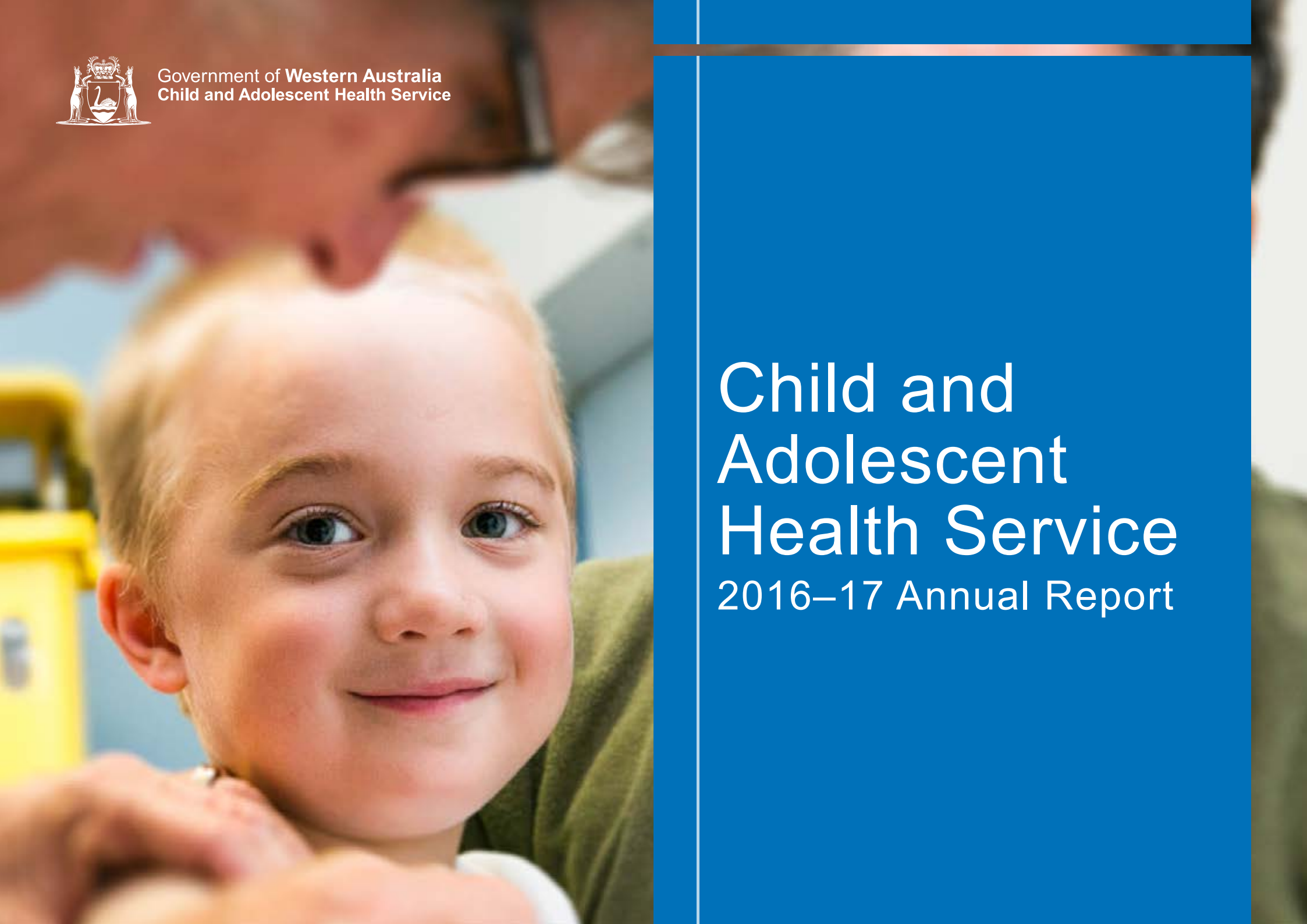

Government of **Western Australia**
Child and Adolescent Health Service

Child and Adolescent Health Service

2016–17 Annual Report

Acknowledgement of Country and People

The Child and Adolescent Health Service acknowledges the Aboriginal people of the many traditional lands and language groups of Western Australia. It acknowledges the wisdom of Aboriginal Elders both past and present and pays respect to 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.

Artist: Richard, John Olman WALLEY 2012

Statement of Compliance

HON ROGER COOK BA GradDipBus MBA MLA

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 2017.

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

Ms Deborah Karasinski

BOARD CHAIR

CHILD AND ADOLESCENT HEALTH SERVICE BOARD

27 September 2017

Mr Brendan Ashdown

BOARD MEMBER

CHILD AND ADOLESCENT HEALTH SERVICE BOARD

27 September 2017

Contents

Overview of Agency

Locations and contact

Child and Adolescent Health Service

STREET ADDRESS Roberts Road, SUBIACO WA 6008
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PHONE (08) 9340 8222 FAX (08) 9340 7000
EMAIL pmh@health.wa.gov.au
WEB www.cahs.health.wa.gov.au

Princess Margaret Hospital for Children

STREET ADDRESS Roberts Road, SUBIACO WA 6008
POSTAL ADDRESS GPO Box D184, PERTH WA 6840
PHONE (08) 9340 8222 FAX (08) 9340 7000
EMAIL pmh@health.wa.gov.au
WEB www.pmh.health.wa.gov.au

Child and Adolescent Community Health

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POSTAL ADDRESS GPO Box S1296, PERTH WA 6845
PHONE (08) 9323 6666 FAX (08) 9323 6699
EMAIL childcommunity@health.wa.gov.au
WEB ww2.health.wa.gov.au/cach

Child and Adolescent Mental Health Service

STREET AND POSTAL ADDRESS:
Level 1, 70 Hay Street, SUBIACO WA 6008
PHONE (08) 6389 5800 FAX (08) 6389 5848
EMAIL CAHSCAMHS.BusinessSupport@health.wa.gov.au
WEB ww2.health.wa.gov.au/camhs

Message from the Board

The 2016–17 year was described by one of our Board Members recently as an 'establishment year' and in many ways it was. As the inaugural Child and Adolescent Health Service (CAHS) Board established under the *Health Services Act 2016,* the Board has established many connections with stakeholder groups and received a number of presentations to develop an in depth understanding of the community to whom we provide services.

Throughout the year, the Board has maintained its focus – to ensure the best health and medical outcomes for the children of Western Australia – and has added value to the work of CAHS as described below.

The Board has overseen a number of important initiatives through its Safety and Quality Committee, Finance Committee and Audit and Risk Committee. This includes:

- agreed timelines with the Executive for the completion of serious adverse event reports and the implementation of recommendations
- undertaken detailed examinations of patient outcomes in three clinical departments, confirming that the outcomes are excellent against both national and international standards
- developed effective policies and training in the management and mitigation of clinical and non-clinical risks and compliance
- developed a higher level of rigor and accountability for financial results, including looking at benchmarking and new performance indicators
- planned for beyond the current year and looked at emerging and strategic financial risks
- linked safety and quality with financial results.

During the year, the Board initiated an independent review across Princess Margaret Hospital for Children (PMH) of safety and quality, including patient outcomes, and of the morale and engagement of clinical staff.

The Board was extremely pleased that this review found that safety and quality were not compromised and that there was "a genuine commitment to the provision of safe, high quality care to patients and families (which) is clearly evident across all levels of the organisation and staff are clearly passionate about ensuring that all children of Western Australia receive world class care."

The review did confirm, however, that there were genuine issues with the morale and engagement of staff at PMH which extended beyond that of the medical staff and the confines of PMH. The Board accepted the 21 recommendations of the review and throughout 2017–18, will work with the Executive to implement these, building and supporting an engaged workforce and fostering a nurturing and respectful culture.

I would like to thank each member of the CAHS staff for their commitment and dedication to excellence in service provision which is evident at all levels of our Health Service. This was referred to in the independent review and I have observed it and been so impressed by it, throughout my year as Chair of the Board.

I would like to thank my fellow Board Members for their considerable contribution to the work of the Board over the year and particularly thank outgoing Board Member Andrew Thompson.

I look forward to working with you all in 2017–18.

Debbie Karasinski
Chair
Child and Adolescent Health Service Board

Message from the Chief Executive

The year 2016–17 has been significant for CAHS. The establishment of the Department of Health as 'System Manager' and the subsequent transition from a centralised governance structure from 1 July 2016 to the establishment of CAHS as a separate statutory authority, governed by a Board, has necessitated a substantial cultural shift across the organisation. Since my appointment to the role of CAHS Chief Executive, I am pleased with the ongoing commitment demonstrated by CAHS staff towards ensuring that we are accountable and responsible for providing a safe and contemporary health care service for the children and young people of Western Australia.

Preparation continues towards the opening of Perth Children's Hospital (PCH) with practical completion earlier this year, marking a time to reflect on the past and future journey towards the closure of PMH. It is fair to say that the CAHS Board, CAHS staff, patients and their families undoubtedly feel a sense of frustration as a result of the unexpected delays in moving to PCH. However, in the short time I have been in the CE role I have experienced, firsthand, the dedication, commitment and perseverance of staff across a range of disciplines who are working as a team towards this important common goal. I am both proud and grateful for their sheer hard work, each and every day, to ensure that the hospital is safe and ready for its first young patients, as well as maintaining the high level of care at PMH. I would like to thank the Perth Children's Hospital Foundation (PCHF) for their ongoing support as the main fundraising body for PMH and PCH. Each year PCHF donations support thousands of children and young people who rely on our health service for care and treatment.

In March 2017, the CAHS Board commissioned a review of issues relating to the conditions, morale and engagement of staff at PMH. While the review identified specific issues, such as areas where there is a need to improve engagement with Junior Medical Officers, it also noted that these needs extend to all our staff. The review provided recommendations to the CAHS Board regarding actions to be taken to address the issues raised by staff. The Board accepted all 21 recommendations.

A number of initiatives are currently underway to address and implement the recommendations involving staff from PMH and from across the health service more broadly. I am working closely with the Board and other staff groups to ensure that all of the recommendations emerging from the review are implemented effectively and in a timely way and that we embed these changes to make CAHS a stronger organisation that continues to strive for excellence.

This year we introduced the PMH Huddle, a 15 minute stand up status report from Monday to Friday, bringing together clinical, support and corporate staff. Aiming to ensure PMH provides safe, high quality hospital care, the Huddle measures operational excellence by focusing on improvements in communication, openness, transparency, teamwork and accountability. An evaluation undertaken in April found that the Huddle is improving the management of bed occupancy, staff shortages, engagement and the patient experience.

In 2016, CAHS subscribed to Patient Opinion, a not-for-profit web-based feedback platform which enables patients and families to provide complaints and compliments about their health care experience. This new approach to patient and family engagement is gathering momentum at CAHS and we are learning a great deal about where we can improve the care and treatment that we provide to our patients and families. The increased involvement of our Consumer Advisory Council and Youth Advisory Committee has had a very positive influence on our functioning and having their Chairs join the Executive table ensures we keep our young patients and their families and carers in focus as we make decisions.

It is widely acknowledged that CAHS has a proud history of putting children and young people and their families at the centre of everything we do. I look forward to continuing to be part of a team of dedicated professionals who demonstrate our values of respect, integrity, equity, excellence and compassion towards not only our patients and families, but towards each other.

Dr Robyn Lawrence
Chief Executive
Child and Adolescent Health Service & Perth Children's Hospital Commissioning

The Health Service Board

The Child and Adolescent Health Service (CAHS) Board is the governing body of CAHS. Appointed by the Minister for Health, 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 2016–17. In this period, there were three committees of the Board: Finance, Audit and Risk, and Safety and Quality, all of which are made up of Board members.

During 2016–17, the Board comprised the following members:

Board Chair, Ms Debbie Karasinski

Ms Debbie Karasinski is the Chief Executive Officer (CEO) of disability service provider Senses Australia, and was formerly CEO of the Multiple Sclerosis Society of WA and Chief Occupational Therapist at Sir Charles Gairdner Hospital.

Ms Karasinski has a strong commitment to people with disabilities, and has worked in the health and disability sectors for the past 30 years.

Deputy Chair, Professor Geoffrey Dobb

Professor Geoffrey Dobb is Head of the Intensive Care Unit at Royal Perth Hospital and is a board member on the Australian Council on Healthcare Standards.

Former Chair of the Southern Country Health Service Governing Council, Professor Dobb has vast clinical experience and knowledge of WA Health, with an interest in safety and quality in health care.

Board Member, Dr Daniel McAullay

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. A Research Associate Professor with the Centre for Improving Health Services for Aboriginal Children, Dr McAullay's primary research areas of interest include maternal, infant and child health and primary health care, and he has specialised in Aboriginal health research.

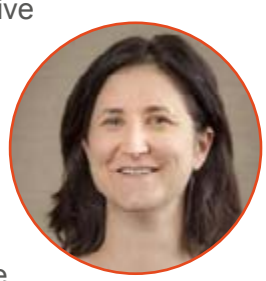
Board Member, Mr Brendan Ashdown

Mr Brendan Ashdown is an experienced lawyer specialising in civil and commercial litigation, and a PhD candidate examining the legal principles and protections relevant to children and those affected by mental health issues.

Mr Ashdown is a former member of the CAHS Governing Council and sits on the Mental Health Human Research Ethics Committee (North Metropolitan Health Service).

The Health Service Board continued

Board Member, Ms Kathleen Bozanic



Ms Kathleen Bozanic is a senior finance executive with over 20 years' experience and significant leadership roles as Partner of a leading professional services firm and as a Chief Financial Officer/General Manager of listed mining companies.

Ms Bozanic brings with her high-calibre skills in financial monitoring, accountability, performance and governance, and a keen interest in WA Health.

Board Member Mr Peter Mott

Mr Peter Mott has over 35 years of health and executive management experience that includes the role of CEO of public and private hospitals in both charitable and for-profit sectors.

Mr Mott is currently Vice President of the Australasian College of Health Service Management, WA Branch Council, and is a past President of the Australian Institute of Management WA.

Board Member, Dr Alexius Julian

Dr Alexius Julian is a highly-skilled clinician with significant experience in Information and Communications Technology (ICT) across WA Health.

In particular, Dr Julian was the Clinical Lead in the commissioning of ICT at Fiona Stanley Hospital, and has also worked as a Medical Leadership Advisor for the Institute of Health Leadership.

Board Member, Ms Linley (Anne) Donaldson

Ms Linley (Anne) Donaldson is a former Director for the Health and Disability Service Complaints Office (HaDSCO), a position that involved strategic leadership in the oversight and management of health, disability and mental health complaints. Ms Donaldson has worked in the health sector for most of her career in a range of positions, and has a depth of experience and understanding of finance, audit, and safety and quality.

Board Member, Mr Andrew Thompson

Mr Andrew Thompson has over 40 years' business and legal experience working for and advising leading Australian and international energy and resources companies. Currently Deputy Chair of the BrightSpark Foundation of WA, Mr Thompson has significant health sector board experience with extensive exposure to the health issues and challenges facing children and adolescents in WA, as well as insight into the operation of teaching hospitals.

"Thank You for taking care of Western Australia"

Vision, mission and values

Vision

We are committed to the pursuit of healthier lives for children and young people.

Values

Compassion

Equity

Excellence

Integrity

Respect

Mission

Place children, young people, families and carers at the centre of everything we do.

Deliver high quality health care in hospital and in the community.

Build partnerships to advocate and deliver care to those who need it most.

Advance internationally recognised research focused on health outcomes.

Attract exceptional staff by offering continued education, training, support and career development.

Executive summary

The 2016–17 financial year marked the first year of operations under the *Health Services Act 2016*. The new legislation allowed for the creation of five Health Service Providers (HSPs) as separate statutory authorities under Board governance.

The Child and Adolescent Health Service (CAHS) Board is legally responsible and accountable for the oversight of the acute and community services within CAHS. The Board is chaired by Ms Debbie Karasinski.

The Board members were:

Professor Geoff Dobb	Dr Daniel McAullay
Mr Brendan Ashdown	Dr Alexius Julian
Ms Kathleen Bozanic	Mr Peter Mott
Ms Anne Donaldson	Mr Andrew Thompson

The first CAHS Board meeting was held on 14 July 2016. The Board hosted a strategic planning session in February 2017 to understand and plan the future of CAHS in the context of our current values of excellence, integrity, equity, compassion and respect.

The *Health Services Act 2016* also established the Department of Health as the 'System Manager', responsible for the overall management, performance and strategic direction of WA Health. The Functional Review and Readiness Assessments supported WA Health's transition to these devolved governance arrangements by ensuring each entity is fully ready to take on these new roles to deliver a safe, high-quality, sustainable health system for all Western Australians by 30 June 2018, following the two year transition period.

A strong focus on reform has been evident across all CAHS directorates over the last 12 months. The CAHS Executive, under the leadership of Professor Frank Daly, strived to build safe, robust and sustainable acute and community service models for Western Australian children, their families and carers. The role of consumer advisory groups through the reform process has been invaluable.

PMH continued to implement the PCH operating cost model endorsed by the PCH Taskforce. The focus in the first half of 2016–17 centred on workforce reform.

Workforce initiatives were completed for administration, nursing, allied health, junior medical officers, clinical support and hotel services. This work has been critical to ensuring a sustainable workforce as we prepare to move to PCH.

Child and Adolescent Community Health completed a major redesign of the Perth metropolitan Child Development Service (CDS). The revised service model was developed in partnership with consumers to ensure that CDS is best meeting the needs of children with developmental delays. The new CDS service model includes a wide range of intervention options, and is enabling more timely and flexible services for children and families. The service redesign has significantly reduced waiting times for all major allied health disciplines.

The Child and Adolescent Mental Health Service (CAMHS) reviewed the models of care for the Acute Community Intervention Team and the Acute Response Team programs, to ensure that services could continue to meet the needs of children, young people and their families and be effective and safe. The redesign team has implemented a 'community integrated model', which incorporates the intervention and acute response functions being decentralised into community CAMHS teams.

Overall, the CAHS reform program has achieved a significant reduction in expenditure growth of 0.8 per cent, an increase in own source revenue of 5.7 per cent, a net cost of service reduction of 2.5 per cent and a reduction in full-time equivalents of 2.1 per cent (n=62).

On 20 March 2017, the CAHS Board commissioned the CAHS Review into the morale and engagement of clinical staff at PMH, led by Professor Gary Geelhoed. The review report, published on 9 June 2017, made 21 recommendations. Importantly, the PMH Review confirmed that the safety and quality of patient care had not been compromised.

Practical completion of PCH was achieved in April 2017. Significant headway has been made in the transition and commissioning programs of work, in preparation for the opening of PCH once all building issues are resolved.

In the 2017–18 year, CAHS will focus on rebuilding the relationship with the workforce, through the implementation of the PMH Review recommendations under the leadership of Dr Robyn Lawrence, appointed as the CAHS Chief Executive on 19 June 2017.

Highlights

CAHS IN NUMBERS

5,802
young people seen by CAMHS

33,105
prescriptions filled at PMH

147,870
vaccinations given

208,913
outpatients treated at PMH

27,327
PMH admissions

16,699
CACH targeted health checks for Aboriginal families

320
meals delivered to PMH patients daily

418
compliments

254
complaints

497,211
total population served by the Health Service

61,379
patients seen at PMH's emergency department

55,211
radiological appointments

27,327
hospital separations

18,843
children receiving services for development

14 per cent
decrease in wait times for community CAMHS services

108,327
universal child health checks

2016
2017

3,544
parenting groups for new parents

60,189
PMH allied health appointments

13,937
operations performed

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.

Amalgamation and establishment of Boards

- North Metropolitan Health Service Board
- South Metropolitan Health Service Board
- East Metropolitan Health Service Board
- Child and Adolescent Health Service Board
- WA Country Health Service Board
- Health Support Services Board
- Western Australian Health Promotion Foundation Board

Acts CAHS is required to comply with that are administered by the Department of Health as at 30 June 2017

- *Food Act 2008*
- *Health Practitioner Regulation National Law (WA) Act 2010*
- *Health Services Act 2016*
- *Human Tissue and Transplant Act 1982*
- *Medicines and Poisons Act 2014*
- *Radiation Safety Act 1975*

Other Acts administered by the Department of Health as at 30 June 2017

- *Anatomy Act 1930*
- *Blood Donation (Limitation of Liability) Act 1985*
- *Cremation Act 1929*
- *Fluoridation of Public Water Supplies Act 1966*
- *Health (Miscellaneous Provisions) Act 1911*
- *Health Legislation Administration Act 1984*
- *Health Professionals (Special Events Exemption) Act 2000*
- *Health Services (Quality Improvement) Act 1994*
- *Human Reproductive Technology Act 1991*
- *National Health Funding Pool Act 2012*
- *Nuclear Waste Storage and Transportation (Prohibition) Act 1999*
- *Pharmacy Act 2010*
- *Private Hospitals and Health Services Act 1927*
- *Prostitution Act 2000 (except s.62 & Part 5, which are administered by the Department of the Attorney General)*
- *Public Health Act 2016*
- *Royal Perth Hospital Protection Act 2016*
- *Surrogacy Act 2008*
- *Tobacco Products Control Act 2006*
- *University Medical School, Teaching Hospitals, Act 1955*
- *Western Australian Health Promotion Foundation Act 2016*

Acts passed during 2016–17

- *Royal Perth Hospital Protection Act 2016*

Bills in Parliament as at June 2017

- Nil

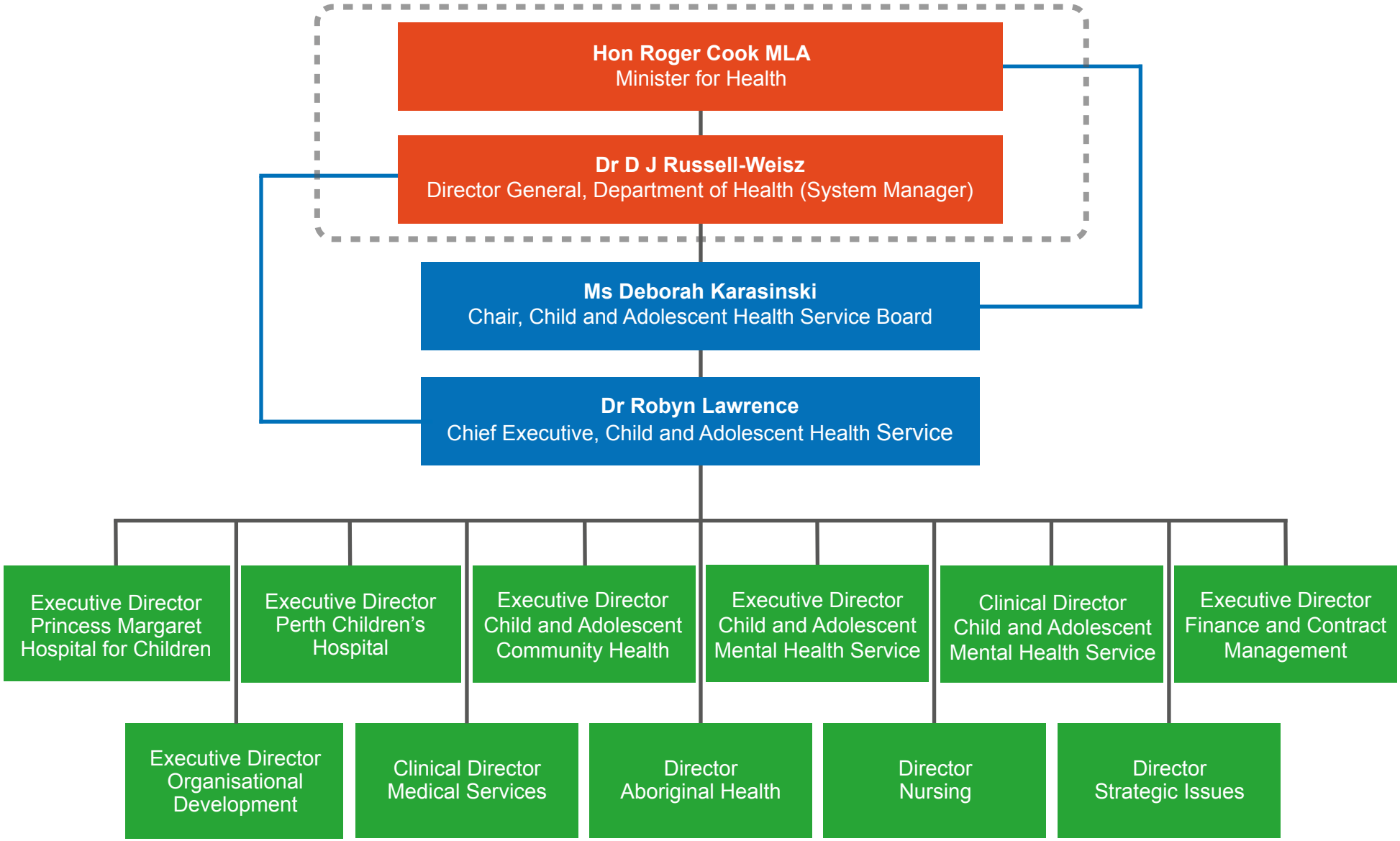
Accountable authority

The Child and Adolescent Health Service Board was the accountable authority for the Child and Adolescent Health Service in 2016–17.

