratives are provided for key major variances, which are greater than 10% and 1% ($7.844 million) of Total Cost of Services for the previous year for the Statements of Comprehensive Income and Statement of Cash Flows, and are greater than 10% and 1% ($16.170 million) of Total Assets for the previous year for the Statement of Financial Position.

Treasurer's Instruction 945 excludes changes in asset revaluation surplus, cash assets, receivables, payables, contributed equity and accumulated surplus from the definition of major variances for disclosure purpose.

9.15.1 Statement of Comprehensive Income Variances

	Variance note	Estimate 2021 $000	Actual 2021 $000	Actual 2020 $000	Variance between estimate and actual $000	Variance between actual results for 2021 and 2020 $000
Expenses						
Employee benefits expense	(c)	549,124	558,987	492,561	9,863	66,426
Fees for visiting medical practitioners		2,545	2,693	2,679	148	14
Contracts for services	(d)	4,596	9,453	52,558	4,857	(43,105)
Patient support costs	(a) (e)	85,676	101,975	87,602	16,299	14,373
Finance costs		153	255	185	102	70
Depreciation and amortisation expense		63,698	59,601	60,192	(4,097)	(591)
Asset revaluation decrements		-	3,723	709	3,723	3,014
Loss on disposal of non-current assets		-	141	63	141	78
Repairs, maintenance and consumable equipment		18,723	23,214	20,065	4,491	3,149
Other supplies and services		42,203	49,390	45,521	7,187	3,869
Other expenses		31,217	25,345	22,124	(5,872)	3,221
Total cost of services		**797,935**	**834,777**	**784,259**	**36,842**	**50,518**

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9.15.1 Statement of Comprehensive Income Variances (cont.)

	Variance note	Estimate 2021 $000	Actual 2021 $000	Actual 2020 $000	Variance between estimate and actual $000	Variance between actual results for 2021 and 2020 $000
Revenue						
Patient charges		19,074	21,787	17,661	2,713	4,126
Other fees for services		25,787	30,470	25,872	4,683	4,598
Grants and contributions		15,830	13,828	14,239	(2,002)	(411)
Donation revenue		510	2,096	1,978	1,586	118
Asset revaluation increments		-	605	-	605	605
Other revenue		4,006	6,219	5,330	2,213	889
Total revenue		65,207	75,005	65,080	9,798	9,925
Total income other than income from State Government		**65,207**	**75,005**	**65,080**	**9,798**	**9,925**
NET COST OF SERVICES		**732,728**	**759,772**	**719,179**	**27,044**	**40,593**
INCOME FROM STATE GOVERNMENT						
Service agreement funding - State		488,853	492,775	451,059	3,922	41,716
Service agreement funding - Commonwealth	(b) (f)	139,854	159,824	140,252	19,970	19,572
Grants from other state government agencies		65,945	68,828	65,044	2,883	3,784
Services provided to other government agencies		1,121	3,981	1,383	2,860	2,598
Assets (transferred)/assumed		-	863	-	863	863
Services received free of charge		36,955	42,368	39,262	5,413	3,106
Total income from State Government		**732,728**	**768,639**	**697,000**	**35,911**	**71,639**
DEFICIT FOR THE PERIOD		**-**	**8,867**	**(22,179)**	**8,867**	**31,046**
OTHER COMPREHENSIVE INCOME						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve		-	-	-	-	-
Total other comprehensive income		-	-	-	-	-
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**-**	**8,867**	**(22,179)**	**8,867**	**31,046**

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2021

9.15.1 Statement of Comprehensive Income Variances (cont.)

Major Variance Narratives

Variances between estimates and actuals

(a) Patient support costs have exceeded the budget estimate by $16.299 million because of the unexpectedly higher drug costs ($10.473 million) and other medical supplies ($5.143 million).

(b) The variance of $19.970 million in the Commonwealth component of service agreement funding consists of $14.732 million for the National Health Reform Agreement, $4.791 million for the National Partnership Agreement for COVID-19 Response and $0.447 million for the National Partnership Agreement - Essential Vaccines.

Variances between actuals for 2020-21 and 2019-20

(c) The $66.388.million increase in employee benefits expense is mainly due to the increased activities at the Perth Children's Hospital and the full year's expenses for neonatal staff at the King Edward Memorial Hospital. Since the neonatal services at KEMH became part of the Health Service in February 2020, five months' expenses for neonatal staff were accounted for in the 2019-20 financial year.

(d) Contracts for services have decreased by $43.105 million predominately as a result of the changes in purchasing arrangements and governance of neonatal services in February 2020. See Note 3.2(a).

(e) The higher costs incurred on drug supplies ($6.227 million), medical and surgical instruments ($1.260 million), personal protective equipment ($2.990 million), pathology charges ($1.100 million) and other medical supplies and services ($1.712 million) have contributed to the overall increase of $14.373 million in patient support costs.

(f) The Commonwealth component of service agreement funding pursuant to the National Health Reform Agreement has increased by $15.132 million. Additionally, $4.791 million was received under the National Partnership Agreement for COVID-19 Response.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2021

9.15.2 Statement of Financial Position Variances

	Variance note	Estimate 2021 $000	Actual 2021 $000	Actual 2020 $000	Variance between estimate and actual $000	Variance between actual results for 2021 and 2020 $000
ASSETS						
Current Assets						
Cash and cash equivalents		53,065	67,836	60,743	14,771	7,093
Restricted cash and cash equivalents		14,250	17,374	15,435	3,124	1,939
Receivables		9,809	11,490	10,403	1,681	1,087
Inventories		3,745	3,580	2,962	(165)	618
Other assets		631	909	669	278	240
Total Current Assets		81,500	101,189	90,212	19,689	10,977
Non-Current Assets						
Restricted cash and cash equivalents		9,972	9,972	7,472	-	2,500
Amounts receivable for services	(a)	410,055	408,937	346,357	(1,118)	62,580
Property, plant and equipment		1,089,721	1,097,608	1,124,827	7,887	(27,219)
Right-of-use assets		10,447	9,768	10,256	(679)	(488)
Intangible assets		32,825	29,370	37,889	(3,455)	(8,519)
Total Non-Current Assets		1,553,020	1,555,655	1,526,801	2,635	28,854
TOTAL ASSETS		**1,634,520**	**1,656,844**	**1,617,013**	**22,324**	**39,831**

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2021

9.15.2 Statement of Financial Position Variances (cont.)

	Variance note	Estimate 2021 $000	Actual 2021 $000	Actual 2020 $000	Variance between estimate and actual $000	Variance between actual results for 2021 and 2020 $000
LIABILITIES						
Current Liabilities						
Payables		26,802	29,999	35,882	3,197	(5,883)
Contract liabilities		-	89	53	89	36
Grant liabilities		868	-	945	(868)	(945)
Lease liabilities		1,834	1,858	1,790	24	68
Employee benefits provisions		108,770	123,317	107,686	14,547	15,631
Other liabilities		-	83	89	83	(6)
Total Current Liabilities		138,274	155,346	146,445	17,072	8,901
Non-Current Liabilities						
Lease liabilities		8,928	8,214	8,645	(714)	(431)
Employee benefits provisions		34,035	26,365	31,340	(7,670)	(4,975)
Total Non-Current Liabilities		42,963	34,579	39,985	(8,384)	(5,406)
TOTAL LIABILITIES		**181,237**	**189,925**	**186,430**	**8,688**	**3,495**
NET ASSETS		**1,453,283**	**1,466,919**	**1,430,583**	**13,636**	**36,336**
EQUITY						
Contributed equity		1,462,057	1,466,826	1,439,357	4,769	27,469
Reserves		-	-	-	-	-
Accumulated surplus		(8,774)	93	(8,774)	8,867	8,867
TOTAL EQUITY		**1,453,283**	**1,466,919**	**1,430,583**	**13,636**	**36,336**

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2021

9.15.2 Statement of Financial Position Variances (cont.)

Major Variance Narratives

Variances between actuals for 2020-21 and 2019-20

(a) The increase of $62.580 million in amounts receivable for services represents the receivable component of service appropriations received from the State Government via the Department of Health (see note 6.2).

