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

Child and Adolescent Health Service

2017–18

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.

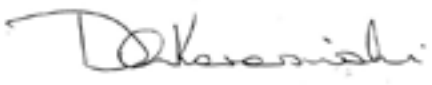
Statement of Compliance

FOR THE YEAR ENDED 30 JUNE 2018

HON ROGER COOK BA GradDipBus MBA MLA DEPUTY PREMIER, MINISTER FOR HEALTH, MINISTER FOR MENTAL HEALTH

In accordance with section 63 of the *Financial Management Act 2006*, we hereby submit for your information and presentation to Parliament, the Annual Report of the Child and Adolescent Health Service for the reporting period ended 30 June 2018.

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



MS DEBORAH KARASINSKI
CHAIR OF THE BOARD
CHILD AND ADOLESCENT HEALTH SERVICE
17 September 2018

PROF GEOFFREY DOBB
DEPUTY CHAIR OF THE BOARD
CHILD AND ADOLESCENT HEALTH SERVICE
17 September 2018

"The Board wants to confirm its vision of leading and providing governance to a world class service for children and young people by making sure it is fully informed of the needs of those it serves and with whom it partners."

Contents

Overview of Agency

Locations and contact information

CHILD AND ADOLESCENT HEALTH SERVICE

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CAHS Board Chair Foreword

THE BEST POSSIBLE HEALTH AND MEDICAL OUTCOMES

The focus of the Child and Adolescent Health Service (CAHS) Board during 2017–18 has been to ensure the best possible health and medical outcomes for the children and young people of Western Australia at a time of great change.

The move to the new Perth Children's Hospital has been a momentous milestone, requiring the sustained hard work and dedication of CAHS staff, while at the same time maintaining the quality of care that the Child and Adolescent Health Service is known for.

Throughout the year, a number of the Board members have joined me to visit different areas of Princess Margaret Hospital (PMH), the Child and Adolescent Mental Health Service (CAMHS) and Child and Adolescent Community Health (CACH). This has enabled the Board to engage with staff in their own environments, receiving direct feedback on issues related to these areas and ensuring the Board's decision making remains informed by knowledge of our service delivery. The Board has also established a Clinical Advisory Group to facilitate more engagement between the Board and staff across the organisation.

The Board's standing committees of Finance, Audit and Risk and Safety and Quality have been extremely active this year.

Safety and Quality

At Princess Margaret Hospital, we have maintained oversight of critical targets and reports, and noted the improvements in the WA Emergency Access Targets and in hand hygiene. There have also been improvements in the completion of discharge summaries, although this remains a focus area for the Board, recognising the importance of a timely and seamless link between inpatient and community-based services.

Finance

Driving a sustainable health service has also occupied the Board, bringing further governance and accountability to financial decision making, financial results and key performance indicators, including oversight of leave balances. I am pleased that CAHS has met its targeted net cost of service and generated a small surplus for the year.

Audit and Risk

The Board was pleased with the appointment of an Audit and Risk Manager and internal auditors reporting to the Board to operationalise the Board's responsibilities around these critical areas. The development of the organisation's risk appetite and tolerance statements and of an annual audit plan are among their first tasks.

Other working groups

Throughout the year, the Board has also had two time-limited working groups. The Review Oversight Committee was created to monitor the implementation of the recommendations of the independent review into staff engagement and morale conducted in the 2017 financial year. The Committee has been very pleased with the progress towards full implementation and has closed out several of the recommendations. The Board recognises that changing organisational culture is a long-term process, and although progress has been made, the Committee and the Board will continue to monitor progress in the coming year.

The Perth Children's Hospital (PCH) Governance Transition Working Group was created to oversee the transfer of governance of PCH from the Department of Health and the Minister for Health to the CAHS Board. The transition process, including the many agreements, Memoranda of Understanding, transition plans, licenses and leases was complex and has required due consideration by the Board. The transition was completed successfully, and the Board took responsibility for the provision of services at PCH on 14 May 2018.

Engagement with patients, families and partners

The Board is acutely interested in hearing the voice of our clients and their families, and this year, a member of the CAHS Consumer Advisory Council has become a permanent invitee of the Board's Safety and Quality Committee. The Board has been investigating more ways of driving clinical excellence through incorporating the experiences of our children and their families, from the Voice of Family surveys, to analysing and responding to compliments and complaint data.

The Board has been engaging with its many stakeholders, from the non-government organisation sector, who have been part of CAHS strategic planning processes, to the Australian Medical Association and Robyn Kruk AC, who led the Sustainable Health Review, which delivered its interim report in February 2018. Through doing this, the Board wants to confirm its vision of leading and providing governance to a world class service for children and young people by making sure it is fully informed of the needs of those it serves and with whom it partners.

The move to PCH

While the Board focused on the transfer of governance, many CAHS staff and others have been involved in the design, building, and commissioning of PCH. Their vision, expertise and commitment to excellence will have a life-long positive impact on the lives of young Western Australians, and their families, for generations to come and I wish to congratulate all the people involved.

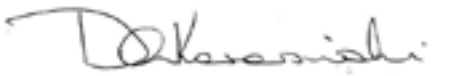
I would also like to acknowledge that in leaving PMH, we are leaving a much-loved institution, held dear in the hearts of many Western Australians, and I recognise the contribution of all who have worked at PMH, providing exceptional services for 109 years.

Thank you

I am immensely proud of all CAHS staff who have worked with dedication and commitment throughout the year to ensure the best health and medical outcomes for the children and young people of Western Australia, whose work has resulted in such positive results in the National Safety and Quality Health Service Accreditation review, who have participated with such enthusiasm in the Speaking Up for Safety program and the change management activities, who have been involved in the clinical commissioning of PCH, and who have joined the many activities to develop our Strategic Plan. I sincerely thank all those staff and our volunteers who have provided exemplary service and have worked so hard towards making CAHS a great place to work.

I would like to acknowledge my fellow Board Members for the time and effort they apply to the discharge of their duties, and for the knowledge and experience they bring to the Board's discussions and decision making.

To conclude, I would like to thank our Chief Executive (CE), Dr Robyn Lawrence for embracing and meeting the key objectives and challenges set by the Board on her commencement as CAHS CE. Robyn's personal integrity and commitment to excellence are exemplary and greatly appreciated.



DEBBIE KARASINSKI
Chair
CAHS Board

Message from the Chief Executive

PROUD TO BE PART OF WESTERN AUSTRALIAN HISTORY

The conclusion of the 2017–18 financial year has brought with it the long awaited opening of Perth Children's Hospital (PCH). PCH is a beautiful, world-class facility that will benefit Western Australian children, their families and our staff for many years to come.

I extend my sincere thanks to our workforce; a dedicated and hard-working group of people, who have shown their commitment to the organisation during the challenging delays over recent years. Every individual who has worked on the building and works within the building should be proud to be part of this important moment in Western Australian history, as I am.

At this time, it is also appropriate that the Child and Adolescent Health Service (CAHS) will commence operating under a new organisational structure, which reflects the modern health service we are. Significant work has been undertaken throughout the last 12 months in preparation for this change. From 1 July 2018, Perth Children's Hospital, Community Health and Mental Health programs will become a single service, support by directorates led by co-directors. As part of these changes, competitive recruitment processes have been undertaken for each role, and I acknowledge the substantial work that has occurred to ensure the new structure would be operational for the start of the 2018-19 financial year.

I would also like to acknowledge the commitment of our staff to the Shape our Future program. Through the Shape our Future Steering Team and CAHS Cultural Ambassadors, a CAHS Culture Action Strategy has been developed and the health service vision and values were reviewed and updated with all staff and volunteers having the opportunity to provide input. I am delighted with the outcome of this work, the CAHS Strategic Plan 2018-2023, and particularly our updated values: compassion, respect, collaboration, equity, accountability and excellence, and aspirational vision – 'healthy kids, healthy communities'.

Together, the values, objectives and vision will guide our organisational strategy development and inform the goals set to determine whether the strategy is on track. Most importantly, I am optimistic that they are representative of the health service we strive to be. The Strategic Plan will help

to provide staff and volunteers with a renewed feeling of purpose with the knowledge that our goals and values as a health service are shared.

The health service underwent Australian Council on Healthcare Standards accreditation in February 2018. I am extremely pleased with the outcome, with seven 'met with merit' results being awarded. The surveyors noted the positivity, passion and pride of our staff, which I am privileged to witness on a day to day basis. The surveyors also commented 'the organisation has done well to establish a robust and well-functioning governance system for quality and safety. The team were impressed with the values of the organisation, which were reflected within all conversations with staff'. While the accreditation process always places additional demands on our staff, I extend my thanks to all who were involved in preparing for the accreditation process, and for everyone involved over the week-long survey for articulating the great work that is undertaken every day at CAHS.

"The strategic plan will help to provide staff and volunteers with a renewed feeling of purpose with the knowledge that our goals and values as a health service are shared."

The Speaking up for Safety program, in partnership with the Cognitive Institute, has been another highlight of the last 12 months. This important program is designed to empower every staff member to speak up whenever they are concerned about safety, and reinforces a workforce-wide culture that embraces safe and high quality care. Speaking up for Safety workshops have been held regularly throughout the year, led by our own CAHS Safety Champions.

Consumer advisory groups continue to have an invaluable role in the health service. This year, Consumer Advisory Council (CAC) Chair Amanda Magraith and Youth Advisory Committee Chair (YAC) April Welsh resigned from their roles. I acknowledge Amanda's and April's vast contributions during their tenure, to CAHS as a whole as well as their involvement with the patient-focused design of Perth Children's Hospital. I welcome Margaret Wood as the incoming CAC Chair and Daniel Staer as incoming Chair of the YAC. I look forward to a similarly collaborative working relationship with both the CAC and YAC under Margaret and Daniel's direction.

Volunteers continue to play an integral role within the health service. Our volunteer team at PCH continues to grow and provide support to families and staff in the Emergency Department, outpatients, on the wards, and in pre and post-theatre support to name a few. Diversity within the team has increased greatly and an 18 year old nursing student may find themselves working with a veteran of 30 years.

Our volunteers are an important and valued part of our organisation, and I express my gratitude to every person who donates their time and talent to this health service; your contributions are sincerely appreciated.

Finally, I would like to thank our non-government partner organisations for their ongoing support, particularly the Perth Children's Hospital Foundation and Telethon, who support thousands of our patients through their fundraising each year.

As we look to the year ahead and the dual challenges that a brand new hospital and organisational restructure may present, I trust that our staff, volunteers, clients and their families can be comfortable we are heading in the right direction. CAHS has a proud history of putting children and young people and their families at the centre of everything we do, and I am confident that this focus will continue to be our strength for the future.

DR ROBYN LAWRENCE
Chief Executive

The Health Service Board

The 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 2017–18. In this period, there were three standing committees of the Board: Finance, Audit and Risk, and Safety and Quality, all of which are made up of Board members, as well as the Review Oversight Committee and a PCH Governance Transition Working Group. During 2017–18, the Board comprised the following members:

Board Chair, Ms Debbie Karasinski

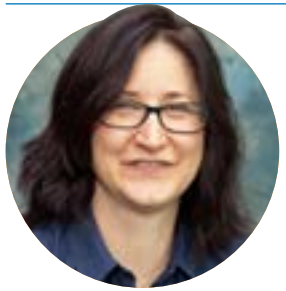
Ms Debbie Karasinski has worked in the health and disability sectors for the past 35 years. Her career has included roles such as Chief Executive Officer (CEO) of disability service provider Senses Australia, CEO of the Multiple Sclerosis Society of WA, and Chief Occupational Therapist at Sir Charles Gairdner Hospital. Ms Karasinski has extensive Board experience, most notably as a member of the National Disability Services Board, the WA Disability Services Commission Board and the Taxi Industry Board, and is currently a member of the Board of the Perth Clinic.

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, 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).



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, 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, 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 currently serves as the Chief Medical Information Officer at the St John of God Health Care Group, was a Clinical Lead in the commissioning of ICT at Fiona Stanley Hospital, and has also worked as a Medical Leadership Advisor for the Institute of Health Leadership.

Board Member, Dr Daniel McAullay

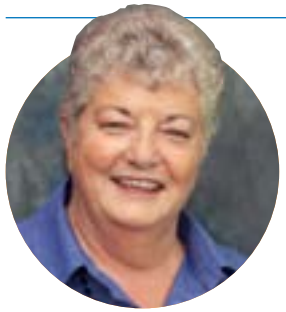
Dr Daniel McAullay is a health professional and a past member of the CAHS Governing Council, and has extensive experience as a member on health boards and committees. A Research Associate Professor with the Centre for Improving Health Services for Aboriginal Children, Dr McAullay's primary research areas of interest include maternal, infant and child health and primary health care, and he has specialised in Aboriginal health research.

Board Member, Mr 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 CEO of Hollywood Private Hospital, Vice President of the Australasian College of Health Service Management, WA Branch Council, board member of the Australian Private Hospitals Association, board member of the Royal Australian College of Surgeons Vascular Training Board, member of the University of Western Australia Business School Advisory Council and past President of the Australian Institute of Management WA.

Board Member, Mr Daniel Morrison

Mr Daniel Morrison has held the position of Chief Executive Officer of the Aboriginal Alcohol and Drug Service for six years, and has worked with passion and care to empower the community through delivering an award winning service. He demonstrates creativity and boldness in his approach and leadership, and has used his position to advocate for the broader wellbeing of Aboriginal individuals, families and communities by rallying for change needed for real improvements in a range of areas that disproportionally affect Aboriginal people including homelessness, justice and out-of-home-care. Mr Morrison has been a member of the Board since July 2017.



Board Member, Professor Di Twigg

Professor Di Twigg is Executive Dean of the School of Nursing and Midwifery at Edith Cowan University, Perth, Western Australia, and Research Consultant in the Centre for Nursing Research at Sir Charles Gairdner Hospital. Previously, Professor Twigg spent most of her career in the health industry and has held several senior health executive roles, most notably as Executive Director of Nursing Services at Sir Charles Gairdner Hospital, a 600-bed Magnet-designated teaching hospital. Professor Twigg has been a member of the Board since July 2017.

Committee Meeting Attendance

JULY 2017 TO JUNE 2018

NAME	NUMBER OF MEETINGS	MEETINGS ATTENDED
FULL CAHS BOARD MEETING		
Ms Debbie Karasinski (Chair)	11	11
Professor Geoffrey Dobb	11	11
Mr Brendan Ashdown	11	10
Ms Kathleen Bozanic	11	11
Mr Peter Mott	11	10
Mr Andrew Thompson *Term concluded in July 2017*	1	1
Dr Alexius Julian	11	8
Dr Daniel McAullay	11	10
Professor Di Twigg *Commenced in August 2017*	9	9
Ms Anne Donaldson	11	11
Mr Daniel Morrison *Commenced in August 2017*	10	7
FINANCE COMMITTEE		
Ms Kathleen Bozanic (Chair)	10	9
Mr Peter Mott	10	7
Professor Geoffrey Dobb	10	10
Ms Anne Donaldson	10	10
AUDIT AND RISK COMMITTEE		
Mr Brendan Ashdown (Chair until March 2018)	9	4
Ms Anne Donaldson (Chair from April 2018)	9	9
Dr Alexius Julian	9	5
Ms Kathleen Bozanic	9	8
Dr Daniel McAullay	9	7

NAME	NUMBER OF MEETINGS	MEETINGS ATTENDED
Professor Di Twigg *Commenced in September 2017*	8	7
Mr Andrew Thompson *Term concluded in July 2017*	1	1
SAFETY AND QUALITY COMMITTEE		
Professor Geoffrey Dobb (Chair)	8	8
Dr Alexius Julian	8	5
Mr Peter Mott	8	4
Ms Anne Donaldson	8	8
Dr Daniel McAullay	8	5
Mr Daniel Morrison *Commenced in August 2017*	7	1
REVIEW OVERSIGHT COMMITTEE		
Ms Debbie Karasinski (Chair)	10	10
Dr Alexius Julian	10	7
Mr Peter Mott	10	8
Ms Anne Donaldson	10	10
Dr Daniel McAullay	10	5
Professor Geoffrey Dobb	10	7
Ms Kathleen Bozanic	10	7
Mr Andrew Thompson *Term concluded in July 2017*	1	1
PCH GOVERNANCE TRANSITION WORKING GROUP		
Ms Debbie Karasinski (Chair)	9	9
Ms Kathleen Bozanic	9	6
Ms Anne Donaldson	9	9
Mr Brendan Ashdown *Commenced February 2018*	6	4

"The surveyors were particularly impressed by the many staff who expressed positivity, passion and pride toward working at CAHS."

CAHS YEAR AT A GLANCE

471 compliments
vs **171** complaints

515,777
children and young people eligible for CAHS service

67,375
prescriptions filled at PMH/PCH

176,486
vaccinations given

26,673
health and development checks for children starting school

23,552
children receiving services for development

5,535
young people seen by CAMHS

23 DAYS
median access time to Community CAMHS

128,116
occasions of service delivered by CAMHS

62,104
patients seen at PMH and PCH's emergency department

243,275
outpatients treated at PMH/PCH

26,618
PMH and PCH admissions

13,250
operations performed

57,392
radiological appointments

28,443
child health checks delivered in the home

56,606
PMH/PCH allied health appointments

4,455
child health 'drop-in' clinics

3,839
parenting groups for new parents

14,798
targeted health checks for Aboriginal children

Our vision

Healthy kids, healthy communities

Our objectives

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

Our values

Compassion – we always act with courtesy and care, so you're treated with real kindness. ***Kindly caring for you.***

Collaboration – we care about our colleagues and partners; by cooperating, we improve. ***Nice work, everyone.***

Accountability – always acting with integrity, we take full responsibility for our actions. ***You can count on us.***

Respect – your dignity is recognised and your self-worth is supported and valued. ***Feelings matter too!***

Equity – by treating people in a fair and just manner, everyone receives the same rights and opportunities. ***A fair go!***

Excellence – by striving to improve, we constantly get better and deliver better care. ***Proudly doing our best!***

Executive Summary

SHAPING OUR FUTURE

The focus and key priorities of the 2017–18 financial year have been the move to Perth Children's Hospital (PCH) and building a positive relationship with the workforce to make the Child and Adolescent Health Service (CAHS) a great place to work while caring for the children and young people of Western Australia.

After an official opening ceremony on 12 May 2018, the staged opening of PCH began on 14 May with the delivery of a number of outpatient clinics including ophthalmology, immunology and enuresis. Two weeks later, on 28 May, select elective surgery commenced, before the final move day on Sunday 10 June, when inpatients were transferred and the PCH Emergency Department opened. At this time, Princess Margaret Hospital for Children (PMH) was formally closed, after a proud 109 year history of delivering world-class care to the children of Western Australia. On 13 June 2018, patients from the specialist adolescent mental health unit at Bentley Hospital were transferred to PCH, and the Bentley Adolescent Unit was closed.

Work to strengthen the relationship between the health service executive and the workforce has occurred through an organisational restructure and the introduction of cultural change initiatives including the Shape our Future program, under the leadership of Dr Robyn Lawrence. Staff engagement is integral to this strategy and for CAHS to realise its full potential as an exceptional, integrated health service that all staff members can be proud of.

A comprehensive organisational restructure has taken place over the past year. As part of this, the structure realigned the existing PMH, Child and Community Health and Child and Adolescent Mental Health Service executive structures into a single service, supported by Directorates with Co-Directors leading each of those Directorates. Significant work was undertaken throughout the year in time for the full implementation date of 1 July 2018. Each Executive role, as well as Co-Director positions, has undergone a competitive recruitment process to appoint our senior leaders across the organisation.

As part of Shape our Future, a number of staff Cultural Ambassadors and the Shape our Future Steering Team were selected through an expression of interest process. The Steering Team has led the development of the CAHS Culture Action Strategy and reviewed the health service values and behaviours. The team is led by Chair, Professor David Forbes who is supported by Dr Asha Bowen as Deputy Chair. The Team worked alongside the Cultural Ambassadors to hold a series of focus groups across CAHS to seek staff input to shape the organisation's values and behaviours, as well as leading development of the CAHS Culture Action Strategy and contributing to strategic planning.

As a result of this work, the CAHS Strategic Plan 2018–2023 was released in June 2018, which identifies a new vision statement to reflect the health service for a new generation – 'healthy kids, healthy communities'. Five strategic objectives have been identified to achieve this vision:

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

The key organisational values that support this new vision and mission are compassion, respect, collaboration, equity, accountability and excellence.

Strategic planning has been a key priority for the CAHS Board and Executive, who took part in strategic planning days in February through to May. The organisation also sought the views of many of its non-government partner organisations and other key stakeholders as part of this planning.

Part of this broader piece of organisational development work is the Speaking up for Safety program, in partnership with the Cognitive Institute. This program empowers every staff member to speak up whenever they are concerned about safety and reinforces a workforce-wide culture that embraces safe and high quality care. To date, 1,583 staff members have attended the hour long training seminar.

In February, CAHS hosted surveyors from the Australian Council on Healthcare Standards. During the five day survey, the surveyors visited 12 community sites and 34 hospital department and wards. There were over 30 meetings held and more than 200 staff involved in those meetings. The feedback from the surveyors was overwhelmingly positive, with seven 'met with merit' results being awarded. The surveyors were particularly impressed by the many staff who expressed positivity, passion and pride toward working at CAHS.

For the second year running, CAHS has achieved a modest surplus, which for 2017-18 is 1.8 per cent of the total service costs, while delivering activity that is above target.

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.

Acts CAHS is required to comply with that are administered by the Department of Health as at 30 June 2018

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
Public Health Act 2016
Radiation Safety Act 1975

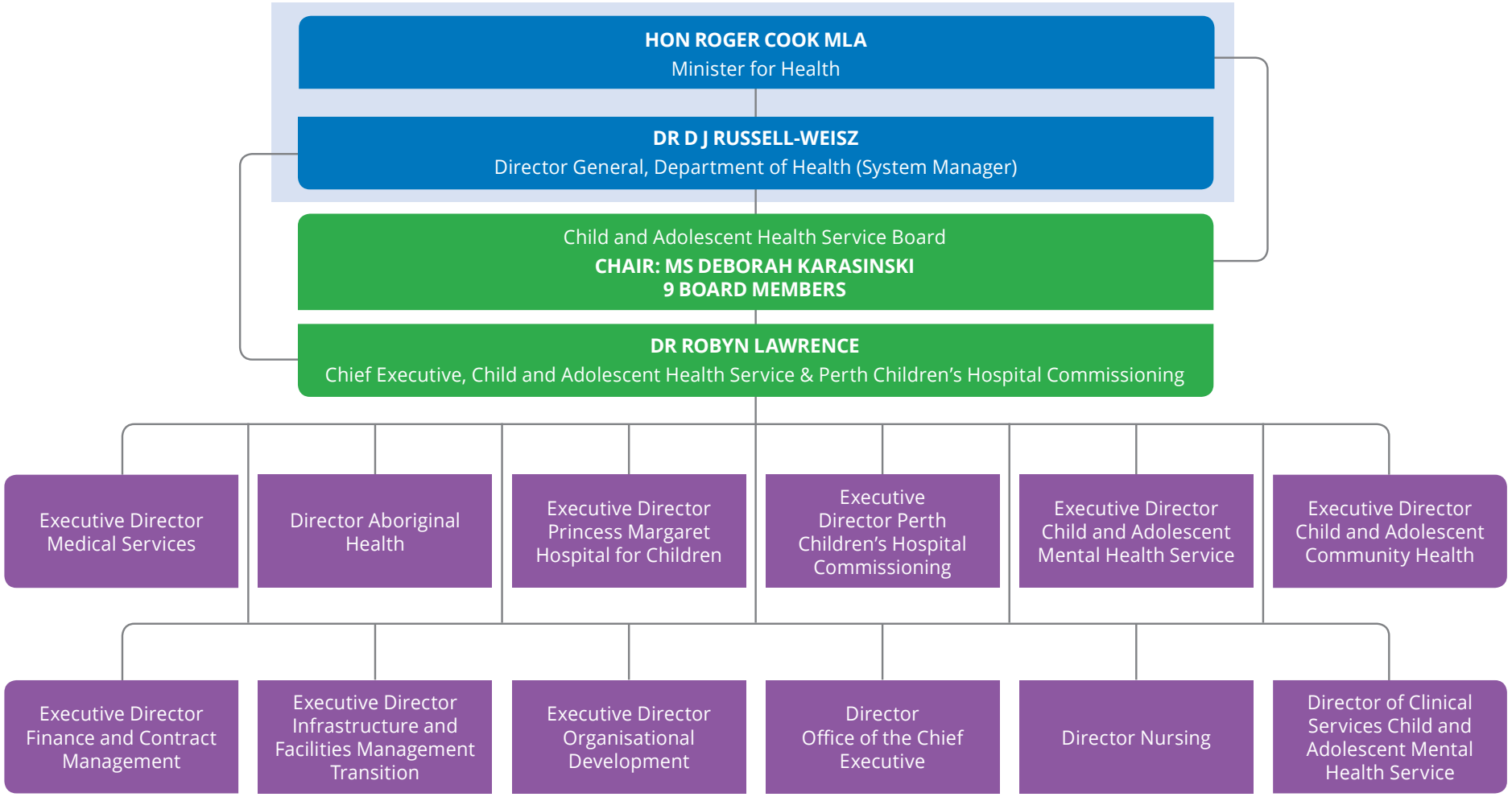
Accountable authority

The Child and Adolescent Health Service Board was the accountable authority for the Child and Adolescent Health Service in 2017–18.

Responsible Minister

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

CAHS management structure 2017–18



Senior officers

AREA OF RESPONSIBILITY	TITLE	NAME	PERIOD OF SERVICE
Child and Adolescent Health Service & Perth Children's Hospital Commissioning	Chief Executive	Dr Robyn Lawrence	1 July 2017 – 30 June 2018
Medical Services	Acting Executive Director	Dr Meredith Arcus	18 December 2017 – 30 June 2018
Aboriginal Health	Director	Ms Leah Bonson	1 July 2017 – 30 June 2018
Princess Margaret Hospital	Executive Director	Dr Victor Cheng	31 July 2017 – 30 June 2018
Perth Children's Hospital Commissioning	Executive Director	Ms Debbie Chiffings	11 September 2017 – 30 June 2018
Child and Adolescent Mental Health Service	Executive Director	Mr Wade Emmeluth	1 July 2017 – 30 June 2018
Child and Adolescent Community Health	Acting Executive Director	Ms Sue Kiely	18 December 2017 – 30 June 2018
Finance and Contract Management	Executive Director	Mr Tony Loiacono	16 October 2017 – 30 June 2018
Infrastructure and Facilities Management Transition	Executive Director	Leon McIvor	13 November 2017 – 30 June 2018
Organisational Development	Executive Director	Ms Mary Miller	16 October 2017 – 30 June 2018
Office of the Chief Executive	Director	Ms Kylie Mulcahy	6 November 2017– 30 June 2018
Nursing	Acting Director	Ms Sue Peter	1 July 2017 – 29 March 2018
Child and Adolescent Mental Health Service	Acting Director of Clinical Services	Dr Kavitha Vijayalakshmi	24 October 2017 to 30 June 2018

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:

- Perth Children's Hospital
- Child and Adolescent Community Health
- Child and Adolescent Mental Health Service

With the closure of Princess Margaret Hospital for Children (PMH) in June 2018, Perth Children's Hospital (PCH) is Western Australia's (WA) only dedicated paediatric hospital and provides tertiary services for the State. The new hospital includes an integrated paediatric research and education facility, and provides inpatient, ambulatory and outpatient services with increased bed capacity to its predecessor.