Responsible Minister

The Child and Adolescent Health Service is responsible to the Minister for Health, the Hon. Roger Cook.

CAHS management structure



Senior officers

Area of responsibility	Title	Name	Period of service
Child and Adolescent Health Service	Chief Executive	Professor Frank Daly	1 July 2016 – 9 June 2017
Aboriginal Health	Director	Ms Leah Bonson	1 July 2016 – 30 June 2017
Child and Adolescent Community Health	Executive Director	Ms Lisa Brennan	1 July 2016 – 30 June 2017
Child and Adolescent Mental Health Service	Acting Executive Director	Mr Wade Emmeluth	1 July 2016 – 30 June 2017
Child and Adolescent Mental Health Service	Director of Clinical Services	Dr Caroline Goossens	1 July 2016 – 30 June 2017
Finance and Contract Management	Acting Executive Director	Mr Wayne Millen	1 July 2016 – 30 June 2017
Medical Services	Director	Dr Mark Salmon	1 July 2016 – 30 June 2017
Nursing	Acting Director	Ms Sue Peter	1 July 2016 – 30 June 2017
Perth Children's Hospital	Acting Executive Director	Dr Gervase Chaney	1 July 2016 – 30 June 2017
Princess Margaret Hospital	Acting Executive Director	Ms Michelle Dillon	1 July 2016 – 30 June 2017
Organisational Development	Acting Executive Director	Ms Erin Gauntlett	1 July 2016 – 30 June 2016
Office of the Chief Executive	Acting Director	Ms Rosie Keely	26 September 2016 – 30 June 2017

Note: As per Treasury guidelines, the definition of Senior Officer excludes any person acting in such a position for a period of three months or less.

About CAHS

CAHS provides a comprehensive service supporting the health, wellbeing and development of young Western Australians. We aim to ensure that children and young people get the best start in life through health promotion, early identification and intervention and patient-centred, family-focused care.

The Child and Adolescent Health Service is made up of:

- Princess Margaret Hospital for Children
- Child and Adolescent Community Health
- Child and Adolescent Mental Health Service
- Perth Children's Hospital Project.

Princess Margaret Hospital (PMH) is WA's only dedicated paediatric hospital and provides tertiary services for the state. This includes an extensive range of specialist paediatric medical and surgical services supported by our doctors, nurses, allied health, diagnostics, pathology and medical imaging staff. PMH will soon be closing after 108 years of service to the community of Western Australia.

Child and Adolescent Community Health (CACH) provides a comprehensive range of health promotion and early identification and intervention community-based services to children and families in the Perth Metropolitan area. Services are provided in a variety of settings including homes, local community health centres, child and parent centres and schools. CACH provides services across the Perth metropolitan area, which covers 7,250 square kilometres. CACH is also responsible for the provision of state-wide child health policies.

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

Perth Children's Hospital (PCH), located at the QEII Medical Centre in Nedlands, will replace PMH.

The new hospital will include an integrated paediatric research and education facility, and will provide inpatient, ambulatory and outpatient services, with increased bed capacity. It will also house WA's only paediatric trauma centre. All specialist services currently provided by PMH will be available at PCH, with many clinical areas expanded including an increase in neonatal and oncology capacity, an expanded Surgical Day Stay Unit and the introduction of a High Dependency Unit alongside the Intensive Care Unit.

Shared responsibilities with other agencies

Integral to the success of CAHS in delivering health services is the ability to partner with other organisations; government and non-government. In delivering care, 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
- Justice.

CAHS partners with a large number of community and non-profit organisations that make significant contributions to support our patients, clients, families and carers.

Outcome Based Management Framework

To comply with its legislative obligations, CAHS operates under the WA health system 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 2016–17 are aligned to the State Government goal of "greater focus on achieving results in key service delivery areas for the benefit of all Western Australians" (see Figure 1 overleaf).

The outcomes for achievement in 2016–17 by CAHS are:

Outcome 1: Restoration of patients' health, provision of maternity care to women and newborns, and support for patients and families during terminal illness.

Outcome 2: Enhanced health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care.

CAHS activities that are aligned to Outcome 1 and 2 are cited in Figure 2 overleaf.

Activities related to Outcome 1 aim to:

1. Provide quality diagnostic and treatment services that ensure the maximum restoration to health after an acute illness or injury.
2. Provide appropriate after-care and rehabilitation to ensure that people's physical and social functioning is restored as far as possible.
3. Provide appropriate care and support for patients and their families during terminal illness.

Activities related to Outcome 2 aim to:

1. Increase the likelihood of optimal health and wellbeing by:
    - providing programs that support optimal physical, social and emotional development of infants and children
    - encouraging healthy lifestyles (e.g. diet and exercise).

2. Reduce the likelihood of onset of disease or injury by:
    - immunisation programs
    - safety programs.
3. Reduce the risk of long-term disability or premature death from injury or illness through prevention, early identification and intervention, such as:
    - programs for early detection of developmental issues in children and appropriate referral for intervention.
    - early identification and intervention of disease and disabling conditions (e.g. screening of newborns) with appropriate referrals.
    - programs that support self-management by people with diagnosed conditions and disease (e.g. diabetic education)
    - monitor the incidence of disease in the population to determine the effectiveness of primary health measures.
4. Provide continuing care services and programs that improve and enhance the wellbeing and environment for people with chronic illness or disability, enabling people with chronic illness or disability to maintain as much independence in their everyday life as their illness or disability permits, supporting people in their homes for as long as possible and providing extra care when long-term residential care is required. Services and programs are delivered to:
    - ensure that people experience the minimum of pain and discomfort from their chronic illness or disability.
    - maintain the optimal level of physical and social functioning.
    - prevent or slow down the progression of the illness or disability.
    - enable people to live as long as possible in the place of their choice supported by, for example, home care services.
    - support families and carers in their roles.
    - provide access to recreation and education.

Performance against these activities and outcomes are summarised in the Agency Performance section, and described in detail under Key Performance Indicators in the Disclosures and Legal Compliance section commencing on page 112.

"Thank you for looking after me when I was a baby"

from Callia

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

WA Strategic Outcome (Whole of Government)

Results-Based Service Delivery: Greater focus on achieving results in key service delivery areas for the benefit of all Western Australians.

WA Health strategic intent

Vision:
To deliver a safe, high quality, sustainable health system for all Western Australians.

Priorities:

- Our strategic priorities are focused on a continuum of care to support and guide health care through integrated service delivery from prevention and health promotion, early intervention, primary care through to diagnosis, treatment, rehabilitation and palliation.
- Ensuring people in Western Australia receive safe, high quality and accessible health services underpins our strategic priorities. This includes delivering health services that are patient-centred, based on evidence and within a culture of continuous improvement.

Outcome 1

Restoration of patients' health, provision of maternity care to women and newborns, and support for patients and families during terminal illness.

Outcome 2

Enhanced health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care.

Key effectiveness indicators contributing to Outcome 1

- Percentage of patients discharged to home after admitted hospital treatment.
- Survival rates for sentinel conditions.
- Proportion of elective wait list patients waiting over boundary for reportable procedures.
- Unplanned hospital readmissions within 28 days for selected surgical procedures.
- Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition.

Key effectiveness indicators contributing to Outcome 2

- Percentage of contacts with community-based public mental health non-admitted services within seven days prior to admission to public mental health inpatient units.
- Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units.

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

Outcome 1
Restoration of patients' health, provision of maternity care to women and newborns, and support for patients and families during terminal illness.

Services delivered to achieve Outcome 1	KPIs measured
1. Public hospital admitted patients.	• Average cost per casemix adjusted separation for tertiary hospitals.
2. Home-based hospital programs.	• Average cost per home-based hospital patient day.
3. Emergency department.	• Average cost per emergency department attendance.
4. Public hospital non-admitted patients.	• Average cost per public patient non-admitted activity.

Outcome 2
Enhanced health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care.

Services delivered to achieve Outcome 2	KPIs measured
5. Prevention, promotion and protection.	• Average cost per capita of Population Health Units.
6. Contracted mental health.	• Average cost per bed-day in specialised mental health inpatient units. • Average cost per three month period of care for community mental health.

Key performance indicator results can be found in the Disclosures and Legal Compliance section commencing on page 112.

Changes to the Outcome Based Management Framework

The WA health system Outcome Based Management Framework was updated in 2016–17 to reflect the implementation of the *Health Services Act 2016* and the formation of separate Health Service Providers.

There were no changes to outcomes or services reported by CAHS in 2016–17. Not all key performance indicators previously reported by the Metropolitan Health Service remained appropriate to CAHS and have been removed. One new key effectiveness indicator is reported from 2016–17: the proportion of elective wait list patients waiting over boundary for reportable procedures.

Performance Highlights

Princess Margaret Hospital

Complex neonatal cardiac surgery

In September 2016, Princess Margaret Hospital (PMH) restarted complex neonatal cardiac surgery, enabling WA patients to receive treatment in Perth rather than travelling to the Eastern States.

For the past seven years, PMH has transferred complex neonatal cardiac cases to the Eastern States to access specialist surgeons and service infrastructure. PMH has invested time and resources to carefully develop a specialist team in order to be able to provide complex neonatal cardiac surgery to WA-based families. Having a local service saves families travelling away from home at what is already a stressful time for them. It is expected that the new service will treat between 10 and 15 patients a year.

Establishment of the 'ED pathway' for oncology and haematology patients

In August 2016, the way Ward 3B patients accessed urgent care changed. Prior to this time, oncology and haematology patients who required urgent care, phoned the ward and were asked to present straight to 3B for assessment. Through collaboration between 3B the Emergency Department (ED) and with consultation and involvement of consumers, a new pathway was developed, to better meet the needs of patients and their families. Each patient now receives a special alert card on discharge, identifying them as a 3B patient. When they need to come in for urgent assessment, they phone a dedicated helpline and if required are advised to present to ED. Upon arrival they show their card and are triaged accordingly and assessed in a dedicated area.

KKIND: Keeping Kids in No Distress

KKIND is a new way of working together for both families and PMH staff, which aims to minimise trauma, anxiety and distress caused by illness, injury and being in hospital. All patients receive universal KKIND care to help them cope with normal stress and anxiety while they are in hospital or having medical procedures. Some patients may need extra care if their distress levels are very high.

Families continue to play a big part in ensuring that their children's individual needs are being met and are provided with resources and clinical support during their stay.

New volunteers and increasingly diverse volunteer team

The PMH volunteer team has more than doubled in size this year in readiness for the move to PCH. Since January 2017, PMH has recruited more than 230 new volunteers. This group is incredibly diverse, with an average age of approximately 30. A total of 45 different languages are spoken, and one in nine are male (previously this was one in 23) as a result of new partnerships with universities across the metropolitan area. PMH supports nursing and education disciplines by providing areas in which student volunteers can gain skills to develop in their chosen careers.

Volunteers undergo training in four different volunteer roles before joining the main roster at PMH, in order to make our volunteer team more flexible. Volunteers are provided with additional training, such as universal play training and wayfinding. The volunteer team will be more visible in the evenings and at weekends as we provide more support to patients and their families.

Child and Adolescent Community Health

School Health

School health services work with school staff and parents to provide health education and health promotion; to develop health care plans for students with complex or chronic health needs; and to connect children and adolescents with other health services and supports as required. In the 2016 school year, there were more than 77,000 occasions of service in primary schools and more than 80,000 occasions of service in high school settings.

The recruitment of additional School Health Nurses has contributed to significant improvement in the number of Kindergarten children receiving a universal School Entry Health Assessment (SEHA). In 2016, 94.8 per cent of Kindergarten children received a SEHA, up from 92.1 per cent in 2014. The SEHA completion rate has consistently exceeded the target rate of 90 per cent.

Child Development Service redesign

In 2016–17, the Perth metropolitan Child Development Service (CDS) completed a major redesign of the service. The revised service model was developed in partnership with consumers to ensure that CDS best meets the needs of children with developmental delays and their families. The CDS redesign focused heavily on service planning, with clinical intake meetings being replaced with individual service planning appointments.

The CDS service model now includes a wide range of intervention options which enables the service to provide more timely and flexible services for children and families, with waiting time reductions maintained for all major allied health disciplines. Waiting times for CDS allied health services are approximately three to five months. This represents a 50 per cent reduction in comparison with 2015–16.

Child Health reform

Based on the recommendations of the WA Metropolitan Birth to School Entry Universal Health Service Delivery Model Review (2015), improvements have been successfully implemented across state-wide community child health services to better meet the needs of all families. Key changes include:

- an updated universal child health contact schedule (0–14 days, 8 weeks, 4 months, 12 months, 2 years and school entry).
- greater flexibility for families through increased drop-in and group sessions.
- improvements in the health check assessment protocols, including use of a more robust parent ages and stages questionnaire for identification of developmental delays.
- targeted individual and group sessions to support families with additional needs.
- an updated Performance Reporting Framework for community child health.

Immunisation

Child and Adolescent Community Health (CACH) delivers a 0–4 year old immunisation service across the Perth metropolitan area and is currently undertaking mapping to ensure services are best placed to reach those in need. CACH also delivers a school-based program encompassing Gardasil (HPV), Varivax (Chicken Pox) and Adacel (Diphtheria Tetanus & Pertussis) vaccines and currently services 152 high schools across the Perth metropolitan area. By the end of 2016, CACH had delivered 72,663 individual vaccines.

In term two of 2017, CACH started the Meningococcal W campaign for high school students in years 10, 11 and 12 across the Perth metropolitan area. The numbers of schools have been increased to include all the senior secondary colleges across the metropolitan area. The majority of vaccinations started in term three for this program. During May and June 2017, CACH school-based teams have vaccinated 2,900 students.

In 2016–17 CACH delivered a total of 147,870 vaccinations in the 0–4 and school-aged immunisation services.

Aboriginal Health

The CACH Aboriginal Health Team (AHT) delivers the Enhanced Aboriginal Child Health Schedule (EACHS) to families who are concerned, at risk, or families who choose to receive services from the AHT. The AHT helps families to raise healthy children by providing the community with child health information and empowering parents to build on the knowledge they have of their children.

State Government funding under the WA Footprints to Better Health Initiative (FBH) enables the AHT to deliver additional services within the Local Government Areas of Joondalup and Wanneroo in the North Metropolitan Area and Gosnells and Armadale in the South Metropolitan Area. Within the Armadale and Kelmscott Shire, the AHT delivers a successful, culturally appropriate and secure Aboriginal Ear Health Clinic. Funding from Rural Health West has enabled the AHT to secure the services of an ear, nose and throat specialist. The clinics are delivered by two nurses (who are of Aboriginal descent) and who have built an excellent rapport with the community, resulting in 100 per cent of referred families attending the clinic this year.

Child and Adolescent Mental Health Service

Implementation of improvement initiatives at Inpatient Unit

The Child and Adolescent Mental Health Service (CAMHS) Inpatient Unit (IPU) has made significant progress against more than 700 action items on their 'IPU Project Plan'. The purpose of this plan is to ensure that the inpatient service transitions to Perth Children's Hospital (PCH) effectively and efficiently. The project plan incorporates recommendations from:

- clinical incidents at the IPU
- performance check and improvement processes across the CAMHS acute services
- suggestions from consumers, carers and families
- operational planning for transition to PCH.

Key achievements to date include:

- implementation of a new recovery focused, trauma informed, patient and family-centred model of care. The model of care is guided by the newly affirmed mission statement, vision and values which have been developed by the IPU team.
- the development of seven clinical packages providing guidance for clinicians in the delivery of evidence-based mental health care for young people presenting with psychosis, depression, emerging personality disorder, anxiety and young people who require medication review, diagnostic clarification or crisis prevention.
- implementation of the Safewards model. Safewards was developed in the United Kingdom by Professor Len Bowers and colleagues. It specifically examines events known in the model as 'conflicts' (events that threaten staff and patient safety, such as self-harm, suicide, aggression, absconding) and 'containments' (things staff do to prevent or reduce harm to staff and patients, such as increased observation, use of extra medication, use of restrictive interventions). The Safewards model offers 10 interventions that are designed to reduce the risk of conflict and containment events occurring. To date, the CAMHS IPU has implemented six of the 10 interventions.
- establishment of and recruitment to a range of new positions.
- development of an extensive staff training program.
- implementation of a furnished sensory modulation room and training staff in sensory modulation.
- redesign of the 'My Recovery Plan' in response to feedback from young people and the development of an accompanying clinician training package.

The IPU presented this plan at the Towards Elimination of Restrictive Practices 11th National Forum.

Realignment of Acute Community Intervention Team and Acute Response Team

CAMHS formed a design team to review the existing models of care for the Acute Community Intervention Team (ACIT) and Acute Response Team (ART) to ensure these services continue to meet the needs of children, young people and their families.

The review incorporated an analysis of demand, feedback from consumers, carers and stakeholders, and focused on maximising the use of clinical capacity, improving equity of access and reducing service transition points. A 'community integrated model' was developed, which involved the acute response and intervention functions of these teams being decentralised and devolved into community CAMHS teams. The new model was successfully implemented on 3 January 2017 and has resulted in improvements in access, care closer-to-home and the removal of transition points and duplication of assessments; all of which are important to children and families.

Aboriginal community engagement and mental health initiatives implemented at Armadale

The Armadale CAMHS Aboriginal Mental Health Worker has led the Armadale Community CAMHS team in implementing a number of initiatives designed to improve access and engagement for Aboriginal young people in the local area.

These include:

- participation in the Armadale Aboriginal Workers Networking Group.
- co-facilitation of a Life Skills for Year 7 and 8 Aboriginal girls considered to be at risk.
- production of a booklet of Aboriginal 'Grandparents' Stories' that has been published and distributed to local schools to promote social and emotional learning.
- establishment of a bi-monthly Aboriginal Grandparents and Elders morning tea.
- supervision of Aboriginal Mental Health Worker Practicum Students.

These initiatives have proved extremely successful at increasing access and engagement for Aboriginal children, young people and families at Armadale CAMHS.

Aboriginal Health Services

The Child and Adolescent Health Service (CAHS) continues to support and invest in the delivery of culturally safe services and programs that seek to close the gaps in health and wellbeing of Aboriginal people.

In 2016–17, CAHS delivered a range of programs aimed at improving the best possible outcomes for patients and clients, such as:

- **Koorliny Moort 'Walking with Families'** – Provides out of hospital care to Aboriginal families who might find it hard to come into hospital for their appointments or who want to stay closer to home.
- **Healthy Kulungas (children)** – A lifestyle program for Aboriginal families experiencing weight related health issues and/or weight related health complications for a child in the family.
- **Aboriginal Liaison Hospital Services** – Provides cultural and practical support and advocacy to children and families identified as most vulnerable within the hospital or community setting.
- **Aboriginal Health Team CACH: EACHS** – Enhanced Aboriginal Child Health Schedule. Involves Community Health Nurses working alongside Aboriginal Health Workers to provide a comprehensive and culturally acceptable primary health care service designed specifically to address the needs of Aboriginal families.
- **Aboriginal Mental Health Services: 'Warlang Nyit Wirrin, Moorditj Koorlangaka's "Healthy little spirits make good strong children and adolescents"** – Provides cultural support and advocacy for Aboriginal infants, children and young people under the age of 18 and their families in accessing CAMHS mental health services.
- **'Kulunga Moort Mia': Children and family place** – A lounge area at PCH provides a culturally sensitive relaxing retreat for families accessing the hospital, away from busy clinical environments.

CAHS has an ongoing commitment to cultural learning, with 85 per cent of staff having completed the cultural e-learning program. A number of Aboriginal publications have been developed to further assist staff with their learning and engagement with Aboriginal patients, their families and communities.

Significant events such as NAIDOC week continued to be celebrated across our services.

Research highlights

Child health research at CAHS enables researchers in CAHS and our partner organisations to perform research of the highest quality that will translate into improvements in overall health for children and young people.

Current ongoing research activity in CAHS to 30 April 2017

Interventional clinical trials	
137 studies	13,943 participants
Observational studies	
116 studies	36,405 participants

Clinicians in CAHS are involved in a number of National Health and Medical Research Council Centres of Research Excellence to improve outcomes for premature infants, children with diabetes, cerebral palsy, food allergies, ear infections, rheumatic heart disease, fetal alcohol spectrum disorder, neurological disorders and to improve health services in emergency medicine and for Aboriginal and Torres Strait Islander children. Researchers at CAHS have published more than 330 scientific publications in the last 12 months.

The Child Health Research Strategic Council was formed in 2016 to provide leadership in child health research across PCH, Telethon Kids Institute (TKI) and partner universities and initiate collaborative strategies to:

- support and encourage opportunities for collaboration between research and clinical service delivery.
- ensure that an optimal environment is provided for world class research, including facilities, training, research support and other resources as appropriate.
- support academic and clinical appointments to maximise the positioning of PCH as a premier academic child health centre.
- oversee the activities of the research facilities at PCH and within CAHS.