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2021

9.15.3 Statement of Cash Flows Variances

	Variance note	Estimate 2021 $000	Actual 2021 $000	Actual 2020 $000	Variance between estimate and actual $000	Variance between actual results for 2021 and 2020 $000
CASH FLOWS FROM STATE GOVERNMENT						
Service agreement funding - State	(e)	425,156	430,195	384,570	5,039	45,625
Service agreement funding - Commonwealth	(a) (f)	139,854	159,824	140,252	19,970	19,572
Grants from other state government agencies		65,945	68,828	65,044	2,883	3,784
Services provided to other government agencies		1,121	3,981	1,383	2,860	2,598
Capital appropriations administered by Department of Health	(b)	22,700	11,769	7,592	(10,931)	4,177
Net cash provided by State Government		**654,776**	**674,597**	**598,841**	**19,821**	**75,756**
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits	(g)	(544,346)	(544,132)	(476,710)	214	(67,422)
Supplies and services	(c)	(159,106)	(178,529)	(181,055)	(19,423)	2,526
Finance costs		(153)	(253)	(151)	(100)	(102)
Receipts						
Receipts from customers		19,158	21,451	15,493	2,293	5,958
Grants and contributions		15,830	12,919	15,237	(2,911)	(2,318)
Donations received		392	123	677	(269)	(554)
Other receipts		29,792	35,437	32,903	5,645	2,534
Net cash used in operating activities		**(638,433)**	**(652,984)**	**(593,606)**	**(14,551)**	**(59,378)**

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2021

9.15.3 Statement of Cash Flows Variances (cont.)

	Variance note	Estimate 2021 $000	Actual 2021 $000	Actual 2020 $000	Variance between estimate and actual $000	Variance between actual results for 2021 and 2020 $000
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Purchase of non-current assets	(d)	(20,855)	(8,239)	(3,713)	12,616	(4,526)
Receipts						
Proceeds from sale of non-current assets		-	11	132	11	(121)
Net cash used in investing activities		**(20,855)**	**(8,228)**	**(3,581)**	**12,627**	**(4,647)**
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Principal elements of lease		(1,848)	(1,853)	(1,380)	(5)	(473)
Net cash used in financing activities		**(1,848)**	**(1,853)**	**(1,380)**	**(5)**	**(473)**
Net increase / (decrease) in cash and cash equivalents		(6,360)	11,532	274	17,892	11,258
Cash and cash equivalents at the beginning of period		83,650	83,650	65,425	-	18,225
Cash transferred from North Metropolitan Health Service		-	-	17,951	-	(17,951)
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**77,290**	**95,182**	**83,650**	**17,892**	**11,532**

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2021

9.15.3 Statement of Cash Flows Variances (cont.)

Major Variance Narratives

Variances between estimates and actuals

(a) Service agreement funding - Commonwealth - see explanation in variance note (b) for the Statement of Comprehensive Income.

(b) The realignment and deferment of the capital works program have resulted in cash flows from capital appropriations to be lower than the original budget by $10.931 million.

(c) The higher than expected drug costs and other medical supplies have largely contributed to the variance of $19.594 million in supplies and services.

(d) Purchase of non-current assets is $12.616 million below budget mainly because of realignment and deferment of the capital works program during the year, including $3.464 million incurred on employee benefits, supplies and services rather than non-current assets.

Variances between actuals for 2020-21 and 2019-20

(e) The overall increase of $45.625 million in the State component of service agreement funding includes $39.594 million for increased activities and $6.031 million for COVID-19.

(f) Service agreement funding - Commonwealth - see explanation in variance note (f) for the Statement of Comprehensive Income.

(g) Employee benefits - see explanation in variance note (c) for the Statement of Comprehensive Income.

Key performance indicators

Certification of key performance indicators

Child and Adolescent Health Service

Certification of Key Performance Indicators for the year Ended 30 June 2021

We hereby certify that the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the Child and Adolescent Health Service's performance, and fairly represent the performance of the Child and Adolescent Health Service for the reporting period ended 30 June 2021.

Dr Rosanna Capolingua

BOARD CHAIR
CHILD AND ADOLESCENT HEALTH SERVICE
2 September 2021

Prof Geoffrey Dobb

DEPUTY BOARD CHAIR
CHILD AND ADOLESCENT HEALTH SERVICE
2 September 2021

The relationship between the following key performance indicators and the Government Goal, Outcomes and Services is described in the Performance Management Framework section commencing on page 32.

The latest available data has been used to report performance, which in some instances means results are for the 2020 calendar year.

KPIs measuring Outcome 1

KPIs measuring Outcome 2

EFFECTIVENESS KPI – OUTCOME 1:

PUBLIC HOSPITAL BASED SERVICES THAT ENABLE EFFECTIVE TREATMENT AND RESTORATIVE HEALTH CARE FOR WESTERN AUSTRALIANS

Unplanned hospital readmissions for patients within 28 days for selected surgical procedures

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.[10] These readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

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

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

Target

The 2020 targets are based on the total child and adult population, and for each procedure is:

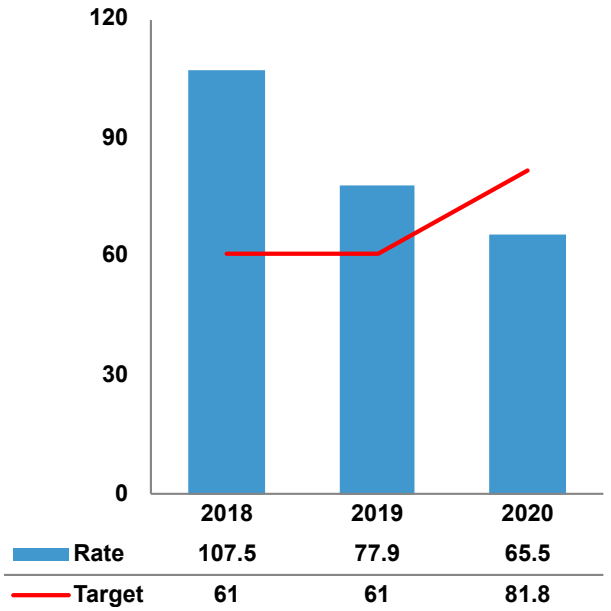
Surgical Procedure	Target (per 1,000)
Tonsillectomy & Adenoidectomy	≤81.8
Appendicectomy	≤25.7

Results

Tonsillectomy & Adenoidectomy

The rate of unplanned readmission for tonsillectomy and adenoidectomy was 65.5 per 1,000, which is lower than previous years and below the target of 81.8 per 1,000. (Figure 5).

Figure 5: Rate of unplanned hospital readmissions for patients within 28 days for tonsillectomy and adenoidectomy, 2018 to 2020

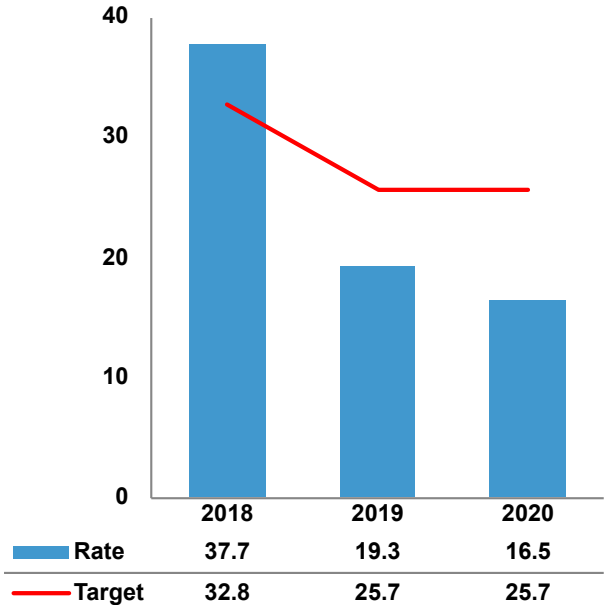


Data sources: Hospital Morbidity Data Collection, WA Data Linkage System.

Appendicectomy

The rate of unplanned readmissions for appendicectomy was 16.5 per 1,000, which is lower than previous years and below the target of 25.7 per 1,000 (Figure 6).

Figure 6: Rate of unplanned hospital readmissions for patients within 28 days for appendicectomy, 2018 to 2020



Data sources: Hospital Morbidity Data Collection, WA Data Linkage System.

