GOVERNMENT OF WESTERN AUSTRALIA

Child and Adolescent Health Service

Compassion
Accountability
Excellence
Equity
Collaboration
Respect

Child and Adolescent Health Service

2018–19 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. We acknowledge the wisdom of Aboriginal Elders both past and present and pay 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.

Peter Farmer Snr
Chirriger Nanap (Blue Wren Braking), 2017
Acrylic and Gold Leaf on Canvas
120 x 106cm (detail)

Statement of Compliance

for the year ended 30 June 2019

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 2019.

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
23 August 2019

Prof Geoffrey Dobb
Deputy Chair of the Board
Child and Adolescent Health Service
23 August 2019

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Perth Children's Hospital

Overview of Agency

Locations and contact information

Child and Adolescent Health Service

Street address
Level 5, Perth Children's Hospital
15 Hospital Avenue
NEDLANDS WA 6009

Postal address
Locked Bag 2010 Nedlands WA 6909

Phone
(08) 6456 2222

Email
CAHSExecutiveOfficeofCE@health.wa.gov.au

Web
health.wa.gov.au/cahs

Perth Children's Hospital

Street address
15 Hospital Avenue
NEDLANDS WA 6009

Postal address
GPO Box D184, PERTH WA 6840

Phone
(08) 6456 2222

Email
perthchildrenshospital.enquires@health.wa.gov.au

Web
pch.health.wa.gov.au

Community Health

Street address
Level 2, International House
26 St Georges Terrace
PERTH WA 6000

Postal address
GPO Box S1296, PERTH WA 6845

Phone
(08) 9323 6666

Fax
(08) 9323 6699

Email
LeadershipCorrespondence.CommunityHealth@health.wa.gov.au

Web
health.wa.gov.au/cach

Child and Adolescent Mental Health Services

Street and postal address
Level 2, 52-54 Monash Avenue
NEDLANDS WA 6009

Phone
(08) 6389 5800

Email
camhs.correspondence@health.wa.gov.au

Web
health.wa.gov.au/camhs

CAHS Board Chair Foreword

The 2018–19 year was transformational for the Child and Adolescent Health Service (CAHS) and the CAHS Board.

The Board welcomed a new Chief Executive, Dr Aresh Anwar and is pleased with the way Dr Anwar has embraced the Strategic Plan and the organisation's values, his commitment to 'one CAHS', and his enthusiasm for the challenges of running a tertiary paediatric hospital and state-wide paediatric health services.

The Board endorsed a Stakeholder Engagement Strategy to hear the views of the people critical to the provision of excellent health care for Western Australia's children and young people. Fundamental amongst these stakeholders are the staff working across CAHS. To this end, the Board has initiated a 'Board Walk' of regular meetings between the Board Chair, the Chief Executive, accompanying Board members, and groups of CAHS staff. Through this process the Board has become aware of the efforts of staff members to work effectively in the new environment of Perth Children's Hospital (PCH). We have also seen the difficulties experienced by Community Health and Child and Adolescent Mental Health Services in providing services in many of our ageing community facilities. The Board is deeply appreciative of the exceptional work of all staff, and the Board is hopeful that the Midland Hub will demonstrate a model of service delivery that addresses some of these issues.

The Engagement Strategy also calls for the Board to partner closely with the patients and families who use CAHS services. The first matter at every Board meeting is a focus on a patient's or their family's experience and the learnings from this. The Board is also exploring ways to engage with the community and has met with the Commissioner for Children and Young people with a view to partnering with the Commission in the new year.

The Board welcomed the first group of CAHS staff to be appointed to the Clinical Advisory Group (CAG) and to their first year of operation. CAG was developed as a consultative group to the Board, acting as a source of expertise, advice, and evidence-based leadership and opinion. The Board is particularly interested in CAG providing advice on matters including staff and community engagement, models of care, research, training and education. The Board has valued the increased involvement and advice from the CAHS workforce through CAG and thanks all of its members particularly the Chair, Dr Paul Bumbak and Deputy Chair Ms Sheena Robertson for their participation.

The Board has had a particular focus on the health of Aboriginal children during the year. It approved the CAHS Aboriginal Health and Wellbeing Action Plan and has asked the Director of Aboriginal Health to report six-monthly on the implementation of the Action Plan. The Board also dedicated its February meeting to listening to experts in Aboriginal Child Health and to CAHS programs supporting Aboriginal children, their families and their communities.

The Board's three Standing Committees undertake much of the work of the Board and have been joined

"In 2019, a People, Capability and Culture Committee was established to focus on all aspects of workforce current and future, with the aim of ensuring CAHS' delivery of its strategic objectives."

this year by a new Committee to oversight governance matters pertaining to our most precious resource – CAHS workforce.

People, capability and culture

To achieve our vision of healthy kids, healthy communities, the Board recognises the importance of our staff in delivering healthcare that is highly valued by the community we serve. In 2019, a People, Capability and Culture Committee was established to focus on all aspects of workforce current and future, with the aim of ensuring CAHS' delivery of its strategic objectives, specifically: consistently high quality and safe patient care; services shaped around patients' needs; a skilled, competent, and motivated workforce; the provision of a positive workplace for staff; and a sustainable workforce. The Board notes the results of the Minister's Survey, and the actions arising from those results will be monitored by the People, Capability and Culture Committee.

Safety and quality

CAHS continues to provide safe and high quality health services when benchmarked against other tertiary paediatric health services in Australia and New Zealand, with leading performance against emergency department targets. CAHS also achieved three-year accreditation for paediatric training by the Australasian College of Physicians. The 'Speaking Up for Safety' program was introduced encouraging all members of staff to intervene if they observe anything that might be a risk to patient safety and borrows from aircraft cockpit safety procedures. Board initiatives have included more comprehensive reporting of information relating to the safety and quality of our health services using 'dashboard' formats to show improvements over time, and agreement to the principle of making safety and quality information publicly available.

Finance

The Board has maintained its focus on driving a sustainable health service, particularly given the transition to PCH and the additional costs this has brought. Increased governance and accountability has been achieved through monitoring of financial results and key performance indicators, risk-focused financial internal audits and an active focus on strategic risk management. Again this year, CAHS has met its targeted net cost of service and generated a small surplus.

Audit and risk

Audit and risk have remained a significant focus for the Board, providing the opportunity for continuous improvement across CAHS. The Board endorsed the risk appetite and tolerance statement for the health service and twenty-four risk workshops were conducted across CAHS including a strategic workshop with the Board and Executive. The annual internal audit plan was approved by the Board along with an internal audit charter and policy, and six internal audits were commissioned. The Board has continued to monitor the integrity and ethics program across CAHS through quarterly reporting.

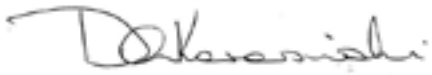
With the move to PCH and with new work underway to improve connections within CAHS, the Board found it an appropriate time to close two of its committees which had been formed in 2017 to oversee particular transitions in the organisation.

Firstly, the Board closed its Review Oversight Committee which had overseen the successful implementation of the recommendations from the 2017 review of staff engagement and morale at Princess Margaret Hospital. The Board was confident that the activities necessary to promote a values-based organisation would continue through the implementation of the Culture Action Plan and the work of the Shape our Future Steering Committee. Both of these are reported regularly to the Board.

Secondly, the Board closed its PCH Governance Transition Working Group. The Group ensured that the move to the new hospital was as risk free as possible, reviewing all governance documents and activities as they arose, with identified risks addressed by appropriate mitigations, and reporting to the Board accordingly.

An Annual Report provides an opportunity to review not only the activities of the Board during the year but also the manner in which it undertakes its work. Since the Board's inception it has commissioned two formal evaluations reviewing its functioning in a number of process, structure and governance areas. These evaluations have showed steady improvement since the Board's inception in 2017, further enhanced with corporate governance training this year aimed at functioning as a high performing Board.

The Board looks forward to working with the children, adolescents and families who use our services, CAHS staff, and the community in the coming year as we expand on our achievements, and to meet our strategic objectives for all children and young people in Western Australia.



Ms Deborah Karasinski
Chair
CAHS Board

“The Board was confident that the activities necessary to promote a values-based organisation would continue through the implementation of the Culture Action Plan and the work of the Shape our Future Steering Committee.”

Message from the Chief Executive

The end of the financial year provides an occasion to reflect on the achievements made over the past 12 months and identify the challenges that lie ahead.

For me, it is also an important opportunity to acknowledge the immense contribution made by our staff and volunteers, and the dedication to our vision and values that is demonstrated on a daily basis by staff and volunteers, during what continues to be a period of significant change.

Celebrating the first birthday of Perth Children's Hospital (PCH) was an extremely proud experience for me. In our first year, we have cared for 67,592 patients in our emergency department, 29,773 inpatients, and 227,337 outpatient appointments were attended. It's been an incredibly busy first year and I acknowledge the inaugural PCH staff, who have balanced this workload with adapting to a brand new hospital environment.

The final report of the Sustainable Health Review (SHR) has provided CAHS with an exciting vision of the future, with opportunities which include the funding to establish a SHR implementation support unit and four key projects including a 'one-stop-shop' for children, young people and their families where they can access child health, development and mental health services, as well as other government agencies such as education and community services. With many CAHS community facilities in need of upgrade, this is an exciting first step towards an exciting future for our patients and families who use our community health services, as well as our community health staff.

I am delighted that 98 Living our Values events were held across CAHS this financial year to celebrate our values of compassion, collaboration, respect, equity, accountability and excellence. This has provided staff across the organisation the opportunity to come together and reflect on what it means to demonstrate these values, in the context of our own workplace and with those with whom we work each day.

I would like to thank staff for embracing the Speaking up for Safety program, with nearly 80 per cent of staff having completed the training by May. Now that the second pillar of Speaking Up for Safety has launched, Promoting Professional Accountability , I encourage all staff to embrace this exciting opportunity to consolidate their Speaking up for Safety training and learn more about how every person within CAHS has a vital role to play in caring for our patients and their families.

I would also like to acknowledge our volunteers, who donate their most precious of resources – their time. This incredible generosity supplements our health service with a wealth of skills and experience, and I extend my heartfelt thanks to everyone who freely gives up their time to be part of our organisation.

Work is underway on the phased transition of the Neonatal Services Directorate from the Women and Newborn Health Service to CAHS. This is an important and exciting step in the evolution of our health service. Bringing these services into CAHS will strengthen the

way we are able to provide our services and support children and families from birth, helping us to realise our vision of 'healthy kids, healthy communities', and I am excited by the opportunities that lie ahead.

In March, staff were invited to participate in the Minister for Health's survey. This survey was the first in a series of five, and will provide a benchmark for measuring the performance of health service entities over the next five years. CAHS had a response rate of 26 per cent which is 1,195 staff having their say, with some very pleasing results including an Employment Engagement Index of 66 per cent. This is an indicator of how connected an employee is with the organisation – how proud they are of CAHS, how much they want to stay working at CAHS and how they strive to make a difference at CAHS. We have also identified clear focus areas for where we need to improve. For example, 40 per cent of staff feel that different areas of this organisation do not communicate effectively with each other and 37 per cent feel it is not safe to speak up and challenge the way things are done in CAHS. There are some clear messages in the results and the CAHS Board and Health Service Executive are committed to taking action where we need to. We are committed to seeing improvements in our results and we have a clear direction from this survey. At CAHS, we are proud to collaborate with a number of non-government organisations, and I would like to extend my sincere thanks to these groups for their ongoing commitment to partnering with CAHS. In particular, I would like to acknowledge the late Stan Perron, who was a significant supporter of CAHS over many years prior to his death in November 2018. Thanks to the generosity of Mr Perron, we have been able to establish the Stan Perron Immunisation Centre at PCH. This service provides free routine vaccinations and advice to patients and families visiting the hospital. I also extend my thanks to the PCH Foundation and Telethon, who through their incredible fundraising support our patients and their families in a myriad of ways.

I feel immensely privileged to be leading this impressive CAHS team, particularly during what is an exciting time for paediatric services in Western Australia as we work to consolidate CAHS as a leader of high quality, innovative and safe health care. I continue to be impressed each day by the commitment and excellence demonstrated by our workforce, and I encourage every staff member to continue to work to our strengths and strive to demonstrate our values of compassion, collaboration, respect, equity, accountability and excellence – these are the values that make us CAHS.

Dr Aresh Anwar
Chief Executive

The Health Service Board

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

The Board meets on a monthly basis and met on 11 occasions during 2018–19. 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, the People, Capability and Culture Committee was established in December 2018. The Clinical Advisory Group, comprised of staff from across CAHS, also advises the Board on strategic issues. During 2018– 19, the Board comprised the following members:

Board Chair, Ms Debbie Karasinski AM

Ms Debbie Karasinski was appointed to the CAHS Board as its inaugural Chair in 2016. She has worked in the health and disability sectors for the past 35 years. Her career has included 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 (SCGH). Ms Karasinski has extensive Board experience, most notably as a member of the National Disability Services Board, the WA Disability Services Commission Board and the Taxi Industry Board, and is currently a member of the Board of the Perth Clinic. She was awarded the Member of the Order of Australia in 2019 for her contribution to people with disability and the Western Australian community.

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. He also has had considerable experience on the Boards of healthcare associated organisations, with an interest in organisational governance.

Board Member, Ms Kathleen Bozanic

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

Board Member, Ms Linley (Anne) Donaldson

Ms Linley (Anne) Donaldson is a former Director for the Health and Disability Service Complaints Office ; 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, Professor Di Twigg AM

Professor Di Twigg is Executive Dean of the School of Nursing and Midwifery at Edith Cowan University, and Research Consultant in the Centre for Nursing Research at SCGH, a 600-bed Magnet-designated teaching hospital. Professor Twigg has worked in the health sector for over 35 years and held several senior health executive roles, most notably as Executive Director of Nursing Services at SCGH.. She was awarded the Life Time Achievement Honour in 2017, and in 2019 was made a Member of the Order of Australia for significant service to nursing through a range of leadership, education and advisory roles.

Board Member, Ms Miriam Bowen

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

Board Member, 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 Adviser 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 Daniel Morrison

Mr Daniel Morrison has held the position of CEO 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.

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, member of the Australian Private Hospitals Association Board, member of the Royal Australasian College of Surgeons Board of Vascular Surgical Training, member of the University of Western Australia Business School Ambassadorial Council, and past President of the Australian Institute of Management WA.

Committee Meeting Attendance

July 2018 to June 2019

Name	Number of meetings	Meetings attended
Full CAHS Board Meeting		
Ms Debbie Karasinski (Chair)	11	11
Professor Geoffrey Dobb	11	11
Ms Kathleen Bozanic	11	10
Ms Anne Donaldson	11	11
Professor Di Twigg	11	11
Ms Miriam Bowen	9	8
Dr Alexius Julian	11	10
Dr Daniel McAullay	11	10
Mr Daniel Morrison	11	8
Mr Peter Mott	11	8
Finance Committee		
Ms Kathleen Bozanic (Chair)	11	11
Professor Geoffrey Dobb	11	10
Ms Anne Donaldson	11	11
Mr Peter Mott	11	8
Audit and Risk Committee		
Ms Anne Donaldson (Chair)	7	7
Ms Kathleen Bozanic	2	2
Professor Geoffrey Dobb	5	3
Dr Alexius Julian	7	3
Dr Daniel McAullay	2	2
Professor Di Twigg	7	7
Safety and Quality Committee		
Professor Geoffrey Dobb (Chair)	6	6
Ms Miriam Bowen	2	2
Ms Anne Donaldson	6	5
Dr Alexius Julian	6	4
Dr Daniel McAullay	6	4
Mr Daniel Morrison	6	1
Mr Peter Mott	6	5
People, Capability and Culture Committee		
Professor Di Twigg (Chair)	4	4
Ms Miriam Bowen	4	3
Ms Anne Donaldson	4	4
Dr Alexius Julian	4	3
Dr Daniel McAullay	4	4

Our year at a glance

501,738
children and young people eligible for service by CAHS

67,592
patients seen at PCH's Emergency Department

29,773
PCH admissions

15,071
operations performed

227,337
outpatients treated at PCH

64,612
radiological appointments

73,898
prescriptions filled PCH

6,319
young people seen by CAMHS

26 DAYS
median access time to Community CAMHS

144,487
occasions of service delivered by CAMHS

54,543
Screens for post-natal depression

75,874
presentations to a school health nurse, including

9,560
mental health presentations

26,456
School Entry Health Assessments

75,874
presentations to a school health nurse, including

42,081
attendances at child health 'drop-in' centres

1,260
children screened through the Aboriginal School Ear Health Program

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 key support 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

CAHS has continued its progress during the 2018–19 financial year towards realising its vision of *healthy kids, healthy communities*.

A number of key milestones have been achieved under the guidance of Dr Aresh Anwar, who commenced in the role of Chief Executive in August 2018.

CAHS has renewed its commitment to the organisation's values of compassion, collaboration, respect, equity, accountability and excellence. There were 98 *Living our Values* events have been held across CAHS to reignite commitment to these values.

Compassion and respect

The CAHS Culture Action Work Plan 2018 – 2020, which was finalised in September 2018, provides a framework for the next steps in steering the organisation in a new direction in organisational culture. A progress report from May 2019 outlined the headway that has been made into the more than 140 individual action items within the Work Plan. Over a number of months, the steering team heard feedback as to how we can improve our way of working together - making CAHS a great place to work and improving the way we relate to each other. This ultimately creates a positive environment for the children and families that receive our care across our range of services, including child health clinics, mental health and the hospital, where they see evidence of compassion and respect in everyday interactions with our staff.

Accountability

The Speaking up for Safety program has continued throughout the year, with nearly 80 per cent of staff having completed the training by May 2019. Thanks to the concerted effort that has seen this goal achieved, the focus has now shifted to the second pillar of Speaking Up for Safety: Promoting Professional Accountability (PPA). Together, the Safety C.O.D.E. (checks, options, demands, elevates) and PPA are the two pillars that create a 'speaking up' culture aligned to the CAHS values.

A number of measures have been implanted to strengthen appropriate standards of conduct and integrity among staff members. A key component of this has been an increase in integrity and ethics related staff resources and communications. CAHS also undertook an internal audit on Fraud and Corruption Prevention, and more than 700 CAHS staff also responded to a survey into awareness of wrongdoing, their confidence in reporting wrongdoing, and their experiences. The staff survey highlighted that staff valued a culture where they felt listened to, protected and taken seriously when raising concerns as well as strong support for CAHS to be addressing wrongdoing in the workplace.

For the third year running, CAHS has achieved a surplus while delivering activity that is above target.

Collaboration

The Sustainable Health Review (SHR) Final Report was published in April 2019, with eight Enduring Strategies and 30 Recommendations that seek to drive a cultural

"CAHS is committed to providing an inclusive, respectful and a culturally appropriate service to improve the health outcomes for Aboriginal children, young people and their families."

and behavioural shift across the health system. There are opportunities for CAHS in the implementation of the recommendations. Most tangibly, this includes the funding to establish a SHR implementation support unit and four key projects, including a 'one-stop-shop' for children, young people and their families, where they can access child health, development and mental health services, as well as other government agencies, such as education and community services.

The development of a CAHS Digital Technology Roadmap is also supported by a focus on investment in digital healthcare within the SHR. The Roadmap focuses on improving CAHS' capability to use and manage clinical and consumer information to deliver high quality health services and patient outcomes.

Excellence

Another key work area for this financial year was the Functional Readiness Assessment. More than 120 interviews were conducted with staff across the organisation as part of this process to define the best delivery model for corporate services, to ensure equitable support to clinical teams in the delivery of safe and high quality care. The organisation is committed to confirming the team structures needed for each corporate service across CAHS by July 2019.

The Stars of CAHS quarterly staff awards recognise and celebrate employee efforts aligned with the CAHS values of compassion, collaboration, equity, respect, excellence and accountability. Patients and families as well as staff are encouraged to submit nominations for outstanding individuals or teams they have encountered. A large volume of nominations were received in 2018/19, for staff across all areas of the organisation, including both clinical and non-clinical areas, reflecting the commitment of the workforce to our core values.

As the new financial year begins, CAHS continues work to transfer the governance of neonatal services at Perth Children's Hospital from the North Metropolitan Health Service. Patients and their families have remained at the centre of decision making in this process. CAHS' goal in bringing the paediatric speciality into the tertiary paediatric health service provider is to continue to strengthen the service and support the outstanding staff and their expertise.

Equity

CAHS is committed to providing an inclusive, respectful and a culturally appropriate service to improve the health outcomes for Aboriginal children, young people and their families. A number of strategies enable CAHS to do this, including the Aboriginal Workforce Strategy 2018–2026, which will help meet the new target of 3.2 per cent Aboriginal representation by 2026. In addition, the action plan for the implementation of the WA Aboriginal Health and Wellbeing Framework 2015–2030 identifies strategies, actions and measures that best fit our priorities toward improving Aboriginal health outcomes.

Operational structure

Legislation

Enabling legislation

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

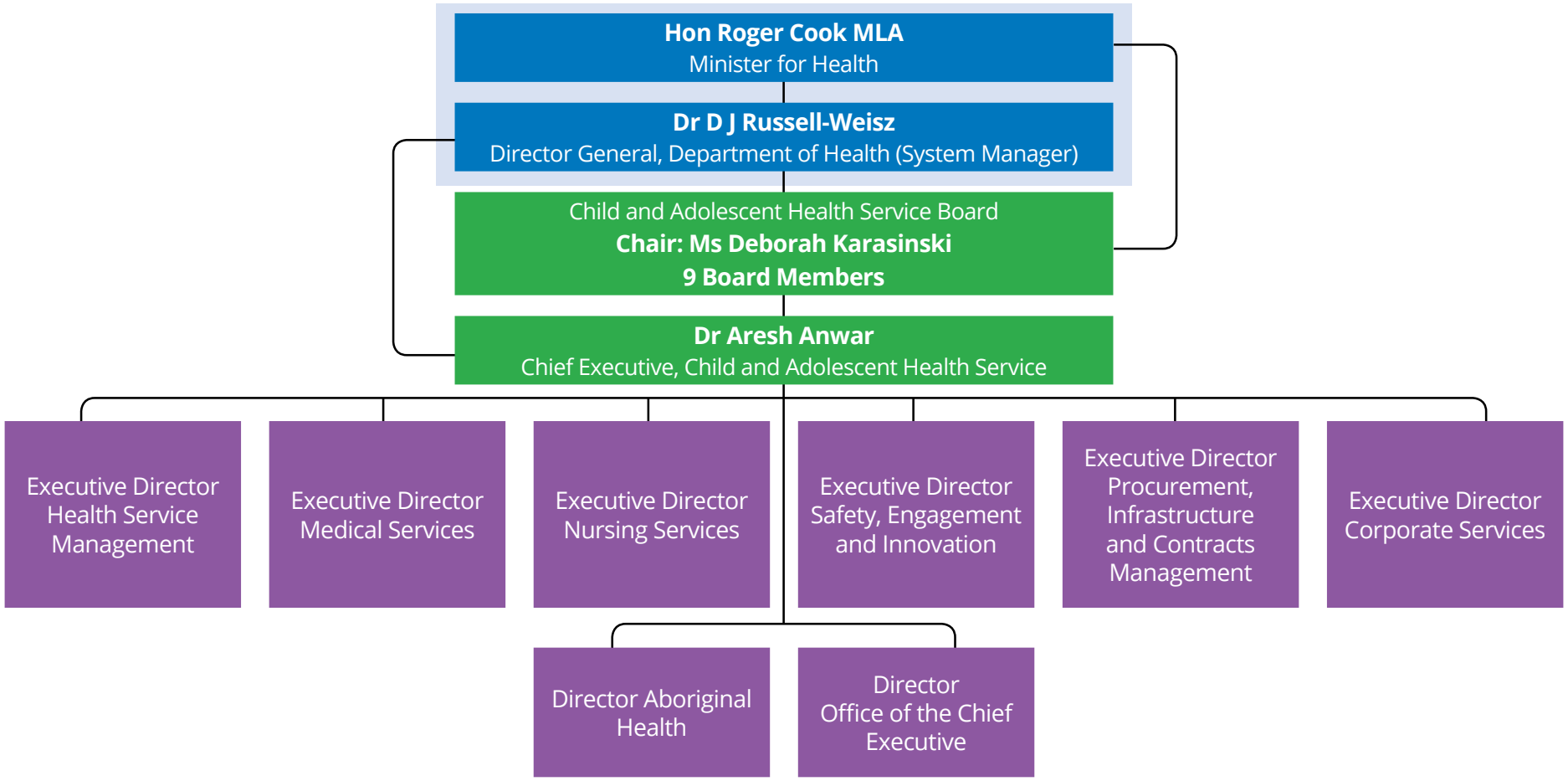
Accountable authority

The CAHS Board was the accountable authority for CAHS in 2018–19.

Responsible Minister

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

CAHS management structure 2018–19



Senior officers

Dr Aresh Anwar
Child and Adolescent Health Service
Chief Executive
2 August 2018 – 30 June 2019

Ms Katie McKenzie
Nursing Services
Executive Director
1 July 2018 – 30 June 2019

Mr Tony Loiacono
Corporate Services
Executive Director
1 July 2018 – 30 June 2019

Dr Victor Cheng
Health Service Management
Executive Director
1 July 2018 – 30 June 2019

Ms Mary Miller
Safety, Engagement and Innovation
Executive Director
1 July 2018 – 30 June 2019

Ms Leah Bonson
Aboriginal Health
Director
3 December 2018 – 20 June 2019

Dr Kavitha Vijayalakshmi
Medical Services
Acting Executive Director
1 April 2019 – 30 June 2019

Mr Danny Rogers
Procurement, Infrastructure and Contracts Management
Executive Director
8 October 2018 – 30 June 2019

Ms Kylie Mulcahy
Office of the Chief Executive
Director
1 July 2018 – 30 June 2019

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

About CAHS

CAHS provides a comprehensive service supporting the health, wellbeing and development of young Western Australians.

Our vision is *healthy kids, healthy communities*, and in striving for this vision, we endeavour 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.

CAHS is made up of:

- Perth Children's Hospital (PCH)
- Community Health
- Child and Adolescent Mental Health Services (CAMHS)

PCH is WA's only dedicated paediatric hospital and provides tertiary services for the State. The 298 bed hospital provides inpatient, ambulatory and outpatient services. PCH is also the home of WA's only paediatric trauma centre and the State's first intraoperative magnetic resonance imaging machine. In late 2018, PCH also opened the Stan Perron Immunisation Centre, which is available to all children and families attending the hospital to help them stay up to date with their scheduled immunisations.

CAMHS provides mental health services to infants, children, adolescents 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.

Community Health provides a comprehensive range of community-based early identification and intervention services, as well as health promotion, to infants, children, adolescents and families across the Perth metropolitan area; a region spanning 7250 square kilometres. A key focus of Community Health is growth and development in the early years and promoting wellbeing during childhood and adolescence. Service delivery is both universal and targeted, with services provided in a variety of settings, including homes, local community health centres, child and parent centres and schools.

