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

Annual Report
2019–2020

Acknowledgement of country and people

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

Image courtesy of www.damiensmithphotography.com.au

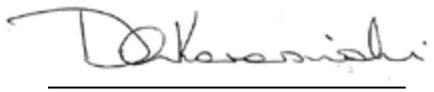
Statement of compliance

For the year ended 30 June 2020

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 2020.

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



Ms Deborah Karasinski AM

Chair of the Board
Child and Adolescent Health Service
3 September 2020

Prof Geoffrey Dobb

Deputy Chair of the Board
Child and Adolescent Health Service
3 September 2020

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Overview of agency

Locations and contact information

Child and Adolescent Health Service

STREET ADDRESS
Level 5, Perth Children's Hospital
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(08) 6456 2222

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CAHS Board Chair foreword

This year has been one of two parts: pre-COVID-19, which ran from July 2019 for the first eight months of the year, and post-COVID-19, in which we have been immersed from March 2020.

For the first eight months of the year, the Board's responsibility for the oversight and governance of safety and quality; people, capability and culture; risk and audit; and finance remained as for previous years. In March 2020 however, with a State of Emergency declared in Western Australia, the Board added the impact of the COVID-19 pandemic to its oversight and governance responsibilities. The Board has also recognised the Child and Adolescent Health Service's (CAHS) responsibility to support the Western Australian health service as a whole as it prepared and responded to the pandemic.

The State of Emergency required that the Board put aside some of its priorities, accept responsibilities outside our normal mandate, including the potential reassignment of some of our facilities, including Perth Children's Hospital (PCH), and support our staff through an extremely anxious time.

Despite the extraordinary difference in the operations of CAHS between the two parts of the year, and acknowledging the difference in the line of responsibility for the Board because of the State of Emergency, the role of the Board has remained largely constant. Our responsibility for oversight and governance has continued throughout the year, and the impact of the COVID-19 pandemic has been considered part of our business.

The Board has continued its strategic oversight of all areas of safety and quality and focused this year on a number of basic practices in CAHS which are critical to providing consistent, high quality and safe patient care. We are pleased to report positive progress in:

- an increased engagement with the families and young people who use our services with a high standard of responding to consumer feedback;
- improved hand hygiene amongst clinical staff at PCH, consistently exceeding the national target; and
- a gradual improvement in the completion of same day and long stay discharge summaries.

The use of restraints and seclusions in clinical care has also been reviewed by the Board, and we are pleased that the use of these practices has been minimised.

Ensuring equity of access to services for Aboriginal and Torres Strait Islander children has been a priority for the Board. An analysis of surgical waitlists undertaken by CAHS in partnership with UWA found no difference in access based on race. However, the number of Aboriginal children requiring service indicates the need for a continuing focus on prevention and working with Aboriginal communities to improve the health and wellbeing of Aboriginal children.

The mental health of children and young people continues to be a mounting issue for the Board as our mental health teams experience a steadily increasing demand for services. The Board met with the Commissioner for Children and Young People and the Mental Health Commission to find ways of dealing with these demands.

The Board has welcomed the transfer of the Neonatology service from the North Metropolitan Health service to CAHS, and welcomes the staff who have become CAHS employees. This transfer means

"These surveys have told us that morale is improving among our staff, with employees feeling more positive about working at CAHS, more valued, and more satisfied with their work."

that CAHS is now the sole Health Service providing critical care to very sick babies.

The Board has continued to oversee activities relating to CAHS' requirement to meet the National Safety and Quality Health Service Standards, and shares the view of the Executive that this is part of business as usual despite the planned accreditation being delayed due to COVID-19.

The Board maintains oversight of extreme, high and emerging risks through regular reports and in-depth briefings, and has noted the risks associated with the transfer of neonatology and supported enhancements in procurement internal controls and processes. The Board is monitoring the new and emerging risks associated with COVID-19, including those related to the increased use of technology and increased remote work. The Board is also monitoring the development of a CAHS Pandemic Response Plan and Recovery Plan.

During the year, the Board approved a Quality Assurance and Improvement Framework, an Integrity and Ethics Governance Framework and a Controlled Medicines Framework. The Board also approved the internal audit plan and received reports on a number of key audits, including Governance Framework for Clinical Incident Management, Corporate Records Management and Financial Controls.

The Board has continued to maintain its focus on being a more sustainable health service, which included the development of a Strategic Asset Plan. The hub and spoke model for community services is part of this plan, along with the commencement of consolidation of leased and licenced properties.

In addition to driving efficiencies and monitoring the cost of service and Key Performance Indicators, the Board has had close oversight of the financial impact on CAHS of the transfer of the neonatology service, and is examining the impact of COVID-19 on its financial position.

The Board has had strategic oversight of the development of an overarching workforce plan, with the initial focus on key professional groups, including allied health, medicine and nursing. This plan is a critical aspect of CAHS 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 was pleased to see the results from the Minister's 'Your Voice in Health' survey and the Barrett's Values Assessment survey conducted during the year. These surveys have told us that morale is improving among our staff, with employees feeling more positive about working at CAHS, more valued, and more satisfied with their work. There are a number of factors that have contributed to this improvement, but very significant among these is the work of the Shape our Future group. The Board is very mindful that there is still much to do before we have the majority of staff reporting that CAHS is a 'great place to work'.

The Board also acknowledges the extraordinary stresses staff have experienced throughout the COVID-19 pandemic in both their personal and professional lives. The Board commends staff who continued to place the children and young people for whom we care at the forefront, and for the way in which they continued to provide compassionate and

"This has been a year of unique challenges, and the Board is immensely proud of the manner in which all staff have dealt with these challenges."

high quality care in what can only be described as unprecedented times.

The Board is also very pleased to see the appointment of the Executive Director of People, Capability and Culture, enabling a dedicated focus on the wellbeing of our staff and the development of our overarching workforce plan.

This has been a year of unique challenges, and the Board is immensely proud of the manner in which all staff have dealt with these challenges.

The Board has valued and enjoyed working with our Chief Executive, Dr Aresh Anwar, who has proved himself to be an excellent communicator and done much to improve the culture and morale of our staff. He has also focused on moving us towards becoming the premier quaternary paediatric hospital in the southern hemisphere – an aspiration of both our Chief Executive and the Board. The Board has been extremely impressed with Dr Anwar's leadership in managing CAHS' response to the COVID-19 pandemic and keeping the Board well apprised of the rapidly changing environment and management response.

Dr Anwar has also led a highly motivated leadership team, including Executive Directors and Co-Directors, who have furthered the work of the Board. The Board has greatly appreciated their input.

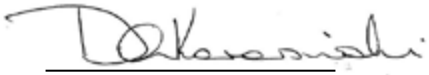
The Board has also appreciated the contribution of the Clinical Advisory Group. Their experience and expertise has provided a litmus test for the Board and enhanced our discussions.

Board members have gained much through 'Boardwalks', where staff have provided valuable insights into the joys and challenges of working within CAHS.

Finally, the Board undertook a review of our Strategic Plan 2018-2023 to ensure our responsibilities under the Sustainable Health Review and the Premier's Priorities are given appropriate recognition and priority. The Board agreed to the following focus areas for the next three years:

- children within their first 1,000 days;
- the most vulnerable children;
- Aboriginal children;
- the culture and wellbeing of our staff;
- technology-enhanced care; and
- clinical excellence.

The Board looks forward to working with our staff in the forthcoming year as we seek to meet our strategic objectives for children and young people in Western Australia.



Ms Deborah Karasinski AM
Chair of the Board
Child and Adolescent Health Service

Message from the Chief Executive

It has been a momentous year in global history, with the COVID-19 pandemic justifiably dominating our minds and lives.

While it is important to acknowledge and reflect on the challenges faced during the pandemic, and the manner in which we responded, we must not let this overshadow the productive work and achievements at CAHS across the 2019–20 year.

When faced with the imminent threat of COVID-19, our health service demonstrated an agile and united approach, adapting our services and work practices to ensure the safety of children, families and staff. I would like to acknowledge the expertise, dedication and adaptability of staff who worked tirelessly on our preparedness planning.

I would also like to thank all CAHS staff who demonstrated their commitment to children and families by providing and contributing to outstanding care during what has been an unprecedented and difficult time in our personal and professional lives.

The impact of COVID-19 will be long-lasting and felt across a range of sectors locally, nationally and internationally. It is important to pause and reflect on the extraordinary changes that have happened in our health service during the pandemic. At CAHS, we want to have a structured approach to keep the best of what we have introduced in response to COVID-19, and return to business as usual where this is best. This presents us with a once-in-a-lifetime opportunity to shape our health service to better respond to the needs of children and families. We are committed to engaging with our staff, consumers and partners to determine the path forward, and the approach we take as part of our future-focused recovery.

Setting aside the challenges of COVID-19, the 2019–20 year has been busy and productive, with a number of significant achievements to be celebrated. January saw the transition of Neonatology from the jurisdiction of the North Metropolitan Health Service to CAHS. Incorporating Neonatology into our health service strengthens the integration and delivery of safe, high-quality health care services to children and families of WA, from birth up to 18 years of age.

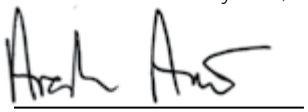
In February, we welcomed Ms Valerie Jovanovic to CAHS as the inaugural Executive Director People, Capability and Culture. This new position will ensure the CAHS structure supports its most valuable asset – its people. It will enable a strategic focus on staff development, training and education, staff engagement, culture and workforce.

The Midland Community Hub Project (the Hub), an initiative supported by the Sustainable Health Review, is an exciting flagship project that will deliver a pilot site for a new 'one-stop shop' approach to the provision of health services using a hub and spoke model of care. The Hub will provide a number of co-located and coordinated health services for children, young people and their families, including child health, mental health, child development and family support services. These services will be provided by CAHS and in partnership with other government and non-government organisations. The Hub, which is scheduled to open in 2022, will replace a number of aged community health sites that are no longer suitable for their purpose.

"Setting aside the challenges of COVID-19, the 2019–20 year has been busy and productive, with a number of significant achievements to be celebrated."

As we prepare for Accreditation against the National Safety and Quality Health Care Standards, I acknowledge the significant body of work that is driving safety and quality across the whole organisation, which is at the core of everything we do.

It is an honour and privilege to lead CAHS, which is an outstanding healthcare service delivering care to the youngest and most vulnerable members of our society. I would like to extend my sincere thanks to every individual who contributes to CAHS. Our Board, staff, volunteers, partner organisations and fundraising supporters - you are the beating heart of our organisation as we continuously strive to deliver our vision of healthy kids, healthy communities.



Dr Aresh Anwar
Chief Executive
Child and Adolescent Health Service

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 2019–20. In this period, there were four standing committees of the Board: Finance, Audit and Risk, Safety and Quality, and People, Capability and Culture, all of which are made up of Board members. The Clinical Advisory Group, comprised of staff from across CAHS, also advises the Board on strategic issues.

During 2019– 20, the Board comprised the following members.

Board Chair, Ms Debbie Karasinski AM

M.Sc., B.AppSc., OTR

Ms Debbie Karasinski was appointed to the CAHS Board as its inaugural Chair in 2016. She has worked in the health and disability sectors for the past 35 years. Her career has included Chief Executive Officer (CEO) of Senses Australia, CEO of the Multiple Sclerosis Society of WA, and Chief Occupational Therapist at Sir Charles Gairdner Hospital (SCGH). Ms Karasinski has extensive Board experience, most notably as a member of the National Disability Services Board, the WA Disability Services Commission Board and the Taxi Industry Board. She is currently a member of the Board of the Perth Clinic and Chair of the Curtin University Health Sciences Faculty Advisory Council. Debbie Karasinski was awarded the Member of the Order of Australia in 2019 for her contribution to people with disability and the Western Australian community, and a Centenary Award in 2001 for her work with people with Multiple Sclerosis.

Deputy Chair, Professor Geoffrey Dobb

B.Sc.(Hons), MBBS, FRCP, FRCA, FANZCA, FCICM

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.

https://cahs.health.wa.gov.au/About-Us/Health-Service-Board

Board Member, Ms Kathleen Bozanic

B.Com., ACA, GAICD

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

M.HMgt, B.AppSc., Postgrad Bus, GAICD

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

PhD, MBA, B.HlthSc. (Nsg) Hons, RN, RM, FACN, FACHSM

Professor Di Twigg is Executive Dean of the School of Nursing and Midwifery at Edith Cowan University. 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

LLB

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

Board Member, Dr Alexius Julian

MBBS

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

Board Member, Dr Daniel McAullay

Ph.D, M AppEpi, B.Sc.

Dr Daniel McAullay is a health professional and a past member of the CAHS Governing Council, and has extensive experience as a member on health Boards and committees. 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

B.AppSc (Indig Comm Mgt and Dvpt)

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

Dip.HospAdmin, B.Bus; MIR; Grad Cert Lship

Mr Peter Mott has more than 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, a member of the Australian Private Hospitals Association National Board and National Council and is Chair of the Workforce Taskforce, a member of the University of Western Australia (UWA) Business School Ambassadorial Council, and a member of the Young Lives Matter Foundation UWA Board of Trustees. Peter is a past Vice President of the Australasian College of Health Service Management WA Branch Council, past President of the Australian Institute of Management (AIM) WA, past Chairman of the AIM WA UWA Business School Executive Education Advisory Board, past Chairman of Lifeline WA, and past Deputy Chairman of John XXIII College. He is a Life Member/ Fellow of the Australian Institute of Management and Fellow of the Australian Institute of Company Directors and the Australasian College of Health Service Management.

Committee meeting attendance

July 2019 to June 2020

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	11	10
Dr Alexius Julian	11	10
Dr Daniel McAullay	11	10
Mr Daniel Morrison	11	8
Mr Peter Mott*	11	10
Finance Committee		
Ms Kathleen Bozanic (Chair)	10	9
Professor Geoffrey Dobb	10	10
Ms Anne Donaldson	10	10
Mr Peter Mott	10	10
Audit and Risk Committee		
Ms Anne Donaldson (Chair)	7	7
Professor Geoffrey Dobb	7	6
Dr Alexius Julian	7	6
Professor Di Twigg	7	7

Name	Number of meetings	Meetings attended
Safety and Quality Committee		
Professor Geoffrey Dobb (Chair)	10	10
Ms Miriam Bowen	10	9
Ms Anne Donaldson	10	10
Dr Alexius Julian	10	8
Dr Daniel McAullay	10	8
Mr Daniel Morrison	10	0
Mr Peter Mott*	5	4
People, Capability and Culture Committee		
Professor Di Twigg (Chair)	5	5
Ms Miriam Bowen	5	5
Ms Anne Donaldson	5	5
Dr Alexius Julian	5	4
Dr Daniel McAullay	5	3
Mr Peter Mott*	2	0

* Mr Mott was on a leave of absence between March and April 2020.

Our year at a glance

Neonatology

3,151
NEONATAL ADMISSIONS

10.3 DAYS
AVERAGE LENGTH OF STAY

1,025
NEONATAL EMERGENCY TRANSPORTS

348
PRE-TERM INFANTS RECEIVED

890 LITRES
OF DONOR MILK

Community Health

124,434
CHILD HEALTH ASSESSMENTS

171,606
SCHOOL HEALTH ASSESSMENTS (2019)

75,875
CHILD DEVELOPMENT ASSESSMENTS

180,101
IMMUNISATIONS (2019)

CAMHS

131,429
SERVICE CONTACTS

7,217
YOUNG PEOPLE SEEN

672
INPATIENT UNIT SEPARATIONS

2,252
MENTAL HEALTH ED PRESENTATIONS

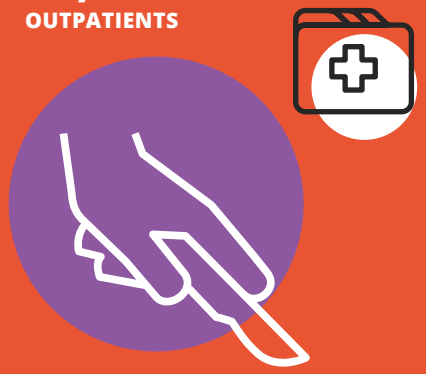
PCH

61,970
EMERGENCY DEPARTMENT ATTENDANCES

28,275
HOSPITAL ADMISSIONS

13,710
SURGERIES PERFORMED

211,525
APPOINTMENTS FOR
56,325
OUTPATIENTS



Vision, objectives, values

Our vision

Healthy kids, healthy communities

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

Our objectives

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

Our values drive us

COMPASSION
We treat others with empathy and kindness

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

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

EQUITY
We are inclusive, respect diversity and aim to overcome disadvantage

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

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

Executive summary

Realising our vision of healthy kids, healthy communities is at the heart of all we do at CAHS, for which we strive through our values of accountability, collaboration, compassion, equity, excellence, and respect.

Despite the challenges of COVID-19, 2019–20 has been productive across the organisation, with key achievements outlined below embodying our values.

Compassion - Consumer feedback

Kindness, compassion and helpful are just some of the words used by consumers who have given feedback on CAHS services. Even throughout the challenges that were posed by COVID-19 and the rapid changes that were made to the way we delivered our services, consumers often described the approach used by our staff as friendly, caring and committed. The organisation also strengthened its focus on the way it uses consumer feedback to learn from consumer experiences and identify how we can better meet the unique needs of our consumers.

During 2020, CAHS made a significant commitment to strengthening the engagement of consumers through the development of the CAHS Consumer Engagement Strategy. With the voices of over 1,000 consumers included, the Strategy shows our commitment to partnering with consumers in all aspects of what we do, so that together we can achieve the best outcomes for their care, treatment and support. The Strategy will be a key step forward in ensuring the organisation continues to communicate compassionately with consumers in ways that work best for them, so that all consumers experience safe, transparent and welcoming healthcare

Collaboration - Neonatology

In January 2020, governance of Neonatology was formally moved from the jurisdiction of the North Metropolitan Health Service (NMHS) to CAHS. Neonatology comprises around 500 staff across two Neonatal Intensive Care Units located at King Edward Memorial Hospital (KEMH) and PCH, the Neonatal Emergency Transport Service, the Perron Rotary Express Milk Bank, a neonatal follow-up program, outpatient clinics, and the Centre for Neonatal Research and Education.

The transfer of Neonatology was the culmination of significant collaboration between CAHS and NMHS. Having Neonatology join our existing portfolio of Community Health, CAMHS and PCH strengthens the integration and delivery of safe, high-quality health care services to WA children, from birth up to 18 years of age, and their families..

Respect - Living our values

We continue to promote the importance of demonstrating compassion, accountability, excellence, equity, respect and collaboration in everything we do, and this has been more visible than ever during the challenge of COVID-19.

In March 2020, we celebrated Living our Values Week, marking 12 months since the launch of the CAHS Values. The week was launched with a smoking ceremony at PCH, where we took a moment to reflect on the important work we do for the health of future generations.

Activities throughout Living our Values Week were designed to ensure all CAHS staff could participate with their colleagues, no matter where they were located. This year, we celebrated with long table

Setting aside the challenges of COVID-19, the 2019–20 year has been busy and productive, with a number of significant achievements to be celebrated.

lunches, mindfulness sessions, a dress-up day and staff mindfulness colouring-in contest. Staff were encouraged to recommit to our values by signing a pledge, and individuals were recognised by their teams through the Local Stars Certificate of Appreciation initiative.

CAHS continues to work towards values-based recruitment. This important initiative not only assists to promote the CAHS vision and values, but enables us to attract candidates whose personal values align with ours.

Equity - Midland Community Hub

The Sustainable Health Review (SHR) Final Report was published in April 2019 and included funding to establish a 'one-stop-shop' for children, young people and their families, where they can access CAHS services, as well as other government agencies, such as education and community services. This is referred to as the Midland Hub.

The Midland Community Hub Project will house a number of services, including child health, mental health, child development and family support services. These services will be provided by CAHS and in partnership with other government and non-government organisations.

CAHS is committed to working with local families and the Midland community to ensure the Midland Community Hub meets their needs. We have undertaken extensive consultation through 2019–20 to understand the needs and expectations of local families, and the opportunities to partner with service providers. An extensive review of the best practice literature on delivering community based health services has also been undertaken. Following the consultation and literature review, a collaborative and seamless service delivery framework is being established. The Midland Community Hub is due to open in 2022, and the design of the building will allow for integrated services to be provided.

Accountability - Managing risk through audit

During 2019-20, the audit function within CAHS contributed to the focus on accountability through a range of activities, including clinical incident management, corporate records management, and financial controls.

A key area of audit this year has been procurement compliance. This audit examined the health service's compliance with government policies and with the conditions of its Partial Exemption. The audit acknowledged CAHS' compliance across a range of requirements, and identified some minor areas of improvement with respect to records and publications. Further to this, CAHS has provided assistance to the Office of the Auditor General in the performance of their annual audit on CAHS, and in responding to their findings and recommendations.

The CAHS Audit and Risk team is committed to monitoring the program of supported audit recommendations and independently assessing their implementation, as well as providing independent assurance to the CAHS Executive and Board on the status of auditing activities findings and responses.

Excellence - COVID-19 response

The CAHS workforce responded to the COVID-19 pandemic with great speed, efficiency and professionalism. During this challenging time, many staff have gone above and beyond their day-to-day responsibilities to ensure CAHS is prepared for COVID-19 patients while continuing to deliver safe services. This includes the rapid growth of the CAHS telehealth program, a temporary expansion of the Emergency Department, ward reconfigurations, and the development and phased implementation of pandemic business continuity plans across all service areas.

As we continue to navigate the impact of COVID-19 in the longer term, we are implementing a structured approach to keep the best of what we have introduced during the pandemic, and return to business as usual where this is best.

The outstanding work of CAHS staff has also been recognised through the WA branch of the Australasian College of Health Service Management's Stars of COVID-19 initiative. A total of 11 individuals and two teams from CAHS were nominated by their peers for demonstrating outstanding leadership qualities during the pandemic.

Members of the CAHS Executive team celebrating Living our Values Week.

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.

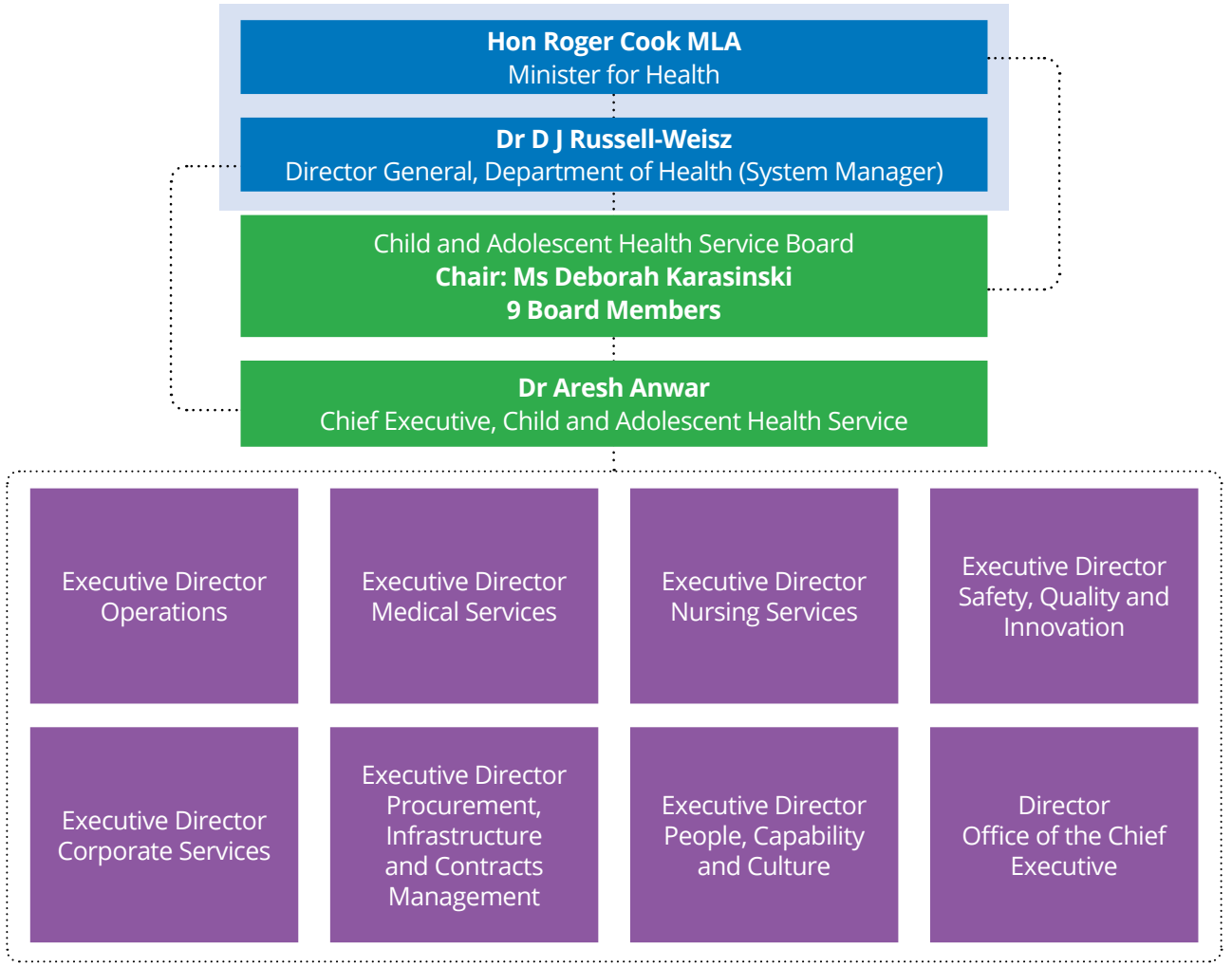
Accountable authority

The CAHS Board was the accountable authority for CAHS in 2019–20.

Responsible Minister

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

CAHS management structure 2019–20



Senior officers

Child and Adolescent Health Service
Chief Executive
Dr Aresh Anwar
1 July 2019 – 30 June 2020

Operations
Executive Director
Dr Victor Cheng
1 July 2019 – 27 September 2019
3 February 2020 – 30 June 2020

Operations
Acting Executive Director
Dr Matthew Skinner
14 October 2019 – 31 January 2020

Medical Services
Acting Executive Director
Dr Kavitha Vijayalakshmi
1 July 2019 – 29 September 2020

Medical Services
Executive Director
Dr Simon Wood
25 November 2019 – 30 June 2020

Nursing Services
Executive Director
Ms Katie McKenzie
1 July 2019 – 30 June 2020

Safety, Engagement and Innovation
Executive Director
Ms Mary Miller
1 July 2019 – 30 June 2020

Corporate Services
Executive Director
Mr Tony Loiacono
1 July 2019 – 30 June 2020

Procurement, Infrastructure and Contracts Management
Executive Director
Mr Danny Rogers
1 July 2019 – 30 June 2020

People, Capability and Culture*
Executive Director
Ms Valerie Jovanovic
17 January 2020 – 30 June 2020

Office of the Chief Executive
Director
Ms Kylie Mulcahy
1 July 2019 – 13 March 2020

Office of the Chief Executive
Acting Director
Ms Joanne Mizen
16 March 2019 – 30 June 2020

* New position created in 2019–20
Note: As per Treasury guidelines, the definition of Senior Officer excludes any person acting in such a position for a period of three months or less.

About CAHS

The Child and Adolescent Health Service (CAHS) is proud to be the leading service provider for paediatric healthcare in Western Australia, as the State's only dedicated health service for infants, children and young people.

CAHS is made up four service areas: Neonatology, Community Health, Child and Adolescent Mental Health Services (CAMHS), and Perth Children's Hospital (PCH).

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

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

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

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

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

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

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 the home of WA's only paediatric trauma centre and the State's first intraoperative magnetic resonance imaging machine. PCH also houses the Stan Perron Immunisation Centre, which is available to all children and families attending the hospital to help them stay up-to-date with their scheduled immunisations.

Shared responsibilities with other agencies

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

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

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

In 2019–20, CAHS partnered with over 75 NGOs through a range of contractual arrangements, including:

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

Performance management framework

To comply with its legislative obligations, CAHS operates under the WA health system 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 2019–20 are aligned to the State Government goal of *strong communities: safe communities and supported families* (see Figure 1).

The outcomes for achievement in 2019–20 by CAHS are:

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

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

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

Performance against activities and outcomes is summarised in the Agency Performance section, and described in detail under Key Performance Indicators in the Disclosures and Legal Compliance section commencing on page 108.

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

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. Provide high value healthcare 3. Collaborate with our key support partners 4. Value and respect our people 5. Promote teaching, training and research

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.

Outcome 2

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

Services delivered to achieve Outcome 1	KPIs measured	Services delivered to achieve Outcome 2	KPIs measured
1. Public hospital admitted services	• Average admitted cost per weighted activity unit	5. Aged and continuing care services	(none)
2. Public hospital emergency services	• Average Emergency Department cost per weighted activity unit	6. Public and community health services	• Average cost per person of delivering population health programs by population health units
3. Public hospital non-admitted services	• Average non-admitted cost per weighted activity unit		
4. Mental health services	• Average cost per bed-day in specialised mental health inpatient services • Average cost per treatment day of non-admitted care provided by mental health services		

Changes to Outcome Based Management Framework

There were no changes to the WA health system Outcome Based Management Framework affecting CAHS in 2019–20.

Performance highlights

Neonatology

In January 2020, the Neonatology Service transitioned from being part of the North Metropolitan Health Service (NMHS) to joining the Child and Adolescent Health Service (CAHS).

The Neonatology Service provides state-wide tertiary neonatal services to the sickest newborn babies and infants in Western Australia. The Service includes two Neonatal Intensive Care Units (NICU) located at separate hospital sites: King Edward Memorial Hospital (KEMH) and Perth Children's Hospital (PCH). The Neonatology Service provides a suite of specialist services to inpatient and community consumers and their families including:

- Neonatal Emergency Transport Service (NETS WA)
- Perron Rotary Express Milk Bank (PREM Bank)
- Retinopathy of Prematurity (ROP) Screening Program
- Neonatal Follow-Up Program
- Neonatology Outpatient Clinics
- Lactation Consultancy Service
- Neonatal Home Visiting Service

The Centre for Neonatal Research and Education was established in 2011 and secured $2.5 million National Health and Medical Research Council funding as a Centre of Research Excellence in 2013. It works to prevent death and disability associated with diseases in newborns by increasing knowledge and understanding of clinical, biochemical and physiological processes of health and disease in newborn babies.

In 2019 -20, there were 3,151 admissions to Neonatology inpatient services, with 54.8 per cent needing intensive care and 45.2 per cent needing special care. The most common reasons for admission included complications of prematurity, respiratory treatment, hypoglycaemia, suspected infection, endocrine disorders, metabolic disorders, surgical requirements, cardiac defects and neurological conditions. The average length of stay for neonatal inpatients was 10.3 days, ranging from less than one day to as many as 183 days.

Neonatal Emergency Transport Service

The Newborn Emergency Transport Service of Western Australia is a specialist team of doctors and nurses solely dedicated to providing neonatal intensive care during transport. NETS WA is the sole statewide retrieval service for Western Australia and is the busiest service of its kind in Australia per 1000 births. The NETS WA Team is based in the NICU at PCH and transfers preterm and sick neonates and young infants from their hospital of birth to the Neonatal Units at PCH and KEMH. NETS WA also provides telephone advice to doctors, nurses and midwives in outer metropolitan, regional and remote centres throughout WA, and coordinates transfer of neonates back to their local hospitals to receive care closer to home once appropriate.

NETS WA carried out 1,025 transports in 2019 -20. The majority (882 or 80.2 per cent) of referrals were within 100km of Perth, with 203 (19.8 per cent) referrals from country WA.

There has been a steady rise in the number of extremely preterm infants being delivered outside of a tertiary Neonatology Centre in WA. The current rate of out-born infants <32 weeks gestation is 9.5 per cent (up from 5 per cent in 2004). NETS WA is a priority service development area for Neonatology to improve timely access to transport to a tertiary service for WA's most vulnerable population.

Perron Rotary Express Milk Bank

Sometimes mothers have difficulty producing enough milk while others are producing more milk than their own infant requires. Established with funding provided by the Rotary Clubs of Belmont and Thornlie and The Perron Charitable Trust, the PREM Bank, based at KEMH, helps babies and mothers by collecting breast milk from healthy screened donors, processing it to ensure safety, and making it available to infants in need.

The PREM Bank operates though collaboration between CAHS, the Women and Infants Research Foundation and the University of Western Australia (UWA), with additional support from Telethon.

In 2019–20, the PREM Bank dispensed 890 litres of donor milk to 348 preterm infants. The PREM Milk Bank's ability to select high-value donors has continued, with an average donation of 21.2 litres per donor.

In July 2019, Dr Ben Hartmann was invited to attend the International Expert Meeting on the Donation and Use of Human Milk, organised by the Institute of Biomedical Ethics and History of Medicine at the University of Zurich and sponsored by the World Health Organisation. Ben was one of only five milk banking experts invited from around the world, and the PREM Bank is recognised internationally as leading best practice in milk banking.

Learning from Excellence

Neonatology 'Learning from Excellence' (LfE) is a peer nominated feedback program for recognition of excellence in care and staff support. LfE is a system for capturing positive feedback from observed episodes of good practice or when things work well, allowing opportunities for reflection and wider learning to improve quality of patient care. The LfE system reflects the ongoing values based commitment in Neonatology to recognise and celebrate excellence.

The newly refurbished Parent Lounge at KEMH Neonatal Unit

Parent lounge refurbishment

In December 2019, a family area for parents and carers of inpatients at KEMH Neonatal Unit was given a much needed refurbishment courtesy of Helping Little Hands and Designfit

Retinopathy of Prematurity Screening Program

Retinopathy of Prematurity (ROP) is an eye disease that affects some babies born prematurely, where the blood vessels in the retina develop abnormally after birth. It is usually mild and goes away by itself, but ROP can lead to blindness if not detected and treated.

The ROP Screening Program is a nurse-led digital imaging program that screens preterm infants for ROP in collaboration with a lead ophthalmologist. Up to 25 babies per week are screened by the ROP Screening Team, with over 1,200 screening sessions completed last year. An electronic reporting system was recently implemented that has streamlined documentation processes and vastly enhanced the screening workflow. In 2019, the ROP Screening

Program was expanded to include the neonatal unit at PCH, ensuring complete digital screening for all eligible preterm infants across CAHS.