Further to this, PCH is the home of WA's only paediatric trauma centre. All specialist services previously provided by PMH are 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.

Child and Adolescent Community Health (CACH) provides a comprehensive range of community-based early identification and intervention services, as well as health promotion, 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 Statewide 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.

Shared responsibilities with other agencies

CAHS' ability to partner with other organisations, both government and non-government, is integral to delivering health services successfully. CAHS partners with a large number of community and non-profit organisations that make significant contributions to support our patients, clients, families and carers.

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, Communities, and Justice, and the Health and Disability Service Complaints Office.

Performance 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 2017–18 are aligned to the State Government goal of "Strong Communities: Safe communities and supported families" (see Figure 1).

The outcomes for achievement in 2017–18 by CAHS are:

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

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

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

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 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 is summarised in the Agency Performance section, and described in detail under Key Performance Indicators in the Disclosures and Legal Compliance section commencing on page 158.

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

WA STRATEGIC OUTCOME (WHOLE OF GOVERNMENT)

Strong Communities: Safe communities and supported families

CAHS VISION

Healthy kids, healthy communities

CAHS OBJECTIVES

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

Outcome 1

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

Key effectiveness indicators contributing to Outcome 1

- Unplanned hospital readmissions of public hospital patients within 28 days for selected surgical procedures
- Proportion of elective wait list patients waiting over boundary for reportable procedures
- Hospital infection rates (Healthcare-associated Staphylococcus aureus bloodstream infections (HA-SABSI) per 10,000 occupied bed-days in public hospitals)
- Survival rates for sentinel conditions
- Percentage of admitted Aboriginal and Non-Aboriginal patients who discharged against medical advice
- Rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit
- Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from an acute public mental health inpatient unit

Outcome 2

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

Key effectiveness indicators contributing to Outcome 2

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

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

Outcome 1 **Public hospital based services that enable effective treatment and restorative health care for Western Australians.**		**Outcome 2** **Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives.**	
SERVICES DELIVERED TO ACHIEVE OUTCOME 1	**KPIs MEASURED**	**SERVICES DELIVERED TO ACHIEVE OUTCOME 2**	**KPIs MEASURED**
1. Public hospital admitted services	• Average admitted cost per weighted activity unit	5. Aged and continuing care services	• (none)
2. Public hospital emergency services	• Average Emergency Department cost per weighted activity unit	6. Public and community health services	• Average cost per person of delivering population health programs by population health units
3. Public hospital non-admitted services	• Average non-admitted cost per weighted activity unit		
4. Mental health services	• Average cost per bed-day in specialised mental health inpatient units • Average cost per treatment day of non-admitted care provided by public clinical mental health services		

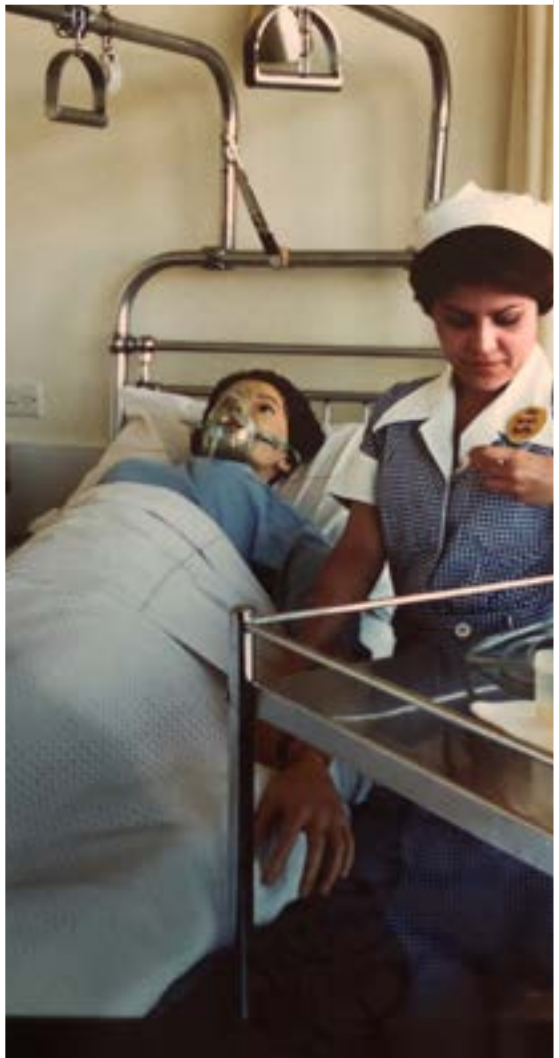
Changes to Outcome Based Management Framework

The WA health system Outcome Based Management (OBM) Framework was updated comprehensively for 2017–18. The outcomes applicable to CAHS were revised to more accurately define the services delivered. Five existing services were renamed and one was removed, as it was no longer relevant. Seven key performance indicators were replaced with six more contemporary measures; three assessing the safety and quality of service provision and three assessing financial efficiency.

Princess Margaret Hospital History


6
5
4
3
OUTPATIENTS


CLOSED
THROUGH
LACK OF
FUNDS

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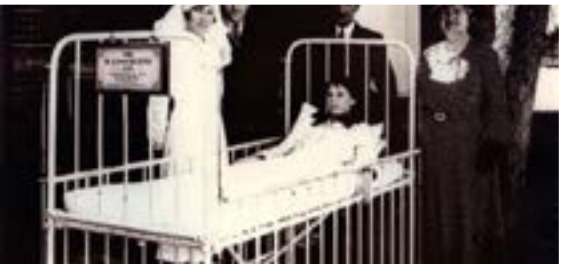


PRINCESS MARGARET HOSPITAL TIMELINE

1897

Perth businessman Charles Moore holds first public meeting to gauge public support for a children's hospital.

1909

The Perth Children's Hospital opens with 40 beds after a rigorous funding campaign by Mr Moore.

1919

In the 10 years after the hospital opened, the mortality rate of admitted patients drops from 12 to 7 per cent.

1921

A new outpatient building opens.

1927

On-site nurse training starts at the hospital.

1964

PMH's renown Burns Unit is established.

1972

Her Royal Highness Princess Margaret makes her first and only trip to PMH.

1978

PMH is declared a public hospital, meaning it now receives government funding.

1985

The first dedicated paediatric oncology ward in WA is established, and Radio Lollipop begins at PMH.

1998

The PMH Foundation is established. It provides over $2 million in grants in its first financial year of operation.

1939

World War II makes retaining staff difficult, but also brings about advances in medicine.

1944

Penicillin is first used at the hospital to treat a five year old girl with Staphylococcal septicaemia; a previously fatal disease.

1949

The Perth Children's Hospital is renamed Princess Margaret Hospital for Children (PMH).

1957

The first students from the University of Western Australia's medical school begin their paediatric placements.

1961

The first televisions are installed on all PMH wards.

2008

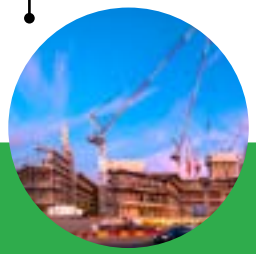
The Carpenter Labor Government announces plans to build a new publicly owned children's hospital alongside Sir Charles Gairdner Hospital in Nedlands.

2009

PMH turns 100 years old.

2012

Construction of the new children's hospital begins at the QEII Medical Centre.



2015

PMH volunteers celebrate 40 years of service. There are now almost 200 volunteers who donate their time to making the hospital a better place.

2018

PMH closes and Perth Children's Hospital opens its doors.

Performance Highlights

Princess Margaret Hospital / Perth Children's Hospital

A MOVING EXPERIENCE

About 650 people banded together on Sunday 10 June 2018 to safely transfer 91 children from Princess Margaret Hospital (PMH) to Perth Children's Hospital (PCH) in the State's biggest-ever paediatric medical move.

The complex logistical operation involved staff from the Child and Adolescent Health Service (CAHS), St John Ambulance, Main Roads, WA Police, the Department of Health's Disaster Preparedness Management Unit and QEII Medical Centre

As the sun rose over PMH for the last time as a working hospital, 12-year-old patient Darius set off at 7am in one of 15 ambulances involved in final move day. After a four kilometre journey to Nedlands, he was welcomed by Health Minister Roger Cook and officially became PCH's first inpatient. Over the next six hours, another 90 children followed Darius, and quickly settled into their new wards and enjoyed welcome packs provided by the PCH Foundation.

The PCH Emergency Department (ED) also opened its doors at 7am, with the PMH ED simultaneously closing at this time. The ED team saw 185 patients during the department's first day and night of operation at PCH. Five emergency cases were seen in theatre and 21 patients were admitted, meaning more than 100 children stayed over at PCH on its first night.

CAHS Chief Executive Dr Robyn Lawrence thanked staff for their dedication and significant contribution. "The move to our new hospital and the immeasurable work leading to this point is something that we can all be extremely proud of," she said.

On Monday June 11, after the move was complete, CAHS Board Chair, Debbie Karasinski, representatives from the Aboriginal Leadership Group and PCH Chaplain Robert Anderson said goodbye to PMH with a Noongar Smoking Ceremony. The group was led by Aboriginal Elder Nigel Wilkes and Alice Keating. They walked around the site and then into the hospital with the Elder leading the culturally appropriate spiritual cleansing of PMH through the Noongar Smoking Ceremony.

Supporting a shift in the complex care model

Throughout 2017–18, PMH supported a shift in the complex care model; moving from an institutional model to a contemporary case management model, where the service is tailored to the needs of the individual child. The new model will provide care closer to home. In addition, it will provide cost efficiencies to the system by targeting support to meet individual needs in a non-hospital environment.

The provision of a pathway-guided, efficient discharge process is likely to reduce length of hospital stay for children with high medical and complex care needs. In addition, cost savings will be generated by the early exploration of funding from external agencies to access other funding sources and services outside of CAHS.

Central Venous Access Devices Service

A multidisciplinary group of clinicians collaborated to improve patient outcomes through:

- the introduction of a specialist team for device insertion and prevention of failure
- a centralised referral process to assess device selection and procedural management
- surveillance and bench marking with targeted quality improvement initiatives
- clinical leadership to support staff, patients and their families.

In 2017–18, key achievements included improved completion of therapy rates, along with reductions in failed insertion rates, device removal due to blockage and central line associated blood stream infections in the oncology and haematology cohort.

Safety Team Response Service (STARS)

STARS is a dedicated team of onsite clinicians tasked with providing care to inpatients seven days a week in the out-of-hours period (4pm to 8am Monday to Friday, and all of Saturday and Sunday) in designated inpatient ward areas.

STARS helps to strengthen the medical and nursing resources available after hours and provide a more coordinated and integrated response to clinical review and management of inpatients. The STARS team works collaboratively to manage and address patient care issues and clinical deterioration, and to provide support and guidance to staff after hours.

The STARS team forms part of the medical emergency response, with the Clinical Nurse working collaboratively with the Hospital Clinical Nurse Manager to provide clinical support and expertise to improve the quality and safety of patient care and assist nursing staff managing patients of concern after hours.

Volunteers

Now well and truly settled into PCH, our volunteer community currently numbers approximately 400 people, with a roster that now includes additional evening and weekend shifts. Wearing their new striking tangerine uniforms, our volunteers come from all walks of life and are diverse in ages ranges from 18-87, with over 50 languages spoken. We are very pleased that we are continuing to reach a gender balance, with more male volunteers joining us than ever before. We are also particularly grateful to the volunteers who participated in over 1,000 training shifts, representing 3,000 hours of on the job training, which ensured a smooth transition from PMH to PCH.

Some of the new roles for volunteers at PCH include Way Finding, Play Leisure and Engagement, and driving the new 'Stitches Shuttle' service from the hospital car parks for children in wheelchairs. Existing volunteer roles include working in the School for Special Education Needs, the Emergency Department, Outpatients, Medical Imaging, Theatre, Speech Pathology, Archives, Admissions, Animal Companions and Ward Friends.

We would like to make special mention of our wonderful Ann Taylor, who enters her 30th year of volunteering for PMH and PCH. Ann personifies the volunteer dedication and commitment to patients and families, and was given the honour of being the first volunteer at PCH to meet and greet its first patients and families in May 2018. We would also like to acknowledge and congratulate Ann for being the recipient of the City of Melville's Citizen of the Year in 2018.

We received some very good news when CAHS successfully completed an Organisation Wide Survey in February 2018. Amongst many other notable comments, one surveyor described the PMH and PCH volunteer service as the best hospital volunteer service she had seen.

We would also like to express our deep gratitude to those volunteers who retired from their volunteering role this year and to warmly welcome all of those people who are now part of our volunteer community.

"We received some very good news when CAHS successfully completed an Organisation Wide Survey in February 2018. Amongst many other notable comments, one surveyor described the PMH/PCH volunteer service as the best hospital volunteer service she had seen."

Child and Adolescent Community Health

GROWTH, DEVELOPMENT AND WELLBEING

School Health

Community school health nurses work with school staff and parents to deliver prevention and health promotion services, develop health care plans for students with complex or chronic health needs, and connect children and adolescents with other health services and supports as required. In the 2017 school year, there were 108,459 occasions of service in primary schools and 74,373 occasions of service in high school settings.

The School Entry Health Assessment (SEHA) completion rate has consistently exceeded the target rate of 90 per cent. In the 2017 school year, 94.3 per cent of Kindergarten children received a SEHA.

In September 2017, work commenced on a review of community school aged health services. This review will help to ensure that school aged health services remain contemporary, are aligned to best practice, and continue to meet the needs of the community into the future.

Child Development Service

The Child Development Service (CDS) provides a range of free allied health and developmental paediatric services across metropolitan Perth for children with developmental delay.

Arising from feedback provided from over 1,000 families, CDS completed a major service redesign during 2017–18. The reforms were aimed at engaging consumers earlier in the client journey, partnering with families to plan services for their child, and providing a range of flexible service delivery options in order to better meet the individual needs of clients. CDS received the 2017 WA Health Award in the Engaging with Consumers, Carers and the Community category for this reform work.

Service redesign has ensured that parents are engaged early in the client journey, with more than 90 per cent of families receiving a service planning appointment within eight weeks of referral. Waiting time reductions have also been maintained for all major allied health disciplines. Median waiting times for CDS allied health services remained between one and six months during 2017–18, despite a significant increase in demand.

In 2017, CDS provided services to 20,502 children across metropolitan Perth.

Child Health

A review of the Universal Child Health Service Delivery Model in 2015 made recommendations for improvements to community child health services across Western Australia aimed at better meeting the needs of families. Following intensive planning and preparation, the new child health service delivery model was successfully implemented across Western Australia on 1 July 2017. Key changes include:

- an updated universal child health contact schedule (0–14 days, 8 weeks, 4 months, 12 months, 2 years and school entry)

"Forty six schools have been booked for ear health screening since the start of the 2018 school year. This has significantly exceeded the 45 schools that were screened during the whole 2017 school year."

- greater flexibility for families to access community child health services through increased drop-in and group sessions
- improvements in the health check assessment protocols, including use of a more robust parent questionnaire for identification of developmental delays
- targeted individual and group sessions to support families with additional needs.

In Perth, the new model has delivered greater flexibility and improved accessibility for families, with the number of contacts at drop-in sessions increasing by more than 50 per cent since implementation. Similarly, the number of parenting group sessions has increased by 8 per cent.

Immunisation

Child and Adolescent Community Health (CACH) delivers a 0–4 year old immunisation service from more than 50 clinics and community facilities across the Perth metropolitan area. Mapping GP and community health immunisation services was undertaken during 2017 to identify areas where CACH immunisation services could better meet the needs of the community. During 2017, CACH delivered 65,752 vaccinations through the 0–4 year old vaccination program.

CACH also delivers a school-based program to high school students across the metropolitan area. The program delivers Gardasil (HPV), Varivax (Chicken Pox) and Adacel (Tetanus, Diptheria and Pertussis) vaccines to students in Year 8. From May 2017, CACH also started providing Meningococcal W vaccinations for students in years 10, 11 and 12 across the metropolitan area.

During the 2017 school year, CACH provided immunisation services to students at 153 high schools, delivering a total of 110,734 vaccinations, including 37,894 meningococcal W vaccinations.

In 2017, CACH delivered a total of 176,486 vaccinations through the 0–4 and school-aged immunisation programs.

Aboriginal health in the community

The Aboriginal Health Team (AHT) delivers the Enhanced Aboriginal Child Health Schedule (EACHS) to approximately 1,000 clients who have elected to receive a service from the AHT or have been referred by mainstream services. This involves Community Health Nurses working alongside Aboriginal Health Workers (AHW) 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 EACHS differs significantly from the Universal Schedule Contact in the number of contacts offered. This is in recognition of the need for a comprehensive approach to supporting and strengthening the mother's or care-giver's parenting abilities and the developmental screening and surveillance of the child in order to maximise positive outcomes.

AHT has a dedicated Ear Health Team offering the Targeted Ear Health School Screening Program to Aboriginal children in primary schools across the metropolitan area. Forty six schools have been booked for ear health screening since the start of the 2018 school year. This has significantly exceeded the 45 schools that were screened during the whole 2017 school year. Children requiring further assessment are seen by an Ear, Nose and Throat (ENT) consultant and audiologist at the ENT clinics. Referrals are also accepted by General Practitioners (GPs), Paediatricians, Speech Pathologists, Audiologists and AHT Medical Officer. A major milestone in 2018 has been the reinstatement of the PCH outreach clinic for Aboriginal children in Padbury. Currently, clinics are offered in Armadale, Peel/Rockingham/Kwinana area and Padbury. Clinics are well attended, with nearly 80 per cent of all children attending. AHT was also successful in securing Rural Health West funding for the Armadale clinic in 2017–18.

AHT's medical and allied health team offer 100 clinics per year to children and their families who access the program. The Medical Officer also liaises regularly with the hospital, providing a link between tertiary hospital services and primary health services in the community for Aboriginal families. Allied health staff have been instrumental in training and supporting AHW in child development specifically in the use of the Ages and Stages Questionnaire – Talking about Raising Aboriginal Kids (ASQ-TRAK). The ASQ-TRAK monitors the developmental progress of children at intervals from 2–48 months of age, and is designed to provide culturally appropriate child development advice and feedback to parents.

AHT's health promotion staff work in partnership with AHT clinicians, external agencies and the local community to deliver better health outcomes in response to community needs, national and local priorities. In 2017–18, the team completed the Our Kulunga and Low Iron survey, which examined the health literacy of parents and caregivers on low iron; a significant issue in the community. In addition, the team delivered the Kiya Wandjoo Wandjoo Nidja (Hello Welcome Here) Lockridge Art Project and Koorlanga Warlang Bidee (Children on a Healthy Path), as well as Aboriginal playgroups.

Child and Adolescent Mental Health Service

A ceremony to celebrate the State-Wide Mental Health Graduate Nursing Program was held on 9 February 2018. Graduate Olivia Strudwick, who was based at the Child and Adolescent Mental Health (CAMHS) Bentley Adolescent Unit, received the Graduate Nurse of the Year Award for her outstanding achievements during the graduate program. Olivia was awarded the title based on her leadership skills, ability to empower others, innovation and professional practice.

CAMHS has received approval from the CAHS Human Research Ethics Committee to commence the first of several studies aimed at integrating mental and physical health. These studies will be undertaken by CAMHS in collaboration with the University of Western Australia. This first study aims to examine barriers and facilitators towards participation in physical activity, as well as perceptions of physical literacy in both children with mental health disorders and their parents and carers. It is intended that information attained from this study will be used to guide the development of a physical activity intervention designed to improve the physical literacy and physical activity levels of children with mental health disorders.

Aboriginal health at CAHS

'Wandju wandju, nidja'. Perth Children's Hospital has been designed as a welcoming place of healing, and the Noongar welcome is proudly displayed at all public entrances to the hospital.

Kulunga Moort Mia – 'children and family place' is a lounge area on the ground floor of PCH that provides a culturally sensitive and relaxing retreat for families accessing the hospital, away from busy clinical environments. Kulunga Moort Mia overlooks the northern green space and is close to Kings Park.

In April 2018, more than 100 guests, including the Minister for Health, the Hon. Roger Cook, attended a smoking ceremony – a traditional blessing of the land and the hospital. The ceremony started with a traditional Welcome to Country performed by Elder Doolann-Leisha Eatts of the Whadjuk nation alongside her husband, Walter Eatts. Guests were then treated to a performance of traditional dances by the Mungart Yongah Aboriginal Dancers.

To conclude the ceremony, Noongar elder Uncle Ben Taylor guided guests through cleansing smoke, produced by burning native plants. Uncle Ben had also performed PCH's very first smoking ceremony prior to commencement of the hospital's construction in 2012. A departing smoking ceremony was held at PMH, performed by Noongar Whadjuk Elder Nigel Wilkes, to cleanse the building and for safe passage to PCH.

Within the hospital, the Aboriginal Liaison Service continues to provide support to patients and families within both hospital and community settings. Support can be in the form of cultural support, advocacy or practical support to those identified as most vulnerable.

Beyond Perth Children's Hospital, the Child and Adolescent Health Service continues to deliver a range of multi-disciplinary, targeted programs and services aimed at engaging effectively with families to provide culturally safe and accessible care.

In 2017–18, the mental health service Warlang Nyit Wirrin, Moorditj Koorlangakas – 'Healthy little spirits make good strong children and adolescents' held two community forums, in Midland and Kwinana, to promote the program to the community. The forums also provided an opportunity for CAHS to hear from community members about how access to mental health services can be improved for young people and their families.

Koorliny Moort 'walking with families', continues to provide in and out-of-hospital care coordination to patients and their families and works in partnership with Aboriginal medical services to support families attending the outreach clinics.

In 2018, an Aboriginal health promotions officer, funded by the PCH Foundation, was employed to assist in the outreach clinics to provide cultural guidance, health promotion and clinical work. Funding has also been secured for a further three years for the two Koorliny Moort Paediatric Registrars through the Royal Australasian College of Physicians Specialist Training Program. This means that longstanding partnerships with researchers, including from the University of Western Australia and the Telethon Kids Institute, will continue at PCH in translating health research into clinical practice.

Significant events continue to be celebrated across CAHS services. During NAIDOC Week, CAHS was a stall holder at a number of community events, including at Armadale and Midland, to raise visibility of programs and services. At PMH, an art display was held, as well as a morning tea and cultural quiz in the social work department.

The Aboriginal Health Leadership Advisory Committee continues to meet on a monthly basis to provide cultural advice and direction in improving Aboriginal child and adolescent health.

Cultural awareness is a significant part of the induction for new staff within CAHS. At the end of the 2017–18 financial year, 85 per cent of staff had completed the cultural e-learning program. In addition to this, the increase in Aboriginal staff across the health service has further assisted staff with engagement with Aboriginal clients, their families and communities.

"The Child and Adolescent Health Service delivers a range of multi-disciplinary, targeted programs and services aimed at engaging effectively with families to provide culturally safe and accessible care."

KEY HIGHLIGHTS INCLUDE

Researchers across CAHS, as well as UWA affiliated researchers and the Telethon Kids Institute, were awarded more than

$24 MILLION

through competitive grants to undertake research, for research fellowships and infrastructure to undertake child health research.

MORE THAN 400 SCIENTIFIC RESEARCH PUBLICATIONS

arising from research on CAHS' locations or involving CAHS staff were published in peer reviewed journals.

A TOTAL OF 61 NEW RESEARCH APPLICATIONS & 247 AMENDMENTS

were reviewed and approved by the CAHS Human Research Ethics Committee and Research Governance.

OVER 300 ONGOING RESEARCH PROJECTS

were successfully approved and have subsequently transitioned to Perth Children's Hospital

The CAHS Human Research Ethics Committee was successful in achieving

NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL (NHMRC) RE-ACCREDITATION IN JULY 2017.

Research

This financial year has been one of many highlights for research at CAHS. Child health research continues to be active and a key priority for the organisation, with significant generation of successful research grants, as well as scientific publications as a result of the research undertaken. Child health research at CAHS empowers both staff and partner organisations to undertake research of the highest quality, with the goal of translating research into improvements in overall health and healthcare for all children and young people in WA.

Other achievements have included the development of the CAHS Child Health Research Strategy 2019–2022.

CAHS was the only WA participant in a successful pilot program which involved having a dedicated support role to improve the efficiency of site assessment and authorisation of clinical trials. As a result of the pilot, the NHMRC has rolled this process out nationally, with funding to support a Clinical Trials Liaison Officer at each WA metropolitan health service.

CAHS continues to provide research education opportunities for WA Health employees and affiliated research institutions through a fortnightly Research Education Seminar series, which occurs at Perth Children's Hospital but is delivered statewide via video broadcast technology. In 2017, over 2800 clinicians and researchers attended this hour-long introduction into good research practices which continues to be rated highly by those attending.

Teaching

CAHS provides extensive Education and Training Programs for staff across the medical, nursing and allied health professions.

Perth Children's Hospital

PCH is the sole tertiary paediatric teaching hospital in Western Australia, and facilitates training for undergraduate medical students from the University of Western Australia as well as the University of Notre Dame. Junior Medical Officers (JMOs) have the option of joining the Royal Australasian College of Physicians training program upon employment at PCH. Accreditation of JMO Terms is performed by the Postgraduate Medical Council of WA for pre-vocational trainees.

In addition, PCH provides undergraduate student placements for nurses from Curtin, Notre Dame, Edith Cowan Universities and Murdoch Universities. Paediatric Nursing Education facilitates mandatory training and continuing education through courses and programs that support evidence-based practice, critical thinking and enhanced career pathways. Continuous education programs are inclusive of the mandatory training requirements set in the CAHS Policy mandatory framework.

The Allied Health professions support clinical placements for undergraduate and post-graduate allied health professionals to gain experience in a paediatric environment.

Child and Adolescent Mental Health Service

Child and Adolescent Mental Health is responsible for the organisation and delivery of education and training to its clinical and non-clinical staff to enhance the delivery of quality, evidence-based child and adolescent community and inpatient mental health services. The education and training of staff is guided by a Core Competency Framework, which is also aligned to the National Practice Standards for the Mental Health Workforce.