CAHS is developing a strong research culture across the organisation by:

- recognising that research strengthens clinical practice.
- supporting departments to develop a research culture and appropriate infrastructure.
- encouraging and providing resources for early career medical, nursing and allied health staff to undertake research as part of their practice.
- prioritising research experience as part of staff selection.

During 2016–17, work has focused on strengthening research ethics and governance processes, including the development of a condensed approval process for low-risk projects and better database systems for research projects.

In 2017, CAHS partnered with TKI and received a grant to further enhance governance and support researchers to navigate the processes that are required.

Like the work undertaken in services, there has been an increased focus on community engagement in the research area. At PCH, there will be a dedicated research facility within the outpatient area and a more formal process for identifying families who are interested in being involved in research.

Statement from the Consumer Advisory Council Chair

"Change is hard at first, messy in the middle and gorgeous at the end." – Robin Sharma

At the end of my second year as Chair of the CAHS Consumer Advisory Council (CAC), I think this quote embodies the turbulent year the service has experienced. It has been a year that saw several members of CAC move onto different things, and new members join.

To all those who have left, I would like to acknowledge their hard work, passion and the dedication they have shown in working with the health service to improve the experience of patients, clients and their families. I would like to welcome new members to CAC and wish them the best for their journey. CAC can be challenging, with frustration and reward sitting side by side.

This year has seen CAC grow in responsibility and focus. Our profile has increased across the service and we have been asked to review policy, workflows, and documents in an increasing number. Projects have included all aspects of the health service at PMH, CACH, CAMHS and PCH. Members have had roles on the Safety and Quality Committee, Infection Control Committee, Wayfinding Working Group, the Consumables and Parking Working Group, a communications committee, the Discharge Summary Working Group, transition planning and PCH commissioning.

Members have also been involved in root cause analysis reviews with clinical incidents; a first for the service and a way to provide valuable consumer insight into a review process specifically designed to improve patient safety and quality.

CAC has faced several challenges with a new board structure and Executive staff, the change has brought uncertainty on the evolving role of consumer engagement but I am hopeful the process can continue and a consumer voice can be heard at the highest level of the organisation. I am optimistic that CAHS can embrace cultural change and truly welcome a consumer partnership approach throughout; from the ward and community centre to the board room.

I would like to acknowledge the support and guidance of the Health Service Executive Committee and the staff of the Child and Family Engagement Service who work tirelessly to support the CAC and all families using services within CAHS.

Amanda Magraith

Chair
Consumer Advisory Council

"Dear PMH, thank you for saving kids' lives and thank you for helping my sister who has club foot"

Paige

Statement from the Youth Advisory Committee Chair

The Youth Advisory Committee (YAC) has had another successful year, boasting the largest number of members YAC has ever seen. The addition of new members has developed the YAC to be a dynamic and enthusiastic group, determined to improve services for Western Australian children and families.

Over the past 12 months, YAC has focused on a number of important issues within PMH, PCH, CAMHS and CACH. YAC has maximised our impact by having representation on a number of additional working groups, committees and project teams.

We are actively involved in the development of the Child Safe Organisation Strategy, encouraging every WA Health Service Provider who engages with young people to recognise their needs within a safe and comfortable environment. It has also been a priority of the YAC to ensure services have the correct procedures implemented when handling a complaint or concern from a young person.

Our profile has been recognised by the Department of Health as we have recently been asked to join the working and writing group for the creation of a WA Youth Health Policy.

The continued support from the Health Service Executive Committee (HSEC) has ensured the “little voices” of the health service have been heard. Our seat at the HSEC table has assisted with providing a youth perspective and ensuring young people are always considered in important decision making.

We have enjoyed being a part of the PCH Project and as a committee have also felt a number of the ongoing frustrations and challenges. The new hospital has provided YAC with a number of exciting new opportunities that we have enjoyed testing and reviewing.

YAC would like to thank and acknowledge the ongoing support of HSEC and the Child and Family Engagement Service for another year of dedication and commitment.

YAC continues to be about the kids doing it for the kids; making it a unique asset for our health service.

April Welsh

Chair
Youth Advisory Committee

Statement from the Disability Advisory Committee Chair

The Disability Advisory Committee (DAC) has had a number of achievements this year that have resulted in improved access to existing services at CACH, CAMHS and PMH; as well as ensuring appropriate access and inclusion of people with disabilities at PCH.

In preparation for the move to PCH, DAC has provided vital input into a number of issues to ensure appropriate access to a range of facilities, services and technologies. This includes access to adolescent change tables 24 hours a day, seven days a week; adequate parking facilities including options for a chariot to transport patients from car parking to the hospital where required; participation in testing and contributing to the design of new technologies such as the patient meal ordering system and the patient entertainment system; and access to a range of on-site facilities such as the vending machine and security door access.

During the year, CAHS implemented another important initiative to obtain feedback on our services; Patient Opinion is an independent platform managed by a non-government organisation where people can tell their story about their experience of the health service. DAC provided important feedback regarding the format and presentation to ensure that people with vision impairments can access the information.

Another key initiative has been initiating discussion and obtaining support to develop a patient passport that will be used by patients and families to provide staff with key information about a child's needs and preferences. This provides clinicians with critical information that they might not otherwise be aware of and helps them to work in partnership with the child and family when providing care. Passports have been introduced in a number of countries and have a range of benefits, including reduced stress for patients and families, a more positive overall patient experience and improved quality of care.

I would like to thank all members of the committee for their input and contribution throughout the year. In particular I would like to acknowledge the consumer representatives for their time and dedication as well as their generosity in sharing their own personal experiences in order to improve the outcomes for all children with disabilities.

In closing, I would like to reflect on our organisation values; excellence, equity, compassion, integrity and respect. Without a strong consumer voice at all levels of the organisation we are unable to truly deliver on any of these. Thank you for your support in our pursuit to ensure that we always deliver on these commitments.

Erin Gauntlett

Chair
Disability Advisory Committee

Agency Performance

Financial targets

	2016–17 Target $000	2016–17 Actual $000	Variation $000
Total cost of services (expense limit) (sourced from Statement of Comprehensive Income)	567,109[1]	555,097	(12,012)[2]
Net cost of services (sourced from Statement of Comprehensive Income)	339,408[1]	345,439	6,031[2]
Total equity (sourced from Statement of Financial Position)	1,421,219[1]	217,910	(1,203,309)[2]
Net increase / (decrease) in cash held (sourced from Statement of Cash Flows)	(728)[1]	12,221	12,949[2]
Approved salary expense level	363,949	372,880	8,931

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

(2) The unexpected deferment in the opening of the Perth Children's Hospital was the main reason for the variations for total cost of services, net cost of services, total equity and net increase / (decrease) in cash held. The expense target (total cost of services) did not include the services received free of charge from Health Support Services ($28.168 million) and North Metropolitan Health Service - PathWest ($6.005 million). Further explanations are contained in Note 56 'Explanatory statement' to the financial statements.

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 the resourcing and delivery of services to the community. Efficiency indicators monitor the relationship between the service delivered and the resources used to produce 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 2016–17 targets is given in Table 1 (overleaf).

Note: Table 1 should be read in conjunction with detailed information on each key performance indicator found in the Disclosures and Legal Compliance section of this report.

Table 1: Actual results versus KPI targets

Key performance indicator	2016–17 Target	2016–17 Actual	Variation	Further info
Percentage of patients discharged to home after admitted hospital treatment (0–39 years)	99.8%	99.8%	0%	p. 113
Survival rates for sentinel conditions (0–49 years) • Stroke • Acute Myocardial Infarction	 95.3% 99.5%	 100% N/A	 4.7% N/A	p. 114
Proportion of elective wait list patients waiting over boundary for reportable procedures • Category 1 (≤30 days) • Category 2 (≤90 days) • Category 3 (≤365 days)	 0% 0% 0%	 0.4% 0.1% 0.0%	 0.4% 0.1% 0.0%	p. 115
Unplanned hospital readmissions within 28 days for selected surgical procedures (per 1,000) • Knee replacement • Hip replacement • Tonsillectomy & Adenoidectomy • Hysterectomy • Prostatectomy • Cataract Surgery • Appendectomy	 22 21 71 47 34 1 39	 N/A N/A 74.6 N/A N/A 0 45.2	 N/A N/A 3.6 N/A N/A -1 6.2	p. 116
Rate of unplanned readmissions within 28 days to the same hospital for a mental health condition (per 1,000)	66	18.6	-47.4	p. 117
Average cost per casemix adjusted separation for tertiary hospitals	$7,280	$7,615	$355	p. 118
Average cost per home based hospital patient day	$583	$1066	$483	p. 118
Average cost per emergency department attendance	$566	$607	$41	p. 119
Average cost per public patient non-admitted activity	$345	$436	$91	p. 119
Percentage of contacts with community-based public mental health non-admitted services within seven days prior to admission to a public mental health inpatient unit	70%	86%	16%	p. 120
Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units	75%	72.9%	-2.1%	p. 121
Average cost per capita of Population Health Units	$236	$225	-$11	p. 122
Average cost per bed-day in specialised mental health inpatient units	$2,857	$4,346	$1,489	p. 122
Average cost per three month period of care for community mental health	$4,991	$3,561	-$1,430	p. 123

Results listed as N/A (not available) are due to zero cases having been treated.

Improvements towards emergency department access

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

With the increasing demand on EDs and health services, it is imperative that health service provision is continually monitored to ensure the effective and efficient delivery of safe high-quality care.

Percentage of emergency department patients seen within recommended times

When patients first enter an ED, they are assessed by specially trained nursing staff on how urgently treatment should be provided. The aim of this process, known as triage, is to ensure treatment is given in the appropriate time, and should prevent adverse conditions arising from deterioration in the patient's condition.

The triage process and scores are recognised by the Australasian College for Emergency Medicine, and is recommended for prioritising those who present to an ED. Patients are 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).

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%

Measuring this indicator permits changes over time to be monitored to assist managing the demand on ED services and assess the effectiveness of service provision. This can enable the development of improved management strategies that ensure optimal restoration of patient health.

In 2016–17, the targets set for patients to be seen within the recommended time were met or exceeded for the highest categories of 1 and 2, and also for Category 5 (see Table 3). These annual results are affected by factors such as high winter demand, the total number of cases, and the timing of presentations. For instance, it is not unusual to have 24 presentations in one hour, which can make it difficult to achieve the targets consistently.

Table 3: Percentage of Child and Adolescent Health Service emergency department patients seen within recommended times, by triage category, 2016–17

Triage category	2016–17	Target
1	100%	100%
2	89.7%	80%
3	61.6%	75%
4	59.5%	70%
5	95.1%	70%

Clinical incidents

Learning from clinical incidents

CAHS embraces a culture of learning and recognises that health care will never be risk free. Learning from clinical incidents is an integral component of the safety and quality culture across the service as we aim for zero harm. To this end, CAHS strives to drive behaviour that creates an environment in which excellence in clinical care flourishes and is maintained through commitment to collaboration, transparency, disclosure, courage, learning and compassion. Safety is fundamental to a positive patient, client and family experience.

Staff across CAHS are encouraged to use the clinical incident management system to record clinical incidents and near misses in the inpatient, outpatient and community settings for children using our acute care, mental health and primary care services.

A Severity Assessment Code (SAC) is assigned to prioritise clinical incident investigations. Incidents or near misses where serious harm or death is, or could be, specifically caused by health care, rather than the patient's underlying condition or illness, are given the highest category of SAC 1.

CAHS has provided nationally recognised training in Root Cause Analysis in 2016–17 to increase the number and skill of the clinical and consumer investigators. This ensures well-trained investigators are available to promptly review and make recommendations on SAC 1 events.

Monthly reports are provided to all levels of the organisation and the Board to identify trends or areas of concern that may warrant a system-wide approach. This assists monitoring and ensuring accountability for patient safety.

SAC 1 incidents 2016–17

SAC1 incidents	Number
Total notified:	26
Investigated	23
Ongoing investigation	3
Declassified*	3
Total confirmed:	20
Confirmed with patient outcome of death	1
Confirmed with patient outcome of serious harm	6
Confirmed with patient outcome of moderate harm	4
Confirmed with patient outcome of minor harm	5
Confirmed with patient outcome of no harm	4

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

"Thank you for looking after me and my little sister Matilda"

Love Amelia xx

Clinical incident case study

Background

A young child with complex health issues was initially referred and admitted to Princess Margaret Hospital for further assessment and treatment before discharge home with scheduled outpatient follow-up appointments. Following a lengthy planned re-admission, the patient was discharged with a Continuous Positive Airway Pressure (CPAP) machine for use at home, with ongoing outpatient clinic appointments scheduled to monitor progress.

Incident

The CPAP machine provided for use at home was expected to be used daily for eight hours or more. As it was not brought in to appointments, data from the machine could not be obtained to monitor the child's progress. When the machine was returned, it was discovered it had only been used about 30 per cent of the total days since discharge, and on average the machine had only been used for about two hours each day.

Findings

The review panel determined there was poor communication between the health professionals and the family, and incomplete information and education on the CPAP machine was provided to the family. This may have contributed to less than ideal use of the CPAP machine. A requirement to bring the CPAP machine in for outpatient appointments for monitoring could have identified the problem earlier.

Outcomes

1. CPAP machines that permit remote monitoring of high-risk patients have been purchased.
2. Existing family educational resources have been revised and a standardised family competency framework has been implemented, including a competency assessment checklist.
3. Standardised non-invasive ventilation clinical practice guidelines for staff are being developed, which will be used in conjunction with the family competency framework. This will enable staff to provide the required education to family to care for and monitor the child in the home.

Significant Issues

Culture and morale

It is widely acknowledged that the culture of any organisation and the morale of the people working there are inextricably linked to an organisation's success. The values, motivation, and personal goals of staff are integral components in creating a positive culture where staff feel valued and enjoy the work they do. In healthcare environments in particular, embedding and maintaining a positive work environment is an essential element in ensuring patient safety and wellbeing. Unquestionably, healthcare organisations can be difficult places to be for patients and families who are often at their most vulnerable. We know, however, that patients and their families feel safer and are more trusting of the health care service when the staff caring for them are meaningfully engaged with the values of the organisation and are happy at work. We also know that patients and families are far more likely to ask questions and become actively involved in their health care when the people caring for them feel valued and respected. The Child and Adolescent Health Service (CAHS) Board recognises that staff morale and engagement are critical to patient safety and the effective functioning of Princess Margaret Hospital (PMH) and are crucial factors in the success of Perth Children's Hospital (PCH). Within this context, the Board is committed to ensuring that CAHS is a rewarding and positive place to work and that our patients and their families have the best possible experience during their journey with us.

Delay in the move to Perth Children's Hospital

The delay in moving to PCH has been widely publicised in the media over the last 12 months. The continuation of the CAHS PCH Project had been a significant cost to the State. The Acting Executive Director PCH has regularly reviewed and changed the project structure and workforce profile to meet the changes in project scope.

Practical completion was accepted by the WA Government in April 2017; however the water quality at the new hospital continues to be a high profile issue directly impacting on confirmation of a move date.

The ageing infrastructure at PMH has required urgent minor works and maintenance to be undertaken to ensure all services can continue to operate safely and efficiently.

An area of priority has been the maintenance and upgrade to the lifts and the Department of Health has funded an on-site resource to respond to lift failure in a timely manner.

The delay in the opening of PCH has meant that the mental health inpatient unit has continued to operate from the Bentley Adolescent Unit (BAU) for far longer than intended. In the absence of a confirmed opening date for PCH, capital works were undertaken to reopen seven inpatient beds in March 2017.

Ageing community infrastructure

A number of community facilities used by Child and Adolescent Community Health (CACH) and the Child and Adolescent Mental Health Service (CAMHS) are poorly located in relation to the population they serve, are not fit for purpose and do not comply with the Building Standards.

CACH faces a constant threat of insecure tenure with mounting pressure to vacate a number of government facilities that have been previously provided free of charge. In the last five years, CACH has been evicted from five sites and is vacating another three sites in 2017/18.

There is no funding for alternative premises. In addition, there is an expectation of some Local Governments to achieve commercial (or near commercial) rents for facilities that CACH leases, which represents a further funding challenge for CACH and impacts the sustainability of the service.

A comprehensive statement of need identifying strategic facility requirements was developed and work is underway toward the preparation of a submission to Treasury to seek financial support for strategic infrastructure needs.

Demand and activity

Overall CAHS has achieved the activity targets set for 2016–17. The stabilisation in activity can be attributed to the increased capacity of paediatric services developed at Fiona Stanley Hospital, Midland Health Campus and Joondalup Health Campus in the State Health Infrastructure Plan.

PMH has strengthened clinical governance and reporting capability across non-admitted services. Allied health services have developed access criteria. Improvements will be realised in the coming year with ongoing review of clinic profiles and productivity, improved access to and quality of wait list data and effective measures to address non-attendance being implemented.

There has been a 17 per cent increase in the number of births in metropolitan Perth in the four years to 2016–17, contributing to a continuing demand for CACH services. In CACH, the population of children aged 0–4 years is forecast to increase by 23 per cent from 2016 to 2026. The total number of children and young people aged 0–14 years is forecast to increase by 25 per cent.

Community CAMHS has undertaken a system wide reform process aimed at maximising efficiency which has resulted in more children and young people being seen. Following the full implementation of the Choice and Partnership Approach model, 3,385 children were assessed and treated, which is 1,062 more than the corresponding period prior to commencement of implementation. This has been achieved with the same level of resourcing. In addition, there has been a reduction in referral to first appointment times from an average of 50 to 20 days.

Workforce challenges

CAHS embarked on an ambitious reform agenda in 2016 to develop safe, robust and sustainable health services. There was a net reduction in the workforce of 62 Full-time Equivalent (FTE) employees in the financial year.

CAHS engaged Press Ganey, a company experienced in patient experience measurement and performance to undertake the 'Voice of Family' and 'Voice of Staff' surveys.

Survey findings identified two key areas for improvement for the workforce: communication and recognition and respect. Each directorate has developed an action plan for implementation over the coming year.

Recruitment and retention of Junior Medical Officers (JMO) for PMH for 2017 presented some challenges, with the implementation of the new workforce model.

The workforce requirements have been revised for 2017–18 with increased resources being allocated to accommodate JMO leave and professional development.

CACH completed the recruitment of more than 160 new child and school health nurses into child and school health services. Graduate nurses have completed the Transition to Community Health Practice Program, which was offered for the first time in 2016. This program was introduced as part of a service wide recruitment and retention strategy, to allow nurses who have completed the academic specialisation in child and adolescent health nursing (or its equivalent) to consolidate their clinical practice in a supportive environment.

Managing funding and costs efficiently

Overall, CAHS contained costs over the last financial year with only 0.8 per cent increase in total expenditure. In addition, own source revenue increased by 5.7 per cent and the cost of service reduced by 2.5 per cent.

The CAHS Finance Oversight Committee, chaired by the Chief Executive, has developed an increased knowledge and understanding of activity based funding and management, managing funding reform and financial management across the Executive group. This is being shared with managers across CAHS to support departmental accountability and responsibility.

Directorate specific budget reduction strategies have been identified to achieve targets and we will build on this in future years.

During 2016–17, CACH undertook comprehensive workforce affordability modelling across the nursing workforce.

This strategy has been used in conjunction with ongoing monitoring of FTE and payroll expenditure, leading to a better understanding of budgetary pressures and improved budget oversight.

CAMHS has reached an agreement with the Mental Health Commission for inpatient services to receive annual funding of $12.26M under a per diem funding model based upon a bed occupancy of 80 per cent.

Health inequalities

Disability services reform across WA, driven by the National Disability Insurance Scheme, requires close collaboration with CAHS, the Disability Services Commission, other government agencies and non-government organisations, to ensure that consumer pathways are well articulated and accessible.

Children with autism and intellectual disability have a higher incidence of mental health difficulties compared with the general population (36 per cent compared with 8 per cent). CAMHS is a key participant in the Young People with Exceptionally Complex Needs initiative which includes children with complex mental health needs and intellectual disability and autism. A senior CAMHS clinician also founded and chairs an Intellectual Developmental Disabilities and Mental Illness special interest group.

The disparity in health outcomes of Aboriginal and Torres Strait Islander children compared to the remainder of the Australian population is well-documented. The reasons for this disparity are complex and multifactorial. Services to Aboriginal children and adolescents are delivered through our primary, secondary and tertiary health care facilities across CAHS. Community health services provided by CACH to Aboriginal children and adolescents were mainly provided through the Aboriginal Health Team ensuring culturally appropriate services.

PMH delivers Koorliny Moort ('Walking with Families'), an Aboriginal care coordination program to bridge the gap in providing services for children who need hospitalisation and out-of-hospital services.

Aboriginal mental health services are provided through the community and acute CAMHS services across the metropolitan area.

"When I grow up I'm going to be a cricket player"

Alfred

Disclosures and Legal Compliance

Auditor General

INDEPENDENT AUDITOR'S REPORT

To the Parliament of Western Australia

CHILD AND ADOLESCENT HEALTH SERVICE

Report on the Financial Statements

Opinion

I have audited the financial statements of the Child and Adolescent Health Service which comprise the Statement of Financial Position as at 30 June 2017, the Statement of Comprehensive Income, Statement of Changes in Equity, Statement of Cash Flows for the year then ended, and 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 2017 and the financial position at the end of that period. They are 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 and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (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.

Responsibility of the Board for the Financial Statements

The Board is responsible for keeping proper accounts, and the preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions, and for such internal control as the Board 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 agency's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and 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.

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Auditor's Responsibility 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.

As part of an audit in accordance with Australian Auditing Standards, I exercise professional judgment and maintain professional scepticism throughout the audit. I also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. 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.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the agency's internal control.

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.

- Conclude on the appropriateness of the Board's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the agency's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report.

- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Report on Controls

Qualified 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, except for the possible effects of the matter described in the Basis for Qualified Opinion paragraph, 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 2017.

Basis for Qualified Opinion

Controls over medical practitioners' treatment charges were deficient as there were inadequate procedures in place to ensure that all revenue associated with the medical practitioners' treatment of chargeable patients has been brought to account. As a result, I was unable to determine whether all patient charges that should have been billed, were billed.

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 the controls, necessary to achieve the overall control objectives, were implemented as designed.

An assurance engagement to report on the design and implementation of controls involves performing procedures to obtain evidence about the suitability of the design of controls to achieve the overall control objectives and the implementation of those controls. The procedures selected depend on my judgement, including the 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 the controls are in operation, the overall control objectives may not be achieved so that fraud, error, or noncompliance 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 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 2017. The key performance indicators are the key effectiveness indicators and the 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 2017.

Matter of Significance
Emergency Department Waiting Times
The Under Treasurer approved the removal of the following indicator as an audited key performance indicator (KPI):

- Percentage of Emergency Department patients seen within recommended times (by triage category).

The approval was conditional on its inclusion as an unaudited performance indicator in the Annual Report and that it be reinstated as an audited KPI following the implementation of a new Emergency Department data collection system. A new system had not been developed at 30 June 2017. Consequently, the KPI has not been included in the audited KPIs for the year ended 30 June 2017. My opinion is not modified in respect of this matter.