RetCam imaging allows medical staff to monitor the development of a baby's eyes. The ROP screening team were recently awarded funding for a new portable RetCam that can allow screening preterm infants at peripheral hospitals, which reduces the need for attendance at outpatient clinics.

ROP Program Clinical Nurse, Karen Shearer, was a finalist in the WA Nursing and Midwifery Excellence awards 2019.

Community Health

NEW BABIES WELCOMED
25,827

CHILD HEALTH CONTACTS
123,443

'UNIVERSAL PLUS' CONTACTS
35,320

GROUP SESSIONS
2,164

Child Health

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

Child Health Services support the principle of progressive universalism, which aims to improve health equity and outcomes by providing support for all, with more support for those who need it most. The Universal Program comprises five high-quality health and developmental assessments at scheduled touch points, as well as a range of group-based and drop-in services. Children and families identified with additional needs are offered more intensive one-to-one support services.

During 2019–20, 25,827 new babies were welcomed into the Universal Child Health Program from birth, with 25,430 (98 per cent) accepting the offer of a Postnatal Home Visit in the early postnatal period.

Community Child Health nurses provided a total of 123,443 individual child health contacts during the year, including 35,320 'Universal Plus' contacts for families needing additional support. This number includes both clinic and home visits. In response to COVID-19, child health nurse contacts were divided into two components: a phone call to discuss progress and concerns, followed by a short face-to-face visit for nurses to complete the physical component of the child health check. The face-to-face component has been recorded as Universal Plus contacts.

In addition to individual contacts, Child Health nurses delivered 2,164 parenting group sessions to 12,480 parents and saw 30,295 families at drop-in sessions throughout the year.

Breastfeeding Support Services were reviewed in 2019, with a number of improvements implemented aimed at providing a more responsive, timely service. These improvements include a pilot of access to telehealth services where appropriate.

School Health

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

Throughout 2019, CAHS, in collaboration with the WA Country Health Service and the Department of Education, undertook further consultation based on the Report on the Review of School-aged Health Services, and commenced planning for implementation of the 32 recommendations. These recommendations relate to key aspects of the service delivery model, the role of community nurses working with children and young people, and workforce utilisation and supports. A number of initiatives have been progressed, including offering school entry health assessments during school holidays to enable parents to attend the appointment.

A core component of primary school health services is a universal school entry health assessment (SEHA). During the 2019 school year, 24,190 (96 per cent) of children enrolled in Kindergarten received a SEHA. In 2020, 152 SEHAs were provided during the January school holidays.

SCHOOL AGED HEALTH REVIEW

32 RECOMMENDATIONS

SCHOOL ENTRY HEALTH ASSESSMENTS

24,190

SECONDARY STUDENT OCCASIONS OF SERVICE

76,224

EDUCATION SUPPORT OCCASIONS OF SERVICE

57,281

School health nurses also support children in secondary and education support schools, providing 76,224 occasions of service to secondary students and 57,281 occasions of service to students in education support facilities.

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

Immunisation

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

During 2019, community health nurses delivered a total of 151,034 vaccinations through the Childhood and School Based Immunisation Programs.

VACCINATIONS ADMINISTERED

151,034

CHILDREN IMMUNISED

20,167

STUDENTS IMMUNISED

65,789

Immunisations for 0–4 years-olds were provided from more than 50 community-based facilities across metropolitan Perth, with 66,610 vaccinations delivered to 20,167 children.

Through the school-based program, Community Health delivered 84,424 vaccinations to 65,789 students at 190 schools across metropolitan Perth.

Child Development Service

The metropolitan Child Development Service (CDS) provides a range of assessment, early intervention and treatment services to children with developmental delay or difficulty that impact on function, participation and/or parent-child relationship. We work closely with families to plan and set goals based on their child's strengths and interests, and the parents' concerns and priorities for their child.

Demand for child development services continues to grow, with 27,479 discipline referrals[1] accepted during 2019-20, up one per cent on 2018-19 and eight per cent in the past three years.

Families referred to the service are invited to attend a service planning appointment within eight weeks of referral. During this appointment, we discuss parents' concerns for their child, goals and priorities, and together we develop an agreed service plan. During 2019–20, 8,184 families received a service planning appointment.

CDS REFERRALS ACCEPTED

27,479

CDS SERVICE PLANNING APPOINTMENTS

8,184 WITHIN 8 WEEKS

CHILDREN SEEN BY CDS

27,605

Depending on the child's needs, service options can include parent workshops, group interventions, home/school visits and individual treatments.

During 2019–20, 27,605 children received services from CDS, representing around six per cent of the 0–18 year old population. Children aged 3–7 years account for the majority of children seen, in line with the focus on early intervention.

The request for an autism assessment continues to grow, with 395 referrals received in 2019–20. This is a 20 per cent increase on the previous year. 182 assessments were completed, with 72 per cent of clients receiving a formal diagnosis of autism spectrum disorder.

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

Child and Adolescent Mental Health Services

Therapeutic Crisis Intervention for Families

Therapeutic Crisis Intervention (TCI) is an evidence-based program developed by Cornell University in New York that teaches staff how to prevent a potential crisis with a young person, or de-escalate it when one occurs. Last year, Child and Adolescent Mental Health Services (CAMHS) introduced the first pilot group for a modified version called Therapeutic Crisis Intervention for families (TCI-f), where TCI-f participants learned how to manage crises safely and therapeutically.

This year, CAMHS invested in TCI and TCI-f training programs for families, CAHS staff and external staff in the youth and adult health spaces. TCI trainers - Service Manager Carl Fletcher, Clinical Nurse Claire Melling and Education Manager Julian James delivered TCI training to mental health colleagues from Rockingham, Fremantle and Fiona Stanley Hospitals. The response from staff was very positive, with all participants agreeing that they "feel confident to apply the skills and knowledge learnt in the workplace".

The next step is for CAMHS to introduce a series of videos demonstrating the TCI-f method for sharing with CAHS families.

YES and CES

CAMHS implemented the Your Experience of Service (YES) and Carer Experience of Service (CES) this year, which replaced the Experience of Service Questionnaire (ESQ). In 2018, the Mental Health Commission rolled out the first annual statewide YES Survey Snapshot across WA, following other successful implementations across NSW and QLD.

The YES and CES have had better response than the ESQ across services, and feedback from families and staff around them has been positive. Given their successful use, CAMHS will continue using the YES and CES throughout its services on an ongoing basis.

Julian James, Therapeutic Crisis Intervention trainer

About the 2019 Your Experience of Service (YES) and Carer Experience (CE) Survey conducted 21 October – 13 December 2019

SURVEYS RETURNED

384
CARER EXPERIENCE OF SERVICE

388
YOUR EXPERIENCE OF SERVICE

CARE EXPERIENCE RATED EXCELLENT OR VERY GOOD BY

69.2%
OF CONSUMERS

77.1%
OF CARERS

SERVICE RECOMMENDATION TO FAMILY OR FRIENDS VERY LIKELY OR LIKELY BY

77.3%
OF CONSUMERS

93.6%
OF CARERS

Tele-Mental Health Services

The COVID-19 pandemic necessitated the rapid roll out of tele-mental health services across CAMHS. CAMHS clinicians are now routinely using Video Call, Healthdirect's video conferencing solution, to communicate with families and deliver the services they would normally receive in clinics. This solution allows for safe physical distancing while maintaining the services young people and their families need.

CAMHS submitted a successful proposal to the Mental Health Commission for the introduction of an Emergency Telehealth Service (ETS) to ensure young people with complex mental health needs can receive care similar to that they would receive in an Emergency Department without having to present. The service will operate seven days a week from 8:00am – 2:30am, and will consist of a team of child and adolescent mental health clinical nurse specialists led by a Consultant Child Psychiatrist and Clinical Nurse Manager.

Perth Children's Hospital

Hospital in The Home

Hospital in the Home (HiTH) provides care to metropolitan patients in their own home who would otherwise be cared for in hospital. The team has maintained the highest compliance delivering intra-muscular Bicillin injections in Australia, benefitting children at high risk of Rheumatic Heart Disease (RHD). HiTH collaborated with the Telethon Kids Institute for a researcher to accompany the nurse on these visits to perform throat swabs for a research project to help develop a vaccine to prevent the reoccurrence of acute rheumatic fever and subsequent RHD. The results of this research were published in the Journal of Antimicrobial Chemotherapy.[2]

HiTH has also been a leader in home delivery of oxygen for patients with bronchiolitis. This has been achieved by working collaboratively with the multidisciplinary team and external agency for timely delivery of oxygen cylinders direct to the patient's home, which reduces the need for families to remain in hospital.

Both these key achievements were presented by the HiTH team at the 12th HiTH Society Scientific Conference held in Perth in November 2019.

Ward 4A eating disorder pod for nutritional restoration

In July 2019, an eight bed pod opened in Ward 4A for patients with an eating disorder requiring admission for nutritional restoration. Aligning with Australasian best-practice principles, a standardised treatment protocol incorporating three levels of care and integrated care planning across the service continuum was introduced. Nursing hours per patient-day were increased to provide a nursing ratio 1:2, and a dedicated group of nurses were educated to deliver care to this vulnerable, complex cohort of patients. Meal support was extended to seven days a week,

Key service improvements

Admissions per month
11.3 BEFORE
15.2 AFTER

Median Length of Stay (days)
18.3 BEFORE
13.1 AFTER

Average number of ED pts in hospital per day (4A)
6.6 BEFORE
7.2 AFTER

Waitlist: admitted within 21 days
79.2% BEFORE
91.7% AFTER

Waitlist: follow up appointment within 14 days of discharge
78.4% BEFORE
85.2% AFTER

Weight gained each week of admission
1.26KG BEFORE
1.82KG AFTER

[2] *https://academic.oup.com/jac/article/74/7/1984/5464313*

six meals a day and fully nurse led. A Clinical Nurse Specialist (CNS) Eating Disorders was introduced to co-ordinate and lead evidence-based clinical care to achieve optimal patient outcomes.

A CNS Mental Health is being trialled on Ward 4A to support patients with mental health illness. This has had a positive impact, with 79 per cent of patients with eating disorder receiving a risk assessment within 24 hours of admission. To support these patients further, two nurses have been accredited as Therapeutic Crisis Intervention trainers, and 95 per cent of nurses have now been trained in dynamic de-escalation processes and techniques.

The multi-disciplinary team has been actively involved in all elements of the change process and embedding of the model of care. Nursing staff have expressed positive feedback about the new model of care:

"Because the Pod is nurse led, it has given 4A nursing staff the ability to feel empowered in delivering high level care"

"It has given us the opportunity to grow a stronger therapeutic nurse-patient relationship"

"Collaboration between the multidisciplinary team is going from strength to strength, based on a mutual respect for each other's expertise"

Supporting children with neurodevelopmental disorders in behavioural crisis

PCH has experienced an increase in Emergency Department (ED) presentations and inpatient admissions of children with neurodevelopmental disorders (such as autism) experiencing severe behaviours of concern. To better support these patients, a pilot program commenced with a full-time Social Worker in the ED to help families access community-based supports and divert admission when clinically appropriate. Working closely with families experiencing complex social crises on top of medical and/or behavioural crisis, this Social Worker saw over 100 families in the first four months. A full-time occupational therapist also now works across ED and the inpatient wards to support sensory and behavioural regulation for these patients, making their time at PCH safer and less traumatic.

Courtenay Wood, WA's first Paediatric Palliative Care Fellow

WA Paediatric Palliative Care Service

The WA Paediatric Palliative Care Service (WA PPCS) provides holistic and compassionate care for children and their families living in Western Australia who have identified palliative care needs. The WA PPCS has developed and expanded its model of care, and continues to support an increasing number of children and families living with life limiting conditions. This came to fruition over the course of 2019 and early 2020 with the addition of specialist clinics and expansion into working alongside Haematology and Oncology to support the palliative care needs of these children as well. In February, the service welcomed WA's first Paediatric Palliative Care Fellow, and in April, a professional advice line was established so specialist paediatric palliative care advice is available 24/7 across WA, helping to support families remain close to home at end of life.

This came to fruition over the course of 2019 and early 2020 with the addition of specialist clinics and expansion into working alongside Haematology and Oncology to support the palliative care needs of these children as well.

Some of the 37 new Resident Medical Officers CAHS recently welcomed undergoing extensive training in paediatrics at Perth Children's Hospital.

Aboriginal Health at CAHS

It is well established that an essential element to improving the health outcomes of Aboriginal people is their representation in the health workforce.

The contributions Aboriginal employees make to the CAHS workforce and service delivery are significant, so CAHS is dedicated to attracting, retaining and growing our Aboriginal employees through rewarding career pathways, and building a positive and inclusive culture through deeper understanding of Aboriginal society.

CAHS' focus on the health and wellbeing of Aboriginal people is also evident from the many programs dedicated to serving their needs.

Community Health

The Community Health Aboriginal Health Team (AHT) provides comprehensive, culturally secure services to Aboriginal families with children aged 0–5 years. AHT helps families raise healthy children by providing the community with child health information and empowering parents to build on the knowledge they have of their children. Aboriginal families are offered the option of receiving services from AHT or remaining with their local child health nurse.

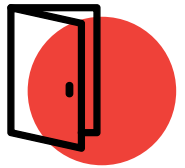
Building respectful and trusting relationships with families and communities is a focus of the AHT. During 2019–20, AHT delivered a total of 20,519 services to Aboriginal children and families. A flexible approach to service delivery was taken to support families, with 48 per cent of individual face- to-face contacts delivered in family homes.

State funding through the Aboriginal Health Programs enables AHT to deliver additional services within the Local Government Areas of Swan, Gosnells and Armadale. Funding from Rural Health West has enabled 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.

AHT also provides targeted ear health screening across metropolitan Perth for Aboriginal children of school age. During the 2019 school year, the School Ear Health Screening team screened 1,648 children across 181 primary schools.

SERVICES PROVIDED

20,519



FBH EAR HEALTH CLINIC ATTENDANCE

59%

SCHOOL EAR HEALTH SCREENING

1,648

Child and Adolescent Mental Health Service

Specialised Statewide Aboriginal Mental Health Service

The Specialised Statewide Aboriginal Mental Health Service (SSAMHS) team supports Aboriginal young people and families access culturally safe mental health services. SSAMHS uses a 'whole of family, whole of life' approach to mental health service delivery that is consistent with the needs of Aboriginal people.

SSAMHS Worker Aaron Panaia made an impression on the international research community as one of the invited presenters to the 7th Australasian Mental Health Outcomes and Information Conference 2019. The presentation: *Using data to enhance*

4.5%
GROWTH IN CAHS ABORIGINAL WORKFORCE IN 2019–20

91.3%
CAHS STAFF COMPLETED ABORIGINAL CULTURAL LEARNING

implementation, delivery and evaluation of Aboriginal mental health services in CAMHS demonstrated success in both engagement and outcomes for Aboriginal patients in locations with an Aboriginal mental health worker. The research showed 88 per cent of Aboriginal young people show an increase in Health of the Nation Outcome Scales for Children and Adolescents results where cared for by an Aboriginal Mental Health Worker.

The inaugural *Waakal Moort Kaadadjiny* Aboriginal Wellbeing Festival was held in Armadale in October 2019, with CAMHS coordination provided by Aboriginal Mental Health Worker Josie Ford. The festival aimed to help prevent suicide by connecting families with services and fostering a sense of togetherness. The festival was such a success, it will be held annually in a different region of Perth each year.

Perth Children's Hospital

Aboriginal Liaison Service

The Aboriginal Liaison Service (ALS) contributes to the cultural safety of Aboriginal families to ensure their care pathway within PCH is well supported by:

- providing cultural and practical support and advocacy to children and families within the hospital or community setting
- assisting to improve communication between the patient, their family and internal service providers
- providing cultural advice, consultation and education to hospital colleagues in partnership with other services at PCH to ensure culturally appropriate care.

Until physical distancing requirements became mandatory to prevent the spread of COVID-19, ALS held weekly morning teas in the Kulunga Moort Mia lounge for Aboriginal families attending inpatient or outpatient appointments. It is hoped this reduces the sense of isolation for many families attending PCH by providing an opportunity for yarning and enjoy some damper. ALS intends to resume holding the morning teas once it is safe to do so.

During 2019–20, ALS completed a pilot project called Keeping our mob healthy to revise orthopaedic and burns facts sheets to ensure they are culturally appropriate for Aboriginal families. The redesign encompassed consultation with medical staff,

Josie Ford, Aboriginal Health Worker.

The Koorliny Moort team visited Kings Park to learn about the significance of the park to Noongar people, family life, and some uses for plants, including bush medicine. The team believes a better understanding of Noongar culture will permit them to engage more effectively with Aboriginal families.

"Koorliny Moort does an amazing job and really is the missing link for rural and remote services"

consumers, and Aboriginal Liaison Officers at CAHS. An application has been made to Perth Children's Hospital Foundation to expand this important work to other medical specialty areas.

CAHS acknowledges the generosity of the PCH Foundation providing 'welcome bags' containing essential personal items for carers attending with a child who is an inpatient. These were redesigned this year based on consumer feedback, and have proven to be very popular with Aboriginal families.

Koorliny Moort (Walking with Families)

Koorliny Moort's 'Walking with Families' service aims to increase the engagement of Aboriginal families with health services, and improve out of hospital care for Aboriginal children in Western Australia, particularly to those who might find it hard to come into hospital for their paediatric appointments or who want to stay closer to home.

Koorliny Moort assists with coordinating care for Aboriginal children with more than two specialities or who have complicated health care needs by:

- improving communication between primary, secondary and tertiary health care services
- improving engagement with local, outreach and PCH services
- initiating telehealth services
- facilitating attendance at PCH appointments through better communication and appointment scheduling
- assisting with discharge arrangements and follow-up plans for patients discharged from PCH.

Koorliny Moort also runs paediatric clinics at PCH, and paediatric Outreach clinics at Derbarl Yerrigan Health Service and Child and Adolescent Community Health - Aboriginal Health Team sites.

The value of the Koorliny Moort service is evident from ever-increasing demand. For instance, while COVID-19 restrictions were in place, clinics were maintained via telehealth services, leading to a 16.3 per cent increase in appointments in 2019–20, and a 17.0 per cent increase in the number of patients attending them. The team's Aboriginal workforce now includes a Senior Social Worker, two clinical nurses and two enrolled nurses, and they are collaborating with the Aboriginal Health Team and Community Health to offer rotations for Aboriginal Health Workers to work with Koorliny Moort.

Improving recognition and management of chronic wet cough in Aboriginal children in the Kimberley

A world first study investigating the barriers and facilitators to timely detection and optimal management of chronic wet cough in Aboriginal children was undertaken in the Kimberley region of WA. Knowledge translation strategies were developed and implemented in partnership with the local Aboriginal community and health services. Some of the strategies included culturally safe health information provided for families and training for clinicians.

The research resulted in a three-fold increase in families seeking help for their child's chronic wet cough, improved health care provision by clinicians and healthier children. This project has been led by PCH Physiotherapist Pamela Laird as part of her doctoral studies, and supervised by Dr André Schultz.

Refugee health at CAHS

Compassion, equity, and excellence are hallmarks of the comprehensive, culturally-safe and trauma-informed care the Refugee Health Service delivers.

The PCH Refugee Health Service (RHS) works collaboratively with the Community Health Refugee Health Team. The staff support the health needs of Western Australian children and adolescents from refugee-like backgrounds and their families as they settle in our local communities and access other mainstream services, such as schooling, General Practice and Dental Health Services.

PCH Refugee Health Service

The PCH Refugee Health Service provides a variety of services to patients, including multidisciplinary outpatient clinics, inpatient consultation and urgent outpatient assessment for children arriving in WA with Federal health undertakings or complex care needs. RHS also assists families navigate the health system, and liaises with other health, educational and non-government services to deliver coordinated care.

In addition to managing existing patients, RHS assessed nearly 600 new patients in 2019–20. This is up from about 400 last year, bringing the total to more than 4,500 new RHS patients managed since 2006. Patients come from more than 20 different ethnic backgrounds, the most common countries of origin being Myanmar, Afghanistan, Syria and Iraq. Very high levels of relative disadvantage were noted that became more evident during COVID-19 restrictions. Increasing numbers of patients with disability and neurocognitive concerns are also being assessed; a trend that is reflected nationally.

Education, research and advocacy

The PCH RHS team also contributes to education, research and advocacy for refugees and asylum seekers. PCH RHS Paediatricians represent CAHS and WA on various state and national committees, including the WA Refugee Health Advisory Group, WA Forced Marriage Network, Refugee Health Network of Australia (Executive), Australian Paediatric Refugee Health Network, and Royal Australasian College of Physicians (RACP) Health of Refugee and Asylum Seekers Working Group. Research describing the complexity of resettlement health concerns for Syrian and Iraqis refugees was shortlisted for the 2020 RACP Rue Wright Award.

Improving dental health

The *New Beginnings: healthy teeth, healthy* lives refugee health dental program continued to gain momentum in 2019–20. Over 210 PCH RHS patients have been recruited into the Arresting Dental Caries Randomised Control Trial, overcoming research enrolment barriers in patients with limited English proficiency. The RHS has also collaborated with the *Clinics to Communities* Oral Health Promotion program, which facilitates providing oral hygiene kits with tailored oral health education as part of a holistic prevention and health promotion strategy for all new PCH RHS families.

Staff achievements

Clinical A/Prof Raewyn Mutch was appointed to the Harvard Program for Refugee Trauma faculty in recognition of her international expertise in refugee health and trauma-informed care.

Clinical A/Prof Sarah Cherian was awarded the 2020 Royal Australasian College of Physicians Mentor of the Year in recognition of her leading contribution to junior doctor education, mentoring, research and advocacy, particularly in the field of paediatric refugee health.

Dr Ifrah Abdullahi, who undertook her PhD in collaboration with the RHS, University of Western Australia and Telethon Kids Institute, was selected as one of Australia's representatives at the 2020 Lindau Nobel Laureate Meeting (Germany) in recognition of her research exploring the neurodevelopment outcomes of migrants and refugees.

Anne Staude (PCH Refugee Health Liaison Nurse) received the 2020 CAHS Emerging Nurse Leader Award in recognition of her leadership, compassionate care and positive influence on individual practice, patient/client care and the team environment. Anne was also awarded the June 2020 Stars of CAHS Chief Executive's Award as she "embodies the CAHS values, which are underlined by her ability to provide compassionate care, collaborate with multidisciplinary professionals to reduce health inequities while operating in a framework of respect, accountability and clinical excellence."

The checks provide targeted coronavirus education to parents (including language specific resources) who are vulnerable due to socio-economic impoverishment, language, literacy, education and/or trauma barriers.

Community Health Refugee Health Team

The role of the CAHS Community Health Refugee Health Team (RHT) is to support newly-arrived refugees and humanitarian entrants connect with community and specialist health care services. RHS comprises 6.7 nursing staff and one Ethnic Health Worker. They provide services across the Perth metropolitan area to children under the age of 18 years and their primary carers who have been referred from the Humanitarian Entrant Health Service and the Perth Children's Hospital Refugee Health Service. Other referrals are assessed on an individual basis.

Clinical Nurses with the RHT support early identification, screening and interventions for child development concerns, aiming to empower families in managing their health needs through supported integration into the wider health systems across both CAHS and the WA health system. All families are reviewed and actively managed to complete immunisation catch-up schedules commenced on arrival to Australia. RHT provides additional support services for health issues relating to refugees, and referral where relevant. These include, but are not limited to nutritional deficiency (including vitamin D and iron deficiency anaemia), infections (parasitic, malaria, latent tuberculosis), physical disabilities, chronic illness, poor oral health and the physical and psychological consequences of torture, trauma or assault. The majority of contacts by RHT are provided by home visits (1,853 in 2019–20), equating to 82.4 per cent of the total clinical contacts with families. A further 6,809 occasions of service support ongoing liaison and consultation needs with other approved interpreter services or the family to support the integration process. All families are contacted using approved interpreter services, with these being a mix of face-to-face and telephone bookings.

Impact of COVID-19

To address the COVID-19 pandemic, RHS and RHT developed joint COVID-19 Refugee Wellbeing Checks to be undertaken during clinical interactions in recognition of the heightened health access barriers of this patient population. The checks provide targeted coronavirus education (including language specific resources) to parents who are vulnerable due to socio-economic impoverishment, language, literacy, education and/or trauma barriers. Specific COVID-related educational risks (e.g. lack of internet access or parental illiteracy), chronic health concerns and social isolation are also being identified, allowing development of support strategies in partnership with key non-health organisations.

Other refugee health initiatives

Discussion of other initiatives CAHS is undertaking to improve refugee health, such as improving the cultural competence of staff and identifying gaps in service delivery, can be found in *Substantive equality* (page 240).

Research

The status of research and research support is a key focus area for our health service given its inclusion in the CAHS Strategic Objectives.

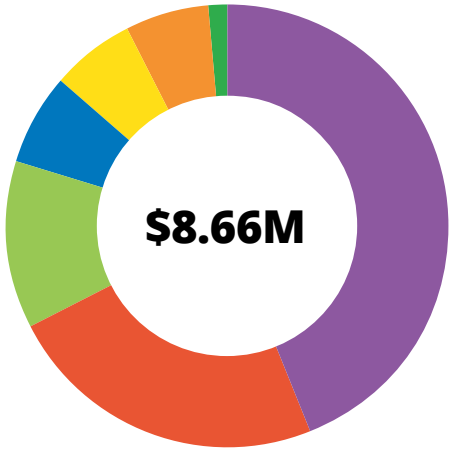
We aspire to build our research capacity and culture, while ensuring maximum impact and translation into clinical care. Increased efforts and focus in the research space over the past year are part of our endeavour to be a world-class paediatric research-focused health service.

CAHS Research Summary

Please note the following figures may not fully capture all research activity at CAHS, and represent the 2019 calendar year unless otherwise indicated.

New studies with CAHS site approval	92
New studies approved by CAHS Human Research Ethics Committee (HREC)	71
Active research studies	566
(Active research studies with CAHS HREC approval)	(439)
Active studies at PCH	531
Active studies at Community Heath	22
Active studies at CAMHS	13
Total number of clinical trials	111
Total number of commercial studies	39
Total number of multi-centre studies	276

Funding for CAHS research activity



Funding for CAHS research activity	Total $8.66 million
Commonwealth funding	$3,819,889
Telethon Trust	$2,033,815
PCH Foundation	$1,074,839
Cancer charities	$556,872
WA Dept of Health	$544,847
Other national funding	$519,034
Commercial	$114,101

> **"I was so glad to have the opportunity to sit on a research committee. It's a good feeling to have my voice heard and considered."**
>
> **Consumer**

Support for research

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

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

Spotlight on consumer participation as a cornerstone of effective research

There is an increasing emphasis on consumer and community member participation in research to improve research outcomes for the WA community. CAHS partners with the Consumer and Community Health Research Network (CCHRN), to support researchers with information and processes for including community members in research.

Consumer coordination by CCHRN:

- 66 consumers in research committees and panels across CAHS
- 52 new and existing research projects supported by consumers.

> **"Involving a consumer as a research buddy completely transformed the research process for me, and one of the fantastic parts of involving consumers is that they help get the research back out to their community."**
>
> **Researcher**

CAHS Research Case studies

Multi-centre research
To increase participant numbers so that research questions can be answered in a timely and valid way, CAHS researchers collaborate with other Australian and international paediatric hospitals on large multi-centre research trials. Data from each site is collated for analysis, with findings shared across sites.

Are treatments for children with life-threatening seizures effective?

Dr Meredith Borland, Emergency Department Consultant

Funding from the PCH Foundation enabled Perth Children's Hospital to participate in a multi-centre evaluation of two drugs used to treat children who present with potentially life-threatening seizures. The results of the study clearly showed that the newer drug is as effective as the traditional drug. As a result, one drug can be given, and if not effective, we have an alternative drug to help stop the seizure.

Over 80 per cent of the time this will reduce the length of the seizure and the need for invasive treatment options. This study gained international recognition and has been implemented for treatment across the world.

Supporting early researchers through PhD research studies: Learn, Engage and Play Study (LEaP) Study

Occupational therapist Jodie Armstrong was awarded a Western Australian Health Translation Network Early Career Fellowship to further develop findings from her PhD project

This study aimed to develop and evaluate the effectiveness of a therapeutic playgroup for children with developmental delays when first referred to an early intervention service. This consumer driven study arose from parents' desire to have a way of early access to information to support their child's development and connect with other families experiencing the same challenges.

In a research environment characterised by inconsistent playgroup definitions and models, this study created new playgroup knowledge, clarifying therapeutic playgroup practice principles and producing the first evidence-based and empirically tested manualised therapeutic playgroup for young children with significant developmental delays.

Collaborative research brings clinicians, health services, research institutes and universities together

Research questions often start in a clinical setting, where clinicians ponder new and better ways to provide clinical care and improve patient outcomes. To take research forward, our clinicians often work with other health services, research institutes and universities to progress their ideas into meaningful research. This allows suitable expertise, effort and capacity from various partners to deliver positive outcomes.

FeBRILe3 project - examining the safety of earlier discharge home for well-looking, low-risk infants with fever

Consultant Paediatrician Dr Ariel Mace is leading the FeBRILe3 project as part of her PhD, which is investigating ways to improve the diagnosis and management of children with fever. The project is a collaboration between CAHS, Fiona Stanley Hospital and Telethon Kids Institute.

The FeBRILe3 study aims to provide local evidence to demonstrate the validity and safety of risk assessment approaches to identify infants at low risk of serious bacterial infections, and to help standardise and optimise patient care within our population. It monitors for unplanned hospital presentations and other complications to show the safety and impact of this intervention in the WA population, utilising a novel prospective real-time Bayesian monitoring approach.

Fever without source is one of the most common reasons young infants less than three months old present to hospital. Although most will have a minor viral infection, all infants are currently hospitalised for at least 48 hours to undergo investigations and receive intravenous antibiotics until serious bacterial infection is excluded.

Recent international evidence indicates that many infants may be safely discharged home much earlier. Earlier discharge of low risk infants may help reduce the risk of iatrogenic complications, promotion of antibiotic resistance, and unnecessary burden for families and the health-care system.

Maintaining good blood glucose levels in young people living with Type 1 Diabetes

Dr Mary Abraham, Consultant and Honorary Research Associate with Telethon Kids Institute, Endocrinology and Diabetes. Raine Medical Research Foundation Clinician Research Fellowship.

Diabetes technology research lead and Perth Children's Hospital paediatric endocrinologist Dr Mary Abraham was awarded a Clinician Research Fellowship to investigate hybrid closed loop systems, a step towards an artificial pancreas, in adolescents with sub-optimal blood glucose control. Her research focuses on improving the lives of young people living with Type 1 Diabetes who are struggling to maintain good blood glucose level control.

Using advanced technology, the semi-automated pump devices will help to keep young people within an optimal blood glucose range, reducing the risk of short and long-term complications.

Community Health nurses participating in the DETECT study: Front row- Deborah Robinson (Community Health), Cath Frauenfelder (PCH). Back row- Stacey Rose (PCH), Cathy Power (PCH), Michelle Adamson (PCH)

Research Fellowships expanding capacity and expertise of our researchers

The Clinician Research Fellowship program is an initiative of the Department of Health in partnership with the Raine Medical Research Foundation. The program is designed to encourage clinicians employed by Health Service Providers to develop their research capability while continuing some clinical duties. The program also facilitates high quality research that will ultimately provide better health care outcomes.

CAHS nurses join forces to DETECT COVID-19

CAHS nursing staff have been instrumental in one of the research programs established in the fight against COVID-19 in WA.

The DETECT Schools program was a key component of a broader research program launched to understand community transmission of COVID-19. This collaborative study entailed testing asymptomatic school students and staff, and is a partnership between CAHS, Telethon Kids Institute, PathWest, the Department of Education and the WA Country Health Service (WACHS).

Over a three month period, nurses from CAHS and WACHS visited 40 schools across WA and conducted over 18,000 tests. Community Health nurses were recruited as team leaders for the three teams in metropolitan Perth.

Staff demonstrated their commitment and dedication by mobilising swiftly to join DETECT, which was formalised and commenced in record time. The Community Health nurses' experience within schools and their positive interactions with students were important elements in the success of the program. The study has helped build community confidence about the absence of community transmission of COVID-19 in WA.

Welcoming neonatology research

The transition of Neonatology into our health service in January 2020 has seen the exceptional neonatology research platform from King Edward Memorial Hospital shift to CAHS. We look forward to supporting and profiling neonatology research activity in the future.

Reducing the burden of neonatal sepsis

Dr Tobias Strunk, Neonatal Consultant

One active neonatology research focus is on sepsis in preterm infants, which is one of the most common complications of very early birth. There are a number of projects, including leading a large international trial of a new sepsis therapy, that have received funding from the United States for a large trial in Australia and New Zealand of topical coconut oil to prevent sepsis, and a National Health and Medical Research Council ideas grant to evaluate new sepsis diagnostics.

"Our innovative research program is centred around the identification and evaluation of underlying mechanisms of sepsis susceptibility, novel diagnostic tools to facilitate earlier accurate diagnosis of sepsis and appropriate treatment, effective prophylactic interventions to reduce the incidence of sepsis, and adjunct therapy to ameliorate the harmful effects of sepsis-triggered inflammation and to improve disability-free survival", Dr Strunk said.

The impact of the COVID-19 pandemic on research

Research is an area that was significantly impacted by the COVID-19 pandemic.

While some research projects slowed down at the beginning of isolation measures, other research activity increased in response to the pandemic. As the potential impact of COVID-19 in Western Australia stabilised, many projects that wound down at the beginning of the pandemic then reactivated their studies as physical distancing measures eased.

Overall, there was a high and sustained demand on the CAHS Department of Research to support and enable safe and effective research across the health service. This also meant adjustments to ensure that research projects operated in line with new and changing guidelines for site access, outpatient appointments and personal protective equipment use.

Data about COVID-19 research activity in Western Australia, as specific activity at CAHS showed:

- 42 research projects proposed across all WA Health sites related to COVID-19. Of these, 28 projects progressed to approval, with 50 per cent obtaining CAHS Human Research Ethics Committee (HREC) and/or site approval at CAHS/PCH.
- Approximately 200 active research projects at CAHS submitted ethics and/or governance change requests or notifications based on COVID-19 impact.
- CAHS HREC completed three scheduled and seven out of session reviews in direct response to COVID-19 impact.
- The CAHS Scientific and Safety Committee completed 29 scheduled and out of session reviews in direct response to COVID-19 impact, as well as undertaking reviews on an ad-hoc basis without an out of session meeting required.
- Clinic activity decreased significantly between 2019 and 2020 as a result of the COVID-19 pandemic (see Telethon Clinical Research Centre section for further details).