Child and Adolescent Community Health

All staff working for CACH are required to complete training, in line with the CAHS Mandatory Training Framework and the CACH Practice Framework. A Clinical Education Team working in the Community Health nursing area provides on-site assistance to all nursing staff. CACH offers limited places for a six month rotation in the community. This opportunity allows graduates to develop their knowledge and skills using a family-centred approach within a variety of settings, including school health, Aboriginal health, refugee health, lactation consultancy, enuresis and immunisation. CACH also offers opportunities for second year Graduate Registered Nurses to undertake their graduate year in a community health setting.

CAHS integrity and ethics

After the appointment of a Manager of Integrity and Ethics, CAHS developed and implemented an Integrity and Ethical Governance Framework during 2017–2018 linked to the Good Governance Principles outlined by the WA Public Sector Commission.

The implementation of a reporting solution has enabled streamlined trending and reporting against the CAHS Integrity and Ethical Governance Framework. CAHS also reviewed policies and procedures relating to Public Interest Disclosure, Outside Employment, Acceptance of Gifts, and Managing Conflicts of Interests. A dedicated space on the CAHS intranet was also created to provide resources and information for employees on reporting issues of concern, legislative requirements for reporting criminal and professional mis-conduct, acceptance of gifts and travel as well as the Code of Conduct. Information was also published on the CAHS public website on conduct standards and integrity to enable consumers and the public to access information and report compliments, complaints, misconduct and Public Interest Disclosures. CAHS employee completion rate of Accountable and Ethical Decision Making (AEDM) training was 92 per cent compliant as at 30 June 2018.

In 2017–18, a total of 55 reports or 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 and where appropriate reported to the Public Sector Commission (7) or the Corruption Crime Commission (24) as required under the *Corruption, Crime and Misconduct Act 2003*. Where breaches were substantiated, the decision maker determined the appropriate action in accordance with the *Health Services Act 2016*.

The CAHS Ethical Conduct Review Committee meets monthly to provide governance oversight around misconduct risks, corrective actions and related systemic improvements. CAHS commenced implementing actions towards the recommendations associated with the Corruption and Crime Commission report on Serious Misconduct Risks Around Dangerous Drugs in Hospitals and also actions arising from the recommendations from the Public Sector Commission review into the management of confidential patient information at the Child and Adolescent Health Service.

"A dedicated space on the CAHS intranet was also created to provide resources and information for employees on reporting issues of concern, legislative requirements for reporting criminal and professional mis-conduct, acceptance of gifts and travel as well as the Code of Conduct."

Statement from the Consumer Advisory Council Chair

I am so pleased to be the Chair of the Consumer Advisory Council (CAC) for CAHS. We are a dedicated group of passionate people with lived experience, either as a parent, family member or previously as a patient, in the paediatric health service who are committed to promoting, developing and maintaining excellence in patient and family-centred care.

CAC has been extremely active in bringing the consumer voice to all areas of the health service. As Chair, I have been welcomed into the CAHS Health Service Executive Committee (HSEC), which signals a vital partnership between the CAHS Executive and CAC.

This past year has seen CAC being increasingly sought out to provide input and feedback, especially with the transition to Perth Children's Hospital (PCH). It has been an exciting year leading up to the long-awaited opening of PCH.

We have seen an increase in CAHS staff awareness of connecting and involving families in their health care across community health, mental health and PMH and PCH. We are also very pleased to continue our relationship with a number of external organisations, including the Health Consumer's Council of WA.

I would like to thank our CAC members for their ongoing dedication in bringing the consumer voice to all areas of CAHS and to all members of the HSEC and the Child and Family Engagement team for their ongoing commitment and support of CAC.

Ma Wood

MARGARET WOOD
Chair
Consumer Advisory Council

Statement from the Youth Advisory Committee Chair

The Youth Advisory Committee (YAC) continues to be a unique and valuable asset for the Child and Adolescent Health Service (CAHS).

Initially formed to assist in the design, development and building of Perth Children's Hospital (PCH), the CAHS YAC has grown into a much more diverse group with an increased strategic reach within WA Health with an awareness of wider State youth health demands.

Over the last 12 months, YAC provided valuable input into a number of key policies and high-level documents, including the important development and implementation of the Department of Health's WA Youth Health Policy 2018–2023.

YAC enthusiastically participated in the Australian Council on Healthcare Standards Organisation Wide Survey and has a seat at the CAHS Health Service Executive Committee table. YAC members sit on numerous other health service committees and working groups to provide their views and valuable insights into how best to create a patient and family-centred approach across CAHS.

During the transition from PMH to PCH, YAC members remained passionately enthusiastic, and while the focus was on the shiny new hospital, YAC was careful not to lose focus on the existing CAHS services to ensure that PMH continued to be responsive to the needs of patients and their families.

Ensuring that the 'little voices' are heard has always been the number one priority for YAC, which is why the YAC members took an active role in assisting with the planning and delivery of key outcomes from the across-CAHS Voice of the Family survey.

At PCH, YAC participated extensively in user testing for the Patient Entertainment System and patient journey flow to ensure that patients and families had a good hospital experience from day one. Currently, YAC is involved in new areas of patient and family engagement, including exciting projects being developed by nursing research.

While we have said goodbye to our beloved PMH, we look forward to a new chapter at PCH and what this means for improving the lives and health of Western Australian children and their families.

DANIEL STAER
Chair
Youth Advisory Committee

APRIL WELSH
Former Chair
Youth Advisory Committee

"DAC has provided significant input into the development of the CAHS Disability Access and Inclusion Plan 2018-2022, which was finalised in early 2018."

Statement from the Disability Advisory Committee Chair

The Disability Advisory Committee (DAC) has a key role in ensuring children and families have improved access to existing services at CACH, CAMHS and PMH, as well as ensuring appropriate access and inclusion of people with disabilities as we transitioned to Perth Children's Hospital.

The Disability Advisory Committee (DAC) has a key role in ensuring children and families have improved access to existing services at CACH, CAMHS and PMH, as well as ensuring appropriate access and inclusion of people with disabilities as we transitioned to Perth Children's Hospital.

DAC has been actively involved in planning a range of key service areas to assist children and their families transition to Perth Children's Hospital. Their input into the facility's design, patient services and Patient Entertainment System has been important in ensuring that the new technology appropriately supports access for all children and youth with disabilities within our services.

Access to disability parking and the introduction of a buggy service to provide assistance to parents with children and adolescents in wheelchairs, provides that extra support while navigating to and from the new hospital.

DAC has provided significant input into the development of the CAHS Disability Access and Inclusion Plan (DAIP) 2018-2022, which was finalised in early 2018. The aim of the DAIP is to ensure people with disability, their carers, families and representatives can access the services provided by CAHS. The DAIP addresses seven key outcome areas to ensure people with disability:

- have the same opportunities as other people to access the services of, and any events organised by, a public authority
- have the same opportunity as other people to access the buildings and facilities of a public authority
- receive information from a public authority in a format that will enable them to access the information as readily as other people are able to access it
- receive the same level and quality of service from the staff of a public authority as other people receive from the staff of the public authority
- have the same opportunities as other people to make complaints to a public authority
- have the same opportunities as other people to participate in any public consultation by a public authority
- have the same opportunities as other people to obtain and maintain employment with a public authority.

An implementation plan is in progress, and reporting on outcomes will occur annually.

I would like to take this opportunity to thank all members of the committee for their valuable input and participation throughout the year. In particular, I would like to acknowledge the consumer representatives for their significant contributions to the committee as well as their generosity in sharing their personal experiences in order to improve the outcomes for all children with disabilities. The consumer perspective assists CAHS to ensure our planning decisions and service provision is inclusive for all children and their families.

MARY MILLER
Chair
Disability Advisory Committee

Agency Performance

Financial targets

	2017-18 TARGET [1] $000	2017-18 ACTUAL $000	VARIATION [6] $000
Total cost of services (expense limit) (sourced from Statement of Comprehensive Income)	551,914	582,957	31,043 [2]
Net cost of services (sourced from Statement of Comprehensive Income)	343,795	362,871	19,076 [2]
Total equity (sourced from Statement of Financial Position)	219,889	1.400,980	1,181,091 [3]
Net increase / (decrease) in cash held (sourced from Statement of Cash Flows)	2,243	13,463	11,220 [4]
Approved salary expense level [5]	380,923	397,294	16,371

Note

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

(2) The $10.502 million cost-shift for the Neonates Ward from the North Metropolitan Health Service's King Edward Memorial Hospital was a main contributing factor for the increase in total cost of services and net cost of services.

(3) The opening of the Perth Children's Hospital (PCH) was the main reason for the variation for total equity. Property, plant and equipment ($1,177.467 million) and intangible assets ($52.400 million) for PCH were transferred from the Health Ministerial Body to the Health Service when the hospital opened in May 2018. The annual estimates did not budget for the transfer of these PCH assets.

(4) The net increase in cash held mainly consisted of unexpended funding from State Government, Mental Health Commission and external organisations.

(5) The amounts for salary expense level do not include superannuation.

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

Summary of Key Performance Indicators

Key performance indicators assist the Child and Adolescent Health Service (CAHS) to 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 2017–18 targets is given in Table 1.

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		2017–18 TARGET[1]	2017–18 ACTUAL	VARIATION	FURTHER INFO
Unplanned hospital readmissions of public hospital patients within 28 days for selected surgical procedures (per 1,000)	Appendicectomy	32.9	20.8	-12.1	p. 159
	Cataract Surgery	1.1	0.0	-1.1	
	Tonsillectomy & Adenoidectomy	61.0	87.8	26.8	
Proportion of elective wait list patients waiting over boundary for reportable procedures	Cat 1 (≤30 days)	0	0.7%	0.7%	p.162
	Cat 2 (≤90 days)	0	0.6%	0.6%	
	Cat 3 (≤365 days)	0	0.1%	0.1%	
Hospital infection rates (HA-SABSI) per 10,000 occupied bed-days in public hospitals		1.0	1.03	0.03	p.164
Survival rates for sentinel conditions	Stroke	94.3%	84.2%	-10.1%	p.166
	Acute Myocardial Infarction	99.2%	N/A	N/A	
Percentage of admitted Aboriginal and Non-Aboriginal patients who discharged against medical advice	Aboriginal	0.77%	0.30%	-0.47%	p.168
	Non-Aboriginal	0.77%	0.09%	-0.68%	
Rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit		12%	28.3%	16.3%	p.170
Percentage of contacts with community-based public mental health non-admitted services within seven days post-discharge from an acute public mental health inpatient unit		75%	72.4%	-2.6%	p.172
Average admitted cost per weighted activity unit		$7,285	$7,116	-$169	p.174
Average Emergency Department cost per weighted activity unit		$7,043	$6,791	-$252	p.175
Average non-admitted cost per weighted activity unit		$7,160	$7,018	-$142	p.176
Average cost per bed-day in specialised mental health inpatient units		$4,543	$4,163	-$380	p.177
Average cost per treatment day of non-admitted care provided by public clinical mental health services		$771	$650	-$121	p.178
Average cost per person of delivering population health programs by population health units		$262	$222	-$40	p.179

[1]As specified in the Budget Statements

N/A – not applicable

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

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

Percentage of emergency department patients seen within recommended times

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

CAHS strives to treat all emergency department patients within the recommended period, but places most emphasis on the sickest and most time critical patients assigned to Categories 1 and 2. In 2017–18, CAHS continued to exceed performance expectations for Category 1, 2 and 5 patients (see Table 3). Performance in Categories 3 and 4 have improved from the previous year despite 449 more patients in these categories being treated during 2017–18. Category 5 access sits well above target. They comprise low acuity cases that represent a small percentage of presentations that can either be treated by a wider multi-disciplinary team or be directed to other providers more directly through the triage process.

Annual results are affected by factors such as high winter demand, the total number of cases and the timing of presentations. For instance, patients mostly arrive at the Emergency Department at intervals between 0 and 5 minutes for several hours in a row, particularly in the evening, which can make it difficult to achieve the targets consistently.

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%

Table 3: Percentage of Child and Adolescent Health Service emergency department patients seen within recommended times, by triage category, 2017–18

TRIAGE CATEGORY	2016–17	2017–18	TARGET
1	100%	100%	100%
2	89.7%	88.9%	80%
3	61.6%	63.3%	75%
4	59.5%	65.5%	70%
5	95.1%	95.1%	70%

Table 4: SAC 1 incidents 2017–18

SAC1 INCIDENT	NUMBER
Total notified	**22**
Investigated	16
Ongoing investigation	5
Declassified*	1
Total confirmed	**21**
Confirmed with patient outcome of death	3
Confirmed with patient outcome of serious harm	10
Confirmed with patient outcome of moderate harm	7
Confirmed with patient outcome of minor harm	0
Confirmed with patient outcome of no harm	1

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

Clinical incidents

Learning from clinical incidents

CAHS wholeheartedly 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 a culture 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 expected 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.

Clinical incidents (including near misses) are divided into three groups based on the severity of the incident; these are called Severity Assessment Codes (SAC). A SAC 1 is the most serious and is thoroughly investigated by a panel of experts who can identify factors that may have led to the incident and make recommendations to prevent it from happening again.

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 to improvements. This assists monitoring and ensuring accountability for patient safety.

Spotlight on:

1. **Healthcare Acquired Infections (HAI)**
   During the 2017–18 year, HAI were the highest reported category of SAC 1 incidents at CAHS. To better understand this increase in HAI, a multi-disciplinary review is being undertaken of the investigations and recommendations over the last three years. This review will identify any weaknesses in the controls implemented, and develop a plan for further improvements to prevent HAIs.
2. **Behaviour**
   Behaviour related incidents were the cause of the second-highest number of SAC 1 incidents and the second-highest number of incidents overall. The majority of behaviour related incidents are associated with our mental health patients. As a result, the Progressive Risk Assessment has been developed to allow staff to track a patient's mental health in the same way they would track physical health and respond quickly to deterioration.

   Work has also been done with the physical environments to reduce opportunities for patients to harm themselves.
3. **Medication**
   Medication errors are the highest number of overall incidents and the third highest SAC 1 incidents at CAHS. Work is being done in this area to improve prescribing, dispensing and administration processes.

   At PCH, new technology has been introduced to assist with the dispensing and administration of medications. On the wards, automated dispensing machines use a system of lights to show staff which medication they need to administer to a particular patient. In the Pharmacy, robots deliver the correct medication. Both of these reduce the chance of a person picking up and giving the incorrect medication to a patient. All staff involved in prescribing, dispensing or administering medications have been trained to use this technology, as well as receiving training in medication safety and how to help prevent medication errors.

Clinical incident case study

Background

A young child with Type 1 diabetes presented to the Princess Margaret Hospital Emergency Department (ED) with abdominal cramping, vomiting, decreased input and output and dizziness, and was admitted to hospital. The ED medical officer recorded that, prior to admission, the mother had given the child *4IU of Lantus and 2 to 3IU of Novorapid insulin when required.*

Incident

Following admission to the ward, the treating nurse noted the Lantus was recorded as *4IU*, which could be mistaken for *41 units*. The child's mother confirmed she gave 4 units only, and the child did not receive an incorrect dose of medication. Lantus was also prescribed in the paediatric national inpatient medication chart as 4IU and 'insulin' 2-3IU when required.

Findings

From this near miss event, the review team found the ED had only recently implemented the use of the Subcutaneous Insulin and Blood Glucose Monitoring Chart, and there was lack of education on the use of the chart in ED. Insulin is usually charted by the Endocrinology medical team and not ED medical team. Both the medication safety training course and mandatory training for all medical staff clearly states that when prescribing insulin, the word 'units' is to written in full and abbreviations such as 'u' or 'IU' should not be used. This is because IU has the potential to be interpreted as international units, which is not in keeping with prescribing practices.

Learnings and outcomes

1. All insulin prescriptions in ED are made after consulting with a diabetes specialist, and ED nurses confirm the insulin dose in person with the doctor.
2. The insulin charts have been redesigned to make them easier to understand and use, and therefore reduce the possibility of error.
3. Diabetes education is available to doctors and nurses in the hospital, as diabetes is a common condition and its management should not be considered specialist knowledge.

Significant Issues

Perth Children's Hospital opening

In April 2018, the opening dates of Perth Children's Hospital (PCH) were confirmed by the Premier and Minister for Health. The staged opening of PCH ran over four weeks, with the first outpatient clinics held on 14 May 2018. A fortnight later, on 28 May 2018, elective surgery started at PCH. The final move day for inpatients and the closure of Princess Margaret Hospital (PMH) occurred successfully on 10 June 2018. Patients from the Bentley Adolescent Unit moved on 13 June 2018.

The confirmation of PCH's opening schedule followed confirmation that the hospital's potable water was safe to drink, after meeting Australian Drinking Water Guidelines and being signed off by the Chief Health Officer.

The transfer of patients on 10 June ran smoothly and was the largest medical move of children in the State's history, with 91 patients transferred from PMH. About 650 people took part on final move day, including teams at both hospitals and staff from the PCH Project, St John Ambulance, Main Roads, WA Police, the Department of Health's Disaster Preparedness Management Unit, the Queen Elizabeth II Medical Centre Trust and local councils located along the transfer route.

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. Some are not fit for purpose or do not comply with the latest building standards pertaining WorkSafe standards for mental health, and improvements are required for disability access, external access points, air conditioning systems and security. Whilst these issues exist Community Health has undertaken the necessary risk mitigations and remains compliant with necessary legislation.

CACH continues to face 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 six years, CACH has been evicted from eight sites and has to vacate at least another two sites in 2018–19. In addition, agencies that previously provided low or no cost tenancy arrangements are increasingly moving to charging commercial rates, which represents a further funding challenge for CACH and impacts the sustainability of the service. CAHS is exploring options for future service delivery.

Demand and activity

Overall CAHS has delivered services slightly above the activity targets set for 2017–18. The variance is due to an increase in the number of outpatient appointments and mental health inpatient services.

The population of 0–19 year olds in metropolitan Perth increased by an estimated 84,543 between 2006 and 2016, which equates to an average 2.1 per cent increase each year. The greatest increase was in the 0–4 year old population, which increased by 33,738 (3.6 per cent each year) over this period. CACH has not received population growth funding since 2014–15, when CACH received 2.85 per cent population growth funding.

Workforce challenges

CAHS continued to re-align the Health Service Delivery units (Community, Mental Health and hospital based services) into a more integrated structure.

The preparation for the transition of hospital-based services at the PMH Subiaco site and Mental Health unit at Bentley to the new Perth Children's Hospital at the Nedlands site provided challenges, with a significant number of employees having to be released from their normal duties for training in the new environment, layout and technology, as well as for hospital commissioning purposes.

CAHS consulted widely with staff in developing a new Vision, Objectives and Values, which formed part of the framework for a new Strategic Plan to provide CAHS with a clear direction and purpose for 2018–23.

The new 2017–18 workforce model for Junior Medical Officers (JMO), with provision for JMO leave and professional development, was successfully implemented despite challenges.

Following concerns regarding staff morale among clinicians at Princess Margaret Hospital in early 2017, the CAHS Board commissioned a review, and the subsequent report was published in June 2017. The report contained 26 recommendations, all but three of which have been successfully implemented.

Outstanding work was done during the year to improve the working environment at CAHS, although it is acknowledged that changing organisational culture requires more than a 12 month program to be adequately addressed. Of considerable assistance in this process was the Shape Our Future Steering Team, comprised of staff members. This team continues to provide advice and input on matters related to staff engagement and morale.

Managing funds and costs efficiently

Overall, CAHS contained costs over the last financial year with only a 4.3 per cent increase in total expenditure. In addition, own source revenue increased by 5.0 per cent and the cost of service increased by 3.9 per cent, resulting in a surplus position at year end. The CAHS Finance Oversight Committee, chaired by the Chief Executive and with membership including the Executive group, continues to apply the principles of activity based funding, funding reform and best practice financial management. This is being shared with managers across CAHS to support departmental accountability and responsibility. Directorate specific budget strategies involving both revenues and expenditures have been identified to assist achieve targets, which will be built on in future years. A new Financial Framework is being developed and implemented to enhance accountability, reporting and the understanding of interrelations between the various components of financial performance.

Health inequalities

The disparity in health outcomes of Aboriginal children compared to the remainder of the Australian population continues to be significant. Services to Aboriginal children and adolescents are delivered through primary, secondary and tertiary health care facilities across CAHS. Within CACH, dedicated community health services are provided to Aboriginal children and adolescents through the Aboriginal Health Team, who deliver culturally safe and appropriate services. 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, continues to be delivered by PCH. Specialist Aboriginal mental health services are provided through Community, Specialised and PCH CAMHS across the metropolitan area

to increase accessibility to services and deliver culturally appropriate and culturally safe services to Aboriginal children and their families. Further information pertaining to Aboriginal Health initiatives can be found on pages 38 and 40.

Each year, the Child Development Service (CDS) provides services to approximately 20,000 children who have developmental difficulties, including intellectual disability, autism spectrum disorder and other developmental disorders. Children with autism and intellectual disabilities 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. Disability services reform across WA continues to be driven by the National Disability Insurance Scheme (NDIS), with collaboration with CAHS, the Disability Services Commission, other government agencies and non-government organisations.

In recognition of ongoing inequalities that exist in healthcare, CAHS seized the opportunity to embrace equity as a key organisational value as part of this year's strategic planning. As noted in the 2018–2023 CAHS Strategic Plan, by treating people in a fair and just manner, everyone receives the same rights and opportunities. In other words, CAHS' vision for being the best we can be includes a fair go for all.

Restructure

Extensive work has been undertaken in the last financial year to review and update the structure of the health service and create a new strategic plan. The primary objective of reviewing the health service structure was to ensure that all the functions required to effectively lead and manage a health service were aligned within the appropriate Executive roles and reporting structures while minimising duplication. As part of this, the structures of other health service providers and other health services across Australia were reviewed to inform planning for the CAHS structure. More than 100 staff submitted feedback on the structure. This feedback drove changes such as renaming directorates and functions, as well as broader themes around the representation of community health and mental health.

CAHS is unique in being a small health service that delivers programs across a number of sites. However, being a small service means the executive structure must reflect the size and budget of CAHS. The new structure aligns the previous PCH, CACH and CAMHS executive structures into a single service supported by directorates: Community Health, Mental Health, Surgical, Medical, and Allied Health.

Further to this, the CAHS Strategic Plan 2018–2023 was developed and released as a result of extensive consultation and collaboration. The new plan features updated strategic priorities and a refreshed Vision: healthy kids, healthy communities, and Values: compassion, collaboration, accountability, respect, equity, and excellence. This work was undertaken as a recommendation of the PMH Review at a time of already significant change for the health service, as CAHS worked towards the opening of Perth Children's Hospital. The success of these concurrent challenges is further testament to the strength and resilience of the CAHS workforce.

Accreditation

CAHS underwent an organisation wide accreditation survey by the Australian Council on Healthcare Standards from 19-23 February 2018. Over these five days, the surveyors visited 12 community sites and 34 hospital department and wards. There were over 30 meetings held and more than 200 staff participated in those meetings.

The four recommendations from the previous survey in 2014 were closed. This year, CAHS achieved seven 'Met with Merits' for the National Safety and Quality Health Service (NSQHS) standards: Governance, Partnering with

Consumers, Preventing and Controlling Hospital Acquired Infections, Medication Safety, Patient Identification and Procedure Matching, and Blood and Blood Products. CAHS also met all the actions of the 10 Mental Health Standards.

CAHS received three 'Not Mets'; these were for developmental actions that CAHS self-rated as 'Not Met' in the Pre-Survey Assessment Report. The 'Not Met' actions relate to ensuring that a system is in place for preparing and/or receiving advance care plans in partnership with patients, families and carers, and will be re-assessed during the next survey.

Overall, the feedback from the surveyors was overwhelmingly positive. The surveyors were particularly impressed by the 'many staff who expressed the positiveness (sic), passion and pride of working within this organisation'. In light of ongoing organisational changes, it was noted that 'the organisation has done well to establish a robust and well-functioning governance system for quality and safety, and the team was impressed with the values of the organisation, which were reflected within all conversations with staff'.

National Disability Insurance Scheme

In addition to the broader need to clarify referral pathways and eligibility for the National Disability Insurance Scheme, two aspects of the NDIS have particular relevance for CACH. These are the proposed introduction of the Early Childhood Early Intervention (ECEI) model, and the potential implications of the introduction of the NDIS on demand for autism assessments provided by the CDS.

"...the organisation has done well to establish a robust and well-functioning governance system for quality and safety"

The ECEI model involves NDIS-funded non-government partners who provide developmental support, service planning and brief intervention for children 0–6 years of age prior to referral to NDIS (if required). There is a risk that this may replicate a small portion of the work carried out by CACH. This would be likely to result in confusion for consumers, fragmentation of the current model of care, and additional administrative burden across the system. CAHS is working with the National Disability Insurance Agency to mitigate this risk by collaboratively developing service pathways.

The second risk specific to CACH relates to the provision of publicly-funded autism assessments. In Perth, these are currently provided by the CDS (approximately 240 assessments per annum) and the Department of Community – Disability Services (approximately 400 per annum).

It is unclear under the Bilateral Agreement between the Commonwealth and Western Australia for the transition to a National Disability Insurance Scheme in Western Australia whether responsibility for autism assessments is held by health or the disability sector. Experience in other states suggests that it is likely that responsibility for these assessments will be solely held by health under the NDIS.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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 2018, 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 2018 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

Opinion

I have undertaken a reasonable assurance engagement on the design and implementation of controls exercised by the Child and Adolescent Health Service. The controls exercised by the Health Service are those policies and procedures established by the Board to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions (the overall control objectives).

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

In my opinion, in all material respects, the controls exercised by the Child and Adolescent Health Service are sufficiently adequate to provide reasonable assurance that the receipt, expenditure and investment of money, the acquisition and disposal of property and the incurring of liabilities have been in accordance with legislative provisions during the year ended 30 June 2018.

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 2018. 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 2018.

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 the 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 2018. Consequently, the KPI has not been included in the audited KPIs for the year ended 30 June 2018. 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 2018 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.

CAROLINE SPENCER
AUDITOR GENERAL
FOR WESTERN AUSTRALIA
Perth, Western Australia
13 September 2018

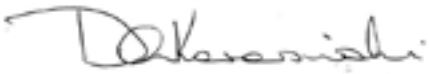
Certification of financial statements

CHILD AND ADOLESCENT HEALTH SERVICE

CERTIFICATION OF FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2018

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 2018 and the financial position as at 30 June 2018.