At CAHS, we strive to exemplify six core values: compassion, collaboration, respect, equity, accountability and excellence. Our objectives, which we aim to deliver through the spectrum of a broad and diverse scope, clinical settings and physical locations, are to:

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

Shared responsibilities with other agencies

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

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

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

In 2018–19, CAHS partnered with over 100 NGOs through a range of contractual arrangements including:

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

Performance management framework

To comply with its legislative obligations, CAHS operates under the WA health system 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 2018–19 are aligned to the State Government goal of *strong communities: safe communities and supported families*. (see Figure 1).

The outcomes for achievement in 2018–19 by CAHS are:

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

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.

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

Activities related to Outcome 2 aim to:

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

Performance against these activities and outcomes 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 78.

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

WA STRATEGIC OUTCOME (WHOLE OF GOVERNMENT)

Strong Communities: Safe communities and supported families

CAHS VISION

Healthy kids, healthy communities

CAHS OBJECTIVES

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

Outcome 1

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

Key effectiveness indicators contributing to Outcome 1

- Unplanned hospital readmissions for patients within 28 days for selected surgical procedures
- Percentage of elective wait list patients waiting over boundary for reportable procedures
- Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days
- Percentage of admitted patients who discharged against medical advice: a) Aboriginal patients; and b) Non-Aboriginal patients
- Readmissions to acute specialised mental health inpatient services within 28 days of discharge
- Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services

Outcome 2

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

Key effectiveness indicators contributing to Outcome 2

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

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

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

Services delivered to achieve Outcome 1	KPIs measured
1. Public hospital admitted services	• Average admitted cost per weighted activity unit
2. Public hospital emergency services	• Average Emergency Department cost per weighted activity unit
3. Public hospital non-admitted services	• Average non-admitted cost per weighted activity unit
4. Mental health services	• Average cost per bed-day in specialised mental health inpatient services • Average cost per treatment day of non-admitted care provided by mental health services

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

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

Changes to Outcome Based Management Framework

The WA Health system Outcome Based Management (OBM) Framework received minor updates for 2018–19. Eight key performance indicators received revisions to their titles, and one (Survival rates for sentinel conditions) was removed on the basis it was no longer appropriate.

Performance highlights

New vaccination centre at Perth Children's Hospital

Patients attending Perth Children's Hospital (PCH) can access a new immunisation centre for important childhood vaccinations.

The new $2.7 million centre has been funded by the Stan Perron Charitable Foundation to reduce hospitalisation rates and protect against serious illness.

The Stan Perron Immunisation Centre is located on Level 1 of PCH. The centre is staffed by an immunisation clinical nurse consultant, a clinical nurse, specialist paediatricians, and administrative support, providing a comprehensive immunisation service, including family education and research. The service is available to all children and families attending the hospital – as inpatients, outpatients, in the emergency department or as visitors. Vaccinations on the Western Australian immunisation schedule can be obtained, and advice on current immunisation recommendations is also provided if requested.

Families attending the hospital can drop in to the centre and have their children vaccinated free of charge and without an appointment or referral.

The service will work with hospital clinics and services to help ensure that all children who come to PCH have easy access to scheduled immunisations, helping to reduce the gap in WA's current childhood immunisation coverage.

In WA, 93.4 per cent of five year old children are fully vaccinated[1]. Many children attending the hospital are overdue for routine vaccinations, including many with chronic medical conditions. The centre aims to ensure that these children are able to access vaccines before leaving the hospital.

[1] As of 31 March 2019. https://beta.health.gov.au/health-topics/immunisation/childhood-immunisation-coverage/immunisation-coverage-rates-for-all-children

"The service will work with hospital clinics and services to help ensure that all children who come to PCH have easy access to scheduled immunisations, helping to reduce the gap in WA's current childhood immunisation coverage."

(L-R) Diana Wood MRI Radiographer, Stuart Calder Siemens Healthcare, Deb Wells MRI Radiographer, Toni Nolan Theatre Nurse, Dr Sharon Lee Consultant Neurosurgeon, Erin Robins MRI Supervisor, Amanda Panizza Theatre CN, Dr Bruce Hullett Consultant Anaesthetist, Michelle Gonzalez Anaesthetic Technician, Siva Subramaniam Consultant Anaesthetist, Ashleigh Lions Theatre Nurse, Andrew Newcombe Chief Anaesthetic Technician.

PCH Intraoperative MRI a WA first

In February 2019, the surgical team at PCH performed the first intraoperative magnetic resonance imaging (MRI) scan in the State. An intraoperative MRI is a scan that can be performed while a patient is undergoing surgery, and is particularly useful for neurosurgery and cardiac procedures.

At PCH, the patient is operated on a special bed that allows them to be taken to through to an intraoperative MRI in the next room to be scanned. Surgeons can then assess the scans in real time and continue operating if necessary.

It's a first for WA – allowing surgeons to perform MRI scans during surgery without having to leave the theatre environment or move a patient from the table, enhancing patient safety, accuracy and effectiveness of operations.

Complex Patient Transition Program

In July 2018, a new program commenced at PCH to enable children with high medical, technological and complex needs to transition from hospital to home. This program was designed to align with the WA Health strategic objective of providing care closer to home, as well as the goals of the Sustainable Health Review.

"It's a first for WA - allowing surgeons to perform MRI scans during surgery without having to leave the theatre environment or move a patient from the table, enhancing patient safety, accuracy and effectiveness of operations."

The new contemporary model increases access to services and ensures a sustainable service for this group of vulnerable children and families. The new model permits a variety of community agencies to provide bespoke and flexible care packages according to the individual needs of the children. It is overseen by a CAHS-based program manager who coordinates the transition of the children, communicates with agencies and ensures minimal disruption to the continuity of care.

Parents and caregivers have been provided with training and access to support that empowers them to participate in the community with their children. Since commencement of the program, children have been able to transition home around two to three months earlier than previously possible.

The Complex Patient Transition Program was a finalist in 2018 WA Health Awards in the category for managing resources effectively and efficiently.

Diabetes Ambulatory Care Service

In March, the Diabetes Service at PCH commenced a year-long trial of a new model of care for children newly diagnosed with Type 1 diabetes. The Diabetes Ambulatory Care Service (DACS) is an integrated ambulatory care service rolled out with the efforts and support of a diverse CAHS-wide team that included inpatient and outpatient hospital departments, corporate services and community health services. The DACS model features CAHS service integration to create sustainable and seamless health care for patients and families.

In DACS, patients and families spend less time hospitalised and receive education, care and support as an outpatient at PCH, in the community, and for some families, in the home. The Hospital in the Home nursing team visit families at home in the days after discharge. Community nurses support newly diagnosed children and their families in the early weeks post-diagnosis to augment support and service engagement. The Diabetes Service has also assembled a team of senior and experienced diabetes clinicians to provide care to children in DACS on an outpatient basis, including clinical nurse specialists, dietitians, social workers and endocrinologists.

With increasing numbers of children being diagnosed with Type 1 diabetes, the model will reduce inpatient length of stay and will produce a range of clinical and hospital benefits.

Planning and Promoting Adolescent and Young Adult Services

Planning and Promoting Adolescent and Young Adult Services (PAPAYAS) is a program established and led by Dr Rachel Collins, a Paediatric consultant at PCH, and Dr Ali Buckland, an adult physician at Sir Charles Gairdner Hospital (SCGH). PAPAYAS is an education and research program aimed at improving awareness of the need for improved transition processes. The program is currently awaiting the outcome of a grant application to increase research in this area, in collaboration with SCGH, the Youth Health Network, the WA Youth Health Policy team and the Department of Health Population Health Genomics.

PAPAYAS now has around 100 members and plans to host joint education events with SCGH, such as a joint grand round.

Engaging with rural and remote communities

The Department of General Paediatrics (DGP) at CAHS has established formal links with each of the regional paediatric centres to improve communication with paediatricians caring for children in regional and remote areas of WA. Each of the DGP teams now has responsibility for the different regions of WA, so when a general paediatrician from that area requests a child to be reviewed or admitted to PCH, they make arrangements directly with the relevant team at PCH. Our regional colleagues have welcomed this arrangement, which means they no longer have to liaise with several teams when children with complex issues come to PCH. Instead, they contact the DGP who will help case manage the admission. The improved links also help ensure that when children from regional WA leave PCH and return home, we can liaise directly with their paediatricians and other health professionals to ensure continuity of care.

Diabetes Ambulatory Care Service team

Evalotte Mörelius

World-class paediatric nurse appointed to PCH

A joint initiative between PCH, Edith Cowan University (ECU) and the Perth Children's Hospital Foundation enabled the appointment of Professor Evalotte Mörelius to the position of ECU and Perth Children's Hospital Foundation's Professor of Nursing for Children and Young People at CAHS.

Professor Mörelius previously a researcher at Linköping University in Sweden is a world-leading expert on childhood stress who has worked in several neonatal intensive care units and paediatric clinics, in addition to completing 36 scientific peer reviewed publications and publishing several books.

Her research will concentrate on innovative ways to prevent and decrease stress in childhood, including new means of assessing early signs of stress, improving the ability for sick new-born infants to become closer to their parents, reducing children's pain during nursing procedures, and guiding parents in how they can read and respond to their infants' communication signals.

A strong commitment to furthering the nursing research agenda by CAHS has been a key driver to creating the Professor of Nursing position based at Perth Children's Hospital. Professor Mörelius will work closely with staff and families at PCH who will ultimately benefit from her research.

Child Health

CAHS Community Health child health services comprise a range of primary prevention and early intervention programs focused on the health, development and wellbeing of children between birth and school entry. A review of services led to the realignment of services from July 2017 to support the principle of progressive universalism, which aims to improve health equity and outcomes by providing support for all, with more support for those who need it most. The Universal Program comprises five high quality health and developmental assessments at scheduled touch points, as well as a range of group-based and drop-in services. Children and families identified with additional needs are offered more intensive one-to-one support services.

During 2018–19, 26,191 new babies were welcomed into the Universal Child Health Program from birth, with 25,592 (98 per cent) accepting the offer of a postnatal home visit in the early postnatal period.

Community child health nurses provided a total of 105,235 individual child health contacts during the year, including 17,379 Universal Plus contacts for families needing additional support.

In addition to individual contacts, child health nurses delivered 20,691 parenting group sessions to 8,240 parents and saw 42,081 families at drop-in sessions throughout the year.

26,191
new babies welcomed

105,235
child health contacts

17,379
'Universal Plus' contacts

20,691
group sessions

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 late 2017, CAHS, in collaboration with the WA Country Health Service (WACHS), commissioned a review of school-aged health services aimed at ensuring services remain contemporary, are aligned with best practice, and continue to meet the needs of the school-aged population. The review culminated in 32 recommendations relating to key aspects of the service delivery model, the role of community nurses working with children and young people, and workforce utilisation and supports. Planning for implementation commenced in late 2018, with a number of key reforms planned for the 2020 school year.

27,083
referrals accepted

26,402
children seen

A core component of primary school health services is a universal school entry health assessment (SEHA). During the 2018 school year, 24,456 (96 per cent) of children enrolled in kindergarten received a SEHA.

School health nurses also support children in secondary and education support schools, providing 75,874 occasions of service to secondary students and 47,512 occasions of service to students in education support facilities.

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.

Demand for child development services continues to grow, with 27,083 discipline referrals[2] accepted during 2018–19, up 11 per cent from 2015.

During 2018–19, 26,402 children received services from CDS, representing around five per cent of the zero to 18 year-old population. Children aged three to seven years account for the majority of children seen, in line with the focus on early intervention.

[2] Some children with complex developmental difficulties are referred to multiple disciplines.

Immunisation

CAHS Community Health provides free vaccinations for zero to four year olds under the Childhood Immunisation Schedule and immunisation services for secondary students under the School Based Immunisation Program. Community Health also plays a key role in vaccination of complex clients, including humanitarian entrants.

During 2018, community health nurses delivered a total of 149,554 vaccinations through the Childhood and School Based Immunisation programs.

Immunisations for zero to four years olds were provided from more than 50 community-based facilities across metropolitan Perth, with 60,518 vaccinations delivered to 18,369 children.

Through the School Based Program, Community Health delivered 89,036 vaccinations to 56,418 children at 161 schools across metropolitan Perth.

18,369
children immunised

56,418
students immunised

149,554
vaccinations administered

"Demand for child development services continues to grow, with 27,083 discipline referrals accepted during 2018–19, up 11 per cent from 2015."

Artist in Residence

There is a large body of evidence demonstrating that participation in art can have a range of health benefits, such as providing comfort, reducing stress or anxiety, and shortening lengths of stay in hospital.

The CAHS Artist in Residence Program was created to provide a positive distraction to children being in hospital and uses art to positively influence their health and wellbeing. Artists who contributed in 2018–19 included Kate Page, who ran music and singing programs, and Steven Aiton, who created digital stop motion animations (available for viewing at https://www.youtube.com/watch?v=prqJJ9dcyxk).

The Artist in Residence program was presented in partnership with the School of Special Educational Needs: Medical and Mental Health and the CAHS Fun on Four team. The project was funded by the Perth Children's Hospital Foundation and their funding partners: Little Athletics, Market City and Austunnel.

Musician Kate Page providing vocal play session in outpatients wait area.

Artist Steven Aiton with Jett Harvey creating an animation

PCH Foundation CE Carrick Robinson and artist Steven Aiton with participants Amelia, Eva and Zoe

Child and Adolescent Mental Health Services

A ceremony to celebrate the Statewide Mental Health Graduate Nursing Program was held in February 2019.

Child and Adolescent Mental Health Services (CAMHS) graduate nurse Lisa Ferguson won Graduate Nurse of the Year for her outstanding achievements during the graduate program. Lisa works at the CAMHS inpatient unit based at Perth Children's Hospital Ward 5A. A total of 36 enrolled and registered nurses from across WA graduated from the program.

Registered Nurse Lisa Ferguson

CAMHS were successful in receiving $312,000 from the Mental Health Commission (MHC) in non-recurrent, non-admitted mental health initiatives in 2018–19. The initiatives that received funding were:

Review of Community CAMHS catchment areas

A senior project officer has been funded to undertake a six month review into the catchment areas and clinic locations of Community CAMHS within the Perth metropolitan area.

Update consumer welcome pack and CAMHS webpage

A senior project officer and peer support worker have been funded to update the consumer welcome pack and CAMHS website. Consumer engagement is integral in ensuring the information provided to CAMHS consumers is clear and helpful.

School nurse and psychologist training and information package

A senior project officer has been funded to develop a training and information package tailored to the needs of school health nurses and school psychologists who work with current or previous clients of CAMHS.

Therapeutic Crisis Intervention for Families (TCI-f) pilot group

CAMHS staff have become accredited trainers in Therapeutic Crisis Intervention (TCI) and TCI-f. TCI is an evidence-based program developed by Cornell University, New York, which teaches staff to stop a potential crisis with a young person from happening by understanding how to prevent it or de-escalate it, and when in a crisis, how to manage it safely and therapeutically.

The ultimate purpose of this initiative is to improve the lives of children and young people by creating a safe and caring family and home environment.

Update the CAMHS Service and Priorities document

A senior project officer has been funded to update the 2012 CAMHS Service and Priorities document. The document shows the capacity of services to meet the needs of the WA population, and identified gaps in service provision. The document provides a readily available source of descriptions of services and other information regarding specialised child and adolescent mental health services.

The document precedes the WA Mental Health, Alcohol and Other Drug Services Plan 2015–2025 and other influences on service delivery, such as the implementation of the *Mental Health Act 2014*, Suicide Prevention 2020, Together We Can Save Lives, Ombudsman Investigation into ways that State Government departments and authorities can prevent or reduce suicide by young people.

Provision of mental health training to other service providers

- CAMHS has received funding to provide clinical skills, infant mental health and TCI training to other government and non-government organisations
- The aim is to improve the lives of young people and their families by increasing the reach of CAMHS training.

CAMHS are collaborating with government agencies, universities and the Telethon Kids Institute to undertake research in the following areas:

- Physical and mental health outcomes in gender diverse children
- Deliberate self-harm and personality disorders
- Exercise and physical literacy
- Biological psychiatry and neuropsychology
- Evaluation of treatment programs
- Paediatric eating disorders
- Recovery in children and adolescents.

Aboriginal health at CAHS

The health and wellbeing of Aboriginal and Torres Strait Islander people remains a priority across the Child and Adolescent Health Service (CAHS).

This is reflected in the focus in the CAHS Strategic and Operational Plans as well as the action plan for the *Implementation Guide for the Aboriginal Health and Wellbeing Framework 2015-2030.* It translates across the health service including in the Culture Action Strategy, Aboriginal Workforce strategy and research projects.

Perth Children Hospital Aboriginal Liaison Service

The Perth Children's Hospital (PCH) Aboriginal liaison officer (ALO) service celebrated its ten year anniversary in March 2019. The service is a unit within the Social Work Department and contributes to the cultural safety of Aboriginal families to ensure their care pathway within PCH is well supported. They assist in achieving this through:

- cultural support and advocacy with children and families identified as most vulnerable, and assistance with culturally sensitive issues impacting on patient care and decision-making.
- cultural advice, consultation and education to hospital colleagues, in partnership with other services at PCH, to ensure culturally appropriate care.

Workforce

- The two ALOs have both been recognised in 2019 for ten years of dedicated service to Princess Margaret Hospital and PCH.
- A Community Health Aboriginal health worker is undertaking a six month placement at PCH to enhance the capacity of the cultural support able to be provided to families across the hospital and to improve opportunities for integration of care between the hospital and community Aboriginal Health teams.

New initiatives

- In April 2019, the ALO service started a weekly educational health yarning session for inpatient carers of Aboriginal children and young people. The session is held in the Kulunga Moort Mia (Aboriginal family lounge) with a goal to reduce isolation for Aboriginal families whose children are inpatients at PCH, and to promote health literacy using culturally appropriate health resources and a yarning model.
- The ALO service and the Koorliny Moort Aboriginal senior social worker, in partnership with nursing colleagues, have started reviewing and redesigning some PCH consumer information to provide a culturally relevant format for Aboriginal families.

Celebrations

- A number of celebrations have been held at PCH in Kulunga Moort Mia, including NAIDOC Week and Reconciliation Week. These have been well attended by patients, families and staff.

In the last year, the ALO service has supported Aboriginal families from rural and remote towns and communities (44 per cent) and from metropolitan Perth (56 per cent). They have assisted inpatients (65 per cent), outpatients (28 per cent) and in the Emergency Department (6 per cent). This breadth of scope across the State requires ongoing consideration as to how to strive to achieve mutual comprehension and understanding of each child and family's circumstances, and how culture may affect health and healthcare.

Koorliny Moort Aboriginal Senior Social Worker

The Aboriginal senior social worker is employed within the Social Work Department and works as an integral member of the Koorliny Moort team. The one full time equivalent senior social worker attends all of the Koorliny Moort outreach clinics held within the community, as well as the PCH-based clinics. This year there have been new paediatric clinics started, at locations both north and south of the river, to enhance the delivery of healthcare closer to where people live. As a part of delivering care in the community, the senior social worker continues to build partnerships and engagement with families and with Aboriginal community service providers. In the last year, the Koorliny Moort program has increased its Aboriginal staff to include an enrolled nurse, health worker and registered nurse. This has further enhanced the cultural competence of the program.

Community Health

The Community Health Aboriginal Health Team (AHT) provides comprehensive, culturally secure services to Aboriginal families with children aged zero to five years and their families, across the metropolitan area. The AHT supports families in raising healthy children, by providing the community with child health information, and empowering parents to build on the knowledge they have of their children.

The AHT provides services from ten clinics across Perth. These services are provided by a multidisciplinary team consisting of child health nurses, Aboriginal health workers, allied health professionals and a medical officer. In addition to the universal contact schedule and immunisations, the AHT offers more intensive support to vulnerable families.

During 2018–19, the AHT delivered a total of 18,105 services to Aboriginal children and families. The building of respectful and trusting relationships with families and communities is a focus of this team. A flexible approach to service delivery is critical to supporting families, with 47 per cent of individual face-to-face contacts delivered in the family home.

State Government funding under the WA Footprints to Better Health initiative enables the AHT to deliver additional services within the local government areas of Swan, Gosnells and Armadale, including a culturally secure Aboriginal ear health clinic. The clinics are delivered by a nurse who is known to the community, resulting in 86 per cent of referred families attending the clinic this year. Funding from Rural Health West has enabled the AHT to secure the services of an ear, nose and throat specialist in the Armadale area and a PCH outpatient clinic in the north metropolitan area.

“A flexible approach to service delivery is critical to supporting families, with 47 per cent of individual face-to-face contacts delivered in the family home.”

"CAMHS has supported the external facilitation of cultural awareness training to increase the capacity of non-Aboriginal clinical and administrative staff to provide a culturally secure service for Aboriginal children, young people and their families."

The AHT also provides targeted ear health screening across metropolitan Perth for Aboriginal children of school age. During the 2018 school year, the school ear health screening team screened 1,260 children across 151 primary schools.

Child and Adolescent Mental Health Services

The Specialised Statewide Aboriginal Mental Health Service (SSAMHS) program funds five Aboriginal Mental Health Workers across the ten Community CAMHS clinics. Data on referrals and ongoing care of Aboriginal children and young people by Community CAMHS clinics found:

- Twice as many referrals of Aboriginal children and young people go to clinics with SSAMHS workers compared to those without (2.1 times).
- Almost three times as many activations of Aboriginal children and young people at clinics with SSAMHS workers compared to those without (2.7 times).

These statistics demonstrate the excellent work SSAMHS workers undertake to engage their communities. CAMHS has been able to access extra non-recurrent funding from the Mental Health Commission to create five more Aboriginal Mental Health Worker and two 50D Senior Social Worker positions. Once recruitment is complete, this will ensure there is an Aboriginal Mental Health Worker available for each of the 10 community CAMHS clinics, and a 50D Senior Social Worker in the north and south to provide support, training, mentoring and supervision to the 10 Aboriginal Mental Health Workers.

CAMHS has supported the external facilitation of cultural awareness training to increase the capacity of non-Aboriginal clinical and administrative staff to provide a culturally secure service for Aboriginal children, young people and their families. SSAMHS workers have developed partnerships with community and service providers to increase help-seeking and provide culturally supportive, locally appropriate responses to suicide.

Aboriginal workforce

Increasing the representation of the Aboriginal workforce within WA Health is well established as a key essential element to improving health outcomes of Aboriginal people (Aboriginal and Torres Strait Islanders Health Performance Framework Report 2014).

In January 2019, CAHS launched their own *Aboriginal Workforce Strategy 2018-2026* setting out initiatives to help CAHS:

- Meet and continue to exceed our Aboriginal representation target
- Grow and develop our Aboriginal employees to build rewarding career pathways
- Build a positive and inclusive culture through deeper understanding of Aboriginal society and issues.

As at the end of June 2019, CAHS employs 65 Aboriginal staff members, representing 1.5 per cent of the CAHS workforce. This is an increase of 14 per cent from the same time last year. There has also been an overall

increase in improving the permanent and fixed term ratios of the Aboriginal workforce and this is now more consistent with the overall CAHS workforce.

Paediatric respiratory outreach clinics: Broome

Every quarter, Perth Children's Hospital (PCH) sends a multidisciplinary team, which includes a respiratory consultant and fellow, respiratory nurse and physiotherapist to see about 30 children in the Kimberley. Most of these children are Aboriginal. A key benefit of the regional clinic is that families do not need to travel the extra 2000 kilometres to Perth to access specialist care. Within this team, paediatric respiratory physician Dr André Schultz and senior respiratory physiotherapist Pam Laird have been conducting respiratory visits to the Kimberley for about ten years to treat children with chronic lung disease.

PCH clinician researchers have partnered with the Telethon Kids Institute, Aboriginal and Government medical services in the Kimberley and Perth, Aboriginal families, and local Aboriginal co-researchers to look at ways to reduce the burden of chronic lung disease by finding ways to effectively detect and manage early lung disease in Aboriginal children. As part of this work, the team has looked at ways to manage chronic wet cough in childhood to prevent a significant proportion of bronchiectasis and related chronic lungdisease in adults.

Through collaboration, mutual respect and knowledge translation, we are witnessing little lungs growing stronger, Aboriginal families empowered with knowledge, and clinicians skilled to provide culturally informed care to children. If we continue engaging and working together, we will find sustainable solutions to improve lung health of Aboriginal children and prevent Aboriginal children with lung disease from flying under the radar.

The Department of Child Health Research strives to enable and support researchers and research excellence throughout CAHS, aiming to assist all child health researchers in WA Health, and partnering with relevant organisations, universities and research institutes to undertake research of the highest quality that will translate into improved health outcomes for all children.

HAPPY FIRST BIRTHDAY TO PCH!

10 JUNE 2019

Refugee health at CAHS

The community-based Refugee Health Team (RHT) provides intensive, culturally appropriate support to humanitarian entrants, helping refugee families transition to access local health services across the Perth metropolitan area and supporting 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 Entrant Health Service. This nurse led program is delivered predominantly as a home visiting model and interpreters are used extensively by the RHT.

Refugee Health nurses also work as part of integrated service centres in partnership with Department of Education to meet the needs of families.

The Perth Children's Hospital Refugee Health Service (RHS) provides comprehensive assessment, diagnosis and management of complex health needs of refugee and asylum-seeker children, adolescents and families within Western Australia. The team work within a holistic framework aligned with current national best practice and provides point-of contact interdisciplinary care, clinical research, transition and advocacy. The multidisciplinary RHS team includes medical, nursing, dental, dietetic, social work, mental health, education, research and volunteer staff from across the Child and Adolescent Health Service.

The RHS model of care is specifically designed to provide substantive equity with provisioning of interpreters, transportation, medications and care coordination to empower and engage this vulnerable CAHS cohort. The CAHS RHS Integration project is currently underway; the goal is to remove access barriers, identify gaps in clinical service provision, improve patient journeys and ensure consistent high level care provision for refugees and asylum-seekers across the organisation.

"The Refugee Health Service model of care is specifically designed to provide substantive equity with provisioning of interpreters, transportation, medications and care coordination to empower and engage this vulnerable CAHS cohort."

Research

Translation and impact

The intention of all research at CAHS is to translate research findings into everyday practice improvements and identify ways to make a positive and meaningful impact on child health and wellbeing. The support of the PCH Foundation enables CAHS researchers to test ideas and undertake research that may result in changes to clinical practice, more effective therapies, or completing scientifically rigorous studies that provide evidence needed for change.

In 2018–19, the PCH Foundation provided over $1.25 million in research funding to CAHS staff via the annual Research Grand Round. This funding scheme is the only grant scheme in Australia to actively involve consumers in the scoring and review process.

The assessment process rates the level of consumer involvement in the design and lifecycle of the research project. Consumers involved in the process provide valuable insight and ensure funded projects are aligned with community priorities for medical research.

CAHS research case studies – demonstrating translation and impact

Australian Infant Communication and Engagement Study

The Australian Infant Communication and Engagement Study (AICES) is a world first clinical trial of a new intervention for infants showing early signs of autism spectrum disorder. This ground-breaking study is a partnership between the Telethon Kids Institute and CAHS Child Development Service and uses video-feedback to help parents learn to respond to their infants' communication signals and expressions, enabling parents to help their child to develop social and communication skills. This novel therapy delivered significant improvements in communication and socialisation compared to current best practice (*in press, Lancet*). A group-AICES trial recently commenced, to explore the feasibility and effectiveness of delivering the therapy in a more cost-effective group setting, with preliminary results very encouraging.