Overall, there was a high and sustained demand on the CAHS Department of Research to support and enable safe and effective research across the health service.

Dr Steve Oo fronts the media as he received his flu vaccination as part of the BRACE Clinical Trial.

COVID-19 Research Case Study

Over 500 staff from Perth Children's Hospital volunteered to participate in the BRACE Clinical Trial, which is a World Health Organisation endorsed research trial to investigate whether a tuberculosis or BCG vaccine can help boost immunity and protect against SARS-like viruses.

BRACE is a collaboration between CAHS, the Murdoch Children's Research Institute in Melbourne, and the Telethon Kids Institute in WA. Fiona Stanley Hospital and Sir Charles Gairdner Hospital are also participating. CAHS Director of Research Dr Peter Richmond is the Clinical Lead for PCH.

To enable the study to coincide with annual influenza vaccinations, preparations for the BRACE trial were organised rapidly. Where traditional vaccine trial planning could take 12 months, the BRACE trial was coordinated and approved in less than three weeks at PCH, Fiona Stanley Hospital and Sir Charles Gairdner Hospital.

The multi-centre randomised controlled trial shows that large-scale collaboration between research organisations and health service providers can progress rapidly when working together to tackle big infection control issues.

PCH participants continue to participate by using their Trial Symptom Tracker smart phone app to monitor symptoms by recording and monitoring illnesses. Digital data recording better enables research clinicians to determine whether the BCG vaccination has resulted in illness or infection, and ensures appropriate COVID-19 testing. Participants will complete three month surveys for risk factors, as well as blood tests for serology at three and 12 months.

Telethon Funding provides boost to CAHS research

Research support enhanced

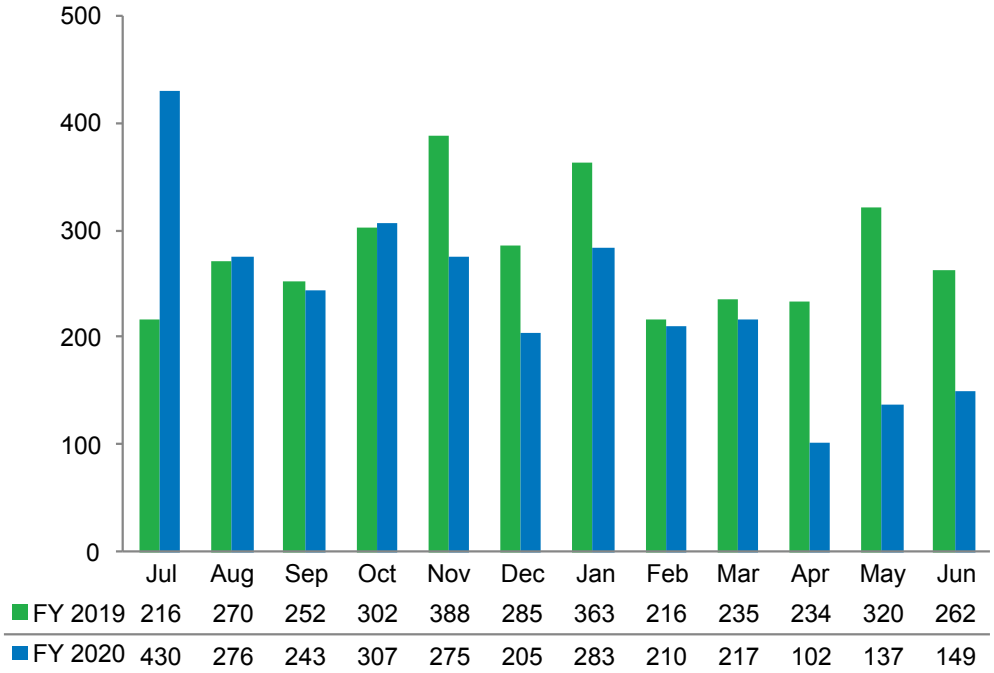
Thanks to a five-year funding commitment from Telethon, the team has received a significant boost to enable great research support and collaboration on the PCH campus. One key change that occurred this year was to integrate support services more officially into the Department of Research team structure. This is part of the plan towards long-term sustainability of the functions. The name Telethon Clinical Research Centre is now solely allocated to the dedicated Research Clinic at PCH.

Telethon Clinical Research Centre: research outpatient clinic

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

The data for 2020 shows the drop in research activity and outpatient appointments at PCH due to the COVID-19 pandemic.

Figure 3: Outpatient research appointments, 2018-19 and 2019-20



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 2019	216	270	252	302	388	285	363	216	235	234	320	262
FY 2020	430	276	243	307	275	205	283	210	217	102	137	149

PCH Foundation continues longstanding support for research

The ongoing relationship with the PCH Foundation and child health research is a valuable partnership for CAHS. In addition to contributing to individual research projects across CAHS as well as funding professorial chairs and research fellowships, the PCH Foundation also funds the annual CAHS Research Grant Round. In 2019, this grant round funded eight seeding, eight project and two implementation research studies, as well as one PhD scholarship.

Child Health Research Symposium

The 2019 Child Health Research Symposium was sponsored by the PCH Foundation. This event has been running for many years, and since the opening of Perth Children's Hospital, is a collaboration between CAHS and the Telethon Kids Institute. The 2019 event enabled 43 child health researchers to present their research projects, with an additional 65 research projects profiled during a poster presentation event.

CAHS Consumer Engagement Strategy and Framework

The CAHS Consumer Engagement Strategy was developed after extensive consultation with consumers, staff, and other internal and external stakeholders, and will drive how staff partner with consumers over the next three years.

In support of the Strategy, the Consumer Engagement Framework was also developed as an internal online resource that will include a vast array of governance information, guides and toolkits to support staff partnering with consumers.

Consumer engagement is already undertaken across many areas of CAHS, and the Strategy and Framework will build on these existing efforts; expanding the scope and approaches used to engage and partner with families. A major focus will be on implementing a more consistent approach throughout CAHS that is supported by appropriate infrastructure and sound governance.

Developing the Consumer Engagement Strategy involved three phases. Each phase was based on the three main ways that CAHS engages with consumers.

These are when consumers:

1. Receive care and support from our nurses, doctors and other clinicians
2. Give feedback about the service; either good, bad or neutral
3. Participate and have a say when we make changes to our service, through surveys, consumer working groups and community forums.

Phase One of the Strategy development included an online survey that was shared with all staff across CAHS, receiving responses from 318 staff. Face-to-face interviews were also conducted with 34 key staff across CAHS, including representation from service delivery, management and Executive.

An online survey of parents and carers received 620 responses from the Perth metropolitan area and 150 responses from regional areas. A separate online survey gathered input from 123 young people in Perth.

Finally, a review of organisational information relevant to consumer engagement was conducted, which considered the National Safety and Quality Health Service Standards, CAHS' complaints and clinical incident data, the CAHS Clinical Governance Framework and other key information sources.

Phase Two built on the findings from Phase One to develop and deliver consumer workshops, allowing further investigation into the actions consumers want. Workshops held in Banksia Grove, Brookman, Leederville, Mirrabooka and Midvale were attended by 84 parents or carers and 23 young people.

Phase Three brought CAHS staff and consumers together in four online Consensus-Building Workshops to finalise the goals and actions that had been developed across Phases one and two. A total of 21 consumers and 29 staff participated in the workshops that developed the final wording for each of the four Strategy goals, and prioritised the list of actions applicable to each.

Consumer feedback

Listening to our consumers is central to improving the safety and quality of our health service. We encourage feedback from children, young people, their families and carers, as it helps us identify where we have done well and where there are opportunities to improve their healthcare experiences. Consumers are welcome to provide their feedback directly to CAHS in person, by telephone, by post, email or online form.[3]

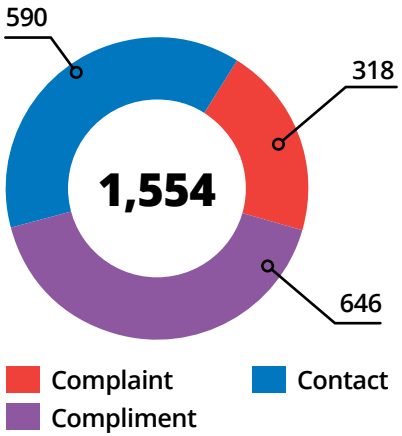
Care Opinion

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

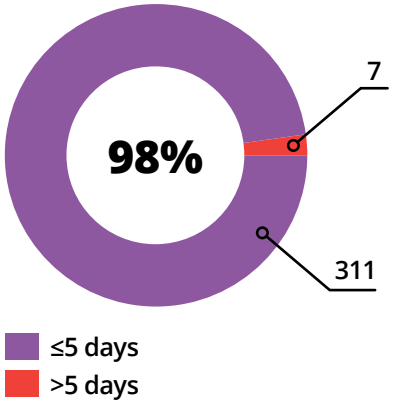
[3] *https://cahs.health.wa.gov.au/For-families-and-carers/Compliments-and-complaints*

[4] *https://www.careopinion.org.au/*

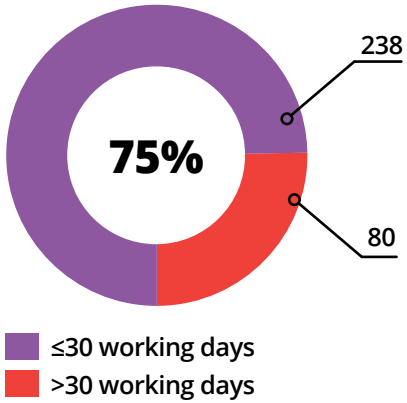
Feedback type



Complaints acknowledged within 5 working days



Complaint response timeframes



Statement from the Consumer Advisory Council Chair

It has been a privilege to be the Chair of the CAHS Consumer Advisory Council (CAC) for my third year.

As Chair, I continue to attend the weekly CAHS Executive Committee meetings, and I thank the Chief Executive, Dr Aresh Anwar, and all the Executive staff for their inclusiveness. For instance, during February 2020, Daniel Staer, the Chair of the Youth Advisory Committee and I were invited to attend the Strategic Planning days, which was a great opportunity to provide consumer input at high level. I also sat on the Escalation of Care Committee led by Associate Professor Fenella Gill, who in turn attended CAC meetings to gain consumer input on her research project. CAC is extremely proud of our initiative to create a CAHS-wide Consumer Network to enable all consumers to be able to provide feedback.

A big thank you to all the CAC members for their dedication and hard work during the past 12 months. The worldwide COVID-19 pandemic has presented unique challenges recently, but as a Council, we have simply switched to an online platform and continued meeting. CAC has had a great year and participated in reviewing a number of key Frameworks and Strategies; in particular, the Clinical Governance Framework and the Consumer Engagement Strategy. We have reviewed policies including the CAHS-wide Restraint Policy, Open Disclosure Policy and Complaints Management Policy. We have had input to the CAHS Staff Induction program, and provided feedback on the Transition Resources for when a child moves to the adult hospital. Safety is always a key concern, so we review the monthly Safety and Quality Reports. We also participated in the Nursing Research Priority Setting Project and the Integrated Services Steering Group.

A sincere thank you to all the staff who have attended our CAC meetings. It was great to hear of the work that the *Keeping Kids in No Distress* program has done with both staff and patients. CAC recently warmly welcomed Matthew Holmes to the new position of Director Consumer Engagement, and we are very much looking forward to working alongside him and the team. Many thanks also to the CAHS Child and Family Engagement Staff and to the Chief Executive for on-going support of the Council and consumer engagement. We are looking forward to expanding our reach to consumers, parents, carers and families to ensure their feedback and patient experience in Neonatology, Community Health, Mental Health and Perth Children's Hospital influences the design and delivery of services throughout CAHS.

Ma Wood

Margaret Wood
Chair
Consumer Advisory Council

"We are looking forward to expanding our reach to consumers, parents, carers and families to ensure their feedback and patient experience in Neonatology, Community Health, Mental Health and Perth Children's Hospital influences the design and delivery of services throughout CAHS."

Statement from the Youth Advisory Committee Chair

Another year has come and gone for the Youth Advisory Committee (YAC) and we are excited for what is coming next.

Over this past year, we have put in much consideration towards how our committee will be structured and how it will engage with CAHS in its entirety. Earlier in the year, we worked alongside the Consumer Engagement Team and provided advice on the youth focus in the new Consumer Engagement Policy and its supporting documents. One of our members has been speaking with staff about, and supporting them to build, a Consumer Training Package. Our Terms of Reference have been revised, and we are excited to begin a new phase of recruitment.

Wide-spread consumer engagement and opening the discussions up to a larger forum of the CAHS patients and families is a priority for us. So, we have been keen to be involved in the consumer consultation around the CAHS Complaints Management Policy and reviewing the range of mediums CAHS uses to hear complaints and compliments from their community.

In seeking to encourage further discussion with consumers currently going through the services, we have been preparing a framework that would support us in visiting the service's sites and hearing the experiences of patients. However, as the world is currently experiencing the devastating effects of COVID-19, we have had to put the physical visits on hold, and are looking to begin these discussions online instead.

It has been an honour as YAC chair to represent the Committee at the weekly executive meetings alongside Margaret Wood, the Consumer Advisory Council Chair. Earlier this year, we both had the privilege of sitting in on some of the planning meetings for CAHS' future endeavours. I am grateful for the opportunity to be involved in the workings of such an organisation and to see the humility and passion of the service's staff.

My thanks go to the Consumer Engagement Team for all the care and support they have shown over this past year, and to Haylee Clark from Child and Adolescent Mental Health Services, whose experience and enthusiasm has been a great help and encouragement. I would also like to thank my team in the Youth Advisory Committee; each member's experience and desire to help the youth of the state has been vital.

Daniel Staer
Chair
Youth Advisory Committee

Statement from the Disability Access and Inclusion Committee Chair

This year has seen important changes for the Disability Access and Inclusion Committee following a review of all CAHS Consumer committees.

The mission of the new Disability Access and Inclusion Committee has been strengthened with a clear role and responsibility for the CAHS Disability Access and Inclusion Plan, and to act as an advisory body for disability access issues across CAHS. The committee is linked to the CAHS governance structure under the People, Capability and Culture pillar.

I would like to thank retiring committee members for their long standing contribution to the work of the Disability Advisory Committee. Thank you also to the members who have transitioned to the new structure for their continued commitment and goodwill in agreeing to participate in this newly focussed work. We welcome the new committee members, who bring their experience and enthusiasm from across the organisation. I would like to acknowledge the ongoing support provided for this committee through the CAHS Consumer Engagement Team.

We look forward to further improving awareness of and disability access for all at CAHS.

Sue-Anne Davidson
Chair
Disability Access and Inclusion Committee

Agency performance

Delivering safe, high-quality care

Learning from clinical incidents

CAHS is committed to the establishment, management and evaluation of safe and high quality paediatric health services for Western Australian children and adolescents. This is firmly guided by the National Safety and Quality Health Service (NSQHS) Standards, which were developed by the Australian Commission on Safety and Quality in Health Care to improve the quality of health service provision and protect the public from harm. CAHS recognises that health care will never be risk-free, and is steadfastly committed to a culture of safe systems and practice through formal safety and quality systems like clinical risk management and continuous quality improvement

The CAHS Clinical Governance Framework supports the systems, processes, relationships and a culture that ensures all consumers of CAHS' services receive safe and high quality health care and good clinical outcomes. Through integrated corporate and clinical governance systems, CAHS is accountable to the consumers and community it serves, and will function on a commitment to continuously improve the safety and quality of its services, delivering on its vision of healthy kids, healthy communities. A key component of Safe Systems and Practice and 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 clinical incidents provides 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. CAHS is further committed to embedding risk mitigation and sustaining lessons learnt. To this end, we are continually developing ways of sharing these important lessons, and evaluating the impact of new and revised practice for all areas of our health service.

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.[5] Incidents are classified according to severity as either SAC 1 (highest priority), SAC 2 or SAC 3.

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 reviews SAC 1 incidents and makes 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 oversight and monitoring of reported clinical incidents occurs. Monthly reports are provided to all levels of the organisation and the CAHS 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 create a culture of accountability for patient safety.

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

Table 1: SAC 1 incidents 2019–20 (including KEMH Neonates from 1 October 2019)

SAC 1 Incident	Number
Total notified:	**26**
Investigated	22
Ongoing investigation	3
Declassified*	1
Total confirmed:	**25**
Confirmed with patient outcome of death	4
Confirmed with patient outcome of serious harm	9
Confirmed with patient outcome of moderate harm	9
Confirmed with patient outcome of minor harm	3
Confirmed with patient outcome of no harm	0

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

Reducing hospital-acquired complications

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

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

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

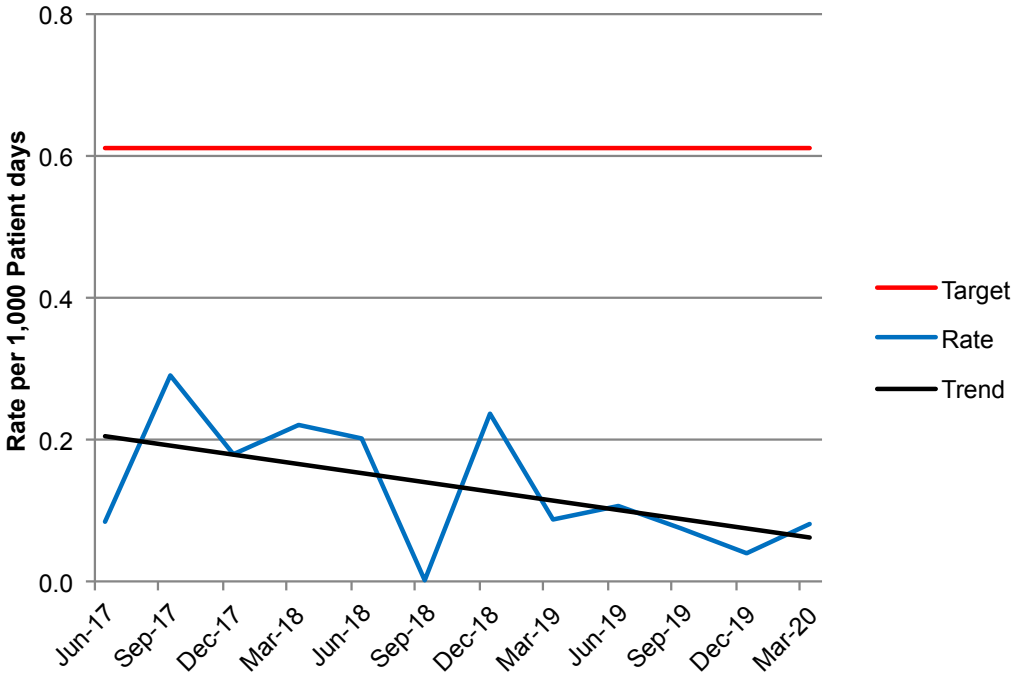
This is attributed to frequent review of data and incidents by the Comprehensive Care Committee, and completing rounds, whereby various medical disciplines come together to discuss the patient's condition and coordinate care.

Pressure injuries

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

Figure 4 shows the success CAHS has had keeping the rate of the most serious Stage III and IV pressure injuries below the target set by the WA Department of Health and reducing the rate over time. This is attributed to frequent review of data and incidents by the Comprehensive Care Committee, and completing rounds, whereby various medical disciplines come together to discuss the patient's condition and coordinate care.

Figure 4: Rate of Stage III & IV pressure injury

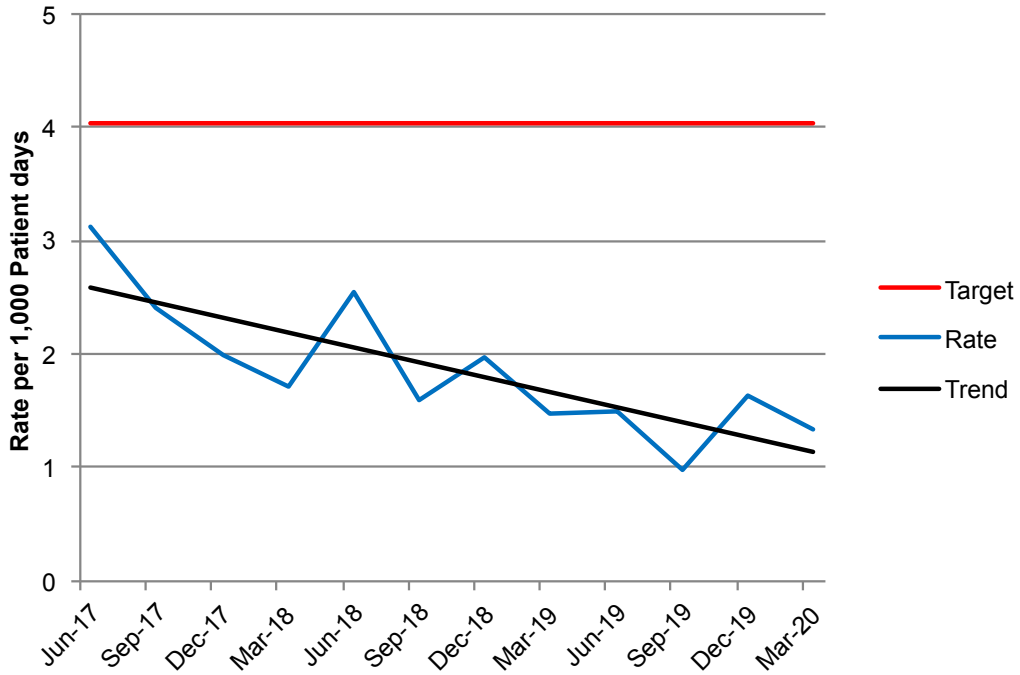


Healthcare-associated infections

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

To reduce HAIs, CAHS implemented an action plan focused on key areas of clinical guidelines and policies, hand hygiene auditing, aseptic technique competencies for central venous access devices for clinical staff, antibiotics prophylaxis, and education regarding documentation of peripheral intravenous devices. The work is monitored and reported regularly via the Preventing and Controlling Healthcare Acquired Infections Committee. Figure 5 indicates the plan has proven successful, with a decreasing trend evident in the rate of HAIs over the past three years and remaining below the target set by the WA Department of Health over that time.

Figure 5: Rate of healthcare associated infection



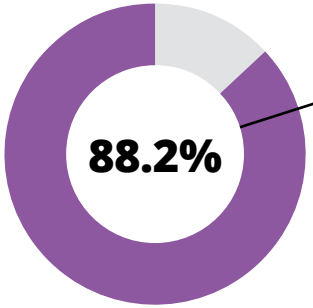
Hand hygiene

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

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

Audits are conducted three times each year, and the most recent audit of 2019–20 shows PCH continues to exceed the benchmark and perform better than the national average.

National

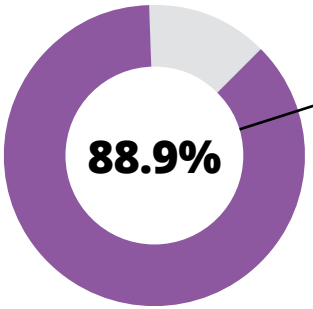


TOTAL MOMENTS

467,464

80%
Benchmark

Perth Children's Hospital

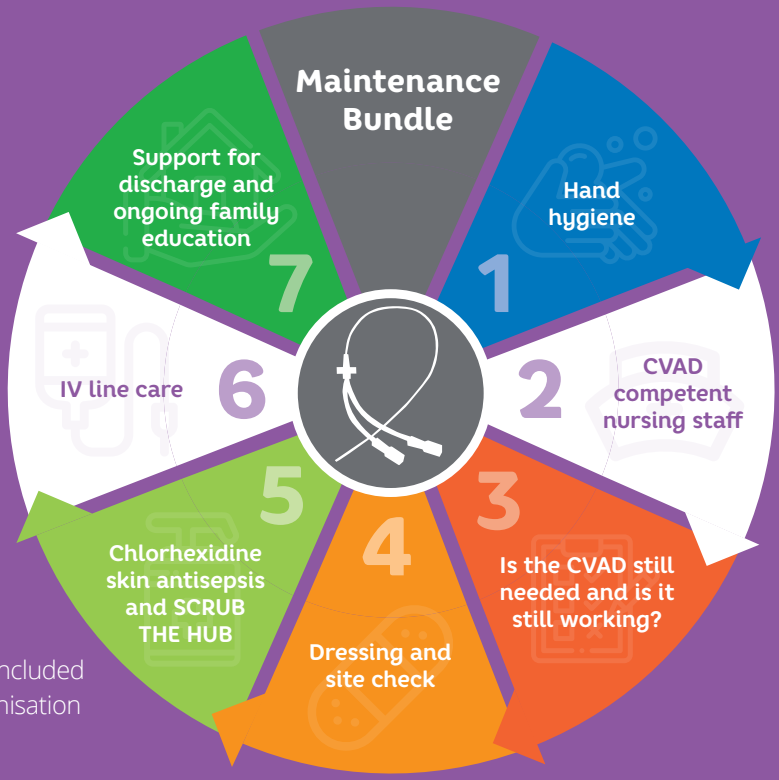


TOTAL MOMENTS

1,972

80%
Benchmark

Clinical incident case study



Background
A young patient with a rare condition compounded by complicating factors required a central venous access device (CVAD) to be fitted to facilitate on-going management.

Incident
The CVAD was fitted, but bleeding from the site was found after the operation and appropriate treatment administered. The patient later developed a fever, so blood cultures were taken and further treatment provided. Tests revealed the patient had contracted a central line associated blood stream infection, which was treated successfully. The incident was given a SAC 1 classification and a Root Cause Analysis investigation instigated as a consequence.

Findings
The investigation found there were factors predisposing the patient to CVAD infection that may have been under-appreciated. This included a known history of *Staphylococcus aureus* colonisation and compromising skin conditions.

Learnings and outcomes
Guidelines recommend reducing the number of bacteria on the skin of leukaemic and high-risk surgical patients to help prevent infection; a process called decolonisation. After an extensive review of the literature, the SAC 1 investigation team, in consultation with the Infectious Diseases team, recommended routine decolonisation of all children undergoing insertion of central venous lines. This is because at least 25 per cent of the population are known carriers of *Staphylococcus aureus*, and decolonisation is a safe, cost-effective strategy that reduces the risk of CVAD infection. This recommendation was accepted and a robust plan has been put in place for implementation.

Emergency Department access

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

The PCH Emergency Department provides a tertiary-level emergency service for paediatric patients including resuscitation, assessment, diagnosis and treatment for patients with a range of conditions including trauma, medical, surgical and psychiatric presentations. The ED typically sees approximately 70,000 patients per year, with a hospital admission rate of 20 per cent. It has three resuscitation bays, a 23 bed acute pod area, an eight cubicle low acuity area, a fast track (minor injuries) area, a psychiatric assessment pod and an 11 bed short stay unit.

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

Table 2: Triage category, description and WA performance targets

TRIAGE CATEGORY	DESCRIPTION	RESPONSE	TARGET
1	Immediately life-threatening	Immediate (≤2 minutes)	100%
2	Imminently life-threatening OR important time-critical treatment OR very severe pain	≤10 minutes	≥80%
3	Potentially life-threatening OR situational urgency	≤30 minutes	≥75%
4	Potentially serious OR situational urgency OR significant complexity or severity	≤60 minutes	≥70%
5	Less urgent	≤120 minutes	≥70%

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

In order to protect staff, patients and families, significant changes were made to workflows and personal protective equipment (PPE) recommendations at PCH ED in light of COVID-19.

Percentage of Emergency Department patients seen within recommended times

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

CAHS strives to treat all Emergency Department patients within the recommended period, but places most emphasis on the sickest and most time critical patients assigned to Categories 1 and 2. In 2019–20, CAHS continued to exceed performance expectations for Categories 1 and 2, although performance in Categories 3 and 4 declined slightly compared with last year (Table 3). Category 5 access sits 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 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. Wait times for Categories 3 and 4 have been negatively impacted in 2019–20; first by an overall increase in presentations for the first eight months of the financial year, and then by the impact of COVID-19 for the remaining four months. In order to protect staff, patients and families, significant changes were made to workflows and personal protective equipment (PPE) recommendations at PCH ED in light of COVID-19. The delays attributable to the sharp rise in the use of PPE, in conjunction with increased cleaning requirements, are reflected in the slight deterioration in performance in the Category 3 and 4 figures for 2019–20.

Table 3: Percentage of Child and Adolescent Health Service Emergency Department patients seen within recommended times, by triage category, 2016–17 to 2019–20

Triage category	2016–17	2017–18	2018–19	2019–20	Target
1	100%	100%	100%	**100%**	**100%**
2	89.7%	88.9%	88.5%	**87.6%**	**≥80%**
3	61.6%	63.3%	66.3%	**61.5%**	**≥75%**
4	59.5%	65.5%	65.8%	**64.7%**	**≥70%**
5	95.1%	95.1%	97.5%	**95.0%**	**≥70%**

Favourable performance **Unfavourable performance**

People, capability and culture

Year in review

Organisational changes continued to shape the future of CAHS by aligning a number of functions to support a more integrated way of working. As part of this change, CAHS created a new Executive Director role in February 2020. The position will lead a new directorate called People, Capability and Culture in line with the heightened focus and governance structure under the People, Capability and Culture Board sub-committee. The directorate will drive a strategic framework to support workforce matters (people), promote staff development (capability), and increase staff engagement (culture).

CAHS welcomed around 500 employees from Neonatology, who officially joined our health service on 20 January 2020. Previously part of the North Metropolitan Health Service, the decision to realign the governance of Neonatology means CAHS now provides a completely integrated health care service from birth to the onset of adulthood.

The COVID-19 pandemic raised a number of workforce concerns and challenges for CAHS, with expectations of the virus' impact being witnessed across the globe.

The pandemic challenged the workplace environment to adapt, with new and alternative ways of working to ensure we both supported our staff and volunteers, and continued to deliver excellent service. Teams became focused on their ability to respond through training, increased use of technology, deployment of staff to areas throughout the WA health system to focus on COVID-19 planning, as well as supporting employees to be work from home ready. To gather an overview of workforce capability and availability during the initial emergency phase, staff were asked to complete a survey to identify skills, capability, readiness to increase hours to support surges in numbers, as well as those who had previous training that could support contact tracing and mental health impacts. The 80 per cent response rate enabled a considered approach to workforce issues to address and prepare the workforce during the various phases of the response. Planning also included identifying staff and volunteers at greater risk of developing serious complications if they were to contract COVID-19, and ensuring that strategies were implemented to minimise their risk of exposure.

While COVID-19 presented CAHS with many challenges, it also provided opportunities to examine and alter the way we work. For example, increased use of technology enabled employees to work remotely during the time when practising physical distancing was essential to reducing the spread of the virus. Teams split into functionally equivalent groups to ensure infection wouldn't compromise continuity of service, and they changed working hours and locations to suit business demands. The lessons learned from these new ways of working will inform future workforce planning efforts to support employees achieve work/life balance, and improve patient experience by capitalising on innovations in digital health.

In 2019, a functional readiness assessment was undertaken of corporate functions supported by a steering committee, advisory group and staff consultation to identify fit-for-purpose operating models for each corporate function, underpinned by clear guiding principles. This resulted in realigning functions to better enable service delivery.

To support the introduction of a new system wide discipline policy in January 2020, CAHS

collaborated with other health service providers to develop a consistent approach to disciplinary processes. A number of educational resources were developed to support decision makers in understanding these changes.

The second Your Voice in Health annual engagement survey was commissioned in March 2020. The impact of COVID-19 detracted from survey promotion activities, however CAHS still achieved a similar response rate to last year. The results of the latest survey show an increase in overall employee engagement.

Our People

Employee profile

CAHS employs thousands of staff who perform a wide variety of roles in the service of WA children and their families and carers. Many are part-time employees, but when measured as full-time equivalents, our Service grew in 2019–20 due to the KEMH Neonatology service joining us (Table 4).

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

Category	Definition	2018–19	2019–20
Administration & clerical	All clerical-based occupations together with patient-facing (ward) clerical support staff	676.5	686.3
Agency	Administration and clerical, medical support, hotel services, site services, medical salaried (excludes visiting medical practitioners) and medical sessional	33.4	29.0
Agency nursing	Workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest	3.1	3.6
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care	15.6	16.0
Dental nursing	Dental nurses and dental clinic assistants	7.2	6.6
Hotel services	Catering, cleaning, stores/supply laundry and transport occupations	167.8	175.3
Medical salaried	All salary-based medical occupations including interns, registrars and specialist medical practitioners	350.8	384.0
Medical sessional	Specialist medical practitioners that are engaged on a sessional basis	69.0	69.3
Medical support	All Allied Health and scientific/technical related occupations	628.3	631.6
Nursing	All nursing occupations. Does not include agency nurses	1,256.5	1,415.4
Site services	Engineering, garden and security-based occupations	3.5	2.2
Other occupations	Aboriginal and ethnic health employees	23.4	25.6
	Total	**3,235.1**	**3,444.8**

Some of the many volunteers serving at Perth Children's Hospital

Volunteer profile and recognition

A team of over 400 volunteers support CAHS to provide a warm and welcoming environment for children, their families and carers. The 'team in tangerine' provides support across 36 different areas throughout Perth Children's Hospital, and supports operations within the community; most notably at Child Development Service sites.

Our volunteers are a diverse group of people from 18 to 85 years old who speak over 50 languages. Partnerships with local universities have seen an influx of students hoping to gain exposure and experience in a health setting, particularly those in the nursing, medical and teaching fields. While these students inevitably move on to start their chosen careers, we take pride in offering a volunteering experience to the next generation of key community workers, and are always delighted to see some become doctors and nurses.

Recognising our people

Stars of CAHS

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

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

In 2019–20, there were 10 winners from 122 nominations. CAHS is grateful for the ongoing support of award sponsors HESTA and Perth Children's Hospital Foundation.

WA Health Excellence Awards

In a showcase of the CAHS value of excellence, the PCH Tube-Feed Weaning Team took out the inaugural Allied Health Award at the 2019 WA Health Excellence Awards for their project "Development of the CAHS PCH Tube-Feed Weaning Program, and Clinical Practice Guideline: Preventing Tube-feed Dependency, Successful Tube-Feed Weaning and Positive Eating".