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
CHAIR OF THE BOARD
CHILD AND ADOLESCENT HEALTH SERVICE
17 September 2018

PROF GEOFFREY DOBB
DEPUTY CHAIR OF THE BOARD
CHILD AND ADOLESCENT HEALTH SERVICE
17 September 2018

MR TONY LOIACONO
CHIEF FINANCIAL OFFICER
CHILD AND ADOLESCENT HEALTH SERVICE
17 September 2018

Financial statements

Statement of comprehensive income
For the year ended 30 June 2018

	Notes	2018 $000	2017 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	3.1(a)	433,218	406,536
Fees for visiting medical practitioners		1,849	1,139
Contracts for services	3.2	7,992	9,260
Patient support costs	3.3	59,045	58,786
Finance costs	7.2	55	79
Depreciation and amortisation expense	5	11,044	11,496
Asset revaluation decrements	5.1	2,047	1,576
Loss on disposal of non-current assets	5.1.2	82	2
Repairs, maintenance and consumable equipment	3.4	8,599	7,592
Other supplies and services	3.5	36,168	31,934
Other expenses	3.6	22,858	26,697
Total cost of services		**582,957**	**555,097**
INCOME			
Revenue			
Patient charges	4.2	12,947	13,185
Other fees for services	4.2	10,841	11,598
Commonwealth grants and contributions	4.3	125,580	120,857
Other grants and contributions	4.3	64,301	58,731
Donation revenue	4.4	1,502	1,293
Commercial activities	4.5	869	963
Other revenue	4.6	4,046	3,031
Total revenue		220,086	209,658
Total income other than income from State Government		**220,086**	**209,658**
NET COST OF SERVICES		**362,871**	**345,439**

	Notes	2018 $000	2017 $000
INCOME FROM STATE GOVERNMENT			
Service appropriations	4.1	334,184	319,539
Assets (transferred)/assumed	4.1	(287)	8
Services received free of charge	4.1	35,569	34,199
Total income from State Government		**369,466**	**353,746**
SURPLUS FOR THE PERIOD		**6,595**	**8,307**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.13	1,087	3,037
Total other comprehensive income		1,087	3,037
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**7,682**	**11,344**

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

Statement of financial position
As at 30 June 2018

	Notes	2018 $000	2017 $000
ASSETS			
Current Assets			
Cash and cash equivalents	7.3	27,696	22,442
Restricted cash and cash equivalents	7.3	29,868	16,712
Receivables	6.1	6,813	10,747
Inventories	6.3	2,344	2,540
Other current assets	6.4	537	448
Total Current Assets		67,258	52,889
Non-Current Assets			
Restricted cash and cash equivalents	7.3	3,308	1,644
Amounts receivable for services	6.2	200,625	186,301
Property, plant and equipment	5.1	1,218,168	107,411
Intangible assets	5.2	51,744	6
Total Non-Current Assets		1,473,845	295,362
TOTAL ASSETS		**1,541,103**	**348,251**
LIABILITIES			
Current Liabilities			
Payables	6.5	32,841	28,047
Borrowings	7.1	703	673
Employee benefits provision	3.1 (b)	84,829	79,595
Other current liabilities	6.6	23	212
Total Current Liabilities		118,396	108,527
Non-Current Liabilities			
Borrowings	7.1	739	1,442
Employee benefits provision	3.1 (b)	20,988	20,372
Total Non-Current Liabilities		21,727	21,814
TOTAL LIABILITIES		**140,123**	**130,341**
NET ASSETS		**1,400,980**	**217,910**
EQUITY			
Contributed equity	9.13	1,381,954	206,566
Reserves	9.13	4,124	3,037
Accumulated surplus		14,902	8,307
TOTAL EQUITY		**1,400,980**	**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 2018

	Notes	2018 $000	2017 $000
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		319,803	304,112
Capital appropriations		1,229	1,121
Net cash provided by State Government	7.3.3	**321,032**	**305,233**
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(427,262)	(398,559)
Supplies and services		(102,813)	(97,744)
Receipts			
Receipts from customers		15,334	11,252
Commonwealth grants and contributions		125,580	120,857
Other grants and contributions		64,301	58,731
Donations received		1,088	805
Other receipts		17,320	14,488
Net cash used in operating activities	7.3.2	**(306,452)**	**(290,170)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Purchase of non-current assets		(1,117)	(2,846)
Receipts			
Proceeds from sale of non-current assets		-	4
Net cash used in investing activities		**(1,117)**	**(2,842)**

	Notes	2018 $000	2017 $000
Net increase / (decrease) in cash and cash equivalents		13,463	12,221
Cash and cash equivalents at the beginnning of the period for the Health Service		28,554	-
Cash and cash equivalents transferred from the Government	9.13	-	16,333
Cash and cash equivalent at the end of the period for the Health Service		42,017	28,554
Cash and cash equivalents held for the Health Ministerial Body	7.3	18,855	12,244
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.3	**60,872**	**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 2018

	Notes	Contributed equity $000	Reserves $000	Accumulated surplus $000	Total equity $000
Balance at 1 July 2016		-	-	-	-
Surplus		-	-	8,307	8,307
Other comprehensive income	9.13	-	3,037	-	3,037
Total comprehensive income for the period		-	3,037	8,307	11,344
Transactions with owners in their capacity as owners:					
Transfer of net assets on establishment of the Health Service	9.13	201,039	-	-	201,039
Capital appropriations		1,764	-	-	1,764
Other contributions by owners		3,763	-	-	3,763
Total		206,566	-	-	206,566
Balance at 30 June 2017		**206,566**	**3,037**	**8,307**	**217,910**
Balance at 1 July 2017		206,566	3,037	8,307	217,910
Surplus		-	-	6,595	6,595
Other comprehensive income	9.13	-	1,087	-	1,087
Total comprehensive income for the period		-	1,087	6,595	7,682
Transactions with owners in their capacity as owners:					
Capital appropriations		1,902	-	-	1,902
Other contributions by owners		1,232,938	-	-	1,232,938
Distributions to owners		(59,452)	-	-	(59,452)
Total		1,175,388	-	-	1,175,388
Balance at 30 June 2018		**1,381,954**	**4,124**	**14,902**	**1,400,980**

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

Notes to the financial statements
For the year ended 30 June 2018

1. Basis of preparation

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

These annual financial statements were authorised for issue by the Accountable Authority of the Health Service on 17 September 2018.

Statement of compliance

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

1) The Financial Management Act 2006 (FMA)

2) The Treasurer's Instructions (the Instructions or TI)

3) Australian Accounting Standards (AAS) including applicable interpretations

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

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

Basis of preparation

These financial statements are presented in Australian dollars applying the accrual basis of accounting and using the historical cost convention. Certain balances will apply a different measurement basis (such as the fair value basis). Where this is the case, the different measurement basis is disclosed in the associated note. All values are rounded to the nearest thousand dollars ($000).

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

The Health Ministerial Body, established under section 10 of the *Health Services Act 2016*, had control of the Perth Children's Hospital (PCH) project during the 2016-17 and 2017-18 financial years. Hence, assets, liabilities, income and expenses for the PCH project were recognised in the Department of Health's financial statements. Property, plant and equipment and Intangible assets for the Perth Children's Hospital were transferred from the Health Ministerial Body to the Health Service, when the hospital opened in May 2018. See Note 5.1 'Property, plant and equipment' and Note 5.2 'Intangible assets'.

Notes to the financial statements
For the year ended 30 June 2018

Judgements and estimates

Judgements, estimates and assumptions are required to be made about financial information being presented. The significant judgements and estimates made in the preparation of these financial statements are disclosed in the notes where amounts affected by those judgements and/or estimates are disclosed. Estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances.

Contributed equity

AASB Interpretation 1038 Contributions by Owners Made to Wholly-Owned Public Sector Entities requires transfers in the nature of equity contributions, other than as a result of a restructure of administrative arrangements, to be designated 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 TI 955 Contributions by Owners made to Wholly Owned Public Sector Entities and have been credited directly to Contributed Equity.

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

2. Health Service outputs

How the Health Service operates

This section includes information regarding the nature of funding the Health Service receives and how this funding is utilised to achieve the Health Service's objectives. This note also provides the distinction between controlled funding and administered funding:

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

2.1 Health Service objectives

Mission

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

The Health Service is predominantly funded by Parliamentary appropriations.

Services

The keys services of the Health Service are:

Public Hospital Admitted Services

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

Public Hospital Emergency Services

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

2.1 Health Service objectives (cont.)

Public Hospital Non-admitted Services

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

Mental Health Services

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

Aged and Continuing Care Services

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

Public and Community Health Services

The Child and Adolescent Community Health provides services and programs delivered to increase optimal health and wellbeing, encourage healthy lifestyle, reduce the onset of disease and disability, reduce the risk of long-term illness as well as detect, protect and monitor the incidence of disease in the population. These include child health services, school health services, child development services, public health programs and Aboriginal health programs.

2.2 Schedule of income and expenses by service

For the year ended 30 June 2018

	Public Hospital Admitted Services		Home-Based Hospital Programs [a]		Public Hospital Emergency Services		Public Hospital Non-Admitted Services	
	2018 $000	2017 $000	2018 $000	2017 $000	2018 $000	2017 $000	2018 $000	2017 $000
COST OF SERVICES								
Expenses								
Employee benefits expense	176,296	156,703	-	1,544	33,542	29,017	71,205	69,733
Fees for visiting medical practitioners	1,151	694	-	7	219	129	465	309
Contracts for services	2,176	3,063	-	30	414	567	879	1,363
Patient support costs	34,876	34,090	-	418	6,636	6,311	14,087	15,197
Finance costs	34	49	-	-	7	9	14	21
Depreciation and amortisation expense	6,489	6,739	-	66	1,234	1,248	2,621	2,999
Asset revaluation decrements	565	915	-	9	107	169	228	407
Loss on disposal of non-current assets	50	2	-	-	10	-	21	-
Repairs, maintenance and consumable equipment	3,421	2,658	-	26	651	492	1,381	1,182
Other supplies and services	16,797	13,752	-	136	3,197	2,546	6,782	6,120
Other expenses	7,235	11,321	-	112	1,377	2,096	2,923	5,038
Total cost of services	249,090	229,986	-	2,348	47,394	42,584	100,606	102,369
Income								
Patient charges	11,204	10,231	-	-	266	270	1,447	2,673
Other fees for services	6,583	6,866	-	68	1,252	1,272	2,659	3,056
Commonwealth grants and contributions	71,792	67,136	-	44	14,208	14,793	31,704	31,837
Other grants and contributions	5,490	3,111	-	31	1,045	576	2,217	1,385
Donation revenue	935	788	-	8	178	146	378	351
Commercial activities	541	587	-	6	103	109	218	261
Other revenue	1,635	1,706	-	17	311	316	661	759
Total income other than income from State Government	98,180	90,425	-	174	17,363	17,482	39,284	40,322
NET COST OF SERVICES	**150,910**	**139,561**	**-**	**2,174**	**30,031**	**25,102**	**61,322**	**62,047**
INCOME FROM STATE GOVERNMENT								
Service appropriations	140,277	131,730	-	1,961	27,676	26,655	56,137	52,399
Assets (transferred)/assumed	(179)	13	-	-	(34)	-	(72)	-
Services received free of charge	17,699	14,690	-	230	3,368	2,717	7,147	6,646
Total income from State Government	157,797	146,433	-	2,191	31,010	29,372	63,212	59,045
SURPLUS / (DEFICIT) FOR THE PERIOD	**6,887**	**6,872**	**-**	**17**	**979**	**4,270**	**1,890**	**(3,002)**

Notes to the financial statements
For the year ended 30 June 2018

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

	Mental Health Services		Aged and Continuing Care Services [a][b]		Public and Community Health Services [c]		Total	
COST OF SERVICES	**2018 $000**	**2017 $000**	**2018 $000**	**2017 $000**	**2018 $000**	**2017 $000**	**2018 $000**	**2017 $000**
Expenses								
Employee benefits expense	56,107	57,158	2,109	-	93,959	92,381	433,218	406,536
Fees for visiting medical practitioners	-	-	14	-	-	-	1,849	1,139
Contracts for services	15	3	26	-	4,482	4,234	7,992	9,260
Patient support costs	1,312	1,134	383	-	1,751	1,636	59,045	58,786
Finance costs	-	-	-	-	-	-	55	79
Depreciation and amortisation expense	66	48	78	-	556	396	11,044	11,496
Asset revaluation decrements	30	-	-	-	1,117	76	2,047	1,576
Loss on disposal of non-current assets	-	-	1	-	-	-	82	2
Repairs, maintenance and consumable equipment	1,051	1,170	41	-	2,054	2,064	8,599	7,592
Other supplies and services	2,572	3,314	204	-	6,616	6,066	36,168	31,934
Other expenses	4,060	3,281	87	-	7,176	4,849	22,858	26,697
Total cost of services	65,213	66,108	2,943	-	117,711	111,702	582,957	555,097
Income								
Patient charges	30	11	-	-	-	-	12,947	13,185
Other fees for services	70	147	79	-	198	189	10,841	11,598
Commonwealth grants and contributions	5,212	6,297	1,914	-	750	750	125,580	120,857
Other grants and contributions	55,463	53,551	66	-	20	77	64,301	58,731
Donation revenue	-	-	11	-	-	-	1,502	1,293
Commercial activities	-	-	7	-	-	-	869	963
Other revenue	6	41	20	-	1,413	192	4,046	3,031
Total income other than income from State Government	60,781	60,047	2,097	-	2,381	1,208	220,086	209,658
NET COST OF SERVICES	**4,432**	**6,061**	**846**	**-**	**115,330**	**110,494**	**362,871**	**345,439**
INCOME FROM STATE GOVERNMENT								
Service appropriations	86	629	801	-	109,207	106,165	334,184	319,539
Assets (transferred)/assumed	-	(5)	(2)	-	-	-	(287)	8
Services received free of charge	1,934	3,657	178	-	5,243	6,259	35,569	34,199
Total income from State Government	2,020	4,281	977	-	114,450	112,424	369,466	353,746
SURPLUS / (DEFICIT) FOR THE PERIOD	**(2,412)**	**(1,780)**	**131**	**-**	**(880)**	**1,930**	**6,595**	**8,307**

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

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

(a) A new Outcome Based Management (OBM) Framework came into effect in the 2017-18 financial year. The 2016-17 amounts were determined under the previous OBM framework which included the Home-Based Hospital Programs and excluded the Aged and Continuing Care Services. The new OBM framework included the Aged and Continuing Care Services, but excluded Home-Based Hospital Programs.

(b) Only the Continuing Care Service component is applicable to the Health Service.

(c) Public and Community Health Services under the 2017-18 OBM framework are equivalent to the Prevention, Promotion and Protection Services under the 2016-17 OBM framework.

Notes to the financial statements
For the year ended 30 June 2018

3. Use of our funding

This section provides information about how the Health Service's funding is applied and the accounting policies that are relevant for an understanding of the items recognised in the financial statements.

Expenses incurred in the delivery of services

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

	Notes	2018 $000	2017 $000
Employee benefits expense	3.1(a)	433,218	406,536
Contracts for services	3.2	7,992	9,260
Patient support costs	3.3	59,045	58,786
Repairs, maintenance and consumable equipment	3.4	8,599	7,592
Other supplies and services	3.5	36,168	31,934
Other expenses	3.6	22,858	26,697

Liabilities incurred in the delivery of services

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

	Notes	2018 $000	2017 $000
Employee benefits provision	3.1(b)	105,817	99,967

3.1(a) Employee benefits expense

	2018 $000	2017 $000
Salaries and wages	395,920	369,481
Termination benefits	1,374	3,399
Superannuation - defined contribution plans	35,924	33,656
	433,218	406,536

Salaries and wages include the costs related to employment including fringe benefits for the employees, fringe benefits tax and leave entitlements. Employee on costs expenses (workers' compensation insurance) are included at Note 3.6 'Other expenses'.

Termination benefits: Payable when employment is terminated before normal retirement date, or when an employee accepts an offer of benefits in exchange for the termination of employment. Termination benefits are recognised when the Health Service is demonstrably committed to terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy. Benefits falling due more than 12 months after the end of the reporting period are discounted to present value.

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

GSS (concurrent contributions) is a defined benefit scheme for the purposes of employees and whole-of-government reporting. It is however a defined contribution plan for the Health Service's purposes because the concurrent contributions (defined contributions) made by the Health Service to the Government Employees Superannuation Board (GESB) extinguishes the Health Service's obligations to the related superannuation liability.

The Health Service does not recognise any defined benefit liabilities because it has no legal or constructive obligation to pay future benefits relating to its employees. The liabilities for the unfunded Pension Scheme and the unfunded GSS transfer benefits attributable to members who transferred from the Pension Scheme, are assumed by the Treasurer. All other GSS obligations are funded by concurrent contributions made by the Health Service to the GESB.

The GESB and other fund providers administer public sector superannuation arrangements in Western Australia in accordance with legislative requirements. Eligibility criteria for membership in particular schemes for public sector employees vary according to commencement and implementation dates.

3.1(b) Employee benefits provision

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

	2018 $000	2017 $000
Current		
Employee benefits provision		
Annual leave [(a)]	42,174	40,754
Time off in lieu leave [(a)]	9,868	7,333
Long service leave [(b)]	31,762	30,488
Deferred salary scheme [(c)]	1,025	1,020
	84,829	79,595
Non-Current		
Employee benefits provision		
Long service leave [(b)]	20,988	20,372
	20,988	20,372
	105,817	99,967

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

	2018 $000	2017 $000
Within 12 months of the end of the reporting period	36,617	33,781
More than 12 months after the end of the reporting period	15,425	14,306
	52,042	48,087

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

3.1(b) Employee benefits provision (cont.)

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

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

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

	2018 $000	2017 $000
Within 12 months of the end of the reporting period	7,990	6,137
More than 12 months after the end of the reporting period	44,760	44,723
	52,750	50,860

The provision of the long service leave liabilities are calculated at present value as the Health Service does not expect to wholly settle the amounts within 12 months. The present value is measured taking into account the present value of expected future payments to be made in relation to services provided by employees up to the reporting date. These payments are estimated using the remuneration rate expected to apply at the time of settlement, discounted using market yields at the end of the reporting period on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

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

	2018 $000	2017 $000
Within 12 months of the end of the reporting period	129	34
More than 12 months after the end of the reporting period	896	986
	1,025	1,020

3.1(b) Employee benefits provision (cont.)

Key sources of estimation uncertainty – long service leave

Key estimates and assumptions concerning the future are based on historical experience and various other factors that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year.

Several estimates and assumptions are used in calculating the Health Service's long service leave provision. These include:

- Expected future salary rates
- Discount rates
- Employee retention rates; and
- Expected future payments

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

In estimating the non-current long service leave liabilities, employees are assumed to leave the Health Service each year on account of resignation or retirement at 7.5%. 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.

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

3.2 Contracts for services

	2018 $000	2017 $000
Child, community and primary health	7,668	9,094
Other contracts	324	166
	7,992	9,260

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

3.3 Patient support costs

	2018 $000	2017 $000
Medical supplies and services	49,358	49,456
Domestic charges	4,728	4,127
Food supplies	1,596	1,541
Fuel, light and power	3,010	2,958
Patient transport costs	146	352
Research, development and other grants	207	352
	59,045	58,786

Expenses are recognised in the reporting period in which they are incurred.

3.4 Repairs, maintenance and consumable equipment

	2018 $000	2017 $000
Repairs and maintenance	6,547	4,988
Consumable equipment	2,052	2,604
	8,599	7,592

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

3.5 Other supplies and services

	2018 $000	2017 $000
Administration and management services	1,721	1,629
Interpreter services	853	955
Sanitation and waste removal services	271	363
Security services	421	266
Shared services for accounting	683	1,494
Shared services for human resources	3,778	6,571
Shared services for information technology	23,620	17,660
Shared services for supply	2,587	2,444
Other	2,234	552
	36,168	31,934

Expenses are recognised in the reporting period in which they are incurred.

3.6 Other expenses

	2018 $000	2017 $000
Workers compensation insurance [a]	5,272	4,880
Other insurances	2,948	4,319
Other employee related expenses	1,403	1,143
Communications	1,477	1,532
Computer services	672	372
Consultancy fees	1,140	2,521
Doubtful debts expense	(167)	1,416
Freight and cartage	851	884
Motor vehicle expenses	413	411
Operating lease expenses	4,501	4,594
Periodical subscription	456	300
Printing and stationery	2,138	1,805
Write-down of assets [b]	208	1,568
Other	1,546	952
	22,858	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 3.1(b) 'Employee benefits provision'. Superannuation contributions accrued as part of the provision for leave are employee benefits and are not included in employment on-costs.

(b) See Note 5.1 'Property, plant and equipment' and Note 5.2 'Intangible assets'.

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

Doubtful debt expense is recognised as the movement in the allowance for uncollectible amounts (doubtful debts). See Note 6.1.1 Movement of the allowance for impairment of receivables.

4. Our funding sources

How we obtain our funding

This section provides information about how the Health Service obtains its funding and the relevant accounting policy notes that govern the recognition and measurement of this funding. The primary income received by the Health Service are:

	Notes	2018 $000	2017 $000
Income from State Government	4.1	369,466	353,746
Patient charges and other fees for services	4.2	23,788	24,783
Grants and contributions	4.3	189,881	179,588
Donations	4.4	1,502	1,293
Commercial activities	4.5	869	963
Other revenue	4.6	4,046	3,031

4.1 Income from State Government

	2018 $000	2017 $000
Appropriation revenue received during the period:		
Service appropriations (funding via the Department of Health)	334,184	319,539
Assets transferred from/(to) other State government agencies during the period:		
Transfer of medical equipment from North Metropolitan Health Service	80	13
Transfer of medical equipment to North Metropolitan Health Service	(88)	-
Transfer of surplus equipment to other Health Services	(279)	-
Transfer of artwork to South Metropolitan Health Service	-	(5)
Net assets transferred	(287)	8
Services received free of charge from other State government agencies during the period:		
Health Support Services - accounting, human resources, information technology and supply services	30,741	28,168
Department of Finance - leasing of accommodation	23	26
North Metropolitan Health Service (PathWest) - pathology services	4,805	6,005
Total services received	35,569	34,199
Total income from State Government	369,466	353,746

(a) **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 in the bank account or credited to the 'Amounts receivable for services' (holding account) held at the Department of Treasury.

Service appropriations fund the net cost of services delivered (as set out in Note 2.2). Appropriation revenue comprises the following:

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

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

- The budgeted depreciation expense for the year; and
- Any agreed increase in leave liabilities during the year.

4.1 Income from State Government (cont.)

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

(c) **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.

4.2 Patient charges and other fees for services

	2018 $000	2017 $000
Patient charges		
Inpatient charges	11,232	10,248
Outpatient charges	1,715	2,937
	12,947	13,185
Other fees for services		
Recoveries from the Pharmaceutical Benefits Scheme	6,806	5,463
Clinical services to other health organisations	3,247	4,495
Non clinical services to other health organisations	788	1,640
	10,841	11,598
	23,788	24,783

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

4.3 Grants and contributions

	2018 $000	2017 $000
Commonwealth grants and contributions		
Recurrent Grants:		
National Health Reform Agreement (funding via Department of Health) [(a)]	117,684	113,765
National Health Reform Agreement (funding via Mental Health Commission) [(a)]	5,212	6,297
National Partnership Agreement - Essential Vaccines	750	750
Other	1,934	45
	125,580	120,857
Other grants and contributions		
Mental Health Commission – service delivery agreement	52,988	51,203
Mental Health Commission – other	2,017	1,964
Disability Services Commission	20	25
Lotteries Commission	-	37
Perth Children's Hospital Foundation	2,040	3,825
Telethon Kids Institute	301	576
Channel 7 Telethon Trust	4,525	-
Stan Perron Charitable Trust	540	-
Medtronic Foundation	446	-
Angela Wright Bennett Foundation	400	-
Other	1,024	1,101
	64,301	58,731

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.

(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.

4.4 Donations

	2018 $000	2017 $000
Channel 7 Telethon Trust	-	523
Perth Children's Hospital Foundation - donations of equipment	414	488
Princess Margaret Hospital Volunteers Inc.	-	250
Deceased Estate	1,020	-
Other	68	32
	1,502	1,293

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

4.5 Commercial activities

	2018 $000	2017 $000
Sales:		
Café sales revenue	1,728	1,823
	1,728	1,823
Cost of sales [(a)]	(859)	(860)
Gross profit	869	963

(a) The cost of sales does not include salaries or other costs.

Revenue is recognised from the sale of goods when the significant risks and rewards of ownership transfer to the purchaser and can be measured reliably.

4.6 Other revenue

	2018 $000	2017 $000
Pharmaceutical manufacturing activities	2,320	1,954
Rent from commercial properties	-	7
RiskCover insurance premium rebate	1,221	76
Respiratory clinical trials	82	327
Immunisation services	152	157
Use of hospital facilities	12	16
Other	259	494
	4,046	3,031

5. Key assets

Assets the Health Service utilises for economic benefit or service potential

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

	Notes	2018 $000	2017 $000
Property, plant and equipment	5.1	1,218,168	107,411
Intangible assets	5.2	51,744	6
Total key assets		1,269,912	107,417

Depreciation and amortisation expense	Notes	2018 $000	2017 $000
Property, plant and equipment	5.1.1	10,388	11,496
Intangible assets	5.2.1	656	-
		11,044	11,496

5.1 Property, plant and equipment

Year ended 30 June 2017	Land $000	Buildings $000	Site infra-structure $000	Leasehold improve-ments $000	Computer equipment $000	Furniture and fittings $000	Medical equipment $000	Other plant and equipment $000	Work in progress $000	Art-works $000	Total $000
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 30 June 2017	**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 previous financial year, where their values were below the asset capitalisation threshold. Refer to Note 3.6 'Other expenses'.

Notes to the financial statements
For the year ended 30 June 2018

5.1 Property, plant and equipment (cont.)

Year ended 30 June 2018	Land $000	Buildings $000	Site infra-structure $000	Leasehold improve-ments $000	Computer equipment $000	Furniture and fittings $000	Medical equipment $000	Motor Vehicle, other plant and equipment $000	Work in progress $000	Art-works $000	Total $000
1 July 2017											
Gross carrying amount	69,744	24,275	2,470	288	8	649	11,270	473	4,180	19	113,375
Accumulated depreciation	-	-	(763)	(39)	(2)	(213)	(4,832)	(116)	-	-	(5,964)
Carrying amount at start of period	**69,744**	**24,275**	**1,707**	**249**	**6**	**436**	**6,438**	**357**	**4,180**	**19**	**107,411**
Additions	-	-	-	205	-	-	1,273	80	106	-	1,664
Transfer of PCH assets from Health Ministerial Body (Note 9.13) [(a)]	-	901,039	10,772	-	82,181	11,140	84,333	83,070	-	4,932	1,177,467
Transfer from South Metropolitan Health Service (Note 9.13)	2,050	920	101	-	-	-	-	-	-	-	3,071
Transfer of PMH assets to Health Ministerial Body (Note 9.13)	(47,800)	(11,652)	-	-	-	-	-	-	-	-	(59,452)
Transfer to other agencies	-	-	-	-	-	-	(106)	(255)	-	-	(361)
Transfers to asset classes	-	-	-	-	-	-	3,907	-	(3,907)	-	-
Disposals	-	-	-	-	-	(4)	(78)	-	-	-	(82)
Revaluation increments / (decrements) [(b)]	(2,047)	1,087	-	-	-	-	-	-	-	-	(960)
Depreciation	-	(4,119)	(285)	(67)	(1,180)	(472)	(3,390)	(875)	-	-	(10,388)
Write-down of assets	-	-	-	-	-	-	-	-	(202)	-	(202)
Carrying amount at 30 June 2018	**21,947**	**911,550**	**12,295**	**387**	**81,007**	**11,100**	**92,377**	**82,377**	**177**	**4,951**	**1,218,168**
Gross carrying amount	21,947	911,550	12,526	492	82,189	11,752	100,394	83,353	177	4,951	1,229,331
Accumulated depreciation	-	-	(231)	(105)	(1,182)	(652)	(8,017)	(976)	-		(11,163)

5.1 Property, plant and equipment (cont.)

(a) The Health Service has the right to operate and control the building for the Perth Children's Hospital (PCH) under the *Memorandum of Understanding No.2 for Management and Control of Land and Buildings* between the Health Ministerial Body and the Health Service.