55
New research projects approved

484
Current active projects

110
Interventional clinical trials

294
Other non-interventional

Approximately
89,000
research participants

284
publications

More than
260
staff involved in research

Dr Dayna Pool using the Walk Aide® with a patient

Dr Dayna Pool – Helping children with cerebral palsy walk

Dayna is a senior physiotherapist who works with patients who struggle to walk due to cerebral palsy, brain injuries and partial spinal cord injuries.

Dayna received funding from the PCH Foundation to investigate use of a device called Walk Aide® to assist her patient groups walk. She has shown Walk Aide® is effective in improving walking ability, strength, balance and even muscle size. Importantly, Walk Aide® is well tolerated by patients and preferred to braces. Dayna is now investigating how to best utilise Walk Aide® as part of routine clinical practice.

Dr Barry Clements – A new treatment for patients with cystic fibrosis

Barry is a respiratory consultant based at Perth Children's Hospital (PCH). With funding from PCH Foundation he recently completed a pilot study investigating if the addition of Calcium-EDTA to routine antibiotic therapy would improve treatments given to patients with cystic fibrosis with lung infections.

Calcium-EDTA is a generic compound used in many therapies. Barry was able to demonstrate improved care with his treatment option, and has now secured funding to develop this treatment for patient use throughout the world.

Dr Michael O'Sullivan – SmartStartAllergy

Michael is an immunologist who leads SmartStartAllergy, a world-first SMS and smartphone-based application used to support and monitor infant feeding and allergy prevention in the community, in conjunction with local general practitioner (GP) Dr Alan Leeb and the SmartVax team, and the National Allergy Strategy.

With support provided by the PCH Foundation, Michael and his team have worked with GPs to assist parents in successfully introducing peanut and other common food allergens to their infants, potentially reducing the risk of developing food allergies. This study is now positioned for national implementation, and will assist improved care for children with allergic disease in the community.

Dr Michael O'Sullivan

Outcomes achieved with our research partners

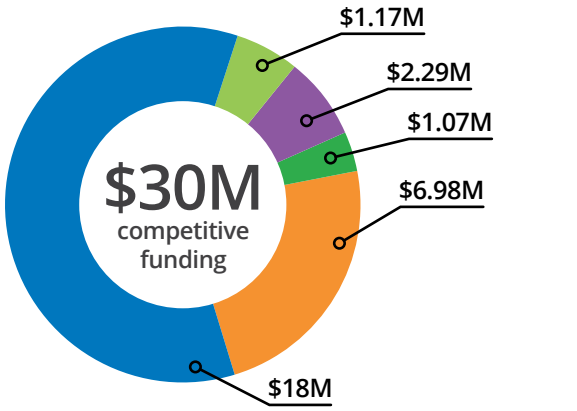
1. Grant funding for research studies

Research at CAHS is closely affiliated with academic partners throughout Western Australia. Our principal partners include the Telethon Kids Institute, the University of Western Australia, and Curtin University. Over the last year, CAHS researchers have achieved over $30 million in competitive funding for projects that ranged from drug discovery and development, to knowledge generation and clinical translation of research findings.

While the majority of research funding is achieved from the Commonwealth Government, important contributions are made by of the WA Department of Health, the Telethon Trust and the PCH Foundation. CAHS researchers have also been successful in attaining funding from smaller entities such as the Raine Foundation, the Vanguard Foundation, the Juvenile Diabetes Foundation and the Cystic Fibrosis Foundation, to name a few. Around $500,000 in commercial clinical trials was also administered through CAHS over 2018–19.

"With over 1200 attendees, 60 talks, 70 poster presentations by child health researchers and a consumer evening session, the Symposium is valuable event for learning, capacity building, networking and sharing of research results. "

96 research projects were successful in achieving $30 million competitive funding used for studies across CAHS



- **Commonwealth funding** (including NHMRC and MRFF)
- **WA Dept of Health**
- **Telethon Trust**
- **Perth Children's Hospital Foundation**
- **Other**

CAHS funded research projects are in the following areas:

- Expanding knowledge in built environment design
- Mental health
- Respiratory system and diseases (incl. asthma)
- Aboriginal and Torres Strait Islander health – health status and outcomes
- Cancer
- Cardiovascular system and diseases
- Child health
- Clinical health
- Diabetes
- Disability and functional capacity
- Evaluation of health outcomes
- Health education and promotion
- Health not elsewhere classified
- Hearing, vision, speech and their disorders
- Immune system and allergy
- Indigenous health not elsewhere classified
- Infectious diseases
- Nervous system and disorders
- Nutrition
- Public health
- School/institution community and environment
- Skin and related disorders

2. Research events

Child Health Research Symposium

The Child Health Symposium is now the largest annual gathering of clinicians, researchers, health care workers and policy makers in child and adolescent health care research in Western Australia. This event is an important opportunity for researchers across the health campus to disseminate their findings to colleagues and the wider community. With over 1200 attendees, 60 talks, 70 poster presentations by child health researchers and a consumer evening session, the Symposium is valuable event for learning, capacity building, networking and sharing of research results.

The 2018 Symposium was held in partnership with the Telethon Kids Institute (TKI), enabling collaboration between researchers and clinicians to facilitate improved outcomes in child health. Through the

partnership TKI, the event was able to feature an internationally renowned keynote speaker. Professor Dame Sally Davies, England's Chief Medical Officer, who was instrumental in prioritising research across the National Health Services in England and Wales, addressed over 250 staff and participated in a panel discussion with CAHS, TKI and WA Health Executive as part of her session.

3. The Research Education Program

The CAHS Research Education Program commenced in September 2013 with funding from PCH Foundation, and reaches participants from:

- all clinical disciplines (medical staff, support staff, nursing, allied health, laboratory, pharmacy, support staff etc.);
- all levels of clinicians, students and researcher seniority;
- all research project types (clinical trials, audits, systematic reviews); and
- all major hospitals, research institutes and universities in WA.

4. Telethon Children's Research Centre

The Telethon Trust has provided $1.5 million in funding to support and work in partnership with current CAHS research support services, to enhance the value and quality of child health research being conducted in Western Australia. Funding from the centre has also enabled administration of research clinics through outpatient clinic D, with over 3000 patients participating over a range of research studies since the opening of PCH in June 2018.

5. Consumer and Community Health Research Network

Community and consumers are valued stakeholders in our research. With the assistance of consumer advocates based at CAHS, we have made important strides involving consumers in consulting on projects, reviewing funding applications and shaping the translation of research in CAHS.

The Research Education Program

15,000+
participants

155
organisations

111
seminars and workshops

23
topics across the Health Research Process

18
speakers from seven instituitions

11
hosted video conference sites

Teaching

CAHS provides extensive education and training programs for staff across the medical, nursing and allied health professions.

PCH Simulation Suite

The simulation suite at PCH has had an exciting first year. With an overall vision of, Improving the quality of care for children and families in WA through the use of simulation education, one of the first events held was SimStart, a simulation instructor course. PCH staff were on hand to showcase our world class simulation facilities to 18 participants who came from all over WA to learn about how to teach using simulation. The learners were from diverse backgrounds including nursing, medical and allied health staff. Simulation is a growing educational technique, but it is technically challenging, with the patient mannequins becoming more complex and more realistic in their capabilities. High level instruction skills are essential for simulation education to be done well. Over three days, the participants learnt about how to write effective scenarios and learning objectives, how to operate the mannequins and how to debrief the scenarios and ensure good learning. They were able to practice their new skills by creating scenarios for each other and testing them in the simulation suites.

Following on from SimStart, PCH alumni have been working hard to embed simulation education into their clinical areas, with a physiotherapy simulation event held in February and a speech therapy simulation event planned for November. Multidisciplinary team training occurs every Thursday, with ward nurses and doctors coming together in the simulation suite to learn how to care for the acutely deteriorating child. Topics covered include communication skills, open disclosure and effective team work.

Importantly, teams of different professionals are learning together, helping to break down silos, improve communication and ultimately improve the quality care for children and their families.

PCH Paediatric Nursing Education

The GREaT Program (Get Real Experience and Try) is a nursing work experience program recently facilitated at Perth Children's Hospital (PCH) through Paediatric Nursing Education, in collaboration with the Department of Health Nursing and Midwifery Office. This program is a Statewide work experience program, created by the Nursing and Midwifery Office, and designed to centrally manage high school students seeking nursing/midwifery work experience at WA Health sites.

"More than 20 volunteer parents from the community come along to assist us and give their valuable time to assist practitioners who are learning to use this assessment tool for a 1-1.5 hr assessment session"

The overall aims of this program are:

- To promote nursing/midwifery as a career option to high school students between years 10 to 12
- To support WA Health sites in providing the best possible experience to high school students to enable them to make informed choices about their future career path.

Individual objectives for the work experience placement are for students to have an opportunity to:

- Experience multiple aspects of nursing and midwifery in a clinical setting
- Observe the nursing and midwifery team in action
- Undertake various procedures, under direct supervision of a registered nurse or midwife
- Gain a sense of whether the nursing or midwifery professions are right for them.

In May, PCH hosted five potential future nurses as part of this program. Over four days, they were provided education on what it's like to nurse children and look after families. They were buddied with senior nurses to observe activities in real clinical areas and clinics including endocrinology, cardiology, the Day Treatment Unit, medical imaging and the Outpatients Department. Feedback from these students was very positive, with every student indicating they hoped to pursue a career in nursing at the end of the four day placement.

Community Health

Griffiths III Developmental Test

Every year the Child Development Service provides 20 -24 Paediatricians and psychologists with training in the use of the Griffiths Scales, which are an important developmental assessment tool for young children.

More than 20 volunteer parents from the community come along to assist us and give their valuable time to assist practitioners who are learning to use this assessment tool for a 1-1.5 hr assessment session.

Last year, Perth Children's Hospital foundation donated a beautiful book from the WA Mint for each child as a thank-you gift for those who came as volunteers. The donation of these gifts was very much appreciated by the course organisers and delighted the children and their parents.

One of our young volunteers with his mother enjoying the PCH foundation donated book and CDS Registrar Dr Lucy Loweth.

We have trained more than 200 clinicians over the last 10 years in the Griffiths, including more than 80 in the new Griffiths III tool since 2016 and have become a leading Australian site for Griffiths training.

Child and Adolescent Mental Health Services

Child and Adolescent Mental Health Services (CAMHS) has undertaken a number of great training initiatives this year, including:

Clinical Skills Training

Clinical skills training (CST) is a series of modules that are undertaken by all new CAMHS staff. It prepares them with an understanding and skills to deliver appropriate and consistent assessments, planning and diagnosis of the young people who come through CAMHS.

All the modules have recently undergone a major review and include new interactive and engaging modules, which were run very successfully in March 2019. The training is developed by our own CAMHS clinical experts who come from a range of disciplines including nursing, psychology, social work and psychiatry. The clinicians use their experiences and developed expertise in their fields to develop the training. We also utilise these clinicians and other experienced clinicians from across the disciplines to deliver the training which runs at least four times a year for CAMHS staff.

This training is also delivered via teleconference to WA Country Health Service CAMHS staff who find the training invaluable to their continued growth as CAMHS clinicians.

Therapeutic Crisis Intervention for Families

The Mental Health Commission (MHC) is funding CAMHS to train staff in Therapeutic Crisis Intervention (TCI) and the associated TCI for Family (TCI-f) program. This will allow CAMHS to pilot a group program for parents and caregivers in acknowledgement of the needs of those supporting children and young people through mental health crises. The goal of this initiative is to improve the lives of children and young people by creating a safe and caring family and home environment. The ability of family and caregivers to respond effectively to their child or young person in crisis is critical in establishing not only a safe environment, but also one that promotes growth and development. TCI is an evidence-based program developed by Cornell University, New York, which teaches staff to stop a potential crisis situation with a young person from happening, by understanding what to do to prevent it or de-escalate it, and when in a crisis situation, how to manage it safely and therapeutically. The TCI-f program complements Community CAMHS' current therapeutic model by bringing parents and carers together to connect and network following a crisis, and to collectively explore risk, safety, crisis management, communication with young people and fostering good self-care.

Recruitment for running a group with parents has taken place and there was an enormous response with nine families (14 people) taking part in the first TCI-F course. CAMHS are also training 20 CAMHS clinicians, who after the training will be able to run TCI-f courses with their clients' families

Project Air Strategy - Clinical skills for working with people with personality disorder

The WA MHC purchased Personality Disorders (PD) training from the University of Wollongong , for all WA

Health Service Providers (HSPs). This allowed CAMHS to deliver two days of young person-focussed training for 100 people in May 2019. Training included adolescent intervention and psychological approaches, and interventions to support carers, families and parents.

The participants were made up of CAMHS clinicians from nearly every CAMHS service, in addition to representatives from the Department of Education School Psychology Service, WACHS CAMHS and the PCH Emergency Department.

Following on from the training, CAMHS is looking at how to implement the outcomes from the training into service delivery to improve assessment and treatment for young people with borderline personality disorders.

Right: Preventing SABSI in the Intensive Care Unit during insertion of central venous access devices (CVADs).

Statement from the Consumer Advisory Council Chair

The Consumer Advisory Council (CAC) has had a really productive year. We bring our lived experience and are passionate about consumer engagement in CAHS.

It is exciting that the demand for consumers' input continues to grow. As Chair, it is pivotal that I sit on the CAHS Executive at the weekly meetings to be able to discuss consumer engagement across all issues and to review the safety and clinical incident data for CAHS.

The CAC has been involved in a wide range of projects, from grassroots issues such as concession parking at the new Perth Children's Hospital to advocating for Safety and Quality issues.

One of our highlights has been to advocate for a CAHS-wide Consumer Network and we're excited about this introduction to enable consumers to be able to provide feedback.

We are currently working towards effectively capturing the "patient experience" throughout CAHS to better inform decision making and meeting the needs of children and their families.

The CAC have seen an increase in our involvement by working across community health, mental health and Perth Children's Hospital. In particular the CAC has been involved in the CAHS Service Integration Project. Another important project the CAC is involved in is input into the Unifying Systems for Recognising and Responding to Paediatric Clinical Deterioration.

The CAC continues to be asked to review policy and strategic plans. We review brochures before distribution to parents to ensure it is meeting needs and is clear and relevant.

The transition of our adolescent patients to adult services remains a focus with the aim to make this a smoother process.

It is heartening to see new initiatives, like parents being invited to contribute to designing services for the CAHS Complex Care Model.

The CAC continues works in collaboration with the CAHS Youth Advisory Council and the Health Consumers Council of WA.

A sincere thank you to all the CAC members for their dedication and hard work during the past 12 months. Much appreciation to CE Dr Aresh Anwar, Executive Sponsor Katie McKenzie and the Consumer Engagement staff for their support of consumers.

Ma Wood

Margaret Wood
Chair
Consumer Advisory Council

“It is heartening to see new initiatives, like parents being invited to contribute to designing services for the CAHS Complex Care Model.”

Statement from the Youth Advisory Committee Chair

The Youth Advisory Committee is made up of a group of young people who use their experiences of the Child and Adolescent Health Services to provide recommendations on how to improve the service for the children of WA.

Over the past 12 months, the Youth Advisory Committee has experienced a transition in our role in CAHS, as many changes have come to into play. The most significant of these was the move to Perth Children's Hospital. With the new setting came a new structure and new focus, with the Child and Adolescent Health Service seeking to create a more integrated approach to its services across Perth Children's Hospital, as well as Mental Health and Community Health.

We, as the committee, have been actively supporting projects across the Health Service, with a special focus on finding different pathways for communication between the Health Service and consumer. This has included the Patient Feedback form, which allows patients of all ages to share their experiences. We have also encouraged the use of screens in the public spaces of the Hospital to ensure patients and consumers are aware of the services that are available.

A big part of our focus has been on planning. We are planning to work in collaboration with multiple Non-Governmental Organisations, both in and out of the hospital, to create events for the young people using the Health Service. With these events, we'd like to encourage a greater sense of community and with that, combat any feeling of isolation that may be felt by young people during their stay in hospital, which can be a lonely and daunting time.

Thanks to all the staff of CAHS who have supported us again this year in our work.

I would like to give my thanks to my fellow members of the YAC, and in particular to April Welsh, who has left the Committee after years of contribution and dedicated service as Chair of this committee.

I look forward to the coming year and the many plans we have coming to fruition with the support of the Health Service Chief Executive and the Executive team.

Daniel Staer
Chair
Youth Advisory Committee

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 services across CAHS.

Since transition to Perth Children's Hospital (PCH), DAC has continued their advocacy role in recommending ongoing improvements to access. Outcomes from this include:

- An adult change table facility available 24 hours per day
- New signage for bathrooms with disability access
- Modifications to check-in booths for ease of access
- Modifications to the patient entertainment systems, including the access to suitable controllers for vision impaired children and adolescents
- Relocation of swipe card access for staff access to office areas
- Ongoing advocacy to improve access to concessional and disabled parking.

I would like to thank the committee for their valuable input throughout the year especially as we have settled into a new facility.

Katie McKenzie
Chair
Disability Advisory Committee

Agency Performance

Financial targets

	2018–19 Target [1] $000	2018–19 Actual $000	Variation [6] $000
Total cost of services (expense limit) (sourced from Statement of Comprehensive Income)	647,982	681,373	33,391[2]
Net cost of services (sourced from Statement of Comprehensive Income)	425,639	441,224	15,585[2]
Total equity (sourced from Statement of Financial Position)	1,410,546	1,425,492	14,946[3]
Net increase / (decrease) in cash held (sourced from Statement of Cash Flows)	(189)	7,941	8,130[4]
Approved salary expense level	406,840	416,059	9,219[5]

Note:

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

[2] The major cost drivers for the variation of $33.391 million in total cost of services are increases in employee benefits expense ($10.661 million) for operating the Perth Children's Hospital (PCH), unexpectedly higher drug costs ($11.609 million), and expenses ($6.371 million) for the PCH project. As a result of additional funding for the higher drug costs from the Pharmaceutical Benefits Scheme, the variation in net cost of services is less than the variance in total cost of services.

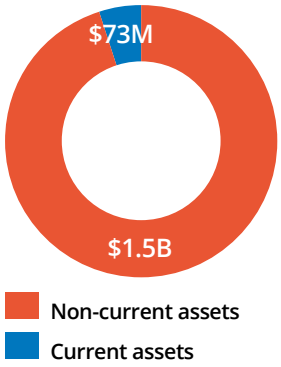
[3] The main reason for the variation for total equity was the transfer of total net assets amounting to $16.154 million from the Health Ministerial Body to the Health Service on 18 September 2018, as a consequence of assuming the control of the PCH project. The details are set out in Note 1 'Basis of preparation' and Note 9.14 'Equity'.

[4] The net increase in cash held consisted of $1.664 million increase in the accrued salaries suspense account, unexpended capital appropriations of $2.503 million, and other unexpended funds amounting to $3.774 million from State Government and external sources.

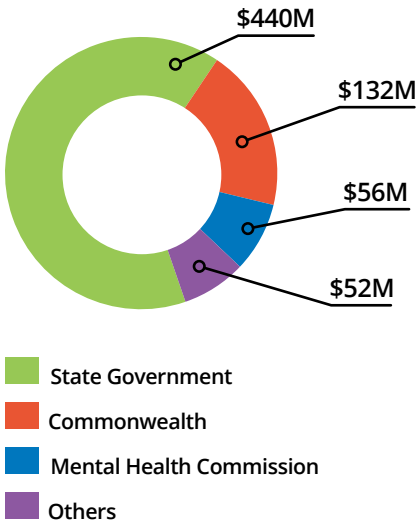
[5] The amounts for salary expense level do not include superannuation.

[6] Further explanations are contained in Note 9.16 'Explanatory Statement' to the financial statements.

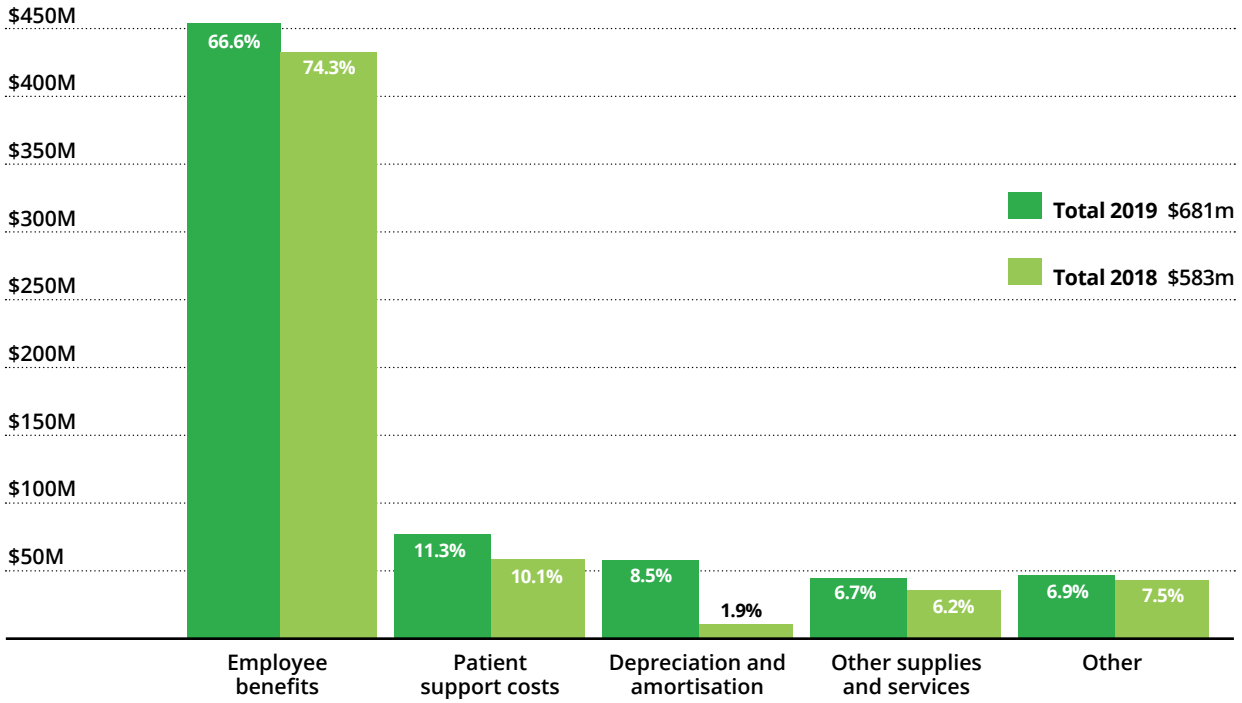
Total assets



Income



Expenditure by type



Total Assets:
The Child and Adolescent Health Service finished the 2019 year with a total asset value of $1,556 million, which represents an increase of $15 million over the previous year. The major components of assets are Property plant and equipment totalling $1,167 million and Cash and cash equivalents totalling $65 million. Further details of the breakdown by asset category can be found within the Statement of financial position in the annual financial statements presented as at 30 June 2019.

Income:
The Child and Adolescent Health Service receives the majority of its income via State Government service appropriations and services received free of charge from State Government entities. This totalled $440 million for the 2019 year. A further $132 million in income was received via Commonwealth grants and contributions and $56 million from the Mental Health Commission towards the cost of providing child and adolescent mental health services. Further details of the breakdown by income category and comparison to the previous year can be found within the Statement of comprehensive income in the annual financial statements presented for the year ended 30 June 2019.

Expenditure by Type:
Employee benefits capture the costs of staff providing services within the Child and Adolescent Health Service and represents the major component of expenditure for the 2019 year. Further details of the breakdown by expense category and comparison to the previous year can be found within the Statement of comprehensive income in the annual financial statements presented for the year ended 30 June 2019.

Summary of key performance indicators

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

Effectiveness indicators provide information that assess the extent to which outcomes have been achieved through the resourcing and delivery of services to the community. Efficiency indicators monitor the relationship between the service delivered and the resources used to produce the service. Key performance indicators also provide a means to communicate to the community how CAHS is performing.

A summary of the CAHS key performance indicators and variation from the 2018–19 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		2018–19 Target[1]	2018–19 Actual	Variation	Further info
Unplanned hospital readmissions for patients within 28 days for selected surgical procedures (per 1,000)	Appendicectomy	32.8	**37.7**	**4.9**	p.176
	Cataract Surgery	1.1	**0.0**	**-1.1**	
	Hip Replacement	17.2	**0.0**	**-17.2**	
	Tonsillectomy & Adenoidectomy	61.0	**107.5**	**46.5**	
Percentage of elective wait list patients waiting over boundary for reportable procedures	Cat 1 (≤30 days)	0	**2.4%**	**2.4%**	p.178
	Cat 2 (≤90 days)	0	**12.2%**	**12.2%**	
	Cat 3 (≤365 days)	0	**5.6%**	**5.6%**	
Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days		1.0	**0.96**	**-0.04**	p.180
Percentage of admitted patients who discharged against medical advice	Aboriginal	0.77%	**0.26%**	**-0.51%**	p.182
	Non-Aboriginal	0.77%	**0.06%**	**-0.71%**	
Readmissions to acute specialised mental health inpatient services within 28 days of discharge		12%	**28.5%**	**16.5%**	p.184
Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services		75%	**73.5%**	**1.5%**	p.186
Average admitted cost per weighted activity unit		$6,948	**$7,937**	**$989**	p.188
Average Emergency Department cost per weighted activity unit		$7,072	**$7,493**	**$421**	p.190
Average non-admitted cost per weighted activity unit		$7,136	**$7,693**	**$557**	p.192
Average cost per bed-day in specialised mental health inpatient services		$3,520	**$3,769**	**$249**	p.194
Average cost per treatment day of non-admitted care provided by mental health services		$687	**$720**	**$33**	p.196
Average cost per person of delivering population health programs by population health units		$256	**$242**	**-$14**	p.198

[1]As specified in the Budget Statements

Unfavourable performance **Favourable performance**

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 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.

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%

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 2018–19, CAHS continued to exceed performance expectations for Categories 1 and 2 (see Table 3). Performance

in Categories 3 and 4 is similar to last year, despite 5,099 more patients in these categories being treated during 2018–19. Category 5 access sits well above target and comprises low acuity cases that represent a small percentage of presentations that can either be treated by a wider multi-disciplinary team or be directed to other providers 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 zero and five minutes for several hours in a row, particularly in the evening, which can make it difficult to achieve the targets consistently.

Table 3: Percentage of Child and Adolescent Health Service Emergency Department patients seen within recommended times, by triage category, 2018–19 (as at 31 May 2019)

TRIAGE CATEGORY	2016–17	2017–18	2018–19	TARGET
1	100%	100%	**100%**	**100%**
2	89.7%	88.9%	**88.2%**	**80%**
3	61.6%	63.3%	**63.4%**	**75%**
4	59.5%	65.5%	**63.2%**	**70%**
5	95.1%	95.1%	**95.4%**	**70%**

Clinical incidents

Learning from clinical incidents

CAHS recognises that health care will never be risk free and is steadfastly committed to a culture of continuous quality improvement.