The Board's Responsibility 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 as the Board determines necessary to enable the preparation of key performance indicators that are free from material misstatement, whether due to fraud or error.

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

Auditor General's Responsibility
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 agency'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.

Matters Relating to the Electronic Publication of the Audited Financial Statements and Key Performance Indicators

This auditor's report relates to the financial statements and key performance indicators of the Child and Adolescent Health Service for the year ended 30 June 2017 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 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 or key performance indicators. If users of the financial statements and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited financial statements and key performance indicators to confirm the information contained in this website version of the financial statements and key performance indicators.

COLIN MURPHY
AUDITOR GENERAL
FOR WESTERN AUSTRALIA
Perth, Western Australia
27 September 2017

Certification of financial statements

CHILD AND ADOLESCENT HEALTH SERVICE

CERTIFICATION OF FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

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 2017 and the financial position as at 30 June 2017.

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.

Ms Deborah Karasinski

BOARD CHAIR

CHILD AND ADOLESCENT HEALTH SERVICE BOARD

27 September 2017

Mr Brendan Ashdown

BOARD MEMBER

CHILD AND ADOLESCENT HEALTH SERVICE BOARD

27 September 2017

Mr Brett Roach

CHIEF FINANCE OFFICER

CHILD AND ADOLESCENT HEALTH SERVICE BOARD

27 September 2017

Statement of comprehensive income
For the year ended 30 June 2017

	Note	2017 $000
COST OF SERVICES		
Expenses		
Employee benefits expense	7	406,536
Fees for visiting medical practitioners		1,139
Contracts for services	8	9,260
Patient support costs	9	58,786
Finance costs	10	79
Depreciation and amortisation expense	11	11,496
Asset revaluation decrements	40	1,576
Loss on disposal of non-current assets	12	2
Repairs, maintenance and consumable equipment	13	7,592
Other supplies and services	14	31,934
Other expenses	15	26,697
Total cost of services		**555,097**
INCOME		
Revenue		
Patient charges	16	13,185
Other fees for services	17	11,598
Commonwealth grants and contributions	18(i)	120,857
Other grants and contributions	18(ii)	58,731
Donation revenue	19	1,293
Commercial activities	20	963
Other revenue	21	3,031
Total revenue		209,658
Total income other than income from State Government		**209,658**
NET COST OF SERVICES		**345,439**

Statement of comprehensive income
For the year ended 30 June 2017

	Note	2017 $000
INCOME FROM STATE GOVERNMENT		
Service appropriations	22	319,539
Assets (transferred)/assumed	23	8
Services received free of charge	24	34,199
Total income from State Government		**353,746**
SURPLUS FOR THE PERIOD		**8,307**
OTHER COMPREHENSIVE INCOME		
Items not reclassified subsequently to profit or loss		
Changes in asset revaluation reserve	40	3,037
Total other comprehensive income		3,037
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**11,344**

Refer also to note 58 'Schedule of income and expenses by service'.

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

Statement of financial position
As at 30 June 2017

	Note	2017 $000
ASSETS		
Current Assets		
Cash and cash equivalents	25	22,442
Restricted cash and cash equivalents	26	16,712
Receivables	27	10,747
Inventories	29	2,540
Other assets	30	448
Total Current Assets		52,889
Non-Current Assets		
Restricted cash and cash equivalents	26	1,644
Amounts receivable for services	28	186,301
Property, plant and equipment	31	107,411
Intangible assets	33	6
Total Non-Current Assets		295,362
TOTAL ASSETS		**348,251**
LIABILITIES		
Current Liabilities		
Payables	35	28,047
Borrowings	36	673
Provisions	37	79,595
Other liabilities	38	212
Total Current Liabilities		108,527

Statement of financial position
As at 30 June 2017

	Note	2017 $000
Non-Current Liabilities		
Borrowings	36	1,442
Provisions	37	20,372
Total Non-Current Liabilities		21,814
TOTAL LIABILITIES		**130,341**
NET ASSETS		**217,910**
EQUITY		
Contributed equity	39	206,566
Reserves	40	3,037
Accumulated surplus	41	8,307
TOTAL EQUITY		**217,910**

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

Statement of cash flows
For the year ended 30 June 2017

	Note	2017 $000
CASH FLOWS FROM STATE GOVERNMENT		
Service appropriations		304,112
Capital appropriations		1,121
Net cash provided by State Government	42	**305,233**
CASH FLOWS FROM OPERATING ACTIVITIES		
Payments		
Employee benefits		(398,559)
Supplies and services		(97,744)
Receipts		
Receipts from customers		11,252
Commonwealth grants and contributions		120,857
Other grants and contributions		58,731
Donations received		805
Other receipts		14,488
Net cash used in operating activities	42	**(290,170)**
CASH FLOWS FROM INVESTING ACTIVITIES		
Payments		
Purchase of non-current assets		(2,846)
Receipts		
Proceeds from sale of non-current assets		4
Net cash used in investing activities		**(2,842)**

Statement of cash flows
For the year ended 30 June 2017

	Note	2017 $000
Net increase / (decrease) in cash and cash equivalents		12,221
Cash and cash equivalents transferred from the Government	39	16,333
Cash and cash equivalents held for the Health Ministerial Body	26	12,244
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	42	**40,798**

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

Statement of changes in equity

For the year ended 30 June 2017

	Note	2017 $000
CONTRIBUTED EQUITY	39	
Balance at 1 July 2016		-
Transactions with owners in their capacity as owners:		
Transfer of net assets on establishment of the Health Service		201,039
Capital appropriations		1,764
Other contributions by owners		3,763
Balance at end of period		206,566
RESERVES	40	
Asset Revaluation Reserve		
Balance at start of period		-
Other comprehensive income for the period		3,037
Balance at end of period		3,037
ACCUMULATED SURPLUS	41	
Balance at start of period		-
Surplus for the period		8,307
Balance at end of period		8,307
TOTAL EQUITY		
Balance at start of period		-
Total comprehensive income for the period		11,344
Transactions with owners in their capacity as owners		206,566
Balance at 30 June 2017		**217,910**

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

Note 1. Australian Accounting Standards

General

The Child and Adolescent Health Service's (The Health Service) financial statements for the year ended 30 June 2017 have been prepared in accordance with Australian Accounting Standards. The term 'Australian Accounting Standards' includes Standards and Interpretations issued by the Australian Accounting Standards Board (AASB).

The Health Service has adopted any applicable new and revised Australian Accounting Standards from their operative dates.

Early adoption of standards

The Health Service cannot early adopt an Australian Accounting Standard unless specifically permitted by Treasurer's Instruction 1101 '*Application of Australian Accounting Standards and Other Pronouncements'*. There has been no early adoption of any other Australian Accounting Standards that have been issued or amended (but not operative) by the Health Service for the annual reporting period ended 30 June 2017.

Note 2. Summary of significant accounting policies

(a) General statement

The Health Service is a not-for-profit reporting entity that prepares general purpose financial statements in accordance with Australian Accounting Standards, the Framework, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board as applied by the Treasurer's instructions. Several of these are modified by the Treasurer's instructions to vary application, disclosure, format and wording.

The *Financial Management Act 2006* and the Treasurer's instructions impose legislative provisions that govern the preparation of financial statements and take precedence over the Australian Accounting Standards, the Framework, Statements of Accounting Concepts and other authoritative pronouncements of the AASB.

Where modification is required and has had a material or significant financial effect upon the reported results, details of that modification and the resulting financial effect are disclosed in the notes to the financial statements.

(b) Basis of preparation

The financial statements have been prepared on the accrual basis of accounting using the historical cost convention, except for land and buildings which have been measured at fair value.

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 accounting policies adopted in the preparation of the financial statements have been consistently applied throughout all periods presented unless otherwise stated.

The financial statements are presented in Australian dollars and all values are rounded to the nearest thousand dollars ($'000).

(b) Basis of preparation (continued)

Note 3 'Judgements made by management in applying accounting policies' discloses judgements that have been made in the process of applying the Health Service's accounting policies resulting in the most significant effect on amounts recognised in the financial statements.

Note 4 'Key sources of estimation uncertainty' discloses key assumptions made concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

(c) Reporting entity

The reporting entity comprises the Child and Adolescent Health Service. The Health Service was established on 1 July 2016 under the *Health Services Act 2016*.

The Health Ministerial Body, established under section 10 of the Health Services Act 2016, has the control of the Perth Children's Hospital (PCH) project during the 2016-17 financial year. Hence, assets, liabilities, income and expenses for the PCH project are recognised in the Department of Health's financial statements.

(d) Contributed equity

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

The transfer 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.

See also note 39 'Contributed equity'.

(e) Income

Revenue recognition

Revenue is recognised and measured at the fair value of consideration received or receivable as follows:

Sale of goods
Revenue is recognised from the sale of goods and disposal of other assets when the significant risks and rewards of ownership are transferred to the purchaser and can be measured reliably.

Provision of services
Revenue is recognised by reference to the stage of completion of the transaction.

Service appropriations
Service appropriations are recognised as revenues at fair value in the period in which the Health Service gains control of the appropriated funds. The Health Service gains control of appropriated funds at the time those funds are deposited to the bank account or credited to the 'Amounts receivable for services' (holding account) held at Treasury. See also note 22 'Service appropriations' for further information.

(e) Income (continued)

Grants, donations, gifts and other non-reciprocal contributions

Revenue is recognised at fair value when the Health Service obtains control over the assets comprising the contributions, usually when cash is received.

Other non-reciprocal contributions that are not contributions by owners are recognised at their fair value. Contributions of services are only recognised when a fair value can be reliably determined and the services would be purchased if not donated.

Gains

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

(f) Borrowing costs

Borrowing costs are expensed in the period in which they are incurred.

(g) Property, plant and equipment

Capitalisation/expensing of assets

Items of property, plant and equipment costing $5,000 or more are recognised as assets and the cost of utilising assets is expensed (depreciated) over their useful lives. 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).

Initial recognition and measurement

Property, plant and equipment are initially recognised at cost.

For items of property, plant and equipment acquired at no cost or for nominal cost, the cost is their fair value at the date of acquisition.

Subsequent measurement

Subsequent to initial recognition as an asset, the revaluation model is used for the measurement of land and buildings, and historical cost for all other property, plant and equipment. Land and buildings are carried at fair value less accumulated depreciation (buildings) and accumulated impairment losses. All other items of property, plant and equipment are stated at historical cost less accumulated depreciation and accumulated impairment losses.

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.

In the absence of market-based evidence, fair value of land and buildings is determined on the basis of existing use. This normally applies where buildings are specialised or where land use is restricted. Fair value for existing use buildings is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset, i.e. the depreciated replacement cost. Fair value for restricted use land is determined by comparison with market evidence for land with similar approximate utility (high restricted use land) or market value of comparable unrestricted land (low restricted use land).

(g) Property, plant and equipment (continued)

When buildings are revalued, the accumulated depreciation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount.

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

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.

See also note 31 'Property, plant and equipment' and note 32 'Fair value measurement' for further information on revaluation.

Derecognition

Upon disposal or derecognition of an item of property, plant and equipment, any revaluation surplus relating to that asset is retained in the asset revaluation reserve.

Asset revaluation reserve

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

Depreciation

All non-current assets 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.

Depreciation is calculated using the straight line method, using rates which are reviewed annually. Estimated useful lives for each class of depreciable asset are:

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

Land is not depreciated.

Artworks controlled by the Health Service are classified as property, plant and equipment. These are anticipated to have indefinite useful lives. Their service potential has not, in any material sense, been consumed during the reporting period and consequently no depreciation has been recognised.

(h) Intangible assets

Capitalisation/expensing of assets

Acquisitions of intangible assets costing $5,000 or more and internally generated intangible assets costing $5,000 or more are capitalised. The cost of utilising the assets is expensed (amortised) over their useful lives. Costs incurred below these thresholds are immediately expensed directly to the Statement of Comprehensive Income.

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.

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

Amortisation for intangible assets with finite useful lives is calculated for the period of the expected benefit (estimated useful life which is reviewed annually) on the straight line basis. All intangible assets controlled by the Health Service have a finite useful life and zero residual value.

Estimated useful lives for each class of intangible assets are:

Computer software	5 - 15 years

Computer software

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

(i) Impairment of assets

Property, plant and equipment and intangible assets are tested for any indication of impairment at the end of each reporting period. Where there is an indication of impairment, the recoverable amount is estimated. Where the recoverable amount is less than the carrying amount, the asset is considered impaired and is written down to the recoverable amount. Where an asset measured at cost is written down to recoverable amount, an impairment loss is recognised in Statement of Comprehensive Income. Where a previously revalued asset is written down to recoverable amount, the loss is recognised as a revaluation decrement in other comprehensive income. As the Health Service is a not-for-profit entity, unless a specialised asset has been identified as a surplus asset, the recoverable amount is the higher of an asset's fair value less costs to sell and depreciated replacement cost.

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 falling replacement costs.

Intangible assets not yet available for use are tested for impairment at the end of each reporting period irrespective of whether there is any indication of impairment.

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

See also note 34 'Impairment of assets' for the outcome of impairment reviews and testing.

Refer also to note 2(o) 'Receivables' and note 27 'Receivables' for impairment of receivables.

(j) Financial instruments

In addition to cash, the Health Service has two categories of financial instrument:

* Loans and receivables; and
* Financial liabilities measured at amortised cost.

Financial instruments have been disaggregated into the following classes:

* Financial assets:
  - Cash and cash equivalents
  - Restricted cash and cash equivalents
  - Receivables
  - Amounts receivable for services
* Financial liabilities:
  - Payables
  - Department of Treasury loans

Initial recognition and measurement of financial instruments is at fair value which normally equates to the transaction cost or the face value. Subsequent measurement is at amortised cost using the effective interest method.

The fair value of short-term receivables and payables is the transaction cost or the face value because there is no interest rate applicable and subsequent measurement is not required as the effect of discounting is not material.

(k) Cash and cash equivalents

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

(l) Accrued salaries

Accrued salaries (see note 35 'Payables') represent the amount due to employees but unpaid at the end of the financial year, as the pay date for the last pay period for that financial year does not coincide with the end of the financial year. Accrued salaries are settled within a fortnight of the financial year end. The Health Service considers the carrying amount of accrued salaries to be equivalent to its fair value.

The accrued salaries suspense account (refer note 26 'Restricted cash and cash equivalents') consists of amounts paid annually into a suspense account over a period of 10 financial years to largely meet the additional cash outflow in each eleventh year when 27 pay days occur instead of the normal 26. No interest is received on this account.

(m) Amounts receivable for services (holding account)

The Health Service receives service appropriation funding from the State Government partly in cash and partly as an asset (holding account receivable). The holding account receivable balance is accessible on the emergence of the cash funding requirement to cover leave entitlements and asset replacement.

See also note 22 'Service appropriations' and note 28 'Amounts receivable for services'.

(n) Inventories

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 (See note 29 'Inventories').

(o) Receivables

Receivables are recognised at original invoice amount less an allowance for any uncollectible amounts (i.e. impairment). The collectability of receivables is reviewed on an ongoing basis and any receivables identified as uncollectible are written-off against the allowance account. The allowance for uncollectible amounts (doubtful debts) is raised when there is objective evidence that the Health Service will not be able to collect the debts. The carrying amount is equivalent to fair value as it is due for settlement within 30 days.

See also note 2(j) 'Financial Instruments' and note 27 '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, Mental Health Commission, Child and Adolescent Health Service, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service, WA Country Health Service, Health Support Services, QE II Medical Centre Trust, and Health and Disability Services Complaints Office.

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

(p) Payables

Payables are recognised 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.

See also note 2(j) 'Financial instruments' and note 35 'Payables'.

(q) Borrowings

All loans payable are initially recognised at fair value, being the net proceeds received. Subsequent measurement is at amortised cost using the effective interest rate method.

See also note 2(j) 'Financial instruments' and note 36 'Borrowings'.

(r) Provisions

Provisions are liabilities of uncertain timing or amount and are recognised where there is a present legal or constructive obligation as a result of a past event and when the outflow of resources embodying economic benefits is probable and a reliable estimate can be made of the amount of the obligation. Provisions are reviewed at the end of each reporting period.

See also note 37 'Provisions'.

Provisions - employee benefits

All annual leave, time off in lieu leave and long service leave provisions are in respect of employees' services up to the end of the reporting period.

Annual Leave and Time Off in Lieu Leave

Annual leave and time off in lieu leave are not expected to be settled wholly within 12 months after the end of the reporting period and are therefore considered to be 'other long-term employee benefits'. The annual leave liability and time off in lieu leave liability are recognised and measured at the present value of amounts expected to be paid when the liabilities are settled using the remuneration rate expected to apply at the time of settlement.

When assessing expected future payments consideration is given to expected future wage and salary levels including non-salary components such as employer superannuation contributions, as well as the experience of employee departures and periods of service. The expected future payments are discounted using market yields 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.

The provisions for annual leave and time off in lieu leave are classified as a current liability 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.

Long service leave

Long service leave is not expected to be settled wholly within 12 months after the end of the reporting period. The long service leave liability is recognised and measured at the present value of amounts expected to be paid when the liabilities are settled using the remuneration rate expected to apply at the time of settlement.

When assessing expected future payments, consideration is given to expected future wage and salary levels including non-salary components such as employer superannuation contributions, as well as the experience of employee departures and periods of service. The expected future payments are discounted using market yields 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.

(r) Provisions (continued)

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.

Sick Leave

Liabilities for sick leave are recognised when it is probable that sick leave paid in the future will be greater than the entitlement that will accrue in the future.

Past history indicates that on average, sick leave taken each reporting period is less than the entitlement accrued. This is expected to continue in future periods. Accordingly, it is unlikely that existing accumulated entitlements will be used by employees and no liability for unused sick leave entitlements is recognised. As sick leave is non-vesting, an expense is recognised in the Statement of Comprehensive Income for this leave as it is taken.

Deferred Salary Scheme

The provision for the deferred salary scheme relates to the employees who have entered into an agreement to self-fund an additional twelve months leave in the fifth year of the agreement. The provision recognises the value of salary set aside for employees to be used in the fifth year. The liability is measured on the same basis as annual leave. It is reported as a current provision as employees can leave the scheme at their discretion at any time.

Superannuation

The Government Employees Superannuation Board (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.

Eligible employees contribute to the Pension Scheme, a defined benefit pension scheme closed to new members since 1987, or the Gold State Superannuation Scheme (GSS), a defined benefit lump sum scheme closed to new members since 1995.

Employees commencing employment prior to 16 April 2007 who were not members of either the Pension Scheme or the GSS became non-contributory members of the West State Superannuation Scheme (WSS). Employees commencing employment on or after 16 April 2007 became members of the GESB Super Scheme (GESBS). From 30 March 2012, existing members of the WSS or GESBS and new employees have been able to choose their preferred superannuation fund provider. The Health Service makes contributions to GESB or other fund providers on behalf of employees in compliance with the *Commonwealth Government's Superannuation Guarantee (Administration) Act 1992.* Contributions to these accumulation schemes extinguish the Health Service's liability for superannuation charges in respect of employees who are not members of the Pension Scheme or GSS.

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

The Health Service has no liabilities under the Pension Scheme or the GSS. 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.

(r) Provisions (continued)

The GESB makes all benefit payments in respect of the Pension Scheme and GSS transfer benefits, and recoups from the Treasurer for the employer's share. See also note 2(t) 'Superannuation expense'.

Employment on-costs

Employment on-costs (workers' compensation insurance) are not employee benefits and are recognised separately as liabilities and expenses when the employment to which they relate has occurred. Employment on-costs are included as part of 'Other expenses' and are not included as part of the Health Service's 'Employee benefits expense'. Any related liability is included in 'Employment on-costs provision'.

See also note 15 'Other expenses' and note 37 'Provisions'.

(s) Superannuation expense

Superannuation expense in the Statement of Comprehensive Income comprises employer contributions paid to the GSS (concurrent contributions), WSS, GESBS, and other superannuation funds.

(t) Services received free of charge or for nominal cost

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

Services received from other State Government agencies are separately disclosed under Income from State Government in the Statement of Comprehensive Income.

(u) Assets transferred between government agencies

Discretionary transfers of net assets (assets and liabilities) between State Government agencies free of charge, are measured at the fair value of those net assets that the Health Service would otherwise pay for, and 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 '*Contributions*' in respect of the net assets transferred.

(v) Comparative figures

The Health Service commenced operations as a new statutory authority on the 1st July 2016. There are no comparative figures for the first year of operations.

(w) Trust accounts

Trust Accounts are used by the Health Service to account for funds that they may be holding on behalf of another party, such as patients' cash. 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.

Details of Trust Accounts are reported as a note to the financial statements (refer to note 53).

Note 3. Judgements made by management in applying accounting policies

The preparation of financial statements requires management to make judgements about the application of accounting policies that have a significant effect on the amounts recognised in the financial statements. The Health Service evaluates these judgements regularly.

The judgements that have been made in the process of applying accounting policies that have the most significant effect on the amounts recognised in the financial statements include:

Buildings

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.

Operating lease commitments

The Health Service has entered into a number of leases for buildings. Some of these leases relate to buildings of a temporary nature and it has been determined that the lessor retains substantially all the risk and rewards incidental to ownership. Accordingly, these leases have been classified as operating leases.

Note 4. Key sources of estimation uncertainty

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 reporting period.

Buildings

In order to estimate fair value on the basis of existing use, the depreciated replacement costs are determined on the assumption that the buildings will be used for the same functions in the future. A major change in utilisation of the buildings may result in material adjustment to the carrying amounts.

Employee benefits 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 7.5%. This assumption was based on an analysis of the historical turnover rates exhibited by employees in the WA health services. 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.

Other estimations and assumptions used in calculating the Health Service's long service leave provision 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.

Note 5. Disclosure of changes in accounting policy and estimates

Initial application of an Australian Accounting Standard

The Health Service has applied the following Australian Accounting Standards effective for annual reporting periods beginning on or after 1 July 2016 that impacted on the Health Service.

AASB 1057 *Application of Australian Accounting Standards*

This Standard lists the application paragraphs for each other Standard (and Interpretation), grouped where they are the same. There is no financial impact.

AASB 2014-4 *Amendments to Australian Accounting Standards – Clarification of Acceptable Methods of Depreciation and Amortisation [AASB 116 & 138]*

The adoption of this Standard has no financial impact for the Health Service as depreciation and amortisation is not determined by reference to revenue generation, but by reference to consumption of future economic benefits.

AASB 2015-1 *Amendments to Australian Accounting Standards - Annual Improvements to Australian Accounting Standards 2012-2014 Cycle (AASB 1, 2, 3, 5, 7, 11, 110, 119, 121, 133, 134, 137 & 140)*

These amendments arise from the issuance of International Financial Reporting Standard Annual Improvements to IFRSs 2012-2014 Cycle in September 2014, and editorial corrections. The Health Service has determined that the application of the Standard has no financial impact.