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

Initial recognition

Items of property, plant and equipment, costing $5,000 or more are measured initially at cost. Where an asset is acquired for no or nominal cost, the cost is valued at its fair value at the date of acquisition. Items of property, plant and equipment costing less than $5,000 are immediately expensed direct to the Statement of Comprehensive Income (other than where they form part of a group of similar items which are significant in total).

The cost of a leasehold improvement is capitalised and depreciated over the shorter of the remaining term of the lease or the estimated useful life of the leasehold improvement.

Subsequent measurement

Subsequent to initial recognition of an asset, the revaluation model is used for the measurement of land and buildings.

Land is carried at fair value.

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

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

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

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

Land and buildings were revalued as at 1 July 2017 by the Western Australian Land Information Authority (Valuations and Property Analytics). The valuations were performed during the year ended 30 June 2018 and recognised at 30 June 2018. In undertaking the revaluation, fair value was determined by reference to market values for land: $0.657 million (2017: $19.589 million) and buildings: $0.118 million (2017: $0.121 million). For the remaining balance, fair value of buildings was determined on the basis of current replacement cost and fair value of land was determined on the basis of comparison with market evidence for land with low level utility (high restricted use land).

5.1 Property, plant and equipment (cont.)

Revaluation model:

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

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

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

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

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

Restricted use land: Fair value is determined by comparison with market evidence for land with similar approximate utility (high restricted use land) or market value of comparable unrestricted land (low restricted use land).

Significant assumptions and judgements

The most significant assumptions and judgements in estimating fair value are made in assessing whether to apply the existing use basis to assets and in determining estimated economic life. Professional judgement by the valuer is required where the evidence does not provide a clear distinction between market type assets and existing use assets.

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

5.1.1 Depreciation and impairment

Charges for the period

Depreciation	2018 $000	2017 $000
Buildings	4,119	5,450
Site infrastructure	285	761
Leasehold improvement	67	39
Medical equipment	3,390	4,909
Computer equipment	1,180	2
Furniture and fittings	472	213
Motor vehicle, other plant and equipment	875	122
Total depreciation for the period	**10,388**	**11,496**

As at 30 June 2018 there were no indications of impairment to property, plant and equipment.

Finite useful lives

All property, plant and equipment having a limited useful life are systematically depreciated over their estimated useful lives in a manner that reflects the consumption of their future economic benefits. The exceptions to this rule include assets held for sale and land.

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

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

Buildings	50 years
Site infrastructure	50 years
Leasehold improvements	Term of the lease
Computer equipment	2 to 10 years
Furniture and fittings	3 to 20 years
Motor vehicles	10 years
Medical equipment	2 to 20 years
Other plant and equipment	2 to 30 years

5.1.1 Depreciation and impairment (cont.)

Land and artworks, which are considered to have an indefinite useful life, are not depreciated. Their service potential has not, in any material sense, been consumed during the reporting period and consequently depreciation is not recognised.

The estimated useful lives, residual values and depreciation method are reviewed at the end of each annual reporting period, and adjustments should be made where appropriate.

Impairment

Non-financial assets, including items of plant and equipment, are tested for impairment whenever there is an indication that the asset may be impaired. Where there is an indication of impairment, the recoverable amount is estimated. Where the recoverable amount is less than the carrying amount, the asset is considered impaired and is written down to the recoverable amount and an impairment loss is recognised.

Where an asset measured at cost is written down to its recoverable amount, an impairment loss is recognised through profit or loss.

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

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

If there is an indication that there has been a reversal in impairment, the carrying amount shall be increased to its recoverable amount. However this reversal should not increase the asset's carrying amount above what would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised in prior years.

The risk of impairment is generally limited to circumstances where an asset's depreciation is materially understated, where the replacement cost is falling or where there is a significant change in useful life. Each relevant class of assets is reviewed annually to verify that the accumulated depreciation/amortisation reflects the level of consumption or expiration of the asset's future economic benefits and to evaluate any impairment risk from declining replacement costs.

5.1.2 Loss on disposal of non-current assets

The Health Service incurred the following losses on disposal of non-current assets:

	2018 $000	2017 $000
Carrying amount of non-current assets disposed:		
Property, plant and equipment	82	6
Proceeds from disposal of non-current assets:		
Property, plant and equipment	-	(4)
Net loss on disposal of non-current assets	82	2

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.

Gains and losses on the disposal of non-current assets are presented by deducting from the proceeds on disposal the carrying amount of the asset and related selling expenses. Gains and losses are recognised in profit or loss in the Statement of Comprehensive Income (from the proceeds of sale).

5.2 Intangible assets

	Computer software $000	Software under development $000	Total $000
Transfer from the Government at 1 July 2016	4	-	4
Additions	-	6	6
Write-down of assets [(a)]	(4)	-	(4)
Carrying amount at 30 June 2017	-	6	6
Write-down of assets	-	(6)	(6)
Transfer from Health Ministerial Body	52,400	-	52,400
Amortisation expense	(656)	-	(656)
Carrying amount at 30 June 2018	51,744	-	51,744
Gross carrying amount	52,400	-	52,400
Accumulated amortisation	(656)	-	(656)

(a) The intangible asset transferred from the Government was expensed in the previous financial year, as it was below the asset capitalisation threshold. Refer to Note 3.6 'Other expenses'.

Initial recognition

Acquisitions of intangible assets costing $5,000 or more and internally generated intangible assets costing $5,000 or more, that comply with the recognition criteria (as noted below), are capitalised.

Costs incurred below these thresholds are immediately expensed directly to the Statement of Comprehensive Income.

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.

5.2 Intangible assets (cont.)

An internally generated intangible asset arising from development (or from the development phase of an internal project) is recognised if, and only if, all of the following are demonstrated:

(a) The technical feasibility of completing the intangible asset so that it will be available for use;

(b) An intention to complete the intangible asset and use it;

(c) The ability to use the intangible asset;

(d) The intangible asset will generate probable future economic benefit;

(e) The availability of adequate technical, financial and other resources to complete the development and to use the intangible asset;

(f) The ability to measure reliably the expenditure attributable to the intangible asset during its development.

Costs incurred in the research phase of a project are immediately expensed.

Software that is an integral part of the related hardware is recognised as property, plant and equipment. Software that is not an integral part of the related hardware is recognised as an intangible asset.

Subsequent measurement

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

5.2.1 Amortisation and impairment

Charges for the period

	2018	2017
Amortisation	$000	$000
Computer software	656	-
Total amortisation for the period	**656**	**-**

The Health Service held no goodwill or intangible assets with an indefinite useful life during the reporting period. At the end of the reporting period there were no intangible assets not yet available for use.

Amortisation of finite life intangible assets is calculated on a straight line basis at rates that allocate the asset's value over its estimated useful life. All intangible assets controlled by the Health Service have a finite useful life and zero residual value. Estimated useful lives are reviewed annually.

The estimated useful lives for each class of intangible asset are:

Computer software [(a)]	5 to 10 years

(a) Software that is not integral to the operation of any related hardware.

Impairment

Intangible assets with finite useful lives are tested for impairment annually or when an indication of impairment is identified. The policy in connection with testing for impairment is outlined in Note 5.1.1.

As at 30 June 2018 there were no indications of impairment to intangible assets.

Notes to the financial statements
For the year ended 30 June 2018

6. Other assets and liabilities

This section sets out those assets and liabilities that arose from the Health Service's controlled operations and includes other assets utilised for economic benefits and liabilities incurred during normal operations:

	Notes	2018 $000	2017 $000
Receivables	6.1	6,813	10,747
Amount receivable for services	6.2	200,625	186,301
Inventories	6.3	2,344	2,540
Other current assets	6.4	537	448
Payables	6.5	32,841	28,047
Other liabilities	6.6	23	212

6.1 Receivables

	2018 $000	2017 $000
Current		
Patient fee debtors	6,523	10,031
GST receivable	439	285
Other receivables	3,044	4,588
Allowance for impairment of receivables	(4,442)	(5,381)
Accrued revenue	1,249	1,224
	6,813	**10,747**

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

Receivables are recognised at original invoice amount less any allowances for uncollectible amounts (i.e. impairment). The carrying amount of net trade receivables is equivalent to fair value as it is due for settlement within 30 days.

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.

6.1.1 Movement of the allowance for impairment of receivables

	2018 $000	2017 $000
Reconciliation of changes in the allowance for impairment of receivables:		
Balance at start of period	5,381	3,975
Doubtful debts expense	(167)	1,416
Amount written off during the period	(772)	-
Amount recovered during the period	-	(10)
Balance at end of period	4,442	5,381

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.

6.2 Amounts receivable for services (Holding Account)

	2018 $000	2017 $000
Current	-	-
Non-Current	200,625	186,301
	200,625	**186,301**

The Health Service receives service appropriations from the State Government, partly in cash and partly as a non-cash asset. Amounts receivable for services represent the non-cash component and it is restricted in that it can only be used for asset replacement or payment of leave liability.

Subject to the State Government's approval, the receivable is accessible on the emergence of the cash funding requirement to cover the payments for leave entitlements and asset replacement.

6.3 Inventories

	2018 $000	2017 $000
Current		
Pharmaceutical stores - at cost	2,344	2,540

Inventories are measured at the lower of cost and net realisable value. Costs are assigned on a weighted average cost basis.

Inventories not held for resale are measured at cost unless they are no longer required, in which case they are measured at net realisable value.

6.4 Other assets

	2018 $000	2017 $000
Current		
Prepayments	537	448
	537	448

Other non-financial assets include prepayments which represent payments in advance of receipt of goods or services or that part of expenditure made in one accounting period covering a term extending beyond that period.

6.5 Payables

	2018 $000	2017 $000
Current		
Trade payables	2,217	2,993
Payable to Health Ministerial Body	18,855	12,244
Other payables	44	55
Accrued expenses	5,298	7,739
Accrued salaries	6,423	5,010
Accrued interest	4	6
	32,841	28,047

Payables are recognised at the amounts payable when the Health Service becomes obliged to make future payments as a result of a purchase of assets or services.

The carrying amount is equivalent to fair value, as settlement is generally within 30 days.

Accrued salaries represent the amount due to employees but unpaid at the end of the reporting period. Accrued salaries are settled within a fortnight of the reporting period end. The Health Service considers the carrying amount of accrued salaries to be equivalent to its fair value.

The accrued salaries suspense account (See Note 7.3.1 'Restricted cash and cash equivalents') consists of amounts paid annually into a Treasury suspense account to meet the additional cash outflow for employee salary payments in the reporting periods with 27 pay days instead of the normal 26. No interest is received on this account.

6.6 Other liabilities

	2018 $000	2017 $000
Current		
Income received in advance	-	150
Paid parental leave scheme	23	62
	23	212

Notes to the financial statements
For the year ended 30 June 2018

7. Financing

This section sets out the material balances and disclosures associated with the financing and cashflows of the Health Service.

	Notes
Borrowings	7.1
Finance costs	7.2
Cash and cash equivalents	7.3
Reconciliation of cash	7.3.1
Reconciliation of operating activities	7.3.2
Reconciliation of cash flows from State Government	7.3.3
Commitments	7.4
Non-cancellable operating lease commitments	7.4.1
Capital commitments	7.4.2
Private sector contracts for the provision of community health services	7.4.3
Other expenditure commitments	7.4.4

7.1 Borrowings

	2018 $000	2017 $000
Current		
Department of Treasury loans	703	673
Non-current		
Department of Treasury loans	739	1,442
	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.

Borrowings are classified as financial instruments. All interest bearing borrowings are initially recognised at the fair value of the consideration received less directly attributable transaction costs. Subsequent measurement is at amortised cost using the effective interest rate method.

7.2 Finance costs

	2018 $000	2017 $000
Interest expense	55	79
	55	**79**

Finance costs are recognised as expenses in the period in which they are incurred.

7.3 Cash and cash equivalents

7.3.1 Reconciliation of cash

	2018 $000	2017 $000
Cash and cash equivalents	27,696	22,442
Restricted cash and cash equivalents		
Current		
Funds repayable to Health Ministerial Body [(a)]	18,855	12,244
Mental Health Commission Funding [(b)]	1,308	695
Restricted cash assets held for other specific purposes [(c)]	9,705	3,773
	29,868	16,712
Non-current		
Accrued Salaries Suspense Account [(d)]	3,308	1,644
Total restricted cash and cash equivalents	33,176	18,356
Balance at end of period	**60,872**	**40,798**

Restricted cash and cash equivalents are assets of which the uses 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.

(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. This account is classified as non-current for 10 out of 11 years.

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

7.3.2 Reconciliation of net cost of services to net cash flows provided by/(used in) operating activities

	Notes	2018 $000	2017 $000
Net cost of services (Statement of Comprehensive Income)		(362,871)	(345,439)
Non-cash items:			
Doubtful debts expense	3.6	(167)	1,416
Write off of inventory		75	123
Depreciation and amortisation expense	5	11,044	11,496
Asset revaluation decrement	5.1	2,047	1,576
Net gain/(loss) from disposal of non-current assets	5.1.2	82	2
Write down of assets	3.6	208	1,568
Interest paid by the Department of Health	7.2	55	79
Donations of equipment received	4.4	(414)	(488)
Services received free of charge	4.1	35,569	34,199
(Increase)/decrease in assets:			
Receivables		4,101	(3,186)
Inventories		121	(7)
Prepayments		(89)	116
Increase/(Decrease) in liabilities:			
Payables		(1,874)	1,458
Current provisions		5,234	6,043
Non-current provisions		616	662
Other current liabilities		(189)	212
Net cash used in operating activities (Statement of Cash Flows)		**(306,452)**	**(290,170)**

7.3.3 Reconciliation of cash flows from State Government

	2018 $000	2017 $000
Notional cash flows		
Service appropriations as per Statement of Comprehensive Income	334,184	319,539
Capital appropriation credited directly to Contributed equity (refer Note 9.13)	1,902	1,764
	336,086	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	(57)	(81)
Repayment of borrowings to the Department of Treasury	(673)	(642)
Accrual appropriations	(14,324)	(15,347)
	(15,054)	(16,070)
Cash Flows from State Government as per Statement of Cash Flows	321,032	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.

7.4 Commitments

7.4.1 Non-cancellable operating lease commitments

	2018 $000	2017 $000
Commitments for mininum lease payments are payable as follows:		
Within 1 year	2,632	3,066
Later than 1 year and not later than 5 years	3,818	3,055
Later than 5 years	1,997	209
	8,447	6,330

Amounts presented for operating lease commitments are GST inclusive.

Operating leases are expensed on a straight line basis over the lease term as this represents the pattern of benefits derived from the leased properties.

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.

7.4.2 Capital commitments

	2018 $000	2017 $000
Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows:		
Within 1 year	2,708	1,371
Later than 1 year, and not later than 5 years	1,543	2,527
	4,251	3,898

Amounts presented for capital expenditure commitments are GST inclusive.

7.4.3 Private sector contracts for the provision of community health services

	2018 $000	2017 $000
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	4,943	5,912
Later than 1 year and not later than 5 years	3,489	4,781
	8,432	10,693

Amounts presented for expenditure commitments relating to the provision of community health services are GST inclusive.

7.4.4 Other expenditure commitments

	2018 $000	2017 $000
Other expenditure commitments contracted for at end of the reporting period but not recognised as liabilities, are payable as follows:		
Within 1 year	17,311	18,804
Later than 1 year and not later than 5 years	3,967	11,607
	21,278	30,411

Amounts presented for other expenditure commitments are GST inclusive.

Judgements made by management in applying accounting policies – 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.

8. Risks and Contingencies

This note sets out the key risk management policies and measurement techniques of the Health Service.

	Notes
Financial risk management	8.1
Contingent assets	8.2.1
Contingent liabilities	8.2.2
Fair value measurements	8.3

Notes to the financial statements
For the year ended 30 June 2018

8.1 Financial risk management

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.

(a) Summary of risks and risk management

Credit risk

Credit risk arises when there is the possibility of the Health Service's receivables defaulting on their contractual obligations resulting in financial loss to the Health Service.

The maximum exposure to credit risk at the end of the reporting period in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any allowance for impairment as shown in the table at Note 8.1(c) 'Ageing analysis of financial assets' and Note 6.1 'Receivables'.

Credit risk associated with the Health Service's financial assets is generally confined to patient fee debtors (see Note 6.1). The main receivable of the Health Service is the amounts receivable for services (holding account). For receivables other than government agencies and patient fee debtors, the Health Service trades only with recognised, creditworthy third parties. The Health Service has policies in place to ensure that sales of products and services are made to customers with an appropriate credit history. In addition, receivable balances are monitored on an ongoing basis with the result that the Health Service's exposure to bad debts is minimised. At the end of the reporting period, there were no significant concentrations of credit risk.

All debts are individually reviewed, on a timely basis at 30, 60, 90 and 120 days. In a circumstance where a third party is responsible for payment, or there are legal considerations, payment of accounts can be delayed considerably. Unpaid debts are referred to an external debt collection service within six months of the accounts being raised.

Allowance for impairment of financial assets is calculated based on objective evidence such as observable data indicating changes in client credit ratings. For financial assets that are either past due or impaired, refer to Note 8.1(c) 'Ageing analysis of financial assets'.

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.

8.1 Financial risk management (cont.)

(b) Categories of financial instruments

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

	2018 $000	2017 $000
Financial Assets		
Cash and cash equivalents	27,696	22,442
Restricted cash and cash equivalents	33,176	18,356
Loans and receivables [(a)]	206,999	196,763
	267,871	**237,561**
Financial Liabilities		
Financial liabilities measured at amortised cost	34,283	30,162
	34,283	**30,162**

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

8.1 Financial risk management (cont.)

(c) Ageing analysis of financial assets

	Carrying amount $000	Not past due and not impaired $000	Past due but not impaired				Impaired Financial assets $000
			1 - 3 months $000	3 - 12 months $000	1-5 years $000	More than 5 years $000	
2018							
Cash and cash equivalents	27,696	27,696	-	-	-	-	-
Restricted cash and cash equivalents	33,176	33,176	-	-	-	-	-
Receivables [(a)]	6,374	4,109	853	1,206	206	-	-
Amounts receivable for services	200,625	200,625	-	-	-	-	-
	267,871	**265,606**	**853**	**1,206**	**206**	**-**	**-**
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).

8.1 Financial risk management (cont.)

(d) Liquidity Risk and Interest Rate Exposure

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

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

	Weighted average effective interest rate %	Carrying amount $000	Interest rate exposure: Fixed interest rate $000	Interest rate exposure: Variable interest rate $000	Interest rate exposure: Non-interest bearing $000	Nominal Amount $000	Maturity dates: Up to 3 months $000	Maturity dates: 3 months to 1 year $000	Maturity dates: 1-5 years $000	Maturity dates: More than 5 years $000
2018										
Financial Assets										
Cash and cash equivalents		27,696	-	-	27,696	27,696	27,696	-	-	-
Restricted cash and cash equivalents		33,176	-	-	33,176	33,176	29,868	-	-	3,308
Receivables [(a)]		6,374	-	-	6,374	6,374	6,374	-	-	-
Amounts receivable for services		200,625	-	-	200,625	200,625	-	-	-	200,625
		267,871	-	-	267,871	267,871	63,938	-	-	203,933
Financial Liabilities										
Payables		32,841	-	-	32,841	32,841	32,841	-	-	-
Department of Treasury loans	3.18%	1,442	-	1,442	-	1,492	185	554	753	-
		34,283	-	1,442	32,841	34,333	33,026	554	753	-

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

8.1 Financial risk management (cont.)

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

	Weighted average effective interest rate %	Carrying amount $000	Interest rate exposure: Fixed interest rate $000	Interest rate exposure: Variable interest rate $000	Interest rate exposure: Non-interest bearing $000	Nominal Amount $000	Maturity dates: Up to 3 months $000	Maturity dates: 3 months to 1 year $000	Maturity dates: 1-5 years $000	Maturity dates: More than 5 years $000
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).

8.1 Financial risk management (cont.)

(e) Interest rate sensitivity analysis

The following table represents a summary of the interest rate sensitivity of the Health Service's financial assets and liabilities at the end of the reporting period on the surplus for the period and equity for a 1% change in interest rates. It is assumed that the change in interest rates is held constant throughout the reporting period.

		-100 basis points		+100 basis points	
	Carrying amount $000	Surplus $000	Equity $000	Surplus $000	Equity $000
2018					
Financial Liabilities					
Department of Treasury loans	1,442	14	14	(14)	(14)
Total Increase/(Decrease)		**14**	**14**	**(14)**	**(14)**
2017					
Financial Liabilities					
Department of Treasury loans	2,115	21	21	(21)	(21)
Total Increase/(Decrease)		**21**	**21**	**(21)**	**(21)**

8.2 Contingent assets and liabilities

Contingent assets and contingent liabilities are not recognised in the Statement of Financial Position but are disclosed and, if quantifiable, are measured at nominal value. Contingent assets and liabilities are presented inclusive of GST receivable or payable respectively.

8.2.1 Contingent assets

At the reporting date, the Health Service is not aware of any contingent assets.

8.2.2 Contingent liabilities

Except for the time off in lieu entitlements for employees, the Health Service is not aware of any contingent liabilities at the reporting date.

Litigation in progress

The Health Service does not have any pending litigation that are not recoverable from RiskCover insurance at the reporting date.

Contaminated sites

Under the *Contaminated Sites Act 2003*, the Health Service is required to report known and suspected contaminated sites to the Department of Water and Environmental Regulation (DWER). In accordance with the Act, DWER classifies these sites on the basis of the risk to human health, the environment and environmental values.

Where sites are classified as contaminated – remediation required or possibly contaminated – investigation required, the Health Service may have a liability in respect of investigation or remediation expenses.

At the reporting date, the Health Service does not have any suspected contaminated sites reported under the Act.

Time off in lieu entitlements for employees

As a result of the inconsistent interpretation of industrial awards and configuration of payroll system, the public holiday time off in lieu entitlements and payments have been incorrectly calculated for the Health Service's employees over a number of years. A solution has recently been implemented in the payroll system for the nursing employees and a total liability amounting to $1.860 million and the related expense have been recognised in the financial statements.

With respect to other groups of employees that are also entitled to the public holiday time off in lieu leave, the liabilities and expenses have not been recognised in the financial statements, because the amounts cannot be reliably estimated at the reporting date.

8.3 Fair value measurements

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

a) quoted prices (unadjusted) in active markets for identical assets (level 1);

b) input other than quoted prices included within level 1 that are observable for the asset either directly or indirectly (level 2); and

c) inputs for the asset that are not based on observable market data (unobservable input) (level 3).

The following table represents the Health Service's assets measured at fair value:

2018	Notes	Level 1 $000	Level 2 $000	Level 3 $000	Fair value at end of period $000
Land	5.1				
Car parks		-	-	-	-
Residential		-	657	-	657
Specialised		-	-	21,290	21,290
Buildings	5.1				
Residential		-	118	-	118
Specialised		-	-	911,432	911,432
		-	775	932,722	933,497
2017					
Land	5.1				
Car parks		-	18,900	-	18,900
Residential		-	689	-	689
Specialised		-	-	50,155	50,155
Buildings	5.1				
Residential		-	121	-	121
Specialised		-	-	24,154	24,154
		-	19,710	74,309	94,019

There were no transfers between Levels 1, 2 or 3 during the current and previous periods.

8.3 Fair value measurements (cont.)

Valuation processes

The Health Service obtains independent valuations of land and buildings from the Western Australian Land Information Authority (Valuations and Property Analytics) annually.

There were no changes in valuation techniques during the period.

Transfers in and out of a fair value level are recognised on the date of the event or change in circumstances that caused the transfer. Transfers are generally limited to assets newly classified as non-current assets held for sale as Treasurer's instructions require valuations of land and buildings to be categorised within Level 3 where the valuations will utilise significant Level 3 inputs on a recurring basis.

Valuation techniques to derive Level 2 fair values

Level 2 fair values of land and buildings (open car parks and converted residential properties) are derived using the market approach. This approach provides an indication of value by comparing the asset with identical or similar properties for which price information is available. Analysis of comparable sales information and market data provides the basis for fair value measurement.

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

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

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

8.3 Fair value measurements (cont.)

Fair value measurements using significant unobservable inputs (Level 3)

	Land	Buildings
2018	**$000**	**$000**
Fair value at start of period	50,155	24,154
Transfer from other agencies	2,050	920
Transfer to other agencies	(29,800)	(11,652)
Additions	-	901,042
Revaluation increments/(decrements) recognised in Profit or Loss	(1,115)	-
Revaluation increments/(decrements) recognised in Other Comprehensive Income	-	1,087
Depreciation expense	-	(4,119)
Fair Value at end of period	**21,290**	**911,432**
2017		
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) recognised in Profit or Loss	(1,525)	-
Revaluation increments/(decrements) recognised in Other Comprehensive Income	-	3,049
Depreciation expense	-	(5,448)
Fair Value at end of period	**50,155**	**24,154**

Valuation techniques to derive Level 3 fair values

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

Land (Level 3 fair values)

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

8.3 Fair value measurements (cont.)

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

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

Buildings (Level 3 fair values)

The Health Service's 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.

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.

9. Other disclosures

This section includes additional material disclosures required by accounting standards or other pronouncements, for the understanding of this financial report.

Notes to the financial statements
For the year ended 30 June 2018

9.1 Events occurring after the end of the reporting period

There were no events occurring after the reporting period which had significant financial effects on these financial statements.

9.2 Future impact of Australian Standards issued not yet operative

The Health Service cannot early adopt an Australian Accounting Standard unless specifically permitted by TI 1101 Application of Australian Accounting Standards and Other Pronouncements or by an exemption from TI 1101. Where applicable, the Health Service plans to apply the following Australian Accounting Standards from their application date.