The team was recognised for successfully formalising a tube-feed weaning program. As a result, 98 per cent

SUCCESSFUL TUBE-WEANING

98%

REDUCTION IN EMERGENCY VISITS

82%

REDUCTION IN INPATIENT ADMISSIONS

94%

REDUCTION IN INPATIENT LENGTH OF STAY

98%

Pictured (L-R) - Olivia Naylor, Linda Correia and Marina Keating - members of the award winning Tube-Feed Weaning Team

of patients undergoing a tube-wean at PCH now have a successful wean. These outcomes also translated to improved outcomes for patients and families by an 82 per cent reduction in Emergency Department visits, a 94 per cent reduction in inpatient admissions, and a 98 per cent reduction in inpatient length of stay.

WA Nursing and Midwifery Excellence Awards

CAHS Community Health Clinical Nurse Jenefer Arrantash was named joint winner of the Excellence in Primary, Public, Community and Residential Care Award at the 2019 WA Nursing and Midwifery Excellence Awards.

Jenefer works to improve the health and wellbeing of children, families and specific community groups using a range of health promotion/education and support strategies focusing on the social determinants of health. She also provides effective and efficient preventative and early intervention programs to individuals and groups. The judges commented that Jenefer represents the core values all nurses should - passion, excellence and continuity.

Jenefer Arrantash, 2019 WA Nursing and Midwifery Award winner for Excellence in Primary, Public, Community and Residential Care.

Employee relations

Highlights in industrial relations during 2019–20

There was no lost time due to industrial disputation. All potential industrial matters or disputes with unions were resolved directly between the parties without the need for external conciliation or arbitration processes.

Rapid and significant structural changes in response to the COVID-19 threat presented significant challenges across CAHS over a short timeframe. Despite these internal upheavals preparing for a pandemic outbreak, our unions took a positive and conciliatory approach to our need to adapt to the emerging situation, which may be attributable to the improved working relationships developed in recent years. There was also significant pressure to provide accurate and timely advice on a wide variety of issues never previously encountered. This included advice on entitlements for those employees affected by the COVID-19 crisis, such as pre-existing health conditions that put them at risk, and those subject to mandatory isolation, either for themselves or those they care for. There was also a strong focus on ensuring service delivery was not compromised by expanded use of flexible working arrangements.

In accordance with Commissioner' Instruction 23, work continued throughout the year filling vacant positions by converting fixed-term contract and casual employees to permanent status. This remained a significant priority regardless of other challenges that emerged during the year.

Activity levels for individual employee issues that required ongoing management and Industrial Relations advice rose again during the year.

Compliance with public sector standards and ethical codes

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

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

The COVID-19 pandemic sparked a public outpouring of gratitude to the WA health system-wide workforce, where a number of sites saw increases in offers of gifts, benefits and support to groups of staff or the whole site. To ensure compliance with current policy requirements, regular communication was promoted, and a streamlined process was created to support employees in ethical practices.

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

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

Compliance monitoring

During 2019–20, there were eight claims lodged against the Employment Standard. Of these, five claims were resolved internally, and three were referred to the Public Sector Commission (PSC) for review, with two subsequently declined by the PSC and one outcome pending. There were no claims lodged against the Grievance Standard in 2019–20.

A total of 76 reports or complaints alleging non-compliance with the Code of Conduct (breaches of discipline) were lodged. Suspected breaches of discipline, including matters of reportable misconduct, were dealt with through the WA Health Disciplinary

processes, and where appropriate, reported to the Public Sector Commission (7) or the Corruption Crime Commission (16) as required under the *Corruption, Crime and Misconduct Act 2003*. Where breaches were substantiated, the decision maker determined the appropriate action in accordance with the *Health Services Act 2016*.

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

	Total
Communication & Official Information	6
Conflict of Interest	3
Fraud & Corrupt Behaviour	24
Personal Behaviour	33
Record Keeping and Use of Information	7
Use of Public Resources	3

Fraud and corruption prevention

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

CAHS' commitment to integrity is supported through:

- internal audits focused on hot spots, including procurement and contract management
- ongoing review and monitoring of the Integrity and Ethics work plan.
- increased communications on mandatory employee obligations to declare pecuniary interests, gifts, benefits and hospitality.

Our capability

CAHS encourages a culture of life-long learning across the organisation through provision of ongoing training and development of employees. In-house training programs are facilitated and supported across CAHS, with dedicated learning and development teams supporting Community Health, Child and Adolescent Mental Health Services and Corporate education. Specific professional education includes Post Graduate Medical Education, Paediatric Nursing Education, and Pharmacy Education.

Pandemic response

Disruptions to the standard workforce training programs were experienced due to the COVID-19 pandemic, which limited participant numbers due to physical distancing requirements. Virtual learning was key to supporting service delivery, client/patient safety, and employee safety, with education teams exploring and developing new ways to support training and education. The CAHS Induction program for new staff switched to online modules from April 2020 to support new employees during the COVID-19 pandemic. Our Community Health development team focused on virtual learning as an alternative modality to study days, and supported important programs such as a refresher on Breastfeeding, how to make a video call using Telehealth, and Virtual Parenting: How to deliver Parenting Groups using Microsoft Teams software (MS Teams); an adaption of the Promoting Early Communication package to enable parents to access via the internet. The Nursing Orientation program was also adapted to be delivered via MS Teams.

Our PCH Simulation Suite facilitated more than 30 COVID-19 scenarios that focussed upon donning and doffing of PPE, and communication issues while

Our Culture

Living our Values

The Shape our Future Steering team continued to provide multi-disciplinary input into making CAHS a great workplace. Living our Values week was again celebrated in 2020, building on the inaugural launch in 2019. A smaller working group of Shape our Future members organised and promoted activities during 24–28 February, including an official welcome and smoking ceremony for Neonatology, mindfulness sessions, dress-up days, values challenges, and long table lunches. The Shape our Future team were inundated with photos and stories of Living our Values Week being celebrated across the organisation.

The second Barrett's Cultural Values Assessment was conducted in November 2019 and showed increased improvement in the alignment of employee values with organisational values. It also highlighted that CAMHS required a specific focus and action to address employee engagement. As a result, a dedicated Shape our Future working group was established to engage with employees about their concerns.

The journey towards a values based organisation continued in line with the CAHS Culture Action Work Plan 2018–20. Part of this work included promoting CAHS' values in job advertising and position descriptions, with future work being undertaken to include values in recruitment activities.

caring for a child who may be infected with COVID-19. During the pandemic response phase, the Simulation Suite collaborated with the Emergency Management Unit to identify potential complexities of transporting COVID positive children between departments and to the operating theatre. This included reviewing plans for high risk procedures, such as intubating children in the theatre complex or ED. These systems tests highlight the enormous benefit of simulation training.

Workforce development

Corporate Learning and Development supports positive working relationships by providing in-house training to employees and managers on evidence-based human resource management practices aligned to CAHS values, current policy and best practice. The programs offered are developed in response to organisational requirements, and information is kept relevant to support continuous improvement. Employees can self-nominate, and departments can request programs be tailored and delivered in-house to support specific objectives.

Specific programs were also offered to support the development of undergraduate students through cadet programs, graduates, as well as emerging and established leaders. Individual employees were supported to achieve Certificate IV in leadership and management, and to undertake a Diploma in Procurement via scholarships through Department of Finance. CAHS also welcomed three Aboriginal cadets, with placements in Child and Adolescent Mental Health Service and Nursing Services.

Mandatory and Core Requirement Training

The CAHS Mandatory and Core Requirement Training Framework outlines minimum standards of training for each employment group to ensure the safety of both staff and consumers of the service.

After achieving over 80 per cent completion rate in the first year of launch, the Speaking Up for Safety program is now mandatory training for all employees. The program has been incorporated into the CAHS Induction schedule to emphasise the importance of supporting a high-performance culture of safety and reliability.

Leadership development

An internal program focused on leading with the CAHS values was launched in 2019 to contribute to a unified and collaborative culture across CAHS, and provide leaders with support and skills development. To date, three cohorts have completed the program.

CAHS developed a Family and Domestic Violence and the Workplace training program in collaboration with Women's Health Strategy and Programs as an extension to the Safe Spaces program launched by Public Sector Commission. It educates managers who are at the frontline of supporting individuals in the workplace who are victims of Family and Domestic Violence by examining case studies against internal procedures, including safety planning in the workplace.

Introduced in late 2019, a series of 30 minute information sessions was created to provide quick focused sessions to educate or refresh managers' knowledge on various aspects of people management processes. The sessions were based on facilitated and dedicated sessions on people management or safety themes. Four sessions were conducted before to COVID-19 led to the remaining sessions having to be cancelled.

Wellbeing

Staff mental health and wellbeing gained momentum during the year in light of the enormous impact COVID-19 had on the community. A specific COVID-19

Staff Wellbeing Strategy was developed to provide an interim approach to protect, promote and support staff and volunteers during the tumultuous time.

A dedicated Health and Wellness Coordinator joined CAHS in June 2020 to support the development of health and wellness initiatives across the organisation. The program will focus on positively influencing the physical and psychological health and wellness of employees and volunteers.

Occupational safety, health and injury management

CAHS demonstrates its commitment to a safe work environment in accordance with the *Occupational Safety and Health Act 1984* by taking a proactive approach to prevention and risk management for all staff, volunteers, patients/clients, families, visitors, and contractors. To support this commitment, CAHS:

- emphasises the importance of safety through the CAHS Occupational Safety and Health (OSH) Statement of Commitment
- promotes the importance of workplace safety upon joining CAHS through local orientations and the Corporate Induction program
- embeds the requirements and responsibility of safety in the workplace in all job descriptions, with additional requirements included in supervisory positions
- promotes and supports the *Stop the Violence* campaign.

Consultation on OSH issues is a management responsibility, but this is supported through elected employee safety representatives across all departments and service areas. Dedicated OSH committees coordinated by the CAHS OSH team meet bi-monthly to:

- monitor workplace hazards
- review OSH policies and procedures
- make recommendations to CAHS about workplace activities affecting safety and health.

The safety representatives also assist management and employees in discussion and resolution of OSH issues. Details of all safety representatives are communicated via the CAHS intranet page and internal newsletters.

To help prevent incidents, workplace hazard inspections are conducted bi-annually and as required. A hazard and incident reporting and investigation system is in place, as is a process to resolve issues and implement control measures.

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

Workers' compensation

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

A total of 91 workers' compensation claims were made in 2019–20 (Table 6).

Table 6: Number of workers' compensation claims in 2019–20

Category	Claims
Nursing Services/Dental Care Assistants	48
Administration and Clerical	13
Medical Support	14
Hotel Services	14
Maintenance	0
Medical (salaried)	2
Total	**91**

OSH performance

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

Table 7: Occupational safety, health and injury performance

Measure	2017–18	2018–19	2019–20	Target	Comment
Fatalities (number of deaths)	0	0	0	0	Target met
Lost time injury/diseases (LTI/D) incidence rate (per 100)	2.3%	2.0%	1.9%	0 or 10% improvement on the previous 3 years	Target met
Lost time injury severity rate (per 100, i.e. percentage of all LTI/D)	40.4%	36.4%	47.8%	0 or 10% improvement on the previous 3 years	Target not met
Percentage of injured workers returned to work within 13 weeks	77%	77%	75%	No target	
Percentage of injured workers returned to work within 26 weeks	81%	77%	88%	≥80%	Target met
Percentage of managers trained in occupational safety, health and injury management responsibilities	72%	48%	80%	≥80%	Target met despite some face-to-face training ceasing due to COVID-19 restrictions


SIEMENS
SOMATOM

Financial targets

	2019-20 TARGET[1] $000	2019–20 ACTUAL $000	VARIATION[6] $000
Total cost of services (expense limit) (sourced from Statement of Comprehensive Income)	729,224	782,841	53,617[2]
Net cost of services (sourced from Statement of Comprehensive Income)	484,810	512,500	27,690[3]
Total equity (sourced from Statement of Financial Position)	1,437,353	1,430,583	-6,770 [4]
Net increase / (decrease) in cash held (sourced from Statement of Cash Flows)	0	274	274
Approved salary expense level	456,994	491,055	34,061[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 $53.617 million in total cost of services are the unexpectedly higher drug costs ($19.036 million) and increased employee benefits expenses ($34.061 million) for operating the Perth Children's Hospital (PCH), the first year of delivering the neonatal services at the King Edward Memorial Hospital, the significant increases in employee benefits provisions, and the costs incurred for COVID-19 pandemic.

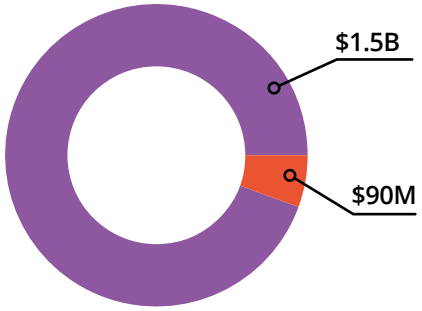
[3] As a result of additional funding ($4.300 million) for the higher drug costs from the Pharmaceutical Benefits Scheme and an increase ($18.157 million) in Commonwealth grants and contributions received under the National Health Reform Agreement, the variation in net cost of services is less than the variance in total cost of services.

[4] The operating deficit of $22.179 million and the reduction of $6.371 million in State Government's appropriations for capital works program have contributed to the decline in total equity. Conversely, the equity decline has been moderated by the transfer of total net assets amounting to $18.825 million from the North Metropolitan Health Service, the capital appropriation of $1.580 million as a new funding source for leases, and other contributions by owners. The details are set out in Note 1 'Basis of preparation' and Note 9.13 'Equity'.

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

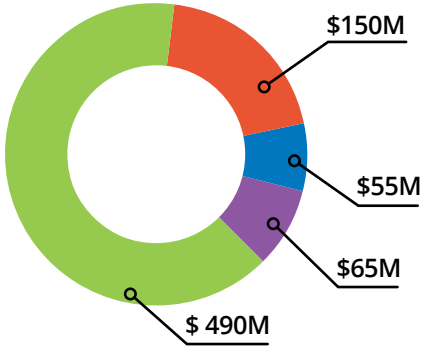
[6] Further explanations are contained in Note 9.15 'Explanatory Statement' to the financial statements.

Total assets



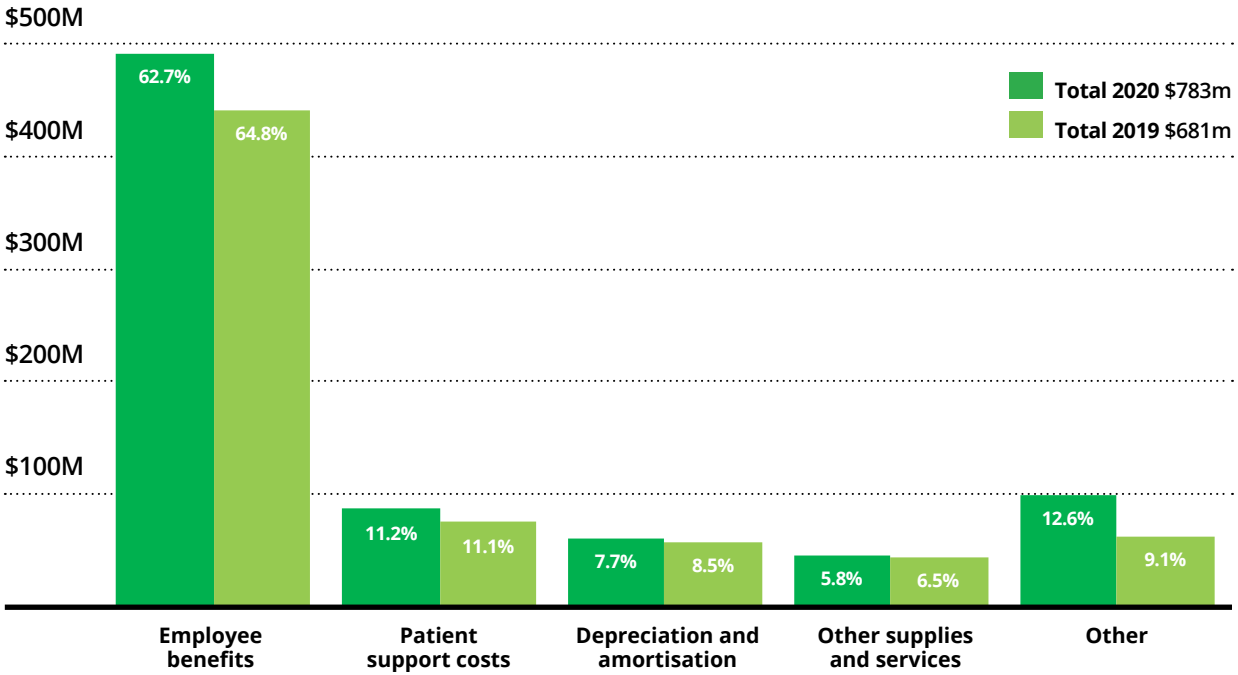
Non-current assets
Current assets

Income



State Government
Commonwealth
Mental Health Commission
Others

Expenditure by type



Total Assets

The Child and Adolescent Health Service finished the 2020 year with a total asset value of $1,617 million, which represents an increase of $61 million over the previous year. The major components of assets are Property, plant and equipment totalling $1,125 million and Cash and cash equivalents totalling $84 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 2020.

Income

The Child and Adolescent Health Service receives the majority of its income via the service appropriations from State Government and services received free of charge from State Government entities. This totalled $490 million for the 2020 year. A further $150 million in income was received via Commonwealth grants and contributions, and $55 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 2020.

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 2020 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 2020.

Summary of key performance indicators

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

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

A summary of the CAHS key performance indicators and variation from the 2019–20 targets is given in Table 8.

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

Table 8: Actual results versus KPI targets

Key performance indicator		2019–20 Target[1]	2019–20 Actual	Variation	Further info
Unplanned hospital readmissions for patients within 28 days for selected surgical procedures (per 1,000)	Appendicectomy	25.7	**19.3**	**-6.4**	p.206
	Cataract Surgery	1.1	**50.0**	**48.9**	
	Tonsillectomy & Adenoidectomy	61.0	**77.9**	**16.9**	
Percentage of elective wait list patients waiting over boundary for reportable procedures	Cat 1 (≤30 days)	0	**4.2**	**4.2**	p.210
	Cat 2 (≤90 days)	0	**16.2**	**16.2**	
	Cat 3 (≤365 days)	0	**13.1**	**13.1**	
Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days		1.0	**0.89**	**-0.11**	p.212
Percentage of admitted patients who discharged against medical advice	Aboriginal	0.77%	**0.13%**	**-0.64%**	p.214
	Non-Aboriginal	0.77%	**0.10%**	**-0.67%**	
Readmissions to acute specialised mental health inpatient services within 28 days of discharge		12%	**26.6%**	**14.6%**	p.216
Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services		75%	**89.1%**	**14.1%**	p.218
Average admitted cost per weighted activity unit		$7,026	**$7,991**	**$965**	p.220
Average Emergency Department cost per weighted activity unit		$7,071	**$8,498**	**$1,427**	p.222
Average non-admitted cost per weighted activity unit		$6,992	**$7,937**	**$945**	p.224
Average cost per bed-day in specialised mental health inpatient services		$3,308	**$4,713**	**$1,405**	p.226
Average cost per treatment day of non-admitted care provided by mental health services		$584	**$575**	**-$9**	p.228
Average cost per person of delivering population health programs by population health units		$222	**$251**	**$29**	p.230

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

Favourable performance **Unfavourable performance**

Significant issues

Healthy kids, healthy communities

CAHS has identified five key strategic objectives to realise our vision and achieve healthy kids, healthy communities. Work is ongoing to address a number of significant issues that require a dedicated approach to meet our strategic objectives within the 2018–2023 timeframe.

Caring for children, young people and families

Child Safe Standards

CAHS is committed to protecting all children and young people, especially those at risk of abuse, including physical, emotional, sexual abuse and neglect. We are focused on taking every necessary step to becoming a Child Safe Organisation and meeting the National Child Safe Principles and National Child Safe Standards, which arose as a key recommendation from the Royal Commission into Institutional Responses to Child Sexual Abuse.

To achieve this, we are committed to a number of initiatives which will help to embed child safe principles and practices across our health service, including promoting a culture where everyone understands they have a vital role to play in protecting children and promoting their safety, identifying, mitigating and managing risks to child safety in our organisation, and providing a clear process to follow if there is a disclosure, allegation or suspicion of child abuse against a staff member, volunteer, contractor or visitor.

Aboriginal health

CAHS aims to improve the lives of Aboriginal children by supporting Closing the Gap initiatives regarding Aboriginal children's health. The aim of Closing the Gap is to improve the lives of all Aboriginal people by working collaboratively across governments, Aboriginal community controlled health organisations and non-government agencies, to work together to deliver better health, education and employment outcomes, and to eliminate the gap between Indigenous and non-Indigenous Australians.

The CAHS Aboriginal Health Plan will outline our approach to improving health outcomes for Aboriginal children and families, adopting the strategic directions outlined in the WA Aboriginal Health and Wellbeing Framework.

CAHS recognises, respects and values Aboriginal cultures, and has a responsibility to listen to Aboriginal voices and act on the experiences of Aboriginal people to improve the systems that lead to the disadvantage, discrimination and inequality faced by Aboriginal people on a daily basis. CAHS is committed to educating our employees on social issues that may impact access and participation of Aboriginal people. To signal our commitment to reconciliation, CAHS is relaunching our Reconciliation Action Plan (RAP) and has established a RAP Working Group.

Providing high-value healthcare

Operating Cost Model

Perth Children's Hospital is over 80 per cent larger than Princess Margaret Hospital and technologically more advanced, with more beds, medical equipment, theatres and outpatient clinic capacity, which has increased operating costs. Due to the hospital's size

and new technologies, planned and preventative maintenance costs, as well as reactive maintenance costs, have increased significantly. Furthermore, medical equipment that is now serviced in-house has increased by 40 per cent.

During 2019–20, CAHS continued to review the financial impact of the increased operating costs. Benefits due to increased activity and efficiency from the move to PCH will be realised in future years. During the 2020–21 State Budget process, CAHS worked with the Department of Health to prepare a submission to secure additional funding for 2020–21 and across the forward estimates. The outcome of the additional funding will be advised after the State Budget is announced in October 2020.

Neonatology

In July 2019, CAHS received the budget for the Neonatology service, which successfully transitioned from the North Metropolitan Health Service (NMHS) to CAHS in January 2020. The transition included the transfer of assets and liabilities associated with the neonate service effective 1 February 2020. A collaborative approach to the financial planning and preparation for the service transition was adopted, and CAHS worked with NMHS and Health Support Services to undertake a comprehensive review of systems, processes and assets prior to the transition of the service.

Post transition, CAHS continued to review and analyse the financial impact of the service transition, and worked with NMHS to understand the corporate overhead costings and other funding adjustments. CAHS is working with NMHS to finalise a Service Level Agreement that will formalise the arrangement between the two health services to support the delivery of neonatal services.

Demand and activity

The amount of activity delivered by CAHS in 2019–20 was on track to exceed last year when the COVID-19 pandemic struck. Non-urgent elective surgeries were cancelled on instruction from the Director General of WA Health, Emergency Department presentations fell by up to 40 per cent as children withdrew from their usual activities, and the number of outpatient appointments attended declined with the imposition of physical distancing restrictions. All told, and despite NMHS Neonatology joining CAHS during the year, total activity across inpatient, Emergency Department and outpatient care fell by 1.1 per cent compared with 2018–19 (when weighted to allow for clinical complexity).

Ceasing non-urgent elective surgeries in March 2020, and only resuming them in stages between May and June 2020 had a marked effect on the number of patients waiting beyond the clinically recommended time. In recognition of the unavoidable growth in the wait list, CAHS received $7.9 million in 2020–21 to increase activity with the goal of returning elective surgery performance to pre-COVID-19 levels by early 2021.

Through this collaboration, we implemented significant adaptations in a short period of time to protect our patients, families, volunteers and staff members, as well as continue to provide an outstanding health care service.

Collaborating with our key support partners

COVID-19

Health service preparation for a COVID-19 outbreak in Western Australia relied on effective planning and collaboration, both internally and externally. Through this collaboration, we implemented significant adaptations in a short period of time to protect our patients, families, volunteers and staff members, as well as continue to provide an outstanding health care service. These adaptations included:

- establishing an Emergency Department (ED) Overflow Clinic at PCH that could be brought on line as required to accommodate increased ED activity during the peak of COVID-19 and the winter period
- Community Health providing online parenting groups
- Expansion of capacity to care for inpatients for emergency mental health cases, contributing to a system-wide planning process to combine efforts across other Health Service Providers
- increasing neonatal capacity at PCH to accommodate overflow from changed activity at other hospitals and to support physical distancing between inpatient cots.

The supply and appropriate clinical use of personal protective equipment was a major concern across the health sector, and CAHS procurement staff worked quickly to audit and secure the existing supply, and establish supply and stock flows to ensure distribution based on need.

A number of CAHS staff were approached to provide their expertise to the State Health Incident Coordination Centre, the central agency responsible for the State Government's management of the pandemic. In addition, 43 Community Health nursing staff were diverted from their usual roles to support contact tracing, COVID-19 testing and influenza vaccination programs within the Department of Health's Public Health Unit.

Valuing and respecting our people

Managing the workforce

Building on the outcomes of the functional readiness assessment conducted in 2019, CAHS continued to realign a number of functions to better integrate how we work. This included appointing an Executive Director of People, Capability and Culture to drive a strategic framework to support workforce matters, promote staff development and increase staff engagement.

The COVID-19 pandemic challenged CAHS to identify and implement ways to support our staff and volunteers while they continued to deliver excellent service. The 80 per cent response rate to a survey of staff skills, capability and readiness to support the response permitted a considered approach to the many workforce issues CAHS faced when preparing for a possible outbreak. Plans included identifying those with greater risk of serious complications from contracting COVID-19, and implementing strategies to minimise their risk of exposure. Teams were split into functionally equivalent groups to ensure continuity of service in the event of infection, and remote working tools were adopted so staff could practice safe physical distancing. The lessons learned are being used to inform future workforce planning strategies, including opportunities to help CAHS staff achieve greater work/life balance.

Promoting teaching, training and research

Research

Over the 2019–20 financial year, there has been a range of consultation and planning work undertaken with the view to strengthen the research platform at CAHS. Key themes emerging during the consultation process relate to culture, support, strategy and prioritisation of research, as well as strengthening our research collaborations.

Now more than ever, there is a unique opportunity for CAHS to take significant steps to build our research capacity and grow as a world-class paediatric research focused health service. Work is already underway to address a number of these opportunities, with a detailed action plan in development to consolidate the way forward. We acknowledge that future success is built upon a solid foundation so we are establishing actions under four strategic pillars of People; Platforms; Partnerships; and Priorities to focus our efforts towards maximum impact.

CAHS researchers have an important role in continuing to identify and shape the improvements and strategic direction we are taking in regard to translational child health research.

Becoming a child safe organisation

Children and young people have the right to be safe, feel safe and be treated with respect wherever they are.

As a paediatric health service, CAHS has a responsibility to promote the safety and wellbeing of children within the organisation, and to take action to protect and respond to all forms of harm from physical, sexual, and emotional abuse and neglect.

The Royal Commission into Institutional Responses to Child Sexual Abuse (Royal Commission) was established to respond to allegations that had emerged over many years of sexual abuse of children in Australian organisations. It found this abuse occurred in almost every type of institution, and was often undetected due to poor practices, inadequate governance, failures to record and report complaints or understand the seriousness of complaints, and where the best interests of children were not a priority.

The Royal Commission set out 10 Child Safe Standards that organisations should apply in order to be child safe, and recommended these Standards be adopted as part of a new National Statement of Principles for Child Safe Organisations (National Principles) led by the National Children's Commissioner. The National Principles were endorsed by the Council of Australian Governments, the Prime Minister and State and Territory First Ministers in 2019. They incorporate the Child Safe Standards as recommended, but go beyond child sexual abuse to include other forms of abuse or potential harm for children and young people.[6] This reflects the understanding that the prevention of sexual abuse is best approached as part of broader efforts to prevent other forms of physical and emotional abuse and neglect of children.

CAHS has committed to becoming a child safe organisation by implementing the National Child Safe Principles. This is a commitment to a strong culture, reflected through strategy, policy and day-to-day actions and behaviour, to ensure that children are protected. As part of this commitment, CAHS is working toward ensuring environments that:

- reduce the likelihood of harm occurring;
- increase the likelihood of harm being discovered; and
- respond appropriately to any disclosure, allegations or suspicions of harm to children.

CAHS established a working group in 2019 and has developed an Action Plan to embed the National Principles across the organisation. Achievements towards the completion of the Action Plan are being regularly monitored by the CAHS Executive Committee and Board. CAHS has also taken a leadership role in the WA health system in partnering with the Department of Health to support the implementation of the National Principles by all Health Service Providers in coming years.

[6] *https://childsafe.humanrights.gov.au/national-principles/about-national-principles*

Global pandemic – CAHS and COVID-19

The looming threat of the global coronavirus pandemic in early 2020 led to rapidly establishing a CAHS COVID-19 Governance Structure. Despite all available data consistently indicating limited evidence of community transmission of COVID-19 across Western Australia, our actions needed to be in proportion to the likelihood of COVID-19 being a global issue for a long period of time, and adequate preparation in the event of sustained community spread.

The overarching objectives of CAHS preparedness and pandemic response were the continued and safe provision of services to children and families across all clinical areas, and the safety and wellbeing of all CAHS staff, volunteers, patients, families and visitors. To achieve this, the CAHS Executive team led key response cells, with support through the CAHS Emergency Management Unit (EMU), Project Management Office and Digital Transformation team. A number of staff across CAHS were diverted from their usual roles to assist with critical work streams as part of preparedness for COVID-19. As part of this work, EMU conducted COVID-19 Clinical Scenario Tests to rigorously examine preparedness across the health service. This intensive process enabled careful refinement of the specific strategies outlined in the pandemic response.

A number of CAHS staff were approached to provide their expertise to the State Health Incident Coordination Centre, the central agency responsible for the State Government's management of the pandemic. In addition, a significant number of Community Health nursing staff were diverted from their usual roles to support contact tracing, COVID-19 testing and influenza vaccination programs within the Department of Health's Public Health Unit.

The CAHS Telehealth Service commenced a rapid expansion of their service in March to maintain the number of outpatient appointments. By 5 April 2020, CAHS had 592 outpatient appointments booked via telehealth, reflecting an 1,100 per cent increase on the weekly average in 2019.

In addition to a momentous increase in telehealth appointments across the health service, key preparatory activities that occurred during the first months of the pandemic included:

Perth Children's Hospital

- Perth Children's Hospital completed a reconfiguration of wards and patient flow to ensure the capability to accommodate any surge in activity or diversion of activity from other public metropolitan hospitals if required.
- As directed by the Commonwealth Government, Category 2 and 3 elective surgery was cancelled, in order to ensure operational readiness for an increase in bed capacity and preserve personal protective equipment (PPE). It has since been announced that CAHS will receive $7.9 million to increase activity and boost elective surgery performance to pre-COVID-19 levels by early 2021.
- Establishment of a PCH Emergency Department (ED) Overflow Clinic that could be brought on line as required to accommodate increased ED activity during the peak of COVID-19 and the winter period.
- Upskilling clinical staff on ventilator capability, alongside a review of capacity to provide high acuity care at PCH.
- Preparation for unused intensive care beds at PCH to be made available to adult patients, should there be a surge in demand surpassing what could be provided by adult public and private providers.

- PCH Pharmacy introduced a process to dispense medicines to patients who attended their appointment via telehealth.
- Videos for a social media campaign were developed to reassure families that it was safe to attend ED and they should continue to present to ED when their children are unwell
- Changes to the visitors policy to limit the number of visitors in the building. Health screening of visitors was also introduced.

Community Health

- COVID-related screening prior to all scheduled appointments and home visits.
- Temporary suspension of Child Health Nursing 'drop-in' clinics.
- Comprehensive planning for reduction in services and continuation of essential core services across Child Health Nursing, School Health Nursing, Immunisation, Aboriginal Health Team, Refugee Health Team, and the Child Development Service.
- Provision of online parenting groups.
- Provision of online access to pre-recorded Parent Information Workshops.
- Redeployment of 43 Community Nurses to support the State Health Incident Coordination Centre with contact tracing.

Child and Adolescent Mental Health Services

- Screening prior to scheduled appointments and home visits.
- Temporary pause of the Pathways day program for children aged 6–12, which recommenced with a modified program from 2 June and the full program from 20 July (start of Term 3).
- Scenario testing for COVID-19 in a mental health community setting to inform COVID-19 planning and identify gaps.
- Expansion of capacity to care for inpatients for emergency mental health cases, contributing to a system-wide planning process to combine efforts across other Health Service Providers.
- Development of a comprehensive Outbreak Plan, including preparing a surge area in Ward 5A for mental health patients who may have been exposed to, or are infected with, COVID-19.
- Roll out of tele-mental health capability to all CAMHS Community Clinics, specialised CAMHS services and hospital-based services, such as Gender Diversity Service and Eating Disorder Service.

Dr Jenn Ha testing the prototype face shield

PCH surgeon Dr Jenn Ha has recently been acknowledged for her instrumental input into the design and testing of specific face-shields. The Minister of Health announced large scale emergency manufacture of face shields here in WA, however Dr Ha raised the concern of behalf on Ear, Nose and Throat (ENT) surgeons that the face shields interfere with head lights. Dr Ha liaised with ENT surgeons at all tertiary hospitals in Perth in order to create a product that continues to serve while fighting COVID-19 and beyond.

- Extensive training of the CAMHS workforce to upskill staff in the use of telehealth, Microsoft Teams and CAHS Virtual Desktop to enable tele-mental health and working from home where required.

Neonatology

- Neonatal capacity at PCH was increased to accommodate any overflow from changed activity at other hospitals and to support physical distancing between inpatient cots.

The supply and appropriate clinical use of PPE was a major concern across the health sector, and CAHS procurement staff worked quickly to audit and secure the existing supply, and establish supply and stock flows to ensure distribution based on need.

Guidelines for the CAHS workforce were developed to provide a framework for decision-making around working from home. A complex Information and Telecommunications Technology process was facilitated alongside this work to ensure prioritisation of remote access capability. Other strategies implemented included physical distancing at work where possible, and splitting teams, either geographically or by shifts.

Staff wellbeing and support resources were developed and made available, acknowledging the understandable level of anxiety caused by the pandemic, along with the added pressures at work and concerns for loved ones and friends.