EFFECTIVENESS KPI – OUTCOME 1:
PUBLIC HOSPITAL BASED SERVICES THAT ENABLE EFFECTIVE TREATMENT AND RESTORATIVE HEALTH CARE FOR WESTERN AUSTRALIANS

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

Rationale

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

Elective surgical services delivered in the WA health system are those deemed to be clinically necessary. Excessive waiting times for these services can lead to deterioration of the patient's condition and/or quality of life, or even death[11]. 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 2020–21 target is zero per cent for each urgency category. Performance is demonstrated by a result that is equal to the target.

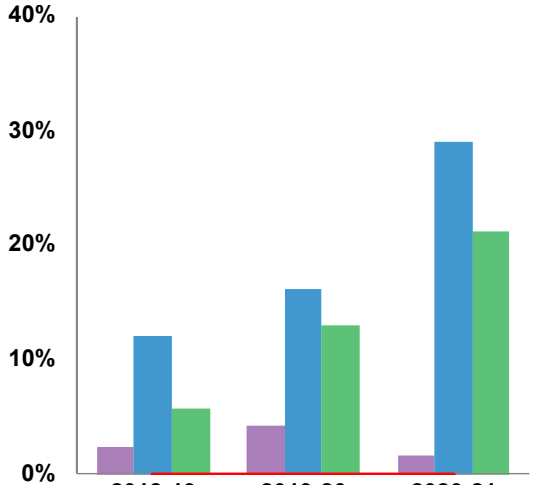
11 Derrett, S., Paul, C., Morris, J.M. (1999). Waiting for Elective Surgery: Effects on Health-Related Quality of Life, International Journal of Quality in Health Care, Vol 11 No. 1, 47-57.

Results

In 2020–21, CAHS' performance with surgical waitlisting of patients and treating them within recommended timeframes improved for the most urgent surgeries (Category 1) but declined for those less urgent (Categories 2 and 3) when averaged across the entire year. Figure 7 shows an average of 1.6 per cent of Category 1 patients were not treated within 30 days, 29.1 per cent of Category 2 patients were not treated within 90 days, and 21.2 per cent of Category 3 patients were not treated within 365 days.

CAHS prioritises the treatment of patients with the most urgent clinical need, i.e. those awaiting elective procedures deemed Category 1, as evidenced by the very small proportion of those whose wait time exceeded the recommended period. The decline in performance for Category 2 and 3 surgeries was due to this prioritisation and the cumulative effects of instances where elective surgeries had to cease or be scaled back in 2020 and 2021 due to COVID-19 related drivers. This includes the reduction in surgical activity between 23 March and 15 June 2020 that occurred on instruction from the Director General of WA Health and the Minister for Health, and the additional impact of further instructions to reduce surgeries during lockdown periods that commenced in January, April and June 2021.

Figure 7: Percentage of elective wait list patients waiting over boundary for reportable procedures, by urgency category, 2018–19 to 2020–21



	2018-19	2019-20	2020-21
Cat. 1	2.4%	4.2%	1.6%
Cat. 2	12.1%	16.2%	29.1%
Cat. 3	5.8%	13.1%	21.2%
Target	0%	0%	0%

Note: The result is based on an average of weekly census data for the financial year. Data source: Elective Services Wait List Data Collection.

EFFECTIVENESS KPI – OUTCOME 1:

PUBLIC HOSPITAL BASED SERVICES THAT ENABLE EFFECTIVE TREATMENT AND RESTORATIVE HEALTH CARE FOR WESTERN AUSTRALIANS

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

Rationale

Staphylococcus aureus bloodstream infection is a serious infection that may be associated with the provision of healthcare. *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[12] in adults and five per cent in children).

HA-SABSI is generally considered to be a preventable adverse event associated with the provision of healthcare, therefore this KPI is a robust measure of the safety and quality of care provided by WA public hospitals. A low or decreasing HA-SABSI rate is desirable, and the WA target reflects the nationally agreed benchmark.

Target

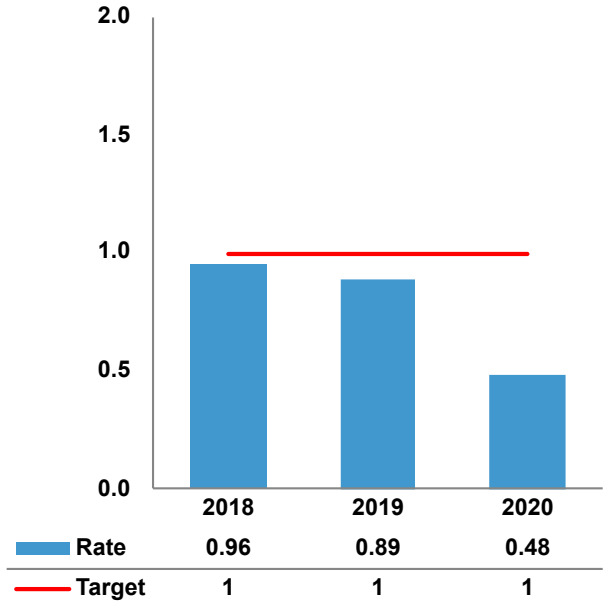
The 2020 target is ≤1.0 HA-SABSI per 10,000 occupied bed-days.

Result

CAHS provides a range of specialised services, including emergency medicine, intensive care, cardiothoracic surgery and oncology. Many patients are therefore at higher risk of *Staphylococcus aureus* (*S. aureus*) infection than those at hospitals providing less specialised services. Despite this, CAHS reduced its S. aureus bloodstream infection rate in 2020 to 0.48 per 10,000 occupied bed-days, which is almost half last year's result and well below the WA health system target of 1.0 per 10,000 bed-days (Figure 8).

The favourable result is due to a number of initiatives CAHS has in place to prevent S. aureus infection, particularly the dedicated central venous access device (CVAD) insertion and management service. New to 2020 was the introduction of CVAD bundles, which are evidence-based practices that cause significant improvement in outcomes for patients with CVADs in place.

Figure 8: Healthcare associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days, 2018 to 2020



Data source: Healthcare Infection Surveillance Western Australia Data Collection.

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

EFFECTIVENESS KPI – OUTCOME 1:

PUBLIC HOSPITAL BASED SERVICES THAT ENABLE EFFECTIVE TREATMENT AND RESTORATIVE HEALTH CARE FOR WESTERN AUSTRALIANS

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

Rationale

Discharge against medical advice (DAMA) refers to patients leaving hospital against the advice of their treating medical team or without advising hospital staff (e.g. absconding or missing and not found). Patients who do so have a higher risk of readmission and mortality[13] and have been found to cost the health system 50 per cent more than patients who are discharged by their physician.[14]

Between July 2013 and June 2015, Aboriginal patients in WA were almost 12.7 times more likely than non-Aboriginal patients to discharge against medical advice, compared with seven times nationally[15]. This statistic indicates a need for improved responses by the health system to the needs of Aboriginal patients.

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

13 Yong et al. Characteristics and outcomes of discharges against medical advice among hospitalised patients. Internal medicine journal 2013:43(7):798-802.
14 Aliyu ZY. Discharge against medical advice: sociodemographic, clinical and financial perspectives. International journal of clinical practice 2002;56(5):325-27.
15 Commonwealth of Australia. (2017). Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report, Commonwealth of Australia, Canberra.

Target

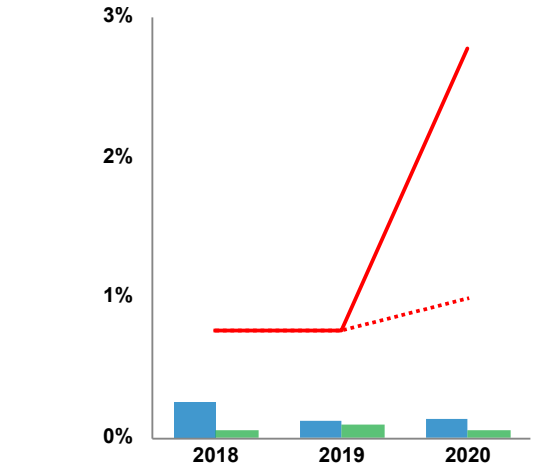
The 2020 targets are based on the total child and adult population:

	Target
Aboriginal patients	≤2.78%
Non-Aboriginal patients	≤0.99%

Results

In 2020, CAHS recorded a rate of discharge against medical advice of 0.14 per cent for Aboriginal patients, which is similar to last year and well below the target of 2.78 per cent. For non-Aboriginal patients, the rate was 0.06 per cent, which is lower than last year and also well below the target of 0.99 per cent (Figure 9). A contributing factor to the favourable result for Aboriginal patients is the Koorliny Moort (Walking with Families) program, which engages with Aboriginal people early and improves communication between health care services in and out of hospital.