AASB 2015-2 *Amendments to Australian Accounting Standards - Disclosure Initiative: Amendments to AASB 101 [AASB 7, 101, 134 & 1049]*

This Standard amends AASB 101 to provide clarification regarding the disclosure requirements in AASB 101. Specifically, the Standard proposes narrow-focus amendments to address some of the concerns expressed about existing presentation and disclosure requirements and to ensure entities are able to use judgement when applying a Standard in determining what information to disclose in their financial statements. There is no financial impact.

AASB 2015-6 *Amendments to Australian Accounting Standards - Extending Related Party Disclosures to Not-for-Profit Public Sector Entities (AASB 10, 124 & 1049)*

The amendments extend the scope of AASB 124 to include application by not-for-profit public sector entities. Implementation guidance is included to assist application of the Standard by not-for-profit public sector entities. There is no financial impact.

Note 5. Disclosure of changes in accounting policy and estimates (continued)

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. By virtue of a limited exemption, the Health Service has early adopted AASB 2015-7 *Amendments to Australian Accounting Standards - Fair Value Disclosures of Non-for-Profit Public Sector Entities*. 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 9	*Financial Instruments* This Standard supersedes AASB 139 *Financial Instruments: Recognition and Measurement*, introducing a number of changes to accounting treatments. The mandatory application date of this Standard is currently 1 January 2018 after being amended by AASB 2012-6, AASB 2013-9 and AASB 2014-1 *Amendments to Australian Accounting Standards*. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 16	*Leases* This Standard introduces a single lessee accounting model and requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. Whilst the impact of AASB 16 has not yet been quantified, the Health Service currently has operating lease commitments for $6.33 million. The Health Service anticipates most of this amount will be brought onto the statement of financial position, excepting amounts pertinent to short-term or low-value leases. Interest and depreciation expenses will increase and operating lease expenses will decrease.	1 Jan 2019
AASB 1058	*Income of Not-for-Profit Entities* This Standard clarifies and simplifies the income recognition requirements that apply to not for profit (NFP) entities, more closely reflecting the economic reality of NFP entity transactions that are not contracts with customers. Timing of income recognition is dependent on whether such a transaction gives rise to a liability, or a performance obligation (a promise to transfer a good or service), or, an obligation to acquire an asset. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2019

Note 5. Disclosure of changes in accounting policy and estimates (continued)

Future impact of Australian Accounting Standards not yet operative

		Operative for reporting periods beginning on/after
AASB 2010-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Int 2, 5, 10, 12, 19 & 127]* This Standard makes consequential amendments to other Australian Accounting Standards and Interpretations as a result of issuing AASB 9 in December 2010. The mandatory application date of this Standard has been amended by AASB 2012-6 and AASB 2014-1 to 1 January 2018. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2014-1	*Amendments to Australian Accounting Standards* Part E of this standard makes amendments to AASB 9 and consequential amendments to other Standards. It has not yet been assessed by the Health Service to determine the application or potential impact of the Standard.	1 Jan 2018
AASB 2014-5	*Amendments to Australian Accounting Standards arising from AASB 15* This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of AASB 15. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2014-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2014)* This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of AASB 9 (December 2014). The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2015-8	*Amendments to Australian Accounting Standards – Effective Date of AASB 15* This Standard amends the mandatory effective date (application date) of AASB 15 *Revenue from Contracts with Customers*' so that AASB 15 is required to be applied for annual reporting periods beginning on or after 1 January 2018 instead of 1 January 2017. For Not For Profit entities, the mandatory effective date has subsequently been amended to 1 January 2019 by AASB 2016 7. The Health Service has not yet determined the application or the potential impact of AASB 15.	1 Jan 2019

Note 5. Disclosure of changes in accounting policy and estimates (continued)

Future impact of Australian Accounting Standards not yet operative

		Operative for reporting periods beginning on/after
AASB 2016-2	*Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 107* This Standard amends AASB 107 *Statement of Cash Flows* (August 2015) to require disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. There is no financial impact.	1 Jan 2017
AASB 2016-3	*Amendments to Australian Accounting Standards – Clarifications to AASB 15* This Standard clarifies identifying performance obligations, principal versus agent considerations, timing of recognising revenue from granting a licence, and, provides further transitional provisions to AASB 15. The Health Service has not yet determined the application or the potential impact.	1 Jan 2018
AASB 2016-4	*Amendments to Australian Accounting Standards – Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities* This Standard clarifies that the recoverable amount of primarily non-cash-generating assets of not-for-profit entities, which are typically specialised in nature and held for continuing use of their service capacity, is expected to be materially the same as fair value determined under AASB 13 *Fair Value Measurement*. The Health Service has not yet determined the application or the potential impact.	1 Jan 2017
AASB 2016-7	*Amendments to Australian Accounting Standards - Deferral of AASB 15 for Not-for-Profit Entities* This Standard amends the mandatory effective date (application date) of AASB 15 and defers the consequential amendments that were originally set out in AASB 2014-5 *Amendments to Australian Accounting Standards arising from AASB 15* for not for profit entities to annual reporting periods beginning on or after 1 January 2019, instead of 1 January 2018. There is no financial impact.	1 Jan 2017
AASB 2016-8	*Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities* This Standard inserts Australian requirements and authoritative implementation guidance for not-for-profit entities into AASB 9 and AASB 15. This guidance assists not-for-profit entities in applying those Standards to particular transactions and other events. There is no financial impact.	1 Jan 2019

Note 6. Services of the Health Service

Information about the Health Service's services and the expenses and revenues which are reliably attributable to those services are set out in note 58 'Schedule of income and expenses by service'. The key services of the Health Service are:

Public Hospital Admitted Patient
Public hospital admitted patient services describe the care services provided to inpatients in public hospitals (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.

Home-Based Hospital Programs
The 'Hospital in the Home' (HITH) and 'Mental Health in the Home' (MITH) programs provide short-term acute care in the patient's home for those who can be safely cared for without constant monitoring for conditions that traditionally required hospital admission and inpatient treatment. These services involve daily home visits by nurses, with medical governance usually by a hospital-based doctor.

Emergency Department
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.

Public Hospital Non-admitted Patients
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
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.

Prevention, Promotion and Protection
Prevention, promotion and protection services describe 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.

	2017 $000
Note 7. Employee benefits expense	
Salaries and wages (a)	372,880
Superannuation - defined contribution plans (b)	33,656
	406,536

(a) Includes the value of the fringe benefits to the employees plus the fringe benefits tax component, the value of the superannuation contribution component of leave entitlements and redundancy expenses of $3.399 million.

(b) Defined contribution plans include West State, Gold State and GESB Super and other eligible funds.

Employment on-costs expenses (workers' compensation insurance) are included at note 15 'Other expenses'.

Note 8. Contracts for services	
Child, community and primary health	9,094
Other contracts	166
	9,260
Note 9. Patient support costs	
Medical supplies and services	49,456
Domestic charges	4,127
Food supplies	1,541
Fuel, light and power	2,958
Patient transport costs	352
Research, development and other grants	352
	58,786
Note 10. Finance costs	
Interest expense	79

	2017 $000
Note 11. Depreciation and amortisation expense	
Buildings	5,450
Site infrastructure	761
Leasehold improvements	39
Computer equipment	2
Furniture and fittings	213
Medical equipment	4,909
Other plant and equipment	122
	11,496
Note 12. Loss on disposal of non-current assets	
Carrying amount of non-current assets disposed:	
Property, plant and equipment	6
Proceeds from disposal of non-current assets:	
Property, plant and equipment	(4)
Net loss	2
See note 31 'Property, plant and equipment'.	
Note 13. Repairs, maintenance and consumable equipment	
Repairs and maintenance	4,988
Consumable equipment	2,604
	7,592

	2017 $000
Note 14. Other supplies and services	
Administration and management services	1,629
Interpreter services	955
Sanitation and waste removal services	363
Security services	266
Shared services for accounting	1,494
Shared services for human resources	6,571
Shared services for information technology	17,660
Shared services for supply	2,444
Other	552
	31,934
Note 15. Other expenses	
Workers compensation insurance (a)	4,880
Other insurances	4,319
Other employee related expenses	1,143
Communications	1,532
Computer services	372
Consultancy fees	2,521
Doubtful debts expense	1,416
Freight and cartage	884
Motor vehicle expenses	411
Operating lease expenses	4,594
Periodical subscription	300
Printing and stationery	1,805
Write-down of assets (b)	1,568
Other	952
	26,697

(a) The employment on-costs include workers' compensation insurance only. Any on-costs liability associated with the recognition of annual and long service leave liabilities is included at note 37 'Provisions'. Superannuation contributions accrued as part of the provision for leave are employee benefits and are not included in employment on-costs.

(b) See note 31 'Property, plant and equipment' and note 33 'Intangible assets'.

	2017 $000
Note 16. Patient charges	
Inpatient charges	10,248
Outpatient charges	2,937
	13,185
Note 17. Other fees for services	
Recoveries from the Pharmaceutical Benefits Scheme	5,463
Clinical services to other health organisations	4,495
Non clinical services to other health organisations	1,640
	11,598
Note 18. Grants and contributions	
i) Commonwealth grants and contributions	
Recurrent Grants:	
National Health Reform Agreement (funding via Department of Health) (a)	113,765
National Health Reform Agreement (funding via Mental Health Commission) (a)	6,297
National Partnership Agreement - Essential Vaccines	750
Other	45
	120,857
ii) Other grants and contributions	
Mental Health Commission – service delivery agreement	51,203
Mental Health Commission – other	1,964
Disability Services Commission	25
Lotteries Commission	37
Perth Children's Hospital Foundation	3,825
Telethon Kids Institute	576
Other	1,101
	58,731

(a) Activity based funding and block grant funding have been received from the Commonwealth Government under the National Health Reform Agreement for services, health teaching, training and research provided by local hospital networks (Health Services). The new 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.

	2017 $000
Note 19. Donation revenue	
Channel 7 Telethon Trust	523
Perth Children's Hospital Foundation - donations of equipment	488
Princess Margaret Hospital Volunteers Inc.	250
Other	32
	1,293
Note 20. Commercial activities	
Sales:	
Café sales revenue	1,823
	1,823
Cost of sales (a)	(860)
Gross profit	963
(a) The cost of sales does not include salaries or other costs.	
Note 21. Other revenue	
Pharmaceutical manufacturing activities	1,954
Rent from commercial properties	7
RiskCover insurance premium rebate	76
Respiratory clinical trials	327
Immunisation services	157
Use of hospital facilities	16
Other	494
	3,031

	2017 $000

Note 22. Service appropriations

Appropriation revenue received during the period:

Service appropriations (funding via the Department of Health)	319,539

Service appropriations fund the net cost of services delivered. Appropriation revenue comprises a cash component and a receivable (asset). The receivable (holding account) comprises the budgeted depreciation expense for the year and any agreed increase in leave liabilities during the year.

Note 23. Assets (transferred)/assumed

Assets transferred from/(to) other State government agencies during the period:

Transfer of medical equipment from North Metropolitan Health Service	13
Transfer of artwork to South Metropolitan Health Service	(5)
	8

Discretionary transfers of net assets (assets and liabilities) between State Government agencies free of charge, 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 '*Contributions*' in respect of net assets transferred.

Note 24. Services received free of charge

Services received free of charge from other State government agencies during the period:

Health Support Services - accounting, human resources, information technology and supply	28,168
Department of Finance - leasing of accommodation	26
North Metropolitan Health Service (PathWest) - pathology services	6,005
	34,199

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.

	2017 $000
Note 25. Cash and cash equivalents	
Current	22,442
Note 26. Restricted cash and cash equivalents	
Current	
Funds repayable to Health Ministerial Body (a)	12,244
Mental Health Commission Funding (b)	695
Restricted cash assets held for other specific purposes (c)	3,773
	16,712
Non-Current	
Accrued Salaries Suspense Account (d)	1,644

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

(a) Funds repayable to the Health Ministerial Body for the Perth Children's Hospital project.

(b) The unspent funds from the Mental Health Commission are committed to the provision of mental health services. See note 54 'Special purpose accounts'.

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

(d) 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.

	2017 $000
Note 27. Receivables	
Current	
Patient fee debtors	10,827
GST receivable	285
Other receivables	4,588
Allowance for impairment of receivables	(5,381)
Accrued revenue	428
	10,747
Reconciliation of changes in the allowance for impairment of receivables:	
Balance transferred from the Government at start of period	3,975
Doubtful debts expense (note 15)	1,416
Amount recovered during the period	(10)
Balance at end of period	5,381

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

See also note 2(o) 'Receivables' and note 57 'Financial instruments'.

Note 28. Amounts receivable for services (Holding Account)	
Current	-
Non-Current	186,301
	186,301

Represents the non-cash component of service appropriations. It is restricted in that it can only be used for asset replacement or payment of leave liability. See note 2(m) 'Amounts receivable for services'.

Note 29. Inventories	
Current	
Pharmaceutical stores - at cost	2,540

See also note 2(n) 'Inventories'.

Note 30. Other assets	
Current	
Prepayments	448

Note 31. Property, plant and equipment	2017 $000
Land	
At fair value (a) (b)	69,744
	69,744
Buildings	
At fair value (a) (b)	24,275
	24,275
Site infrastructure	
At cost	2,470
Accumulated depreciation	(763)
	1,707
Leasehold improvements	
At cost	288
Accumulated depreciation	(39)
	249
Computer equipment	
At cost	8
Accumulated depreciation	(2)
	6
Furniture and fittings	
At cost	649
Accumulated depreciation	(213)
	436
Medical equipment	
At cost	11,270
Accumulated depreciation	(4,832)
	6,438
Other plant and equipment	
At cost	473
Accumulated depreciation	(116)
	357
Works in progress	
Buildings under construction (at cost)	117
Other works in progress (at cost)	4,063
	4,180
Artworks	
At cost	19
Total property, plant and equipment	107,411

Note 31. Property, plant and equipment (continued)

(a) Land and buildings were revalued as at 1 July 2016 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2017 and recognised at 30 June 2017. In undertaking the revaluation, fair value was determined by reference to market values for land: $19.589 million and buildings: $0.121 million. For the remaining balance, fair value of buildings was determined on the basis of depreciated replacement cost and fair value of land was determined on the basis of comparison with market evidence for land with low level utility (high restricted use land). See also note 2(g) 'Property, plant and equipment'.

(b) Information on fair value measurement is provided in note 32.

	Land	Building	Site infra-structure	Leasehold improve-ments	Computer equipment	Furniture and fittings	Medical equipment	Other plant and equipment	Work in progress	Art-works	Total
	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
2017											
Transfer from the Government at start of period	70,730	26,436	2,418	269	1	824	8,054	668	2,416	24	111,840
Additions	-	-	-	-	10	-	1,053	45	2,297	-	3,405
Transfer from other agencies	590	194	50	-	-	-	2,942	-	-	(5)	3,771
Transfers to asset classes	-	58	-	19	-	-	456	-	(533)	-	-
Disposals	-	-	-	-	-	-	(2)	-	-	-	(2)
Revaluation increments/(decrements)	(1,576)	3,037	-	-	-	-	-	-	-	-	1,461
Depreciation	-	(5,450)	(761)	(39)	(2)	(213)	(4,909)	(122)	-	-	(11,496)
Write-down of assets [(a)]	-	-	-	-	(3)	(175)	(1,156)	(234)	-	-	(1,568)
Carrying amount at end of period	69,744	24,275	1,707	249	6	436	6,438	357	4,180	19	107,411

(a) Certain items of property, plant and equipment transferred from the Government were expensed in the current financial year, where their values were below the asset capitalisation threshold. Refer to note 15 'Other expenses'.

Note 32. Fair value measurement

(a) Fair value hierarchy

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

1) quoted prices (unadjusted) in active markets for identical assets (level 1);
2) input other than quoted prices included within level 1 that are observable for the asset either directly or indirectly (level 2); and
3) 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 at 30 June 2017.

	Level 1 $000	Level 2 $000	Level 3 $000	Total $000
Land				
Car parks	-	18,900	-	18,900
Residential	-	689	-	689
Specialised	-	-	50,155	50,155
Buildings				
Residential	-	121	-	121
Specialised	-	-	24,154	24,154
	-	19,710	74,309	94,019

(b) Valuation techniques

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

Market Approach (Comparable Sales)

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

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

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

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

Note 32. Fair value measurement (continued)

Cost Approach

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

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

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

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

The Health Service's hospitals and medical centres are specialised buildings valued under the cost approach. 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;

Note 32. Fair value measurement (continued)

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.

(c) Changes in level 3 assets for the period ended 30 June 2017

	Land	Buildings
2017	**$000**	**$000**
Transfer from the Government at start of period	51,090	26,301
Transfer from other agencies	590	194
Transfer from works in progress	-	58
Revaluation increments/(decrements)	(1,525)	3,049
Depreciation expense	-	(5,448)
Fair value at end of period	50,155	24,154

(d) Valuation processes

The valuation processes include the provision of property information to quantity surveyor and Landgate Valuation Services and the review of the valuation reports.

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

	2017 $000
Note 33. Intangible assets	
Works in progress	
Computer software under development (at cost)	6
Total intangible assets	6

Reconciliations:

Reconciliations of the carrying amount of intangible assets at the beginning and end of the reporting period are set out below:

Computer software	
Transfer from the Government at start of period	4
Write-down of assets (a)	(4)
Carrying amount at end of period	-
Works in progress	
Transfer from the Government at start of period	-
Additions	6
Carrying amount at end of period	6
Total intangible assets	
Transfer from the Government at start of period	4
Additions	6
Write-down of assets (a)	(4)
Carrying amount at end of period	6

(a) The intangible asset transferred from the Government was expensed in the current financial year, as it was below the asset capitalisation threshold. Refer to note 15 'Other expenses'.

Note 34. Impairment of assets

There were no indications of impairment to property, plant and equipment or intangible assets at 30 June 2017.

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.

	2017 $000
Note 35. Payables	
Current	
Trade payables	2,993
Payable to Health Ministerial Body	12,244
Other payables	55
Accrued expenses	7,739
Accrued salaries	5,010
Accrued interest	6
	28,047

See also note 2(p) 'Payables' and note 57 'Financial instruments'.

Note 36. Borrowings

Current	
Department of Treasury loans	673
Non-current	
Department of Treasury loans	1,442
	2,115

This debt relates to funds advanced to the Health Service via the now defunct General Loan and Capital Works Fund. Funds advanced and related interest costs are repaid to the Department of Treasury by the Department of Health on behalf of the Health Service. Interest rates are linked to the State Government's debt servicing costs.

	2017 $000
Note 37. Provisions	
Current	
Employee benefits provision	
Annual leave (a)	40,754
Time off in lieu leave (a)	7,333
Long service leave (b)	30,488
Deferred salary scheme (c)	1,020
	79,595
Non-current	
Employee benefits provision	
Long service leave (b)	20,372
	99,967

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

Within 12 months of the end of the reporting period	33,781
More than 12 months after the end of the reporting period	14,306
	48,087

(b) Long service leave liabilities have been classified as current where there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

Within 12 months of the end of the reporting period	6,137
More than 12 months after the end of the reporting period	44,723
	50,860

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

Within 12 months of the end of the reporting period	34
More than 12 months after the end of the reporting period	986
	1,020

	2017 $000
Note 38. Other liabilities	
Current	
Income received in advance	150
Paid parental leave scheme	62
	212

Note 39. Contributed equity

The Western Australian Government holds the equity interest in the Health Service on behalf of the community. Equity represents the residual interest in the net assets of the Health Service. The asset revaluation reserve represents that portion of equity resulting from the revaluation of non-current assets (note 40).

Balance at start of period	-
Contributions by owners	
Transfer of net assets on establishment of the Health Service (b) (e)	201,039
Capital appropriations (a)	1,764
Transfer of net assets from other agencies (b) (c) (d)	3,763
Balance at end of period	206,566

(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'.*

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

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

(c) The transfer of the East Perth property site ($0.834 million) from the Department of Health to the Health Service occurred in 2016-17 for setting up a Child Health Centre.

(d) Equipment with a total value of $2.929 million were transferred from the Health Ministerial Body (Perth Children Hospital's project) to the Princess Margaret Hospital during the financial year.

Note 39. Contributed equity (continued)

(e) Pursuant to the Transfer Order made on 30 June 2016 by the Minister for Health under section 238 of the *Health Services Act 2016*, the assets and liabilities of the Metropolitan Health Service were allocated the health service providers established under clause 12(1) of the *Health Services (Health Service Providers) Order 2016* as published in the Government Gazette dated 17 June 2016. The health service providers are the Child and Adolescent Health Service, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service and Health Support Services.

Below are the portions of assets and liabilities allocated by the Government to the Child and Adolescent Health Service on 01 July 2016:

	2017 $000
Assets	
Cash and cash equivalents	8,323
Restricted cash and cash equivalents	8,010
Amounts receivable for services	170,958
Receivables	8,977
Inventories	2,654
Property, plant and equipment	111,840
Intangible assets	4
Other assets	564
	311,330
Liabilities	
Payables	14,274
Borrowings	2,756
Provisions	93,261
	110,291
Transfer of net assets on establishment of the Health Service	201,039

	2017 $000
Note 40. Reserves	
Asset revaluation reserve	
Balance at start of period	-
Net revaluation increments/(decrements) (a):	
Buildings	3,037
Balance at end of period	3,037
Asset revaluation decrements recognised as an expense (b):	
Land	1,576
	1,576

(a) Any revaluation increment is credited directly to 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.

(b) Any revaluation decrement is recognised as an expense, except to the extent of any balance existing in the asset revaluation reserve in respect of that class of assets.

Note 41. Accumulated surplus	
Balance at start of period	-
Result for the period	8,307
Balance at end of period	8,307

	2017 $000

Note 42. Notes to the Statement of Cash Flows

Reconciliation of cash

Cash assets at the end of the reporting period as shown in the Statement of Cash Flows are reconciled to the related items in the Statement of Financial Position as follows:

Cash and cash equivalents	22,442
Restricted cash and cash equivalents	18,356
	40,798

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

Net cash used in operating activities (Statement of Cash Flows)	(290,170)
Increase/(decrease) in assets:	
Receivables	3,186
Inventories	7
Prepayments	(116)
Decrease/(increase) in liabilities:	
Payables	(1,458)
Current provisions	(6,043)
Non-current provisions	(662)
Other current liabilities	(212)
Non-cash items:	
Doubtful debts expense (note 15)	(1,416)
Write off of inventory	(123)
Depreciation and amortisation expense (note 11)	(11,496)
Asset revaluation decrement (note 40)	(1,576)
Net gain/(loss) from disposal of non-current assets (note 12)	(2)
Write down of assets (note 15)	(1,568)
Interest paid by the Department of Health (note 10)	(79)
Donations of equipment received (note 19)	488
Services received free of charge (note 24)	(34,199)
Net cost of services (Statement of Comprehensive Income)	(345,439)

	2017 $000
Note 42. Notes to the Statement of Cash Flows (continued)	
Notional cash flows	
Service appropriations as per Statement of Comprehensive Income	319,539
Capital appropriation credited directly to Contributed equity (refer note 39)	1,764
	321,303
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 paid to the Department of Treasury	(81)
Repayment of borrowings to the Department of Treasury	(642)
Accrual appropriations	(15,347)
	(16,070)
Cash Flows from State Government as per Statement of Cash Flows	305,233

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.