As the end of the financial year approached, CAHS recognised the sweeping changes made in preparation for the pandemic presented a once-in-a-lifetime opportunity to reshape the health service, and started exploring what a new 'business as usual' might look like for both our families and staff. As part of this, we asked staff to take part in a recovery survey to better understand what they felt worked well and hadn't worked so well. Common themes identified through this survey included maintaining the ability to use telehealth or other virtual contacts with families (where appropriate), continuing the use of Microsoft Teams software for meetings, ongoing flexible work arrangements, maintaining open and transparent communication, and a continued focus on remaining diligent with infection control; in particular, hand hygiene and physical distancing. This feedback has been paramount in helping inform our planning, and continues to inform our work recovery.

A vast amount of work occurred to prepare our health service for the rapidly changing conditions in response to COVID-19. CAHS has at all times been well prepared, and responded to the evolving situation on a daily basis. We acknowledge those staff who have stepped up to support our preparation by working additional hours, and those who moved to new roles and areas to support CAHS. Due to the hard work and commitment of our entire CAHS team, our health service has continued to provide outstanding care to children and families.

Scenario tests are designed to identify risks and issues within systems, processes, policy and other practicalities that may need review or improvement. In this instance, the Clinical Scenario Testing team staged the arrival by helicopter of suspected or confirmed COVID-19 patients.

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 2020, the Statement of Comprehensive Income, Statement of Changes in Equity, Statement of Cash Flows, Schedule of Income and Expenses by Service, Schedule of Assets and Liabilities by Service, and Summary of Consolidated Account Appropriations for the year then ended, and Notes comprising a summary of significant accounting policies and other explanatory information, including administered transactions and balances.

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 2020 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 Responsibility 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 entity'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.

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.

A further description of my responsibilities for the audit of the financial statements is located on the Auditing and Assurance Standards Board website at https://www.auasb.gov.au/auditors_responsibilities/ar4.pdf. This description forms part of my auditor's report.

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 Health Service 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 2020.

The Board's responsibilities

The Board is responsible for designing, implementing and maintaining controls to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities are in accordance with the *Financial Management Act 2006*, the Treasurer's Instructions and other relevant written law.

Auditor General's responsibilities

As required by the *Auditor General Act 2006*, my responsibility as an assurance practitioner is to express an opinion on the suitability of the design of the controls to achieve the overall control objectives and the implementation of the controls as designed. I conducted my engagement in accordance with Standard on Assurance Engagements ASAE 3150 *Assurance Engagements on Controls* issued by the Australian Auditing and Assurance Standards Board. That standard requires that I comply with relevant ethical requirements and plan and perform my procedures to obtain reasonable assurance about whether, in all material respects, the controls are suitably designed to achieve the overall control objectives and were implemented as designed.

An assurance engagement 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 non-compliance with laws and regulations may occur and not be detected. Any projection of the outcome of the evaluation of the suitability of the design of controls to future periods is subject to the risk that the controls may become unsuitable because of changes in conditions.

Report on the 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 2020. The key performance indicators are the Under Treasurer-approved key effectiveness indicators and key efficiency indicators that provide performance information about achieving outcomes and delivering services.

In my opinion, in all material respects, the key performance indicators of the Child and Adolescent Health Service are relevant and appropriate to assist users to assess the agency's performance and fairly represent indicated performance for the year ended 30 June 2020.

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 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 entity's performance and whether the key performance indicators are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. I conducted my engagement in accordance with Standard on Assurance Engagements ASAE 3000 *Assurance Engagements Other than Audits or Reviews of Historical Financial Information* issued by the Australian Auditing and Assurance Standards Board. That standard requires that I comply with relevant ethical requirements relating to assurance engagements.

An assurance engagement involves performing procedures to obtain evidence about the amounts and disclosures in the key performance indicators. It also involves evaluating the relevance and appropriateness of the key performance indicators against the criteria and guidance in Treasurer's Instruction 904 for measuring the extent of outcome achievement and the efficiency of service delivery. The procedures selected depend on my judgement, including the assessment of the risks of material misstatement of the key performance indicators. In making these risk assessments I obtain an understanding of internal control relevant to the engagement in order to design procedures that are appropriate in the circumstances.

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

My independence and quality control relating to the reports on controls and key performance indicators

I have complied with the independence requirements of the *Auditor General Act 2006* and the relevant ethical requirements relating to assurance engagements. In accordance with ASQC 1 *Quality Control for Firms that Perform Audits and Reviews of Financial Reports and Other Financial Information, and Other Assurance Engagements*, the Office of the Auditor General maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

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 2020 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 contact the entity to confirm the information contained in the website version of the financial statements and key performance indicators.

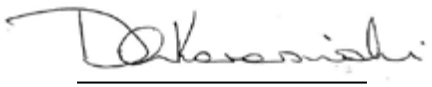
CAROLINE SPENCER
AUDITOR GENERAL
FOR WESTERN AUSTRALIA
Perth, Western Australia
4 September 2020

Certification of financial statements

CHILD AND ADOLESCENT HEALTH SERVICE
CERTIFICATION OF FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2020

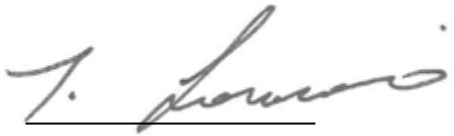
The accompanying financial statements of the Child and Adolescent Health Service have been prepared in compliance with the provisions of the *Financial Management Act 2006* from proper accounts and records to present fairly the financial transactions for the reporting period ended 30 June 2020 and the financial position as at 30 June 2020.

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 AM
CHAIR OF THE BOARD
CHILD AND ADOLESCENT HEALTH SERVICE
3 September 2020

Prof Geoffrey Dobb
DEPUTY CHAIR OF THE BOARD
CHILD AND ADOLESCENT HEALTH SERVICE
3 September 2020



Mr Tony Loiacono
CHIEF FINANCIAL OFFICER
CHILD AND ADOLESCENT HEALTH SERVICE
3 September 2020

Child and Adolescent Health Service
Statement of comprehensive income
For the year ended 30 June 2020

	Notes	2020 $000	2019 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	3.1(a)	491,055	441,448
Fees for visiting medical practitioners		2,679	2,537
Contracts for services	3.2	52,558	20,567
Patient support costs	3.3	87,602	75,611
Finance costs	7.3	185	35
Depreciation and amortisation expense	5	60,192	57,782
Asset revaluation decrements	5.1	709	5,071
Loss on disposal of non-current assets	5.1.2	63	-
Repairs, maintenance and consumable equipment	3.4	20,054	9,424
Other supplies and services	3.5	45,501	44,462
Other expenses	3.6	22,243	24,436
Total cost of services		**782,841**	**681,373**
INCOME			
Revenue			
Patient charges	4.2	17,661	15,968
Other fees for services	4.2	25,872	21,260
Commonwealth grants and contributions	4.3	150,133	131,658
Other grants and contributions	4.3	69,367	64,048
Donation revenue	4.4	1,978	1,857
Gain on disposal of non-current assets	5.1.2	-	6
Other revenue	4.5	5,330	5,352
Total revenue		270,341	240,149
Total income other than income from State Government		**270,341**	**240,149**
NET COST OF SERVICES		**512,500**	**441,224**

	Notes	2020 $000	2019 $000
INCOME FROM STATE GOVERNMENT			
Service appropriations	4.1	451,059	401,270
Assets (transferred)/assumed	4.1	-	14
Services received free of charge	4.1	39,262	38,579
Total income from State Government		**490,321**	**439,863**
DEFICIT FOR THE PERIOD		**(22,179)**	**(1,361)**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.13	-	(4,124)
Total other comprehensive income		-	(4,124)
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**(22,179)**	**(5,485)**

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 2020

	Notes	2020 $000	2019 $000
ASSETS			
Current Assets			
Cash and cash equivalents	7.4	60,743	48,327
Restricted cash and cash equivalents	7.4	15,435	12,126
Receivables	6.1	10,403	9,040
Inventories	6.3	2,962	2,560
Other current assets	6.4	669	622
Total Current Assets		90,212	72,675
Non-Current Assets			
Restricted cash and cash equivalents	7.4	7,472	4,972
Amounts receivable for services	6.2	346,357	264,960
Property, plant and equipment	5.1	1,124,827	1,167,368
Right-of-use assets	5.2	10,256	-
Intangible assets	5.3	37,889	46,409
Total Non-Current Assets		1,526,801	1,483,709
TOTAL ASSETS		**1,617,013**	**1,556,384**
LIABILITIES			
Current Liabilities			
Payables	6.5	35,882	18,941
Contract liabilities	6.6	53	-
Grant liabilities	6.7	945	-
Borrowings	7.1	-	736
Lease liabilities	7.2	1,790	-
Employee benefits provisions	3.1 (b)	107,686	87,072
Other current liabilities	6.8	89	69
Total Current Liabilities		146,445	106,818

	Notes	2020 $000	2019 $000
Non-Current Liabilities			
Borrowings	7.1	-	3
Lease liabilities	7.2	8,645	-
Employee benefits provisions	3.1 (b)	31,340	24,071
Total Non-Current Liabilities		39,985	24,074
TOTAL LIABILITIES		**186,430**	**130,892**
NET ASSETS		**1,430,583**	**1,425,492**
EQUITY			
Contributed equity	9.13	1,439,357	1,412,087
Reserves	9.13	-	-
Accumulated surplus/(deficit)		(8,774)	13,405
TOTAL EQUITY		**1,430,583**	**1,425,492**

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 2020

	Notes	2020 $000	2019 $000
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		384,570	336,898
Capital appropriations		7,592	11,387
Net cash provided by State Government	7.4.3	**392,162**	**348,285**
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(475,204)	(434,987)
Supplies and services		(181,143)	(138,432)
Finance costs		(151)	-
Receipts			
Receipts from customers		15,493	14,048
Commonwealth grants and contributions		150,133	131,658
Other grants and contributions		70,365	63,851
Donations received		677	91
Other receipts		32,903	25,038
Net cash used in operating activities	7.4.2	**(386,927)**	**(338,733)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Purchase of non-current assets		(3,713)	(1,664)
Receipts			
Proceeds from sale of non-current assets	5.1.2	132	53
Net cash used in investing activities		**(3,581)**	**(1,611)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Principal elements of lease		(1,380)	-
Net cash used in financing activities		**(1,380)**	**-**

	Notes	2020 $000	2019 $000
Net increase / (decrease) in cash and cash equivalents		274	7,941
Cash and cash equivalents at the beginnning of the period		65,425	42,017
Cash and cash equivalents transferred from Health Ministerial Body	9.13	-	15,467
Cash and cash equivalents transferred from North Metropolitan Health Service	9.13	17,951	-
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.4	**83,650**	**65,425**

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 2020

	Notes	Contributed equity $000	Reserves $000	Accumulated surplus $000	Total equity $000
Balance at 1 July 2018		1,381,954	4,124	14,902	1,400,980
Changes in accounting policy		-	-	(136)	(136)
Restated balance at 1 July 2018		**1,381,954**	**4,124**	**14,766**	**1,400,844**
Deficit		-	-	(1,361)	(1,361)
Other comprehensive income	9.13	-	(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	9.13	12,090	-	-	12,090
Other contributions by owners	9.13	18,043	-	-	18,043
Total		30,133	-	-	30,133
Balance at 30 June 2019		**1,412,087**	**-**	**13,405**	**1,425,492**
Balance at 1 July 2019		1,412,087	-	13,405	1,425,492
Deficit		-	-	(22,179)	(22,179)
Other comprehensive income	9.13	-	-	-	-
Total comprehensive income for the period		-	-	(22,179)	(22,179)
Transactions with owners in their capacity as owners:					
Capital appropriations	9.13	7,335	-	-	7,335
Other contributions by owners	9.13	19,935	-	-	19,935
Total		27,270	-	-	27,270
Balance at 30 June 2020		**1,439,357**	**-**	**(8,774)**	**1,430,583**

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

Child and Adolescent Health Service
Summary of consolidated account appropriations
For the year ended 30 June 2020

	2020 Budget Estimate $000	2020 Supplementary Funding $000	2020 Revised Budget $000	2020 Actual $000	2020 Variance $000
Delivery of Services					
Item 51 Net amount appropriated to deliver services	447,888	-	447,888	451,059	3,171
Section 25 Transfer of service appropriation	-	-	-	-	-
Amount Authorised by Other Statutes:					
Salaries and Allowances Act 1975	-	-	-	-	-
Lotteries Commission Act 1990	-	-	-	-	-
Total appropriations provided to deliver services	447,888	-	447,888	451,059	3,171
Capital					
Item 125 Capital Appropriations	21,148		21,148	7,335	(13,813)
Total Approriations	**469,036**	**-**	**469,036**	**458,394**	**(10,642)**

1. Basis of preparation

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

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

These annual financial statements were authorised for issue by the Accountable Authority (the Board) of the Health Service on 3 September 2020.

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 for the Perth Children's Hospital were transferred from the Health Ministerial Body to the Health Service, when the clinical commissioning of the hospital was completed on 17 September 2018. See Note 5.1 'Property, plant and equipment'.

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 9.13(c) 'Equity' provides the details of assets and liabilities transferred from the Health Ministerial Body on 18 September 2018.

The neonatal services at the King Edward Memorial Hospital (KEMH) have formally become part of the Child and Adolescent Health Service, after being operated as part of the North Metropolitan Health Service up to January 2020. In the first seven months of the financial year, the KEMH neonatal services were operated under a purchasing arrangement whereby the Child and Adolescent Health Service is the purchaser and the North Metropolitan Health Service is the service provider.

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

Judgements and estimates

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

Contributed equity

AASB Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities* requires transfers in the nature of equity contributions, other than as a result of a restructure of administrative arrangements, to be designated 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	
	2020	2019	2020	2019	2020	2019	2020	2019
COST OF SERVICES	$000	$000	$000	$000	$000	$000	$000	$000
Expenses								
Employee benefits expense	208,966	178,177	38,929	32,796	75,091	71,612	57,600	59,102
Fees for visiting medical practitioners	1,831	1,594	284	293	551	641	-	-
Contracts for services	48,577	10,246	164	2,031	797	4,039	35	7
Patient support costs	55,863	45,913	9,796	8,390	17,124	17,065	1,484	1,476
Finance costs	32	22	5	4	9	9	60	-
Depreciation and amortisation expense	37,424	34,048	5,805	6,267	11,261	13,685	3,688	3,189
Asset revaluation decrements	783	2,932	122	539	236	1,178	-	338
Loss on disposal of non-current assets	43	-	7	-	13	-	-	-
Repairs, maintenance and consumable equipment	9,347	3,878	1,479	713	2,867	1,558	1,582	881
Other supplies and services	22,120	19,552	3,561	3,599	6,900	7,858	4,079	4,756
Other expenses	8,487	7,790	1,320	1,434	2,561	3,130	2,724	4,384
Total cost of services	393,473	304,152	61,472	56,066	117,410	120,775	71,252	74,133
Income								
Patient charges	14,759	12,961	715	530	1,765	2,071	422	406
Other fees for services	17,449	13,088	2,706	2,409	5,250	5,261	140	146
Commonwealth grants and contributions	84,963	72,752	16,410	11,605	38,122	40,996	9,881	5,895
Other grants and contributions	9,673	4,277	1,501	788	2,911	1,720	54,976	57,186
Donation revenue	1,318	1,167	205	215	397	469	-	-
Gain on disposal of non-current assets	-	13	-	(1)	-	(3)	-	-
Other revenue	3,419	2,641	530	486	1,029	1,062	22	59
Total income other than income from State Government	131,581	106,899	22,067	16,032	49,474	51,576	65,441	63,692
NET COST OF SERVICES	**261,892**	**197,253**	**39,405**	**40,034**	**67,936**	**69,199**	**5,811**	**10,441**
INCOME FROM STATE GOVERNMENT								
Service appropriations	227,898	177,901	34,273	39,821	61,093	62,995	3,688	3,610
Assets (transferred)/assumed	-	13	-	3	-	6	-	(8)
Services received free of charge	20,021	17,903	3,557	3,380	5,064	5,729	3,637	4,304
Total income from State Government	247,919	195,817	37,830	43,204	66,157	68,730	7,325	7,906
SURPLUS / (DEFICIT) FOR THE PERIOD	**(13,973)**	**(1,436)**	**(1,575)**	**3,170**	**(1,779)**	**(469)**	**1,514**	**(2,535)**

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

	Aged and Continuing Care Services [a]		Public and Community Health Services		Total	
	2020 $000	2019 $000	2020 $000	2019 $000	2020 $000	2019 $000
COST OF SERVICES						
Expenses						
Employee benefits expense	1,809	1,021	108,660	98,740	491,055	441,448
Fees for visiting medical practitioners	13	9	-	-	2,679	2,537
Contracts for services	7	8	2,978	4,236	52,558	20,567
Patient support costs	400	226	2,935	2,541	87,602	75,611
Finance costs	-	-	79	-	185	35
Depreciation and amortisation expense	266	183	1,748	410	60,192	57,782
Asset revaluation decrements	-	-	(432)	84	709	5,071
Loss on disposal of non-current assets	-	-	-	-	63	-
Repairs, maintenance and consumable equipment	69	21	4,710	2,373	20,054	9,424
Other supplies and services	137	87	8,704	8,610	45,501	44,462
Other expenses	59	42	7,092	7,656	22,243	24,436
Total cost of services	2,760	1,597	136,474	124,650	782,841	681,373
Income						
Patient charges	-	-	-	-	17,661	15,968
Other fees for services	124	71	203	285	25,872	21,260
Commonwealth grants and contributions	-	-	757	410	150,133	131,658
Other grants and contributions	69	23	237	54	69,367	64,048
Donation revenue	9	6	49	-	1,978	1,857
Gain on disposal of non-current assets	-	-	-	(3)	-	6
Other revenue	24	13	306	1,091	5,330	5,352
Total income other than income from State Government	226	113	1,552	1,837	270,341	240,149
NET COST OF SERVICES	**2,534**	**1,484**	**134,922**	**122,813**	**512,500**	**441,224**
INCOME FROM STATE GOVERNMENT						
Service appropriations	2,296	1,437	121,811	115,506	451,059	401,270
Assets (transferred)/assumed	-	-	-	-	-	14
Services received free of charge	114	74	6,869	7,189	39,262	38,579
Total income from State Government	2,410	1,511	128,680	122,695	490,321	439,863
SURPLUS / (DEFICIT) FOR THE PERIOD	**(124)**	**27**	**(6,242)**	**(118)**	**(22,179)**	**(1,361)**

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	2020 $000	2019 $000
Employee benefits expense	3.1(a)	491,055	441,448
Contracts for services	3.2	52,558	20,567
Patient support costs	3.3	87,602	75,611
Repairs, maintenance and consumable equipment	3.4	20,054	9,424
Other supplies and services	3.5	45,501	44,462
Other expenses	3.6	22,243	24,436

Liabilities incurred in the delivery of services

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

	Notes	2020 $000	2019 $000
Employee benefits provision	3.1(b)	139,026	111,143

3.1(a) Employee benefits expense

	2020 $000	2019 $000
Employee benefits	449,836	404,612
Termination benefits	224	-
Superannuation - defined contribution plans	40,995	36,836
	491,055	441,448

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

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

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

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

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

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

3.1(b) Employee benefits provisions

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

	2020 $000	2019 $000
Current		
Employee benefits provisions		
Annual leave [(a)]	55,370	43,682
Time off in lieu leave [(a)]	11,715	9,229
Long service leave [(b)]	39,369	33,071
Deferred salary scheme [(c)]	1,232	1,090
	107,686	87,072
Non-Current		
Employee benefits provisions		
Long service leave [(b)]	31,340	24,071
	31,340	24,071
	139,026	111,143

(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:

	2020 $000	2019 $000
Within 12 months of the end of the reporting period	46,837	37,176
More than 12 months after the end of the reporting period	20,248	15,735
	67,085	52,911

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 provisions (cont.)

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

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

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

	2020 $000	2019 $000
Within 12 months of the end of the reporting period	9,759	8,261
More than 12 months after the end of the reporting period	60,950	48,881
	70,709	57,142

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:

	2020 $000	2019 $000
Within 12 months of the end of the reporting period	274	298
More than 12 months after the end of the reporting period	958	792
	1,232	1,090

3.1(b) Employee benefits provisions (cont.)

Key sources of estimation uncertainty – long service leave

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

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

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

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

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

	2020 $000	2019 $000
Neonatal services [(a)]	48,001	15,000
Community and primary health	4,065	5,036
Other contracts	492	531
	52,558	20,567

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.

(a) Neonatal services are purchased from the North Metropolitan Health Service for the Perth Children's Hospital (PCH) and the King Edward Memorial Hospital (KEMH) under different purchasing arrangements over the last two years.

3.3 Patient support costs

	2020 $000	2019 $000
Medical supplies and services [(a)]	73,489	62,692
Domestic charges	6,202	5,490
Food supplies	1,410	1,321
Power and water charges	5,287	5,685
Patient transport costs	698	307
Research, development and other grants	516	116
	87,602	75,611

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 $5.319 million from PathWest Laboratory Medicine WA (2019: $5.082 million). See Note 4.1 'Income from State Government'.

3.4 Repairs, maintenance and consumable equipment

	2020 $000	2019 $000
Repairs and maintenance	15,503	5,245
Consumable equipment	4,551	4,179
	20,054	9,424

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

	2020 $000	2019 $000
Facility management services	5,288	6,120
Administrative services	3,549	2,489
Interpreter services	839	991
Shared services for accounting [(a)]	937	490
Shared services for human resources [(a)]	4,062	3,892
Shared services for information technology [(a)]	26,513	26,542
Shared services for supply [(a)]	2,386	2,546
Other	1,927	1,392
	45,501	44,462

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

(b) 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

	2020 $000	2019 $000
Workers compensation insurance	3,748	3,517
Other insurances	2,800	3,167
Other employee related expenses	1,330	1,137
Communications	1,626	1,270
Computer services	1,123	834
Consultancy fees	2,231	2,760
Expected credit losses expense [(a)]	172	1,401
Freight and cartage	316	380
Motor vehicle expenses	513	453
Rental expenses [(b)(c)]	1,325	-
Other accommodation expenses [(c)]	1,130	4,081
Periodical subscription	490	434
Printing and stationery	2,320	2,396
Write-down of assets [(d)]	244	78
Other	2,875	2,528
	22,243	24,436

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

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

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

(c) **Other accommodation expenses** for 2019 include rental and outgoing expenses which were not separately recorded. The 2020 amount is for outgoing expenses only.

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

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	2020 $000	2019 $000
Income from State Government	4.1	490,321	439,863
Patient charges and other fees for services	4.2	43,533	37,228
Commonwealth grants and contributions	4.3	150,133	131,658
Other grants and contributions	4.3	69,367	64,048
Donations	4.4	1,978	1,857
Other revenue	4.5	5,330	5,352

4.1 Income from State Government

	2020 $000	2019 $000
Appropriation revenue received during the period:		
Service appropriations (funding via the Department of Health)	451,059	401,270
Assets transferred from/(to) other State government agencies during the period:		
Transfer of medical equipment from other Health Services	-	64
Transfer of medical equipment to other Health Services	-	(18)
Transfer of furniture and fittings to other Health Services	-	(37)
Transfer of artwork from other Health Services	-	5
Net assets transferred	-	14
Services received free of charge from other State government agencies during the period:		
Health Support Services - accounting, human resources, information technology and supply services	33,898	33,471
Department of Finance - leasing of accommodation	45	26
PathWest Laboratory Medicine WA - pathology services	5,319	5,082
Total services received	39,262	38,579
Total income from State Government	490,321	439,863

(a) **Service Appropriations** are recognised as income 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; and
- Any agreed increase in leave liabilities.

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

	2020 $000	2019 $000
Patient charges [(a)]		
Inpatient charges	15,181	13,332
Outpatient charges	2,480	2,636
	17,661	15,968
Other fees for services		
Recoveries from the Pharmaceutical Benefits Scheme [(b)]	22,789	18,032
Clinical services to other health organisations [(c)]	2,888	2,987
Non clinical services to other health organisations [(c)]	195	241
	25,872	21,260
	43,533	37,228

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

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

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

4.3 Grants and contributions

	2020 $000	2019 $000
Commonwealth grants and contributions		
Operational Grants:		
National Health Reform Agreement (funding via Department of Health) [(a)]	139,455	125,412
National Health Reform Agreement (funding via Mental Health Commission) [(a)]	9,881	5,895
National Partnership Agreement - Essential Vaccines	758	307
Other	39	44
	150,133	131,658

(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.

4.3 Grants and contributions (cont.)

Other grants and contributions	2020 $000	2019 $000
Operational Grants:		
Mental Health Commission – service delivery agreement	54,352	54,425
Mental Health Commission – other	410	2,071
Disability Services Commission	-	8
Perth Children's Hospital Foundation	3,866	3,258
Telethon Kids Institute	1,921	229
Channel 7 Telethon Trust	4,817	917
Stan Perron Charitable Trust	540	540
Medtronic Foundation	80	30
Angela Wright Bennett Foundation	400	400
University of Western Australia	179	445
Cystic Fibrosis clinical research	117	341
Raine Medical Research Foundation	253	296
Royal Australasian College of Physicians	395	154
University of Queensland	215	-
WA Health Translation Network	206	-
Redkite	198	99
Department of Health - Research Development Unit	366	-
Royal Australian & NZ College of Radiologists	131	23
Other	921	812
	69,367	64,048

Up to 30 June 2019, operational and capital grants were recognised as income when the Health Service obtained control over the assets comprising the contributions, usually when cash is received. This accounting treatment continues for operational grants where the arrangements are not classified as contract with customers. For contracts with customers, the operational grants are recognised as revenue either over time or at a point in time, when the specific performance obligations are satisfied.

From 1 July 2019, capital grants are recognised as income when the Health Service achieves milestones specified in the grant agreements.

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

4.4 Donation revenue

	2020 $000	2019 $000
Perth Children's Hospital Foundation - donations of equipment	1,242	1,766
City of Stirling - Donation of building	50	-
Paul Moncrieff - Donation of artwork	9	-
Deceased Estate	648	29
Other	29	62
	1,978	1,857

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

4.5 Other revenue

	2020 $000	2019 $000
Pharmaceutical manufacturing activities	2,099	2,388
Rent from commercial tenants	325	428
Expense recoupment from tenants	2,149	1,341
RiskCover insurance premium rebate	97	693
Immunisation services	160	134
Use of hospital facilities	20	15
Other	480	353
	5,330	5,352

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

Rent and recoupment of outgoing expenses are received in accordance with the agreements with tenants, and are recognised as revenue on a monthly basis.

Insurance premium rebate is recognised as revenue, when the cash is received from RiskCover,

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	2020 $000	2019 $000
Property, plant and equipment	5.1	1,124,827	1,167,368
Right-of-use assets	5.2	10,256	-
Intangible assets	5.3	37,889	46,409
Total key assets		1,172,972	1,213,777

Depreciation and amortisation expense	Notes	2020 $000	2019 $000
Property, plant and equipment	5.1.1	50,140	49,793
Right-of-use assets	5.2	1,532	-
Intangible assets	5.3.1	8,520	7,989
		60,192	57,782

5.1 Property, plant and equipment

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
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)[(a)]	-	4,287	1,319	-	9	-	271	(143)	-	-	5,743
Transfer from other agencies (Note 9.13)	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**

(a) Assets from the PCH project were transferred from the Health Ministerial Body to the Health Service on 18 September 2018, as a consequence of assuming the control of the project by the Health Service.

(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.)

Year ended 30 June 2020	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 2019											
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)
Carrying amount at start of period	**23,363**	**941,113**	**19,656**	**145**	**64,185**	**10,505**	**82,845**	**20,148**	**373**	**5,035**	**1,167,368**
Additions	-	-	-	106	18	95	4,012	-	408	17	4,656
Transfer of Neonatal assets from North Metropolitan Health Service (Note 9.13) [(a)]	-	-	-	-	18	-	2,851	62	-	-	2,931
Transfer from other agencies [(c)]	1,110	50	-	-	-	-	-	-	-	-	1,160
Disposals (Note 5.1.2)	-	-	-	-	-	-	(195)	-	-	-	(195)
Revaluation increments / (decrements) [(b)]	(150)	(559)	-	-	-	-	-	-	-	-	(709)
Depreciation (Note 5.1.1)	-	(19,915)	(479)	(43)	(14,299)	(731)	(12,187)	(2,486)	-	-	(50,140)
Write-down of assets (Note 3.6)	-	-	-	-	-	-	(240)	-	(4)	-	(244)
Carrying amount at 30 June 2020	**24,323**	**920,689**	**19,177**	**208**	**49,922**	**9,869**	**77,086**	**17,724**	**777**	**5,052**	**1,124,827**
Gross carrying amount	24,323	920,689	20,380	598	77,089	11,454	106,271	22,982	777	5,052	1,189,615
Accumulated depreciation	-	-	(1,203)	(390)	(27,167)	(1,585)	(29,185)	(5,258)	-	-	(64,788)

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

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

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

5.1 Property, plant and equipment (cont.)

Initial recognition

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

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

Subsequent measurement

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

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

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

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

Land and buildings are independently valued annually by the Western Australian Land Information Authority (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 2019 by the Western Australian Land Information Authority (Valuations and Property Analytics). The valuations were performed during the year ended 30 June 2020 and recognised at 30 June 2020. In undertaking the revaluation, fair value was determined by reference to market values for land: $0.603 million (2019: $0.623 million) and buildings: $0.102 million (2019: $0.107 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

	Notes	2020 $000	2019 $000
Depreciation			
Buildings	5.1	19,915	20,126
Site infrastructure	5.1	479	481
Leasehold improvement	5.1	43	242
Medical equipment	5.1	12,187	11,300
Computer equipment	5.1	14,299	14,005
Furniture and fittings	5.1	731	661
Motor vehicles, other plant and equipment	5.1	2,486	2,978
Total depreciation for the period		**50,140**	**49,793**

As at 30 June 2020 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.)

Finite useful lives (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. Depreciation is not recognised in respect of these assets because their service potential has not, in any material sense, been consumed during the reporting period.

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

5.1.1 Depreciation and impairment (cont.)

Impairment (cont.)

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

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

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

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

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

	2020 $000	2019 $000
Carrying amount of non-current assets disposed:		
Property, plant and equipment	(195)	(47)
Proceeds from disposal of non-current assets:		
Property, plant and equipment	132	53
Net gain/(loss) on disposal of non-current assets	(63)	6

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 Right-of-use assets

Year ended 30 June 2020	Buildings $000	Vehicles $000	Total $000
As at 30 June 2019			
Opening net carrying amount	-	-	-
Recognition of right-of-use assets on initial application of AASB 16	4,304	1,238	5,542
Restated opening carrying amount	4,304	1,238	5,542
1 July 2019			
Gross carrying amount	4,304	1,238	5,542
Accumulated depreciation	-	-	-
Carrying amount at start of period	4,304	1,238	5,542
Additions	5,443	348	5,791
Adjustments	469	7	476
Disposals	-	(21)	(21)
Impairment losses	-	-	-
Depreciation	(1,049)	(483)	(1,532)
Carrying amount at 30 June 2020	9,167	1,089	10,256
Gross carrying amount	9,996	1,535	11,531
Accumulated depreciation	(829)	(446)	(1,275)

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

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

Up to 30 June 2019, the Health Service classified lease as operating leases. From 1 July 2019, the Health Service recognises leases as right-of-use assets and associated lease liabilities in the Statement of Financial Position.

The corresponding lease liabilities in relation to these right-of-use assets have been disclosed in Note 7.2. This section should also be read in conjunction with Note 9.2(b).

5.2 Right-of-use assets (cont.)

Initial recognition

Right-of-use assets are measured at cost including the following:

- the amount of the initial measurement of lease liability
- any lease payments made at or before the commencement date less any lease incentives received
- any initial direct costs, and
- restoration costs, including dismantling and removing the underlying asset

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

Subsequent Measurement

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

Depreciation and impairment of right-of-use assets

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

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

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

	Notes	2020 $000	2019 $000
Depreciation expense of right-of-use assets	5.2	1,532	-
Lease interest expense	7.3	173	-
Expenses relating to variable lease payments not included in lease liabilities	3.6	-	-
Short-term leases	3.6	382	-
Low-value leases	3.6	7	-
Total amount recognised in the Statement of Comprehensive Income		2,094	-

The total cash outflow for leases in 2020 was $1.422 million.

5.3 Intangible assets

	Computer software $000	Software under development $000	Total $000
Carrying amount at 1 July 2018	51,744	-	51,744
Transfers between asset classes (Note 5.1)	2,600	-	2,600
Additions	54	-	54
Amortisation expense (Note 5.3.1)	(7,989)	-	(7,989)
Carrying amount at 30 June 2019	46,409	-	46,409
Transfers between asset classes (Note 5.1)	-	-	-
Additions	-	-	-
Amortisation expense (Note 5.3.1)	(8,520)	-	(8,520)
Carrying amount at 30 June 2020	37,889	-	37,889
Gross carrying amount	55,638	-	55,638
Accumulated amortisation	(17,749)	-	(17,749)
	37,889	-	37,889

Initial recognition

Intangible assets are initially recognised at cost. For assets acquired at no cost or for nominal cost, the cost is their fair value at the date of acquisition.

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

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

5.3 Intangible assets (cont.)

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

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

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

(c) The ability to use the intangible asset;

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

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

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

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

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

Subsequent measurement

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

5.3.1 Amortisation and impairment

Charges for the period

Amortisation	2020 $000	2019 $000
Computer software	8,520	7,989
Total amortisation for the period	**8,520**	**7,989**

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 2020 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	2020 $000	2019 $000
Receivables	6.1	10,403	9,040
Amount receivable for services	6.2	346,357	264,960
Inventories	6.3	2,962	2,560
Other current assets	6.4	669	622
Payables	6.5	35,882	18,941
Contract liabilities	6.6	53	-
Grant liabilities	6.7	945	-
Other liabilities	6.8	89	69

6.1 Receivables

	2020 $000	2019 $000
Current		
Patient fee debtors	6,567	6,489
GST receivable	536	542
Receivable from North Metropolitan Health Service	1,281	-
Other receivables	3,430	3,531
Allowance for impairment of receivables	(3,729)	(4,333)
Accrued revenue	2,318	2,811
	10,403	**9,040**

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

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

Accounting procedure for Goods and Services Tax

Rights to collect amounts receivable from the Australian Taxation Office (ATO) and responsibilities to make payments for GST have been assigned to the Department of Health. This accounting procedure was a result of application of the grouping provisions of "*A New Tax System (Goods and Services Tax) Act 1999*" whereby the Department of Health became the Nominated Group Representative (NGR) for the GST Group as from 1 July 2012. The entities in the GST group include the Department of Health, Child and Adolescent Health Service, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service, WA Country Health Service, Health Support Services, PathWest Laboratory Medicine WA, Queen Elizabeth II Medical Centre Trust, Mental Health Commission, and Health and Disability Services Complaints Office.