		Operative for reporting periods beginning on/after
AASB 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 anticipates that the application will not have material financial impact to the financial statements.	1 Jan 2018
AASB 15	*Revenue from Contracts with Customers* This Standard establishes the principles that the Health Service shall apply to report useful information to users of financial statements about the nature, amount, timing and uncertainty of revenue and cash flows arising from a contract with a customer. The mandatory application date of this Standard is currently 1 January 2019 after being amended by AASB 2016-7. The Health Service's income is principally derived from appropriations which will be measured under AASB 1058 and will be unaffected by this change. However, the Health Service has not yet determined the potential impact of the Standard on 'Patient charges' and 'Other fees for services' revenues. In broad terms, it is anticipated that the terms and conditions attached to these revenues will defer revenue recognition until the Health Service has discharged its performance obligations.	1 Jan 2019

		Operative for reporting periods beginning on/after
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 commitments for $8.4 million worth of non-cancellable operating leases which will mostly be brought onto the Statement of Financial Position, excepting amounts pertinent to short-term or low-value leases. Interest and amortisation expenses will increase and operating lease expense 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 other performance obligation (a promise to transfer a good or service), or a contribution by owners, related to an asset (such as cash or another asset) received by an entity. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2019
AASB 1059	*Service Concession Arrangements: Grantors* This Standard addresses the accounting for a service concession arrangement (a type of public private partnership) by a grantor that is a public sector entity by prescribing the accounting for the arrangement from the grantor's perspective. Timing and measurement for the recognition of a specific asset class occurs on commencement of the arrangement and the accounting for associated liabilities is determined by whether the grantee is paid by the grantor or users of the public service provided. The Health Service has not identified any public private partnerships within scope of the Standard.	1 Jan 2019
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 anticipates no material financial impact from the application of the Standard.	1 Jan 2018

Notes to the financial statements
For the year ended 30 June 2018

		Operative for reporting periods beginning on/after
AASB 2014-1	*Amendments to Australian Accounting Standards* Part E of this Standard makes amendments to AASB 9 and consequential amendments to other Standards. These changes have no impact as Appendix E has been superseded and the Health Service was not permitted to early adopt AASB 9.	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 mandatory application date of this Standard has been amended by AASB 2015-8 to 1 January 2018. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2014-7	*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 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 when the deferred AASB 15 becomes effective from 1 January 2019.	1 Jan 2018
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

9.3 Key management personnel

The key management personnel include Ministers, board members, and senior officers of the Health Service. The Health Service does not incur expenditures to compensate Ministers and those disclosures may be found in the *Annual Report on State Finances*.

The total fees, salaries, superannuation, non-monetary benefits and other benefits for members of the Accountable Authority for the reporting period are presented within the following bands:

Compensation band ($)	**2018**	**2017**
$0	1	1
$0 - $10,000	1	-
$40,001 - $50,000	8	7
$70,001 - $80,000	1	1
	11	9

	2018 $000	**2017 $000**
Short-term employee benefits	383	343
Post-employment benefits	36	33
Total compensation of members of the Accountable Authority	**419**	**376**

Notes to the financial statements
For the year ended 30 June 2018

9.3 Key management personnel (cont.)

The total fees, salaries, superannuation, non-monetary benefits and other benefits for senior officers for the reporting period are presented within the following bands:

Compensation band ($)	2018	2017 [(a)]
$10,001 - $20,000	-	1
$30,001 - $40,000	1	-
$50,001 - $60,000	1	-
$80,001 - $90,000	1	-
$110,001 - $120,000	1	-
$130,001 - $140,000	1	-
$150,001 - $160,000	2	-
$160,001 - $170,000	1	-
$190,001 - $200,000	1	1
$200,001 - $210,000	-	1
$210,001 - $220,000	-	3
$220,001 - $230,000	1	-
$240,001 - $250,000	-	1
$250,001 - $260,000	1	-
$480,001 - $490,000	-	1
$530,001 - $540,000	1	-
$550,001 - $560,000	-	1
$570,001 - $580,000	1	-
$810,001 - $820,000	-	1
	13	10

9.3 Key management personnel (cont.)

	2018 $000	2017 [a] $000
Short-term employee benefits	2,197	2,474
Post-employment benefits	244	287
Other long-term benefits	243	278
Termination benefits	-	113
Total compensation of senior officers	**2,684**	**3,152**

(a) 2016-17 amounts have been revised to remove the non-executive positions so as to be comparable with the amounts presented for 2017-18.

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

9.4 Related party transactions

The Health Service is a wholly-owned public sector entity that is controlled by the State of Western Australia.

Related parties of the Health Service include:

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

9.4 Related party transactions (cont.)

Significant transactions with Government-related entities

In conducting its activities, the Health Service is required to transact with the State and entities related to the State. These transactions are generally based on the standard terms and conditions that apply to all agencies. Such transactions include:

	Notes	2018 $000	2017 $000
Income			
Service appropriations	4.1	334,184	319,539
Assets assumed/(transferred)	4.1	(287)	8
Services received free of charge	4.1	35,569	34,199
Funding received from the Mental Health Commission	4.3	55,005	53,167
Expenses			
Contracts for services - Department of Communities [(a)]		1,022	468
Interest expense on loan - Department of Treasury	7.2	55	79
Insurance payments - Insurance Commission (RiskCover)	3.6	8,220	9,199
Operating lease expenses - Department of Finance [(a)]		1,252	1,577
Operating lease expenses - State Fleet [(a)]		526	501
Remuneration for audit services - Office of the Auditor General	9.12	216	126
Borrowings			
Department of Treasury loans	7.1	1,442	2,115
Contributed Equity			
Capital appropriations	9.13	1,902	1,764
Transfer of assets from/(to) Health Ministerial Body and government agencies	9.13	1,173,486	3,763

(a) These transactions are included at Note 3.2 ‘Contracts for services’ and Note 3.6 ‘Other expenses’.

9.4 Related party transactions (cont.)

Operating lease commitments with Department of Finance	2018 $000	2017 $000
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	639	308
Later than 1 year and not later than 5 years	1,772	21
Later than 5 years	1,715	-
	4,126	329

Material transactions with other related parties

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

	2018 $000	2017 $000
Superannuation payments to GESB	32,265	30,892
Payable to GESB	549	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.

9.5 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.

9.6 Affiliated bodies

An affiliated body is a body which receives more than half its funding and resources from the Health Service but is not subject to operational control by the Health Service.

The Health Service had no affiliated bodies during the financial year.

9.7 Not for profit leases

The following not-for-profit organisations lease spaces and facilities at the Perth Children's Hospital on a peppercorn rental basis. These arrangements commenced on 14 May 2018 when the hospital opened.

Children's Hospital Child Care Centre

HeartKids WA Inc.

The Humour Foundation

Parents of Children With Special Needs Inc. (Kalparrin)

Perth Children's Hospital Foundation Limited

Redkite

Radio Lollipop (Australia) Limited

Starlight Children's Foundation Australia Inc.

Telethon Kids Institute

The Home Away from Home Incorporated (Ronald McDonald House).

9.8 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:

	2018 $000	2017 $000
Department for Communities - health assessments for children in care	284	281
Department for Communities - paediatric services for children with disability	2,786	2,903
Department of Education - school health services	13,711	12,230
	16,781	15,414

9.9 Other statement of receipts and payments

	2018 $000	2017 $000
Commonwealth Grant - Christmas and Cocos Island		
Balance at the start of period	-	-
Receipts		
Commonwealth grant - provision of paediatric services	46	107
Payments		
Costs of visiting specialists	(88)	(107)
Balance at the end of period [(a)]	**(42)**	**-**

(a) A grant amount of $42,073 will be received from Commonwealth in July 2018.

9.10 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*.

	2018 $000	2017 $000
Balance at the start of period	695	-
Transferred from the Government	-	558
Receipts		
Service delivery agreement - Commonwealth contributions	5,212	6,297
Service delivery agreement - State contributions	52,988	51,203
Other	2,017	1,964
	60,217	59,464
Payments	(59,604)	(59,327)
	613	137
Balance at the end of period	**1,308**	**695**

9.11 Administered trust accounts

Trust Accounts are used by the Health Service to account for funds that they may be holding on behalf of another party. The Health Service does not have control of the use of these funds, and cannot deploy them to meet its objectives. Trust Accounts do not form part of the resources available to the Health Service, and are not reported as assets in the financial statements.

The Health Service administers a trust account for the purpose of holding patients' private moneys.

The trust account did not have any receipts or payments during the financial year.

9.12 Remuneration of auditors

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

	2018 $000	2017 $000
Auditing the accounts, financial statements, controls, and key performance indicators	216	126

9.13 Equity

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

	2018 $000	2017 $000
Contributed equity		
Balance at start of period	206,566	-
Contributions by owners		
Transfer of net assets on establishment of the Health Service [b] [h]	-	201,039
Capital appropriations [a]	1,902	1,764
Transfer of net assets from other agencies [b]		
PCH assets from the Health Ministerial Body [e]	1,229,867	-
Land, building and site infrastructure from the Department of Health [c]	-	834
Land, buildings and site infrastructure from South Metropolitan Health Service [f]	3,071	-
Equipment from the Health Ministerial Body [d]	-	2,929
Total contributions by owners	**1,234,840**	**206,566**
Distributions to owners		
Transfer of net asset to other agencies [b]		
PMH land and buildings to the Health Ministerial Body [g]	(59,452)	-
Total distributions to owners	**(59,452)**	**-**
Balance at end of period	**1,381,954**	**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 from the Department of Health to the Health Service occurred in 2016-17 for setting up a Child Health Centre.

9.13 Equity (cont.)

(d) Equipment were transferred from the Health Ministerial Body (Perth Children Hospital's project) to the Princess Margaret Hospital during the 2016-17 financial year.

(e) Assets for the Perth Children's Hospital (PCH) were transferred from the Health Ministerial Body (Perth Children's Hospital's Project) to the Health Service upon commissioning:

	Notes	2018 $000
Property, plant and equipment	5.1	1,177,467
Intangible assets	5.2	52,400
Total PCH assets transferred		1,229,867

(f) Three properties for the provision of community health services and mental health services were transferred from South Metropolitan Health Service to the Health Service during the current financial year.

(g) The Princess Margaret Hospital (PMH) site was transferred to the Health Ministerial Body on 10 June 2018.

9.13 Equity (cont.)

(h) 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 1 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**

9.13 Equity (cont.)

	2018 $000	2017 $000
Assets revaluation reserve		
Balance at start of period	3,037	-
Net revaluation increments/(decrements):		
Buildings	1,087	3,037
Balance at end of period	4,124	3,037

9.14 Supplementary financial information

(a) Revenue, public and other property written off

	2018 $000	2017 $000
Revenue and debts written off under the authority of the Accountable Authority	772	-
	772	-

(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.

9.15 Explanatory statement

All variances between estimates (original budget) and actual results for 2018, and between the actual results for 2018 and 2017 are shown below. Narratives are provided for key major variances, which are generally greater than:

(i) 5% and $11 million for Statement of Comprehensive Income;

(ii) 5% and $6.8 million for Statement of Financial Position; and

(iii) 5% and $11 million for Statement Cash Flows.

9.15.1 Statement of Comprehensive Income Variances

	Variance note	Estimate 2018 $000	Actual 2018 $000	Actual 2017 $000	Variance between estimate and actual $000	Variance between actual results for 2018 and 2017 $000
Expenses						
Employee benefits expense	(b)	415,325	433,218	406,536	17,893	26,682
Fees for visiting medical practitioners		972	1,849	1,139	877	710
Contracts for services		11,009	7,992	9,260	(3,017)	(1,268)
Patient support costs		53,212	59,045	58,786	5,833	259
Finance costs		57	55	79	(2)	(24)
Depreciation and amortisation expense		3,839	11,044	11,496	7,205	(452)
Asset revaluation decrements		-	2,047	1,576	2,047	471
Loss on disposal of non-current assets		-	82	2	82	80
Repairs, maintenance and consumable equipment		7,167	8,599	7,592	1,432	1,007
Other supplies and services		35,587	36,168	31,934	581	4,234
Other expenses		24,746	22,858	26,697	(1,888)	(3,839)
Total cost of services		**551,914**	**582,957**	**555,097**	**31,043**	**27,860**

9.15.1 Statement of Comprehensive Income Variances (cont.)

	Variance note	Estimate 2018 $000	Actual 2018 $000	Actual 2017 $000	Variance between estimate and actual $000	Variance between actual results for 2018 and 2017 $000
Revenue						
Patient charges		13,917	12,947	13,185	(970)	(238)
Other fees for services		12,080	10,841	11,598	(1,239)	(757)
Commonwealth grants and contributions		117,040	125,580	120,857	8,540	4,723
Other grants and contributions		58,854	64,301	58,731	5,447	5,570
Donation revenue		2,507	1,502	1,293	(1,005)	209
Commercial activities		-	869	963	869	(94)
Other revenue		3,721	4,046	3,031	325	1,015
Total revenue		208,119	220,086	209,658	11,967	10,428
Total income other than income from State Government		**208,119**	**220,086**	**209,658**	**11,967**	**10,428**
NET COST OF SERVICES		**343,795**	**362,871**	**345,439**	**19,076**	**17,432**
INCOME FROM STATE GOVERNMENT						
Service appropriations	(a)	309,709	334,184	319,539	24,475	14,645
Assets (transferred)/assumed		-	(287)	8	(287)	(295)
Services received free of charge		31,932	35,569	34,199	3,637	1,370
Total income from State Government		**341,641**	**369,466**	**353,746**	**27,825**	**15,720**
SURPLUS / (DEFICIT) FOR THE PERIOD		**(2,154)**	**6,595**	**8,307**	**8,749**	**(1,712)**
OTHER COMPREHENSIVE INCOME						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve		-	1,087	3,037	1,087	(1,950)
Total other comprehensive income		-	1,087	3,037	1,087	(1,950)
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**(2,154)**	**7,682**	**11,344**	**9,836**	**(3,662)**

9.15.1 Statement of Comprehensive Income Variances (cont.)

Major Variance Narratives

Variances between estimate and actual

(a) Service appropriations are higher than budget estimate by $24.475 million due to the unbudgeted accrual appropriations for funding the depreciation and amortisation expense at the Perth Children's Hospital (PCH) and additional cash appropriations for funding services.

Variances between actuals for 2017-18 and 2016-17

(b) Employee benefits expense increased by $26.682 million due to the $10.502 million cost-shift for the Health Service's Neonates Ward from the North Metropolitan Health Service's King Edward Memorial Hospital, pay increases to employees and slight increase in staffing level.

9.15.2 Statement of Financial Position Variances

	Variance note	Estimate 2018 $000	Actual 2018 $000	Actual 2017 $000	Variance between estimate and actual $000	Variance between actual results for 2018 and 2017 $000
ASSETS						
Current Assets						
Cash and cash equivalents		23,016	27,696	22,442	4,680	5,254
Restricted cash and cash equivalents		4,468	29,868	16,712	25,400	13,156
Receivables		7,833	6,813	10,747	(1,020)	(3,934)
Inventories		2,482	2,344	2,540	(138)	(196)
Other assets		456	537	448	81	89
Total Current Assets		38,255	67,258	52,889	29,003	14,369
Non-Current Assets						
Restricted cash and cash equivalents		3,313	3,308	1,644	(5)	1,664
Amounts receivable for services	(c) (e)	190,301	200,625	186,301	10,324	14,324
Property, plant and equipment	(d) (f)	106,642	1,218,168	107,411	1,111,526	1,110,757
Intangible assets	(d) (f)	4	51,744	6	51,740	51,738
Total Non-Current Assets		300,260	1,473,845	295,362	1,173,585	1,178,483
TOTAL ASSETS		**338,515**	**1,541,103**	**348,251**	**1,202,588**	**1,192,852**

9.15.2 Statement of Financial Position Variances (cont.)

	Variance note	Estimate 2018 $000	Actual 2018 $000	Actual 2017 $000	Variance between estimate and actual $000	Variance between actual results for 2018 and 2017 $000
LIABILITIES						
Current Liabilities						
Payables		15,672	32,841	28,047	17,169	4,794
Borrowings		703	703	673	-	30
Provisions		80,773	84,829	79,595	4,056	5,234
Other liabilities		62	23	212	(39)	(189)
Total Current Liabilities		97,210	118,396	108,527	21,186	9,869
Non-Current Liabilities						
Borrowings		738	739	1,442	1	(703)
Provisions		20,678	20,988	20,372	310	616
Total Non-Current Liabilities		21,416	21,727	21,814	311	(87)
TOTAL LIABILITIES		**118,626**	**140,123**	**130,341**	**21,497**	**9,782**
NET ASSETS		**219,889**	**1,400,980**	**217,910**	**1,181,091**	**1,183,070**
EQUITY						
Contributed equity		209,333	1,381,954	206,566	1,172,621	1,175,388
Reserves		3,037	4,124	3,037	1,087	1,087
Accumulated surplus		7,519	14,902	8,307	7,383	6,595
TOTAL EQUITY		**219,889**	**1,400,980**	**217,910**	**1,181,091**	**1,183,070**

9.15.2 Statement of Financial Position Variances (cont.)

Major Variance Narratives

Variances between estimate and actual

(c) Amounts receivable for services are higher than budget estimate by $10.324 million due to the unbudgeted accrual appropriations for funding the depreciation and amortisation expense at the Perth Children's Hospital (PCH).

(d) Property, plant and equipment and intangible assets for PCH were transferred from the Health Ministerial Body to the Health Service, when the hospital opened in May 2018. The budget estimates did not include these PCH assets.

Variances between actuals for 2017-18 and 2016-17

(e) Amounts receivable for services increased by $14.324 million due to the additional accrual appropriations for funding the depreciation and amortisation expense at PCH.

(f) Property, plant and equipment have increased by $1,110.757 million and intangible assets increased by $51.738 million predominately as a result of the transfer of assets for PCH from the Health Ministerial Body to the Health Service, and the transfer of land and buildings at the Princess Margaret Hospital from the Health Service to the Health Ministerial Body. Details are provided in Note 5.1 and Note 5.2.

9.15.3 Statement of Cash Flows Variances

	Variance note	Estimate 2018 $000	Actual 2018 $000	Actual 2017 $000	Variance between estimate and actual $000	Variance between actual results for 2018 and 2017 $000
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriations	(g)	305,650	319,803	304,112	14,153	15,691
Capital appropriations		5,024	1,229	1,121	(3,795)	108
Net cash provided by State Government		**310,674**	**321,032**	**305,233**	**10,358**	**15,799**
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits	(h)	(412,781)	(427,262)	(398,559)	(14,481)	(28,703)
Supplies and services		(99,328)	(102,813)	(97,744)	(3,485)	(5,069)
Receipts						
Receipts from customers		16,058	15,334	11,252	(724)	4,082
Commonwealth grants and contributions		117,040	125,580	120,857	8,540	4,723
Other grants and contributions		58,854	64,301	58,731	5,447	5,570
Donations received		1,826	1,088	805	(738)	283
Other receipts		14,924	17,320	14,488	2,396	2,832
Net cash used in operating activities		**(303,407)**	**(306,452)**	**(290,170)**	**(3,045)**	**(16,282)**

9.15.3 Statement of Cash Flows Variances (cont.)

	Variance note	Estimate 2018 $000	Actual 2018 $000	Actual 2017 $000	Variance between estimate and actual $000	Variance between actual results for 2018 and 2017 $000
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Purchase of non-current assets		(5,024)	(1,117)	(2,846)	3,907	1,729
Receipts						
Proceeds from sale of non-current assets		-	-	4	-	(4)
Net cash used in investing activities		**(5,024)**	**(1,117)**	**(2,842)**	**3,907**	**1,725**
Net increase / (decrease) in cash and cash equivalents		2,243	13,463	12,221	11,220	1,242
Cash and cash equivalents at the beginning of period for the Health Service		28,554	28,554	-	-	28,554
Cash and cash equivalents transferred from the Government		-	-	16,333	-	(16,333)
Cash and cash equivalents at the end of the period for the Health Service		30,797	42,017	28,554	11,220	13,463
Cash and cash equivalents at the beginning of period for the Health Ministerial Body		12,244	12,244	-	-	12,244
Cash and cash equivalents transferred to the Health Ministerial Body		(12,244)	-	-	12,244	-
Net increase in cash and cash equivalents for the Health Ministerial Body		-	6,611	12,244	6,611	(5,633)
Cash and cash equivalents at the end of the period for the Health Ministerial Body		-	18,855	12,244	18,855	6,611
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**30,797**	**60,872**	**40,798**	**30,075**	**20,074**

9.15.3 Statement of Cash Flows Variances (cont.)

Major Variance Narratives

Variances between actuals for 2017-18 and 2016-17

(g) Service appropriations has increased by $15.691 million to fund the increased costs of services, which were also supplemented by increases in receipts from patient charges, fees for services, Commonwealth grants and contributions and other grants and contributions.

(h) See explanation in variance note (b).

"As we look to the year ahead and the dual challenges that a brand new hospital and organisational restructure may present, I trust that our staff, volunteers, clients and their families can be comfortable we are heading in the right direction."

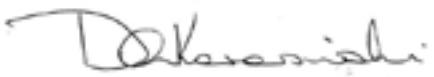
Key performance indicators

Certification of key performance indicators

CHILD AND ADOLESCENT HEALTH SERVICE

CERTIFICATION OF KEY PERFORMANCE INDICATORS FOR THE YEAR ENDED 30 JUNE 2018

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 2018.



MS DEBORAH KARASINSKI
CHAIR OF THE BOARD
CHILD AND ADOLESCENT HEALTH SERVICE
17 September 2018

PROF GEOFFREY DOBB
DEPUTY CHAIR OF THE BOARD
CHILD AND ADOLESCENT HEALTH SERVICE
17 September 2018

Key Performance Indicators

The relationship between the following Key Performance Indicators and the Government Goal, Outcomes and Services is described in the Performance management framework section commencing on page 24.

The latest available data has been used to report performance.

KPIs measuring Outcome 1

KPIs measuring Outcome 2

OUTCOME 1 – EFFECTIVENESS KPI

Unplanned hospital readmissions of public hospital patients within 28 days for selected surgical procedures

Rationale

After a successful hospital stay, the most important task for WA public hospital patients and staff is preparing for a successful discharge home. Tracking the number of patients who experience unplanned readmissions to WA health system hospitals within 28 days for selected surgical procedures assists in assessing the quality of hospital services provided to the community.

Unplanned readmissions are those readmissions where the principal diagnosis and readmission interval indicate that the readmission may be related to the care provided by the hospital in an index surgical episode of care. This indicator measures readmissions to any public hospital or as a public patient in Contracted Health Entities.

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 within our health system, and lessons can be learnt from a higher than target unplanned readmission rate through the creation of a variety of improvement strategies.

The surgeries selected to be measured by this indicator have a risk associated with post-surgery complications. Good discharge plans can help to decrease the likelihood of unplanned hospital readmissions, by providing patients with the care instructions they need after a hospital stay and by helping patients recognise symptoms that may require immediate medical attention. However, it is important to note that unplanned hospital readmissions may or may not be related to the previous visit, and some unplanned readmissions are not preventable.

Target

The 2017 targets are based on the total child and adult population, and for each procedure is:

SURGICAL PROCEDURE	TARGET (PER 1,000)
Knee Replacement	26.2
Hip Replacement	17.2
Tonsillectomy & Adenoidectomy	61.0
Hysterectomy	41.3
Prostatectomy	38.8
Cataract Surgery	1.1
Appendicectomy	32.9

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

Results

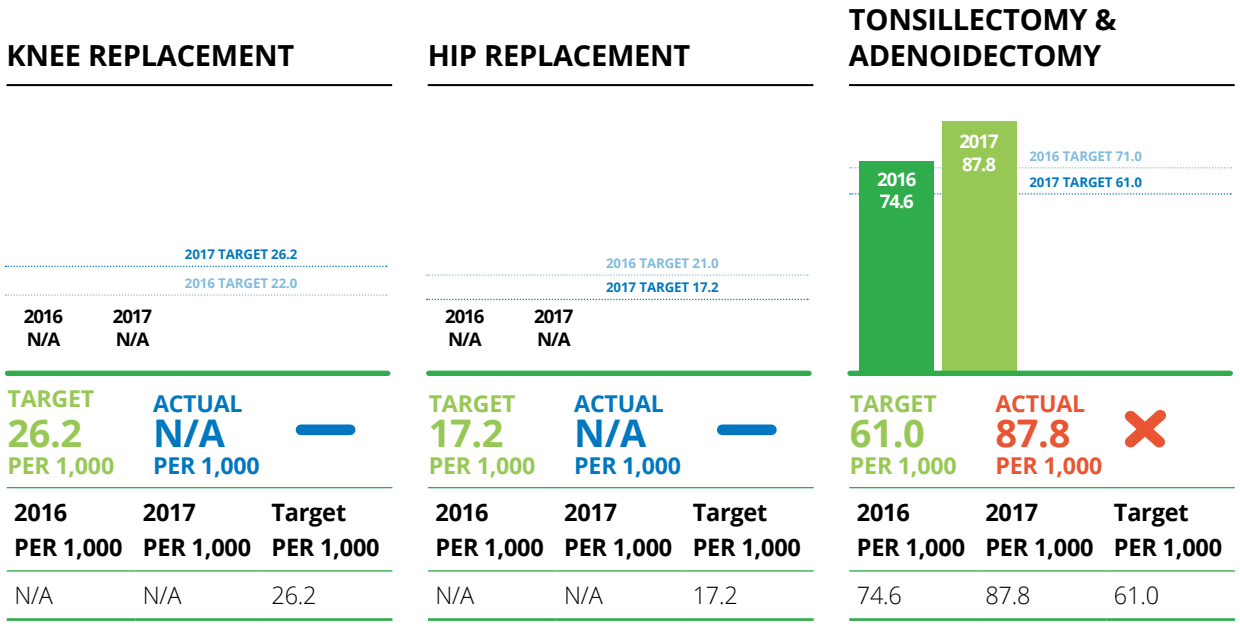
The rates of unplanned readmissions within 28 days to a Child and Adolescent Health Service (CAHS) hospital for selected surgical procedures in 2016 and 2017 are presented in Figure 3.

The rate of unplanned readmission for tonsillectomy and adenoidectomy was 87.8 per 1,000, which is above the target of 61.0 per 1,000. This result reflects the conservative approach that CAHS takes to managing patients, whereby parents are advised to stay in the metropolitan area post-surgery and to re-present to hospital should they have any concerns. Managing the pain experienced by younger patients following tonsillectomy and adenoidectomy can be challenging, as it changes rapidly over the first few days after surgery, thereby requiring regular assessment and delivery of the appropriate amounts of medicine. Barriers to effective pain relief in children include the frequency of administering medicine (including the need to wake them), the taste and volume of medicine to be consumed, and the pain swallowing medicine can cause.