Note 43. Services provided free of charge

During the reporting period, the following services were provided to other agencies free of charge for functions outside the normal operations of the Health Service:

Department for Child Protection and Family Support - health assessments	281
Department of Education - school health services	12,230
Disability Services Commission - paediatric services	2,903
	15,414

Note 44. Compensation of key management personnel

The key management personnel include Ministers, board members, and senior officers of the Health Service. However, the Health Service is not obligated to compensate Ministers and therefore disclosures in relation to Ministers' compensation may be found in the *Annual Report on State Finances*:

Compensation of members of the accountable authority

Below are the numbers of board members that received compensation in the financial year:

	2017
$0	1
$40,001 - $50,000	7
$70,001 - $80,000	1
	9

	$000
Short-term employee benefits	343
Post-employment benefits	33
Total compensation of members of the accountable authority	376

Compensation of senior officers

Below are the numbers of senior officers that received compensation in the financial year:

	2017
$0	2
$10,001 - $20,000	1
$160,001 - $170,000	1
$170,001 - $180,000	1
$190,001 - $200,000	1
$200,001 - $210,000	1
$210,001 - $220,000	3
$240,001 - $250,000	1
$480,001 - $490,000	1
$530,001 - $540,000	1
$550,001 - $560,000	1
$810,001 - $820,000	1
Total:	15

	$000
Short-term employee benefits	3,194
Post-employment benefits	358
Other long-term benefits	364
Termination benefits	113
Total compensation of senior officers	4,029

The short-term employee benefits includes salary, motor vehicle benefits and travel allowances incurred by the Health Service in respect of senior officers.

Note 45. Related party transactions

The Health Service is a wholly-owned and control 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 senior officers and their close family members, and their controlled or jointly controlled entities;
- public sector entities, including their related bodies, that are included in the whole of government consolidated financial statements;
- associates and joint ventures of public sector entities that are included in the whole of government consolidated financial statements; and
- the Government Employees Superannuation Board (GESB).

	2017 $000
Transactions with government related entities	
Significant transactions include:	
Income	
Service appropriations (note 22)	319,539
Assets assumed/(transferred) (note 23)	8
Services received free of charge (note 24)	34,199
Funding received from the Mental Health Commission (note 18)	53,167
Expenses	
Interest expense for the Department of Treasury Loan (note 10)	79
Operating lease expenses - Department of Finance (note 15)	1,577
Operating lease expenses - State Fleet (note 15)	501
Operating lease commitments with Department of Finance	
Commitments in relation to non-cancellable operating leases contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:	
Within 1 year	308
Later than 1 year and not later than 5 years	21
	329

	2017 $000

Note 45. Related Party Transactions (continued)

Transactions with other related parties

Details of significant transactions between the Health Service and other related parties are as follows:

Superannuation payments to GESB (note Child, community and primary health)	(2,764)
Payable to GESB	475

All other transactions (including general 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.

Note 46. Remuneration of auditor

Remuneration payable to the Auditor General in respect of the audit for the current financial year is as follows:

Auditing the accounts, financial statements, controls and key performance indicators	126

	2017 $000

Note 47. Commitments

The commitments below are inclusive of GST where relevant.

Capital expenditure commitments:

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

Within 1 year	1,371
Later than 1 year, and not later than 5 years	2,527
	3,898

Operating lease commitments:

Commitments in relation to non-cancellable operating leases contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:

Within 1 year	3,066
Later than 1 year and not later than 5 years	3,055
Later than 5 years	209
	6,330

Operating lease commitments predominantly consist of contractual agreements for community health centres. The basis of which contingent operating leases payments are determined is the value for each lease agreement under the contract terms and conditions at current values.

Private sector contracts for the provision of community health services:

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

Within 1 year	5,912
Later than 1 year and not later than 5 years	4,781
	10,693

Other expenditure commitments:

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

Within 1 year	18,804
Later than 1 year and not later than 5 years	11,607
	30,411

Note 48. Contingent liabilities and contingent assets

At the reporting date, the Health Service is not aware of any contingent assets or 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 Environment Regulation (DER). In accordance with the Act, DER 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.

Note 49. 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.

Note 50. 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.

Note 51. 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.

	2017 $000
Note 52. Other statement of receipts and payments	
Commonwealth Grant - Christmas and Cocos Island	
Balance at the start of period	-
Receipts	
Commonwealth grant - provision of Paediatric Services	107
Payments	
Costs of visiting specialists	(107)
Balance at the end of period	-

Note 53. Administered trust accounts

Funds held in these trust accounts are not controlled by the Health Service and are therefore not recognised in the financial statements.

The Health Service administers 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.

Note 54. 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* .

	2017 $000
Balance transferred from the Government at the start of period	558
Receipts	
Service delivery agreement	
Commonwealth contributions	6,297
State contributions	51,203
Other	1,964
	59,464
Payments	(59,327)
	137
Balance at the end of period	695

Note 55. Supplementary financial information

a) **Write-offs**

There were no write-offs during the period.

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.

Note 56. Explanatory statement

All variances between estimates (original budget) and actual results for 2017 are shown below. Narratives are provided for selected major variances, which are generally greater than:

(i) 5% and $11 million for Statement of Comprehensive Income;
(ii) 5% and $25 million for Statement of Financial Position and
(iii) 5% and $11 million for Statement of Cash Flows.

	Variance Note	2017 Estimates $000	2017 Actual $000	Variance between estimate and actual $000
STATEMENT OF COMPREHENSIVE INCOME				
Expenses				
Employee benefits expense		397,381	406,536	9,155
Fees for visiting medical practitioners		2,143	1,139	(1,004)
Contracts for services		9,894	9,260	(634)
Patient support costs		50,788	58,786	7,998
Finance costs		86	79	(7)
Depreciation and amortisation expense	(a)	56,980	11,496	(45,484)
Asset revaluation decrements	(b)	-	1,576	1,576
Loss on disposal of non-current assets		-	2	2
Repairs, maintenance and consumable equipment		7,170	7,592	422
Other supplies and services	(c)	2,591	31,934	29,343
Other expenses	(d)	40,076	26,697	(13,379)
Total Cost of Services		**567,109**	**555,097**	**(12,012)**

Note 56. Explanatory statement (continued)

STATEMENT OF COMPREHENSIVE INCOME (continued)

	Variance Note	2017 Estimates $000	2017 Actual $000	Variance between estimate and actual $000
INCOME				
Revenue				
Patient charges	(e)	16,439	13,185	(3,254)
Other fees for services		9,505	11,598	2,093
Commonwealth grants and contributions	(f)	142,633	120,857	(21,776)
Other grants and contributions		56,714	58,731	2,017
Donation revenue		1,888	1,293	(595)
Commercial activities	(g)	-	963	963
Other revenue	(h)	522	3,031	2,509
Total Revenue		**227,701**	**209,658**	**(18,043)**
Total Income other than Income from State Government		**227,701**	**209,658**	**(18,043)**
NET COST OF SERVICES		**339,408**	**345,439**	**6,031**
Income from State Government				
Service appropriations	(i)	338,313	319,539	(18,774)
Assets (transferred)/assumed		-	8	8
Services received free of charge	(j)	-	34,199	34,199
Total income from State Government		**338,313**	**353,746**	**15,433**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(1,095)**	**8,307**	**9,402**
OTHER COMPREHENSIVE INCOME				
Items not reclassified subsequently to profit or loss				
Changes in asset revaluation reserve		-	3,037	3,037
Total other comprehensive income		**-**	**3,037**	**3,037**
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE PERIOD		**(1,095)**	**11,344**	**12,439**

Note 56. Explanatory statement (continued)

Significant variances between estimated and actual results for 2017

(a) Depreciation and amortisation expense
The variance was caused by deferment in the opening of the Perth Children's Hospital (PCH) to the next financial year.

(b) Asset revaluation decrements
Decrements in the revaluation of land were unexpected.

(c) Other supplies and services
The variance is largely the expenses in relation to the accounting, human resources, information technology and supply services received free of charge from the Health Support Services ($28.168 million). The recognition of the expenses was not anticipated in the estimates (also see note 56(j)).

(d) Other expenses
The actual results exclude the costs associated with the Organisational Change and Redesign component of the PCH project. These costs, which formed part of 'Other expenses' in the original estimates, are included in the Department of Health's financial statements (see note 2(c)).

(e) Patient charges
The patient charges for the Perth Children's Hospital were not realised in the 2016-2017 financial year, as the hospital was not opened as planned.

(f) Commonwealth grants and contributions
Changes in certain funding from the Commonwealth grants and contributions to service appropriations had resulted in the variance.

(g) Commercial activities
The revenue for the café at the Princess Margaret Hospital was not included in the estimates.

(h) Other revenue
The revenue from Auspman, also known as the WA Hospitals Central Pharmaceutical Manufacturing Facility, is included in the actual results, but was not part of the estimates.

(i) Service appropriations
The variance was largely driven by the reduction in accrual component of the service appropriations and the realignment of $21.2 million funding for the Organisational Change and Redesign (OCR) component of the PCH project to the Health Ministerial Body. The funding for OCR is recognised in the Department of Health's financial statements (see note 2(c)).

(j) Services received free of charge
The estimates did not include the income in relation to services received free of charge from the Health Support Services ($28.168 million) (also see note 56(c)) and North Metropolitan Health Service - PathWest ($6.005 million).

Note 56. Explanatory statement (continued)

	Variance Note	2017 Estimates $000	2017 Actual $000	Variance between estimate and actual $000
STATEMENT OF FINANCIAL POSITION				
ASSETS				
Current Assets				
Cash and cash equivalents		7,505	22,442	14,937
Restricted cash and cash equivalents		8,100	16,712	8,612
Receivables		9,216	10,747	1,531
Inventories		2,654	2,540	(114)
Other current assets		559	448	(111)
Total Current Assets		28,034	52,889	24,855
Non-Current Assets				
Restricted cash and cash equivalents		-	1,644	1,644
Amounts receivable for services	(a)	232,328	186,301	(46,027)
Property, plant and equipment	(b)	1,221,785	107,411	(1,114,374)
Intangible assets	(b)	75,488	6	(75,482)
Total Non-Current Assets		1,529,601	295,362	(1,234,239)
TOTAL ASSETS		**1,557,635**	**348,251**	**(1,209,384)**
LIABILITIES				
Current Liabilities				
Payables		36,897	28,047	(8,850)
Borrowings		-	673	673
Provisions		77,695	79,595	1,900
Other current liabilities		-	212	212
Total Current Liabilities		114,592	108,527	(6,065)

Note 56. Explanatory statement (continued)

STATEMENT OF FINANCIAL POSITION (continued)

	Variance Note	2017 Estimates $000	2017 Actual $000	Variance between estimate and actual $000
Non-Current Liabilities				
Borrowings		2,114	1,442	(672)
Provisions		19,710	20,372	662
Total Non-Current Liabilities		21,824	21,814	(10)
TOTAL LIABILITIES		**136,416**	**130,341**	**(6,075)**
NET ASSETS		**1,421,219**	**217,910**	**(1,203,309)**
EQUITY				
Contributed equity		1,422,315	206,566	(1,215,749)
Reserves		-	3,037	3,037
Accumulated surplus/(deficit)		(1,096)	8,307	9,403
TOTAL EQUITY		**1,421,219**	**217,910**	**(1,203,309)**

Significant variances between estimates and actual for 2017

(a) Amounts receivable for services

The accrual component of the service appropriations has not increased as expected due to deferment in the opening of the Perth Children's Hospital (PCH) to the next financial year.

(b) Property, plant and equipment and Intangible assets

The variance relates to the assets for the Perth Children's Hospital that have not been transferred from the Health Ministerial Body to the Health Service due to the postponement in the hospital opening. The assets for the new hospital prior to commissioning are reported in the Department of Health's financial statements (see note 2(c)).

Note 56. Explanatory statement (continued)

	Variance Note	2017 Estimates $000	2017 Actual $000	Variance between estimate and actual $000
STATEMENT OF CASH FLOWS				
CASH FLOWS FROM STATE GOVERNMENT				
Service appropriations	(a)	277,103	304,112	27,009
Capital appropriations	(a)	93,245	1,121	(92,124)
Net cash provided by State Government		**370,348**	**305,233**	**(65,115)**
CASH FLOWS FROM OPERATING ACTIVITIES				
Payments				
Employee benefits		(393,237)	(398,559)	(5,322)
Supplies and services	(b)	(111,729)	(97,744)	13,985
Finance costs	(c)	(86)	-	86
Receipts				
Receipts from customers	(d)	16,439	11,252	(5,187)
Commonwealth grants and contributions	(e)	142,633	120,857	(21,776)
Other grants and contributions		56,714	58,731	2,017
Donations received		1,888	805	(1,083)
Other receipts	(f)	10,026	14,488	4,462
Net cash used in operating activities		**(277,352)**	**(290,170)**	**(12,818)**
CASH FLOWS FROM INVESTING ACTIVITIES				
Payments				
Purchase of non-current assets	(g)	(93,082)	(2,846)	90,236
Receipts				
Proceeds from sale of non-current assets		-	4	4
Net cash used in investing activities		**(93,082)**	**(2,842)**	**90,240**

Note 56. Explanatory statement (continued)

	Variance Note	2017 Estimates $000	2017 Actual $000	Variance between estimate and actual $000
CASH FLOWS FROM FINANCING ACTIVITIES				
Payments				
Repayment of borrowings	(h)	(642)	-	642
Net cash used in financing activities		**(642)**	**-**	**642**
Net increase/(decrease) in cash and cash equivalents		(728)	12,221	12,949
Cash and cash equivalents transfer from the Government		16,334	16,333	(1)
Cash and cash equivalents held for the Health Ministerial Body	(i)	-	12,244	12,244
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD		**15,606**	**40,798**	**25,192**

Significant variances between estimates and actual for 2017

(a) Service appropriations and Capital appropriations

The variance was largely caused by the additional service appropriations which were offset by the realignment of capital and recurrent funding for the Perth Children's Hospital (PCH) project. The funding for the PCH project is recognised in the Department of Health's financial statements (see note 2(c)).

(b) Supplies and services

The original estimates included the costs relating to the Organisational Change and Redesign component of the PCH project, but these costs are not included in the Health Service's financial statements.

(c) Finance costs

Interest expense for Treasury loan was paid by the Department of Health on behalf of the Health Service (see note 42).

(d) Receipts from customers

Additional receipts for patient charges expected from the opening of the new hospital did not eventuate in this financial year.

(e) Commonwealth grants and contributions

The variance was mainly resulted from the changes in certain funding from the Commonwealth grants and contributions to service appropriations.

Note 56. Explanatory statement (continued)

Significant variances between estimates and actual for 2017 (continued)

(f) Other receipts

Additional receipts from services provided to other health organisations and the inclusion of the Auspman (WA Hospitals Central Pharmaceutical Manufacturing Facility) revenue in the actual results contributed to the variance. The revenue from Auspman was not included in the estimates.

(g) Purchase of non-current assets

The estimates included the payments for non-current assets relating to PCH, but these assets were actually paid by the Health Ministerial Body during the financial year and reported in the Department of Health's financial statements.

(h) Repayment of borrowings

Repayments of Treasury loan were made by the Department of Health on behalf of the Health Service (see note 42).

(i) Cash and cash equivalents held for the Health Ministerial Body

Details are disclosed in note 26 'Restricted cash and cash equivalents' and note 35 'Payables'.

Note 57. Financial instruments

(a) Financial risk management objectives and policies

Financial instruments held by the Health Service are cash and cash equivalents, restricted cash and cash equivalents, borrowings, 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.

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 table at note 57(c) 'Financial instrument disclosures' and note 27 'Receivables'.

Credit risk associated with the Health Service's financial assets is generally confined to patient fee debtors (see note 27). 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. For financial assets that are either past due or impaired, refer to note 57 (c) 'Financial instrument disclosures'.

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. The Health Service's borrowings consist of the Department of Treasury (DT) loans. The interest rate risk for the loans is managed by DT through portfolio diversification.

Note 57. Financial instruments (continued)

(b) Categories of financial instruments

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

	2017 $000
Financial Assets	
Cash and cash equivalents	22,442
Restricted cash and cash equivalents	18,356
Loans and receivables (a)	196,763
Financial Liabilities	
Financial liabilities measured at amortised cost	30,162

(a) The amount of loans and receivables excludes GST recoverable from ATO (statutory receivable).

Note 57. Financial instruments (continued)

(c) Financial instrument disclosures

Credit risk

The following table discloses the Health Service's maximum exposure to credit risk and the ageing analysis of financial assets. The Health Service's maximum exposure to credit risk at the end of the reporting period is the carrying amount of financial assets as shown below. The table discloses the ageing of financial assets that are past due but not impaired and impaired financial assets.

The Health Service does not hold any collateral as security or other credit enhancements relating to the financial assets it holds.

Ageing analysis of financial assets

	Carrying amount	Not past due and not impaired	Past due but not impaired				Impaired Financial assets
			1 - 3 months	3 - 12 months	1-5 years	More than 5 years	
	$000	$000	$000	$000	$000	$000	$000
2017							
Cash and cash equivalents	22,442	22,442	-	-	-	-	-
Restricted cash and cash equivalents	18,356	18,356	-	-	-	-	-
Receivables (a)	10,462	5,238	2,386	2,281	557	-	-
Amounts receivable for services	186,301	186,301	-	-	-	-	-
	237,561	**232,337**	**2,386**	**2,281**	**557**	**-**	**-**

(a) The amount of receivables excludes the GST recoverable from ATO (statutory receivable)

Note 57. Financial instruments (continued)

(c) Financial instrument disclosures (continued)

Liquidity risk and interest rate exposure

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

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

		Interest rate exposure					Maturity dates			
	Weighted average effective interest rate	Carrying amount	Fixed interest rate	Variable interest rate	Non-interest bearing	Nominal Amount	Up to 3 months	3 months to 1 year	1-5 years	More than 5 years
	%	$000	$000	$000	$000	$000	$000	$000	$000	$000
2017										
Financial Assets										
Cash and cash equivalents	-	22,442	-	-	22,442	22,442	22,442	-	-	-
Restricted cash and cash equivalents	-	18,356	-	-	18,356	18,356	16,712	-	-	1,644
Receivables (a)	-	10,462	-	-	10,462	10,462	10,462	-	-	-
Amounts receivable for services	-	186,301	-	-	186,301	186,301	-	-	-	186,301
		237,561	**-**	**-**	**237,561**	**237,561**	**49,616**	**-**	**-**	**187,945**
Financial Liabilities										
Payables	-	28,047	-	-	28,047	28,047	28,047	-	-	-
Department of Treasury Loans	3.18%	2,115	-	2,115	-	2,225	184	548	1,493	-
		30,162	**-**	**2,115**	**28,047**	**30,272**	**28,231**	**548**	**1,493**	**-**

(a) The amount of receivables excludes the GST recoverable from ATO (statutory receivable)

Note 57. Financial instruments (continued)

(c) Financial instrument disclosures (continued)

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.

	Amount Exposed to Interest Rate Risk $000	-100 basis points		+100 basis points	
		Surplus $000	Equity $000	Surplus $000	Equity $000
2017					
Financial Liabilities					
Department of Treasury Loans	2,115	21	21	(21)	(21)
Total Increase/(Decrease)		**21**	**21**	**(21)**	**(21)**

All financial assets and liabilities recognised in the Statement of Financial Position, whether they are carried at cost or fair value, are recognised at amounts that represent a reasonable approximation of fair value unless otherwise stated in the applicable notes.

Note 58. Schedule of income and expenses by service

	Public Hospital Admitted Patient	Home-Based Hospital Programs	Emergency Department	Public Hospital Non-Admitted Patients	Mental Health	Prevention, Promotion and Protection	Total
	2017 $000	2017 $000	2017 $000	2017 $000	2017 $000	2017 $000	2017 $000
COST OF SERVICES							
Expenses							
Employee benefits expense	156,703	1,544	29,017	69,733	57,158	92,381	406,536
Fees for visiting medical practitioners	694	7	129	309	-	-	1,139
Contracts for services	3,063	30	567	1,363	3	4,234	9,260
Patient support costs	34,090	418	6,311	15,197	1,134	1,636	58,786
Finance costs	49	-	9	21	-	-	79
Depreciation and amortisation expense	6,739	66	1,248	2,999	48	396	11,496
Asset revaluation decrements	915	9	169	407	-	76	1,576
Loss on disposal of non-current assets	2	-	-	-	-	-	2
Repairs, maintenance and consumable equipment	2,658	26	492	1,182	1,170	2,064	7,592
Other supplies and services	13,752	136	2,546	6,120	3,314	6,066	31,934
Other expenses	11,321	112	2,096	5,038	3,281	4,849	26,697
Total cost of services	229,986	2,348	42,584	102,369	66,108	111,702	555,097
Income							
Patient charges	10,231	-	270	2,673	11	-	13,185
Other fees for services	6,866	68	1,272	3,056	147	189	11,598
Commonwealth grants and contributions	67,136	44	14,793	31,837	6,297	750	120,857
Other grants and contributions	3,111	31	576	1,385	53,551	77	58,731
Donation revenue	788	8	146	351	-	-	1,293
Commercial activities	587	6	109	261	-	-	963
Other revenue	1,706	17	316	759	41	192	3,031
Total income other than income from State Government	90,425	174	17,482	40,322	60,047	1,208	209,658
NET COST OF SERVICES	**139,561**	**2,174**	**25,102**	**62,047**	**6,061**	**110,494**	**345,439**
INCOME FROM STATE GOVERNMENT							
Service appropriations	131,730	1,961	26,655	52,399	629	106,165	319,539
Assets (transferred)/assumed	13	-	-	-	(5)	-	8
Services received free of charge	14,690	230	2,717	6,646	3,657	6,259	34,199
Total income from State Government	146,433	2,191	29,372	59,045	4,281	112,424	353,746
SURPLUS / (DEFICT) FOR THE PERIOD	**6,872**	**17**	**4,270**	**(3,002)**	**(1,780)**	**1,930**	**8,307**

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

Key Performance Indicators

Certification of key performance indicators

CHILD AND ADOLESCENT HEALTH SERVICE

CERTIFICATION OF KEY PERFORMANCE INDICATORS FOR THE YEAR ENDED 30 JUNE 2017

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 2017.

Ms Deborah Karasinski

BOARD CHAIR

CHILD AND ADOLESCENT HEALTH SERVICE BOARD

27 September 2017

Mr Brendan Ashdown

BOARD MEMBER

CHILD AND ADOLESCENT HEALTH SERVICE BOARD

27 September 2017

KPIs measuring Outcome 1

KPIs measuring Outcome 2

Percentage of patients discharged to home after admitted hospital treatment

Rationale

The main goals of healthcare provision are to ensure that people receive appropriate evidenced-based health care without experiencing preventable harm and that effective partnerships are forged between consumers, healthcare providers and organisations. Through achieving improvements in the specific priority areas that these goals describe, hospitals can deliver safer and higher-quality care, better outcomes for patients and provide a more effective and efficient health system.