Figure 9: Percentage of admitted patients who discharged against medical advice, 2018 to 2020



	2018	2019	2020
Abor.	0.26%	0.13%	0.14%
Non-Abor.	0.06%	0.10%	0.06%
Target (Abor.)	0.77%	0.77%	2.78%
Target (Non-Abor.)	0.77%	0.77%	0.99%

Data source: Hospital Morbidity Data Collection.

EFFECTIVENESS KPI – OUTCOME 1:

PUBLIC HOSPITAL BASED SERVICES THAT ENABLE EFFECTIVE TREATMENT AND RESTORATIVE HEALTH CARE FOR WESTERN AUSTRALIANS

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

Rationale

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

While multiple hospital admissions over a lifetime may be necessary for someone with ongoing illness, a high proportion of readmissions shortly after discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was not adequate to maintain the patient's recovery out of hospital.[16] 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.

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

Target

The 2020 target is ≤12 per cent.[17]

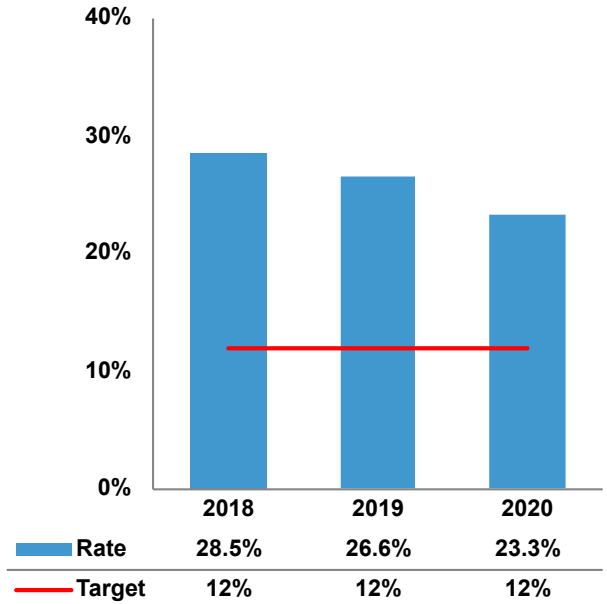
Result

Although above the target of 12 per cent, the rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit in 2020 improved for the second successive year to 23.3 per cent (Figure 10). The reduction is in part due to the commencement of the Emergency Telehealth Service to provide mental health assessments within the home.

It should be noted that this indicator does not distinguish between planned and unplanned readmissions. Child and Adolescent Mental Health Services provide planned admissions for those who require frequent inpatient admissions and non-acute interventions as part of their care. The record high bed occupancy of the mental health ward in 2020 also contributed to a reduction in planned readmissions.

17 The source of this target was the Fourth National Mental Health Measurement Strategy (May 2011) produced by the Mental Health Information Strategy Subcommittee, Australian Health Ministers' Advisory Council, Mental Health Standing Committee. http://www.health.gov.au/internet/main/publishing.nsf/content/1ED20240320A3A11CA257D9B007B31C6/$File/meas.pdf

Figure 10: Readmissions to acute specialised mental health inpatient services within 28 days of discharge, 2018 to 2020



Data source: Hospital Morbidity Data Collection

EFFECTIVENESS KPI – OUTCOME 1:

PUBLIC HOSPITAL BASED SERVICES THAT ENABLE EFFECTIVE TREATMENT AND RESTORATIVE HEALTH CARE FOR WESTERN AUSTRALIANS

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

Rationale

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

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

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

18 https://www.abs.gov.au/ausstats/abs@.nsf/mf/4364.0.55.001

Target

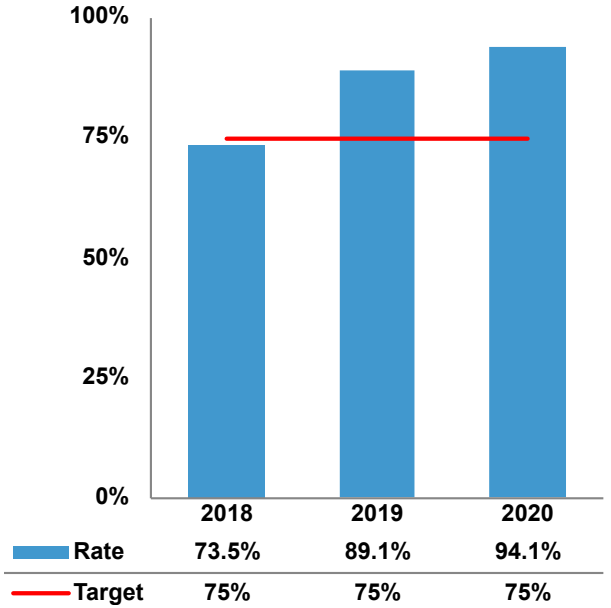
The 2020 target is ≥75 per cent.

Result

In 2020, 94.1 per cent of young people who were admitted to CAHS acute specialised mental health inpatient services or their carers were contacted by a community-based public mental health non-admitted health service within seven days of discharge, which is well above the target of 75 per cent (Figure 11). The creation of the Emergency Telehealth Service in 2020 contributed to this improvement by establishing a formal process of follow up for those young people discharged to private and not-for-profit care providers.

The improvement in performance since 2018 is also partly due to revision to the methodology in accordance with the national definition to include contacts with carers. This is considered particularly appropriate and relevant where, for example, the patient is a minor.

Figure 11: Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services, 2018 to 2020



Data source: Mental Health Information Data Collection, Hospital Morbidity Data Collection.

EFFICIENCY KPI – OUTCOME 1 – SERVICE 1:
PUBLIC HOSPITAL ADMITTED SERVICES

Average admitted cost per weighted activity unit

Rationale
This indicator is a measure of the cost per weighted activity unit (WAU) compared with the State (aggregated) target, as approved by the Department of Treasury and published in Volume 1 of the 2020–21 Budget Paper No. 2.

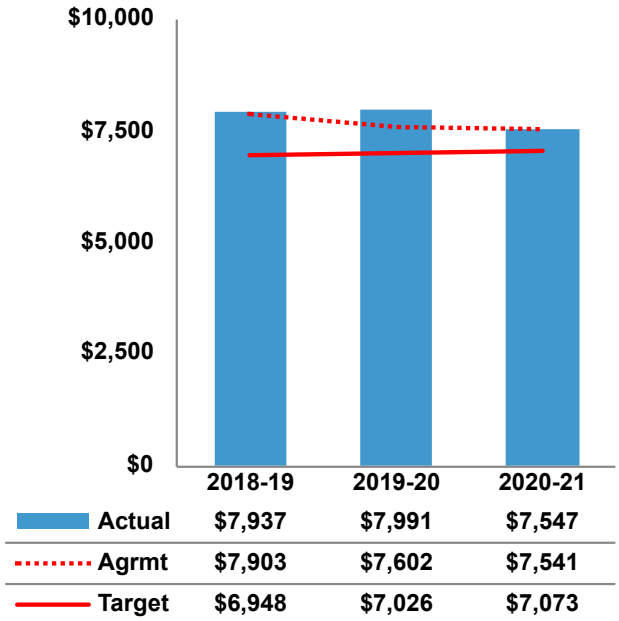
The measure ensures a consistent methodology is applied to calculating and reporting the cost of delivering inpatient activity against the State's funding allocation. As admitted services received nearly half of the overall 2020–21 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

Target
The 2020–21 target is ≤$7,073 per weighted activity unit.

Result
The average admitted cost per weighted activity unit fell to $7,547 in 2020–21, which is 6.7 per cent above the target. It is important to note that the target was developed at a whole of WA health system level, and it applies to all Health Service Providers (HSPs), despite each having a different cost structure dependent on the nature of their operations and the facilities they work from. For instance, CAHS provides specialist paediatric services and operates a new, state of the art hospital, whereas other HSPs cater primarily to adults from older facilities subject to less depreciation.

CAHS has a Service Agreement with the Department of Health that specifies the funding it has been allocated to meet the services it delivers. This effectively set a CAHS-specific performance expectation that is higher than the Annual Report target. By that standard, CAHS performed at expectation by being less than 0.1 per cent above the value determined by the Service Agreement (Figure 12).