The Aiming for Zero Harm framework outlines CAHS vision of a service where all members of the Health Service aim for zero preventable clinical incidents that result in death or injury in every area, every day.

A key component of the Aiming for Zero Harm framework, and of the safety and quality culture in general, is to learn as much as we can from clinical incidents when they occur. It is recognised that learning from "always" events provide valuable insight into the factors that promote excellence in health care related outcomes.

The only way that CAHS can learn from things going wrong is to report, record, investigate and improve our practices. It is the responsibility of all CAHS staff to identify and report on clinical incidents in a timely manner via the clinical incident management system.

Incidents are classified according to severity, which are described on the WA Department of Health website[3] as:

- SAC 1 includes all clinical incidents/near misses where serious harm or death is/could be specifically caused by health care rather than the patient's underlying condition or illness.
- SAC 2 includes all clinical incidents/near misses where moderate harm is/could be specifically caused by health care rather than the patient's underlying condition or illness.
- SAC 3 includes all clinical incidents/near misses where minimal or no harm is/could be specifically caused by health care rather than the patient's underlying condition or illness.

Once an incident has occurred, CAHS has clear processes in place to investigate the incident from a systems perspective and understand what factors may have contributed to that incident. A panel of experts conducts the reviews of SAC 1 incidents, and make recommendations for improvements where their findings suggest that systems could be improved to prevent a similar incident occurring to another child or young person. The CAHS governance process ensures that oversight and monitoring of reported clinical incidents occurs. 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 learnings from clinical incidents creates a culture of accountability for patient safety.

[3] https://ww2.health.wa.gov.au/Articles/S_T/Severity-assessment-codes

Table 4: SAC 1 incidents 2018–19

SAC 1 INCIDENT	NUMBER
Total notified	**17**
Investigated	14
Ongoing investigation	2
Declassified*	1
Total confirmed	**16**
Confirmed with patient outcome of death	3
Confirmed with patient outcome of serious harm	8
Confirmed with patient outcome of moderate harm	3
Confirmed with patient outcome of minor harm	1
Confirmed with patient outcome of no harm	1

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

A Focus on Improvement

1. Healthcare Associated Infections (HAI)

Healthcare Associated Infections are reported as the number of infections identified for every 10,000 bed-days occupied by a patient in a Western Australian Public Hospital. Hospitals report against a national benchmark of 2.0[4].

Hospital surveillance programs monitor infections to ensure the data is reviewed to identify infection rates over time and improve patient safety, as infections can add to patient harm and increased length of stay.

Healthcare Associated Infections were identified as the highest reported category of SAC 1 incidents at CAHS for the 2018–19 year. Following the identification of this trend, a working group was established and undertook a multi-disciplinary review of all Healthcare acquired infections SAC 1 investigations and recommendations over the past three years. The outcome of the review was an action plan that focused on key areas of clinical guidelines and policies, hand hygiene auditing, aseptic technique competencies for central venous access devices for clinical staff, antibiotics prophylaxis, and education regarding documentation of peripheral intravenous devices. The work is continuing and is monitored and reported regularly via the Standard 3 Preventing and Controlling Healthcare Acquired Infections Committee.

Over the 12 months to March 2019, we have seen a significant reduction in Healthcare Associated Infections.

[4] https://ww2.health.wa.gov.au/Articles/F_I/Healthcare-associated-infections-and-surveillance

2. Pressure Injury Prevention

A pressure injury is defined as localised injury to the skin or underlying tissue or both, and usually over a bony prominence. Pressure injuries are considered largely preventable, however can have a serious impact on patients' pain, comfort, infection and result in delayed healing and poor outcomes if serious. Therefore, strategies to assess skin integrity and prevent development of pressure injury are critical to harm prevention.

There has been a demonstrated improvement in pressure injury audit compliance across medical and surgical wards at PCH. The wards are undertaking Quality Initiative Plans that focus on a variety of areas relating to pressure injury prevention, including the completion of daily skin and pressure assessments. A pressure injury study day was held in February 2019, which saw the creation of a pressure injury Champion group who meet with the Nurse Practitioner Stomal/Wound Management every six weeks to help drive continual improvement in pressure care and management on the PCH wards. The Nurse Practitioner also undertakes a clinical review of all reported pressure injuries to ensure best practices are adhered to and improvements made to minimise harm to our patients.

3. Allergy Management

Following the move to Perth Children's Hospital in June 2018, an increase in the number of reported clinical incidents related to food allergies was observed. An end-to-end review of the PCH Diet Kitchen operations was undertaken with a focus on workforce, stakeholders, communication, integration, delivery and infrastructure. As a result, a number

of improvement initiatives were identified, with an Action Plan developed to implement a number of areas of improvement.

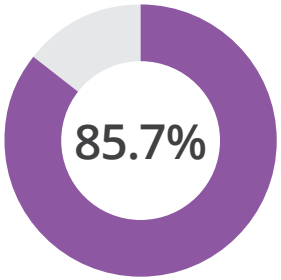
4. Hand Hygiene

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

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

The last audit of 2018–19 shows PCH is performing slightly better than the national average.

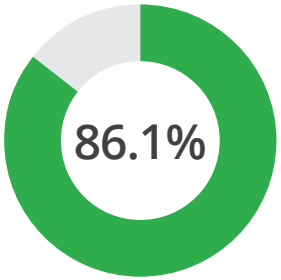
National



Total moments

588,959

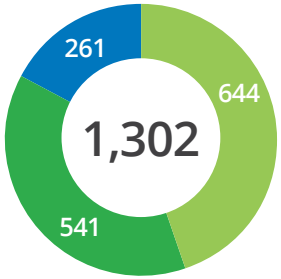
Perth Children's Hospital



Total moments

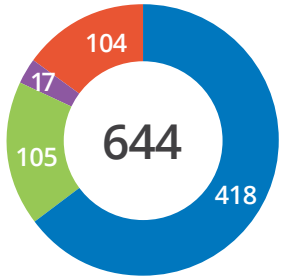
1,424

Feedback type



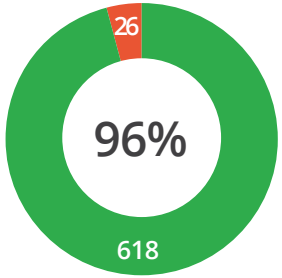
Contact
Compliment
Complaint

Complaint response timeframes



>30 days
In time
<30 days
Response overdue

Complaints acknowledged within 5 working days



Acknowledged within 5 working days
Not acknowledged within 5 working days

Speaking Up for Safety

Speaking up for safety is a program introduced by CAHS to promote a culture where staff can raise concerns at any time they identify an issue that they feel may impact on patient safety, or potentially cause harm to children or young people. Over the past twelve months, CAHS rolled out a training program for staff with the support of the Cognitive Institute, and a number of expert safety champions have delivered the training to almost 80 percent of our staff. The program involves using a safety CODE which provides a framework for staff at any level to speak up if concerned, and escalate to a more senior staff member until satisfied that the issue is resolved.

Phase two of the program has commenced to promote professional accountability and report behaviours that undermine CAHS values, and a culture of safety via an anonymous online reporting system. Phase two is in its infancy and will be monitored and reported in alignment with our cultural action and values.

Feedback from our consumers

Working in partnership with our children, young people and their families and seeking their feedback is important in understanding their experience of our services, especially where we have done well and opportunities for improvement. CAHS has a number of mechanisms to seek feedback from our children, young people and their families, including complaints and compliments. The complaints and compliments come in via verbal and written feedback.

In addition, Patient Opinion is another mechanism for consumers to provide anonymous feedback both positive and negative via an online platform. This allows a timely response from the senior executive at CAHS, and is also viewed by other consumers and staff. Regular review of trends allows services to seek opportunities to improve our services.

you said

There needs to be better coordination between medical and mental health treatments for patients with eating disorders.

we did

- Convened a Steering Group that included carers, consumers and mental health advocates, and consulted with interstate peer exemplars to develop a new Model of Care
- Trained more staff in management of eating disorders
- Implemented standard treatment protocols and care plans
- Allocated dedicated nurses each shift to improved continuity of care
- Improved communication between wards for those patients with both medical and mental health needs.

you said

Help decrease the possibility of flu transmission at Perth Children's Hospital.

we did

- Updated our public information screens to ask patients, families, visitors and staff to be vigilant in stopping the spread of the flu by washing their hands regularly using the hand sanitising gel dispensers available around the hospital
- Further asked people to help protect our patients, families and staff by postponing visits where possible if they have a cough, sore throat, runny nose or fever.
- Made masks available at the front reception in addition to the Emergency Department and wards.

you said

Cleanliness in the ED waiting area could be improved.

we did

- Increased inspection and auditing of the area, and increased cleaning throughout the day and night where it did not impact clinical activity.

Significant Issues

Perth Children's Hospital post commissioning and first birthday

On 12 May 2019, CAHS celebrated a year since Perth Children's Hospital (PCH) was formally opened. A month of milestones followed, reflecting the staged opening of the hospital, culminating in a birthday party on 10 June to mark the one year anniversary since inpatients were transferred from Princess Margaret Hospital for Children (PMH) and the opening of the PCH Emergency Department. In PCH's first year, there were 29,773 inpatient admissions, 67,592 Emergency Department presentations, 227,337 outpatient appointments, and 15,071 operations carried out. To celebrate PCH's first birthday, a circus themed hospital-wide celebration was held, which included a scavenger hunt, face painting, roving entertainment, popcorn and, of course, birthday cake.

Issues experienced in previous financial years with the quality of the drinking water at PCH have been resolved, with regular water sampling and testing continuing to ensure the drinking water complies with the Australian Drinking Water Guidelines.

Ageing community infrastructure

The Sustainable Health Review (SHR) Final Report, which was published in April 2019, included a recommendation to establish a 'one-stop-shop' for children, young people and their families where they can access child health, development and mental health services, as well as other government agencies such as education and community services. CAHS has been allocated funds to commence development of a Community Health Hub in the Midland area in line with this recommendation to commence in 2019/2020.

The creation of the CAHS Community Health Hub in Midland will be a positive step for this region in addressing the multiple issues experienced by CAHS in relation to community infrastructure. However, there remains a number of community facilities used by CAHS Community Health and the Child and Adolescent Mental Health Services (CAMHS) that are not fit for purpose or do not comply with building standards pertaining to WorkSafe standards for mental health. In order to comply, improvements are required to address issues including disability access, external access points, air conditioning systems and security. In addition, a number of facilities are poorly located in relation to the population they serve.

Community Health and CAMHS continue to face a constant threat of insecure tenure, with mounting pressure to vacate a number of government facilities. CAHS will continue to build a business case for redevelopment of community infrastructure across the metropolitan area.

"In the 11 years since the apology, we have made some progress in Closing the Gap in areas such as infant mortality and immunisation, but there is still a great deal to be done in other health and social areas."

Managing funds and costs efficiently

The move to PCH was a highlight for 2018–19 with considerable planning and preparation work being completed in the lead up to the move. Commencing as it did during May of 2018, this was the first full year that the hospital was operational and as such, this was a significant journey for CAHS. There was a substantial planning phase prior to the move with a large amount of resources devoted to it. The planning for the hospital's operations, including its finances, were based on detailed and systematic information with a strong governance oversight, which resulted in a robust financial framework and financial business cases that were comprehensively analysed, including external reviews. As a result, the forecast models were logical and have resulted in a firm financial basis for this year of its operations ensuring that the State's resources are utilised effectively and efficiently.

CAHS has several key performance indicators results that performed below target. However, these result from set targets being shared by all Health Service Providers (HSPs) rather than unique targets based on CAHS only financial data.

CAHS operates a new, state of the art, paediatric specialty hospital, and hence it has a different cost structure to other HSPs that operate older facilities and cater primarily to adults. Perth Children's Hospital incurred nearly five times as much depreciation as Princess Margaret Hospital did, and when this is accounted for, financial performance in 2018–19 was similar to last year. Most importantly, CAHS has performed in line with the expectations of its formal Service Agreement with the Department of Health.

Health inequalities

Over the 2018–19 financial year, CAHS has had the opportunity to provide a voice in a number of important initiatives. This included consultation by the Department of Justice regarding the Royal Commission into Institutional Responses to Child Sexual Abuse, the Auditor General's report into ear health in Aboriginal communities, and attendance at the Joint Standing Committee on the Commissioner for Children and Young People hearing by our Chief Executive, Dr Aresh Anwar.

This year marked the eleventh anniversary of National Apology Day, marking the day former Prime Minister Kevin Rudd delivered the National Apology to Aboriginal and Torres Strait Islanders and to the Stolen Generations for the pain and suffering they endured through the past laws, policies and practices of forcible removal of children from their families. In the 11 years since the apology, we have made some progress in Closing the Gap in areas such as infant mortality and immunisation, but there is still a great deal to be done in other health and social areas.

CAHS also provided feedback relating to the Coroner's Inquest into the deaths of 13 children and young persons in the Kimberley region. CAHS acknowledges our ongoing role in improving health care outcomes for those in our care, their families and communities. As the peak paediatric healthcare organisation in Western Australia, CAHS has a real ability to help

support meaningful change and is committed to working in partnership with the WA Country Health Service in helping address these concerns.

Information about CAHS Aboriginal Health initiatives can be found on page 39.

Each year, the Child Development Service (CDS) provides services to approximately 20,000 children who have developmental difficulties, including developmental delay, intellectual disability, autism spectrum disorder and other developmental disorders. The Child Development Service provides assessment services for these children and continuing allied health and paediatric medical care. CDS clinicians are involved in the Behavioural Paediatric Society. 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, in collaboration with CDS, provides mental health care for children with developmental disorders and comorbid mental health difficulties. These children are seen within various CAMHS settings including community clinics and the inpatient unit at PCH. Unfortunately, there are no specialist mental health services for children, adolescents or adults with intellectual developmental disability in WA. This has been recognised as a service gap. A senior CAMHS clinician founded and chairs the WA branch of the RANZCP Section of Intellectual Developmental Disabilities and Mental Illness, which seeks to share resources, provide professional development and advocate for the commissioning of specialist services. CAMHS is also a member of the Neuropsychiatry and Developmental Disability Mental Health Sub network established by the Mental Health Commission.

CAMHS is also 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 is part of the Neuropsychiatry and Developmental Disability Mental Health Subnetwork which provides multi-agency and carer/consumer advice on initiatives for people with developmental disorders and mental health problems

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. The full roll-out of NDIS across WA will be complete on 1 July 2019. There are still a number of issues to be resolved about services for children who were eligible for services under State funding but may now not meet NDIS eligibility. In addition, as NDIS does not provide ongoing medical services, the added complexity of having multiple allied health providers can be a challenge for paediatricians in the CDS regarding ongoing medical case management of complex neurodevelopmental issues.

CAHS and CAMHS also have representatives on the working group for a potential Department of Communities initiative with regards to the provision of more intensive disability support for young people with complex needs in crisis.

Demand and activity

In 2018–19, CAHS delivered 3.3 per cent more weighted activity than expected, which is 7.7% per cent more than last year. Increased activity occurred across inpatient, emergency and outpatient care, with the specialties of child psychiatry, oncology and haematology, and cardiothoracic surgery experiencing the largest growth relative to expectations. Presentations to the Emergency Department increased 8.8% per cent, which is substantially higher than the estimated 1.5 per cent growth in the population of zero to 17 year olds that occurred over the year.

The move to PCH in June 2018 required reducing the amount of elective surgery performed to facilitate training and commissioning. Unfortunately, this coincided with sufficient growth in the waitlist to result in an increased number of patients being over-boundary, i.e. waiting longer than the recommended time for their surgery. CAHS addressed this by directing extra activity to treating dental and ear, nose and throat patients in particular. This resulted in steadily improving performance across all urgency categories in the latter half of the year, and by 30 June 2019, there were no over-boundary patients for both Categories 1 and 2, and only 1.9% of patients were over-boundary for Category 3.

The prevalence of moderate to severe mental illness among children and adolescents in metropolitan Perth is estimated to be 5.6 per cent, or about 26,780 young people.

In the 2018–19 financial year, 6160 children and young people (metro, rural & remote) accessed at least one of the CAMHS non-admitted services; a 6 per cent increase from the previous financial year. This number highlights there is a significant proportion of the Perth metropolitan population of children and adolescents with moderate to severe mental illness that are not accessing non-admitted CAMHS services.

In this period, CAMHS experienced a 2.3 per cent increase in referral demand for its non-admitted services, and an increase in non-admitted occasions of service of 5 per cent. The target percentage growth of non-admitted occasions of service for this period was 1 per cent.

CAMHS is undertaking a review of the Community CAMHS catchment areas and clinic locations. Recommendations from the review will be implemented to ensure CAMHS optimises operations within the current funding structure.

Admitted activity in the 2018–19 financial year was 21.7 per cent above the Mental Health Commission target.

Following a period of accelerated growth between 2006 and 2016, growth in the zero to 18 year old population slowed during 2017 and 2018. Despite this, demand for community health services, particularly the Child Development Service (CDS), continues to grow. In the four years to 2018 -19, the number of referrals accepted by CDS increased from 24,434 to 27,083 (11 per cent).

"The CAHS Culture Action Work Plan 2018 – 2020, which was finalised in September 2018, provides a framework for the next steps in steering the organisation in a new direction in organisational culture."

Managing the workforce

Commissioned in November 2018, the Functional Readiness Assessment aimed to determine how to organise corporate services to deliver an integrated health service equipped to deliver exceptional care and meet strategic priorities.

Feedback obtained over 12 weeks was considered along with best practice advice to determine an intended structure for corporate services. This also highlighted the need to review responsibilities of the Executive team to facilitate an integrated operating model and promote professional accountability. This led to realigned accountability for a number of corporate and non-clinical support services; the Director, Allied Health joined the Health Service Executive Committee, representing the allied health workforce; the Executive Director, Health Service Management became the Executive Director, Operations with shared accountability for clinical services, along with the Executive Director, Nursing and Executive Director, Medical Services; a new Executive Director, People, Capability and Culture to deliver a strategic focus on staff development, engagement and workforce matters. The intended corporate structure was shared with staff in July 2019. Extended consultation was required to establish a CAHS Strategy and Planning function.

Implementation is ongoing, including transactional realignment of the corporate workforce, and review of key activities to ensure the needs of service units are met in this new operating model. Changes to workforce and staff engagement will be considered on appointment of the new Executive Director. A six month project commenced in mid-July to deliver an integrated Training and Education function.

There were 98 Living our Values events held across CAHS to promote the organisation's values of compassion, collaboration, respect, equity, accountability and excellence. The CAHS Culture Action Work Plan 2018 – 2020, which was finalised in September 2018, provides a framework for the next steps in steering the organisation in a new direction in organisational culture. A progress report from May 2019 outlined the headway that has been made into the more than 140 individual action items within the Work Plan.

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 2019 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 2019 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.

7th Floor Albert Facey House 469 Wellington Street Perth MAIL TO: Perth BC PO Box 8489 Perth WA 6849 TEL: 08 6557 7500 FAX: 08 6557 7600

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 2019.

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 2019. 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 2019.

Matter of Significance

Emergency Department Waiting Times

The Under Treasurer has continued his approval to remove the following indicator as a key performance indicator (KPI):

- Percentage of emergency department patients seen within the recommended times

The Under Treasurer's approval requires WA Health to reassess whether this indicator can be re-instated as a KPI once a new emergency department data collection system has been implemented. There is currently no set timeframe for the implementation of a new system.

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 2019 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
28 August 2019

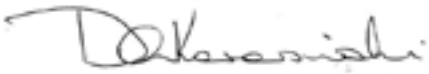
Certification of financial statements

Child and Adolescent Health Service

CERTIFICATION OF FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2019

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 2019 and the financial position as at 30 June 2019.

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
23 August 2019

Prof Geoffrey Dobb
Deputy Chair of the Board
Child and Adolescent Health Service
23 August 2019

Mr Tony Loiacono
Chief Financial Officer
Child and Adolescent Health Service
23 August 2019

Child and Adolescent Health Service
Statement of comprehensive income
For the year ended 30 June 2019

	Notes	2019 $000	2018 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	3.1(a)	453,888	433,218
Fees for visiting medical practitioners		2,537	1,849
Contracts for services	3.2	5,567	7,992
Patient support costs	3.3	77,166	59,045
Finance costs	7.2	35	55
Depreciation and amortisation expense	5.1, 5.2	57,782	11,044
Asset revaluation decrements	5.1	5,071	2,047
Loss on disposal of non-current assets	5.1.2	-	82
Repairs, maintenance and consumable equipment	3.4	9,461	8,599
Other supplies and services	3.5	45,346	36,168
Other expenses	3.6	24,520	22,858
Total cost of services		**681,373**	**582,957**
INCOME			
Revenue			
Patient charges	4.2	15,968	12,947
Other fees for services	4.2	21,260	10,841
Commonwealth grants and contributions	4.3	131,658	125,580
Other grants and contributions	4.3	64,048	64,301
Donation revenue	4.4	1,857	1,502
Commercial activities	4.5	-	869
Gain on disposal of non-current assets	5.1.2	6	-
Other revenue	4.6	5,352	4,046
Total revenue		240,149	220,086
Total income other than income from State Government		**240,149**	**220,086**
NET COST OF SERVICES		**441,224**	**362,871**

	Notes	2019 $000	2018 $000
INCOME FROM STATE GOVERNMENT			
Service appropriations	4.1	401,270	334,184
Assets (transferred)/assumed	4.1	14	(287)
Services received free of charge	4.1	38,579	35,569
Total income from State Government		**439,863**	**369,466**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(1,361)**	**6,595**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.14	(4,124)	1,087
Total other comprehensive income		(4,124)	1,087
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**(5,485)**	**7,682**

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

Child and Adolescent Health Service
Statement of financial position
As at 30 June 2019

	Notes	2019 $000	2018 $000
ASSETS			
Current Assets			
Cash and cash equivalents	7.3	48,327	27,696
Restricted cash and cash equivalents	7.3	12,126	29,868
Receivables	6.1	9,040	6,813
Inventories	6.3	2,560	2,344
Other current assets	6.4	622	537
Total Current Assets		72,675	67,258
Non-Current Assets			
Restricted cash and cash equivalents	7.3	4,972	3,308
Amounts receivable for services	6.2	264,960	200,625
Property, plant and equipment	5.1	1,167,368	1,218,168
Intangible assets	5.2	46,409	51,744
Total Non-Current Assets		1,483,709	1,473,845
TOTAL ASSETS		**1,556,384**	**1,541,103**
LIABILITIES			
Current Liabilities			
Payables	6.5	18,941	32,841
Borrowings	7.1	736	703
Employee benefits provision	3.1 (b)	87,072	84,829
Other current liabilities	6.6	69	23
Total Current Liabilities		106,818	118,396
Non-Current Liabilities			
Borrowings	7.1	3	739
Employee benefits provision	3.1 (b)	24,071	20,988
Total Non-Current Liabilities		24,074	21,727
TOTAL LIABILITIES		**130,892**	**140,123**
NET ASSETS		**1,425,492**	**1,400,980**
EQUITY			
Contributed equity	9.14	1,412,087	1,381,954
Reserves	9.14	-	4,124
Accumulated surplus		13,405	14,902
TOTAL EQUITY		**1,425,492**	**1,400,980**

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

Child and Adolescent Health Service
Statement of cash flows
For the year ended 30 June 2019

	Notes	2019 $000	2018 $000
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		336,898	319,803
Capital appropriations		11,387	1,229
Net cash provided by State Government	7.3.3	**348,285**	**321,032**
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(447,427)	(427,262)
Supplies and services		(125,992)	(102,813)
Receipts			
Receipts from customers		14,048	15,334
Commonwealth grants and contributions		131,658	125,580
Other grants and contributions		63,851	64,301
Donations received		91	1,088
Other receipts		25,038	17,320
Net cash used in operating activities	7.3.2	**(338,733)**	**(306,452)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Purchase of non-current assets		(1,664)	(1,117)
Receipts			
Proceeds from sale of non-current assets	5.1.2	53	-
Net cash used in investing activities		**(1,611)**	**(1,117)**

	Notes	2019 $000	2018 $000
Net increase / (decrease) in cash and cash equivalents		7,941	13,463
Cash and cash equivalents at the beginnning of the period for the Health Service		42,017	28,554
Cash and cash equivalents transferred from Health Ministerial Body	9.14	15,467	-
Cash and cash equivalent at the end of the period for the Health Service		65,425	42,017
Cash and cash equivalents held for the Health Ministerial Body	7.3	-	18,855
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.3	**65,425**	**60,872**

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

Child and Adolescent Health Service
Statement of changes in equity
For the year ended 30 June 2019

	Notes	Contributed equity $000	Reserves $000	Accumulated surplus $000	Total equity $000
Balance at 1 July 2017		206,566	3,037	8,307	217,910
Surplus		-	-	6,595	6,595
Other comprehensive income	9.14	-	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	9.14	1,902	-	-	1,902
Other contributions by owners	9.14	1,232,938	-	-	1,232,938
Distributions to owners	9.14	(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**
Balance at 1 July 2018		1,381,954	4,124	14,902	1,400,980
Changes in accounting policy	9.2	-	-	(136)	(136)
Restated balance at 1 July 2018		**1,381,954**	**4,124**	**14,766**	**1,400,844**
Surplus		-	-	(1,361)	(1,361)
Other comprehensive income	9.14	-	(4,124)	-	(4,124)
Total comprehensive income for the period		-	(4,124)	(1,361)	(5,485)
Transactions with owners in their capacity as owners:					
Capital appropriations	9.14	12,090	-	-	12,090
Other contributions by owners	9.14	18,043	-	-	18,043
Total		30,133	-	-	30,133
Balance at 30 June 2019		**1,412,087**	**-**	**13,405**	**1,425,492**

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

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).

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

These annual financial statements were authorised for issue by the Accountable Authority of the Health Service on 23 August 2019.

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 period from 1 July 2016 to 17 September 2018. Hence, assets, liabilities, income and expenses relating to this period 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 and when the clinical commissioning of the hospital was completed on 17 September 2018. See Note 5.1 'Property, plant and equipment' and Note 5.2 'Intangible assets'.

As a consequence of assuming the control of the PCH project by the Health Service, assets, liabilities, income and expenses for the project have been recognised in the Health Service's financial statements as from 18 September 2018. Note 9.14(c) 'Equity' provides the details of assets and liabilities transferred from the Health Ministerial Body on 18 September 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 deliver high quality health care in hospital and in the community by placing children, young people, families and carers at the centre of everything, as well as build partnerships to advocate and delivery care to those who need it most, advance internationally recognised research focuses on health outcomes and attract exceptional staff by offering continued education, training, support and career development.

The Health Service is predominantly funded by Parliamentary appropriations.