Measuring the number of patients discharged to home after hospital care allows for the monitoring of changes over time that can enable the identification of the priority areas for improvement. This in turn enables the determination of targeted interventions and health promotion strategies, aimed at ensuring optimal restoration of patients' health.

Target

The 2016 target is 99.8 per cent. Performance is demonstrated by a result that equals or exceeds the target.

Result

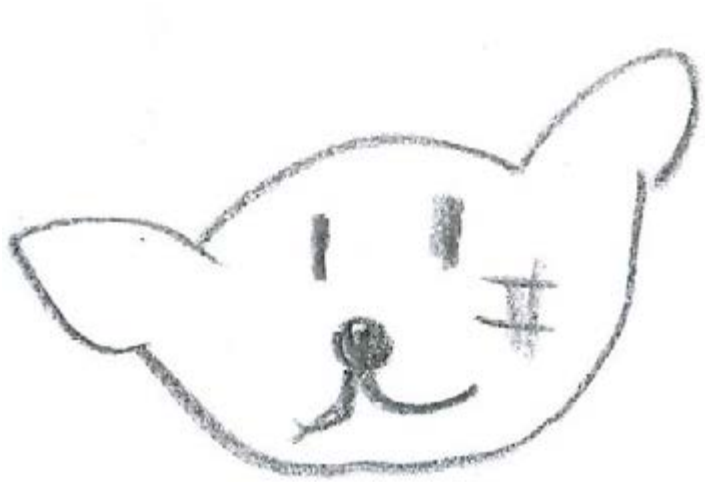
During 2016, a total of 99.8 per cent of Child and Adolescent Health Service patients were discharged home after receiving admitted hospital treatment (Table 4). This result is equal to the target.

Table 4: Percentage of patients discharged to home after admitted hospital treatment, 2016

Age group (years)	Discharged home	
	2016 (%)	Target (%)
0–39	99.8	99.8

Notes:
1. The devolved governance structure for the WA health system enacted by the Health Services Act 2016 took effect from 1 July 2016. For 2016, data is reported from 1 July to 31 December 2016.
2. The Child and Adolescent Health Service treats patients aged 0–17 years.

Data source: Hospital Morbidity Data Collection.



"Thank you PMH for everything, I owe you guys my life :)"

Survival rates for sentinel conditions

Rationale

Hospital survival indicators should be used as screening tools, rather than being assumed to be definitively diagnostic of poor quality and/or safety.

This indicator measures a hospital's performance in relation to restoring the health of people who have suffered a sentinel condition-specifically a stroke or Acute Myocardial Infarction (AMI). For these conditions, a good recovery is more likely when there is early intervention and appropriate care on presentation to an emergency department and on admission to hospital.

These two conditions have been chosen as they are particularly significant for the health care of the community and are leading causes of death and hospitalisation in Australia.

Patient survival after being admitted for one of these two sentinel conditions can be affected by many factors that include the diagnosis, the treatment given or procedure performed, age, co-morbidities at the time of the admission and complications which may have developed while in hospital.

Target

The 2016 target for each condition, by age group:

Age group (years)	Sentinel condition	
	Stroke (%)	AMI (%)
0–49	95.3	99.5

Performance is demonstrated by a result that equals or exceeds the target.

Results

The Child and Adolescent Health Service recorded a 100 per cent survival rate for stroke in 2016 (Table 5). There is no result to report for acute myocardial infarction, as no patients with this condition were treated during 2016 (Table 6).

Table 5: Survival rate for stroke, by age group, 2016

Age group (years)	Stroke	
	2016 (%)	Target (%)
0–49	100	95.3

Notes:
1. The devolved governance structure for the WA health system enacted by the *Health Services Act 2016* took effect from 1 July 2016. For 2016, data is reported from 1 July to 31 December 2016.
2. The Child and Adolescent Health Service treats patients aged 0–17 years

Data source: Hospital Morbidity Data Collection.

Table 6: Survival rate for acute myocardial infarction, by age group, 2016

Age group (years)	Acute Myocardial Infarction	
	2016 (%)	Target (%)
0–49	N/A	99.5

Notes:
1. The devolved governance structure for the WA health system enacted by the *Health Services Act 2016* took effect from 1 July 2016. For 2016, data is reported from 1 July to 31 December 2016.
2. The Child and Adolescent Health Service treats patients aged 0–17 years.
3. Result listed as N/A (not available) is due to zero cases having been treated.

Data source: Hospital Morbidity Data Collection.

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

Rationale

On 1 April 2016, WA Health introduced a new state-wide performance target for the provision of elective services. The new target requires no patients (nil) on the elective waiting lists wait longer than the clinically recommended time for their procedure, according to their urgency category.

Reportable cases are defined as all waiting list cases that are not listed on the Elective Surgery Wait List Data Collection Commonwealth Non-Reportable Procedures list. This list is consistent with the Australian Institute of Health and Welfare (AIHW) excluded procedures list. It also includes additional procedure codes that are intended to better reflect the procedures identified in the AIHW excluded procedures list.

Target

The 2016–17 target is 0 (nil) for all urgency categories. Performance is demonstrated by a result that equals the target.

Results

In 2016–17, only 0.4 per cent of Child and Adolescent Health Service Category 1 elective wait list patients were not treated within 30 days, and only 0.1 per cent of Category 2 patients were not treated within 90 days. For Category 3 patients, nearly all patients were treated within 365 days, as the result was 0.0 per cent being over boundary.

Table 7: Proportion of elective wait list patients waiting over boundary for reportable procedures, by urgency category, 2016–17

Urgency	2016–17 Over-boundary (%)	Target (%)
Category 1 (≤30 days)	0.4	0
Category 2 (≤90 days)	0.1	0
Category 3 (≤365 days)	0.0	0

Notes:
1. The result is based on an average of weekly census data for the financial year.

Data source: Elective Surgery Wait List Data Collection.

Unplanned hospital readmissions within 28 days for selected surgical procedures

Rationale

Readmission rate is considered a global performance measure, as it potentially points to deficiencies in the functioning of the overall healthcare system. Good intervention, appropriate treatment together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. A low unplanned readmission rate suggests that good clinical practice is in operation. These readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

By measuring and monitoring this indicator, the level of potentially avoidable hospital readmissions can be assessed in order to identify key areas for improvement. This in turn can facilitate the development and delivery of targeted care pathways and interventions, which can help to ensure effective restoration to health and improve the quality of life of Western Australians.

Target

The 2016 target for each procedure:

Surgical Procedure	Target (per 1,000)
Knee Replacement	22
Hip Replacement	21
Tonsillectomy & Adenoidectomy	71
Hysterectomy	47
Prostatectomy	34
Cataract Surgery	1
Appendicectomy	39

Performance is demonstrated by a result that equals or is below the target.

Results

The rates of unplanned readmissions within 28 days to a Child and Adolescent Health Service hospital for selected surgical procedures in 2016 are presented in Table 8 below. There were no unplanned readmissions for cataract surgery. The rate of unplanned readmissions for tonsillectomy and adenoidectomy was 74.6 per 1,000, which was marginally above the target of 71 per 1,000. The rate of unplanned readmissions for appendicectomy was 45.2 per 1,000, which was above target of 39 per 1,000. Only a small number of patients were readmitted to hospital, so the reported rates of unplanned readmissions should be interpreted with caution. The Child and Adolescent Health Service did not perform any knee replacements, hip replacements, hysterectomies or prostatectomies in 2016.

Table 8: Rate of unplanned readmissions within 28 days for selected surgical procedures, 2016

Surgical Procedure	2016 (per 1,000)	Target (per 1,000)
Knee Replacement	N/A	22
Hip Replacement	N/A	21
Tonsillectomy & Adenoidectomy	74.6	71
Hysterectomy	N/A	47
Prostatectomy	N/A	34
Cataract Surgery	0	1
Appendicectomy	45.2	39

Notes:
1. The devolved governance structure for the WA health system enacted by the *Health Services Act 2016* took effect from 1 July 2016. For 2016, data is reported from 1 July to 31 December 2016.
2. Results listed as N/A (not available) are due to zero cases having been treated.

Data source: Hospital Morbidity Data Collection.

Rate of unplanned readmissions within 28 days to the same hospital for a mental health condition

Rationale

Readmission rate is considered a global performance measure because it potentially points to deficiencies in the functioning of the overall healthcare system. Admissions to a psychiatric facility following a recent discharge may indicate that inpatient treatment was incomplete or ineffective, or that follow-up care was inadequate to maintain the person out of hospital. These readmissions necessitate patients spending additional time in hospital and utilise additional hospital resources.

Good intervention and appropriate treatment together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. A low unplanned readmission rate suggests that good clinical practice is in operation.

By measuring and monitoring this indicator, the level of potentially avoidable hospital readmissions for mental health patients can be assessed to identify key areas for improvement. This in turn can facilitate the development and delivery of targeted care pathways and interventions, which can aim to improve mental health and the quality of life of Western Australians.

For this indicator a sample period of three months is used, and relevant data is subjected to clinical review to ensure the accuracy of the readmission status – unplanned or otherwise.

Target

The 2016 target is 66 unplanned readmissions per 1,000. Performance is demonstrated by a result that equals or is below the target.

Result

In 2016, the rate of unplanned readmissions within 28 days to the same public hospital for a mental health condition was 18.6 per 1,000. This is below the target of 66 per 1,000 (Table 9).

Table 9: Rate of unplanned readmissions within 28 days to the same hospital relating to the previous mental health condition for which they were treated, 2016

	2016 (per 1,000)	Target (per 1,000)
Unplanned readmissions	18.6	66

Notes:
1. This indicator is based on a 3 month period each year. For 2016, data is reported from 1 September to 30 November 2016.

Data source: Hospital Morbidity Data Collection.

Average cost per casemix adjusted separation for tertiary hospitals

Rationale

Tertiary hospitals provide critical healthcare for Western Australians and generally treat patients with complex health needs. While the role of tertiary hospitals is constantly evolving to meet the changing needs and characteristics of the population, they still provide core healthcare services such as acute medical care, emergency and intensive care services, complex specialty procedures, clinical research and training.

Target

The target for 2016–17 is $7,280 per casemix adjusted separation from a tertiary hospital. A result below the target is desirable.

Result

The average cost per casemix adjusted separation for the Child and Adolescent Health Service was $7,615, which was above the target of $7,280 (Table 10).

Table 10: Average cost per casemix adjusted separation, 2016–17

	2016–17 ($)	Target ($)
Average cost per casemix adjusted separation for tertiary hospitals	7,615	7,280

Notes:
1. Casemix adjusted separations adjust raw activity data to reflect the complexity of services provided for treating the various conditions for admitted patients. WA Health hospitals utilise the Australian Refined Diagnosis Related Groups (DRGs) classifications to assign cost weights to each diagnostic group.

Data sources: Hospital Morbidity Data Collection, health service financial system.

Average cost per home based hospital patient day

Rationale

WA Health aims to provide safe, high-quality health care to ensure healthier, longer, and better quality lives for all Western Australians.

Home-based hospital programs i.e. Hospital in the Home (HITH), Rehabilitation in the Home (RITH) and Mental Health in the Home (MITH), have been implemented as a means of ensuring all Western Australians have timely access to effective health care. These home-based programs, provided by the public health system, aim to provide safe and effective medical care for suitable patients in their home. These patients would otherwise require admission to hospital.

Target

The target for 2016–17 is $583 per home based hospital patient day. A result below the target is desirable.

Result

The average cost per home based hospital patient day in 2016–17 was $1,066, which was above the target of $583 (Table 11). The higher expenditure to target is attributed to an overestimate of activity used when deriving the target, and revisions to the actual cost allocation system to increase accuracy of reporting since the targets were developed in early 2016.

Table 11: Average cost per home based hospital patient day, 2016–17

	2016–17 ($)	Target ($)
Average cost per home based hospital patient day	1,066	583

Data sources: Hospital Morbidity Data Collection, health service financial system.

Average cost per emergency department attendance

Rationale

WA Health aims to provide safe, high-quality health care to ensure healthier, longer and better quality lives for all Western Australians.

Emergency departments are specialist multidisciplinary units with expertise in managing acutely unwell patients for the first few hours in hospital. With the ever increasing demand on emergency departments and health services, it is imperative that health service provision is continually monitored to ensure the effective and efficient delivery of safe and high-quality care.

Target

The target for 2016–17 is $566 per emergency department attendance. A result below the target is desirable.

Result

The average cost per emergency department attendance for the Child and Adolescent Health Service was $607, which was above the target of $566 (Table 12).

Table 12: Average cost per emergency department attendance, 2016–17

	2016–17 ($)	Target ($)
Average cost per emergency department attendance	607	566

Data sources: Hospital Morbidity Data Collection, health service financial system.

Average cost per public patient non-admitted activity

Rationale

WA Health aims to provide safe, high-quality health care to ensure healthier, longer, and better quality lives for all Western Australians.

Non-admitted care encompasses services provided to patients who do not undergo a formal admission process and do not occupy a hospital bed. These services provide consultations with a clinician or specialist to determine the most appropriate treatment of a patient's condition.

Target

The target for 2016–17 is $345 per public patient non-admitted activity. A result below the target is desirable.

Result

The average cost per non-admitted patient activity for the Child and Adolescent Health Service in 2016–17 was $436, which is above the target of $345 (Table 13). The higher expenditure to target is attributed to an overestimate of activity used when deriving the target, and revisions to the actual cost allocation system to increase accuracy of reporting since the targets were developed in early 2016.

Table 13: Average cost per public hospital non-admitted patient activity, 2016–17

	2016–17 ($)	Target ($)
Average cost per public patient non-admitted activity	436	345

Data sources: Non Admitted Patient Activity and Wait List Data Collection, health service financial system.

Percentage of contacts with community-based public mental health non-admitted services within seven days prior to admission to a public mental health inpatient unit

Rationale

The impact of mental illness within the Australian population has become increasingly apparent with mental illness being one of the leading causes of non-fatal burden of disease in Australia.

In 2014–15 there were 4.0 million Australians (17.5 per cent) who reported having a mental or behavioural condition[1]. That's why it is crucial to ensure effective and appropriate care is provided not only in a hospital setting but also in the community care setting.

A large proportion of treatment of mental illness is carried out in community care setting through ambulatory mental health services. The aim is to provide the best health outcomes for the individual through the provision of accessible and appropriate community mental health care. Thus, alleviating the need for, or assisting with improving the management of, admissions to hospital-based inpatient care for mental illness.

Monitoring the level of accessibility to community mental health services pre-admission to hospital can be gauged in order to assist in the development of effective programs and interventions. This in turn can help to improve the health and wellbeing of Western Australians with mental illness and ensure sustainability of the public health system.

[1]National Health Survey 2014–15

Target

The target for 2016 is 70 per cent, with a result above the target being desirable. This target was endorsed by the Australian Health Ministers' Advisory Council Mental Health Standing Committee in May 2011. The target of 70 per cent is based on a national definition, with the majority of jurisdictions, including WA, being unable to achieve this aspirational target from 2007–08.

Result

The Child and Adolescent Mental Health Service Inpatient Unit (CAMHS IPU) Model of Care recommends that all patients who require an inpatient admission should be seen by the non-admitted service prior to admission to clearly articulate the goals of admission and maximise the benefits of admission.

The CAMHS IPU provides planned admissions for patients who require frequent inpatient admissions and for patients requiring non-acute interventions. This is usually complementary to ongoing community service involvement.

In 2016, 86.0 per cent of young people who were admitted to a Child and Adolescent Health Service mental health inpatient unit had been in contact with a community-based public mental health non-admitted health service in the previous seven days (Table 14). This result is well above the aspirational target of 70 per cent.

Table 14: Percentage of contacts with a community-based public mental health non-admitted service seven days prior to admission, 2016

	2016 (%)	Target (%)
Pre-admission community based contact	86.0	70

Notes:
1. The devolved governance structure for the WA health system enacted by the *Health Services Act 2016* took effect from 1 July 2016. For 2016, data is reported from 1 July to 31 December 2016.

Data sources: Mental Health Information System, Hospital Morbidity Data Collection.

Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units

Rationale

In 2014–15 there were 4.0 million Australians (17.5 per cent) who reported having a mental or behavioural condition[2]. 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 heightened levels of vulnerability and, without adequate follow up, may relapse or be readmitted. This KPI measures the performance of the overall health system in providing continuity of mental health care.

A responsive community support system for people 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 discharge with a formal discharge plan, involving linkages with public community based services and support, are less likely to need avoidable readmission.

The standard underlying the measure is that continuity of care involves prompt community follow up in the vulnerable period following discharge from hospital. Overall, the variation in post-discharge follow up rates suggests important differences between mental health systems in terms of their practices.

[2]National Health Survey 2014–15

Target

The target for 2016 is 75 per cent, with a result above the target being desirable. This target was endorsed by the Australian Health Ministers' Advisory Council Mental Health Standing Committee in May 2011. The target is considered aspirational, as the measure only includes follow-up by public community mental health services.

Result

Decentralisation of community services across the metropolitan area has increased capacity to provide urgent response locally, including providing community-based, post-discharge follow up. The Child and Adolescent Mental Health Service Inpatient Unit has also implemented a new process whereby additional telephone follow up support is provided within 48 hours post-discharge.

In 2016, 72.9 per cent of young people who were admitted to a Child and Adolescent Health Service mental health inpatient unit were contacted by a community-based public mental health non-admitted health service within seven days of discharge (Table 15). This result is marginally below the aspirational target of 75 per cent.

Table 15: Percentage of contacts with a community-based public mental health non-admitted service seven days post discharge, 2016

	2016 (%)	Target (%)
Post-discharge community based contact	72.9	75

Notes:
1. The devolved governance structure for the WA health system enacted by the *Health Services Act 2016* took effect from 1 July 2016. For 2016, data is reported from 1 July to 31 December 2016.

Data sources: Mental Health Information System, Hospital Morbidity Data Collection

Average cost per capita of Population Health Units

Rationale

Population health units support individuals, families and communities to increase control over and improve their health. With the aim of improving health, population health works to integrate all activities of the health sector and link them with broader social and economic services and resources by utilising the WA Health Promotion Strategic Framework 2012–2016 (the latest version is due for public at the end of this year). This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

The target for 2016–17 is $236 per capita served by population health units. A result below the target is desirable.

Result

Average cost per person of delivering population health programs by Population Health Units was $225, which is below the target of $236 (Table 16).

Table 16: Average cost per person of delivering population health programs by Population Health Units, 2016–17

	2016–17 ($)	Target ($)
Average cost per capita of Population Health Units	225	236

Notes:

1. The 2016 calendar year population estimate has been used to represent the 2016–17 reporting year.

Data Sources: Australian Bureau of Statistics, health service financial system.

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

Rationale

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

Target

The target for 2016–17 is $2,857 per bed-day in specialised mental health units. A result below the target is desirable.

Result

In 2016–17, the average cost per bed-day in specialised mental health inpatient units was $4,346, which is above the target (Table 17).

The higher expenditure to target is attributed to several factors. There was an overestimate of activity used when deriving the target, and revisions have been made to the actual cost allocation system to increase accuracy of reporting since the targets were developed in early 2016. Furthermore, as a result of staff shortages and to prepare for the scheduled opening of Perth Children's Hospital, activity had to be reduced, which increased the average cost per bed-day.

Table 17: Average cost per bed-day in specialised mental health inpatient units, 2016–17

	2016–17 ($)	Target ($)
Average cost per bed-day in specialised mental health inpatient units	4,346	2,857

Data Sources: BedState, health service financial system.

Average cost per three month period of care for community mental health

Rationale

Mental illness is having an increasing impact on the Australian population and is one of the leading causes of disability burden in Australia. In 2014–15, there were 4.0 million Australians (17.5 per cent) who reported having a mental or behavioural condition[3]. Therefore, it is important to ensure effective and appropriate care is provided to mental health clients not only in a hospital setting, but also in the community through the provision of community mental health services.

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

Target

The target for 2016–17 is $4,991 per three month period of care for a person receiving community mental health services. A result below the target is desirable.

Result

In 2016–17, the average cost per three month period of care for a person receiving public community mental health services was $3,561, which is below target (Table 18). The lower expenditure to target is attributable to an overestimate of expenditure when deriving the target, and improved efficiency of service delivery.

Table 18: Average cost per three month period of care for a person receiving community mental health services, 2016–17

	2016–17 ($)	Target ($)
Average cost per three month period of care for community mental health	3,561	4,991

Data sources: Mental Health Information System, health service financial system.

[3]National Health Survey 2014–15

Other Financial Disclosures

Board and committee remuneration

Annual remuneration for each board or committee is listed in Table 19.

Table 19: State Government boards and committees within the Child and Adolescent Health Service, 2016–17

Position	Name	Type of remuneration	2016–17 period of membership	2016–17 total remuneration
Child and Adolescent Health Service Board				
Chair	Ms Deborah Karasinski	Board member allowance	12 months	$65,926
Member	Professor Geoffrey Dobb	Ineligible	12 months	$0
Member	Dr Daniel McAullay	Board member allowance	12 months	$39,555
Member	Mr Brendan Ashdown	Board member allowance	12 months	$39,555
Member	Ms Kathleen Bozanic	Board member allowance	12 months	$39,555
Member	Ms Linley (Anne) Donaldson	Board member allowance	12 months	$39,555
Member	Mr Peter Mott	Board member allowance	12 months	$39,555
Member	Mr Andrew Thompson	Board member allowance	12 months	$39,555
Member	Dr Alexius Julian	Board member allowance	12 months	$39,555
Total				**$342,811**
Eating Disorders Program Consumer Advisory Group				
Member	Member 1*	Per meeting	12 Months	$420
Member	Ashleigh Hardcastle	Per meeting	12 Months	$600
Member	Emily Wheeler	Per meeting	12 Months	$240
Member	Linelle Fields	Per meeting	12 Months	$480
Member	Melanie Coleman	Per meeting	12 Months	$240
Member	Teagan Martin	Per meeting	12 Months	$60
Total				**$2,040**

* To protect patient confidentiality, approval to withhold the name of this committee member was sought from the Minister for Health.

Notes:

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 2016–17 financial year.

Pricing policy

The National Health Reform Agreement 2011 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 that are embedded in the National Health Reform Agreement.

The majority of hospital fees and charges for public hospitals are set under the Health Services (Fees and Charges) Order 2016 and the WA Health Fees and Charges Manual 2017/18, as established under the policy frameworks under the *Health Services Act 2016,* and are reviewed annually. These set WA public hospital patient fees and charges for:

- Compensable or ineligible patients

Patients who are either 'private' or 'compensable' and Medicare ineligible (overseas visitors, residents and students) may be charged an amount for public hospital services as determined by the State. Compensable and ineligible hospital accommodation fees are set at an appropriate recovery rate by the Department of Health.

- 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. 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 or dependents are determined under a separate Commonwealth-State agreement with the Department of Veterans' Affairs. Under this agreement, the Department of Health does not charge medical treatment to eligible patients. Instead, medical charges are fully recouped from the Department of Veterans' Affairs.