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

6.1.1 Movement of the allowance for impairment of receivables

	2020 $000	2019 $000
Reconciliation of changes in the allowance for impairment of receivables:		
Balance at start of period	4,333	4,442
Remeasurement under AASB 9	-	136
Restated balance at start of period	4,333	4,578
Transfer from North Metropolitan Health Service (Note 9.13(d))	255	-
Expected credit losses expense	172	1,401
Amount written off during the period	(1,031)	(1,646)
Balance at end of period	3,729	4,333

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)

	2020 $000	2019 $000
Current	-	-
Non-Current	346,357	264,960
	346,357	**264,960**

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

	2020 $000	2019 $000
Current		
Pharmaceutical stores - at cost	2,962	2,560

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

	2020 $000	2019 $000
Current		
Prepayments	599	582
Unearned patient charges	68	36
Others	2	4
	669	622

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

	2020 $000	2019 $000
Current		
Trade payables	5,465	2,928
Payable for purchase of neonatal services [(a)]	8,796	-
Payable - return of capital appropriations	996	-
Other payables	25	38
Accrued expenses	8,946	8,512
Accrued salaries	11,654	7,461
Accrued interest	-	2
	35,882	18,941

(a) A final payment amounting to $8.796 million for neonatal services has not been made to the North Metropolitan Health Service (NMHS) within the 2019-20 financial year. See Note 3.2 for the details of neonatal services purchased from NMHS,

(b) $0.996 million is payable to the Department of Health as the return of capital appropriations in excess of funding requirement for the principal repayments of lease liabilities (see Note 9.13).

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

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

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

The accrued salaries suspense account (See 'Restricted cash and cash equivalents' in Note 7.4.1) 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 Contract liabilities

	2020 $000	2019 $000
Current	53	-
Non-current	-	-
	53	-

Contract liabilities are the values of payments received for services yet to be provided to the customers at the reporting date. Refer to Note 4.3 for details of the revenue recognition policy.

6.6.1 Movement in contract liabilities

	2020 $000	2019 $000
Reconciliation of changes in contract liabilities		
Opening balance	-	-
Additions	108	-
Revenue recognised in the reporting period	(55)	-
Balance at end of period	53	-

The Health Service expects to satisfy the performance obligations within the next 12 months.

6.7 Grant liabilities

	2020 $000	2019 $000
Current	945	-
Non-current	-	-
	945	-

The Health Service's grant liabilities related to capital grants received from the Channel 7 Telethon Trust for purchases of equipment. Income is recognised when the Health Service achieves milestones specified in the grant agreement.

6.7 Grant liabilities (cont.)

6.7.1 Movement in grant liabilities

	2020 $000	2019 $000
Reconciliation of changes in grant liabilities		
Opening balance	-	-
Additions	945	-
Revenue recognised in the reporting period	-	-
Balance at end of period	945	-

6.7.2 Expected satisfaction of grant liabilities

	2020 $000	2019 $000
Income recognition		
1 year	945	-
1 to 5 years	-	-
Over 5 years	-	-
	945	-

6.8 Other liabilities

	2020 $000	2019 $000
Current		
Paid parental leave scheme	89	69
	89	69

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
Lease liabilities	7.2
Finance costs	7.3
Cash and cash equivalents	7.4
Reconciliation of cash	7.4.1
Reconciliation of cash flows used in operating activities	7.4.2
Reconciliation of cash flows from State Government	7.4.3
Capital commitments	7.5

7.1 Borrowings

	2020 $000	2019 $000
Current		
Department of Treasury loans	-	736
Non-current		
Department of Treasury loans	-	3
	-	739

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 Lease liabilities

	2020 $000	2019 $000
Current	1,790	-
Non-current	8,645	-
Total lease liabilities	10,435	-

The Health Service measures a lease liability, at the commencement date, at the present value of the lease payments that are not paid at that date. The lease payments are discounted using the interest rate implicit in the lease. If that rate cannot be readily determined, the Health Service uses the incremental borrowing rate provided by Western Australia Treasury Corporation.

Lease payments included by the Health Service as part of the present value calculation of lease liability include:

- Fixed payments (including in-substance fixed payments), less any lease incentives receivable;
- Variable lease payments that depend on an index or a rate initially measured using the index or rate as at the commencement date;
- Amounts expected to be payable by the lessee under residual value guarantees;

7.2 Lease liabilities (cont.)

- The exercise price of purchase options (where these are reasonably certain to be exercised);
- Payments for penalties for terminating a lease, where the lease term reflects the lessee exercising an option to terminate the lease.

The interest on the lease liability is recognised in profit or loss over the lease term so as to produce a constant periodic rate of interest on the remaining balance of the liability for each period. Lease liabilities do not include any future changes in variable lease payments (that depend on an index or rate) until they take effect, in which case the lease liability is reassessed and adjusted against the right-of-use asset.

Periods covered by extension or termination options are only included in the lease term by the Health Service if the lease is reasonably certain to be extended (or not terminated).

Variable lease payments, not included in the measurement of lease liability, are recognised by the Health Service in profit or loss in the period in which the condition that triggers the payment occurs.

This section should be read in conjunction with Note 5.2 and Note 9.2(b).

Subsequent Measurement

Lease liabilities are measured by increasing the carrying amount to reflect interest on the lease liabilities; reducing the carrying amount to reflect the lease payments made; and remeasuring the carrying amount at amortised cost, subject to adjustments to reflect any reassessment or lease modifications.

Significant assumptions and judgements

Judgements have been made in the identification of leases within contracts, assessment of lease terms by considering the reasonable certainty in exercising extension or termination options, and identification of appropriate rate to discount the lease payments.

7.3 Finance costs

	2020 $000	2019 $000
Interest expense on borrowings	12	35
Lease interest expense	173	-
	185	**35**

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

Finance costs include the interest on the Department of Treasury loans and the interest component of lease liability repayments.

7.4 Cash and cash equivalents

7.4.1 Reconciliation of cash

	2020 $000	2019 $000
Cash and cash equivalents	60,743	48,327
Restricted cash and cash equivalents		
Current		
Capital work projects	808	2,504
Mental Health Commission Funding [(a)]	2,175	1,356
Restricted cash assets held for other specific purposes [(b)]	12,452	8,266
	15,435	12,126
Non-current		
Accrued Salaries Suspense Account [(c)]	7,472	4,972
Total restricted cash and cash equivalents	22,907	17,098
Balance at end of period	**83,650**	**65,425**

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

(a) The unspent funds from the Mental Health Commission are committed to the provision of mental health services.

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

(c) The Accrued Salaries Suspense Account has been established for the Health Service at the Department of Treasury for the purpose of meeting the 27th pay which occurs in each eleventh year. This account is classified as non-current for 10 out of 11 years.

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

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

	Notes	2020 $000	2019 $000
Net cost of services (Statement of Comprehensive Income)		(512,500)	(441,224)
Non-cash items:			
Expected credit losses expense	3.6	172	1,401
Write off of inventory		(8)	129
Depreciation and amortisation expense	5	60,192	57,782
Asset revaluation decrement	5.1	709	5,071
Net gain/(loss) from disposal of non-current assets	5.1.2	63	(6)
Write down of assets	3.6	244	78
Interest expense paid by the Department of Health	7.3	12	35
Interest capitalised		22	-
Donations of assets	4.4	(1,003)	(1,766)
Services received free of charge	4.1	39,262	38,579
(Increase)/decrease in assets:			
Receivables		(399)	(3,655)
Inventories		(394)	(345)
Other current assets		(47)	(85)
Increase/(Decrease) in liabilities:			
Payables		14,238	(99)
Current provisions		7,276	2,243
Non-current provisions		4,216	3,083
Grant liabilities		945	-
Contract liabilities		53	-
Other current liabilities		20	46
Net cash used in operating activities (Statement of Cash Flows)		**(386,927)**	**(338,733)**

7.4.3 Reconciliation of cash flows from State Government

	2020 $000	2019 $000
Notional cash flows		
Service appropriations as per Statement of Comprehensive Income	451,059	401,270
Capital appropriation credited directly to Contributed equity (refer Note 9.13)	7,335	12,090
	458,394	413,360
Return of capital appropriations to the Department of Health (refer Note 6.5)	996	-
Less notional cash flows:		
Items paid directly by the Department of Health for the Health Service and are therefore not included in the Statement of Cash Flows:		
Interest payments to the Department of Treasury	(14)	(37)
Repayment of borrowings to the Department of Treasury	(739)	(703)
Accrual appropriations	(66,475)	(64,335)
	(67,228)	(65,075)
Cash Flows from State Government as per Statement of Cash Flows	392,162	348,285

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.

7.5 Capital commitments

	2020 $000	2019 $000
Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows:		
Within 1 year	3,304	561
Later than 1 year, and not later than 5 years	45	-
	3,349	561

Amounts presented for capital expenditure commitments are GST inclusive.

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 tables at Note 8.1(c) 'Credit risk exposure' and Note 6.1 'Receivables'.

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

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

Allowance for impairment of financial assets is calculated based on objective evidence such as observable data indicating changes in client credit ratings. For financial assets that are either past due or impaired.

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:

	2020 $000	2019 $000
Financial Assets		
Cash and cash equivalents	60,743	48,327
Restricted cash and cash equivalents	22,907	17,098
Financial assets at amortised cost [(a)]	356,224	273,458
	439,874	**338,883**
Financial Liabilities		
Financial liabilities measured at amortised cost	47,315	19,680
	47,315	**19,680**

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

(c) Credit risk exposure

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

		Days past due					
	Total $000	Current $000	31-60 days $000	61-90 days $000	91-180 days $000	181-365 days $000	>1 year $000
30 June 2020							
Expected credit loss rate		3%	7%	22%	29%	45%	77%
Estimated total gross carrying amount at default	9,690	3,242	779	220	633	1,130	3,686
Expected credit losses	(3,728)	(101)	(53)	(49)	(182)	(508)	(2,835)
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)

8.1 Financial risk management (cont.)

(d) Liquidity Risk and Interest Rate Exposure

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

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

	Weighted average effective interest rate %	Carrying amount $000	Interest rate exposure: Fixed interest rate $000	Interest rate exposure: Variable interest rate $000	Interest rate exposure: Non-interest bearing $000	Nominal Amount $000	Maturity dates: Up to 3 months $000	Maturity dates: 3 months to 1 year $000	Maturity dates: 1-5 years $000	Maturity dates: More than 5 years $000
2020										
Financial Assets										
Cash and cash equivalents		60,743	-	-	60,743	60,743	60,743	-	-	-
Restricted cash and cash equivalents		22,907	-	-	22,907	22,907	15,435	-	-	7,472
Receivables [(a)]		9,867	-	-	9,867	9,867	9,867	-	-	-
Amounts receivable for services		346,357	-	-	346,357	346,357	-	-	-	346,357
		439,874	-	-	439,874	439,874	86,045	-	-	353,829
Financial Liabilities										
Payables		35,882	-	-	35,882	35,882	35,882	-	-	-
Contract liabilities		53	-	-	53	53	32	21	-	-
Grant liabilities		945	-	-	945	945	945	-	-	-
Lease liabilities	2.17%	10,435	10,435		-	11,876	518	1,474	5,180	4,704
		47,315	10,435	-	36,880	48,756	37,377	1,495	5,180	4,704

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

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
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.)

(e) Interest rate sensitivity analysis

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

		-100 basis points		+100 basis points	
	Carrying amount $000	Surplus $000	Equity $000	Surplus $000	Equity $000
2020					
Financial Liabilities					
Department of Treasury loans	-	-	-	-	-
Lease liabilities	10,435	104	104	(104)	(104)
Total Increase/(Decrease)		**104**	**104**	**(104)**	**(104)**
2019					
Financial Liabilities					
Department of Treasury loans	739	7	7	(7)	(7)
Total Increase/(Decrease)		**7**	**7**	**(7)**	**(7)**

8.2 Contingent assets and liabilities

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

8.2.1 Contingent assets

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

8.2.2 Contingent liabilities

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:

2020	Notes	Level 1 $000	Level 2 $000	Level 3 $000	Fair value at end of period $000
Land	5.1				
Residential		-	603	-	603
Specialised		-	-	23,720	23,720
Buildings	5.1				
Residential		-	102	-	102
Specialised		-	-	920,587	920,587
		-	705	944,307	945,012
2019					
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

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 (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)

2020	Land $000	Buildings $000
Fair value at start of period	22,740	941,006
Transfer from other agencies	1,110	50
Revaluation increments/(decrements) recognised in Profit or Loss	(130)	(556)
Depreciation expense	-	(19,913)
Fair Value at end of period	**23,720**	**920,587**
2019		
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**

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.

9.1 Events occurring after the end of the reporting period

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

9.2 Initial application of Australian Accounting Standards

(a) AASB 15 Revenue from Contract with Customers and AASB 1058 Income of Not-for-Profit Entities

AASB 15 *Revenue from Contracts with Customers* replaces AASB 118 *Revenue* and AASB 111 *Construction Contracts* for annual reporting periods on or after 1 January 2019. Under the new model, an entity shall recognise revenue when (or as) the entity satisfies a performance obligation by transferring a promised good or service to a customer and is based upon the transfer of control rather than transfer of risks and rewards.

AASB 15 focuses on providing sufficient information to the users of financial statements about the nature, amount, timing and uncertainty of revenue and cash flows arising from the contracts with customers. Revenue is recognised by applying the following five steps:

- Identifying contracts with customers
- Identifying separate performance obligations
- Determining the transaction price of the contract
- Allocating the transaction price to each of the performance obligations
- Recognising revenue as each performance obligation is satisfied.

Revenue is recognised either over time or at a point in time. Any distinct goods or services are separately identified and any discounts or rebates in the contract price are allocated to the separate elements.

In addition, income other than from contracts with customers are subject to AASB 1058 *Income of Not-for-Profit Entities*. Income recognition under AASB 1058 depends on whether such a transaction gives rise to liabilities or a contribution by owners related to an asset (such as cash or another asset) recognised by the Health Service.

The Health Service adopts the modified retrospective approach on transition to AASB 15 and AASB 1058. No comparative information is restated under this approach, and the Health Service recognises 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 (1 July 2019).

Under this transition method, the Health Service elects not to apply the standards retrospectively to non-completed contracts at the date of initial application.

Refer to Note 4.1, 4.2, 4.3, 4.4 and 4.5 for the revenue and income accounting policies adopted from 1 July 2019.

9.2 Initial application of Australian Accounting Standards (cont.)

The effect of adopting AASB 15 and AASB 1058 are as follows:

	30 June 2020	Adjustments	30 June 2020 under AASB 118 and 1004
Patient charges	17,661	-	17,661
Other fees for services	25,872	-	25,872
Commonwealth grants and contributions	150,133	-	150,133
Other grants and contributions	69,367	989	70,356
Net result	**263,033**	**989**	**264,022**

(b) AASB 16 Leases

AASB 16 *Leases* supersedes AASB 117 *Leases* and related Interpretations. AASB 16 primarily affects lessee accounting and provides a comprehensive model for the identification of lease arrangements and their treatment in the financial statements of both lessees and lessors.

The Health Service applies AASB 16 *Leases* from 1 July 2019 using the modified retrospective approach. As permitted under the specific transition provisions, comparatives are not restated. The cumulative effect of initially applying this Standard is recognised as an adjustment to the opening balance of accumulated surplus/(deficit).

The main changes introduced by this Standard include identification of lease within a contract and a new lease accounting model for lessees that require lessees to recognise all leases (operating and finance leases) on the Statement of Financial Position as right-of-use assets and lease liabilities, except for short term leases (lease terms of 12 months or less at commencement date) and low-value assets (where the underlying asset is valued less than $5,000). The operating lease and finance lease distinction for lessees no longer exists.

Under AASB 16, the Health Service takes into consideration all operating leases that were off balance sheet under AASB 117 and recognises:

a) right of use assets and lease liabilities in the Statement of Financial Position, initially measured at the present value of future lease payments, discounted using the incremental borrowing rate (2.17%) on 1 July 2019;
b) depreciation of right-of-use assets and interest on lease liabilities in the Statement of Comprehensive Income; and
c) the total amount of cash paid as principal amount, which is presented in the cash flows from financing activities, and interest paid, which is presented in the cash flows from operating activities, in the Statement of Cash Flows.

The Health Service measures concessionary leases that are of low value terms and conditions at cost at inception. There is no financial impact as the Health Service is not in possession of any concessionary leases at the date of transition.

9.2 Initial application of Australian Accounting Standards (cont.)

The right-of-use assets are assessed for impairment at the date of transition and the Health Service has not identified any impairment to its right-of-use assets.

On transition, the Health Service has elected to apply the following practical expedients in the assessment of their leases that were previously classified as operating leases under AASB 117:

a) A single discount rate has been applied to a portfolio of leases with reasonably similar characteristics;
b) The Health Service has relied on its assessment of whether existing leases were onerous in applying AASB 137 *Provisions, Contingent Liabilities and Contingent Assets* immediately before the date of initial application as an alternative to performing an impairment review. The Health Service has adjusted the ROU asset at 1 July 2019 by the amount of any provisions included for onerous leases recognised in the Statement of Financial Position at 30 June 2019;
c) Where the lease term at initial application ended within 12 months, the Health Service has accounted for these as short-term leases;
d) Initial direct costs have been excluded from the measurement of the right-of-use asset;
e) Hindsight has been used to determine if the contracts contained options to extend or terminate the lease.

The Health Service has not reassessed whether existing contracts are, or contained a lease at 1 July 2019. The requirements of paragraphs 9-11 of AASB 16 are applied to contracts that came into existence post 1 July 2019.

Measurement of lease liabilities	**Buildings**	**Vehicles**
	$000	**$000**
Operating Lease Commitments disclosed as at 30 June 2019	6,566	-
Operating Lease Commitments not disclosed as at 30 June 2019	-	1,284
Less: Goods and Services Tax	(596)	-
Less: Leases with the Department of Finance not recognised as liability	(3,275)	-
Less: Short term leases not recognised as liability	(181)	-
Less: Lease payments not qualified under AASB 16	(159)	-
Add: Lease terms qualified under AASB 16, but not under AASB 117	2,301	-
Leases qualified under AASB 16	4,656	1,284
Discounted using incremental borrowing rate at date of initial application[1]	(352)	(46)
Lease liabilities recognised at 1 July 2019	**4,304**	**1,238**
Current lease liabilities	793	405
Non-current lease liabilities	3,511	833

[1] The WATC incremental borrowing rate was used for the purposes of calculating the lease transition opening balance.

9.3 Future impact of Australian Accounting Standards not yet operative

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

		Operative for reporting periods beginning on/after
AASB 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 agency by prescribing the accounting for the arrangement from the grantor's perspective. Timing and measurement for the recognition of a specific asset class occurs on commencement of the arrangement and the accounting for associated liabilities is determined by whether the grantee is paid by the grantor or users of the public service provided.	
	The Health Service does not manage any public private partnership that is within the scope of the Standard.	
AASB 2018-6	*Amendments to Australian Accounting Standards – Definition of a Business*	1 Jan 2020
	The Standard amends AASB 3 to clarify the definition of a business, assisting entities to determine whether a transaction should be accounted for as a business combination or as an asset acquisition.	
	There is no financial impact.	
AASB 2018-7	*Amendments to Australian Accounting Standards – Definition of Material*	1 Jan 2020
	The Standard principally amends AASB 101 and AASB 108. The amendments refine the definition of material in AASB 101. The amendments clarify the definition of material and its application by improving the wording and aligning the definition across AASB Standards and other publications. The amendment also includes some supporting requirements in AASB 101 in the definition to give it more prominence and clarifies the explanation accompanying the definition of material.	
	There is no financial impact.	

9.3 Future impact of Australian Accounting Standards not yet operative (cont.)

AASB 2019-1 *Amendments to Australian Accounting Standards – References to the Conceptual Framework* — 1 Jan 2020

This Standard sets out amendments to Australian Accounting Standards, Interpretations and other pronouncements to reflect the issuance of the Conceptual Framework for Financial Reporting (Conceptual Framework) by the AASB.

There is no financial impact.

AASB 2019-2 *Amendments to Australian Accounting Standards – Implementation of AASB 1059* — 1 Jan 2020

This Standard makes amendments to AASB 16 and AASB 1059 to: (a) amend the modified retrospective method set out in paragraph C4 of AASB 1059; (b) modify AASB 16 to provide a practical expedient to grantors of service concession arrangements so that AASB 16 would not need to be applied to assets that would be recognised as service concession assets under AASB 1059; and (c) include editorial amendments to the application guidance and implementation guidance accompanying AASB 1059.

The Health Service does not maintain any public private partnership that is within the scope of the Standard.

AASB 2020-1 *Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-current* — 1 Jan 2022

This Standard amends AASB 101 to clarify requirements for the presentation of liabilities in the statement of financial position as current or non-current.

There is no financial impact.

9.4 Remuneration of auditors

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

	2020 $000	2019 $000
Auditing the accounts, financial statements, controls, and key performance indicators	221	216

9.5 Key management personnel

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

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

Compensation band ($)	**2020**	**2019**
$0	1	1
$1 - $10,000	-	-
$30,001 - $40,000	-	1
$40,001 - $50,000	8	7
$70,001 - $80,000	-	1
$80,001 - $90,000	1	-
Total number of members of the Accountable Authority	10	10

	2020 $000	**2019 $000**
Short-term employee benefits	410	376
Post-employment benefits	39	36
Total compensation of members of the Accountable Authority	**449**	**412**

9.5 Key management personnel (cont.)

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

Compensation band ($)	2020	2019
$60,001 - $70,000	-	1
$70,001 - $80,000	-	1
$80,001 - $90,000	1	-
$130,001 - $140,000	-	1
$140,001 - $150,000	-	1
$170,001 - $180,000	1	-
$190,001 - $200,000	2	-
$200,001 - $210,000	-	1
$210,001 - $220,000	-	1
$220,001 - $230,000	1	-
$230,001 - $240,000	1	-
$240,001 - $250,000	-	2
$310,001 - $320,000	1	-
$480,001 - $490,000	-	-
$530,001 - $540,000	1	1
$540,001 - $550,000	1	-
$590,001 - $600,000	-	1
Total number of senior officers	9	10

	2020 $000	2019 $000
Short-term employee benefits	2,052	1,997
Post-employment benefits	235	232
Other long-term benefits	218	235
Total compensation of senior officers	**2,505**	**2,464**

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

9.6 Related party transactions

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

Related parties of the Health Service include:

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

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	2020 $000	2019 $000
Income			
Service appropriations	4.1	451,059	401,270
Assets assumed/(transferred)	4.1	-	14
Services received free of charge	4.1	39,262	38,579
Funding received from the Mental Health Commission	4.3	54,762	56,496
Expenses			
Contracts for services - Department of Communities [(a)]		515	506
Contracts for services - Disability Services Commission [(a)]		-	520
Insurance payments - Insurance Commission (RiskCover)	3.6	6,548	6,684
Rental and other accommodation expenses - Department of Finance [(a)]		1,085	1,046
Rental and other accommodation expenses - State Fleet [(a)]		-	506
Interest expense on loan - Department of Treasury	7.3	12	35
Lease interest expense - State Fleet	7.3	29	-
Remuneration for audit services - Office of the Auditor General	9.12	221	216

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

9.6 Related party transactions (cont.)

Significant transactions with Government-related entities (cont.)

	Notes	2020 $000	2019 $000
Assets			
Receivables at 30 June - North Metropolitan Health Service	6.1	1,281	-
Liabilities			
Borrowings at 30 June - Department of Treasury loans	7.1	-	739
Payables at 30 June - North Metropolitan Health Service	6.5	8,796	-
Payables at 30 June - Department of Health	6.5	996	-
Lease liabilities at 30 June - State Fleet	7.2	1,142	-
Repayments of lease liabilities - State Fleet		432	-
Contributed Equity			
Capital appropriations	9.13	7,335	12,090
Transfer of assets from/(to) Health Ministerial Body and government agencies	9.13	19,935	18,043

Material transactions with other related parties

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

	2020 $000	2019 $000
Superannuation payments to GESB	34,421	31,861
Payable to GESB	921	636

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.

9.7 Related bodies

A related body is a body which receives more than half its funding and resources from the Health Service and is subject to operational control by the Health Service.

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

9.8 Affiliated bodies

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

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

9.9 Services provided free of charge

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

	2020 $000	2019 $000
Department for Communities - health assessments for children in care	293	291
Disability Services Commission - paediatric services for children with disability	3,197	2,877
Department of Education - school health services	16,543	15,651
	20,033	18,819

9.10 Other statement of receipts and payments

	2020 $000	2019 $000
Commonwealth Grant - Christmas and Cocos Island		
Balance at the start of period	-	(42)
Receipts		
Commonwealth grant - provision of paediatric services	35	101
Payments		
Costs of visiting specialists	(65)	(59)
Balance at the end of period	**(30)**	**-**

A grant amount of $29,673 will be received from Commonwealth in the 2020-21 financial year.

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.*

	2020 $000	2019 $000
Balance at the start of period	1,356	1,308
Receipts		
Service delivery agreement - Commonwealth contributions	9,881	5,895
Service delivery agreement - State contributions	54,352	54,425
Other	410	2,071
	64,643	62,391
Payments	(63,824)	(62,343)
	819	48
Balance at the end of period	**2,175**	**1,356**

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 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.

	2020 $000	2019 $000
Contributed equity		
Balance at start of period	1,412,087	1,381,954
Contributions by owners		
Capital appropriations (a)	7,335	12,090
Transfer of net assets from other agencies (b)		
PCH assets and liabilities from the Health Ministerial Body (c)	-	16,154
Neonatal assets and liabilities from North Metropolitan Health Service (d)	18,825	-
Crown land from the Department of Planning, Lands and Heritage (f)	1,110	-
Land and building from the Department of Communities (e)	-	1,889
Total contributions by owners	**27,270**	**30,133**
Distributions to owners	**-**	**-**
Balance at end of period	**1,439,357**	**1,412,087**

(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*'.

	2020 $000	2019 $000
Capital appropriations received in cash	7,592	11,387
Plus: Capital appropriations received notionally	739	703
Less: Payable - return of capital appropriations	(996)	-
	7,335	12,090

(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.

9.13 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
Property, plant and equipment	5.1	5,743
Cash and cash equivalents		15,467
Receivables		109
Payables		(5,165)
Total PCH assets and liabilities transferred		16,154

(d) Assets and liabilities for Neonatal Services were transferred from North Metropolitan Health Service (NMHS) to the Health Service:

	Notes	2020 $000
Property, plant and equipment		2,931
Right-of-use assets		30
Cash and cash equivalent		17,423
Restricted cash and cash equivalent		528
Patient fee debtors (i)		1,136
Amount receivable for services		14,922
Payables		(1,724)
Lease liabilities		(30)
Employee benefits provision		(16,391)
Total Neonatal service assets and liabilities transferred		18,825

(i) The transfer of patient fee debtors included the allowance for impairment of receivables amounting to $0.254 million.

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

(f) Crown land for the Karrinyup Child Health Centre and Hilton Child Health Centre has been transferred from the Department of Planning, Lands and Heritage during the 2019-20 financial year.

9.13 Equity (cont.)

	2020 $000	2019 $000
Assets revaluation reserve		
Balance at start of period	-	4,124
Net revaluation increments/(decrements) [(a) (b)]		
Buildings	-	(4,124)
Balance at end of period	-	-

(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.

9.14 Supplementary financial information

(a) Revenue, public and other property written off

	2020 $000	2019 $000
Revenue and debts written off under the authority of the Accountable Authority	1,418	1,696
Public and other property written off under the authority of the Accountable Authority	-	70
	1,418	1,766

(b) Losses through theft, defaults and other causes

There were no losses of public money and public and other property through theft or default during the period.

(c) Gifts of public property

There were no gifts of public property provided by the Health Service during the period.

9.15 Explanatory statement

All variances between estimates (original budget) and actual results for 2020 and between the actual results for 2020 and 2019 are shown below. Narratives are provided for key major variances, which are generally greater than 10% and $1 million.

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

9.15.1 Statement of Comprehensive Income Variances

	Variance note	Estimate 2020 $000	Actual 2020 $000	Actual 2019 $000	Variance between estimate and actual $000	Variance between actual results for 2020 and 2019 $000
Expenses						
Employee benefits expense	(j)	456,994	491,055	441,448	34,061	49,607
Fees for visiting medical practitioners		2,275	2,679	2,537	404	142
Contracts for services	(k)	49,285	52,558	20,567	3,273	31,991
Patient support costs	(a) (l)	64,668	87,602	75,611	22,934	11,991
Finance costs	(b)	2,705	185	35	(2,520)	150
Depreciation and amortisation expense	(c)	68,076	60,192	57,782	(7,884)	2,410
Asset revaluation decrements	(m)	-	709	5,071	709	(4,362)
Loss on disposal of non-current assets		-	63	-	63	63
Repairs, maintenance and consumable equipment	(d) (n)	13,675	20,054	9,424	6,379	10,630
Other supplies and services		45,572	45,501	44,462	(71)	1,039
Other expenses	(e)	25,974	22,243	24,436	(3,731)	(2,193)
Total cost of services		**729,224**	**782,841**	**681,373**	**53,617**	**101,468**

9.15.1 Statement of Comprehensive Income Variances (cont.)

	Variance note	Estimate 2020 $000	Actual 2020 $000	Actual 2019 $000	Variance between estimate and actual $000	Variance between actual results for 2020 and 2019 $000
Revenue						
Patient charges	(f) (o)	15,709	17,661	15,968	1,952	1,693
Other fees for services	(p)	24,713	25,872	21,260	1,159	4,612
Commonwealth grants and contributions	(g) (q)	131,976	150,133	131,658	18,157	18,475
Other grants and contributions		67,685	69,367	64,048	1,682	5,319
Donation revenue	(h)	540	1,978	1,857	1,438	121
Gain on disposal of non-current assets		-	-	6	-	(6)
Other revenue	(i)	3,791	5,330	5,352	1,539	(22)
Total revenue		244,414	270,341	240,149	25,927	30,192
Total income other than income from State Government		**244,414**	**270,341**	**240,149**	**25,927**	**30,192**
NET COST OF SERVICES		**484,810**	**512,500**	**441,224**	**27,690**	**71,276**
INCOME FROM STATE GOVERNMENT						
Service appropriations	(r)	447,888	451,059	401,270	3,171	49,789
Assets (transferred)/assumed		-	-	14	-	(14)
Services received free of charge		36,922	39,262	38,579	2,340	683
Total income from State Government		**484,810**	**490,321**	**439,863**	**5,511**	**50,458**
DEFICIT FOR THE PERIOD		**-**	**(22,179)**	**(1,361)**	**(22,179)**	**(20,818)**
OTHER COMPREHENSIVE INCOME						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve		-	-	(4,124)	-	4,124
Total other comprehensive income		-	-	(4,124)	-	4,124
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**-**	**(22,179)**	**(5,485)**	**(22,179)**	**(16,694)**

9.15.1 Statement of Comprehensive Income Variances (cont.)

Major Variance Narratives

Variances between estimates and actuals

(a) Patient support costs have exceeded the budget estimate by $22.934 million because of the unexpectedly higher drug costs ($19.036 million) and other medical supplies ($4.309 million).

(b) The variance of $2.520 million in finance costs mostly relates to lease interest expense. The inclusion of payments that are not lease payments has resulted in the higher amount in the budget estimate.

(c) Depreciation and amortisation expense is $7.884 million below the budget estimate due to realignment and deferment of the capital works program during the year.

(d) Repairs, maintenance and consumable equipment are $6.379 million higher than the budget estimate. The variance includes the unexpectedly higher costs of maintenance and consumable equipment for the Perth Children's Hospital and the unbudgeted expenses for the capital works program.

(e) Other expenses are $3.731 million below the budget estimate mainly due to the cancellation of the Sustainable Health Review project.

(f) The variance of $1.952 million in patient charges consists of $1.491 million for neonatal services which has not been included in the budget estimate.

(g) The variance of $18.157 million in Commonwealth grants and contributions is mostly for the National Health Reform Agreement.

(h) Only cash donations were included in the budget estimate of $0.540 million. During the financial year, the Health Service has also received donations of equipment ($1.047 million) from the Perth Children's Hospital Foundation, donation of a building ($0.050 million) from the City of Stirling and donation of an artwork ($0.009 million). See Note 4.4 Donation Revenue.

(i) Other revenue is $1.539 million above budget because of the tenant expense recoupment of $2.149 million not being budgeted for (see Note 4.5).

Variances between actuals for 2019-20 and 2018-19

(j) The $49.607 million increase in employee benefits expense includes $28.151 million for salaries of neonatal employees transferred from the North Metropolitan Health Service, $0.819 million salary costs incurred for COVID-19 pandemic and $11.898 million expenses arising from the increases in employee benefits provisions (see Note 9.15.2 (f)).

(k) Contracts for services have increased by $31.991 million predominately as a result of the changes in purchasing arrangements and governance of neonatal services.

9.15.1 Statement of Comprehensive Income Variances (cont.)

Major Variance Narratives (cont.)

Variances between actuals for 2019-20 and 2018-19

(l) The higher costs incurred on drug supplies ($7.270 million), medical and surgical instruments ($1.769 million) and pathology charges ($1.110 million) have contributed to the overall increase of $11.991 million in patient support costs.

(m) Asset revaluation decrements for the 2018-19 financial year were $4.362 million more than the 2019-20 amount because of the revision of building cost index undertaken in that year's valuation of buildings.

(n) Repairs, maintenance and consumable equipment have increased by $10.630 million due to the higher maintenance costs for the Perth Children's Hospital.

(o) The increase in patient charges is mostly for the neonatal services ($1.491 million) delivered by the Health Service since 1 February 2020.

(p) The $4.612 million increase in other fees for services consists of $4.757 million for reimbursements of drug costs from the Pharmaceutical Benefits Scheme and $0.145 million reduction for clinical services to other health organisations (see Note 4.2).

(q) Commonwealth grants and contributions received from the National Health Reform Agreement have increased by $18.029 million (see Note 4.3).