Services

The key services of the Health Service are:

Public Hospital Admitted Services

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

Public Hospital Emergency Services

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

2.1 Health Service objectives (cont.)

Public Hospital Non-admitted Services

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

Mental Health Services

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

Aged and Continuing Care Services

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

Public and Community Health Services

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

2.2 Schedule of income and expenses by service

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

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

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

	Public Hospital Admitted Services		Public Hospital Emergency Services		Public Hospital Non-Admitted Services		Mental Health Services	
	2019	2018	2019	2018	2019	2018	2019	2018
COST OF SERVICES	$000	$000	$000	$000	$000	$000	$000	$000
Expenses								
Employee benefits expense	186,021	176,296	34,239	33,542	74,765	71,205	59,102	56,107
Fees for visiting medical practitioners	1,594	1,151	293	219	641	465	-	-
Contracts for services	788	2,176	290	414	238	879	7	15
Patient support costs	46,893	34,876	8,571	6,636	17,459	14,087	1,476	1,312
Finance costs	22	34	4	7	9	14	-	-
Depreciation and amortisation expense	34,048	6,489	6,267	1,234	13,685	2,621	3,189	66
Asset revaluation decrements	2,932	565	539	107	1,178	228	338	30
Loss on disposal of non-current assets	-	50	-	10	-	21	-	-
Repairs, maintenance and consumable equipment	3,901	3,421	718	651	1,567	1,381	881	1,051
Other supplies and services	20,110	16,797	3,701	3,197	8,082	6,782	4,756	2,572
Other expenses	7,843	7,235	1,443	1,377	3,152	2,923	4,384	4,060
Total cost of services	304,152	249,090	56,065	47,394	120,776	100,606	74,133	65,213
Income								
Patient charges	12,961	11,204	530	266	2,071	1,447	406	30
Other fees for services	13,088	6,583	2,409	1,252	5,261	2,659	146	70
Commonwealth grants and contributions	72,752	71,792	11,605	14,208	40,996	31,704	5,895	5,212
Other grants and contributions	4,277	5,490	788	1,045	1,720	2,217	57,186	55,463
Donation revenue	1,167	935	215	178	469	378	-	-
Commercial activities	-	541	-	103	-	218	-	-
Gain/(loss) on disposal of non-current assets	13	-	(1)	-	(3)	-	-	-
Other revenue	2,641	1,635	486	311	1,062	661	59	6
Total income other than income from State Government	106,899	98,180	16,032	17,363	51,576	39,284	63,692	60,781
NET COST OF SERVICES	**197,253**	**150,910**	**40,033**	**30,031**	**69,200**	**61,322**	**10,441**	**4,432**
INCOME FROM STATE GOVERNMENT								
Service appropriations	177,901	140,277	39,821	27,676	62,995	56,137	3,610	86
Assets (transferred)/assumed	13	(179)	3	(34)	6	(72)	(8)	-
Services received free of charge	17,903	17,699	3,380	3,368	5,729	7,147	4,304	1,934
Total income from State Government	195,817	157,797	43,204	31,010	68,730	63,212	7,906	2,020
SURPLUS / (DEFICIT) FOR THE PERIOD	**(1,436)**	**6,887**	**3,171**	**979**	**(470)**	**1,890**	**(2,535)**	**(2,412)**

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

	Aged and Continuing Care Services [a]		Public and Community Health Services		Total	
	2019 $000	2018 $000	2019 $000	2018 $000	2019 $000	2018 $000
COST OF SERVICES						
Expenses						
Employee benefits expense	1,021	2,109	98,740	93,959	453,888	433,218
Fees for visiting medical practitioners	9	14	-	-	2,537	1,849
Contracts for services	8	26	4,236	4,482	5,567	7,992
Patient support costs	226	383	2,541	1,751	77,166	59,045
Finance costs	-	-	-	-	35	55
Depreciation and amortisation expense	183	78	410	556	57,782	11,044
Asset revaluation decrements	-	-	84	1,117	5,071	2,047
Loss on disposal of non-current assets	-	1	-	-	-	82
Repairs, maintenance and consumable equipment	21	41	2,373	2,054	9,461	8,599
Other supplies and services	87	204	8,610	6,616	45,346	36,168
Other expenses	42	87	7,656	7,176	24,520	22,858
Total cost of services	1,597	2,943	124,650	117,711	681,373	582,957
Income						
Patient charges	-	-	-	-	15,968	12,947
Other fees for services	71	79	285	198	21,260	10,841
Commonwealth grants and contributions	-	1,914	410	750	131,658	125,580
Other grants and contributions	23	66	54	20	64,048	64,301
Donation revenue	6	11	-	-	1,857	1,502
Commercial activities	-	7	-	-	-	869
Gain/(loss) on disposal of non-current assets	-	-	(3)	-	6	-
Other revenue	13	20	1,091	1,413	5,352	4,046
Total income other than income from State Government	113	2,097	1,837	2,381	240,149	220,086
NET COST OF SERVICES	**1,484**	**846**	**122,813**	**115,330**	**441,224**	**362,871**
INCOME FROM STATE GOVERNMENT						
Service appropriations	1,437	801	115,506	109,207	401,270	334,184
Assets (transferred)/assumed	-	(2)	-	-	14	(287)
Services received free of charge	74	178	7,189	5,243	38,579	35,569
Total income from State Government	1,511	977	122,695	114,450	439,863	369,466
SURPLUS / (DEFICIT) FOR THE PERIOD	**27**	**131**	**(118)**	**(880)**	**(1,361)**	**6,595**

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	2019 $000	2018 $000
Employee benefits expense	3.1(a)	453,888	433,218
Contracts for services	3.2	5,567	7,992
Patient support costs	3.3	77,166	59,045
Repairs, maintenance and consumable equipment	3.4	9,461	8,599
Other supplies and services	3.5	45,346	36,168
Other expenses	3.6	24,520	22,858

Liabilities incurred in the delivery of services

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

	Notes	2019 $000	2018 $000
Employee benefits provision	3.1(b)	111,143	105,817

3.1(a) Employee benefits expense

	2019 $000	2018 $000
Salaries and wages	416,059	395,920
Termination benefits	-	1,374
Superannuation - defined contribution plans	37,829	35,924
	453,888	433,218

Salaries and wages: Employee expenses include all costs related to employment including wages and salaries, fringe benefits tax and leave entitlements.

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.

	2019 $000	2018 $000
Current		
Employee benefits provision		
Annual leave [(a)]	43,682	42,174
Time off in lieu leave [(a)]	9,229	9,868
Long service leave [(b)]	33,071	31,762
Deferred salary scheme [(c)]	1,090	1,025
	87,072	84,829
Non-Current		
Employee benefits provision		
Long service leave [(b)]	24,071	20,988
	24,071	20,988
	111,143	105,817

(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:

	2019 $000	2018 $000
Within 12 months of the end of the reporting period	37,176	36,617
More than 12 months after the end of the reporting period	15,735	15,425
	52,911	52,042

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

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:

	2019 $000	2018 $000
Within 12 months of the end of the reporting period	8,261	7,990
More than 12 months after the end of the reporting period	48,881	44,760
	57,142	52,750

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:

	2019 $000	2018 $000
Within 12 months of the end of the reporting period	298	129
More than 12 months after the end of the reporting period	792	896
	1,090	1,025

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 6.8%. This assumption was based on an analysis of the historical turnover rates exhibited by employees in the Health Service. Employees with leave benefits to which they are fully entitled are assumed to take all available leave uniformly over the following five years or to age 65 if earlier.

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

3.2 Contracts for services

	2019 $000	2018 $000
Child, community and primary health	5,036	7,668
Other contracts	531	324
	5,567	7,992

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

	2019 $000	2018 $000
Medical supplies and services [(a)]	64,057	49,358
Domestic charges	5,642	4,728
Food supplies	1,359	1,596
Power and water charges	5,685	3,010
Patient transport costs	307	146
Research, development and other grants	116	207
	77,166	59,045

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

(a) Medical supplies and services include the pathology services received free of charge amounting to $5.082 million from PathWest Laboratory Medicine WA (2018: $4.805 million). See Note 4.1 'Income from State Government'.

3.4 Repairs, maintenance and consumable equipment

	2019 $000	2018 $000
Repairs and maintenance	5,248	6,547
Consumable equipment	4,213	2,052
	9,461	8,599

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

	2019 $000	2018 $000
Facility management services	6,120	-
Administrative services	2,489	2,142
Interpreter services	991	853
Shared services for accounting [(a)]	490	683
Shared services for human resources [(a)]	3,892	3,778
Shared services for information technology [(a)]	26,542	23,620
Shared services for supply [(a)]	2,546	2,587
Other	2,276	2,505
	45,346	36,168

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

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

3.6 Other expenses

	2019 $000	2018 $000
Workers compensation insurance	3,517	5,272
Other insurances	3,167	2,948
Other employee related expenses	1,221	1,403
Communications	1,270	1,477
Computer services	834	672
Consultancy fees	2,760	1,140
Doubtful debts expense [(a)]	-	(167)
Expected credit losses expense [(a)]	1,401	-
Freight and cartage	380	851
Motor vehicle expenses	453	413
Operating lease expenses	4,081	4,501
Periodical subscription	434	456
Printing and stationery	2,396	2,138
Write-down of assets [(b)]	78	208
Other	2,528	1,546
	24,520	22,858

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

(a) **Doubtful debts expense** was recognised as the movement in the allowance for doubtful debts in the previous financial years. From 2018-19, **expected credit losses expense** is recognised as the movement in the allowance for expected credit losses. The allowance for expected credit losses of trade receivables is measured at the lifetime expected credit losses at each reporting date. The Health Service has established a provision matrix that is based on its historical credit loss experience, adjusted for forward-looking factors specific to the debtors and the economic environment. See Note 6.1.1 Movement of the allowance for impairment of receivables.

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

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	2019 $000	2018 $000
Income from State Government	4.1	439,863	369,466
Patient charges and other fees for services	4.2	37,228	23,788
Commonwealth grants and contributions	4.3	131,658	125,580
Other grants and contributions	4.3	64,048	64,301
Donations	4.4	1,857	1,502
Commercial activities	4.5	-	869
Other revenue	4.6	5,352	4,046

4.1 Income from State Government

	2019 $000	2018 $000
Appropriation revenue received during the period:		
Service appropriations (funding via the Department of Health)	401,270	334,184
Assets transferred from/(to) other State government agencies during the period:		
Transfer of medical equipment from other Health Services	64	80
Transfer of medical equipment to other Health Services	(18)	(88)
Transfer of furniture and fittings to other Health Services	(37)	-
Transfer of surplus equipment to other Health Services	-	(279)
Transfer of artwork from other Health Services	5	-
Net assets transferred	14	(287)
Services received free of charge from other State government agencies during the period:		
Health Support Services - accounting, human resources, information technology and supply services	33,471	30,741
Department of Finance - leasing of accommodation	26	23
PathWest Laboratory Medicine WA - pathology services	5,082	4,805
Total services received	38,579	35,569
Total income from State Government	439,863	369,466

(a) **Service Appropriations** are recognised as revenue 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. A corresponding expense is recognised for services received (Note 3.3 'Patient support costs' and Note 3.5 'Other supplies and services').

4.2 Patient charges and other fees for services

	2019 $000	2018 $000
Patient charges		
Inpatient charges	13,332	11,232
Outpatient charges	2,636	1,715
	15,968	12,947
Other fees for services		
Recoveries from the Pharmaceutical Benefits Scheme	18,032	6,806
Clinical services to other health organisations	2,987	3,247
Non clinical services to other health organisations	241	788
	21,260	10,841
	37,228	23,788

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

4.3 Grants and contributions

	2019 $000	2018 $000
Commonwealth grants and contributions		
Recurrent Grants:		
National Health Reform Agreement (funding via Department of Health) [(a)]	125,412	117,684
National Health Reform Agreement (funding via Mental Health Commission) [(a)]	5,895	5,212
National Partnership Agreement - Essential Vaccines	307	750
Other	44	1,934
	131,658	125,580
Other grants and contributions		
Mental Health Commission – service delivery agreement	54,425	52,988
Mental Health Commission – other	2,071	2,017
Disability Services Commission	8	20
Perth Children's Hospital Foundation	3,258	2,040
Telethon Kids Institute	229	301
Channel 7 Telethon Trust	917	4,525
Stan Perron Charitable Trust	540	540
Medtronic Foundation	30	446
Angela Wright Bennett Foundation	400	400
University of Western Australia	445	-
Cystic Fibrosis clinical research	341	-
Raine Medical Research Foundation	296	-
Other	1,088	1,024
	64,048	64,301

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 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

	2019 $000	2018 $000
Perth Children's Hospital Foundation - donations of equipment	1,766	414
Deceased Estate	29	1,020
Other	62	68
	1,857	1,502

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

4.5 Commercial activities

	2019 $000	2018 $000
Sales:		
Café sales revenue	-	1,728
	-	1,728
Cost of sales [(a)]	-	(859)
Gross profit	-	869

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.

The café at the Princess Margaret Hospital was closed in June 2018.

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

4.6 Other revenue

	2019 $000	2018 $000
Pharmaceutical manufacturing activities	2,388	2,320
Rent from commercial tenants	428	-
Expense recoupment from tenants	1,341	-
RiskCover insurance premium rebate	693	1,221
Respiratory clinical trials	-	82
Immunisation services	134	152
Use of hospital facilities	15	12
Other	353	259
	5,352	4,046

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	2019 $000	2018 $000
Property, plant and equipment	5.1	1,167,368	1,218,168
Intangible assets	5.2	46,409	51,744
Total key assets		1,213,777	1,269,912

Depreciation and amortisation expense	Notes	2019 $000	2018 $000
Property, plant and equipment	5.1.1	49,793	10,388
Intangible assets	5.2.1	7,989	656
		57,782	11,044

5.1 Property, plant and equipment

Year ended 30 June 2018	Land	Build-ings	Site infra-struc-ture	Lease-hold improve-ments	Com-puter equip-ment	Furni-ture & fittings	Medical equip-ment	Motor vehicles, other plant & equip-ment	Work in progress	Art-works	Total
	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
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 9.14) [(a)]	-	894,505	17,306	-	82,181	11,140	84,333	83,070	-	4,932	1,177,467
Transfer from South Metropolitan Health Service (Note 9.14)	2,050	920	101	-	-	-	-	-	-	-	3,071
Transfer of PMH assets to Health Ministerial Body (Note 9.14)	(47,800)	(11,652)	-	-	-	-	-	-	-	-	(59,452)
Transfer to other agencies (Note 4.1)	-	-	-	-	-	-	(106)	(255)	-	-	(361)
Transfers between asset classes	-	-	-	-	-	-	3,907	-	(3,907)	-	-
Disposals (Note 5.1.2)	-	-	-	-	-	(4)	(78)	-	-	-	(82)
Revaluation increments / (decrements) [(b)]	(2,047)	1,087	-	-	-	-	-	-	-	-	(960)
Depreciation (Note 5.1.1)	-	(4,108)	(296)	(67)	(1,180)	(472)	(3,390)	(875)	-	-	(10,388)
Write-down of assets (Note 3.6)	-	-	-	-	-	-	-	-	(202)	-	(202)
Carrying amount at 30 June 2018	**21,947**	**905,027**	**18,818**	**387**	**81,007**	**11,100**	**92,377**	**82,377**	**177**	**4,951**	**1,218,168**

(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.

5.1 Property, plant and equipment (cont.)

Year ended 30 June 2019	Land $000	Build-ings $000	Site infra-struc-ture $000	Lease-hold improve-ments $000	Com-puter equip-ment $000	Furni-ture & fittings $000	Medical equip-ment $000	Motor vehicles, other plant & equip-ment $000	Work in progress $000	Art-works $000	Total $000
1 July 2018											
Gross carrying amount	21,947	905,027	19,060	492	82,189	11,752	100,394	83,353	177	4,951	1,229,342
Accumulated depreciation	-	-	(242)	(105)	(1,182)	(652)	(8,017)	(976)	-	-	(11,174)
Carrying amount at start of period	**21,947**	**905,027**	**18,818**	**387**	**81,007**	**11,100**	**92,377**	**82,377**	**177**	**4,951**	**1,218,168**
Additions	-	15	-	-	7	103	1,497	502	1,064	79	3,267
Transfer of PCH assets from Health Ministerial Body (Note 9.14)	-	4,287	1,319	-	9	-	271	(143)	-	-	5,743
Transfer from other agencies (Note 9.14)	1,500	389	-	-	-	-	-	-	-	-	1,889
Transfer from/(to) other Health Services (Note 4.1)	-	-	-	-	-	(37)	46	-	-	5	14
Transfers between asset classes	-	60,632	-	-	(2,833)	-	59	(59,592)	(866)	-	(2,600)
Disposals (Note 5.1.2)	-	-	-	-	-	-	(47)	-	-	-	(47)
Revaluation increments / (decrements) [(b)]	(84)	(9,111)	-	-	-	-	-	-	-	-	(9,195)
Depreciation (Note 5.1.1)	-	(20,126)	(481)	(242)	(14,005)	(661)	(11,300)	(2,978)	-	-	(49,793)
Write-down of assets (Note 3.6)	-	-	-	-	-	-	(58)	(18)	(2)	-	(78)
Carrying amount at 30 June 2019	**23,363**	**941,113**	**19,656**	**145**	**64,185**	**10,505**	**82,845**	**20,148**	**373**	**5,035**	**1,167,368**
Gross carrying amount	23,363	941,113	20,380	492	78,789	11,359	100,073	22,920	373	5,035	1,203,897
Accumulated depreciation	-	-	(724)	(347)	(14,604)	(854)	(17,228)	(2,772)	-	-	(36,529)

(b) Revaluation increment is recorded in the asset revaluation reserve, except to the extent that any increment reverses a revaluation decrement of the same class of assets previously recognised as an expense. Revaluation decrement is recognised as an expense, except to the extent of any balance existing in the asset revaluation reserve in respect of that classes of assets. In 2018-19, revaluation decrement of $4.124 million for buildings is recognised in the asset revaluation reserve, and revaluation decrement of $5.071 million consisting of $4.987 million for buildings and $0.084 million for land is recognised as an expense.

5.1 Property, plant and equipment (cont.)

Initial recognition

Items of property, plant and equipment, costing $5,000 or more are measured initially at cost. Where an asset is acquired for no 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 2018 by the Western Australian Land Information Authority (Valuations and Property Analytics). The valuations were performed during the year ended 30 June 2019 and recognised at 30 June 2019. In undertaking the revaluation, fair value was determined by reference to market values for land: $0.623 million (2018: $0.657 million) and buildings: $0.107 million (2018: $0.118 million). For the remaining balance, fair value of buildings was determined on the basis of current replacement cost and fair value of land was determined on the basis of comparison with market evidence for land with low level utility (high restricted use land).

Revaluation model:

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

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

(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).

5.1 Property, plant and equipment (cont.)

Significant assumptions and judgements

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

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

5.1.1 Depreciation and impairment

Charges for the period

Depreciation	2019 $000	2018 $000
Buildings	20,126	4,108
Site infrastructure	481	296
Leasehold improvement	242	67
Medical equipment	11,300	3,390
Computer equipment	14,005	1,180
Furniture and fittings	661	472
Motor vehicles, other plant and equipment	2,978	875
Total depreciation for the period	**49,793**	**10,388**

As at 30 June 2019 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.

5.1.1 Depreciation and impairment (cont.)

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

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

Land and artworks, which are considered to have an indefinite useful life, are not depreciated. 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 gains (losses) on disposal of non-current assets:

	2019 $000	2018 $000
Carrying amount of non-current assets disposed:		
Property, plant and equipment	(47)	(82)
Proceeds from disposal of non-current assets:		
Property, plant and equipment	53	-
Net gain/(loss) on disposal of non-current assets	6	(82)

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
Carrying amount at 1 July 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
Transfers between asset classes (Note 5.1)	2,600	-	2,600
Additions	54	-	54
Amortisation expense (Note 5.2.1)	(7,989)	-	(7,989)
Carrying amount at 30 June 2019	46,409	-	46,409
Gross carrying amount	55,638	-	55,638
Accumulated amortisation	(9,229)	-	(9,229)
	46,409	-	46,409

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

	2019 $000	2018 $000
Amortisation		
Computer software	7,989	656
Total amortisation for the period	**7,989**	**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 2019 there were no indications of impairment to intangible assets.

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	2019 $000	2018 $000
Receivables	6.1	9,040	6,813
Amount receivable for services	6.2	264,960	200,625
Inventories	6.3	2,560	2,344
Other current assets	6.4	622	537
Payables	6.5	18,941	32,841
Other liabilities	6.6	69	23

6.1 Receivables

	2019 $000	2018 $000
Current		
Patient fee debtors	6,489	6,523
GST receivable	542	439
Other receivables	3,531	3,044
Allowance for impairment of receivables	(4,333)	(4,442)
Accrued revenue	2,811	1,249
	9,040	**6,813**

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, Child and Adolescent Health Service, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service, WA Country Health Service, Health Support Services, PathWest Laboratory Medicine WA, Queen Elizabeth II Medical Centre Trust, Mental Health Commission, and Health and Disability Services Complaints Office.

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

6.1.1 Movement of the allowance for impairment of receivables

	2019 $000	2018 $000
Reconciliation of changes in the allowance for impairment of receivables:		
Balance at start of period	4,442	5,381
Remeasurement under AASB 9	136	-
Restated balance at start of period	4,578	5,381
Doubtful debts expense	-	(167)
Expected credit losses expense	1,401	-
Amount written off during the period	(1,646)	(772)
Balance at end of period	4,333	4,442

The collectability of receivables is reviewed on an ongoing basis and any receivables identified as uncollectible are written-off against the allowance account.

6.2 Amounts receivable for services (Holding Account)

	2019 $000	2018 $000
Current	-	-
Non-Current	264,960	200,625
	264,960	**200,625**

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.

Amounts receivable for services are considered not impaired (i.e. there is no expected credit loss for the holding account).

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

6.3 Inventories

	2019 $000	2018 $000
Current		
Pharmaceutical stores - at cost	2,560	2,344

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

	2019 $000	2018 $000
Current		
Prepayments	582	537
Unearned patient charges	36	-
Others	4	-
	622	537

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

	2019 $000	2018 $000
Current		
Trade payables	2,928	2,217
Payable to Health Ministerial Body	-	18,855
Other payables	38	44
Accrued expenses	8,512	5,298
Accrued salaries	7,461	6,423
Accrued interest	2	4
	18,941	32,841

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

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

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

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

6.6 Other liabilities

	2019 $000	2018 $000
Current		
Paid parental leave scheme	69	23
	69	23

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 cash flows used in 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

	2019 $000	2018 $000
Current		
Department of Treasury loans	736	703
Non-current		
Department of Treasury loans	3	739
	739	1,442

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

	2019 $000	2018 $000
Interest expense	35	55
	35	**55**

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

	2019 $000	2018 $000
Cash and cash equivalents	48,327	27,696
Restricted cash and cash equivalents		
Current		
Funds repayable to Health Ministerial Body [(a)]	-	18,855
Mental Health Commission Funding [(b)]	1,356	1,308
Restricted cash assets held for other specific purposes [(c)]	10,770	9,705
	12,126	29,868
Non-current		
Accrued Salaries Suspense Account [(d)]	4,972	3,308
Total restricted cash and cash equivalents	17,098	33,176
Balance at end of period	**65,425**	**60,872**

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	2019 $000	2018 $000
Net cost of services (Statement of Comprehensive Income)		(441,224)	(362,871)
Non-cash items:			
Doubtful debts expense	3.6	1,401	(167)
Write off of inventory		129	75
Depreciation and amortisation expense	5,1, 5,2	57,782	11,044
Asset revaluation decrement	5.1	5,071	2,047
Net gain/(loss) from disposal of non-current assets	5.1.2	(6)	82
Write down of assets	3.6	78	208
Interest expense paid by the Department of Health	7.2	35	55
Donations of equipment received	4.4	(1,766)	(414)
Services received free of charge	4.1	38,579	35,569
(Increase)/decrease in assets:			
Receivables		(3,655)	4,101
Inventories		(345)	121
Other current assets		(85)	(89)
Increase/(Decrease) in liabilities:			
Payables		(99)	(1,874)
Current provisions		2,243	5,234
Non-current provisions		3,083	616
Other current liabilities		46	(189)
Net cash used in operating activities (Statement of Cash Flows)		**(338,733)**	**(306,452)**

7.3.3 Reconciliation of cash flows from State Government

	2019 $000	2018 $000
Notional cash flows		
Service appropriations as per Statement of Comprehensive Income	401,270	334,184
Capital appropriation credited directly to Contributed equity (refer Note 9.14)	12,090	1,902
	413,360	336,086
Less notional cash flows:		
Items paid directly by the Department of Health for the Health Service and are therefore not included in the Statement of Cash Flows:		
Interest payments to the Department of Treasury	(37)	(57)
Repayment of borrowings to the Department of Treasury	(703)	(673)
Accrual appropriations	(64,335)	(14,324)
	(65,075)	(15,054)
Cash Flows from State Government as per Statement of Cash Flows	348,285	321,032

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

	2019 $000	2018 $000
Commitments for mininum lease payments are payable as follows:		
Within 1 year	1,768	2,632
Later than 1 year and not later than 5 years	3,200	3,818
Later than 5 years	1,598	1,997
	6,566	8,447

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 and mental health facilities. 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

	2019 $000	2018 $000
Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows:		
Within 1 year	561	22
	561	22

Amounts presented for capital expenditure commitments are GST inclusive.

7.4.3 Private sector contracts for the provision of community health services

	2019 $000	2018 $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	4,550	4,943
Later than 1 year and not later than 5 years	1,542	3,489
	6,092	8,432

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

7.4.4 Other expenditure commitments

	2019 $000	2018 $000
Other expenditure commitments contracted for at end of the reporting period but not recognised as liabilities, are payable as follows:		
Within 1 year	22,632	17,311
Later than 1 year and not later than 5 years	26,847	3,967
Later than 5 years	564	-
	50,043	21,278

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

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(d) '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(d) '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:

	2019 $000	2018 $000
Financial Assets		
Cash and cash equivalents	48,327	27,696
Restricted cash and cash equivalents	17,098	33,176
Loans and receivables [(a)]	-	206,999
Financial assets at amortised cost [(a)]	273,458	-
	338,883	**267,871**
Financial Liabilities		
Financial liabilities measured at amortised cost	19,680	34,283
	19,680	**34,283**

(a) The amount of Loans and receivables/Financial assets at amortised cost excludes GST recoverable from ATO (statutory receivable).

(c) Credit risk exposure

The following table details the credit risk exposure on the Health Service's trade receivables using a provision matrix.