- Other Patient Charges

The following fees and charges also apply:

  - 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 WA Health Fees and Charges Manual 2016–17, which include the supply of surgically implanted prostheses, orthoses, diagnostic imaging services and pathology services. The pricing for these hospital services is determined according to Commonwealth schedules and to their cost of service as applicable.

Capital works

The WA health system has a substantial Asset Investment Program that facilitates re-modelling and development of health infrastructure. Program initiatives include the continuation of major projects to reconfigure metropolitan tertiary hospitals, equipment replacement and minor building works.

Please refer to Table 20 and to the Department of Health Annual Report 2016–17 for financial details of the Child and Adolescent Health (CAHS) capital works program.

Table 20: Major Asset Investment Program works completed in 2016–17

Initiative	2016–17
Equipment Replacement Program	$723,834
Minor Building Works	$398,288
Total	**$1,122,122**

Employment profile

CAHS is required to report a summary of the number of employees, by category, compared with the preceding financial year.

The devolved governance structure for the WA health system enacted by the *Health Services Act 2016* took effect from 1 July 2016, so comparative figures for CAHS are not available. Table 21 shows the number of Full-time Equivalent (FTE) employees for 2016–17.

Table 21: Total full-time employees of CAHS, by category

Category	Definition	2016–17
Administration & clerical	Includes all clerical-based occupations together with patient-facing (ward) clerical support staff.	721.8
Agency	Includes the following occupational categories: administration and clerical, medical support, hotel services, site services, medical salaried (excludes visiting medical practitioners) and medical sessional.	46.4
Agency nursing	Includes workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest.	5.4
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care.	5.7
Dental nursing	Includes dental nurses and dental clinic assistants.	5.8
Hotel services	Includes catering, cleaning, stores/supply laundry and transport occupations.	149.0
Medical salaried	Includes all salary-based medical occupations including interns, registrars and specialist medical practitioners.	324.5
Medical sessional	Includes specialist medical practitioners that are engaged on a sessional basis.	65.6
Medical support	Includes all Allied Health and scientific/technical related occupations.	608.6
Nursing	Includes all nursing occupations. Does not include agency nurses.	1,158.3
Site services	Includes engineering, garden and security-based occupations.	1.6
Other occupations	Includes, but is not limited to, Aboriginal and ethnic health employees.	16.2
Total		**3,108.9**

Notes:
1. Data Source: HR Data Warehouse.
2. FTE is calculated as the monthly average FTE and is the average hours worked during a period of time divided by the Award full-time hours for the same period. Hours include ordinary time, overtime, all leave categories, public holidays, time off in lieu and workers compensation.
3. FTE figures provided are based on Actual (paid) month to date FTE.
4. The devolved governance structure for the WA health system enacted by the *Health Services Act 2016* took effect from 1 July 2016, so results prior to this date are not available.

Workforce development

CAHS is committed to training and development of staff to support the delivery of quality health services.

Essential corporate training is provided to all new staff and includes accountable and ethical decision making, record keeping awareness, Aboriginal cultural awareness, emergency procedures, manual handling and occupational health and safety. Additional ongoing training is available to staff in the areas of human resource management, recruitment, selection and appointment, cultural diversity and professional codes of conduct (including bullying in the workplace).

Specific role-related clinical and non-clinical training and education is provided by health service sites, delivered either internal or external to the organisation and through online e-learning resources. Additionally, ongoing undergraduate, graduate, staff training and leadership development programs are available to employees. There is a range of general corporate training courses (conducted under policies) including:

- a corporate induction program and an orientation to work area for new staff.
- general management skills training programs including Performance Development, Coaching for Improved Performance, Managing Poor Performance, Conflict Resolution and Assertive Communication.
- CAHS training courses are offered either as face-to-face programs, or as an e-learning program using adult learning principles and practices. Training courses contain a feedback mechanism for participants for continuous improvement.

Perth Children's Hospital education and training

The CAHS Learning Management System (iLearn), implemented in April 2016, continues to successfully allow scheduling and reporting on training required as well providing a one-stop place to access online learning options. This system has been successful.

More than 2,500 staff (90 per cent) completed induction and orientation training and 2,200 (80 per cent) completed pre-requisite e-learning for Perth Children's Hospital (PCH). This training includes orientation to the site and local area, emergency preparedness, infection control, information and communications technology, medications management, occupational health and safety and specialised equipment training.

Graduate Registered Nurses complete hoist training at PCH.

Industrial relations

The WA Health Industrial Relations Service function ceased during the 2016–17 financial year, with the industrial relations function transferred directly to CAHS with resources as a result of the introduction of the *Health Services Act 2016*. The newly established industrial relations support within CAHS continues to provide representation and consultancy support in industrial relations for significant workforce management issues.

During 2016–17, CAHS experienced organisational change and restructuring within Princess Margaret Hospital (PMH), Child and Adolescent Community Health (CACH), the Child and Adolescent Mental Health Service (CAMHS) and the corporate support structures. Due to the magnitude of restructuring and reconfigurations in 2016–17, CAHS was required to formally consult with unions to a far greater extent than previous years. This has resulted in a more positive and collaborative working relationship with some of the unions.

PMH underwent a complete organisational restructure to align to the new ward structures, ward sizes and changes in workflows at PCH. While the organisational change engagement processes started in 2015–16, it continued during 2016–17. This restructuring needed to occur well in advance of any physical relocation to PCH, and involved the transition of 2,570 staff (across PMH and CAMHS) from the old structures to the new structures, with new patient service delivery models also being introduced during this restructuring.

As a result of effective and regular communication with both staff and unions on the restructuring process, there was no lost time due to industrial disputation. Similarly, there was no industrial disputation arising from the significant reconfigurations that occurred within CAMHS.

There were no issues directly involving CAHS that proceeded to arbitration before industrial courts or tribunals, with all formal disputes lodged by the unions being resolved through conciliation processes.

Human Resources staff continued to provide an ongoing, effective service during the above transition processes. There was a surge of activity relating to individual employee issues in 2016–17 that required ongoing management throughout the year.

Workers' compensation

The WA Workers' Compensation system was established by the State Government and exists under the statute of the *Workers' Compensation & Rehabilitation Act 1981*.

CAHS is committed to providing staff with a safe and healthy work environment, and recognises this as pivotal in attracting and maintaining the workforce necessary to deliver effective and efficient health care services. In 2016–17, a total of 66 workers' compensation claims were made (see Table 22).

Table 22: Number of workers' compensation claims in 2016–17

Employee Category	Number
Nursing Services/Dental Care Assistants	28
Administration and Clerical	15
Medical Support	9
Hotel Services	14
Maintenance	0
Medical (salaried)	0
Total	**66**

Note: For the purpose of the annual report, employee categories are defined as:

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

Governance disclosures

Contracts with senior officers

At the date of reporting, no senior officers, or firms of which senior officers are members, or entities in which senior officers have substantial interests, had any interests in existing or proposed contracts with CAHS other than normal contracts of employment of service.

Unauthorised use of credit cards

WA Health uses Purchasing Cards for purchasing goods and services to achieve savings through improved administrative efficiency and more effective cash management. The Purchasing Card is a personalised credit card that provides a clear audit trail for management.

WA Health credit cards are provided to employees who require one as part of their role. Credit cards are not for personal use by the cardholder. Should a cardholder use a credit card for a personal purpose, they must give written notice to the accountable authority within five working days and refund the total amount of expenditure.

Despite being made aware of obligations pertaining to the use of credit cards, one CAHS cardholder used their card for personal purposes. The transaction was identified just prior to the end of the reporting period, and the full amount ($102.90) was refunded after the new reporting period commenced (see Table 23).

Table 23: Credit card personal use expenditure 2016–17

Credit card personal use expenditure	2016–17
Aggregate amount of personal use expenditure for the reporting period	$102.90
Aggregate amount of personal use expenditure settled by the due date (within 5 working days)	$0
Aggregate amount of personal use expenditure settled after the period (after 5 working days)	$102.90
Aggregate amount of personal use expenditure outstanding at the end of the reporting period	$0

Government policy requirements

Government building contracts

CAHS has a commitment to the Government Building Training Policy. CAHS included appropriate clauses in tender documentation and monitored compliance of in scope building, construction or maintenance contractors for projects with a duration of greater than three months and a value of greater than $2 million. As at 30 June 2017, no contracts subject to the Government Building Training Policy had been awarded.

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.

Ms Deborah Karasinski (CAHS Board Chair) is the Chief Executive Officer of Senses Australia, which currently uses facilities at PMH and provides training to PMH staff. In 2016–17, Senses Australia entered into a new non-financial Service Agreement with PCH, which will maintain the long standing and mutually beneficial relationship it currently has with PMH. To avoid any perceived or potential conflict of interest, the Director General of the WA health system agreed to Ms Karasinski's request that other parties from Senses Australia manage the new Service Agreement, which was signed by the President.

Professor Geoffrey Dobb (CAHS Board Member) is a member of the Australian Council on Healthcare Standards (ACHS), which will be responsible for accrediting PCH. In 2016–17, Professor Dobb did not take part in discussions, votes or any other matters in relation to PCH at meetings of the ACHS Board.

Ms Kathleen Bozanic (CAHS Board Member) declared that her partner is employed by the North Metropolitan Health Service (NMHS). Although the perceived or potential conflict of interest is considered minimal, Ms Bozanic requested that she not receive information that could be perceived to provide benefit to her partner, and to be excluded from any decision where NMHS Mental Health has potential to benefit or incur loss.

Mr Peter Mott (CAHS Board Member) is employed by a private healthcare provider that does not support the pursuit of private patient care in public hospitals, as it potentially devalues private health insurance. This conflict of interest is managed by Mr Mott excluding himself from any discussions, votes or other matters related to private patient treatment in public hospitals.

In 2016–17, the CAHS Director of Clinical Services declared that he is a surveyor for ACHS, which is the preferred accreditation body of the WA health system. Dr Mark Salmon undertakes surveys in other states and in WA private hospitals, with flights, accommodation and meals paid for by the ACHS. Dr Salmon's role for ACHS does not constitute a conflict of interest, as he does not survey WA public hospitals.

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 Child and Adolescent Health Service (CAHS) received no Ministerial directives during 2016–17.

Advertising

In accordance with section 175Z of the *Electoral Act 1907*, CAHS incurred the following advertising expenditure in 2016–17 (see Table 24).

Table 24: Summary of advertising for 2016–17

Summary of advertising	Amount ($)
Advertising agencies	0
Market research organisations	0
Polling organisations	0
Direct mail organisations	0
Media advertising organisations	783.37
Total advertising expenditure	**783.37**

Adcorp was the only organisation to provide services in 2016–17.

Disability Access and Inclusion Plan

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.

Access to Service and Events

A range of equipment is provided by CAHS to assist people with disabilities to access services. All relevant policies consider the access requirements of people with disabilities. Within PMH, events are held in venues that are accessible by people with disabilities.

Access to Buildings and Other Facilities

Access to buildings and facilities for people with disabilities is ensured through ongoing management and maintenance. Additionally, a CAHS Disability Access and Inclusion Plan (2016–21) continues to be refined as part of the transition to the new Perth Children's Hospital (PCH).

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 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

An e-learning package is available on the CAHS intranet for staff education on disability access and inclusion. New staff are advised of the importance of disability access and inclusion during CAHS wide corporate induction. Regular staff presentations continue in collaboration with the Disability Services Commission. An example of the improved quality of service includes the recent incorporation of an adult change table to cater to the toileting requirements of older children and adolescents.

Opportunity to Provide Feedback

All staff are available to assist people with disabilities to provide feedback. A dedicated Child and Family Engagement Service is also available during office hours. There are also easily accessible comments, complaints, and suggestion boxes available throughout CAHS facilities.

The CAHS website provides for comments, complaints, and suggestions to be sent via an email. Feedback is processed and managed through the Child and Family Engagement Service and discussed at the Consumer Advisory Council and the Disability Access Committee to ensure that any changes to policy or updates to services are considered.

Participation in Public Consultation

The CAHS Disability Advisory Committee has recently been expanded to include a wider range of CAHS staff and consumer representation. Additionally, all venues for public consultation are required to meet the needs of people with disabilities.

Opportunities to Obtain and Maintain Employment

CAHS uses inclusive recruitment practices and encourages people with disability to apply for positions advertised across the organisation. In the transition to PCH, CAHS will be working with disability employment providers to actively recruit and employ people with disabilities, and ensure that workplaces are tailored to employee needs.

Compliance with public sector standards

CAHS Human Resources (HR) maintains a database of all matters pertaining to discipline, performance, redeployment and grievances. Any breach claims that are received through CAHS HR or Health Support Services are recorded and addressed accordingly.

CAHS received three breach claims in the 2016–17 financial year. All were in relation to recruitment, selection and appointment processes.

The Learning and Development Department holds training sessions regularly throughout the year and managers who are involved in these processes are encouraged to attend.

In the 2016–17 financial year, updates were made to the WA Health Code of Conduct, WA Health Discipline Policy and WA Health Managing Unsatisfactory and Substandard Performance Policy.

These policies are introduced at the CAHS corporate induction for all new staff members. New staff members are advised of the process for reporting suspected breaches of discipline or unethical behaviour.

Code of Conduct posters are also displayed across CAHS. Further to this, it is mandatory for all staff to undertake Accountable and Ethical Decision Making training, which aligns with the themes of the WA Health Code of Conduct.

The Chief Executive (CE) has key performance indicators including compliance with legislative and administrative requirements (WA Health Code of Conduct and Public Sector Management Act). These are measured by participating in monthly and quarterly performance review meetings. Integrity and conduct-related matters are also discussed as part of the formal performance management process between the CE and Tier 2 employees.

CAHS has recently appointed a Manager of Integrity and Ethics who will participate in monitoring and assessing compliance.

In 2016–17, a total of 34 complaints alleging non-compliance with the Code of Conduct were lodged.

Suspected breaches of discipline including matters of reportable misconduct were dealt with through the WA Health Disciplinary Processes. Where breaches were substantiated, the decision maker determined the appropriate action in accordance with the Health Services Act.

CAHS HR has undertaken industrial relations training relating to the Discipline and Managing Unsatisfactory and Substandard Performance policies. This is to ensure that advice given to managers within CAHS is consistent and adheres to the relevant standards and policies. CAHS HR has also undertaken training regarding reportable misconduct through the Corporate Governance Directorate.

In November 2016, CAHS ran the ‘Voice of Staff’ survey. Questions sought feedback from staff relating to ethical behaviour, trust and respect within the organisation.

CAHS has an Ethical Conduct Review Committee that meets on a monthly basis to review all discipline and reportable misconduct matters within the organisation.

Recordkeeping plans

The *State Records Act 2000* was established to mandate the standardisation of statutory recordkeeping practices for every State Government agency. Government agency practice is subject to 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 *State Records Act 2000*, states that every government organisation must have a Recordkeeping Plan (RKP) that has been approved by the State Records Commission. The CAHS RKP was approved by the State Records Commission on 26 November 2015. In accordance with section 28 of the *State Records Act 2000*, the CAHS RKP is to be reviewed within five years of its approval date. Once completed, a report of the review must be submitted to the State Records Office by November 2020.

CAHS has established procedures and guidelines to support staff capture and manage government information to comply with the *State Records Act 2000*. This includes access to:

- records awareness training enrolment and assessment.
- CAHS Records intranet hub where staff can access training videos, quick help guides and frequently asked questions on how to manage their records.
- the official Electronic Document and Records Management System (EDRMS) for corporate records.

CAHS has conducted a health check of the EDRMS, identifying areas of improvement to deliver a more effective system in accordance with requirements outlined in the CAHS RKP.

An evaluation of the effectiveness of these procedures and guidelines, including coverage across CAHS, will be provided to the State Records Office in December 2017.

On 3 August 2016, a records team comprising three staff commenced for a fixed term of six months to address the major risks identified, and provide ongoing corporate recordkeeping support for CAHS. Following this initiative, a permanent position of Manager Records and Compliance position was established.

During the period 2016–17, over 92,000 records were captured into the official CAHS EDRMS.

Substantive equality

Child and Adolescent Community Health

The Aboriginal Health Team (AHT) delivers services to Aboriginal children and families. Services are provided by a multidisciplinary team depending on the needs of the family. When an Aboriginal child is born in the metropolitan area, the AHT is notified via a birth notification. The first universal visit is conducted by the child health nurse. If the child health nurse is unable to contact the family after reasonable attempts, or if the family requests the service of AHT, the child is referred to AHT and is offered the Enhanced Aboriginal Child Health Schedule (EACHS).

EACHS sees Community Health Nurses working alongside Aboriginal Health Workers to provide a comprehensive and culturally acceptable primary health care service designed specifically to address the needs of Aboriginal families. The program is delivered predominantly as a home visiting model.

The Refugee Health Team (RHT) helps transitioning families to access local health services independently and supports young children to enter the child health service. All refugee families in the metropolitan area are referred to the RHT. Interpreters are used extensively by the RHT.

Child and Adolescent Mental Health Service

Six Aboriginal Mental Health Workers and Aboriginal Liaison Officers were appointed in October 2016 to work within Child and Adolescent Mental Health Service (CAMHS) multidisciplinary teams. The role of these workers is to provide cultural support and advocacy for Aboriginal young people and their families who require access to CAMHS services. The addition of these six workers has increased the total number of Aboriginal Mental Health Workers within CAMHS to eight.

A large culturally and linguistically diverse community lives and works within the Warwick CAMHS catchment. To meet the needs of this culturally and linguistically diverse (CALD) community, the following two services are in operation in the area.

- In partnership with Child and Adolescent Community Health (CACH), the Department of Education and Edmund Rice WA, Warwick CAMHS runs Integrated Service Centres at Koondoola Primary School and Thornlie Primary School. These centres support recent refugee and humanitarian entrant children who are enrolled in Intensive English Centres at these schools to transition into their new school environments. The centres also support families with accessing mainstream education, health care and community support systems. Two CAMHS Senior Social Workers work in these Integrated Service Centres, providing specialist mental health assessments and helping families to access mainstream mental health services
- Warwick Community CAMHS also has a specialist Cross Cultural Mental Health Clinician who provides mental health care to CALD children, adolescents and their families. This clinician uses a range of interventions when working with CALD families, including family therapy, individual psychotherapy, parental counselling, and group work. The Cross Cultural Clinician also develops and maintains collaborative working relationships with ethnic and mainstream service providers to raise community awareness of multicultural child and adolescent mental health issues. This aims to improve the delivery of culturally appropriate services for young people and their families within the community. The Cross Cultural Clinician also acts as a resource consultant for other mental health, health and community professionals within the scope of cross-cultural mental health issues.

Princess Margaret Hospital

PMH provides culturally safe services to Aboriginal patients and their families. The Koorliny Moort 'Walking with Families' program provides care coordination for inpatients and out of hospital care to families who might find it hard to come into hospital for their appointment or who want to stay closer to home.

The Aboriginal Liaison Service provides cultural and practical support and advocacy to children and families identified as most vulnerable within the hospital or community setting.

The Refugee Service provides holistic health care to refugee children, adolescents and their families, humanitarian entrants, children presently in detention or waiting for immigration processing (e.g. on bridging visas) and review of refugee and asylum children during and after an inpatient episode of care.

Occupational safety, health and injury

Child and Adolescent Health Service (CAHS) is committed to the provision of a safe work environment for all employees, patients, clients, visitors, and contractors in accordance with the *Occupational Safety and Health Act 1984* and the injury management requirements of the *Workers' Compensation and Injury Management Act 1981*.

Commitment to occupational safety, health and injury management

CAHS takes a proactive approach to occupational safety and health (OSH). The OSH committees and Executives are supportive to raising the OSH profile and taking a proactive approach to OSH prevention and risk management.

Compliance with occupational safety, health and injury management

The CAHS Executive is accountable for the occupational safety and health of all CAHS employees and, in particular, for providing leadership, support, direction and resources to ensure that CAHS meets its commitment to occupational safety and health. The CAHS Executive seeks the cooperation of all employees in achieving its occupational safety and health objectives, and in creating a safe and healthy working environment that benefits everyone.

To achieve this, CAHS:

- promotes a culture that integrates safety as a core activity into all aspects of work.
- ensures that managers and supervisory staff accept responsibility for the safety and health of themselves and others at work.
- provides instruction, supervision, training and ready access to information to all employees to enable safe work practices that minimise risk to health.
- complies with OSH legislation regulations and relevant Australian Standards.

- communicates, consults and cooperates with employees and OSH representatives to ensure that all practicable measures are undertaken to improve OSH performance.
- establishes measureable OSH objectives and targets to ensure continuous improvement in safety and health performance.
- undertakes risk management activities to identify, eliminate or manage risks in the workplace.
- ensures plant, equipment and substances are safe and without risk to health when properly used.

Employee consultation

The OSH consultation system comprises election of OSH representatives, OSH committees, local OSH groups, hazard and incident reporting and investigation system, bi-annual and as required workplace hazard inspections, resolution of issues process and implementation of control measures to prevent incident occurring. The consultation process for employees starts at the line manager level, manager's responsibility to consult and manage OSH issues and involve OSH representatives to assist and OSH consultants to advise and assist. The CAHS Board and Executive also have formal consultation mechanisms in place to fulfil their legislative role.

Employee rehabilitation

To support injured workers, CAHS has a comprehensive injury management service in accordance with the *Workers Compensation and Injury Management Act 1981* and the Injury Management Code of Practice (WorkCover WA). This service is provided by professional injury management staff and includes claims lodgement assistance and processing, early intervention, return to work programs and claims management.

Occupational safety and health assessment and performance indicators

An external audit of the CAHS OSH management system was undertaken in October 2014, which concluded that 'in general, OSH was well managed by the Child and Adolescent Health Service', although some changes were recommended to strengthen and improve the function. These five recommendations have been implemented.

An internal audit of occupational safety and health management systems using SafetyMAP was under taken in 2014 and 2017. An external audit was conducted in 2015, where CAHS was found to be compliant with OSH and Workers Compensation requirements.

The annual performance reported for CAHS in relation to occupational safety, health and injury for 2016–17 is summarised in Table 25. Comparative data from prior years is not available given the devolved governance structure for the WA health system enacted by the *Health Services Act 2016* that took effect from 1 July 2016.

Table 25: Occupational safety, health and injury performance for 2016–17

Measure	2016–17	Target	Comment
Fatalities (number of deaths)	0	0	Target achieved
Lost time injury/diseases (LTI/D) incidence rate (per 100)	1.4	0 or 10% improvement on the previous three years	See Note
Lost time injury severity rate (per 100, i.e. percentage of all LTI/D)	28.9	0 or 10% improvement on the previous three years	See Note
Percentage of injured workers returned to work within 13 weeks	97%	No target	
Percentage of injured workers returned to work within 26 weeks	98%	≥80%	Target achieved
Percentage of managers trained in occupational safety, health and injury management responsibilities	84%	≥80%	Target achieved

Note: Comparative data to determine whether the target was met is not available given the devolved governance structure for the WA health system enacted by the *Health Services Act 2016* that took effect from 1 July 2016.

The Child and Adolescent Health Service acknowledges and thanks the original artists of the drawings and quotes used throughout this publication.

This document can be made available in alternative formats on request.