The rate of unplanned readmissions for appendicectomy was 20.8 per 1,000, which is below the target of 32.9 per 1,000. There were no unplanned readmissions for cataract surgery, and CAHS did not perform any knee replacements, hip replacements, hysterectomies or prostatectomies in 2017.

Figure 3

Rate of unplanned readmissions within 28 days for selected surgical procedures, 2016 to 2017



2016 PER 1,000	2017 PER 1,000	Target PER 1,000
N/A	N/A	26.2

2016 PER 1,000	2017 PER 1,000	Target PER 1,000
N/A	N/A	17.2

2016 PER 1,000	2017 PER 1,000	Target PER 1,000
74.6	87.8	61.0

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, WA Data Linkage System

Figure 3 continued

HYSTERECTOMY

TARGET **41.3** PER 1,000 | ACTUAL **N/A** PER 1,000 | —

2016 PER 1,000	2017 PER 1,000	Target PER 1,000
N/A	N/A	41.3

PROSTATECTOMY

TARGET **38.8** PER 1,000 | ACTUAL **N/A** PER 1,000 | —

2016 PER 1,000	2017 PER 1,000	Target PER 1,000
N/A	N/A	38.8

CATARACT SURGERY

TARGET **1.1** PER 1,000 | ACTUAL **0.0** PER 1,000 | ✓

2016 PER 1,000	2017 PER 1,000	Target PER 1,000
0	0.0	1.1

APPENDICECTOMY

TARGET **32.9** PER 1,000 | ACTUAL **20.8** PER 1,000 | ✓

2016 PER 1,000	2017 PER 1,000	Target PER 1,000
45.2	20.8	32.9

OUTCOME 1 – EFFECTIVENESS KPI

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

Rationale

Elective surgery refers to planned surgery that can be booked in advance as a result of a specialist assessment resulting in placement on an elective surgery waiting list. Waiting lists are actively managed by hospitals to ensure all patients are treated in clinically appropriate timeframes. Patients should be prioritised based on their assigned clinical urgency category:

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

On 1 April 2016, the WA health system introduced a new state-wide performance target for the provision of elective services. The new target requires no patients (0%) 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 Services Wait List Data Collection Commonwealth Non-Reportable Procedures list. This list is consistent with the Australian Institute of Health and Welfare (AIHW) list of Code 2 (other) procedures that do not meet the definition of elective surgery. It also includes additional procedure codes that are intended to better reflect the procedures identified in the AIHW Code 2 list.

Target

The 2017–18 target is 0 per cent for each urgency category. Performance is demonstrated by a result that is equal to the target.

Results

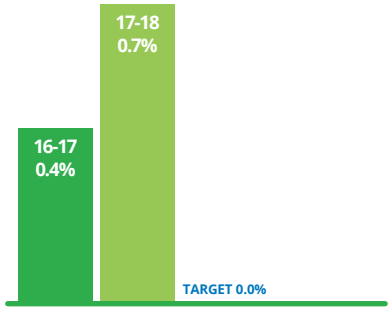
In 2017–18, CAHS maintained a high level of performance with surgical waitlisting of patients and treating them within recommended timeframes. Figure 4 shows that only 0.7 per cent of Category 1 patients were not treated within 30 days, 0.6 per cent of Category 2 patients were not treated within 90 days and 0.1 per cent of Category 3 patients were not treated within 365 days.

The hospital's Surgical Directorate routinely audits waitlist categorisations to ensure treatment is booked efficiently and effectively. In 2017–18, additional effort to reduce Category 1 over boundary cases was made prior to the move to Perth Children's Hospital (PCH). Factors that contribute to patient treatment going over boundary include the availability of surgeons and whether patients are ready for care. The move to PCH in June 2018 and the commensurate reduction of elective surgery to facilitate training and commissioning had a slightly negative effect on performance in the last few months of the financial year. Even small variations in performance will cause the hospital to exceed the 0 per cent over boundary targets, and the results for 2017–18 reflect this.

Figure 4

Proportion of elective wait list patients waiting over boundary for reportable procedures, by urgency category, 2016–17 to 2017–18

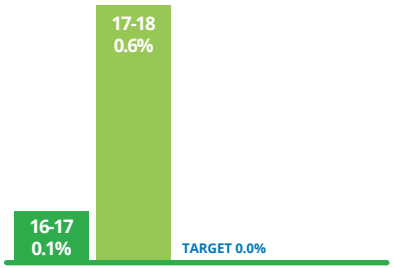
CATEGORY 1
≤ 30 DAYS



TARGET 0.0% ACTUAL 0.7% ✗

2016–17	2017–18	Target
0.4%	0.7%	0%

CATEGORY 2
≤ 90 DAYS



TARGET 0.0% ACTUAL 0.6% ✗

2016–17	2017–18	Target
0.1%	0.6%	0%

CATEGORY 3
≤ 365 DAYS

TARGET 0.0% ACTUAL 0.1% ✗

2016–17	2017–18	Target
0.0%	0.1%	0%

Notes

1. The result is based on an average of weekly census data for the financial year.
Data source: Elective Services Wait List Data Collection.

"Even small variations in performance will cause the hospital to exceed the 0 per cent over boundary targets, and the results for 2017–18 reflect this."

OUTCOME 1 – EFFECTIVENESS KPI

Hospital infection rates (HA-SABSI) per 10,000 occupied bed-days in public hospitals

Rationale

Staphylococcus aureus bloodstream infection (SABSI) is a serious infection that may be associated with the provision of healthcare. *Staphylococcus aureus* is a highly pathogenic organism, and even with advanced medical care, infection caused by this organism is associated with prolonged hospital stays, increased healthcare costs and a marked increase in morbidity and mortality – mortality estimated at 20–25 per cent in adults and 5 per cent in children.

Healthcare associated SABSI (HA-SABSI) are generally considered to be preventable adverse events associated with the provision of healthcare.

This KPI has been selected for inclusion as it is a robust KPI of the safety and quality of WA public hospitals, and aligns to the principle of increased transparency and accountability of performance information provided to the public. A low or decreasing HA-SABSI rate is desirable and a target for WA based on historical data has been set.

Target

The 2017 target is 1.0 HA-SABSI per 10,000 occupied bed-days. Performance is demonstrated by a result that is equal to or below the target.

Result

Staphylococcus aureus (S. aureus) is a bacterium found on the skin or in the nose of many individuals. In this form, it is usually harmless, and most people are unaware that they are carrying it. In the community, it is commonly spread from person to person. In hospitals, transmission is most commonly via the hands of healthcare workers and contaminated surfaces, such as furnishings and medical equipment. Bacteria from the patient's skin or from the hand of a healthcare worker can gain direct entry into the patient's bloodstream if they have an open wound or intravascular device inserted, such as central or peripheral venous catheter.

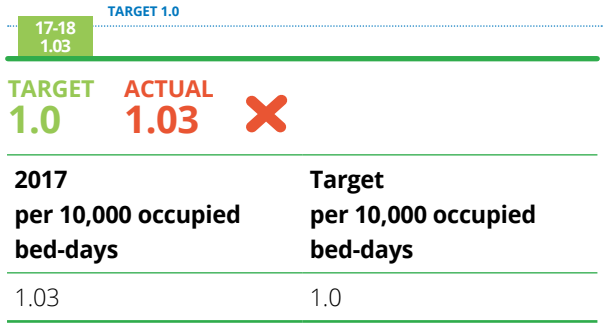
CAHS provides a range of specialised services, including emergency medicine, intensive care, cardiothoracic surgery and oncology. Many patients are therefore at higher risk of infection than those at hospitals providing less specialised services. In 2017, CAHS recorded a *Staphylococcus aureus* bloodstream infection rate of 1.03 per 10,000 occupied bed-days, which is marginally above the WA health system target (see Figure 5), but below the national benchmark of 2.0 per 10,000 bed-days[2].

[2] Australian Institute of Health and Welfare 2017. Staphylococcus aureus bacteraemia in Australian public hospitals 2016–17: Australian hospital statistics. Health services series no. 83. Cat. no. HSE 198. Canberra: AIHW.

Figure 5

Hospital infection rates (HA-SABSI) per 10,000 occupied bed-days in public hospitals, 2017

HA-SABSI RATE



2017 per 10,000 occupied bed-days	Target per 10,000 occupied bed-days
1.03	1.0

Notes

1. As a new indicator for 2017, no prior year comparative data is available.

Data source: Healthcare Infection Surveillance Western Australia Data Collection.

CAHS recognises all *S. aureus* infections as significant clinical incidents by assigning the highest Severity Assessment Code of SAC1. Root Cause Analyses are conducted to determine the reasons for infection and inform mitigation strategies. New strategies to reduce the rate of infection that have either been introduced in 2018 or are under consideration include:

- decolonising all patients undergoing high risk surgical procedures rather than just those colonised with *S. aureus*
- screening patients due to receive chemotherapy for malignancy, and decolonising those demonstrated to be colonised with *S. aureus*
- ongoing compliance assessment and training to ensure best practice guidelines are used when managing central venous access devices and peripheral intravenous cannulas
- preferential use of skin preparations containing alcohol, which is demonstrated to reduce the rate of surgical wound infection.

OUTCOME 1 – EFFECTIVENESS KPI

Survival rates for sentinel conditions

Rationale

This indicator measures hospital performance in relation to restoring the health of people who have suffered a sentinel condition - specifically a stroke and acute myocardial infarction. 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 healthcare of the community, and are leading causes of death and hospitalisation in Australia[3]. 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 that may have developed while in hospital.

Hospital survival indicators, including this KPI, are considered screening tools, as they are not definitively diagnostic of poor quality and/or safety.

Target

The 2017 targets are based on the total child and adult population, and for each procedure, by age group, is:

	SENTINEL CONDITION	
AGE GROUP (YEARS)	STROKE (%)	ACUTE MYOCARDIAL INFARCTION (%)
0–49	94.3	99.2

Performance is demonstrated by a result that is equal to or above the target.

Results

The very low number of cases of stroke treated each year means that the calculated survival rate is prone to be highly volatile from one year to the next, and must be interpreted with caution. In 2017, CAHS recorded a survival rate of 84.2 per cent (Figure 6). It should be noted that all deaths were thoroughly reviewed by the hospital's Mortality and Morbidity Review Committee, and none were found to be preventable.

Acute myocardial infarction is rare in children and adolescents. Like last year, CAHS did not treat any patients with this condition in 2017, and hence there is no result to report (Figure 7).

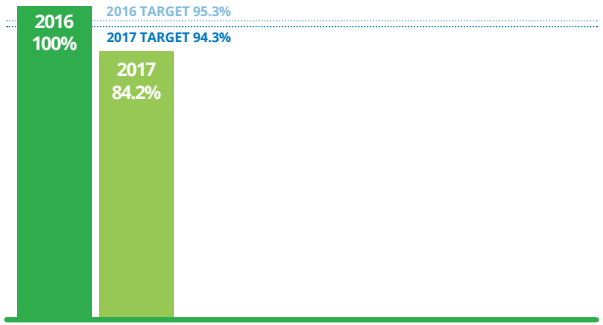
[3] These conditions are a leading cause of death and hospitalisation across the entire Australian population. The Child and Adolescent Health Service treats patients aged 0–17 years, for whom these conditions are extremely uncommon.

Figure 6

Survival rate for stroke, by age group, 2016 to 2017

AGE GROUP 0-49 YEARS

STROKE



TARGET **94.3%** ACTUAL **84.2%** ✗

2016 (%)	2017 (%)	Target (%)
100	84.2	94.3

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.

Figure 7

Survival rate for acute myocardial infarction, by age group, 2016 to 2017

AGE GROUP 0-49 YEARS

ACUTE MYOCARDIAL INFARCTION

TARGET **99.2%** ACTUAL **N/A**

2016 (%)	2017 (%)	Target (%)
N/A	N/A	99.2%

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.

OUTCOME 1 – EFFECTIVENESS KPI

Percentage of admitted Aboriginal and Non-Aboriginal patients who discharged against medical advice

Rationale

WA health system public hospitals employ a range of initiatives to ensure the delivery of culturally secure health services to Aboriginal people. The inclusion of this new KPI will assist in measuring the success of these initiatives. A high percentage reported for this KPI will reflect the need for improved responses by the health system to the needs of Aboriginal patients, and provides a measure of the quality of the services provided.

Patients who left against medical advice (also called discharged against medical advice or DAMA) have been found to cost the health system 50 per cent more than the cost of patients who are discharged by physicians[4]. Published data contends that high DAMA rates reflect the need for improved responses by the health system to the needs of Aboriginal patients, and provides a measure of the safety, quality and cultural security of the services provided.

Monitoring this indicator will enable identification of performance improvement opportunities, as well as the collaborative and effective addressing of the underlying factors in achieving an equitable treatment outcome for Aboriginal patients.

Target

The 2017 target is 0.77 per cent. Performance is demonstrated by a result that is equal to or below the target.

Results

In 2017, CAHS recorded a rate of discharge against medical advice of 0.30 per cent for Aboriginal patients, and 0.09 per cent for non-Aboriginal patients. Both these results are below the target of 0.77 per cent (see Figure 8). A contributing factor to the favourable result for Aboriginal patients is the Koorliny Moort (Walking with Families) program. The program aims to provide better care coordination delivery by engaging Aboriginal people early in their health care and providing effective communication between health services, led by Aboriginal service providers.

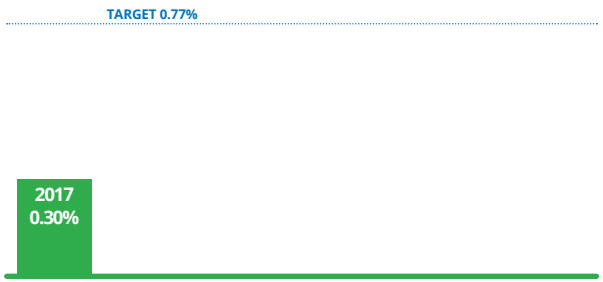
[4] Aliyu ZY. Discharge against medical advice: sociodemographic, clinical and financial perspectives. International journal of clinical practice 2002;56(5):325-27.

"A high percentage reported for this KPI will reflect the need for improved responses by the health system to the needs of Aboriginal patients, and provides a measure of the quality of the services provided."

Figure 8

Percentage of admitted Aboriginal and Non-Aboriginal patients who discharged against medical advice, 2017

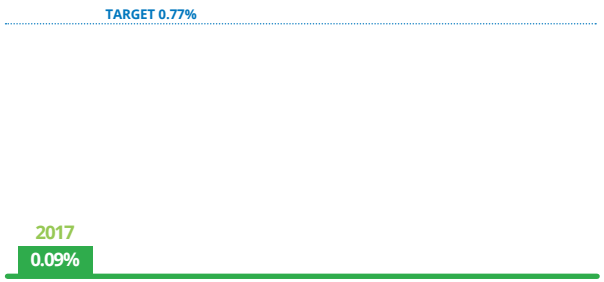
ABORIGINAL PATIENTS



TARGET 0.77% ACTUAL 0.30%

2017 (%)	Target (%)
0.30	0.77

NON-ABORIGINAL PATIENTS



TARGET 0.77% ACTUAL 0.09%

2017 (%)	Target (%)
0.09	0.77

Notes

As a new indicator for 2017–18, no prior year comparative data is available.

Data source: Hospital Morbidity Data Collection.

OUTCOME 1 – EFFECTIVENESS KPI

Rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit

Rationale

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

While multiple hospital admissions over a lifetime may be necessary for someone with ongoing illness, a high proportion of readmissions shortly after discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was not adequate to maintain the patient's recovery out of hospital. These readmissions mean that patients spend additional time in hospital and utilise additional resources. A low readmission rate suggests that good clinical practice is in operation. This indicator is reported at the facility at which the initial admission occurred rather than the facility at which the patient was readmitted.

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

Target

The 2017 target is 12 per cent[5]. Performance is demonstrated by a result that is equal to or below the target.

Result

The rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit comprises both planned and unplanned readmissions. The Child and Adolescent Mental Health Service provides planned admissions for those who require frequent inpatient admissions and non-acute interventions. This is usually complementary to community provided care. There are also many instances where the return of young people to hospital is not planned, but is also not unexpected given the nature of their conditions.

In 2017, the rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit was 28.3 per cent, which is above the target of 12 per cent (Figure 9). It should be noted that a high readmission rate does not necessarily mean poor clinical practice.

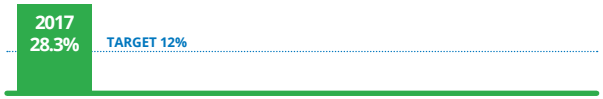
And while a low readmission rate may indicate clinical effectiveness, it can also indicate resource limitations, such as a lack of access to beds. The inability to distinguish planned and unplanned readmissions affects the interpretation of this indicator. This is because there are benefits to returning the patient to the community in anticipation of readmitting them later, which not only improves their recovery, but reduces the total cost of their treatment. In this case, the result includes many instances where the return of young people to hospital was required to attend to progressive and chronic conditions that do not require long term admission. Frequent admissions are currently being used as part of an evidence-based clinical package of care for a young person with a chronic condition.

[5]The source of this target was the *Fourth National Mental Health Measurement Strategy (May 2011)* produced by the Mental Health Information Strategy Subcommittee, Australian Health Ministers' Advisory Council, Mental Health Standing Committee. http://www.health.gov.au/internet/main/publishing.nsf/content/1ED20240320A3A11CA257D9B007B31C6/$File/meas.pdf

Figure 9

Rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit, 2017

READMISSION RATE



TARGET 12% ACTUAL 28.3% ✗

2017 (%)	Target (%)
28.3	12

Notes

1. As a new indicator for 2017, no prior year comparative data is available.

Data source: Hospital Morbidity Data Collection.

OUTCOME 1 – EFFECTIVENESS KPI

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

Rationale

In 2014-15, there were 4.0 million Australians (17.5 per cent) who reported having a mental or behavioural condition[6]. 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 admission 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.

Target

The 2017 target is 75 per cent. Performance is demonstrated by a result that is equal to or above the target.

Result

In 2017, 72.4 per cent of young people who were admitted to a CAHS mental health inpatient unit were contacted by a community-based public mental health non-admitted health service within seven days of discharge (Figure 10). This result is marginally below the aspirational target of 75 per cent.

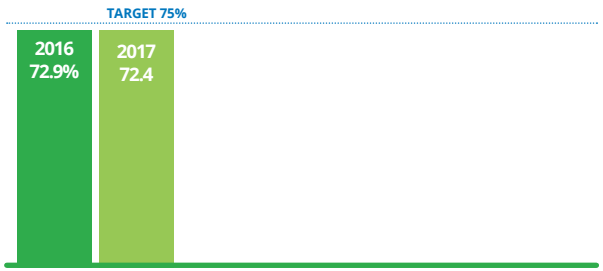
The variance to target is due to multiple factors. Not all patients elect to schedule an appointment within seven days, and some choose not to make an appointment at all. Contact with parents (e.g. due to the age of the patient) is not included in the result even where it occurs within seven days. Some patients are discharged to health professionals in the private and not for profit sectors. These services do not use the Psychiatric Services Online Information System, so it is not possible to confirm follow up activity occurred within seven days. The result is therefore very likely to under-report actual performance.

[6] National Health Survey 2014-15: http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/CDA852A349B4CEE6CA257F150009FC53/$File/national%20health%20survey%20first%20results,%202014-15.pdf

Figure 10

Percentage of contacts with community-based public mental health non-admitted services within seven days post-discharge from an acute public mental health inpatient unit, 2016 to 2017

POST-DISCHARGE COMMUNITY BASED CONTACT



TARGET **75%** **ACTUAL** **72.4%** ✗

2016 (%)	2017 (%)	Target (%)
72.9	72.4	75

Notes

1. Previously reported as *Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units*.
2. 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 source: Mental Health Information System Data Collections, Hospital Morbidity Data Collection.

EFFICIENCY KPI – SERVICE 1: PUBLIC HOSPITAL ADMITTED SERVICES

Average admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per weighted activity unit compared with the Health Service Provider's Health Service Allocation Price set each year in the WA Activity Based Funding Operating Model.

The measure ensures that a consistent methodology is applied to calculating and then measuring the performance of Health Service Providers against the funding they receive through the Government Budget Statement and subsequent Service Agreements, and the activity delivered by each hospital site (reported at an aggregated entity level). Admitted services received approximately 47.2 per cent of the 2017–18 budget allocation, so it is important that the efficiency of service delivery is accurately monitored and reported.

Target

The 2017–18 target is $7,285 per weighted activity unit. Performance is demonstrated by a result that is equal to or below the target.

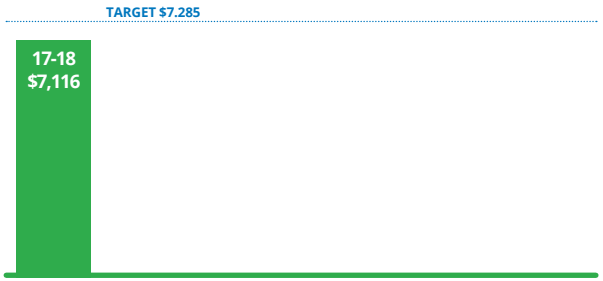
Result

The average admitted cost per weighted activity unit in 2017–18 was $7,116, which is slightly below the target.

Figure 11

Average admitted cost per weighted activity unit, 2017–18

AVERAGE ADMITTED COST PER WEIGHTED ACTIVITY UNIT



TARGET **$7,285** **ACTUAL** **$7,116%** ✔

2017-18	Target (%)
$7,116	$7,285

Notes:

1. Weighted activity units adjust raw activity data to reflect the complexity of services provided to treat various conditions. WA health system hospitals utilise the Australian Refined Diagnosis Related Groups classifications to assign cost weights to each diagnostic group.
2. The original target of $6,868 published in the 2017–18 State Budget has been revised to include the full cost of PathWest services and funding for admitted teaching, training and research.
3. As a new indicator for 2017–18, no prior year comparative data is available.

Data sources: Health Service financial system, Hospital Morbidity Data Collection

OUTCOME 1 – EFFICIENCY KPI – SERVICE 2: PUBLIC HOSPITAL EMERGENCY SERVICES

Average Emergency Department cost per weighted activity unit

Rationale

This indicator is a measure of the cost per weighted activity unit compared with the Health Service Provider's Health Service Allocation Price set each year in the WA Activity Based Funding Operating Model.

The measure ensures that a consistent methodology is applied to calculating and then measuring the performance of Health Service Providers against the funding they receive through the Government Budget Statement and subsequent Service Agreements and the activity delivered by each hospital site (reported at an aggregated entity level). Emergency Department (ED) services received approximately 9.0 per cent of the 2017–18 budget allocation, and with the ever-increasing demand on EDs and health services, it is important that ED service provision is continually monitored to ensure the efficient delivery of safe and high-quality care.

Target

The 2017–18 target is $7,043 per weighted activity unit. Performance is demonstrated by a result that is equal to or below the target.

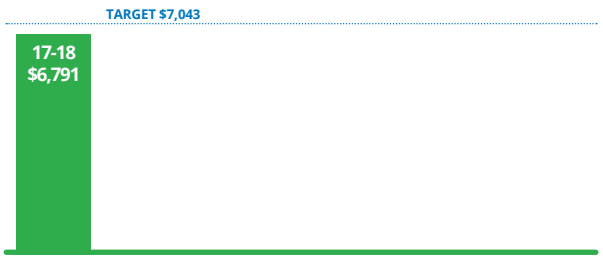
Result

The average Emergency Department cost per weighted activity unit in 2016–17 was $6,791, which is slightly below the target.

Figure 12

Average Emergency Department cost per weighted activity unit, 2017–18

AVERAGE EMERGENCY DEPARTMENT COST PER WEIGHTED ACTIVITY UNIT



TARGET **$7,043** ACTUAL **$6,791** ✔

2017–18	Target
$6,791	$7,043

Notes

1. Weighted activity units adjust raw activity data to reflect the complexity of services provided to treat various conditions. WA health system hospitals utilise the Australian Refined Diagnosis Related Groups classifications to assign cost weights to each diagnostic group.
2. The original target of $6,642 has been revised to correct an error made during the 2017–18 State Budget development process.
3. As a new indicator for 2017–18, no prior year comparative data is available.

Data sources: Health Service financial system, Emergency Department Data Collection

OUTCOME 1 – EFFICIENCY KPI – SERVICE 3: PUBLIC HOSPITAL NON-ADMITTED SERVICES

Average non-admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per weighted activity unit compared with the Health Service Provider's Health Service Allocation Price set each year in the WA Activity Based Funding Operating Model.

The measure ensures that a consistent methodology is applied to calculating and then measuring the performance of Health Service Providers against the funding they receive through the Government Budget Statement and subsequent Service Agreements and the activity delivered by each hospital site (reported at an aggregated entity level). Non-Admitted services received approximately 9 per cent of the 2017–18 budget allocation, so it is important that efficiency of service delivery is accurately monitored and reported.

Target

The 2017–18 target is $7,160 per weighted activity unit. Performance is demonstrated by a result that is equal to or below the target.

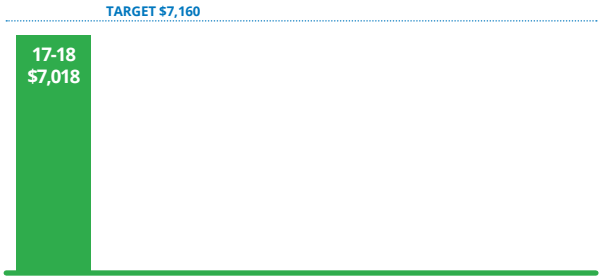
Result

The average non-admitted cost per weighted activity unit in 2017-18 was $7,018, which is slightly below the target.

Figure 13

Average non-admitted cost per weighted activity unit, 2017–18

AVERAGE NON-ADMITTED COST PER WEIGHTED ACTIVITY UNIT



TARGET **$7,160**

ACTUAL **$7,018** ✔

2017–18	Target (%)
$7,018	$7,160

Notes

1. Weighted activity units adjust raw activity data to reflect the complexity of services provided to treat various conditions. WA health system hospitals utilise the Australian Refined Diagnosis Related Groups classifications to assign cost weights to each diagnostic group.
2. The original target of $6,738 published in the 2017–18 State Budget has been revised to include the full cost of PathWest services and funding for non-admitted teaching, training and research.
3. As a new indicator for 2017–18, no prior year comparative data is available.

Data sources: Health Service financial system, Non-admitted Patient Activity and Wait List Data Collection.

OUTCOME 1 – EFFICIENCY KPI – SERVICE 4: MENTAL HEALTH SERVICES

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 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 healthcare, and enable the reallocation of funds to appropriate alternative non-admitted care.