		Days past due					
	Total $000	Current $000	31-60 days $000	61-90 days $000	91-180 days $000	181-365 days $000	>1 year $000
30 June 2019							
Expected credit loss rate		3%	2%	28%	43%	57%	83%
Estimated total gross carrying amount at default	12,185	2,408	3,172	754	1,444	1,170	3,237
Expected credit losses	(4,333)	(65)	(78)	(209)	(626)	(665)	(2,690)
1 July 2018 (Remeasurement)							
Expected credit loss rate		8%	15%	16%	43%	40%	94%
Estimated total gross carrying amount at default	10,044	3,824	546	205	1,012	891	3,566
Expected credit losses	(4,578)	(307)	(81)	(33)	(440)	(357)	(3,360)

8.1 Financial risk management (cont.)

(d) Ageing analysis of financial assets

	Carrying amount $000	Not past due and not impaired $000	Past due but not impaired 1 - 3 months $000	3 - 12 months $000	1-5 years $000	More than 5 years $000	Impaired Financial assets $000
2019							
Cash and cash equivalents	48,327	48,327	-	-	-	-	-
Restricted cash and cash equivalents	17,098	17,098	-	-	-	-	-
Receivables [(a)]	8,498	4,959	1,637	1,353	546	3	-
Amounts receivable for services	264,960	264,960	-	-	-	-	-
	338,883	**335,344**	**1,637**	**1,353**	**546**	**3**	**-**
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**	**-**	**-**

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

8.1 Financial risk management (cont.)

(e) 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
2019										
Financial Assets										
Cash and cash equivalents		48,327	-	-	48,327	48,327	48,327	-	-	-
Restricted cash and cash equivalents		17,098	-	-	17,098	17,098	12,126	-	-	4,972
Receivables [(a)]		8,498	-	-	8,498	8,498	8,498	-	-	-
Amounts receivable for services		264,960	-	-	264,960	264,960	-	-	-	264,960
		338,883	-	-	338,883	338,883	68,951	-	-	269,932
Financial Liabilities										
Payables		18,941	-	-	18,941	18,941	18,941	-	-	-
Department of Treasury loans	3.15%	739	-	739	-	753	188	562	3	-
		19,680	-	739	18,941	19,694	19,129	562	3	-

(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
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.)

(f) 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
2019					
Financial Liabilities					
Department of Treasury loans	739	7	7	(7)	(7)
Total Increase/(Decrease)		**7**	**7**	**(7)**	**(7)**
2018					
Financial Liabilities					
Department of Treasury loans	1,442	14	14	(14)	(14)
Total Increase/(Decrease)		**14**	**14**	**(14)**	**(14)**

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

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

Litigation in progress

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

Contaminated sites

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

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

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

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:

2019	Notes	Level 1 $000	Level 2 $000	Level 3 $000	Fair value at end of period $000
Land	5.1				
Residential		-	623	-	623
Specialised		-	-	22,740	22,740
Buildings	5.1				
Residential		-	107	-	107
Specialised		-	-	941,006	941,006
		-	730	963,746	964,476
2018					
Land	5.1				
Residential		-	657	-	657
Specialised		-	-	21,290	21,290
Buildings	5.1				
Residential		-	118	-	118
Specialised		-	-	904,909	904,909
		-	775	926,199	926,974

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)

2019	Land $000	Buildings $000
Fair value at start of period	21,290	904,909
Transfer from Health Ministerial Body	-	4,287
Transfer from other agencies	1,500	389
Reclassification between asset classes	-	60,632
Additions	-	14
Revaluation increments/(decrements) recognised in Profit or Loss	(50)	(4,978)
Revaluation increments/(decrements) recognised in Other Comprehensive Income	-	(4,124)
Depreciation expense	-	(20,123)
Fair Value at end of period	**22,740**	**941,006**
2018		
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	-	894,508
Revaluation increments/(decrements) recognised in Profit or Loss	(1,115)	-
Revaluation increments/(decrements) recognised in Other Comprehensive Income	-	1,087
Depreciation expense	-	(4,108)
Fair Value at end of period	**21,290**	**904,909**

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 hospital and medical centres are specialised buildings valued under the cost approach. This approach uses the depreciated replacement cost method which estimates the current cost of reproduction or replacement of the buildings, on its current site, less deduction for physical deterioration and relevant forms of obsolescence. Depreciated replacement cost is the current replacement cost of an asset less, where applicable, accumulated depreciation calculated on the basis of such cost to reflect the already consumed or expired future economic benefits of the asset.

The techniques involved in the determination of the current replacement costs include:

a) Review and updating of the 'as-constructed' drawing documentation;

b) Categorisation of the drawings using the Building Utilisation Categories (BUC's) which designate the functional areas within the clinical facilities. Each BUC has different cost rates which are calculated from the historical construction costs of similar clinical facilities and are adjusted for the year-to-year change in building costs using building cost index;

c) Measurement of the general floor areas;

d) Application of the BUC cost rates per square meter of general floor areas.

The maximum effective age used in the valuation of specialised buildings is 50 years. The effective age of buildings is initially calculated from the commissioning date, and is reviewed after the buildings have undergone substantial renewal, upgrade or expansion.

The straight line method of depreciation is applied to derive the depreciated replacement cost, assuming a uniform pattern of consumption over the initial 37 years of asset life (up to 75% of current replacement costs). All specialised buildings are assumed to have a residual value of 25% of their current replacement costs.

The valuations are prepared on a going concern basis until the year in which the current use is discontinued.

Buildings with definite demolition plan are not subject to annual revaluation. The depreciated replacement costs at the last valuation dates for these buildings are written down to the Statement of Comprehensive Income as depreciation expenses over their remaining useful life.

9. Other disclosures

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

	Notes
Events occurring after the end of the reporting period	9.1
Initial application of Australian Accounting Standards	9.2
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9.1 Events occurring after the end of the reporting period

The phased transition of the Neonatal Services Directorate at the North Metropolitan Health Service to the Child and Adolescent Health Service will occur in the 2019-20 financial year. The new Neonatal Directorate is to include the Perth Children's Hospital's Neonate Ward, the King Edward Memorial Hospital's Neonatal Intensive Care Unit, Perron Rotary Express Milk Bank, Newborn Emergency Transport Service, outpatient neonatal follow-up service, home visits, and the Centre for Neonatal Research and Education.

9.2 Initial application of Australian Accounting Standards

AASB 9 *Financial instruments*

AASB 9 *Financial Instruments* replaces AASB 139 *Financial instruments: Recognition and Measurements* for annual reporting periods beginning on or after 1 January 2018, bringing together all three aspects of the accounting for financial instruments: classification and measurement; impairment; and hedge accounting.

The Health Service applied AASB 9 prospectively, with an initial application date of 1 July 2018. The adoption of AASB 9 has resulted in changes in accounting policies and adjustments to the amounts recognised in the financial statements. In accordance with paragraph 7.2.15 of AASB 9, the Health Service has not restated the comparative information which continues to be reported under AASB 139. Differences arising from adoption have been recognised directly in Accumulated surplus/(deficit).

The effect of adopting AASB 9 as at 1 July 2018 was, as follows:

	Adjustments	1 July 2018 $000
Assets		
Patient fee debtors	(a), (b)	(136)
Other receivables	(a)	-
Amount receivable for services (Holding Account)	(a)	-
Total Assets		(136)
Total adjustments on Equity		
Accumulated surplus	(a), (b)	(136)
		(136)

The natures of these adjustments are described below:

9.2 Initial application of Australian Accounting Standards (cont.)

(a) Classification and measurement

Under AASB 9, financial assets are subsequently measured at amortised cost, fair value through other comprehensive income (fair value through OCI) or fair value through profit or loss (fair value through P/L). The classification is based on two criteria: the Health Service's business model for managing the assets; and whether the assets' contractual cash flows represent 'solely payments of principal and interest' on the principal amount outstanding.

The assessment of the Health Service's business model was made as of the date of initial application, 1 July 2018. The assessment of whether contractual cash flows on financial assets are solely comprised of principal and interest was made based on the facts and circumstances as at the initial recognition of the assets.

The classification and measurement requirements of AASB 9 did not have a significant impact to the Health Service. The following are the changes in the classification of the Health Service's financial assets:

- Patient fee debtors, other receivables and amount receivable for services classified as Loans and receivables as at 30 June 2018 are held to collect contractual cash flows and give rise to cash flows representing solely payments of principal and interest. These are classified and measured as financial assets at amortised cost beginning 1 July 2018.
- The Health Service did not designate any financial assets as at fair value through P/L.

In summary, upon the adoption of AASB 9, the Health Service had the following required (or elected) reclassifications as at 1 July 2018:

	AASB 139 category	AASB 9 category		
	Loans and receivables $000	Amortised cost $000	Fair value through OCI $000	Fair value through P/L $000
Patient fee debtors*	2,519	2,383	-	-
Other receivables	3,855	3,855	-	-
Amount receivable for services (Holding Account)	200,625	200,625		
	206,999	206,863	-	-

* The change in carrying amount is a result of additional impairment allowance. See the discussion on impairment below.

9.2 Initial application of Australian Accounting Standards (cont.)

(b) Impairment

The adoption of AASB 9 has fundamentally changed the Health Service's accounting for impairment losses for financial assets by replacing AASB 139's incurred loss approach with a forward-looking expected credit loss (ECL) approach. AASB 9 requires the Health Service to recognise an allowance for ECLs for all financial assets not held at fair value through P/L.

Upon adoption of AASB 9, the Health Service recognised an additional impairment on the Health Service's receivables of $136,000 which resulted in a decrease in Accumulated surplus of $136,000 as at 1 July 2018.

Set out below is the reconciliation of the ending impairment allowances in accordance with AASB 139 to the opening loss allowances determined in accordance with AASB 9:

	Impairment under AASB 139 as at 30 June 2018 $000	Remeasurement $000	ECL under AASB 9 as at 1 July 2018 $000
Loans and receivables under AASB 139 / Financial assets at amortised costs under AASB 9	4,442	136	4,578
	4,442	136	4,578

9.3 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 15	*Revenue from Contracts with Customers*	1 Jan 2019

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 contracts with customers. The mandatory effective date of this Standard is currently 1 January 2019 after being amended by AASB 2016-7.

The Health Service's income is primarily derived from appropriations which will be measured under AASB 1058, and thus will not be materially affected by this change. Although the recognition of patient charges and other fees for services will be deferred until the Health Service has discharged its performance obligations, these revenues are expected to be fully recognised at year-end and no contract liability will exist,

The Health Service will adopt the modified retrospective approach on transition to AASB 15. No comparative information will be restated under this approach, and the Health Service will recognise the cumulative effect of initially applying the Standard as an adjustment to the opening balance of accumulated surplus/(deficit) at the date of initial application.

		Operative for reporting periods beginning on/after
AASB 16	*Leases*	1 Jan 2019

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.

The recognition of additional assets and liabilities, mainly from operating leases, will increase the Health Service's total assets by $10.296 million and total liabilities by $10.296 million. In addition, interest and depreciation expenses will increase, offset by a decrease in rental expense for the year ending 30 June 2020 and beyond.

The above assessment is based on the following accounting policy positions :

- Option 1/Option 2 of the modified retrospective approach on transition;
- the 'low value asset' threshold set at $5,000 (except for leases with State Fleet);
- For leases classified as 'short term' (12 months or less), these are not recognised under AASB 16 (except for leases with State Fleet);
- Right-of-use property assets (land and buildings) are measured under the fair value model, subsequent to initial recognition; and
- Discount rates are sourced from WA Treasury Corporation.

The Health Service will adopt the modified retrospective approach on transition to AASB 16. No comparative information will be restated under this approach, and the agency will recognise the cumulative effect of initially applying the Standard as an adjustment to the opening balance of accumulated surplus/(deficit) at the date of initial application.

AASB 1058	*Income of Not-for-Profit Entities*	1 Jan 2019

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 a NFP entity.

AASB 1058 will have no impact on appropriations and recurrent grants received by the Health Service – they will continue to be recognised as income when funds are deposited in the bank account or credited to the holding account.

The Health Service will adopt the modified retrospective approach on transition to AASB 1058. No comparative information will be restated under this approach.

		Operative for reporting periods beginning on/after
AASB 1059	*Service Concession Arrangements: Grantors*	1 Jan 2020
	This Standard addresses the accounting for a service concession arrangement (a type of public private partnership) by a grantor that is a public sector 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. Currently, the Health Service does not have any public private partnerships within the scope of the Standard.	
AASB 2016-8	*Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities*	1 Jan 2019
	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.	
AASB 2018-4	*Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Public Sector Licensors*	1 Jan 2019
	This Standard amends AASB 15 to add requirements and authoritative implementation guidance for application by not-for-profit public sector licensors to transactions involving the issue of licences. There is no financial impact as the Health Service does not issue licences.	
AASB 2018-5	*Amendments to Australian Accounting Standards – Deferral of AASB 1059*	1 Jan 2019
	This Standard amends the mandatory effective date of AASB 1059 so that AASB 1059 is required to be applied for annual reporting periods beginning on or after 1 January 2020 instead of 1 January 2019. There is no financial impact.	
AASB 2018-7	*Amendments to Australian Accounting Standards – Definition of Material*	1 Jan 2020
	This Standard clarifies the definition of material and its application by improving the wording and aligning the definition across AASB Standards and other publications. There is no financial impact.	
AASB 2018-8	*Amendments to Australian Accounting Standards – Right-of-Use Assets of Not-for-Profit Entities*	1 Jan 2019
	This Standard provides a temporary option for not-for-profit entities to not apply the fair value initial measurement requirements for right-of-use assets arising under leases with significantly below-market terms and conditions principally to enable the entity to further its objectives. The Health Service will elect to apply the option to measure right-of-use assets under peppercorn leases at cost (which is generally about $1). As a result, the financial impact of this Standard is not material.	

9.4 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 ($)	**2019**	**2018**
$0	1	1
$1 - $10,000	-	1
$30,001 - $40,000	1	-
$40,001 - $50,000	7	8
$70,001 - $80,000	1	1
Total number of members of the Accountable Authority	10	11

	2019	**2018**
	$000	**$000**
Short-term employee benefits	376	383
Post-employment benefits	36	36
Total compensation of members of the Accountable Authority	**412**	**419**

9.4 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 ($)	2019	2018
$30,001 - $40,000	-	1
$50,001 - $60,000	-	1
$60,001 - $70,000	1	-
$70,001 - $80,000	1	-
$80,001 - $90,000	-	1
$110,001 - $120,000	-	1
$130,001 - $140,000	1	1
$140,001 - $150,000	1	-
$150,001 - $160,000	-	2
$160,001 - $170,000	-	1
$190,001 - $200,000	-	1
$200,001 - $210,000	1	-
$210,001 - $220,000	1	-
$220,001 - $230,000	-	1
$240,001 - $250,000	2	-
$250,001 - $260,000	-	1
$530,001 - $540,000	1	1
$570,001 - $580,000	-	1
$590,001 - $600,000	1	-
Total number of senior officers	10	13

9.4 Key management personnel (cont.)

	2019 $000	2018 $000
Short-term employee benefits	1,997	2,197
Post-employment benefits	232	244
Other long-term benefits	235	243
Total compensation of senior officers	**2,464**	**2,684**

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

9.5 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).

9.5 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	2019 $000	2018 $000
Income			
Service appropriations	4.1	401,270	334,184
Assets assumed/(transferred)	4.1	14	(287)
Services received free of charge	4.1	38,579	35,569
Funding received from the Mental Health Commission	4.3	56,496	55,005
Expenses			
Contracts for services - Department of Communities [(a)]		506	520
Contracts for services - Disability Services Commission [(a)]		520	502
Interest expense on loan - Department of Treasury	7.2	35	55
Insurance payments - Insurance Commission (RiskCover)	3.6	6,684	8,220
Operating lease expenses - Department of Finance [(a)]		1,046	1,252
Operating lease expenses - State Fleet [(a)]		506	526
Remuneration for audit services - Office of the Auditor General	9.13	216	225
Borrowings			
Department of Treasury loans	7.1	739	1,442
Contributed Equity			
Capital appropriations	9.14	12,090	1,902
Transfer of assets from/(to) Health Ministerial Body and government agencies	9.14	18,043	1,173,486

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

9.5 Related party transactions (cont.)

Operating lease commitments with Department of Finance	2019 $000	2018 $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	577	639
Later than 1 year and not later than 5 years	1,451	1,772
Later than 5 years	1,247	1,715
	3,275	4,126

Material transactions with other related parties

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

	2019 $000	2018 $000
Superannuation payments to GESB	32,854	32,265
Payable to GESB	636	549

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.

9.6 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.

9.7 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.

9.8 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 Association

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).

9.9 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:

	2019 $000	2018 $000
Department for Communities - health assessments for children in care	291	284
Disability Services Commission - paediatric services for children with disability	2,877	2,786
Department of Education - school health services	12,510	13,711
	15,678	16,781

9.10 Other statement of receipts and payments

	2019 $000	2018 $000
Commonwealth Grant - Christmas and Cocos Island		
Balance at the start of period	(42)	-
Receipts		
Commonwealth grant - provision of paediatric services	101	46
Payments		
Costs of visiting specialists	(59)	(88)
Balance at the end of period [(a)]	**-**	**(42)**

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

9.11 Special purpose accounts

Mental Health Commission Fund (Child and Adolescent Health Service) Account

The purpose of the special purpose account is to receive funds from the Mental Health Commission, to fund the provision of mental health services as jointly endorsed by the Department of Health and the Mental Health Commission, in the Child and Adolescent Health Service, in accordance with the annual Service Agreement and subsequent agreements.

The special purpose account has been established under section 16(1)(d) of *the Financial Management Act 2006.*

	2019 $000	2018 $000
Balance at the start of period	1,308	695
Receipts		
Service delivery agreement - Commonwealth contributions	5,895	5,212
Service delivery agreement - State contributions	54,425	52,988
Other	2,071	2,017
	62,391	60,217
Payments	(62,343)	(59,604)
	48	613
Balance at the end of period	**1,356**	**1,308**

9.12 Administered trust accounts

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

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

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

9.13 Remuneration of auditors

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

	2019 $000	2018 $000
Auditing the accounts, financial statements, controls, and key performance indicators	216	225

The 2018 amount for remuneration of auditors has been restated.

9.14 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.

	2019 $000	2018 $000
Contributed equity		
Balance at start of period	1,381,954	206,566
Contributions by owners		
Capital appropriations (a)	12,090	1,902
Transfer of net assets from other agencies (b)		
PCH assets and liabilities from the Health Ministerial Body (c)	16,154	1,229,867
Land and building from the Department of Communities (d)	1,889	-
Land, buildings and site infrastructure from South Metropolitan Health Service (d)	-	3,071
Total contributions by owners	**30,133**	**1,234,840**
Distributions to owners		
Transfer of net asset to other agencies (b)		
PMH land and buildings to the Health Ministerial Body (e)	-	(59,452)
Total distributions to owners	**-**	**(59,452)**
Balance at end of period	**1,412,087**	**1,381,954**

(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.

9.14 Equity (cont.)

(c) Assets and liabilities for the Perth Children's Hospital (PCH) were transferred from the Health Ministerial Body (Perth Children's Hospital's Project) to the Health Service:

	Notes	2019 $000	2018 $000
Property, plant and equipment	5.1	5,743	1,177,467
Intangible assets	5.2	-	52,400
Cash and cash equivalents		15,467	-
Receivables		109	-
Payables		(5,165)	-
Total PCH assets and liabilities transferred		16,154	1,229,867

(d) A property was transferred from the Department of Communities during the 2018-19 financial year.

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 2017-18 financial year.

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

	2019 $000	2018 $000
Assets revaluation reserve		
Balance at start of period	4,124	3,037
Net revaluation increments/(decrements) [(a) (b)]		
Buildings	(4,124)	1,087
Balance at end of period	-	4,124

(a) Any revaluation increment is credited directly to the asset revaluation reserve, except to the extent that any increment reverses a revaluation decrement of the same class of assets previously recognised as an expense.

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

9.15 Supplementary financial information

(a) Revenue, public and other property written off

	2019 $000	2018 $000
Revenue and debts written off under the authority of the Accountable Authority	1,696	772
Public and other property written off under the authority of the Accountable Authority	70	-
	1,766	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.

9.16 Explanatory statement

All variances between estimates (original budget) and actual results for 2019 and between the actual results for 2019 and 2018 are shown below. Narratives are provided for key major variances, which are generally greater than:

(i) 5% and $12 million for Statement of Comprehensive Income;

(ii) 5% and $31 million for Statement of Financial Position; and

(iii) 5% and $12 million for Statement Cash Flows.

TI 945 excludes changes in asset revaluation surplus, cash assets, receivables, payables, contributed equity and accumulated surplus from the definition of major variances for disclosure purpose.

9.16.1 Statement of Comprehensive Income Variances

	Variance note	Estimate 2019 $000	Actual 2019 $000	Actual 2018 $000	Variance between estimate and actual $000	Variance between actual results for 2019 and 2018 $000
Expenses						
Employee benefits expense		443,227	453,888	433,218	10,661	20,670
Fees for visiting medical practitioners		2,495	2,537	1,849	42	688
Contracts for services		1,512	5,567	7,992	4,055	(2,425)
Patient support costs	(a) (c)	65,016	77,166	59,045	12,150	18,121
Finance costs		38	35	55	(3)	(20)
Depreciation and amortisation expense	(d)	64,844	57,782	11,044	(7,062)	46,738
Asset revaluation decrements		-	5,071	2,047	5,071	3,024
Loss on disposal of non-current assets		-	-	82	-	(82)
Repairs, maintenance and consumable equipment		7,700	9,461	8,599	1,761	862
Other supplies and services		42,859	45,346	36,168	2,487	9,178
Other expenses		20,291	24,520	22,858	4,229	1,662
Total cost of services		**647,982**	**681,373**	**582,957**	**33,391**	**98,416**

9.16.1 Statement of Comprehensive Income Variances (cont.)

	Variance note	Estimate 2019 $000	Actual 2019 $000	Actual 2018 $000	Variance between estimate and actual $000	Variance between actual results for 2019 and 2018 $000
Revenue						
Patient charges		15,369	15,968	12,947	599	3,021
Other fees for services	(b)	8,960	21,260	10,841	12,300	10,419
Commonwealth grants and contributions		123,783	131,658	125,580	7,875	6,078
Other grants and contributions		65,705	64,048	64,301	(1,657)	(253)
Donation revenue		552	1,857	1,502	1,305	355
Commercial activities		-	-	869	-	(869)
Gain on disposal of non-current assets		-	6	-	6	6
Other revenue		7,974	5,352	4,046	(2,622)	1,306
Total revenue		222,343	240,149	220,086	17,806	20,063
Total income other than income from State Government		**222,343**	**240,149**	**220,086**	**17,806**	**20,063**
NET COST OF SERVICES		**425,639**	**441,224**	**362,871**	**15,585**	**78,353**
INCOME FROM STATE GOVERNMENT						
Service appropriations	(e)	389,939	401,270	334,184	11,331	67,086
Assets (transferred)/assumed		-	14	(287)	14	301
Services received free of charge		35,700	38,579	35,569	2,879	3,010
Total income from State Government		**425,639**	**439,863**	**369,466**	**14,224**	**70,397**
SURPLUS / (DEFICIT) FOR THE PERIOD		**-**	**(1,361)**	**6,595**	**(1,361)**	**(7,956)**
OTHER COMPREHENSIVE INCOME						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve		-	(4,124)	1,087	(4,124)	(5,211)
Total other comprehensive income		-	(4,124)	1,087	(4,124)	(5,211)
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**-**	**(5,485)**	**7,682**	**(5,485)**	**(13,167)**

9.16.1 Statement of Comprehensive Income Variances (cont.)

Major Variance Narratives

Variances between estimates and actuals

(a) Patient support costs are $12.150 million above the budget estimate because of the unexpectedly higher drug costs and unplanned increases in oncology and respiratory activities.

(b) Other fees for services have exceeded the budget estimate by $12.300 million as a consequence of higher recoveries of drug costs from the Pharmaceutical Benefits Scheme.

Variances between actuals for 2018-19 and 2017-18

(c) Patient support costs have risen by $18.121 million predominately due to the higher costs of drug supplies ($11.609 million increase) resulting from the uses of expensive new drugs and increased oncology and respiratory activities, along with higher power and water charges ($2.675 million increase) for the Perth Children's Hospital (PCH) as compared to the former Princess Margaret Hospital.

(d) The increase of $46.738 million in depreciation and amortisation expense is largely for the property, plant and equipment and intangible assets for PCH transferred from the Health Ministerial Body to the Health Service, when the hospital opened in May 2018.

(e) The $67.086 million increase in service appropriations mainly consists of $17.095 million in cash appropriations and $50.011 million in accrual appropriations for funding the depreciation and amortisation expense at PCH.

9.16.2 Statement of Financial Position Variances

	Variance note	Estimate 2019 $000	Actual 2019 $000	Actual 2018 $000	Variance between estimate and actual $000	Variance between actual results for 2019 and 2018 $000
ASSETS						
Current Assets						
Cash and cash equivalents		39,675	48,327	27,696	8,652	20,631
Restricted cash and cash equivalents		17,700	12,126	29,868	(5,574)	(17,742)
Receivables		8,291	9,040	6,813	749	2,227
Inventories		2,385	2,560	2,344	175	216
Other assets		-	622	537	622	85
Total Current Assets		68,051	72,675	67,258	4,624	5,417
Non-Current Assets						
Restricted cash and cash equivalents		3,308	4,972	3,308	1,664	1,664
Amounts receivable for services	(f)	265,469	264,960	200,625	(509)	64,335
Property, plant and equipment		1,168,782	1,167,368	1,218,168	(1,414)	(50,800)
Intangible assets		43,872	46,409	51,744	2,537	(5,335)
Total Non-Current Assets		1,481,431	1,483,709	1,473,845	2,278	9,864
TOTAL ASSETS		**1,549,482**	**1,556,384**	**1,541,103**	**6,902**	**15,281**

9.16.2 Statement of Financial Position Variances (cont.)

	Variance note	Estimate 2019 $000	Actual 2019 $000	Actual 2018 $000	Variance between estimate and actual $000	Variance between actual results for 2019 and 2018 $000
LIABILITIES						
Current Liabilities						
Payables		33,886	18,941	32,841	(14,945)	(13,900)
Borrowings		806	736	703	(70)	33
Provisions		82,513	87,072	84,829	4,559	2,243
Other liabilities		-	69	23	69	46
Total Current Liabilities		117,205	106,818	118,396	(10,387)	(11,578)
Non-Current Liabilities						
Borrowings		739	3	739	(736)	(736)
Provisions		20,992	24,071	20,988	3,079	3,083
Total Non-Current Liabilities		21,731	24,074	21,727	2,343	2,347
TOTAL LIABILITIES		**138,936**	**130,892**	**140,123**	**(8,044)**	**(9,231)**
NET ASSETS		**1,410,546**	**1,425,492**	**1,400,980**	**14,946**	**24,512**
EQUITY						
Contributed equity		1,381,638	1,412,087	1,381,954	30,449	30,133
Reserves		10,580	-	4,124	(10,580)	(4,124)
Accumulated surplus		18,328	13,405	14,902	(4,923)	(1,497)
TOTAL EQUITY		**1,410,546**	**1,425,492**	**1,400,980**	**14,946**	**24,512**

9.16.2 Statement of Financial Position Variances (cont.)

Major Variance Narratives

Variances between actuals for 2018-19 and 2017-18

(f) Amounts receivable for services increased by $64.335 million due to the additional accrual appropriations for funding the full year's depreciation and amortisation expense for the Perth Children's Hospital.