Figure 12: Average admitted cost per weighted activity unit, 2018–19 to 2020–21



	2018-19	2019-20	2020-21
Actual	$7,937	$7,991	$7,547
Agrmt	$7,903	$7,602	$7,541
Target	$6,948	$7,026	$7,073

Note: Weighted activity units adjust raw activity data to reflect the complexity of services provided to treat various conditions. WA health system hospitals utilise the Australian Refined Diagnosis Related Groups classifications to assign cost weights to each diagnostic group.

Data sources: Health Service financial system, Hospital Morbidity Data Collection.

EFFICIENCY KPI – OUTCOME 1 – SERVICE 2:
PUBLIC HOSPITAL EMERGENCY SERVICES

Average Emergency Department cost per weighted activity unit

Rationale

This indicator is a measure of the cost per weighted activity unit (WAU) compared with the State (aggregated) target as approved by the Department of Treasury and published in Volume 1 of the 2020–21 Budget Paper No. 2.

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

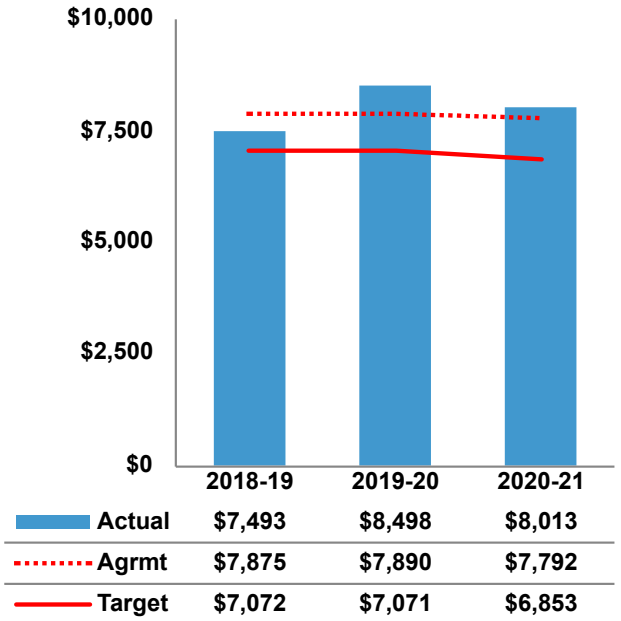
The 2020–21 target is ≤$6,853 per weighted activity unit.

Result

The average Emergency Department cost per weighted activity unit fell to $8,013 in 2020–21, which is 16.9 per cent above the target. It is important to note that the target was developed at a whole of WA health system level, and it applies to all Health Service Providers (HSPs), despite each having a different cost structure dependent on the nature of their operations and the facilities they work from. For instance, CAHS provides specialist paediatric services and operates a new, state of the art hospital, whereas other HSPs cater primarily to adults from older facilities subject to less depreciation.

CAHS has a Service Agreement with the Department of Health that specifies the funding it has been allocated to meet the services it delivers. This effectively set a CAHS-specific performance expectation that is higher than the Annual Report target. By that standard, CAHS' performance was slightly unfavourable in 2020–21, being 2.8 per cent above the value determined by the Service Agreement (Figure 13).

Figure 13: Average Emergency Department cost per weighted activity unit, 2018–19 to 2020–21



Note: Weighted activity units adjust raw activity data to reflect the complexity of services provided to treat various conditions. WA health system hospitals utilise the Australian Refined Diagnosis Related Groups classifications to assign cost weights to each diagnostic group.

Data sources: Health Service financial system, Emergency Department Data Collection.

EFFICIENCY KPI – OUTCOME 1 – SERVICE 3:
PUBLIC HOSPITAL NON-ADMITTED SERVICES

Average non-admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per weighted activity unit (WAU) compared with the State (aggregated) target, as approved by the Department of Treasury and published in Volume 1 of the 2020–21 Budget Paper No. 2.

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 2020–21 target is ≤$7,025 per weighted activity unit.

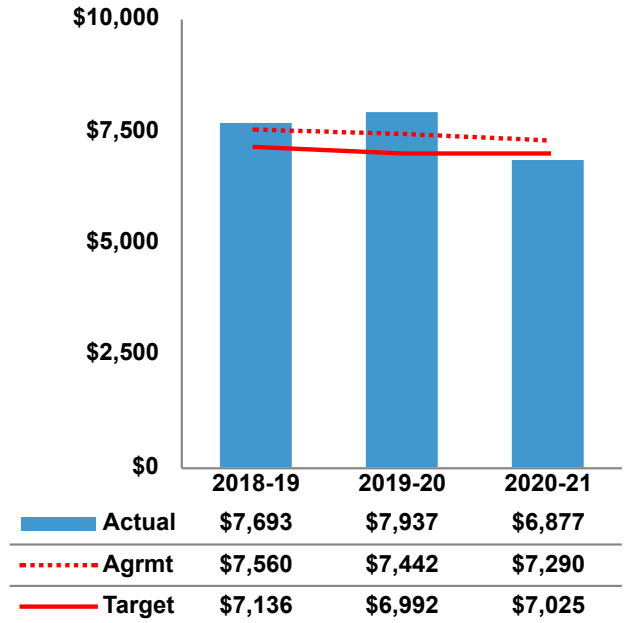
Result

The average non-admitted cost per weighted activity unit fell significantly in 2020–21 to $6,877. This is 2.1 per cent below the target developed at a whole of WA health system level that applies to all Health Service Providers (HSPs), despite each having a different cost structure dependent on the nature of their operations and the facilities they work from. For instance, CAHS provides specialist paediatric services and operates a new, state of the art hospital, whereas other HSPs cater primarily to adults from older facilities subject to less depreciation.

CAHS has a Service Agreement with the Department of Health that specifies the funding it has been allocated to meet the services it delivers. This effectively set a CAHS-specific performance expectation that is higher than the Annual Report target. By that standard, CAHS' performance remained favourable, being 5.7 per cent lower than the value determined by the Service Agreement (Figure 14).

Improved financial performance in 2020–21 is attributable to both higher activity and a revision to how the Independent Hospital Pricing Authority weights activity to account for paediatric patients.

Figure 14: Average non-admitted cost per weighted activity unit, 2018–19 to 2020–21



	2018-19	2019-20	2020-21
Actual	$7,693	$7,937	$6,877
Agrmt	$7,560	$7,442	$7,290
Target	$7,136	$6,992	$7,025

Note: Weighted activity units adjust raw activity data to reflect the complexity of services provided to treat various conditions. WA health system hospitals utilise the Australian Refined Diagnosis Related Groups classifications to assign cost weights to each diagnostic group.

Data sources: Health Service financial system, non-admitted Patient Activity and Wait List Data Collection.

EFFICIENCY KPI – OUTCOME 1 – SERVICE 4:
MENTAL HEALTH SERVICES

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

Rationale

Specialised mental health inpatient services provide patient care in authorised hospitals and designated mental health units located within 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 cost of providing mental health care, and enable the reallocation of funds to appropriate alternative non-admitted care.

Target

The 2020–21 target is ≤$3,815 per bed-day.

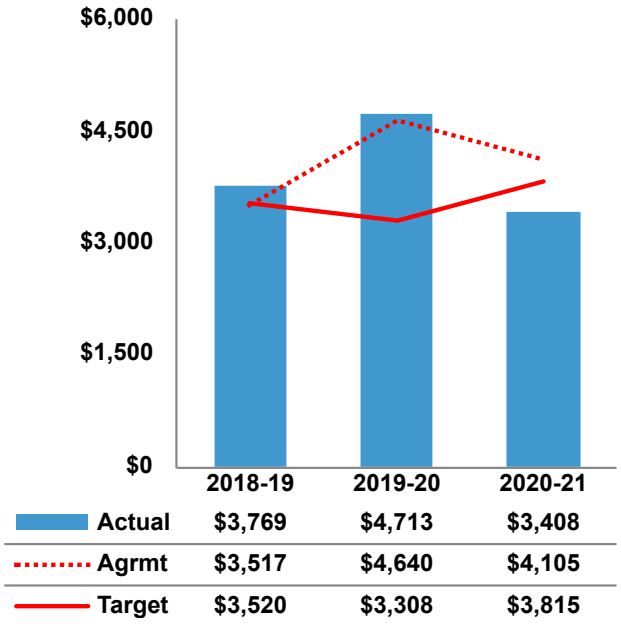
Result

The average cost per bed-day in specialised mental health inpatient services fell significantly in 2020–21 to $3,408 which is 10.7 per cent below the target.