Target

The 2017–18 target is $4,543 per bed-day. Performance is demonstrated by a result that is equal to or below the target.

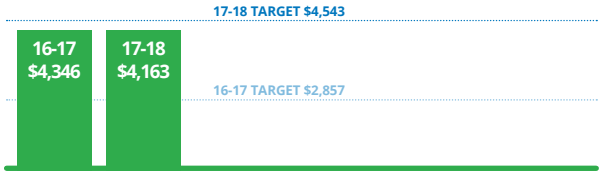
Result

In 2017–18, the average cost per bed-day in specialised mental health inpatient units was $4,163, which is below the target and less than the average cost in 2016-17. Improved cost efficiency is the result of an increase in the average number of inpatient beds operated; from 14 in 2016–17 to 19 in 2017–18. Despite the challenges the delayed opening of Perth Children's Hospital presented, the Child and Adolescent Mental Health Service Inpatient Unit undertook significant reform during 2017–18, including changes to its workforce profile, which further improved efficiency.

Figure 14

Average cost per bed-day in specialised mental health inpatient units, 2016–17 to 2017–18

AVERAGE COST PER BED-DAY



TARGET **$4,543** ACTUAL **$4,163** ✔

2016–17	2017–18	Target
$4,346	$4,163	$4,543

Notes

1. The original target of $4,287 published in the 2017 -18 State Budget has been revised to include funding for mental health inpatient teaching, training and research

Data sources: Health Service financial system, BedState.

OUTCOME 1 – EFFICIENCY KPI – SERVICE 4: MENTAL HEALTH SERVICES

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

Rationale

Efficient functioning of public community mental health services is critical to ensure that finite funds are used effectively to deliver maximum community benefit. Services provided by public community-based mental health services include assessment, treatment and continuing care.

The majority of services provided by public community-based mental health services are for people in the acute phase of a mental illness who are receiving post-acute care. This indicator gives a measure of the cost effectiveness of treatment for public psychiatric patients under public community mental healthcare (non-admitted and ambulatory patients).

Target

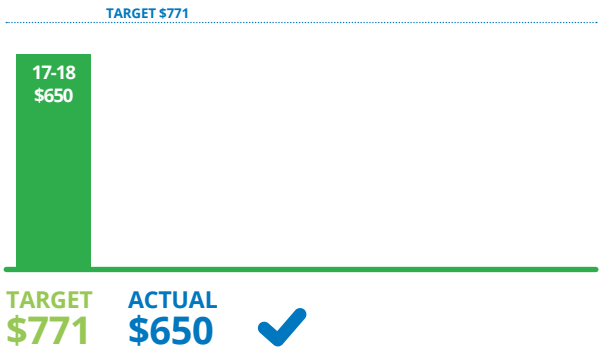
The 2017–18 target is $771 per treatment day. Performance is demonstrated by a result that is equal to or below the target.

Result

In 2017–18, the average cost per treatment day of non-admitted care provided by public clinical mental health services was $650, which is below the target. Demand for community based mental health services increased during 2017–18, particularly for urgent local response services. Despite this increase in demand, a number of reform initiatives undertaken by the Child and Adolescent Mental Health Service led to more treatment days being provided and more timely access to services.

Figure 15

Average cost per treatment day of non-admitted care provided by public clinical mental health services, 2017–18



2017–18	Target (%)
$650	$771

Notes

Notes:

1. The original target of $428 has been revised to correct an error made during the 2017–18 State Budget development process.
2. As a new indicator for 2017–18, no prior year comparative data is available.

Data sources: Health Service financial system, Mental Health Information Data Collection.

OUTCOME 2 – EFFICIENCY KPI – SERVICE 6: PUBLIC AND COMMUNITY HEALTH SERVICES

Average cost per person of delivering population health programs by population health units

Rationale

Population health units support individuals, families and communities to increase control over and improve their health.

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 2017–2021. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

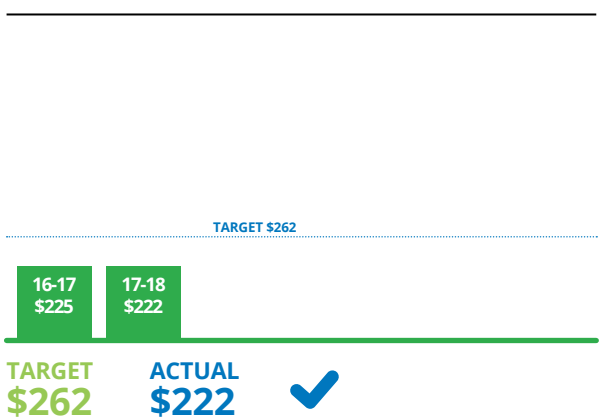
The 2017–18 target is $262 per person. Performance is demonstrated by a result that is equal to or below the target.

Result

In 2017-18, the average cost per person of delivering population health programs was $222, which is comparable to the average cost per person in 2016–17 and below the target of $262 (Figure 16). The variance to target is attributable to an overestimate of expenditure used when developing the 2017-18 WA health system budget, and a higher population being served than anticipated.

Figure 16

Average cost per person of delivering population health programs by population health units, 2016–17 to 2017–18



2016–17	2017–18	Target
$225	$222	$262

Notes

1. The 2016 and 2017 calendar year population estimates have been used to represent the 2016–17 and 2017–18 reporting years respectively.
2. Previously reported as *Average cost per capita of Population Health Units.*

Data sources: Health Service financial system, Australian Bureau of Statistics.

Other Financial Disclosures

Board and Committee Remuneration

Annual remuneration for each board or committee is listed in Tables 5 and 6.

Table 5: Child and Adolescent Health Service Board, 2017–18

POSITION	NAME	TYPE OF REMUNERATION	2017–18 PERIOD OF MEMBERSHIP	2017–18 TOTAL REMUNERATION
Chair	Ms Debbie Karasinski	Board member allowance	12 months	$72,356
Deputy Chair	Professor Geoffrey Dobb	Ineligible	12 months	$0
Member	Mr Brendan Ashdown	Board member allowance	12 months	$43,413
Member	Ms Kathleen Bozanic	Board member allowance	12 months	$43,413
Member	Ms Anne Donaldson	Board member allowance	12 months	$43,413
Member	Dr Alexius Julian	Board member allowance	12 months	$43,413
Member	Dr Daniel McAullay	Board member allowance	12 months	$43,413
Member	Mr Daniel Morrison	Board member allowance	11 months	$40,931
Member	Mr Peter Mott	Board member allowance	12 months	$43,413
Member	Mr Andrew Thompson	Board member allowance	1 months	$4,355
Member	Professor Di Twigg	Board member allowance	11 months	$40,909
			Total	**$419,029**

Table 6: Eating Disorders Program Consumer Advisory Group, 2017–18

POSITION	NAME	TYPE OF REMUNERATION	2017–18 PERIOD OF MEMBERSHIP	2017–18 TOTAL REMUNERATION
Member	Melanie Coleman	Per meeting	12 months	$0
Member	Linelle Fields	Per meeting	12 months	$180
Member	Ashleigh Hardcastle	Per meeting	12 months	$420
Member	Teagan Martin	Per meeting	12 months	$0
Member	Asha McAllister	Per meeting	12 months	$360
Member	Emily Wheeler	Per meeting	12 months	$180
			Total	**$1,140**

Notes to Tables 5 and 6:

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 2017–18 financial year.

Pricing policy

The National Health Reform Agreement sets the policy framework for the charging of public hospital fees and charges. Under the Agreement, an eligible person who receives public hospital services as a public patient in a public hospital or a publicly contracted bed in a private hospital is treated 'free of charge'. This arrangement is consistent with the Medicare principles which are embedded in the Health Services Act 2016 (WA).

The majority of hospital fees and charges for public hospitals are set under Schedule 1 of the Health Services (Fees and Charges) Order 2016 and are reviewed annually. The following informs WA public hospital patients' fees and charges for:

Compensable or ineligible patients

Patients who are either 'private' or 'compensable' and Medicare ineligible (overseas residents) may be charged an amount for public hospital services as determined by the State. The setting of compensable and ineligible hospital accommodation fees is set close to, or at, full cost recovery.

Private patients (Medicare eligible Australian residents)

The Commonwealth Department of Health regulates the Minimum Benefit payable by health funds to privately insured patients for private shared ward and same day accommodation. The Commonwealth also regulates the Nursing Home Type Patient 'contribution' based on March and September pension increases. To achieve consistency with the *Commonwealth Private Health Insurance Act 2007*, the State sets these fees at a level equivalent to the Commonwealth Minimum Benefit.

Veterans

Hospital charges of eligible war service veterans are determined under a separate Commonwealth-State agreement with the Department of Veterans' Affairs. Under this agreement, the Department of Health does not charge medical treatment to eligible war service veteran patients, instead medical charges are fully recouped from the Department of Veterans' Affairs.

Other fees and charges

The Pharmaceutical Benefits Scheme regulates and sets the price of pharmaceuticals supplied to outpatients, patients on discharge and for day admitted chemotherapy patients. Inpatient medications are supplied free of charge.

There are other categories of fees specified under the terms of Health Services (Fees and Charges) Order 2016, which include the supply of surgically implanted prostheses, orthoses, Magnetic Resonance Imaging services and pathology services. The pricing for these hospital services is determined according to their cost of service.

Capital works

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 7 for financial details of the Child and Adolescent Health (CAHS) capital works program.

Major capital projects completed during the year include the construction of the Perth Children's Hospital in Nedlands. Management and control of the facility transferred from the Health Ministerial Body to CAHS on the date of the first patient arrival on 14 May 2018.

Table 7: Major asset investment program works completed in 2017–18

CAPITAL WORKS PROGRAMS COMPLETED	2017–18 ($'000)
Perth Children's Hospital	
Building and site infrastructure	911,811
Plant, equipment and vehicles	82,631
Medical equipment	85,536
Furniture and fittings	11,046
Artworks	4,922
Computer equipment	81,847
Software	52,400
Total	**1,230,193**
Other programs	
Minor building works	204
Plant and equipment	71
Medical equipment replacement	4,054
Total	**4,329**

Employment profile

The Child and Adolescent Health Service (CAHS) is required to report a summary of the number of employees, by category, compared with the preceding financial year. Table 8 shows the number of full-time equivalent employees for 2016–17 and 2017–18.

Table 8: Total full-time employees of CAHS, by category

CATEGORY	DEFINITION	2016–17	2017–18
Administration & clerical	Includes all clerical-based occupations together with patient-facing (ward) clerical support staff.	721.8	731.1
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	31.4
Agency nursing	Includes workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest.	5.4	5.2
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care.	5.7	12.5
Dental nursing	Includes dental nurses and dental clinic assistants.	5.8	6.9
Hotel services	Includes catering, cleaning, stores/supply laundry and transport occupations.	149.0	162.4
Medical salaried	Includes all salary-based medical occupations including interns, registrars and specialist medical practitioners.	324.5	324.9
Medical sessional	Includes specialist medical practitioners that are engaged on a sessional basis.	65.6	68.7
Medical support	Includes all Allied Health and scientific/technical related occupations.	608.6	618.1
Nursing	Includes all nursing occupations. Does not include agency nurses.	1,158.3	1,217.3
Site services	Includes engineering, garden and security-based occupations.	1.6	1.1
Other occupations	Includes, but is not limited to, Aboriginal and ethnic health employees.	16.2	18.9
	Total	**3,108.9**	**3,198.5**

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, Workers Compensation.
3. FTE figures provided are based on Actual (Paid) month to date FTE.

Workforce development

CAHS is committed to the 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
- occupational health and safety
- infection control.

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:

1) Corporate induction program and an orientation to work areas for new staff. Topics covered include:
    a) infection control
    b) cultural awareness
    c) human resources
    d) occupational safety and health
    e) emergency preparedness
    f) child protection
2) General management skills training programs, including:
    a) assertive communication
    b) bullying in the workplace (Code of Conduct)
    c) conflict resolution
    d) recruitment selection and appointment
    e) performance development, namely:
        i. coaching for improved performance
        ii. managing substandard performance

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.

Further to this, compliance with and reporting for the Speaking Up for Safety program is monitored by Workforce Education.

Workforce continues to provide support to:

- paediatric nursing education
- ward-based education
- community health areas as and when requested, covering topics areas such as management development, and recruiting and selection policies.

Perth Children's Hospital education and training

The CAHS Learning Management System (iLearn), implemented in April 2016, continues to 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.

Industrial relations

WA Health Industrial Relations Services were devolved from the Department of Health to CAHS in the 2016–17 financial year. The Industrial

Relations function has since been fully integrated as an integral aspect of Workforce Services, working closely with colleagues from the Human Resources function.

During 2017–18, 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. Additionally, there has been the commissioning of Perth Children's Hospital, the decommissioning of Princess Margaret Hospital and the physical relocation of all staff and services from the Subiaco campus to the QEII Medical Centre campus in Nedlands. While the organisational change engagement processes started in 2015–16, it has continued throughout 2016–17 and 2017–18, with further re-alignments of medical and nursing streams within the hospital taking place in 2018-19.

Due to the magnitude of restructuring and reconfigurations over the last two financial years, including the Health Service Executive team, CAHS has been consulting formally with unions to a far greater extent than previous years. This has resulted in a more positive and collaborative working relationship with the unions, creating a positive approach to resolving workplace matters in dispute.

Significant effort was made in 2017–18 to create a more positive workplace culture in terms of consulting on the specific employment needs of clinical employees, with regular meetings scheduled for the newly established Clinical Advisory Group.

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 across the health service.

There were no issues directly involving CAHS that proceeded to arbitration before industrial courts or tribunals, with all such formal disputes lodged by the unions or employees being resolved through conciliation processes. Generally, there has been a noticeable increase in unions utilising internal dispute resolution processes in preference to lodging formal disputes with industrial courts or tribunals.

Like the previous financial year, the number of human resource issues relating to individual employees during 2017–18, that required ongoing management, continued to surge. Human Resources and Industrial Relations staff worked collaboratively to effectively manage these individual employee matters in a timely manner, while concurrently managing matters arising from organisational change and the transition to the new hospital site.

Workers' compensation

The WA Workers' Compensation system was established by the State Government and exists under the statute of the *Workers' Compensation and 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 2017–18, a total of 73 workers' compensation claims were made (see Table 9).

Governance disclosures

Unauthorised use of credit cards

The WA health system 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 system credit cards are provided to employees who require one as part of their role. Purchasing cards are not for personal use by the cardholder. Should a cardholder use a purchasing 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 purchasing cards, three CAHS cardholders mistakenly used their card for personal purposes. The transactions were identified by the cardholders and repayment initiated by them, with the full amount of $209.00 being refunded during 2017–18 (see Table 10).

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 2018, 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. In 2017 -18, no Child and Adolescent Health Service senior officer declared a pecuniary interest.

Table 9: Number of workers' compensation claims in 2017–18

EMPLOYEE CATEGORY	NUMBER
Nursing Services/Dental Care Assistants	31
Administration and Clerical	13
Medical Support	9
Hotel Services	20
Maintenance	0
Medical (salaried)	0
Total	**73**

Note

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

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

Table 10: Credit card personal use expenditure in 2017–18

CREDIT CARD PERSONAL USE EXPENDITURE	2017–18
Aggregate amount of personal use expenditure for the reporting period	$209.00
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)	$209.00
Aggregate amount of personal use expenditure outstanding at the end of the reporting period	$0

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 2017–18.

Advertising

In accordance with section 175Z of the Electoral Act 1907, CAHS incurred the following advertising expenditure in 2017–18 (see Table 11).

Table 11: Summary of advertising for 2017–18

SUMMARY OF ADVERTISING	AMOUNT ($)
Advertising agencies	0
Market research organisations	0
Polling organisations	0
Direct mail organisations	0
Media advertising organisations	980.64
Total advertising expenditure	**980.64**

Adcorp was the only organisation to provide services in 2017–18.

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. The CAHS Disability Access and Inclusion Plan (2018–2022) has been endorsed and published[1]. The CAHS Disability Access and Inclusion Working Group are responsible for development, implementation and evaluation and report to the CAHS Disability Advisory Committee.

Access to service and events

A range of equipment is provided by CAHS to assist people with disabilities to access services. 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. All relevant policies consider the access requirements of people with disabilities. Within PCH (and previously at Princess Margaret Hospital), 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.

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 Department of Communities Disability Services and the WA Health Network Disability Advisory Group. In December 2017, CAHS participated in the International Day of Disability, with presentations and displays to promote awareness and inclusion.

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

[1]http://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/CAHS/CAHS%20_DAIP_2018-2022_Final_Mar2018.pdf

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 Advisory Committee to ensure that any changes to policy or updates to services have consumer input. These committees have provided ongoing feedback to inform the Perth Children's Hospital project design and policy development, including access to parking, the location of adolescent change tables, and improving access to patient entertainment systems.

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. CAHS is working with disability employment providers to actively recruit and employ people with disabilities, and ensure that workplaces are tailored to employee needs. People with disabilities are employed in a variety of roles at CAHS.

Compliance with public sector standards

During 2017–18, CAHS engaged in a number of human resource activities that resulted in 12 Employment Standard Breach Claims being lodged in accordance with the Public Sector Standards in Human Resource Management Framework. This increase, up from three in the previous financial year, is attributed to CAHS' preparation and move to PCH and resulting increase in recruitment and selection activity. Seven claims were resolved internally within CAHS and four claims were referred to the Public Sector Commission for review and subsequently dismissed or declined. One employment standard breach claim remains outstanding and will be progressed in the next financial year.

CAHS has appropriate systems and processes in place to inform and educate employees on their rights in accordance with the Public Sector Standards in Human Resource Management. These include a database to record and monitor human resource management activities including breach claims as well as the following policies and guidelines which are available electronically via the CAHS and WA Health intranet sites:

- WA Health Employee Grievance Resolution Policy
- CAHS Grievance Guideline
- WA Health Recruitment and Appointment Policy and Procedure
- WA Health Discipline Policy and Explanatory Notes
- CAHS Performance Development and Review Policy & Resource Tools

Where relevant, written communication to employees provides information about the Public Sector Standards and generally about processes to achieve resolution, including breach claim rights. Additionally, the Human Resources (HR) Manager and HR Consultants are available to provide information and resources to support individual workplace concerns and Selection Panel Chairs and Line Managers on HR related issues, including recruitment and selection, performance development, grievance, potential breach of discipline, redeployment and termination.

The CAHS Learning and Development framework further supports employees in this area by providing a number of training packages for staff and managers on a range of HR issues. As part of the transition to Perth Children's Hospital, all new and existing staff have completed a number of e-learning packages, including induction and compliance with the WA Health Employment Framework and local CAHS Policy and Process.

Record keeping plans

The *State Records Act 2000* (the Act) was established to mandate the standardisation of statutory record keeping practices for every State Government agency. Government agency practice is subject of the provision of the Act, the standards and policies. Government agencies are also subject to scrutiny by the State Records Commission (SRC).

Section 19 of the Act states that every government organisation must have a Record Keeping Plan (RKP) that has been approved by the State Records Commission. The CAHS RKP was approved by the SRC on 26 November 2015. In accordance with section 28 of the Act, the CAHS RKP is to be reviewed within five years and a report submitted to the State Records Office (SRO) by November 2020. An interim review has been performed and a report on CAHS progress towards completing the documented

commitments was presented to the SRO in December 2017. Of significance was the recruitment of a permanent Records Manager and endorsement of a Corporate Records Management Policy.

A review of the CAHS information management framework established to support staff to capture and manage corporate records is being performed and content updated to reflect the Electronic Document and Records Management System (EDRMS) upgrade to HP RM8.3 and significant organisational changes.

The CAHS induction and orientation program provides new, casual and agency employees with relevant information to their employment within six weeks of commencement. The program includes reference to the WA Health Code of Conduct (which includes best practice records management) and workplace specific work practices and procedures.

CAHS staff are required to complete mandatory Department of Health Records Awareness Training and CAHS EDRMS training upon allocation of a licence. The CAHS Records and Compliance intranet site (currently under review) contains training resources, quick help guides, policies, procedures, work instructions and supporting information to enable staff to comply with the Act. Over 100 staff have attended regularly scheduled classroom based training delivered by the Records and Compliance team. Staff attending training completes an evaluation form which identifies the effectiveness of the training delivery and content and allows the material to be refined.

CAHS is committed to the ongoing deployment of the EDRMS throughout administrative functions and has procured additional licences to meet this need. CAHS currently has 720 licences, of which 651 are active. A system health check performed in April 2017 made 113 recommendations, of which 105 were accepted and resources directed to implement those recommendations. Of the recommendations, 76 have been implemented, 20 have transitioned to business as usual and a further nine relate to infrastructure and require additional planning and funding.

During 2017–18, over 230,000 records were captured into the CAHS EDRMS.

Substantive equality

Child and Adolescent Community Health

The Aboriginal Health Team (AHT) delivers culturally acceptable primary prevention community child health services to Aboriginal children and families across the Perth metropolitan area. Services are provided by a multidisciplinary team consisting of child health nurses and Aboriginal Health Workers. When an Aboriginal child is born in the metropolitan area, the AHT is notified via a birth notification from midwifery services. The first universal visit is conducted by the child health nurse in mainstream

child health services. If the family requests the service of AHT or if the mainstream child health nurse is unable to contact the family after reasonable attempts, the child is referred to the AHT. Depending on family need, Aboriginal families may also be offered the Enhanced Aboriginal Child Health Schedule (EACHS).

EACHS provides a more comprehensive and intensive and culturally acceptable primary health care service designed specifically to address the needs of Aboriginal families with additional health needs. The program is delivered predominantly as a home visiting model.

The Refugee Health Team (RHT) helps refugee families transition to access local health services across the Perth metropolitan area and supports families with young children to access community child health services. All refugee families in the metropolitan area are referred to the RHT by the Humanitarian Health Service. 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 treatment and helping families to access mainstream mental health services
- Warwick Community CAMHS has a specialist Cross Cultural Mental Health Clinician who provides mental health assessment and 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 and Perth Children's Hospital

PCH (and previously 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 Kulunga Moort Mia (Aboriginal Family Lounge) located on the ground floor of PCH provides a culturally sensitive environment for Aboriginal families that aims to enhance their healthcare experience and promote engagement with mainstream health services.

The Refugee Health Service provides holistic multidisciplinary health care to refugee and asylum-seeker children, adolescents and their families within Western Australia. Consultative review of refugee and asylum children during and after an inpatient episode of care is also provided.

Occupational safety, health and injury

CAHS is committed to the provision of a safe work environment for all employees, volunteers, 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 staff and volunteers 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 with the line manager level. It is the manager's responsibility to consult and manage OSH issues and involve OSH representatives when appropriate. OSH consultants are available 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 undertaken 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 2017–18 is summarised in Table 12.

Table 12: Occupational safety, health and injury performance for 2017–18

MEASURE	2017–18	TARGET	COMMENT
Fatalities (number of deaths)	0	0	Target achieved
Lost time injury/diseases (LTI/D) incidence rate (per 100)	2.3%	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)	40.4%	0 or 10% improvement on the previous three years	See Note
Percentage of injured workers returned to work within 13 weeks	77%	No target	
Percentage of injured workers returned to work within 26 weeks	81%	≥80%	Target achieved
Percentage of managers trained in occupational safety, health and injury management responsibilities	72%	≥80%	Target not 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.

Annual estimates for 2018–19

The CAHS annual operational budget estimates for the following financial year are reported to the Minister for Health under Section 40 of the Financial Management Act 2006 and Treasurer's Instruction 953. The annual estimates for 2018–19, as approved by the Minister for Health, are:

PART A - STATEMENT OF COMPREHENSIVE INCOME	2018-2019 Estimates $'000
COST OF SERVICES	
Expenses	
Employment Benefits	443,227
Visiting medical practitioners expense	2,495
Contract for Services	1,512
Patient Support costs	58,340
Finance Costs	38
Depreciation and Amortisation	64,844
Repairs, Maintenance and Consumable Equipment	23,660
Other Supplies and Services	35,647
Other Expenses	18,220
Total Cost of Services	**647,983**
INCOME	
Revenue	
Patient Charges	15,369
Commonwealth Grants and Contributions	123,783
Other Grants and Contributions	62,077
Donation Revenue	241
Other Revenue	20,874
Total Revenue	**222,344**
NET COST OF SERVICE	**425,639**

PART A - STATEMENT OF COMPREHENSIVE INCOME

	2018-2019 Estimates $'000
INCOME FROM STATE GOVERNMENT	
Service Appropriations	389,939
Services Received Free of Charge	35,701
Total Income from State Government	**425,639**
SURPLUS/(DEFICIT) FOR THE PERIOD	**0**

PART B - STATEMENT OF FINANCIAL POSITION

	2018-2019 Estimates $'000
ASSETS	
Current Assets	
Cash and Cash Equivalents	39,675
Restricted Cash and Cash Equivalents	17,700
Receivables	8,291
Inventories	2,385
Total Current Assets	**68,051**
Non-Current Assets	
Receivables	265,469
Property Plant and Equipment	1,212,654
Other Non-Current Assets	3,308
Total Non-current assets	**1,481,431**
Total Assets	**1,549,482**

PART B - STATEMENT OF FINANCIAL POSITION

	2018-2019 Estimates $'000
LIABILITIES	
Current Liabilities	
Payables	33,886
Provisions	82,513
Other Current Liabilities	806
Total Current Liabilities	**117,205**
Non-Current Liabilities	
Borrowings	739
Provisions	20,992
Total Non-Current Liabilities	**21,731**
Total Liabilities	**138,936**
NET ASSETS	
EQUITY	
Contributed Equity	10,580
Reserves	1,381,639
Accumulated Surplus / (Deficit)	18,328
TOTAL EQUITY	**1,410,546**

PART C - STATEMENT OF CASH FLOWS

	2018-2019 Estimates $'000
CASHFLOWS FROM STATE GOVERNMENT	
Service Appropriations	325,095
Capital Appropriations	6,914
Total Cost of Services	**332,009**
CASHFLOWS FROM OPERATING ACTIVITIES	
Payments	
Employee Benefits	-443,649
Supplies and Services	-103,133
Receipts	
Receipts from Customers	14,524
Commonwealth Grants and Contributions	123,783
Other Grants and Contributions	62,077
Donations Received	241
Other Receipts	20,874
Net cash used in operating activities	**-325,284**
CASH FLOWS FROM INVESTING ACTIVITIES	
Payments	
Purchase of Non-Current Assets	-6,914
Receipts	
Proceeds from Sale of Non-Current Assets	-
Net cash used in investing activities	**-6,914**

PART C - STATEMENT OF CASH FLOWS

	2018-2019 Estimates $'000
Net increase / (decrease) in cash and cash equivalents	-189
Cash and Cash Equivalents at the Beginning of the Period	57,564
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	**57,375**


Perth Children's Hospital
Main Entrance
HAZCHEM

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

Child and Adolescent Health Service

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