(r) The $49.789 million increase in service appropriations from State Government is mainly for funding the costs of operating the neonatal services at the King Edward Memorial Hospital (KEMH) in 2019-20.

9.15.2 Statement of Financial Position Variances

	Variance note	Estimate 2020 $000	Actual 2020 $000	Actual 2019 $000	Variance between estimate and actual $000	Variance between actual results for 2020 and 2019 $000
ASSETS						
Current Assets						
Cash and cash equivalents		33,578	60,743	48,327	27,165	12,416
Restricted cash and cash equivalents		26,095	15,435	12,126	(10,660)	3,309
Receivables		9,203	10,403	9,040	1,200	1,363
Inventories		2,669	2,962	2,560	293	402
Other assets		565	669	622	104	47
Total Current Assets		72,110	90,212	72,675	18,102	17,537
Non-Current Assets						
Restricted cash and cash equivalents		6,572	7,472	4,972	900	2,500
Amounts receivable for services	(c)	329,036	346,357	264,960	17,321	81,397
Property, plant and equipment		1,116,492	1,124,827	1,167,368	8,335	(42,541)
Right-of-use assets		55,746	10,256	-	(45,490)	10,256
Intangible assets	(d)	39,135	37,889	46,409	(1,246)	(8,520)
Total Non-Current Assets		1,546,981	1,526,801	1,483,709	(20,180)	43,092
TOTAL ASSETS		**1,619,091**	**1,617,013**	**1,556,384**	**(2,078)**	**60,629**

9.15.2 Statement of Financial Position Variances (cont.)

	Variance note	Estimate 2020 $000	Actual 2020 $000	Actual 2019 $000	Variance between estimate and actual $000	Variance between actual results for 2020 and 2019 $000
LIABILITIES						
Current Liabilities						
Payables		18,703	35,882	18,941	17,179	16,941
Contract liabilities		-	53	-	53	53
Grant liabilities		-	945	-	945	945
Borrowings		-	-	736	-	(736)
Lease liabilities	(e)	2,257	1,790	-	(467)	1,790
Employee benefits provisions	(a) (f)	84,650	107,686	87,072	23,036	20,614
Other liabilities		44	89	69	45	20
Total Current Liabilities		105,654	146,445	106,818	40,791	39,627
Non-Current Liabilities						
Borrowings		-	-	3	-	(3)
Lease liabilities	(b) (e)	54,565	8,645	-	(45,920)	8,645
Employee benefits provisions	(a) (f)	21,519	31,340	24,071	9,821	7,269
Total Non-Current Liabilities		76,084	39,985	24,074	(36,099)	15,911
TOTAL LIABILITIES		**181,738**	**186,430**	**130,892**	**4,692**	**55,538**
NET ASSETS		**1,437,353**	**1,430,583**	**1,425,492**	**(6,770)**	**5,091**
EQUITY						
Contributed equity		1,419,767	1,439,357	1,412,087	19,590	27,270
Reserves		-	-	-	-	-
Accumulated surplus		17,586	(8,774)	13,405	(26,360)	(22,179)
TOTAL EQUITY		**1,437,353**	**1,430,583**	**1,425,492**	**(6,770)**	**5,091**

9.15.2 Statement of Financial Position Variances (cont.)

Major Variance Narratives

Variances between estimates and actuals

(a) The budget estimates do not include the transfer of employee benefits provisions ($16.391 million) for neonatal employees from the North Metropolitan Health Service (see Note 9.13 (d)) and the increase ($5.712 million) in the present values of future payments at the reporting date. The planned reduction of leave accumulation ($4.000 million) has not occurred during the year, and conversely the leave accumulation has increased by $6.186 million as a result of COVID-19 pandemic.

(b) The variance of $45.920 million in non-current lease liabilities is due to the significantly longer lease terms used in the budget estimate and the inclusion of payments that are not lease payments.

Variances between actuals for 2019-20 and 2018-19

(c) The increase of $81.397 million in amounts receivable for services includes the receivable component of service appropriations ($66.475 million) from State Government during the year and the transfer of neonatal assets ($14.922 million) from the North Metropolitan Health Service (see Note 9.13 (d)).

(d) The decrease of $8.520 million in intangible assets is caused by amortisation (see Note 5.3).

(e) The initial application of AASB 16 *Leases* has resulted in the recognition of lease liabilities on 1 July 2019 (see Note 9.2 (b)). All lease payments were expensed in the 2018-19 financial year.

(f) Employee benefits provisions have increased by $27.883 million as a consequence of the transfer of neonatal employees ($16.391 million) to the Health Service (see Note 9.13 (d)), the increase ($5.712 million) in the present values of future payments at the reporting date, and increase ($6.186 million) in accumulation of leave caused by decline in staff taking leave during the COVID-19 pandemic.

9.15.3 Statement of Cash Flows Variances

	Variance note	Estimate 2020 $000	Actual 2020 $000	Actual 2019 $000	Variance between estimate and actual $000	Variance between actual results for 2020 and 2019 $000
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriations	(f)	379,812	384,570	336,898	4,758	47,672
Capital appropriations	(a) (g)	21,148	7,592	11,387	(13,556)	(3,795)
Net cash provided by State Government		**400,960**	**392,162**	**348,285**	**(8,798)**	**43,877**
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits		(453,779)	(475,204)	(434,987)	(21,425)	(40,217)
Supplies and services	(h)	(167,759)	(181,143)	(138,432)	(13,384)	(42,711)
Finance costs	(b)	(2,689)	(151)	-	2,538	(151)
Receipts						
Receipts from customers	(i)	15,709	15,493	14,048	(216)	1,445
Commonwealth grants and contributions	(c) (j)	131,976	150,133	131,658	18,157	18,475
Other grants and contributions	(k)	67,685	70,365	63,851	2,680	6,514
Donations received		540	677	91	137	586
Other receipts	(d) (l)	28,505	32,903	25,038	4,398	7,865
Net cash used in operating activities		**(379,812)**	**(386,927)**	**(338,733)**	**(7,115)**	**(48,194)**

9.15.3 Statement of Cash Flows Variances (cont.)

	Variance note	Estimate 2020 $000	Actual 2020 $000	Actual 2019 $000	Variance between estimate and actual $000	Variance between actual results for 2020 and 2019 $000
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Purchase of non-current assets	(e) (m)	(19,024)	(3,713)	(1,664)	15,311	(2,049)
Receipts						
Proceeds from sale of non-current assets		-	132	53	132	79
Net cash used in investing activities		**(19,024)**	**(3,581)**	**(1,611)**	**15,443**	**(1,970)**
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Principal elements of lease	(n)	(2,124)	(1,380)	-	744	(1,380)
Net cash used in financing activities		**(2,124)**	**(1,380)**	**-**	**744**	**(1,380)**
Net increase / (decrease) in cash and cash equivalents		-	274	7,941	274	(7,667)
Cash and cash equivalents at the beginning of period		66,245	65,425	42,017	(820)	23,408
Cash transferred from Health Ministerial Body		-	-	15,467	-	(15,467)
Cash transferred from North Metropolitan Health Service		-	17,951	-	17,951	17,951
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**66,245**	**83,650**	**65,425**	**17,405**	**18,225**

9.15.3 Statement of Cash Flows Variances (cont.)

Major Variance Narratives

Variances between estimates and actuals

(a) The realignment and deferment of the capital works program have resulted in cash inflows from capital appropriations to be lower than the original budget by $13.556 million.

(b) Payments for finance costs - see explanation in variance note (b) for the Statement of Comprehensive Income.

(c) Commonwealth grants and contributions - see explanation in variance note (g) for the Statement of Comprehensive Income.

(d) The higher than expected recoveries of drug costs ($4.299 million) from the Pharmaceutical Benefits Scheme have largely contributed to the variance of $4.398 million in other receipts.

(e) Purchase of non-current assets is $15.311 million below budget mainly because of realignment and deferment of the capital works program during the year, including $3.133 million incurred on employee benefits, supplies and services rather than non-current assets.

Variances between actuals for 2019-20 and 2018-19

(f) Service appropriations - see explanation in variance note (r) for the Statement of Comprehensive Income.

(g) Capital appropriations of $2.576 million have been received for the principal repayments of lease liabilities in 2019-20, with an excess amount $0.996 million not repaid back to the Department of Health at the reporting date (see Note 6.5). The new funding receipts offsets the reduction of $6.371 million in cash funding requirements of the capital works program, resulting in an overall reduction of $3.795 million in capital appropriations.

(h) Payments for supplies and services have increased by $42.711 million because of the higher costs for drug supplies, medical and surgical instruments, pathology services and neonatal services. See explanations in variance notes (k) and (l) for the Statement of Comprehensive Income.

(i) The improved collection of patient debts has contributed to the increase in receipts from customers during the year.

(j) Commonwealth grants and contributions - see explanation in variance note (q) for the Statement of Comprehensive Income.

(k) The increase of $6.514 million in other grants and contributions is mainly from the Channel 7 Telethon Trust, Perth Children's Hospital Foundation and Telethon Kids Institute. See Note 4.3.

9.15.3 Statement of Cash Flows Variances (cont.)

Major Variance Narratives (cont.)

Variances between actuals for 2019-20 and 2018-19

(l) Other receipts have increased by $7.865 million due to the higher recoveries from the Pharmaceutical Benefits Scheme and more recoups of expenses received from tenants.

(m) The increase of $2.049 million in payments for the purchase of non-current assets was mostly for medical equipment.

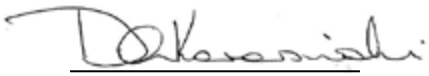
(n) The initial application of AASB 16 *Leases* has resulted in the recognition of lease liabilities on 1 July 2019 (see Note 9.2 (b)). The principal repayments of lease liabilities are cash flows from financing activities. In the previous years, all lease payments were recognised as cash flows from operating activities.

Key performance indicators

Certification of key performance indicators

CHILD AND ADOLESCENT HEALTH SERVICE
CERTIFICATION OF KEY PERFORMANCE INDICATORS FOR THE YEAR ENDED 30 JUNE 2020

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 2020.



Ms Deborah Karasinski AM
CHAIR OF THE BOARD
CHILD AND ADOLESCENT HEALTH SERVICE
3 September 2020

Prof Geoffrey Dobb
DEPUTY CHAIR OF THE BOARD
CHILD AND ADOLESCENT HEALTH SERVICE
3 September 2020

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 32.

The latest available data has been used to report performance.


3

OUTCOME 1 – EFFECTIVENESS KPI

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

Rationale

Unplanned hospital readmissions may reflect less than optimal patient management and ineffective care pre-discharge, post-discharge and/or during the transition between acute and community-based care.[7] These readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

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

The seven surgeries selected for this indicator are based on those in the current National Health Agreement Unplanned Readmission performance indicator (NHA PI 23).

Target

The 2019 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	≤17.1
Tonsillectomy & Adenoidectomy	≤61.0
Hysterectomy	≤41.3
Prostatectomy	≤38.8
Cataract Surgery	≤1.1
Appendicectomy	≤25.7

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

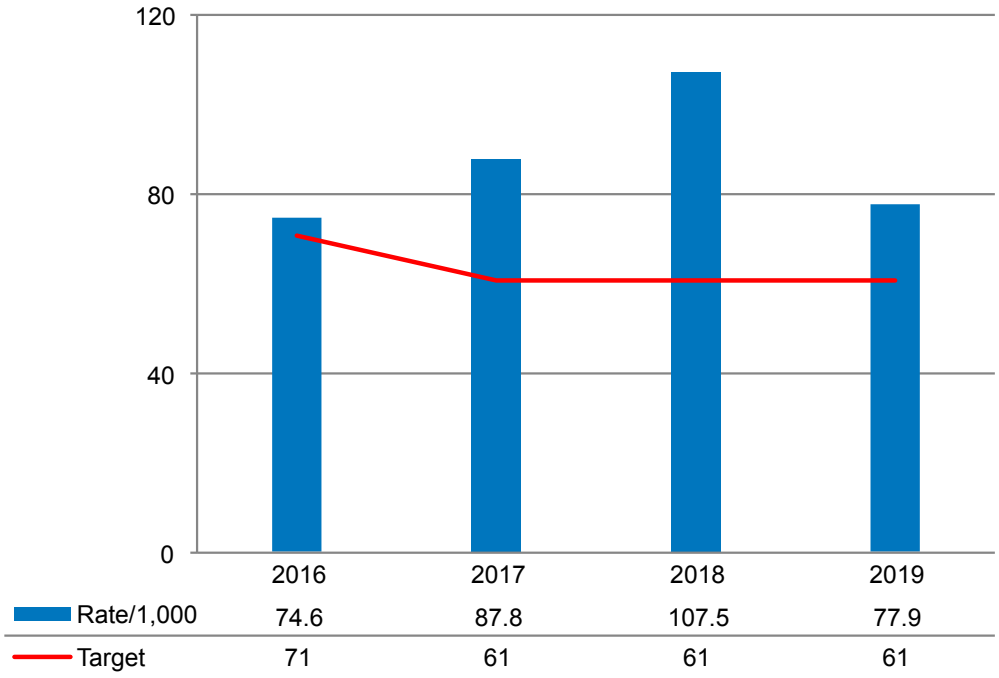
Results

Tonsillectomy & Adenoidectomy

The rate of unplanned readmission for tonsillectomy and adenoidectomy was 77.9 per 1,000, which is lower than the previous year but above the target of 61.0 per 1,000 (Figure 6). This result reflects the conservative approach 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.[7]

[7] *Australian Institute of Health and Welfare (2009). Towards national indicators of safety and quality in health care. Cat. no. HSE 75. Canberra: AIHW. Available at: https://www.aihw.gov.au/reports/health-care-quality-performance/towards-national-indicators-of-safety-and-quality/contents/table-of-contents*

Figure 6: Rate of Unplanned hospital readmissions for patients within 28 days for tonsillectomy and adeboidectomy, 2016 to 2019



Only a small proportion of patients required a return to theatre in 2019. The rest of those readmitted received clinical observation combined with hydration or medicine for pain relief or to reduce incidences of small, self-limiting bleeds, as required.

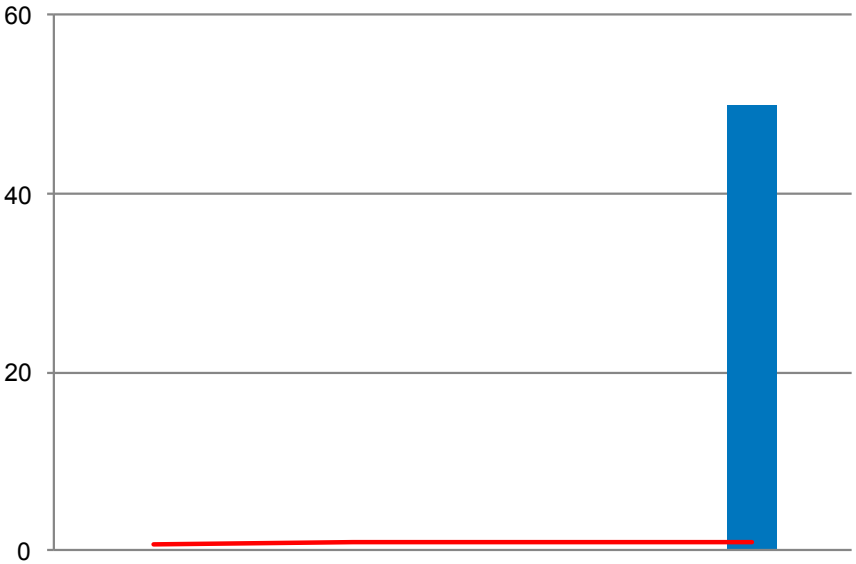
Note: The devolved governance structure for the WA health system enacted by the *Health Services Act 2016* took effect from 1 July 2016. For 2016, data is reported from 1 July to 31 December 2016.

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

Cataract Surgery

The rate of unplanned readmissions for cataract surgery was 50.0 per 1,000, which is above the target of 1.1 per 1,000. As Figure 7 shows, it is extremely rare for cataract patients at CAHS to require readmission, and as the 2019 result is attributable to one patient only, it must be interpreted with caution. The Perth Children's Hospital Ophthalmology department investigated this case and determined the readmission was appropriate.

Figure 7: Rate of unplanned readmissions for patients within 28 days for cataract surgery, 2016 to 2019



	2016	2017	2018	2019
Rate/1,000	0	0	0	50.0
Target	1	1.1	1.1	1.1

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

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

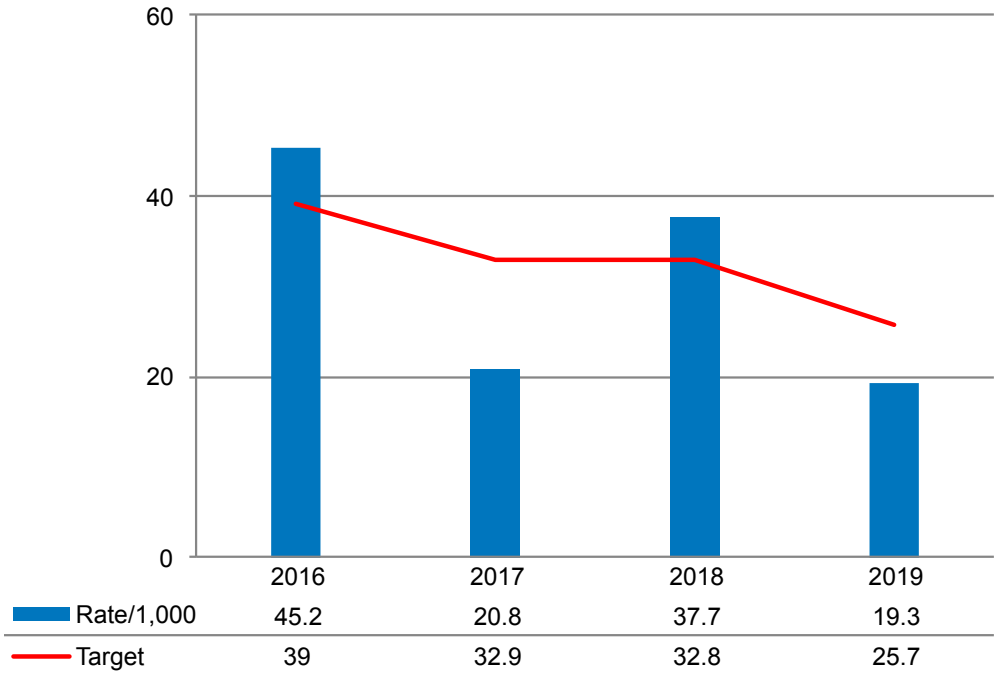
Appendicectomy

The rate of unplanned readmissions for appendicectomy was 19.3 per 1,000, which is below the target of 25.7 per 1,000 (Figure 8).

Other surgical procedures

CAHS did not perform any knee replacements, hip replacements, hysterectomies or prostatectomies in 2019.

Figure 8: Rate of unplanned readmissions for patients within 28 days for appendicectomy, 2016 to 2019



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

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

OUTCOME 1 – EFFECTIVENESS KPI

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

Rationale

Elective surgery refers to planned surgery that can be booked in advance following specialist assessment that results in placement on an elective surgery waiting list.

Elective surgical services delivered in the WA health system are those deemed to be clinically necessary. Excessive waiting times for these services can lead to deterioration of the patient's condition and/or quality of life, or even death. Waiting lists must be actively managed by hospitals to ensure fair and equitable access to limited services, and that all patients are treated within clinically appropriate timeframes.

Patients are prioritised based on their assigned clinical urgency category:

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

On 1 April 2016, the WA health system introduced a new state-wide performance target for the provision of elective services. For reportable procedures, the target requires that no patients (zero per cent) on the elective waiting lists wait longer than the clinically recommended time for their procedure, according to their urgency category.

Target

The 2019–20 target is zero per cent for each urgency category. Performance is demonstrated by a result that is equal to the target.

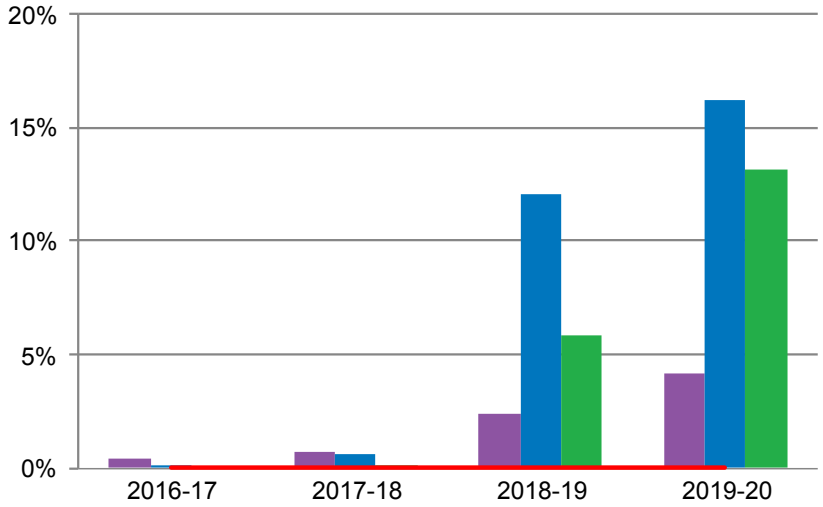
Results

In 2019–20, CAHS' performance with surgical waitlisting of patients and treating them within recommended timeframes declined when averaged across the entire year. Figure 9 shows an average of 4.2 per cent of Category 1 patients were not treated within 30 days, 16.2 per cent of Category 2 patients were not treated within 90 days, and 13.1 per cent of Category 3 patients were not treated within 365 days.

The decline in performance is largely due to elective surgeries being scaled back from 23 March 2020 due to a number of COVID-19 related drivers. Performance to that date was similar to last year, but although Category 1 bookings and surgeries mostly continued as normal, those for Categories 2 and 3 variously ceased or were cancelled on instruction from the Director General of WA Health and the Minister for Health.

Activity resumed in stages, commencing at 50 per cent from 18 May, rising to 75 per cent from 2 June and returning to 100 per cent from 15 June 2020. On 1 July, the State government announced additional funding for the WA health system to address unavoidable growth in the elective surgery wait list during the COVID-19 pandemic. CAHS will receive $7.9 million to increase activity with the goal of returning elective surgery performance to pre-COVID-19 levels by early 2021.

Figure 9: Percentage of elective wait list patients waiting over boundary for reportable procedures, by urgency category, 2016-17 to 2019-20



	2016-17	2017-18	2018-19	2019-20
Cat 1 ≤30 days	0.4%	0.7%	2.4%	4.2%
Cat 2 ≤90 days	0.1%	0.6%	12.1%	16.2%
Cat 3 ≤365 days	0.0%	0.1%	5.8%	13.1%
Target	0%	0%	0%	0%

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

Data source: Elective Services Wait List Data Collection.

OUTCOME 1 – EFFECTIVENESS KPI

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

Rationale

Staphylococcus aureus bloodstream infection is a serious infection that may be associated with the provision of healthcare. *Staphylococcus aureus* is a highly pathogenic organism and even with advanced medical care, infection is associated with prolonged hospital stays, increased healthcare costs and a marked increase in morbidity and mortality (SABSI mortality rates are estimated at 20–25 per cent[8] in adults and five per cent in children).

HA-SABSI is generally considered to be a preventable adverse event associated with the provision of healthcare, therefore this KPI is a robust measure of the safety and quality of care provided by WA public hospitals. A low or decreasing HA-SABSI rate is desirable, and the WA target was developed based on historical results.

Target

The 2019 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.[8]

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 SAC 1. Root Cause Analyses are conducted to determine the reasons for infection and inform mitigation strategies.

The steps CAHS takes to prevent *S. aureus* infection include:

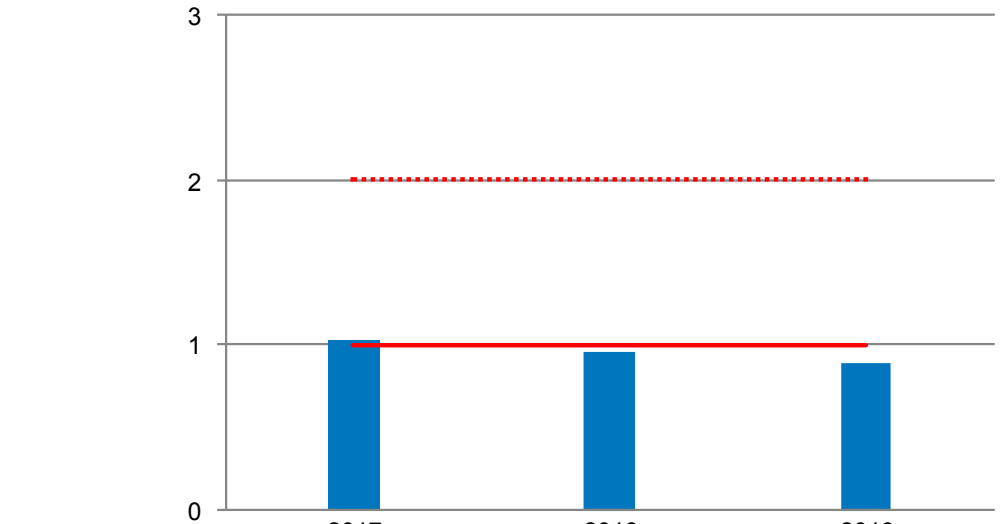
- decolonising all patients undergoing high-risk surgical procedure, including those having a central line inserted
- ensuring ongoing compliance assessment and training with best practice guidelines when managing CVAD and peripheral intravenous cannulas
- encouraging the use of skin preparations containing alcohol and chlorhexidine, which are demonstrated to reduce the rate of surgical wound infection
- working with consumers to improve family education.

CAHS reduced its *S. aureus* bloodstream infection rate in 2019 to 0.89 per 10,000 occupied bed-days, which is below the WA health system target and less than half the national benchmark of 2.0 per 10,000 bed-days[9] (Figure 10).

[8] *van Hal, S. J., Jensen, S. O., Vaska, V. L., Espedido, B. A., Paterson, D. L., & Gosbell, I. B. (2012). Predictors of mortality in Staphylococcus aureus Bacteremia. Clinical microbiology reviews, 25(2), 362–386. doi:10.1128/CMR.05022-11*

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

Figure 10: Healthcare associated *Staphylococcus aureus* bloodstream infection (HA-SABSI) per 10,000 occupied bed days, 2017 to 2019



	2017	2018	2019
Rate	1.03	0.96	0.89
Benchmark	2.0	2.0	2.0
Target	1.0	1.0	1.0

Data source: Healthcare Infection Surveillance Western Australia Data Collection.

OUTCOME 1 – EFFECTIVENESS KPI

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

Rationale

Discharge against medical advice (DAMA) refers to patients leaving hospital against the advice of their treating medical team or without advising hospital staff (e.g. absconding or missing and not found). Patients who do so have a higher risk of readmission and mortality[10] and have been found to cost the health system 50 per cent more than patients who are discharged by their physician.[11]

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.[12] This statistic indicates a need for improved responses by the health system to the needs of Aboriginal patients.

This indicator provides a measure of the safety and quality of inpatient care. Reporting the results by Aboriginality measures the effectiveness of initiatives within the WA health system to deliver culturally secure services to Aboriginal people and achieve equitable treatment outcomes for Aboriginal patients.

Target

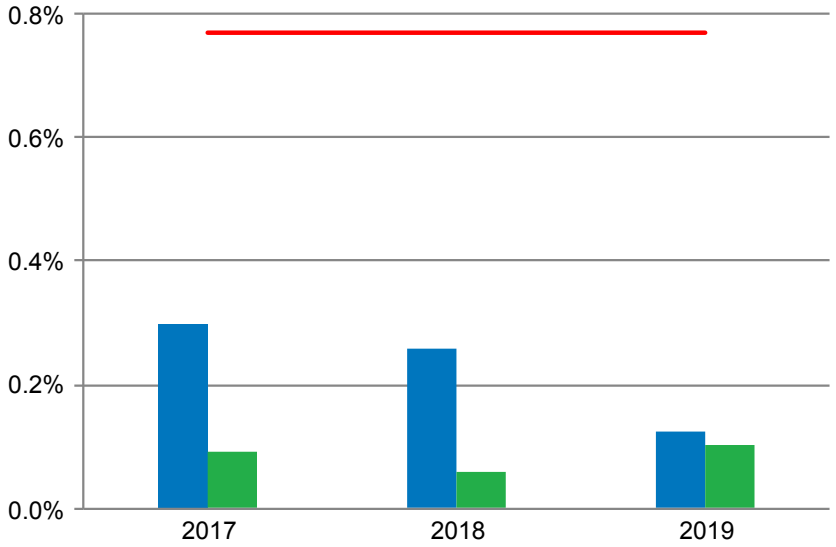
The 2019 target is 0.77 per cent. Performance is demonstrated by a result that is equal to or below the target.

Results

In 2019, CAHS recorded a rate of discharge against medical advice of 0.13 per cent for Aboriginal patients, and 0.10 per cent for non-Aboriginal patients. These results are below the target of 0.77 per cent (Figure 11). A contributing factor to the favourable result for Aboriginal patients is the Koorliny Moort (Walking with Families) program, which engages with Aboriginal people early and improves communication between health care services in and out of hospital.

[10] *Yong et al. Characteristics and outcomes of discharges against medical advice among hospitalised patients. Internal medicine journal 2013:43(7):798-802.*
[11] *Aliyu ZY. Discharge against medical advice: sociodemographic, clinical and financial perspectives. International journal of clinical practice 2002;56(5):325-27.*
[12] *Commonwealth of Australia. (2017). Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report, Commonwealth of Australia, Canberra.*

Figure 11: Percentage of admitted patients who discharged against medical advice, 2017 to 2019



	2017	2018	2019
Aboriginal	0.30%	0.26%	0.13%
Non-Aboriginal	0.09%	0.06%	0.10%
Target	0.77%	0.77%	0.77%

Data source: Hospital Morbidity Data Collection.

OUTCOME 1 – EFFECTIVENESS KPI

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.[13] These readmissions mean that patients spend additional time in hospital and utilise additional resources. A low readmission rate suggests that good clinical practice is in operation.

Readmissions are attributed to the facility at which the initial separation (discharge) occurred rather than the facility to which the patient was readmitted. By monitoring this indicator, key areas for improvement can be identified. This can facilitate the development and delivery of targeted care pathways[13] and interventions aimed at improving the mental health and quality of life of Western Australians.

Target

The 2019 target is 12 per cent.[14] 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. Frequent admissions are currently being used as part of an evidence-based clinical package of care for young people with certain conditions.

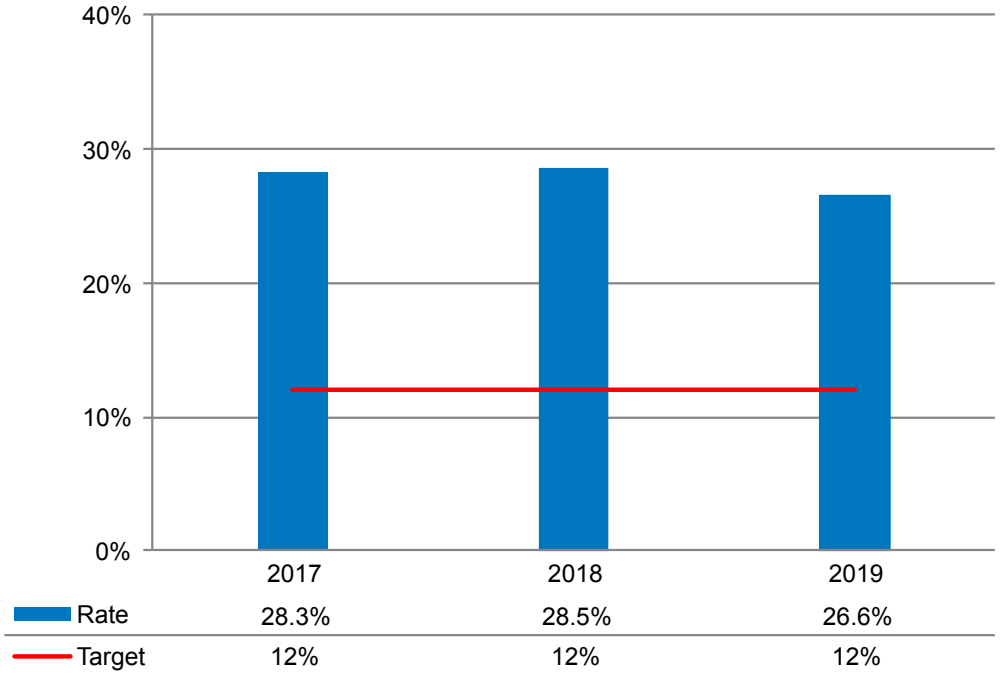
In 2019, the rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit improved to 26.6 per cent, which is above the target of 12 per cent (Figure 12). It should be noted that a high readmission rate does not necessarily mean poor clinical practice. Furthermore, while a low readmission rate may indicate clinical effectiveness, it can also indicate resource limitations, such as a lack of access to beds. This indicator does not distinguish between planned and unplanned readmissions.

CAHS investigates instances where a readmission is not planned or expected in order to address any underlying causes. A comprehensive review of readmissions initiated in October 2019 identified potential areas of focus to reduce the need for readmission, such as more intensive specialist community mental health services for children with complex mental health care needs.

[13] *Australian Health Ministers Advisory Council Mental Health Standing Committee (2011). Fourth National Mental Health Plan Measurement Strategy. Available at: https://www.aihw.gov.au/getmedia/d8e52c84-a53f-4eef-a7e6-f81a5af94764/Fourth-national-mental-health-plan-measurement-strategy-2011.pdf.aspx*

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

Figure 12: Readmissions to acute specialised mental health inpatient services within 28 days of discharge, 2017 to 2019



Data source: Hospital Morbidity Data Collection

OUTCOME 1 – EFFECTIVENESS KPI

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

Rationale

In 2017-18, one in five (4.8 million) Australians reported having a mental or behavioural condition.[15] Therefore, it is crucial to ensure effective and appropriate care is provided not only in a hospital setting but also in the community.

Discharge from hospital is a critical transition point in the delivery of mental health care. People leaving hospital after an admission for an episode of mental illness have increased vulnerability and, without adequate follow up, may relapse or be readmitted.

The standard underlying this measure is that continuity of care requires prompt community follow-up in the period following discharge from hospital. A responsive community support system for persons who have experienced a psychiatric episode requiring hospitalisation is essential to maintain their clinical and functional stability, and to minimise the need for hospital readmissions. Patients leaving hospital after a psychiatric admission with a formal discharge plan that includes links with public community based services and support are less likely to need avoidable hospital readmissions.[15]

Target

The 2019 target is 75 per cent. Performance is demonstrated by a result that is equal to or above the target.