CAHS has a Service Agreement with the Department of Health that specifies the funding it has been allocated to meet the services it delivers. This effectively set a different performance expectation that is higher than the Annual Report target. By that standard, CAHS' performance remained favourable, being 17.0 per cent lower than the value determined by the Service Agreement (Figure 15).

Improved financial performance in 2020–21 is attributable to a combination of lower operating costs and higher activity.

Figure 15: Average cost per bed-day in specialised mental health inpatient units, 2018–19 to 2020–21



Data sources: Health Service financial system, BedState

EFFICIENCY KPI – OUTCOME 1 – SERVICE 4:
MENTAL HEALTH SERVICES

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

Rationale

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

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

Target

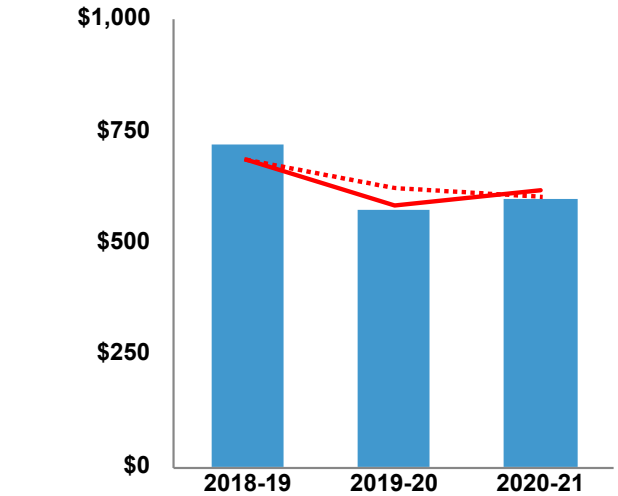
The 2020–21 target is ≤$617 per treatment day.

Result

The average cost per treatment day of non-admitted care provided by public clinical mental health services rose slightly in 2020–21 to $598, which is 3.0 per cent below the target.

CAHS has a Service Agreement with the Department of Health that specifies the funding it has been allocated to meet the services it delivers. This effectively set a different performance expectation that is lower than the Annual Report target. By that standard, CAHS' performance remained favourable, being 1.2 per cent lower than the value determined by the Service Agreement (Figure 16).

Figure 16: Average cost per treatment day of non-admitted care provided by mental health services, 2018–19 to 2020–21



	2018-19	2019-20	2020-21
Actual	$720	$575	$598
Agrmt	$686	$621	$605
Target	$687	$584	$617

Data sources: Health Service financial system, Mental Health Information Data Collection.

EFFICIENCY KPI – OUTCOME 2 – SERVICE 6:
PUBLIC AND COMMUNITY HEALTH SERVICES

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

Rationale

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

Population health aims to improve health by integrating all activities of the health sector and linking them with broader social and economic services and resources, as described in the WA Health Promotion Strategic Framework 2017–21. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

The 2020–21 target is ≤$255 per person.

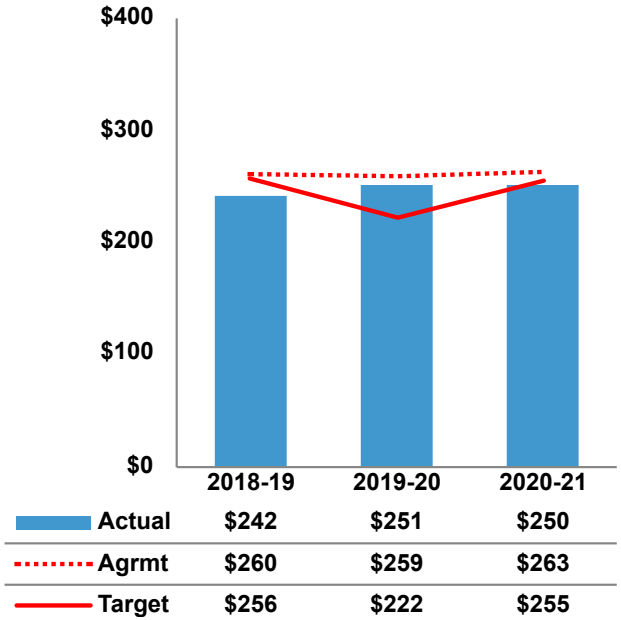
Result

The average cost per person of delivering population health programs by population health units fell slightly in 2020–21 to $250, which is 1.8 per cent below the target.

CAHS has a Service Agreement with the Department of Health that specifies the funding it has been allocated to meet the services it delivers. This effectively set a different performance expectation that is higher than the Annual Report target. By that standard, CAHS' performance remained favourable in 2020–21, being 4.8 per cent below the value determined by the Service Agreement (Figure 17).

Favourable performance is attributable to higher estimated expenditure when setting the target.

Figure 17: Average cost per person of delivering population health programs by population health units, 2018–19 to 2020–21



Data sources: Health Service financial system, Australian Bureau of Statistics.


Face Shield
Protective Isolation Mask

Other financial disclosures

Board and committee remuneration

Annual remuneration for each board or committee is listed in Tables 9 and 10.

Table 9: Child and Adolescent Health Service Board, 2020–21

Position	Name	Type of remuneration	2020–21 period of membership	2020–21 total remuneration[1]
Chair	Dr Rosanna Capolingua	Annual	1 month	$2,972
Former Chair	Ms Debbie Karasinski	Annual	11 months	$74,545
Deputy Chair	Professor Geoffrey Dobb	Ineligible	12 months	$0
Member	Ms Miriam Bowen	Annual	12 months	$45,762
Member	Ms Kathleen Bozanic	Annual	12 months	$45,762
Member	Ms Anne Donaldson	Annual	12 months	$45,762
Member	Dr Alexius Julian	Annual	12 months	$45,762
Member	Dr Daniel McAullay	Annual	12 months	$45,762
Member	Mr Peter Mott	Annual	12 months	$45,762
Member	Ms Maria Osman	Annual	12 months	$44,530
Member	Professor Di Twigg	Annual	12 months	$45,762
			Total	**$442,401**

[1] *includes superannuation payments*

Table 10: Eating Disorders Program Consumer Advisory Group, 2020–21

Position	Name	Type of remuneration	2020–21 period of membership	2020–21 total remuneration
Member	Melanie Coleman	Per meeting	12 months	$0
Member	Casey Croghan	Per meeting	12 months	$0
Member	Linelle Fields	Per meeting	12 months	$0
Member	Natasha Hambleton	Per meeting	12 months	$0
Member	Ashleigh Hardcastle	Per meeting	12 months	$0
Member	Teagan McNeil	Per meeting	12 months	$0
Member	Teagan Martin	Per meeting	12 months	$0
Member	Asha McAllister	Per meeting	12 months	$0
Member	Emily Wheeler	Per meeting	12 months	$0
			Total	**$0**

Notes to Tables 9 and 10:

1. The above list of boards is as per the State Government Boards and Committees Register.
2. Remuneration is provided to private sector and consumer representative members of a board/committee. Individuals are ineligible for remuneration if their membership on the board/committee is considered to be an integral part of their organisational role.
3. Remuneration amounts can vary depending on the type of remuneration, the number of meetings attended, and whether a member submitted a remuneration claim.
4. 'Period of membership' is defined as the period (in months) that an individual was a member of a board/committee during the 2020–21 financial year.

Pricing policy

The National Health Reform Agreement sets the policy framework for the charging of public hospital fees and charges. Under the Agreement, an eligible person who receives public hospital services as a public patient in a public hospital or a publicly contracted bed in a private hospital is treated free of charge. This arrangement is consistent with the Medicare principles which are embedded in the Health Services Act 2016 (WA).

The majority of hospital fees and charges for public hospitals are set under Schedule 1 of the Health Services (Fees and Charges) Order 2016 and are reviewed annually. The following informs WA public hospital patients' fees and charges for:

Compensable or ineligible patients

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

Private patients (Medicare eligible Australian residents)

The Commonwealth Department of Health regulates the Minimum Benefit payable by health funds to privately insured patients for private shared ward and same day accommodation. The Commonwealth also regulates the Nursing Home Type Patient contribution based on March and September pension increases. To achieve consistency with the Commonwealth Private Health Insurance Act 2007, the State sets these fees at a level equivalent to the Commonwealth Minimum Benefit.