9.16.3 Statement of Cash Flows Variances

	Variance note	Estimate 2019 $000	Actual 2019 $000	Actual 2018 $000	Variance between estimate and actual $000	Variance between actual results for 2019 and 2018 $000
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriations	(h)	325,095	336,898	319,803	11,803	17,095
Capital appropriations		6,914	11,387	1,229	4,473	10,158
Net cash provided by State Government		**332,009**	**348,285**	**321,032**	**16,276**	**27,253**
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits		(443,649)	(447,427)	(427,262)	(3,778)	(20,165)
Supplies and services	(g) (i)	(103,133)	(125,992)	(102,813)	(22,859)	(23,179)
Receipts						
Receipts from customers		14,523	14,048	15,334	(475)	(1,286)
Commonwealth grants and contributions		123,783	131,658	125,580	7,875	6,078
Other grants and contributions		62,077	63,851	64,301	1,774	(450)
Donations received		241	91	1,088	(150)	(997)
Other receipts		20,874	25,038	17,320	4,164	7,718
Net cash used in operating activities		**(325,284)**	**(338,733)**	**(306,452)**	**(13,449)**	**(32,281)**

9.16.3 Statement of Cash Flows Variances (cont.)

	Variance note	Estimate 2019 $000	Actual 2019 $000	Actual 2018 $000	Variance between estimate and actual $000	Variance between actual results for 2019 and 2018 $000
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Purchase of non-current assets		(6,914)	(1,664)	(1,117)	5,250	(547)
Receipts						
Proceeds from sale of non-current assets		-	53	-	53	53
Net cash used in investing activities		**(6,914)**	**(1,611)**	**(1,117)**	**5,303**	**(494)**
Net increase / (decrease) in cash and cash equivalents		(189)	7,941	13,463	8,130	(5,522)
Cash and cash equivalents at the beginning of period for the Health Service		38,709	42,017	28,554	3,308	13,463
Cash transferred from Health Ministerial Body		-	15,467	-	15,467	15,467
Cash and cash equivalents at the end of the period for the Health Service		38,520	65,425	42,017	26,905	23,408
Cash and cash equivalents at the beginning of period for the Health Ministerial Body		18,855	18,855	12,244	-	6,611
Cash transferred to the Health Ministerial Body		-	(15,467)	-	(15,467)	(15,467)
Net increase / (decrease) in cash and cash equivalents for the Health Ministerial Body		-	(3,388)	6,611	(3,388)	(9,999)
Cash and cash equivalents at the end of the period for the Health Ministerial Body		18,855	-	18,855	(18,855)	(18,855)
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**57,375**	**65,425**	**60,872**	**8,050**	**4,553**

9.16.3 Statement of Cash Flows Variances (cont.)

Major Variance Narratives

Variances between estimates and actuals

(g) Supplies and services are higher than the budget estimate by $22.859 million due to the underestimation of payments for the Perth Children's Hospital (PCH). In addition to the unplanned drug costs and increases in hospital activities, the unbudgeted payments also include $6.371 million for the PCH project for the period from 18 September 2018 to 30 June 2019.

Variances between actuals for 2018-19 and 2017-18

(h) The increase of $17.095 million in the cash component of service appropriations is principally for the payments of higher costs incurred at the Perth Children's Hospital.

(i) See explanation in variance note (c) for the Statement of Comprehensive Income.

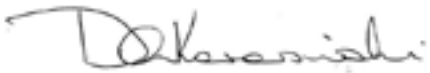
Key performance indicators

Certification of key performance indicators

Child and Adolescent Health Service

CERTIFICATION OF KEY PERFORMANCE INDICATORS FOR THE YEAR ENDED 30 JUNE 2019

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 2019.



Ms Deborah Karasinski
Chair of the Board
Child and Adolescent Health Service
23 August 2019

Prof Geoffrey Dobb
Deputy Chair of the Board
Child and Adolescent Health Service
23 August 2019

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 25.

The latest available data has been used to report performance.

KPIs measuring Outcome 1

Unplanned hospital readmissions for patients within 28 days for selected surgical procedures 176

Percentage of elective wait list patients waiting over boundary for reportable procedures 178

Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days 180

Percentage of admitted patients who discharged against medical advice: a) Aboriginal patients; and b) Non-Aboriginal patients 182

Readmissions to acute specialised mental health inpatient services within 28 days of discharge 184

Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services 186

Average admitted cost per weighted activity unit 188

Average Emergency Department cost per weighted activity unit 190

Average non-admitted cost per weighted activity unit 192

Average cost per bed-day in specialised mental health inpatient services 194

Average cost per treatment day of non-admitted care provided by mental health services 196

KPIs measuring Outcome 2

Average cost per person of delivering population health programs by population health units 198

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

Rationale

Higher hospital readmission rates may be the result of patients being discharged prematurely and/or ineffective discharge planning and communication[5]. Many unplanned hospital readmissions are associated with the original reason for hospitalisation. These readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

Readmission rate is considered a global performance measure, as it potentially points to deficiencies in the functioning of the overall healthcare system. Along with the provision of appropriate interventions, good discharge planning can help to decrease the likelihood of unplanned hospital readmissions by providing patients with the care instructions they need after a hospital stay and helping patients recognise symptoms that may require medical attention.

5 Pearson, B., Skelly, R., Wileman, D., Masud, T. (2002). Unplanned readmission to hospital: a comparison of the views of general practitioners and hospital staff. Age and Ageing, Vol. 31 No. 2, 141-143.

The surgeries selected to be measured by this indicator are based on the seven surgery types in the current National Health Agreement Unplanned Readmission performance indicator (NHA PI 23).

Target

The 2018 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	32.8

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

Results

The rates of unplanned readmissions within 28 days for selected surgical procedures from 2016 to 2018 are presented Table 5.

The rate of unplanned readmission for tonsillectomy and adenoidectomy was 107.5 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. CAHS has been working to reduce the readmission rate and has seen significant improvements since close to the end of the reporting period.

The rate of unplanned readmissions for appendicectomy was 37.7 per 1,000, which is above the target of 32.8 per 1,000. The result should be interpreted with caution given it is based on few readmissions.

There were no unplanned readmissions for hip replacement or cataract surgery, and CAHS did not perform any knee replacements, hysterectomies or prostatectomies in 2018.

Table 5: Rate of unplanned readmissions for patients within 28 days for selected surgical procedures, 2016 to 2018

SURGICAL PROCEDURE	2016 (PER 1,000)	2017 (PER 1,000)	2018 (PER 1,000)	TARGET (PER 1,000)
Knee Replacement	N/A	N/A	N/A	26.2
Hip Replacement	N/A	N/A	0.0	17.2
Tonsillectomy & Adenoidectomy	74.6	87.8	107.5	61.0
Hysterectomy	N/A	N/A	N/A	41.3
Prostatectomy	N/A	N/A	N/A	38.8
Cataract Surgery	0.0	0.0	0.0	1.1
Appendicectomy	45.2	20.8	37.7	32.8

Notes:

1. Previously reported as *Unplanned hospital readmissions of public hospital patients within 28 days for selected surgical procedures.*
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.
3. Results listed as N/A (not available) are due to zero cases having been treated.

Data sources: Hospital Morbidity Data Collection, WA Data Linkage System.

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

Rationale

Elective surgery refers to planned surgery that can be booked in advance following specialist assessment that results in placement on an elective surgery waiting list. Elective surgery wait lists should be actively managed by hospitals to ensure fair and equitable access to the limited elective services available within the public health system.

Elective services delivered in the WA health system are those deemed to be clinically necessary procedures, and potential negative impacts of excessive waiting times for these services include the likelihood of a worsening of the patient's condition and/or quality of life or even death[6]. Therefore, waiting lists must be actively managed by hospitals to ensure all patients are treated in clinically appropriate timeframes. Patients are prioritised based on their assigned clinical urgency category:

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

On 1 April 2016, WA Health introduced a new Statewide performance target for the provision of elective services. The new target requires no patients (0 per cent) on the elective waiting lists to wait longer than the clinically recommended time for their procedure, according to their urgency category.

Target

The 2018–19 target is zero per cent for each urgency category. Performance is demonstrated by a result that is equal to the target.

Results

In 2018–19, CAHS' performance with surgical waitlisting of patients and treating them within recommended timeframes unfortunately declined when averaged across the entire year. Table 6 shows an average of 2.4 per cent of Category 1 patients were not treated within 30 days, 12.1 per cent of Category 2 patients were not treated within 90 days and 5.8 per cent of Category 3 patients were not treated within 365 days.

The move to PCH in June 2018 required reducing the amount of elective surgery performed to facilitate training and commissioning. Unfortunately, this coincided with substantial growth in the waitlist resulting in an increased number of patients being over-boundary. Although CAHS did not achieve the target result of no over-boundary patients, extra activity directed to treating dental and ear, nose and throat patients in particular resulted in steadily improving performance across all urgency categories over the latter half of the reporting period. As of 30 June 2019, CAHS recorded no over-boundary patients for both Categories 1 and 2, and only 1.9 per cent over-boundary for Category 3.

6 Derrett, S., Paul, C., Morris, J.M. (1999). Waiting for Elective Surgery: Effects on Health-Related Quality of Life, International Journal of Quality in Health Care, Vol 11 No. 1, 47-57.

Table 6: Percentage of elective wait list patients waiting over boundary for reportable procedures, by urgency category, 2016–17 to 2018–19

URGENCY	2016–17 (%)	2017–18 (%)	2018–19 (%)	TARGET (%)
Category 1 (≤30 days)	0.4	0.7	2.4	0
Category 2 (≤90 days)	0.1	0.6	12.1	0
Category 3 (≤365 days)	0.0	0.1	5.8	0

Notes:

1. Previously reported as *Proportion of elective wait list patients waiting over boundary for reportable procedures.*
2. The result is based on an average of weekly census data for the financial year.

Data source: Elective Services Wait List Data Collection.

Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days

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 is estimated at 20–25 per cent in adults and five per cent in children).

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

This key performance indicator (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 2018 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. 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. In 2018, CAHS introduced the following strategies to reduce the rate of infection:

- 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*

"CAHS reduced its *S. aureus* bloodstream infection rate in 2018 to 0.96 per 10,000 occupied bed-days, which is below the WA health system target and less than half the national benchmark"

- 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.

CAHS reduced its *S. aureus* bloodstream infection rate in 2018 to 0.96 per 10,000 occupied bed-days, which is below the WA health system target (see Table 7) and less than half the national benchmark of 2.0 per 10,000 bed-days[7].

7 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.

Table 7: Hospital infection rates (HA-SABSI) per 10,000 occupied bed-days, 2017–2018

	2017 (PER 10,000 OCCUPIED BED-DAYS)	2018 (PER 10,000 OCCUPIED BED-DAYS)	TARGET (PER 10,000 OCCUPIED BED-DAYS)
HA-SABSI rate	1.03	0.96	1.0

Notes:
1. Previously reported as *Hospital infection rates (HA-SABSI) per 10,000 occupied bed-days in public hospitals.*

Data source: Healthcare Infection Surveillance Western Australia Data Collection.

Percentage of admitted patients who discharged against medical advice: a) Aboriginal patients; and b) Non-Aboriginal patients

Rationale

Discharge against medical advice (DAMA) refers to patients leaving hospital against the advice of their treating medical team or without advising hospital staff (i.e. absconding or missing and not found). Patients who DAMA have a higher risk of readmission and mortality[8] and have been found to cost the health system 50 per cent more than patients who are discharged by their physician.[9]

Between July 2013 and June 2015, Aboriginal patients in WA were almost 12.7 times more likely than non-Aboriginal patients to discharge against medical advice, compared with seven times nationally[10]. This statistic indicates a need for improved responses to the needs of Aboriginal patients by the health system.

This indicator provides a measure of the safety and quality of inpatient care. Reporting the results by Aboriginality assists in measuring the effectiveness of initiatives within the WA health system to deliver culturally secure services to Aboriginal people and addressing underlying factors in achieving an equitable treatment outcome for Aboriginal patients compared with non-Aboriginal patients.

Target

The 2018 target is 0.77 per cent. Performance is demonstrated by a result that is equal to or below the target.

Results

In 2018, CAHS recorded a rate of discharge against medical advice of 0.26 per cent for Aboriginal patients, and 0.06 per cent for non-Aboriginal patients. These results are below the target of 0.77 per cent and improvements on 2017 (see Table 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.

8 Yong et al. Characteristics and outcomes of discharges against medical advice among hospitalised patients. Internal medicine journal 2013:43(7):798-802.

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

10 Commonwealth of Australia. (2017). Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report, Commonwealth of Australia, Canberra.

"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."

Table 8: Percentage of admitted patients who discharged against medical advice, 2017–2018

	2017 (%)	2018 (%)	TARGET (%)
Aboriginal patients	0.30	0.26	0.77
Non-Aboriginal patients	0.09	0.06	0.77

Notes:

1. Previously reported as Percentage of admitted Aboriginal and Non-Aboriginal patients who discharged against medical advice.

Data source: Hospital Morbidity Data Collection.

Readmissions to acute specialised mental health inpatient services within 28 days of discharge

Rationale

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

While multiple hospital admissions over a lifetime may be necessary for someone with ongoing illness, a high proportion of readmissions shortly after discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was not adequate to maintain the patient's recovery out of hospital.[11] 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.

International literature identifies the concept of one month as an appropriate defined time period for the measurement of readmissions following separation from an acute inpatient mental health service. Based on this, a timeframe of 28 days for this indicator has been set and endorsed by the Australian Health Ministers' Advisory Council Mental Health Information Strategy Standing Committee (as at 24 March 2011).

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 2018 target is 12 per cent[12]. 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. Child and Adolescent Mental Health Services 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 2018, the rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit was 28.5 per cent, which is above the target of 12 per cent (Table 9). It should be noted that a high readmission rate does not necessarily mean poor clinical practice. Furthermore,

11 Pearson, B., Skelly, R., Wileman, D., Masud, T. (2002). Unplanned readmission to hospital: a comparison of the views of general practitioners and hospital staff. Age and Ageing, Vol. 31 No. 2, 141-143.

12 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

"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."

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.

Table 9: Rate of readmission to acute specialised mental health inpatient services within 28 days of discharge, 2017–2018

	2017 (%)	2018 (%)	TARGET (%)
Readmission rate	28.3	28.5	12

Notes:
1. Previously reported as Rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit.

Data source: Hospital Morbidity Data Collection.

Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services

Rationale

In 2014–15, there were 4.0 million Australians (17.5 per cent) who reported having a mental or behavioural condition[13]. 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 key performance indicator 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 2018 target is 75 per cent. Performance is demonstrated by a result that is equal to or above the target.

Result

In 2018, 73.5 per cent of young people who were admitted to CAHS acute specialised mental health inpatient services were contacted by a community-based public mental health non-admitted health service within seven days of discharge (Table 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 (i.e. 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.

13 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

"The standard underlying the measure is that continuity of care involves prompt community follow-up in the vulnerable period following discharge from hospital."

Table 10: Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services, 2016 to 2018

	2016 (%)	2017 (%)	2018 (%)	TARGET (%)
Post-discharge community based contact	72.9	72.4	73.5	75

Notes:

1. Previously reported as *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.*
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 Data Collection, Hospital Morbidity Data Collection.

Average admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per weighted activity unit compared with the State (aggregated) target, as approved by the Department of Treasury and published in the 2018–19 Budget Paper No. 2, Volume 1.

The measure ensures a consistent methodology is applied to calculating and reporting the cost of delivering inpatient activity against the State's funding allocation. As admitted services received nearly half of the overall 2018–19 budget allocation, it is important the efficiency of this service delivery is accurately monitored and reported.

Target

The 2018–19 target is $6,948 per weighted activity unit. Performance is demonstrated by result that is equal to or below the target.

Result

The average admitted cost per weighted activity unit in 2018–19 was $7,937, which is above the target.

It is important to note that the target was developed at a whole of WA health system level, and it applies to all Health Service Providers (HSPs).

CAHS operates a new, state of the art, paediatric specialty hospital, and hence it has a different cost structure to other HSPs that operate older facilities and cater primarily to adults. For example, in 2018–19, Perth Children's Hospital incurred over five times as much depreciation for the building, equipment and infrastructure as it did when operating Princess Margaret Hospital. Excluding the effect of this additional depreciation reveals similar financial performance in 2018–19 to last year (see Note 2).

CAHS has a Service Agreement with the Department of Health that specifies the funding it has been allocated to meet the services it is expected to deliver. This effectively sets CAHS-specific performance targets that are substantially higher than the Annual Report targets, as it includes allocations for items such as the depreciation applicable to PCH. In 2018–19, CAHS performed in line with the financial expectations of its Service Agreement when delivering inpatient care.

"The measure ensures a consistent methodology is applied to calculating and reporting the cost of delivering inpatient activity against the State's funding allocation."

Table 11: Average admitted cost per weighted activity unit, 2017–18 to 2018–19

	2017–18	2018–19	TARGET
Average admitted cost per weighted activity unit	$7,116	$7,937 (see Note 2)	$6,948

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. When excluding depreciation for comparative purposes, the *Average admitted cost per weighted activity unit* was $6,989 in 2017-18 and $7,048 in 2018–19.

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

Average Emergency Department cost per weighted activity unit

Rationale

This indicator is a measure of the cost per weighted activity unit compared with the State (aggregated) target as approved by the Department of Treasury, which is published in the *2018–19 Budget Paper No. 2, Volume 1*.

The measure ensures a consistent methodology is applied to calculating reporting the cost of delivering Emergency Department (ED) activity against the State's funding allocation. With the increasing demand on EDs and health services, it is important ED service provision is monitored to ensure the efficient delivery of safe and high-quality care.

Target

The 2018–19 target is $7,072 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 2018 -19 was $7,493, which is above the target. It is important to note that the target was developed at a whole of WA health system level, and it applies to all Health Service Providers (HSPs).

CAHS operates a new, state of the art, paediatric specialty hospital, and hence it has a different cost structure to other HSPs that operate older facilities and cater primarily to adults. For example, in 2018–19, Perth Children's Hospital incurred over five times as much depreciation for the building, equipment and infrastructure as it did when operating Princess Margaret Hospital. Excluding the effect of this additional depreciation reveals similar financial performance in 2018 -19 to last year (see Note 2).

CAHS has a Service Agreement with the Department of Health that specifies the funding it has been allocated to meet the services it is expected to deliver. This effectively sets CAHS-specific performance targets that are substantially higher than the Annual Report targets, as it includes allocations for items such as the depreciation applicable to PCH. In 2018–19, CAHS performed within the financial expectations of its Service Agreement when delivering emergency care.

Table 11: Average Emergency Department cost per weighted activity unit, 2017–18 to 2018–19

	2017–18	2018–19	TARGET
Average Emergency Department cost per weighted activity unit	$6,791	$7,493 (see Note 2)	$7,072

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. When excluding depreciation for comparative purposes, the *Average Emergency Department cost per weighted activity unit* was $6,672 in 2017-18 and $6,583 in 2018–19.

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

Average non-admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per weighted activity unit compared with the State (aggregated) target, as approved by the Department of Treasury, which is published in the 2018–19 Budget Paper No. 2, Volume 1.

The measure ensures a consistent methodology is applied to calculating and reporting the cost of delivering non-admitted activity against the State's funding allocation. Non-admitted services play a pivotal role within the spectrum of care provided to the WA public, therefore it is important non-admitted service provision is monitored to ensure the efficient delivery of safe and high-quality care.

Target

The 2018–19 target is $7,136 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 2018–19 was $7,693, which is above the target. It is important to note that the target was developed at a whole of WA health system level, and it applies to all Health Service Providers (HSPs).

CAHS operates a new, state of the art, paediatric specialty hospital, and hence it has a different cost structure to other HSPs that operate older facilities and cater primarily to adults. For example, in 2018–19, Perth Children's Hospital incurred over five times as much depreciation for the building, equipment and infrastructure as it did when operating Princess Margaret Hospital. Excluding the effect of this additional depreciation still indicates less efficient financial performance in 2018–19 than last year (see Note 2).

CAHS has a Service Agreement with the Department of Health that specifies the funding it has been allocated to meet the services it is expected to deliver. This effectively sets CAHS-specific performance targets that are substantially higher than the Annual Report targets, as it includes allocations for items such as the depreciation applicable to PCH. In 2018 -19, CAHS performed in line with the financial expectations of its Service Agreement when delivering non-admitted care.

"Non-admitted services play a pivotal role within the spectrum of care provided to the WA public, therefore it is important non-admitted service provision is monitored to ensure the efficient delivery of safe and high-quality care."

Table 13: Average non-admitted cost per weighted activity unit, 2017–18 to 2018–19

	2017–18	2018–19	TARGET
Average non-admitted cost per weighted activity unit	$7,018	$7,693 (see Note 2)	$7,136

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. When excluding depreciation for comparative purposes, the *Average non-admitted cost per weighted activity unit* was $6,886 in 2017-18 and $7,114 in 2018–19.

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

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

Rationale

Specialised mental health inpatient services provide patient care in authorised hospitals and designated mental health units located within hospitals. 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 services. The efficient use of hospital resources can help minimise the overall cost of providing mental health care, and enable the reallocation of funds to appropriate alternative non-admitted care.

Target

The 2018–19 target is $3,520 per bed-day. Performance is demonstrated by a result that is equal to or below the target.

Result

In 2018–19, the average cost per bed-day in specialised mental health inpatient units was $3,769, which although above the target, is significantly less than the average cost in 2016–17 and 2017–18 (Table 14). The improvement in cost efficiency is a result of delivering more activity at lower operational cost, which was offset by the sharp rise in depreciation, equipment and infrastructure costs associated with operating at Perth Children's Hospital.

Table 14: Average cost per bed-day in specialised mental health inpatient services, 2016–17 to 2018–19

	2016–17	2017–18	2018–19	TARGET
Average cost per bed-day	$4,346	$4,163	$3,769	$3,520

Notes:
1. Previously reported as Average cost per bed-day in specialised mental health inpatient units.

Data sources: Health Service financial system, BedState.

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

Rationale

Public community mental health services consist of a range of community-based services, such as emergency assessment and treatment, case management, day programs, rehabilitation, psychosocial, residential services and continuing care. The aim of these services is to provide the best health outcomes for the individual through the provision of accessible and appropriate community mental health care. Efficient functioning of public community mental health services is critical to ensure that finite funds are used effectively to deliver maximum community benefit.

Public community-based mental health services are generally targeted towards people in the acute phase of a mental illness who are receiving post-acute care. This indicator provides a measure of the cost effectiveness of treatment for public psychiatric patients under public community mental healthcare (non-admitted and ambulatory patients).

Target

The 2018–19 target is $687 per treatment day. Performance is demonstrated by a result that is equal to or below the target.

Result

In 2018–19, the average cost per treatment day of non-admitted care provided by public clinical mental health services was $720, which is above the target. There is a continued increase in demand for services, with a need to offer timely access to services. The higher average cost reflects the increase in levels of acuity, which require more intensive treatment interventions.

"The higher than target average cost reflects the increase in levels of acuity, which require more intensive treatment interventions."

Table 15: Average cost per treatment day of non-admitted care provided by mental health services, 2017–18 to 2018–19

	2017–18	2018–19	TARGET
Average cost per treatment day	$650	$720	$687

Notes:

1. Previously reported as Average cost per treatment day of non-admitted care provided by public clinical mental health services.

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

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 2018–19 target is $256 per person. Performance is demonstrated by a result that is equal to or below the target.

Result

In 2018–19, the average cost per person of delivering population health programs was $242, which is higher than the average cost per person in 2017–18 but below the target of $256. The rise in average cost compared with 2017–18 is attributable to both an increase in public health expenditure and a decrease in the estimated population served.

"The rise in average cost compared with 2017–18 is attributable to both an increase in public health expenditure and a decrease in the estimated population served."

Table 16: Average cost per person of delivering population health programs by population health units, 2016–17 to 2018–19

	2016–17	2017–18	2018–19	TARGET
Average cost per person	$225	$222	$242	$256

Notes:

1. The 2016, 2017 and 2018 calendar year population estimates have been used to represent the 2016–17, 2017–18 and 2018–19 reporting years respectively.
2. The 2016 Census was used to estimate the 2018 population, whereas the 2011 Census was used for 2016 and 2017 population estimates.

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 Table 17 and 18.

Table 17: Child and Adolescent Health Service Board, 2018–19

POSITION	NAME	TYPE OF REMUNERATION	2018–19 PERIOD OF MEMBERSHIP	2018–19 TOTAL REMUNERATION
Chair	Ms Debbie Karasinski (Chair)	Board member allowance	12 months	$72,356
Deputy Chair	Professor Geoffrey Dobb	Ineligible	12 months	$0
Member	Ms Kathleen Bozanic	Board member allowance	12 months	$43,413
Member	Ms Anne Donaldson	Board member allowance	12 months	$43,413
Member	Professor Di Twigg	Board member allowance	12 months	$43,413
Member	Ms Miriam Bowen	Board member allowance	9 months	$35,065
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	12 months	$43,413
Member	Mr Peter Mott	Board member allowance	12 months	$43,413
			Total	**$411,312**

Table 18: Eating Disorders Program Consumer Advisory Group, 2018–19

POSITION	NAME	TYPE OF REMUNERATION	2018–19 PERIOD OF MEMBERSHIP	2018–19 TOTAL REMUNERATION
Member	Melanie Coleman	Per meeting	12 months	$660
Member	Linelle Fields	Per meeting	12 months	$680
Member	Natasha Hambleton	Per meeting	11 months	$1,840
Member	Ashleigh Hardcastle	Per meeting	12 months	$300
Member	Teagan Martin	Per meeting	12 months	$280
Member	Asha McAllister	Per meeting	12 months	$620
Member	Emily Wheeler	Per meeting	12 months	$180
			Total	**$4,560**

Notes to Tables 17 and 18:

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 2018–19 financial year.

Pricing policy

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

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

Compensable or ineligible patients

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

Private patients (Medicare eligible Australian residents)

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

Veterans

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

Other fees and charges

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

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

Capital works

Perth Children's Hospital (PCH) continues to be a major capital project for 2018–19. With the Health Ministerial Body relinquishing control over the PCH project, the CAHS Board has assumed the governance responsibilities since 18 September 2018. After the construction was officially completed in April 2017 and the commissioning of the hospital in May 2018, the PCH project has been in the closeout stage, which includes management of the defect liability period of the main construction contract and completion of various residual works.

The Medical Equipment Replacement Program also has completed capital works in 2018–19. Table 19 shows the financial details of the capital works program.

Table 19: Major asset investment program works completed in 2018–19

CAPITAL WORKS PROGRAMS COMPLETED	2018–19 ($'000)
Perth Children's Hospital:	
Building and site infrastructure	6,646
Plant and equipment	137
Total	**6,783**
Other programs:	
Medical Equipment Replacement Program [1]	774
Total	**774**

[1] The Medical Equipment Replacement Program does not include equipment funded outside of the State Government's Asset Investment Program.

Employment profile

CAHS is required to report a summary of the number of employees, by category, compared with the preceding financial year. Table 20 shows the number of full-time equivalent employees for 2017–18 and 2018–19.