Result

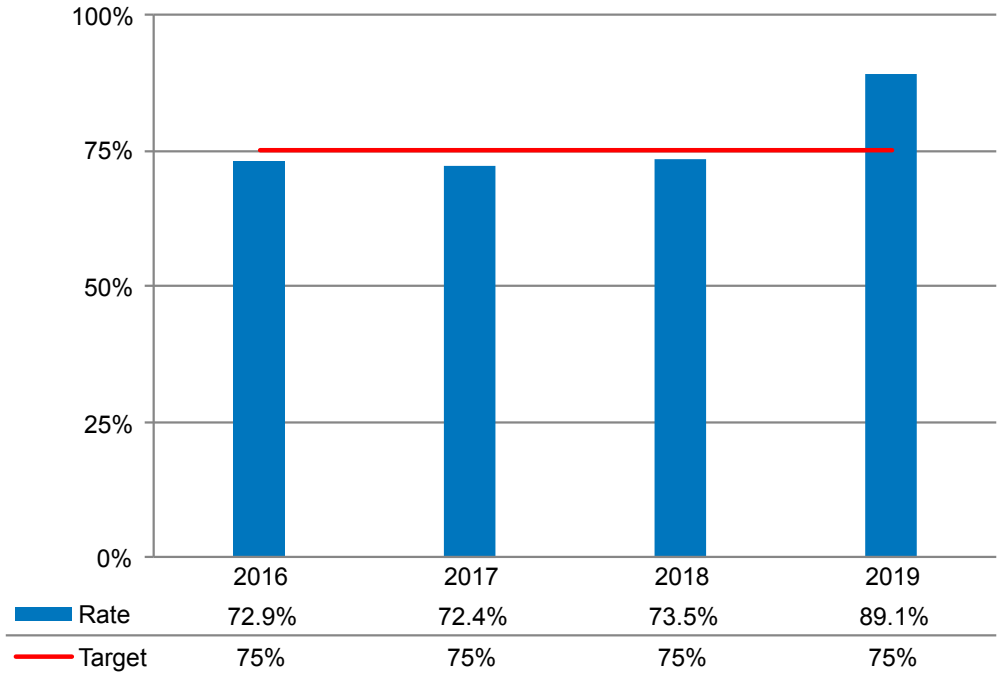
In 2019, 89.1 per cent of young people who were admitted to CAHS acute specialised mental health inpatient services or their carers were contacted by a community-based public mental health non-admitted health service within seven days of discharge, which is above the target of 75 per cent (Figure 13).

The improvement in performance since 2018 is partly due to revision to the methodology in accordance with the national definition to include contacts with carers. This is considered particularly appropriate and relevant where, for example, the patient is a minor. It should be further noted that not all patients or carers elect to schedule an appointment within seven days, and some choose not to make an appointment at all. 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.

[15] *https://www.abs.gov.au/ausstats/abs@.nsf/mf/4364.0.55.001*

Figure 13: Percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services, 2016 to 2019



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 (WAU) compared with the State (aggregated) target, as approved by the Department of Treasury and published in Volume 1 of the 2019–20 Budget Paper No. 2.

The measure ensures a consistent methodology is applied to calculating and reporting the cost of delivering inpatient activity against the State's funding allocation. As admitted services received nearly half of the overall 2019–20 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

Target

The 2019–20 target is $7,026 per weighted activity unit. Performance is demonstrated by a result that is equal to or below the target.

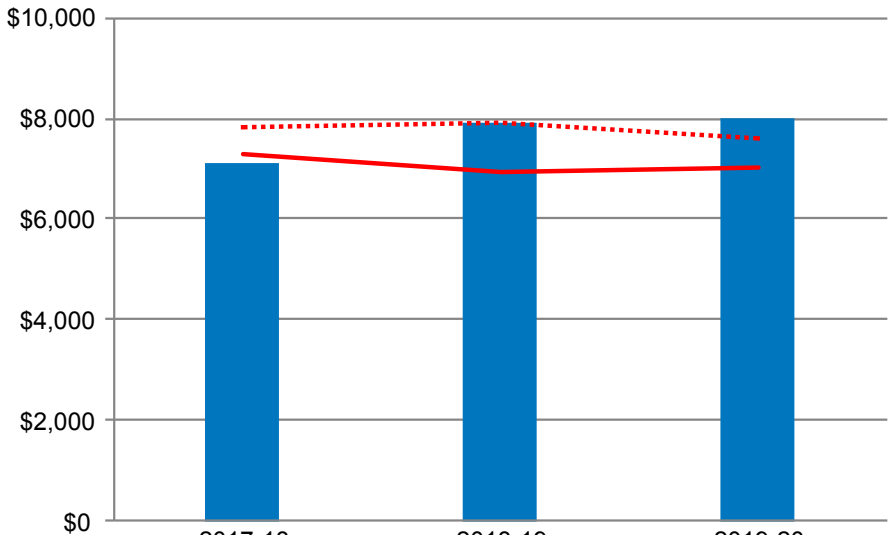
Result

The average admitted cost per weighted activity unit in 2019–20 was $7,991, which is similar to last year but above the target. It is important to note that the target was developed at a whole of WA health system level, and it applies to all Health Service Providers (HSPs), despite each having a different cost structure dependent on the nature of their operations and the facilities they work from. For instance, CAHS provides specialist paediatric services and operates a new, state of the art hospital, whereas other HSPs cater primarily to adults from older facilities subject to less depreciation.

CAHS has a Service Agreement with the Department of Health that specifies the funding it has been allocated to meet the services it delivers. This effectively sets CAHS-specific performance expectations that are higher than the Annual Report targets.

When delivering inpatient care in 2019–20, CAHS exceeded the financial expectations of its Service Agreement, which was prepared before the COVID-19 outbreak, by 5.1 per cent (Figure 14). This is a consequence of a number of COVID-19 related drivers, including completing lower than expected activity after scaling back elective surgery from 23 March – 15 June 2020 under instruction from the Director General of WA Health and the Minister for Health.

Figure 14: Average admitted cost per weighted activity unit, 2017-18 to 2019-20



	2017-18	2018-19	2019-20
Actual	$7,116	$7,937	$7,991
Agreement	$7,837	$7,903	$7,602
Target	$7,285	$6,948	$7,026

Note: Weighted activity units adjust raw activity data to reflect the complexity of services provided to treat various conditions. WA health system hospitals utilise the Australian Refined Diagnosis Related Groups classifications to assign cost weights to each diagnostic group.

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

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

Average Emergency Department cost per weighted activity unit

Rationale

This indicator is a measure of the cost per weighted activity unit (WAU) compared with the State (aggregated) target as approved by the Department of Treasury and published in Volume 1 of the 2019–20 Budget Paper No. 2.

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

Target

The 2019–20 target is $7,071 per weighted activity unit. Performance is demonstrated by a result that is equal to or below the target.

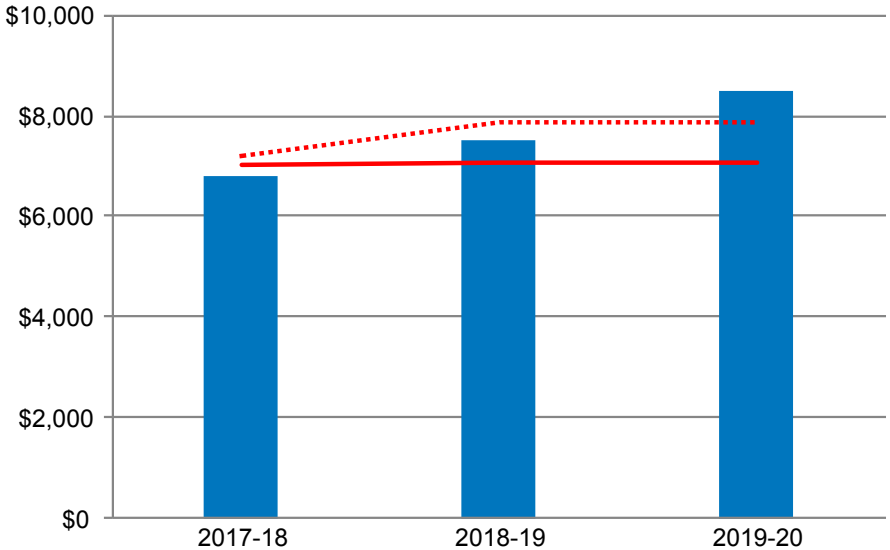
Result

The average Emergency Department cost per weighted activity unit in 2019–20 was $8,498, 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), despite each having a different cost structure dependent on the nature of their operations and the facilities they work from. For instance, CAHS provides specialist paediatric services and operates a new, state of the art hospital, whereas other HSPs cater primarily to adults from older facilities subject to less depreciation.

CAHS has a Service Agreement with the Department of Health that specifies the funding it has been allocated to meet the services it delivers. This effectively sets CAHS-specific performance expectations that are higher than the Annual Report targets.

When delivering Emergency Department care in 2019–20, CAHS exceeded the financial expectations of its Service Agreement, which was prepared before the COVID-19 outbreak, by 7.7 per cent (Figure 15). This is largely a consequence of the sharp reduction in Emergency Department attendances experienced after restrictions were put in place in response to COVID-19. Thus, the high fixed costs associated with keeping an ED permanently open could not be spread across the larger number of presentations normally experienced during the year.

Figure 15: Average Emergency Department cost per weighted activity unit, 2017-18 to 2019-20



	2017-18	2018-19	2019-20
Actual	$6,791	$7,493	$8,498
Agreement	$7,181	$7,875	$7,890
Target	$7,043	$7,072	$7,071

Note: Weighted activity units adjust raw activity data to reflect the complexity of services provided to treat various conditions. WA health system hospitals utilise the Australian Refined Diagnosis Related Groups classifications to assign cost weights to each diagnostic group.

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

Average non-admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per weighted activity unit (WAU) compared with the State (aggregated) target, as approved by the Department of Treasury and published in Volume 1 of the *2019–20 Budget Paper No. 2*.

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

Target

The 2019–20 target is $6,992 per weighted activity unit. Performance is demonstrated by a result that is equal to or below the target.

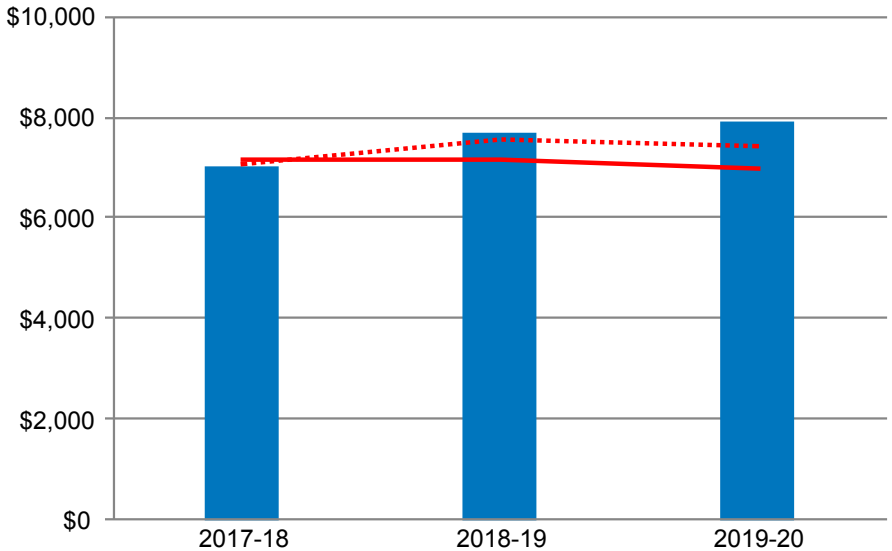
Result

The average non-admitted cost per weighted activity unit in 2019–20 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), despite each having a different cost structure dependent on the nature of their operations and the facilities they work from. For instance, CAHS provides specialist paediatric services and operates a new, state of the art hospital, whereas other HSPs cater primarily to adults from older facilities subject to less depreciation.

CAHS has a Service Agreement with the Department of Health that specifies the funding it has been allocated to meet the services it delivers. This effectively sets CAHS-specific performance expectations that are higher than the Annual Report targets.

When delivering non-admitted care in 2019–20, CAHS exceeded the financial expectations of its Service Agreement, which was prepared before the COVID-19 outbreak, by 6.7 per cent (Figure 16). This is a consequence of both the increased cost of taking precautions against the spread of COVID-19, such as increased screening of patients and carers prior to attending appointments, and the reduction in outpatient appointments experienced during the lockdown period.

Figure 16: Average non-admitted cost per weighted activity unit, 2017-18 to 2019-20



	2017-18	2018-19	2019-20
Actual	$7,018	$7,693	$7,937
Agreement	$7,076	$7,560	$7,442
Target	$7,160	$7,136	$6,992

Note: Weighted activity units adjust raw activity data to reflect the complexity of services provided to treat various conditions. WA health system hospitals utilise the Australian Refined Diagnosis Related Groups classifications to assign cost weights to each diagnostic group.

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

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

Rationale

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

Target

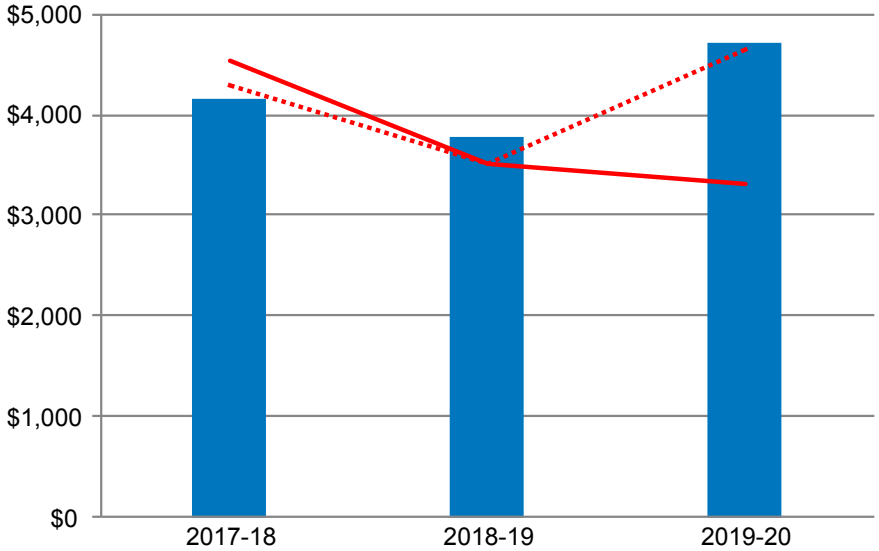
The 2019–20 target is $3,308 per bed-day. Performance is demonstrated by a result that is equal to or below the target.

Result

CAHS has a Service Agreement with the Department of Health that specifies the funding it has been allocated to meet the services it delivers. This effectively sets CAHS-specific performance expectations that are higher than the Annual Report targets.

In 2019–20, the average cost per bed-day in specialised mental health inpatient units was $4,713. This is above the target and slightly above the financial expectations of the Service Agreement (Figure 17). The increase in average cost compared with last year is due to the combined effect of a revision to how depreciation is allocated, which increased total cost, and a reduction in activity. The high average cost relative to the target is largely due to the Department of Health using a lower estimated cost when setting the target.

Figure 17: Average cost per bed-day in specialised mental health inpatient units, 2017-18 to 2019-20



	2017-18	2018-19	2019-20
Actual	$4,163	$3,769	$4,713
Agreement	$4,282	$3,517	$4,640
Target	$4,543	$3,520	$3,308

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 essential to ensure that finite funds are used effectively to deliver maximum community benefit.

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

Target

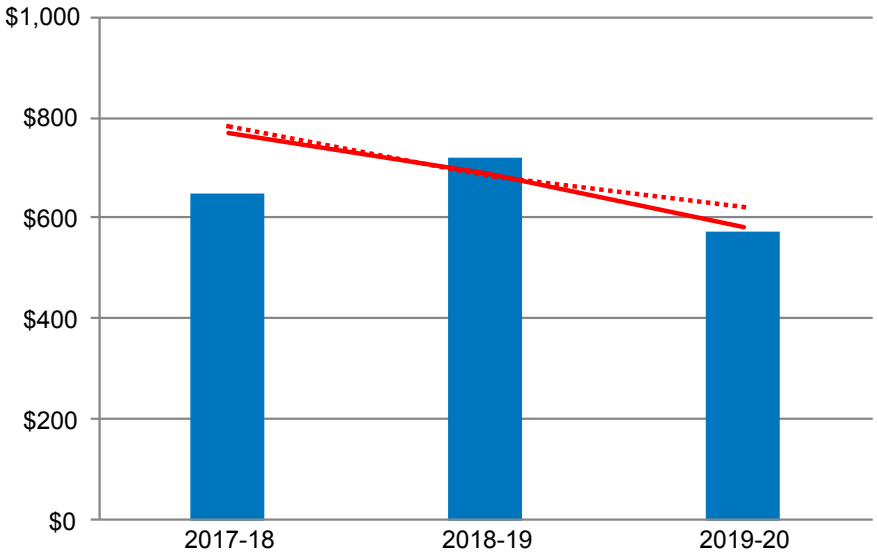
The 2019–20 target is $584 per treatment day. Performance is demonstrated by a result that is equal to or below the target.

Result

CAHS has a Service Agreement with the Department of Health that specifies the funding it has been allocated to meet the services it delivers. This effectively sets CAHS-specific performance expectations that are higher than the Annual Report targets.

In 2019–20, the average cost per treatment day of non-admitted care provided by public clinical mental health services was $575, which is below the target and lower than previous years (Figure 18). The reduction in average cost compared with last year is due to the combined effect of a revision to how depreciation is allocated, which decreased total cost, and an increase in activity.

Figure 18: Average cost per treatment day of non-admitted care provided by public clinical mental health services, 2017-18 to 2019-20



	2017-18	2018-19	2019-20
Actual	$650	$720	$575
Agreement	$784	$686	$621
Target	$771	$687	$584

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

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

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

Rationale

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

Population health aims to improve health by integrating all activities of the health sector and linking them with broader social and economic services and resources, as described in the WA Health Promotion Strategic Framework 2017–21. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

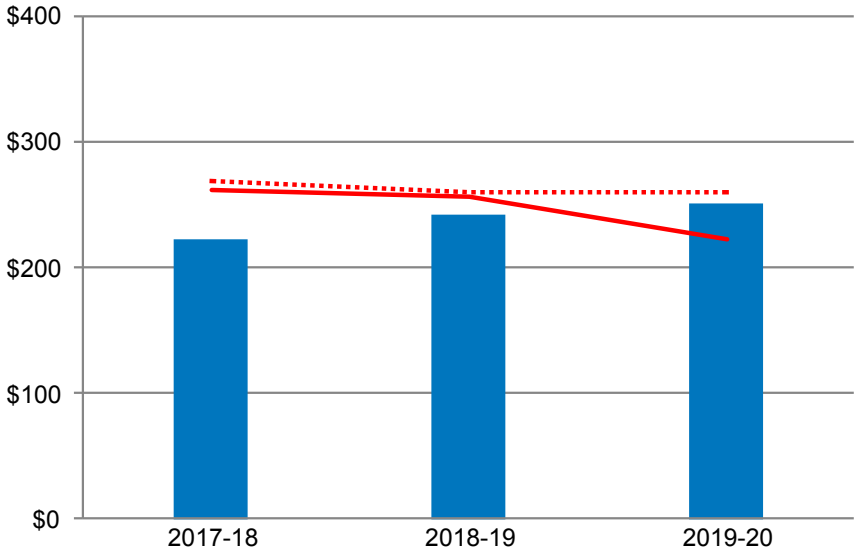
The 2019–20 target is $222 per person. Performance is demonstrated by a result that is equal to or below the target.

Result

CAHS has a Service Agreement with the Department of Health that specifies the funding it has been allocated to meet the services it delivers. This effectively sets CAHS-specific performance expectations that are higher than the Annual Report targets.

In 2019–20, the average cost per person of delivering population health programs was $251, which although above the target, remains below the financial expectations of the Service Agreement (Figure 19). The average cost is higher than the target largely due to the Department of Health using both a lower estimated cost and a higher population estimate when setting the target.

Figure 19: Average cost per person of delivering population health programs by population health units, 2017-18 to 2019-20



	2017-18	2018-19	2019-20
Actual	$222	$242	$251
Agreement	$268	$260	$259
Target	$262	$256	$222

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

Other financial disclosures

Board and committee remuneration

Annual remuneration for each board or committee is listed in Tables 9 and 10.

Table 9: Child and Adolescent Health Service Board, 2019–20

Position	Name	Type of remuneration	2019–20 period of membership	2019–20 total remuneration[1]
Chair	Ms Debbie Karasinski (Chair)	Annual	12 months	$82,997
Deputy Chair	Professor Geoffrey Dobb	Ineligible	12 months	$0
Member	Ms Kathleen Bozanic	Annual	12 months	$45,717
Member	Ms Anne Donaldson	Annual	12 months	$45,717
Member	Professor Di Twigg	Annual	12 months	$45,717
Member	Ms Miriam Bowen	Annual	12 months	$45,717
Member	Dr Alexius Julian	Annual	12 months	$45,717
Member	Dr Daniel McAullay	Annual	12 months	$45,717
Member	Mr Daniel Morrison	Annual	12 months	$45,717
Member	Mr Peter Mott	Annual	12 months	$45,717
			Total	**$448,733**

(1) includes superannuation payments

Table 10: Eating Disorders Program Consumer Advisory Group, 2019–20

Position	Name	Type of remuneration	2019–20 period of membership	2019–20 total remuneration
Member	Melanie Coleman	Per meeting	12 months	$0
Member	Casey Croghan	Per meeting	3 months	$120
Member	Linelle Fields	Per meeting	12 months	$60
Member	Natasha Hambleton	Per meeting	12 months	$120
Member	Ashleigh Hardcastle	Per meeting	12 months	$60
Member	Jade Levens	Per meeting	3 months	$60
Member	Teagan Martin	Per meeting	12 months	$0
Member	Asha McAllister	Per meeting	12 months	$0
Member	Jessica O'Neil	Per meeting	3 months	$60
Member	Emily Wheeler	Per meeting	12 months	$0
			Total	**$480**

Notes to Tables 9 and 10:

The above list of boards is as per the State Government Boards and Committees Register.

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.

Remuneration amounts can vary depending on the type of remuneration, the number of meetings attended, and whether a member submitted a remuneration claim.

'Period of membership' is defined as the period (in months) that an individual was a member of a board/committee during the 2019–20 financial year.

Pricing policy

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

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

Compensable or ineligible patients

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

Private patients (Medicare eligible Australian residents)

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

Veterans

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

Other fees and charges

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

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

Capital works

Since the CAHS Board assumed governance responsibilities in September 2018, works for the Perth Children's Hospital Project have continued and are ongoing. Works include refinements and enhancements to the hospital facilities and ICT infrastructure to improve workflows, safety and security.

The construction of a new pharmaceutical manufacturing facility (Auspman Facility) is due to be completed in May 2021, with operations commencing July 2021. The total project budget is $5.725m. The estimated remaining cost to complete the project at 30 June 2020 is $4.947m. The facility will be located on a commercially leased site in Balcatta.

The Medical Equipment Replacement Program also completed capital works in 2019–20. Table 11 shows the financial details of the capital works program.

Table 11: Major asset investment program works completed in 2019–20

Capital works programs completed	2019–20 ($'000)
Medical equipment replacement program	2,573
Minor building works and other plant and equipment	85
Total	**2,659**

Governance disclosures

Indemnity insurance

In 2019–20, the amount of insurance premium paid to indemnify any 'director' (as defined in Part 3 of the *Statutory Corporations (Liability of Directors) Act 1996*) against a liability incurred under sections 13 or 14 of that Act was $58,023.

Government policy requirements

Pecuniary interests

Senior officers of government are required to declare any interest in an existing or proposed contract that has, or could result in, the member receiving financial or other benefits. In 2019–20, no Child and Adolescent Health Service senior officer declared a pecuniary interest.

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 2019–20.

Advertising expenses

In accordance with section 175Z of the *Electoral Act 1907*, CAHS incurred the following advertising expenditure in 2019–20 (see Table 12).

Unauthorised use of credit cards

In accordance with State Government policy, CAHS has issued corporate credit cards to certain employees where their functions warrant usage of this facility for purchasing goods and services. These credit cards are not to be used for personal (unauthorised) purposes. Despite each cardholder being reminded annually of their obligations under the credit card policy, six employees inadvertently utilised the corporate credit card for personal expenditure on six occasions. Review of these transactions confirmed that they were the result of honest mistakes. Notification and full repayments were made by the employees concerned (Table 13).

Table 12: Summary of advertising for 2019–20

Summary of advertising	Amount
Advertising agencies	$0
Market research organisations	$0
Polling organisations	$0
Direct mail organisations	$0
Media advertising organisations	
Australian College of Emergency Medicine	$550
Australia & New Zealand College of Anaesthetists	$850
Facebook	$7,027
Initiative Media	$363
LinkedIn	$500
Royal Australian College of Physicians	$66
Total advertising expenditure	**$9,356**

Table 13: Credit card personal use expenditure in 2019–20

Credit card personal use expenditure	2019–20
Aggregate amount of personal use expenditure for the reporting period	$54.86
Aggregate amount of personal use expenditure settled by the due date (within 5 working days)	$18.89
Aggregate amount of personal use expenditure settled after the period (after 5 working days)	$35.79
Aggregate amount of personal use expenditure outstanding at the end of the reporting period	$0

Disability Access and Inclusion Plan outcomes

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

Access to service and events

There has been a large increase in the use of telehealth clinics across CAHS in response to the COVID-19 pandemic. This has maintained access to services for many families and children during this time, and improved access for those who find it difficult to attend all appointments face to face at the health service sites.

Access to equipment provided by CAHS to assist people with disabilities access services is being reviewed to improve access at all times. 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. Information about facility access at all CAHS sites is being reviewed to improve service delivery at accessible locations.

Access to information

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

Quality of service by staff

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 Consumer Engagement Team 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 Consumer Engagement Team 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 has been completed and a new Disability Access and Inclusion Committee formed with a clear remit to act as an advisory committee for CAHS with monitoring responsibility for the Disability Access and Inclusion Plan. This review included consultation with consumers about the new committee and active recruitment to attract more participants.

Opportunities to obtain and maintain employment

CAHS uses inclusive recruitment practices and encourages people with disability to apply for positions advertised across the organisation. CAHS is working with disability employment providers to actively recruit and employ people with disabilities, and ensure that workplaces are tailored to employee needs. People with disabilities are employed in a variety of roles at CAHS.

Record keeping plans

The *State Records Act 2000* (the Act) was established to mandate the standardisation of statutory record keeping practices for every State Government agency. Government agency practice is subject to the provision of the Act, the standards and policies. Government agencies are also subject to scrutiny by the State Records Commission (SRC). Section 19 of the Act states that every government organisation must have a Record Keeping Plan (RKP) that has been approved by the State Records Commission.

The CAHS RKP was approved by the SRC on 26 November 2015. The five year review was conducted and identified the need to prepare a new plan. The State Records Office is developing new templates and tools for preparing an RKP to be released late 2020, so an extension has been granted to 29 January 2021.

The CAHS induction and orientation program provides new, casual and agency employees with relevant information to their employment within six weeks of commencement. The program includes reference to the WA Health Code of Conduct, which includes best practice records management for clinical and corporate information, and workplace specific work practices and procedures. Targeted My Health Record training is provided for administrative and clinical staff.

CAHS staffs 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. 231 staff have attended regularly scheduled classroom based training and completed a training evaluation form that identifies the effectiveness of the training delivery and content. The CAHS Records and Compliance intranet site contains training resources, quick help guides, policies, procedures, work instructions and supporting information to enable staff to comply with the Act.

An internal audit of CAHS Corporate Records Management was conducted by KPMG in January 2020. The audit assessed the controls and processes in place to encourage compliance at an entity level with the Act, and the adequacy and suitability of the CAHS corporate records management control environment. The Auditors note several strengths in CAHS approach to corporate records management,

including the very positive 'tone at the top' around CAHS' dedication to moving towards exclusive use of the EDRMS for corporate records retention. The key findings included two emerging issues and four findings regarding the management of corporate records within CAHS. The findings related to system access controls within the EDRMS, processes in place to manage hardcopy records, guidance available to staff regarding records management and monitoring of compliance with relevant records practices. Detailed recommendations and actions identified in the audit will be completed by June 2021.

CAHS is committed to the continuing deployment of the EDRMS throughout all corporate areas, and during this reporting period, 210,800 records were captured into the EDRMS. Health Information and Administrative Services and the Corporate Records and Compliance team provide ongoing advisory services for the retention and disposal of records, and contribute to the development of policies and procedures that result in creation and management of records.

Substantive equality

CAHS aims to achieve equitable outcomes for all our clients by recognising and promoting awareness of the different needs of our client groups. In particular, CAHS addresses the unique needs of people with disabilities, Aboriginals and refugees through initiatives such as the Disability Access and Inclusion Committee (page 71), and programs directed at improving Aboriginal health (page 48) and refugee health (page 52).

Additional refugee health initiatives

The PCH Refugee Health Service (RHS) and Community Refugee Health Team are committed to identifying, modifying and eliminating institutional and wider health access barriers for refugee and asylum-seeker patients. Refugee health staff undertake quality assurance processes and clinical research, and work in partnership with key non-government organisations providing services to refugees. Identifying gaps in systems or clinical services allows development of improvement strategies, and continuous quality assurance and clinical research themes align strongly with the 2019 WA Sustainable Health Review priority populations and key strategic recommendations.

Quality and safety improvements

RHS has undertaken quality improvement audits to identify gaps in health service delivery. One recent audit found many patients with limited English proficiency have refugee-like backgrounds, and highlighted the need for the broader use of professional interpreters by staff. The results were presented at the 2019 Child and Adolescent Health Research Symposium and received the 2019 Royal Australasian College of Physicians Paediatric Trainee Research Award (WA). The RHS team was also invited to lead the inaugural 2019 Academy of Child and Adolescent Health Conference Workshop on improving interpreter use within health settings. Qualitative research is presently underway to identify barriers and facilitators to interpreter use within PCH.

Another RHS audit outlined the significant socioeconomic vulnerability of refugee families following resettlement. These vulnerabilities are accompanied by superimposed mental health risks and trauma and cumulative adverse childhood experiences. Increasing culturally targeted social work and mental health support within CAHS is essential

to achieve positive health outcomes for refugee children and families.

Further improvements are required to improve substantive equity for refugee patients and those with limited English proficiency. Future goals include employment of bilingual staff from refugee-like backgrounds, increasing health access for 16-18 year old refugee adolescents, developing outreach capacity, and strengthening refugee health service delivery across CAHS.

Improving cultural competence

RHS continues to provide interdisciplinary health education to improve cross-cultural competence within CAHS. RHS staff teach medical, dental, nursing and allied health students and staff. A new two-part cross-cultural training module for junior doctors has been piloted, and evaluations are underway. The University of Western Australia Crossing Borders for Health RHS Cultural Competence attachment continues to be well-regarded. The PCH RHS was showcased as a health care model attaining health care equity in the 2019 WA Health Consumer's Council: World Kindness Day and the 2019 Office of Multicultural Affairs' Cultural Diversity Unit's Multicultural Diversity Café 10: Improving health equity for young people from culturally and linguistically diverse backgrounds. RHS staff were also invited to speak at the 2019 Sydney Children's Hospital Network Refugee Health Conference and lecture at the 2019 Harvard Refugee Trauma Course.

Annual estimates for 2020–21

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 can only be prepared after the WA State Budget has been handed down, which for 2020–21 is after the date of Annual Report publication.

Abbreviations

AHT	Aboriginal Health Team
ALS	Aboriginal Liaison Service
AIM	Australian Institute of Management
CES	Carer Experience of Service
CVAD	Central Venous Access Device
CEO	Chief Executive Officer
CAHS	Child and Adolescent Health Service
CAMHS	Child and Adolescent Mental Health Services
CDS	Child Development Service
CNS	Clinical Nurse Specialist
CAC	Consumer Advisory Council
CCHRN	Consumer and Community Health Research Network
DVA	Department of Veterans' Affairs
ENT	Ear, Nose and Throat
EDRMS	Electronic Document and Records Management System
ED	Emergency Department
EMU	Emergency Management Unit
ETS	Emergency Telephone Service
ESQ	Experience of Service Questionnaire
FBH	Footprints to Better Health
HSP	Health Service Provider
HAI	Healthcare Associated Infection
HA-SABSI	Healthcare-associated Staphylococcus aureus bloodstream infection
HAC	Hospital Acquired Complication
HiTH	Hospital in the Home
HREC	Human Research Ethics Committee
ICT	Information and Communications Technology
KEMH	King Edward Memorial Hospital
LfE	Learning from Excellence
NSQHS	National Safety and Quality Health Service
NETS	Neonatal Emergency Transport Service
NICU	Neonatal Intensive Care Unit
NGO	Non-Government Organisation
NMHS	North Metropolitan Health Service
OSH	Occupational Safety and Health
PREM Bank	Perron Rotary Express Milk Bank
PPE	Personal Protective Equipment
PCH	Perth Children's Hospital
PSC	Public Sector Commission
RAP	Reconciliation Action Plan
RKP	Record Keeping Plan
RHS	Refugee Health Service
RHT	Refugee Health Team
ROP	Retinopathy of Prematurity
RHD	Rheumatic Heart Disease
RACP	Royal Australasian College of Physicians
SEHA	School Entry Health Assessment
SAC	Severity Assessment Code
SCGH	Sir Charles Gairdner Hospital
SSAMHS	Specialised Statewide Aboriginal Mental Health Service
SRC	State Records Commission
SHR	Sustainable Health Review
TCI	Therapeutic Crisis Intervention
TCI-f	Therapeutic Crisis Intervention for families
UWA	University of Western Australia
WACHS	WA Country Health Service
WA PPCS	WA Paediatric Palliative Care Service
WAU	Weighted Activity Unit
YES	Your Experience of Service
YAC	Youth Advisory Committee

This mural at PCH was inspired by the flora and fauna of nearby King's Park and painted by artist Melski (Mel McVee) with help from patients. It was developed through the CAHS Artist in Residence Program and funded by the PCH Foundation.

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Child and Adolescent Health Service

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