Veterans

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

Other fees and charges

The Pharmaceutical Benefits Scheme regulates and sets the price of pharmaceuticals supplied to outpatients, patients on discharge and for day admitted chemotherapy patients. Inpatient medications are supplied free of charge.

There are other categories of fees specified under the terms of Health Services (Fees and Charges) Order 2016, which include the supply of surgically implanted prostheses, orthoses, magnetic resonance imaging services and pathology services. The pricing for these hospital services is determined according to their cost of service.

Capital works

Since the CAHS Board assumed governance responsibilities in September 2018, works for the Perth Children's Hospital Project have continued and are ongoing. Works include refinements and enhancements to the hospital facilities and ICT infrastructure to improve workflows, safety and security.

Practical completion was awarded by the builder for the construction of a new pharmaceutical manufacturing facility (Auspman Facility) in March 2021. The facility is located on a commercially leased site in Balcatta. Some outstanding building works are remaining due to COVID-19 related procurement delays. The total project budget is $5.725m. The estimated remaining cost to complete the CAHS managed portion of the project (furniture, fixtures and fittings, commissioning and Therapeutic Goods Administration licensing) at 30 June 2021 is $0.694m.

The Medical Equipment Replacement Program also completed capital works in 2020–21. Table 11 shows the financial details of the capital works program.

Table 11: Major asset investment program works completed in 2020–21

Capital works programs completed[1]	2020–21 ($'000)
Medical Equipment Replacement	899
Minor Building Works and Other Plant and Equipment	207
Total	**1,106**

(1) Excludes equipment funded outside of the State Government's Asset Investment Program

Governance disclosures

Indemnity insurance

In 2020–21, the amount of insurance premium paid to indemnify any 'director' (as defined in Part 3 of the *Statutory Corporations (Liability of Directors) Act 1996*) against a liability incurred under sections 13 or 14 of that Act was $69,795.

Government policy requirements

Pecuniary interests

Senior officers of government are required to declare any interest in an existing or proposed contract that has, or could result in, the member receiving financial or other benefits. In 2020–21, no Child and Adolescent Health Service senior officer declared a pecuniary interest.

Automated Guided Vehicles are used at PCH for the bulk transportation of materials, supplies and equipment for patient food, linen, pharmacy services and waste. They are self-guided and constantly scan the surrounding environment using laser sensors that allow them to stop before hitting walls, doors and other obstacles, including people.

Other legal requirements

Ministerial directives

Treasurer's Instructions 903 (12) requires disclosing information on any written Ministerial directives relevant to the setting of desired outcomes or operational objectives, the achievement of desired outcomes or operational objectives, investment activities, and financing activities.

The Minister for Health has directed Health Service Providers to disclose all gifts and payments over $100,000 made under section 36(5) of the *Health Services Act 2016* within their annual reports. In 2020–21, the Child and Adolescent Health Service (CAHS) did not provide any ex-gratia gift or make any ex-gratia payment over $100,000.

Advertising expenses

In accordance with section 175Z of the Electoral Act 1907, CAHS incurred the following advertising expenditure in 2020–21 (Table 12).

Unauthorised use of credit cards

In accordance with State Government policy, CAHS has issued corporate credit cards to certain employees where their functions warrant usage of this facility for purchasing goods and services. These credit cards are not to be used for personal (unauthorised) purposes. Despite each cardholder being reminded annually of their obligations under the credit card policy, seven employees inadvertently utilised the corporate credit card for personal expenditure on nine occasions. Review of these transactions confirmed that they were the result of honest mistakes. Notification and full repayments were made by the employees concerned (Table 13).

Table 12: Summary of advertising for 2020–21

Summary of advertising	Amount
Advertising agencies	$0
Market research organisations	$0
Polling organisations	$0
Direct mail organisations	$0
Media advertising organisations	
Australian Diabetes Educators' Association Ltd	$135
Department of Planning, Lands and Heritage	$1,193
Facebook	$503
Your Membership.com	$1,182
Total	**$3,013**

Table 13: Credit card personal use expenditure in 2020–21

Credit card personal use expenditure	Amount
Aggregate amount of personal use expenditure for the reporting period	$274
Aggregate amount of personal use expenditure settled by the due date (within 5 working days)	$130
Aggregate amount of personal use expenditure settled after the period (after 5 working days)	$144
Aggregate amount of personal use expenditure outstanding at the end of the reporting period	$0

Disability Access and Inclusion Plan outcomes

The Disability Services Act 1993 was introduced to ensure that people with disability have the same opportunities to fully access the range of health services, facilities and information available in the public health system, and to participate in public consultation regarding WA Health services. As at June 2014, amendments to the Act require public authorities to ensure that people with disability have equal employment opportunities. CAHS ensures compliance with the Act and all other principles through the implementation of a Disability Access and Inclusion Plan. The CAHS Disability Access and Inclusion Plan (2018–2022) has been endorsed and published. The CAHS Disability Access and Inclusion Committee is responsible for its development, implementation, monitoring and evaluation, and reports to the People, Capability and Culture Executive Committee.

Access to service and events

An increased use of telehealth compared with previous years has been maintained since the rapid increase that occurred during COVID–19 lock down periods in WA. Telehealth consultations provide more flexible access to services for many families and children; especially those who find it difficult to attend all appointments face-to-face at CAHS sites.

Access to buildings and other facilities

At PCH, access to adult change facilities at all times is now possible in the Kalparrin Family Resource Centre. A Changing Places accessible bathroom is being constructed on Level 1 at PCH (near the Green lifts), and is scheduled to open in October 2021.

Access to information

CAHS consumer publications are available in alternative formats and languages on request, including large print and audio formats for patients with literacy or vision difficulties. The health service website has the capability to assist people who are hearing impaired, as well as providing details on where people can find information and make contact with services. The health service aims to achieve a minimum of level AA rating of the Web Content Accessibility Guidelines 2.0 on all internal and external websites, with clear guidelines around developing content on digital platforms.

Quality of service by staff

A new e-learning package about Disability Access and Inclusion is being tailored with input from consumers and staff on the CAHS Disability Access and Inclusion Committee. It will be updated and made available on the CAHS intranet for staff education. New staff are advised of the importance of disability access and inclusion during the CAHS corporate induction.

Opportunity to provide feedback

All staff are available to assist people with disabilities to provide feedback, with a dedicated Consumer Engagement Service also available during office hours. Comments, complaints, and suggestions may be made via the CAHS website or sent via email, and suggestion boxes are also available throughout CAHS facilities. Feedback is processed and managed through the Community Engagement Service and discussed at the Consumer Advisory Council and the Disability Access and Inclusion Committee to ensure any changes to policy or services have consumer input.

Participation in public consultation

The Disability Access and Inclusion Committee is one of several CAHS committees with members who are consumers with a disability, or parents of children with disabilities. The committee continues to act as an advisory committee for CAHS and has responsibility for the Disability Access and Inclusion Plan.

Opportunities to obtain and maintain employment

CAHS uses inclusive recruitment practices and encourages people with disability to apply for positions advertised across the organisation. CAHS is working with disability employment providers to actively recruit and employ people with disabilities, and ensure that workplaces are tailored to employee needs. People with disabilities are employed in a variety of roles at CAHS.

Record keeping plans

The *State Records Act 2000* (the Act) was established to mandate the standardisation of statutory record keeping practices for every State Government agency.

Government agency practice is subject of the provision of the Act, the standards and policies. Government agencies are also subject to scrutiny by the State Records Commission. Section 19 of the Act states that every government organisation must have a Record Keeping Plan that has been approved by the Commission.

An amended CAHS Record Keeping Plan was approved by the Commission on 26 March 2021, which provides an overarching guidance regarding our current record keeping systems, policies, practices, processes and disposal arrangements. The Record Keeping Plan identified one area for improvement that relates to establishing a comprehensive and centralised approach to the lifecycle management of inactive hardcopy records sent off-site. Progress on this area of improvement will be provided to the Commission in the next Record Keeping Plan review.