Table 20: Total full-time employees of CAHS, by category

CATEGORY	DEFINITION	2017–18	2018–19
Administration & clerical	Includes all clerical-based occupations together with patient-facing (ward) clerical support staff.	731.1	676.5
Agency	Includes the following occupational categories: administration and clerical, medical support, hotel services, site services, medical salaried (excludes visiting medical practitioners) and medical sessional.	31.4	33.4
Agency nursing	Includes workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest.	5.2	3.1
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care.	12.5	15.6
Dental nursing	Includes dental nurses and dental clinic assistants.	6.9	7.2
Hotel services	Includes catering, cleaning, stores/supply laundry and transport occupations.	162.4	167.8
Medical salaried	Includes all salary-based medical occupations including interns, registrars and specialist medical practitioners.	324.9	350.8
Medical sessional	Includes specialist medical practitioners that are engaged on a sessional basis.	68.7	69.0
Medical support	Includes all Allied Health and scientific/technical related occupations.	618.1	628.3
Nursing	Includes all nursing occupations. Does not include agency nurses.	1,217.3	1,256.5
Site services	Includes engineering, garden and security-based occupations.	1.1	3.5
Other occupations	Includes, but is not limited to, Aboriginal and ethnic health employees.	18.9	23.4
	Total	**3,198.5**	**3,235.1**

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. The Mandatory and Core Requirement Training Framework outlines the minimum standards of mandatory and core requirement training for each employment group and how frequently the training must occur. The Framework also ensures a standardised approach to content and delivery.

Mandatory training provided for all staff includes:

- Aboriginal cultural eLearning
- Accountable and ethical decision making
- Aiming for zero harm
- Basic/hospital paediatric life support
- CAHS corporate induction
- Emergency management (Theory and Evacuation Drill)
- Hand hygiene
- Manual tasks
- Speaking Up For Safety
- Workplace aggression and violence education
- Record keeping awareness.

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. Programs are also offered to support the development of undergraduate students (through cadet programs), graduates, as well as emerging and current leaders.

Additional ongoing corporate training is available to staff in the areas of human resource management (including recruitment and selection, and performance management and development), conflict resolution, bullying in the workplace, and family and domestic violence and in the workplace.

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 and evaluation mechanism for participants, to ensure continuous improvement.

Compliance with, and reporting, the Speaking Up for Safety program is monitored by Workforce Education. To this point, compliance reports are prepared from the data warehouse when requested.

Perth Children's Hospital education and training

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

Industrial relations

The industrial relations function within CAHS continues to provide employer representative services and consultancy support for significant workforce management issues.

During 2018–19, CAHS experienced organisational change and restructuring, however, with no job losses. The level of consultation with unions has increased on all matters throughout the year resulting in a more positive and collaborative working relationship.

As a result, there was no lost time due to industrial disputes. Additionally, there were no issues directly involving CAHS that proceeded to arbitration before industrial courts or tribunals, with all formal disputes lodged by the unions resolved through conciliation processes.

A major challenge for 2018–19 has been the onerous task of undertaking the CAHS permanency review to fill existing vacant positions by converting fixed term contract and casual employees to permanent status.

There continued to be high activity levels relating to individual employee issues in 2018–19 that required ongoing management and advice throughout the year. This is due to increased focus on managing workplace behaviours, integrity issues and ethical matters, with improved processes in place to ensure they are all adequately addressed in accordance with broader government expectations.

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 2018–19, a total of 80 workers' compensation claims were made (see Table 21).

Table 21: Number of workers' compensation claims in 2018–19

EMPLOYEE CATEGORY	NUMBER
Nursing Services/Dental Care Assistants	39
Administration and Clerical	9
Medical Support	8
Hotel Services	22
Maintenance	0
Medical (salaried)	2
Total	**80**

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

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

Governance disclosures

Unauthorised use of credit cards

In accordance with State Government policy, CAHS has issued corporate credit cards to certain employees where their functions warrant usage of this facility for purchasing goods and services. These credit cards are not to be used for personal (unauthorised) purposes. Despite each cardholder being reminded annually of their obligations under the credit card policy, five employees inadvertently utilised the corporate credit card for personal expenditure on eight occasions. Review of these transactions confirmed that they were the result of honest mistakes. Prompt notification and full repayments were made by the employees concerned.

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 duration of greater than three months and a value of greater than $2 million. As at 30 June 2019, no contracts subject to the Government Building Training Policy had been awarded in 2018–19.

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 2018–19, no Child and Adolescent Health Service senior officer declared a pecuniary interest.

Table 22: Credit card personal use expenditure in 2018–19

CREDIT CARD PERSONAL USE EXPENDITURE	2018–19
Aggregate amount of personal use expenditure for the reporting period	$1,700.75
Aggregate amount of personal use expenditure settled by the due date (within 5 working days)	$1,667.03
Aggregate amount of personal use expenditure settled after the period (after 5 working days)	$33.72
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 2018–19.

Advertising

In accordance with section 175ZE of the Electoral Act 1907, CAHS incurred the following advertising expenditure in 2018–19 (see Table 23).

Disability Access and Inclusion Plan outcomes

The *Disability Services Act 1993* was introduced to ensure that people with disability have the same opportunities to fully access the range of health services, facilities and information available in the public health system, and to participate in public consultation regarding WA Health services. As at June 2014, amendments to the Act require public authorities to ensure that people with disability have equal employment opportunities. CAHS ensures compliance with the Act and all other principles through the implementation of a Disability Access and Inclusion Plan. The *CAHS Disability Access and Inclusion Plan (2018–2022)* has been endorsed and published[14]. The CAHS Disability Access and Inclusion Working Group are responsible for development, implementation and evaluation and report to the CAHS Disability Advisory Committee.

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

Access to service and events

Telehealth clinics are offered at PCH and have been introduced at the Child Development Service to facilitate access for children with neurological disorders who may find attendance in person difficult. A range of equipment is provided by CAHS to assist people with disabilities to access services, including provision of an adult change table to cater for older children and adolescents. All relevant policies consider the access requirements of people with disabilities. Within PCH, 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 at PCH has been improved with the relocation of access card swipe points and increased signage to accessible bathroom facilities.

Access to information

CAHS consumer publications are available in alternative formats and languages on request, including large print and audio formats for patients with literacy or vision difficulties. The health service website has the capability to assist people who are hearing impaired, as well as providing details on where people can find information and make contact with services. The health service aims to achieve a minimum of level AA rating of the Web Content Accessibility Guidelines 2.0 on all internal and external websites, with clear guidelines around developing content on digital platforms.

Table 23: Summary of advertising for 2018–19

SUMMARY OF ADVERTISING	AMOUNT ($)
Advertising agencies	
Goolarri Media Enterprises	$1,820
Market research organisations	$0
Polling organisations	$0
Direct mail organisations	$0
Media advertising organisations	
Brainestorm Digital Prod.	$2,100
Yourmembership.com	$983
Job Posting Automation	$901
Other (all)	$814
Total advertising expenditure	**$6,618**

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 the CAHS corporate induction. Regular staff presentations continue in collaboration with Department of Communities Disability Services and the WA Health Network Disability Advisory Group.

Opportunity to provide feedback

All staff are available to assist people with disabilities to provide feedback, with a dedicated Child and Family Engagement Service (CaFES) also available during office hours. Comments, complaints, and suggestion boxes are also available throughout CAHS facilities. The CAHS website provides the facility for comments, complaints, and suggestions to be sent via an email. Feedback is processed and managed through the CaFES and discussed at the Consumer Advisory Council and the Disability Advisory Committee to ensure any changes to policy or updates to services have consumer input.

Participation in public consultation

A review of advisory committees is underway. This includes the Disability Advisory Committee, with the aim to improve opportunities for consumers with disabilities to inform service review and delivery.

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.

Maintaining appropriate standards of conduct and integrity among staff members

CAHS is committed to maintaining an ethical, transparent and accountable workforce and actively encourages employees to uphold the highest standard of conduct and integrity at all times. The Chief Executive (CE) has key performance indicators including compliance with legislative and administrative requirements (*WA Health Code of Conduct and Public Sector Management Act*). These are measured by participating in monthly and quarterly performance review meetings. Integrity and conduct-related matters are also discussed as part of the formal performance management process between the CE and Executive employees. Furthermore, measures for a values-based organisation are being developed.

Living our Values

CAHS continued the Shaping our Future program led by cultural ambassadors, which has been instrumental in guiding CAHS on becoming a values-based organisation. This resulted in the launch of Living Our Values and the revitalisation of the new CAHS values of compassion, collaboration, accountability, respect, equity and excellence. Nearly 100 team events were held to celebrate Living our Values to reignite our commitment to the CAHS values and part of delivering the actions under objective of the Cultural Action Strategy. The Cultural Action Strategy has provided CAHS with a change roadmap over six priority areas towards a more inclusive, rewarding and cohesive workplace culture with the responsibility for its implementation shared amongst the executive leadership team. This strategy supports the CAHS Operational Plan to deliver on the Strategic Objective Value and Respect our People.

Internal communications were reviewed resulting in the implementation of a new e-newsletter structure including topical discussions to celebrate the values to guide, help and lead staff decisions and actions towards the shared CAHS vision of healthy kids, healthy communities. The values have also been incorporated into organisational templates such as letterheads and meeting agendas formats.

Leadership and management based programs commenced to develop leadership, soft skills, coaching and mentoring skills to ensure that leadership behaviours and performance all levels reflect the values of CAHS. Senior leaders ensured their presence at induction, staff forums, the "Board Walk", "Walk in my Shoes" and "A Day in the Life" initiatives and programs.

The staff recognition program was reviewed and revamped to the "Stars of CAHS Staff Awards, recognising employees who go above and beyond to provide exceptional care and service in line with the CAHS values. Further strategies towards embedding our values include the refocus of the CAHS values narrative within orientation programs, updated job descriptions with the values, implemented values based exit interviews and planning for values based recruitment processes.

Ethical Culture Promotion

The CAHS Integrity and Ethics program implementation continued during 2018–2019 with stronger alignment towards the revised CAHS vision, values and strategic objectives. A key CAHS value for ethical promotion is accountability; *always acting with integrity, we take full responsibility for our actions. You can count on us*. This new value has been the cornerstone of communicating and promoting an ethical culture within CAHS during this reporting year. This has involved a focus on strengthening the planning and

prevention strategies towards maintaining integrity and ethical behaviour within CAHS through an increase in staff information resources and communications. The newly developed integrity and ethics communications plan was implemented to convey online messages for employees and other key stakeholders to increase workforce knowledge, skills and capability by providing guidance and awareness on appropriate integrity and ethical behaviours with strong links to the CAHS Cultural Action plan.

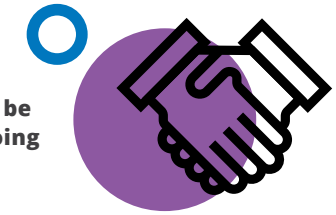
The CAHS Ethical Conduct Review Committee (ECRC) meets monthly to provide governance oversight around misconduct risks, corrective actions, related systemic improvements and strategic direction for the Integrity and Ethics program. The implementation of the integrity and ethics reporting solution has enabled streamlined trending and reporting against the CAHS Integrity and Ethical Governance Framework.

Risk assessment workshops involving relevant stakeholders to assess and devise assurance mechanisms around risk areas of misconduct of fraud and corruption, confidentiality of official information, misuse of public resources, conflict of interest, and medication diversion theft. Risks arising from these risk assessment workshops have been developed and discussed at ECRC, resulting in ten key risks within the integrity and ethics realm and the development of 42 associated treatment action plans. These have been integrated into the CAHS risk register.

CAHS surveyed employees to gain insight into staff experiences, awareness of wrongdoing and their confidence in reporting wrongdoing.

CAHS Ethical Conduct Review Committee

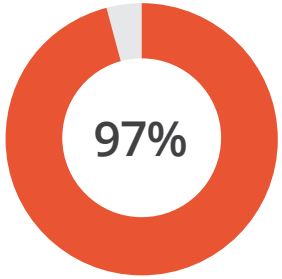
Although the participation rate only represented around 16 per cent of the workforce, responses were relatively well spread across CAHS and, the survey provided the following insights:



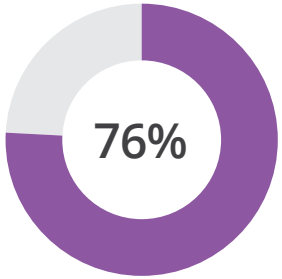
There was strong support for CAHS to be addressing wrongdoing in the workplace.

Staff want a culture where they feel listened to, protected, and taken seriously when raising concerns.

This survey has resulted in a number of improvements to strengthen the CAHS culture. This includes increasing available resource information, such as fact sheets to assist staff to navigate different ethical situations and demystifying processes, and expanded mechanisms for reporting and improving responses to wrong-doing.



are aware of expected workplace behaviour, what might be wrongdoing, and their responsibility to report wrongdoing.

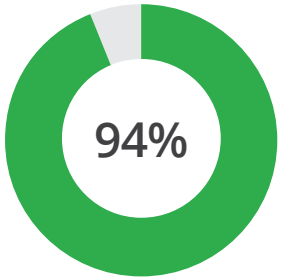


know how and when to report something that might be unethical or illegal.

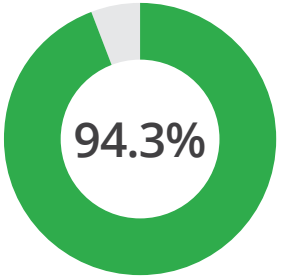
A review of the Integrity and Ethical Governance Framework commenced following inputs from the staff survey and risk assessment workshops.

Information is published on the CAHS website on conduct standards and integrity enables consumers and the public to access information and report compliments, complaints, misconduct and Public Interest Disclosures. The CAHS intranet has been enhanced, providing further resources and information for employees on reporting issues of concern, legislative requirements reporting to criminal and professional conduct, acceptance of gifts and travel as well as the Code of Conduct. New staff members are advised of the process for reporting suspected breaches of discipline or unethical behaviour. Code of Conduct posters are displayed across CAHS.

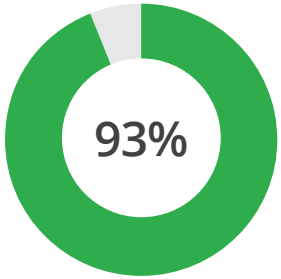
Accountable & Ethical Decision Making



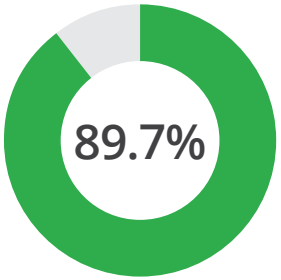
Recordkeeping awareness



Aboriginal Cultural Awareness



CAHS Corporate Induction



In addition to online communications, CAHS also informs and educates employees about their responsibilities through eLearning, face to face training programs and site based induction programs. There is training for all staff (including mandatory training) which is designed to communicate the expectations of workplace conduct. CAHS has also recently developed a training package for decision makers appointed for breach of discipline matters.

The following shows training completion rates as at 30 June 2019.

Continued CAHS representation, attendance and consultation with the WA Health Integrity Working Group

Continued CAHS representation, attendance and consultation with the WA Health Integrity Working Group (IWG) has contributed towards significant reform towards WA health system-wide Integrity and Ethics planning and consistencies. CAHS has embraced the introduction of the new WA Health Integrity Policy Framework and reviewed policies and procedures relating to public interest disclosure, fraud and corruption control, statutory health professional registration, data breach response, speaking outside the health service as well as the acceptance of gifts and managing conflicts of interests, to facilitate the move towards online lodgement of declarations.

CAHS has continued to meet regularly with the Corruption Crime Commission (CCC) to maintain the established partnership for misconduct resistance and prevention. CAHS also commenced regular meetings with the Public Sector Commission (PSC) to also entrench an integrity prevention partnership.

Fraud and corruption prevention

CAHS is committed to the highest possible standards of openness, probity and accountability in all aspects of services, and has zero tolerance of fraud and corruption. Suspected fraud or corruption reporting is strongly encouraged, will be investigated and resolved in accordance with internal policies and procedures, and the *Corruption, Crime and Misconduct Act 2003*. The development and implementation of the CAHS Fraud and Corruption Control Plan to complement new CAHS policy has provided significant improvements to integrity, fraud and corruption prevention. The plan has been developed in line with Australian Standard AS8001-2008 Fraud and Corruption Control.

In August 2018, the Corruption and Crime Commission (CCC) released an independent report into the bribery and corruption risks around procurement and contract management practices in the North Metropolitan Health Service. CAHS initially conducted an audit into procurement and contract practices within the health service, which included a forensic financial audit, and implemented annual communications to suppliers and vendors around their ongoing commitment to ensure their business relationship with CAHS is conducted with uncompromising integrity, respect, professionalism, accountability and ethical conduct. CAHS also undertook an internal audit on fraud and corruption prevention, which highlighted the strong strategic controls in place, good proactive capabilities and identified recommendations consistent with

the direction of the Integrity an Ethics work plan. CAHS reviewed internal procurement processes and mechanisms and conducted formal risk assessment workshop around procurement and contract management risks. In addition, the CCC also delivered a presentation on fraudulent behaviour to CAHS staff. Senior CAHS employees are now also required to complete mandatory declarations of interests, gifts, benefits and hospitality tri-annually to enhance probity.

Since the opening of Perth Children's Hospital, CAHS has also continued implementing improvement actions towards the recommendations associated with external oversight agency reports by the CCC into the management of medicines and the Public Sector Commission review into the management of confidential patient information. Progress of the actions arising from these reviews are regularly reported and monitored whilst embedded within the CAHS risk management framework.

CAHS joined other State Government agencies by acknowledging International Anti-Corruption Day, calling all employees to commit to action towards corruption prevention and misconduct resistance as part of living the core CAHS value of accountability.

In accordance with section 23(1)(f) of the *Public Interest Disclosure Act 2003*, CAHS is required to report to the Public Sector Commissioner on the number of Public Interest Disclosures received, the results and any action taken during the reporting period. In 2018–19, there were no Public Interest Disclosures received or managed by CAHS.

Compliance with public sector standards and ethical codes

During 2018–19, CAHS engaged in a number of human resource activities that resulted in five Employment Standard Breach Claims and two Grievance Standard Breach claims being lodged in accordance with the Public Sector Standards in Human Resource Management Framework. This is a significant decrease from the previous financial year. Two claims were resolved internally within CAHS and five claims were referred to the Public Sector Commission for review and subsequently dismissed or withdrawn.

Human Resource (HR) management activities, including breach claims, are recorded and monitored within HR and reported on quarterly by matter type and directorate.

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. The following policies and guidelines 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
- Supporting Employee Performance and Development.

In addition to the above resources, in 2018–19 CAHS reviewed and introduced new policies on Supporting Employee Performance and Employee Development and also updated resources with respect to Workplace Bullying, Family and Domestic Violence and Fitness for Work.

In 2018–19, a total of 56 reports or complaints alleging non-compliance with the Code of Conduct (breaches of discipline) were lodged (as detailed in the table below). 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 (11) or the Corruption Crime Commission (12) 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*.

COMPLAINTS ALLEGING NON-COMPLIANCE WITH THE CODE OF CONDUCT BY AREA OF COMPLIANCE	TOTAL
Communication & Official Information	1
Conflict of Interest	8
Fraud & Corrupt Behaviour	12
Personal Behaviour	24
Record Keeping and Use of Information	7
Use of Public Resources	0
To be determined/unspecified	4

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 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.

The mandatory 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 electronic document and records management system (EDRMS) training upon allocation of a licence. A total of 243 staff have attended regularly scheduled classroom-based training and completed a training evaluation form, which identifies the effectiveness of the training delivery and content. The CAHS Records and Compliance intranet page contains training resources, quick help guides, policies, procedures, work instructions and supporting information to enable staff to comply with the Act.

A review of the Corporate Records activities including the EDRMS, training, user satisfaction survey and individual interviews was conducted in November 2018. Feedback obtained has been implemented and is informing ongoing improvements. CAHS is committed to the continuing deployment of the EDRMS throughout all administrative functions and reduced use of network shares. During this reporting period, over 165,000 records were captured into the EDRMS.

Substantive equality

The Aboriginal Health Team within CAHS Community Health offers more intensive support to those families identified with additional needs, establishing a relationship of trust and connectedness to guide and support all families through the early childhood years. Making services more accessible to families is an important focus of service delivery, with the program delivered predominantly as a home visiting model.

The Koorliny Moort team at PCH provides a Statewide service for Aboriginal and Torres Strait Islander families aimed to improve health outcomes through improved client engagement with health services and improved co-ordination of service care. The program is a multidisciplinary team consisting of clinical nurse specialists, specialist paediatricians, a social worker, an Aboriginal health worker, an enrolled nurse, a school teacher, two advanced training paediatric registrars and administration support; including a number of the staff who are Aboriginal. The Koorliny Moort program has developed effective partnerships with community based providers throughout Western Australia, particularly the Aboriginal Controlled Community Health Care Services (ACCHS). The service provides nursing led care co-ordination for both metropolitan and rurally based families who have appointments based at Perth Children's Hospital including supporting the families during their visit, co-ordinating appointments and then providing information back to local health services. The service also provides outreach paediatric clinics for families within the Perth metropolitan region allowing families the option to have their health care provided closer to home and flexibility in appointment times if attending PCH clinics. This program has now been in operation since mid-2012. The program receives approximately 360 new referrals per year and has approximately 1000 active clients at any one time. The program has exceeded its target outcomes each year, including achievements

such as increasing the number of patients attending at least one scheduled outpatient appointment from 33 per cent pre-program to 93.2 in 2018 and reduction of length of hospital stay from 8.81 per 1000 child days per program to 2.38 per 1000 child days at our last evaluation.

Further discussion of substantive equality issues affecting Aboriginal and refugee families can be found in the Aboriginal Health and Refugee Health sections.

Occupational safety, health and injury

CAHS is committed to the provision of a safe work environment for all employees, patients, clients, visitors, and contractors in accordance with the *Occupational Safety and Health Act 1984* and the injury management requirements of the *Workers' Compensation and Injury Management Act 1981*. As part of this commitment, strategic action planning has been scoped for psychological, violence and aggression and manual tasks, slip trip and fall.

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, inclusive of promoting/staff induction presentations under the CAHS Values as listed below:

- Compassion: listening and understanding of OSH concerns raised
- Collaboration: joint problem solving
- Accountability: take responsibility for maintaining your safety and the safety of others
- Respect: follow OSH processes and procedures, value all opinions
- Equity: fair and equitable investigations, outcomes and feedback
- Excellence: strive to provide a safe workplace

Compliance with occupational safety, health and injury management

The CAHS Executive is accountable for the occupational safety and health of all CAHS employees and, in particular, for providing leadership, support, direction and resources to ensure that CAHS meets its commitment to occupational safety and health. The CAHS Executive seeks the cooperation of all employees in achieving its occupational safety and health objectives, and in creating a safe and healthy working environment that benefits everyone, as listed in the CAHS OSH Statement of Commitment[15].

Employee consultation

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

15 https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/CAHS/WorkforcePolicies/2019_CAHS_OSHCommitment.pdf

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. An external and internal review of work processes occurred and the identified actions are being progressed.

Occupational safety and health assessment and performance indicators

Community Health and CAMHS annual internal audits of occupational safety and health management systems were undertaken during 2018 and recommendations have progressed. Community Health and CAMHS OSH Working Alone or Providing Home Based Services Internal Audit was conducted and an action plan is being processed. Quarterly OSH and workers compensation data are provided to the Health Service Executive Committee.

The annual performance reported for CAHS in relation to occupational safety, health and injury for 2018–19 is summarised in Table 24.

Table 24: Occupational safety, health and injury performance for 2018–19

MEASURE	2018–19	TARGET	COMMENT
Fatalities (number of deaths)	0	0	Target achieved
Lost time injury/diseases (LTI/D) incidence rate (per 100)	2.0%	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)	36.4%	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	77%	≥80%	Target not achieved
Percentage of managers trained in occupational safety, health and injury management responsibilities	48%	≥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 2019–20

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 2019–20, as approved by the Minister for Health, are:

STATEMENT OF COMPREHENSIVE INCOME	2019-20 Estimates $'000
COST OF SERVICES	
Expenses	
Employee benefits expense	492,446
Fees for visiting medical practitioners	2,275
Contracts for services	7,082
Patient support costs	78,195
Finance costs	2,705
Depreciation and amortisation expense	68,076
Repairs, maintenance and consumable equipment	12,477
Other supplies and services	37,264
Other expenses	26,974
Total Cost of Services	**727,492**
INCOME	
Revenue	
Patient charges	15,709
Other fees for services	6,413
Commonwealth grants and contributions	150,466
Other grants and contributions	67,685
Donation revenue	540
Other revenue	1,868
Total revenue	**242,682**
Total Income other than income from State Government	**242,682**

STATEMENT OF COMPREHENSIVE INCOME

	2019-20 Estimates $'000
NET COST OF SERVICES	**484,810**
INCOME FROM STATE GOVERNMENT	
Service Appropriations	447,888
Services Received Free of Charge	36,922
Total Income from State Government	**484,810**
SURPLUS / DEFICIT FOR THE PERIOD	**0**

STATEMENT OF FINANCIAL POSITION

ASSETS	
Current Assets	
Cash and cash equivalents	33,578
Restricted cash and cash equivalents	26,095
Receivables	9,203
Inventories	2,669
Other current assets	565
Total Current Assets	**72,110**
Non-Current Assets	
Restricted cash and cash equivalents	6,572
Receivables	264,160
Right of use assets	55,746
Property, plant and equipment	1,173,368

STATEMENT OF FINANCIAL POSITION

	2019-20 Estimates $'000
Intangible assets	47,135
Total Non-Current Assets	**1,546,981**
TOTAL ASSETS	**1,619,091**
LIABILITIES	
Current Liabilities	
Payables	18,883
Provisions	84,650
Other current liabilities	44
Total Current Liabilities	**103,577**
Non-Current Liabilities	
Provisions	21,519
Lease liabilities	56,822
Total Non-Current Liabilities	**78,341**
TOTAL LIABILITIES	**181,918**
NET ASSETS	**1,437,353**
EQUITY	
Contributed equity	1,419,767
Accumulated surplus	17,586
Total Equity	**1,437,353**

STATEMENT OF CASHFLOWS

	2019-20 Estimates $'000
CASHFLOWS FROM STATE GOVERNMENT	
Service appropriations	379,812
Capital appropriations	19,024
Net cash provided by State Government	**398,836**
CASH FLOWS FROM OPERATING ACTIVITIES	
Payments	
Employee benefits	-489,230
Supplies and services	-133,264
Receipts	
Receipts from customers	15,709
Commonwealth grants and contributions	150,466
Other grants and contributions	67,685
Donations received	540
Other receipts	8,282
Net cash used in operating activities	**-379,812**
CASH FLOWS FROM INVESTING ACTIVITIES	
Payments	
Purchase of non-current assets	-19,024
Receipts	
Proceeds from sale of non-current assets	0
Net cash used in investing activities	**-19,024**

STATEMENT OF CASHFLOWS

	2019-20 Estimates $'000
Net Increase / (decrease) in cash and cash equivalents	0
Cash and cash equivalent at the beginning of the period	65,425
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	**65,425**


Children's Hospital

Photo by Cox Architecture

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

Child and Adolescent Health Service

STREET ADDRESS
Level 5
Perth Children's Hospital
15 Hospital Avenue, NEDLANDS WA 6009

POSTAL ADDRESS
Locked Bag 2010 Nedlands WA 6909

PHONE
(08) 6456 2222

EMAIL
CAHSExecutiveOfficeofCE@health.wa.gov.au

WEB
health.wa.gov.au/cahs

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