CAHS has a number of programs and training in place to orientate and provide guidance to staff on good record keeping practices. This commences with the CAHS induction and orientation program that provides new, casual and agency employees with relevant information to their employment within six weeks of commencement. The program has been updated and includes a session for *Accountability in CAHS*; a general introduction to understanding key accountabilities in terms of public sector record keeping, procurement, confidentiality and cybersecurity. The information presented references the Act and the WA Health Code of Conduct (which includes best practice records management for clinical and corporate information) and CAHS workplace-specific work practices and procedures.

CAHS staff are required to complete mandatory Department of Health Records Awareness Training (RAT) and CAHS electronic document and records management system (EDRMS) training upon allocation of a licence. A total of 634 staff completed the RAT course during the year. Due to the impact of COVID-19, alternate training delivery methods were introduced for the EDRMS training. A total of 89 staff attended classroom based training, 108 participated in virtual training sessions, and a further 20 completed one-on-one training sessions. Staff participating in training completed a training evaluation form that identifies the effectiveness of the training delivery and content. Feedback received identified a requirement for ongoing support to improve and maintain system usage. The CAHS Records and Compliance intranet site contains training resources, quick help guides, policies, procedures, work instructions and supporting information to enable staff to comply with the Act.

An internal audit conducted by KPMG in early 2020 of CAHS Corporate Records Management identified key findings relating to system access controls within the EDRMS, processes in place to manage hardcopy records, guidance available to staff regarding records management and the monitoring of compliance with relevant records practices. One recommendation relating to external storage of hardcopy records is being progressed and all other recommendations have been completed.

The CAHS Executive maintains their commitment to the continuing deployment of the EDRMS for management of all corporate records. Significant progress has been made within PCH operational and administrative areas and Child and Adolescent Mental Health Services. Ongoing deployments with Neonatology, Allied Health and Community Health are being transitioned to business as usual. A deliverable of the project has been improved monitoring and reporting of record keeping compliance within CAHS. During this reporting period, 421,188 records were captured into the EDRMS.

Health Information and Administrative Services along with the Corporate Records and Compliance team provide ongoing advisory services for the retention and disposal of records and contribute to the development of policies and procedures that result in creation and management of corporate and clinical records.

Substantive equality

CAHS aims to achieve equitable outcomes for all our patients and clients by recognising and promoting awareness of the different needs of our client groups.

In particular, CAHS addresses the unique needs of people with disabilities, Aboriginals and refugees through initiatives such as the Disability Access and Inclusion Committee (page 75), and programs directed at improving Aboriginal health (page 52) and refugee health (page 57).

Employment equity and diversity

CAHS recognises the role of an open and inclusive workplace culture where diversity is valued and the cultural backgrounds of all employees are respected. It is committed to ensuring the workforce is representative of the Western Australian community and is responsive to the diverse needs of patients and clients.

Following cessation of the whole of WA Health Equal Employment Opportunity Plan and publication of the Public Sector Commission Workforce Diversification and Inclusion Strategy, CAHS submitted its own Equal Employment Opportunity (EEO) Plan to the Director of Equal Opportunity in Public Employment in January 2021.

The EEO Plan contains targets that were developed as a part of the CAHS workforce planning base-line review. This review analysed the diversity of the workforce both in service units and health professions.

To assist with the commitment to improve Aboriginal representation in the workforce, CAHS appointed an Aboriginal Employment Coordinator in March 2021. CAHS also increased its commitment to the Aboriginal Cadetship program to six cadets. The program is a key workforce initiative aimed at attracting high-calibre Aboriginal students and assisting build a highly skilled, tertiary qualified Aboriginal workforce. It provides Aboriginal students with an opportunity to gain an income while studying full-time for an undergraduate degree qualification.

A new WA Health Aboriginal Cultural e-Learning course was released April 2021 and is mandatory for employees to complete. As at 30 June 2021, 24.3 per cent of employees had undertaken the training.

Diversity group	30 June 2020 Actual	30 June 2021 Actual	2022 Target
Women in management	65.5%	68.0%	68%
People from culturally diverse backgrounds	17.7%*	13.7%	17.8%
Aboriginal people	1.4%	1.8%	1.9%
People with disability	1.5%	1.2%	2.5%
Youth	3.1%	6.8%	3.8%

**extrapolated from responses to survey*

CAHS Multicultural Plan 2021

Western Australia is home to a growing and diverse multicultural society, and in accordance with requirements of the WA Multicultural Policy Framework, the CAHS Consumer Engagement Team worked with key stakeholders to develop the first CAHS Multicultural Plan.

The Plan outlines the strategies and actions CAHS will take to strengthen the diversity and cultural competence of our workforce, contribute to the elimination of systemic discrimination, and deliver health services that are welcoming, inclusive, and equitable for the children, adolescents, and families of WA's diverse communities. CAHS strongly values equity and strives to achieve the goals of equitable care and outcomes for all children and young people we serve, and equity of opportunity for all who work with us.

The CAHS Multicultural Plan includes 21 actions across the three priority areas of the Framework. It was submitted to the Office of Multicultural Interests in January 2021 for approval and officially launched to the health service in March.

Policy Priority 1 seeks the outcome that every Western Australian values cultural, linguistic and religious diversity and feels that they belong. One of the key actions in this area is the development of a Diversity and Inclusion Intranet Hub full of information, tools and resources related to equal opportunity, substantive equality, cultural competency, health literacy and translated health information. The CAHS People, Capability & Culture and Consumer Engagement teams are continuing to develop this space into an appealing and convenient resource to support staff development and increase the multicultural capability, awareness and understanding of our workforce.

Accessible and culturally appropriate service provision is the focus of Priority 2. The key actions for CAHS in this area include improving the ways that we collect and use our culture and language diversity data, and culturally and linguistically diverse (CALD) consumer experience data, in planning, design and improvement of services.

The third priority area seeks to ensure that Western Australians from culturally and linguistically diverse backgrounds are equitably represented in all communities and workplaces. CAHS is committed to increasing all forms of diversity across our workforce and will utilise the Public Sector Commission Equity Index tool to identify and address barriers to recruitment and retention of staff from CALD backgrounds.

Abbreviations

ACSQHC	Australian Commission on Safety and Quality in Health Care
AHT	Aboriginal Health Team
AIM	Australian Institute of Management
AMA	Australian Medical Association
CAHS	Child and Adolescent Health Service
CALD	Culturally and Linguistically Diverse
CAMHS	Child and Adolescent Mental Health Services
CDS	Child Development Service
CEO	Chief Executive Officer
ChAMP	Children's Antimicrobial Management Program
CP	Cerebral Palsy
CRHT	Community Refugee Health Team
CVAD	Central Venous Access Device
DAMA	Discharge Against Medical Advice
DMD	Duchenne Muscular Dystrophy
DSH	Deliberate Self Harm
DVA	Department of Veterans' Affairs
ED	Emergency Department
EDRMS	Electronic Document and Records Management System
EEO	Equal Employment Opportunity
EMR	Electronic Medical record
ESWL	Elective Surgery Waitlist
ETS	Emergency Telehealth Service
FBH	Footprints to Better Health
HAC	Hospital Acquired Complication
HAI	Healthcare Associated Infection
HA-SABSI	Healthcare-associated Staphylococcus aureus bloodstream infection
HREC	Human Research Ethics Committee
HSP	Health Service Provider
ICT	Information and Communications Technology
KEMH	King Edward Memorial Hospital
KPI	Key Performance Indicator
NGO	Non-Government Organisation
NHA	National Healthcare Agreement
NICU	Neonatal Intensive Care Unit
NMHS	North Metropolitan Health Service
NSQHS	National Safety and Quality Health Service
OBM	Outcome Based Management
PARROT	Paediatric Acute Recognition and Response Observation Tool
PCC	People, Capability and Culture
PCH	Perth Children's Hospital
PCL	Paediatric Consultation Liaison
PHEOC	Public Health Emergency Operations Centre
PI	Performance Indicator
PPE	Personal Protective Equipment
PSC	Public Sector Commission
RACP	Royal Australasian College of Physicians
RAT	Records Awareness Training
RHS	Refugee Health Service
RRP	Respiratory Protection Program
SAC	Severity Assessment Code
SCGH	Sir Charles Gairdner Hospital
SEHA	School Entry Health Assessment
SHICC	State Health incident Command Centre
SHR	Sustainable Health Review
SSAMHS	Statewide Specialised Aboriginal Mental Health Service
UWA	University of Western Australia
WAU	Weighted Activity Unit
WHS	Work Health and Safety
YAC	Youth Advisory Council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