

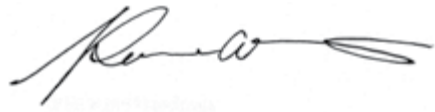
Key performance indicators

Certification of key performance indicators

Child and Adolescent Health Service

Certification of Key Performance Indicators for the year Ended 30 June 2021

We hereby certify that the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the Child and Adolescent Health Service's performance, and fairly represent the performance of the Child and Adolescent Health Service for the reporting period ended 30 June 2021.



Dr Rosanna Capolingua

BOARD CHAIR
CHILD AND ADOLESCENT HEALTH SERVICE
2 September 2021



Prof Geoffrey Dobb

DEPUTY BOARD CHAIR
CHILD AND ADOLESCENT HEALTH SERVICE
2 September 2021



The relationship between the following key performance indicators and the Government Goal, Outcomes and Services is described in the Performance Management Framework section commencing on page 32.

The latest available data has been used to report performance, which in some instances means results are for the 2020 calendar year.

KPIs measuring Outcome 1

Unplanned hospital readmissions for patients within 28 days for selected surgical procedures p. 218

Percentage of elective wait list patients waiting over boundary for reportable procedures p. 220

Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days..... p. 221

Percentage of admitted patients who discharged against medical advice: a) Aboriginal patients; and b) Non-Aboriginal patients p. 222

Readmissions to acute specialised mental health inpatient services within 28 days of discharge p. 223

Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services p. 224

Average admitted cost per weighted activity unit p. 225

Average Emergency Department cost per weighted activity unit p. 226

Average non-admitted cost per weighted activity unit p. 227

Average cost per bed-day in specialised mental health inpatient services p. 228

Average cost per treatment day of non-admitted care provided by mental health services p. 229

KPIs measuring Outcome 2

Average cost per person of delivering population health programs by population health units p. 230

EFFECTIVENESS KPI – OUTCOME 1:**PUBLIC HOSPITAL BASED SERVICES THAT ENABLE EFFECTIVE TREATMENT AND RESTORATIVE HEALTH CARE FOR WESTERN AUSTRALIANS****Unplanned hospital readmissions for patients within 28 days for selected surgical procedures****Rationale**

Unplanned hospital readmissions may reflect less than optimal patient management and ineffective care pre-discharge, post-discharge and/or during the transition between acute and community-based care.¹⁰ These readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

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

The surgeries selected for this indicator are based on those in the current National Health Agreement Unplanned Readmission performance indicator (NHA PI 23).

¹⁰ Australian Institute of Health and Welfare (2009). *Towards national indicators of safety and quality in health care. Cat. no. HSE 75. Canberra: AIHW. Available at: <https://www.aihw.gov.au/reports/health-care-quality-performance/towards-national-indicators-of-safety-and-quality/contents/table-of-contents>*

Target

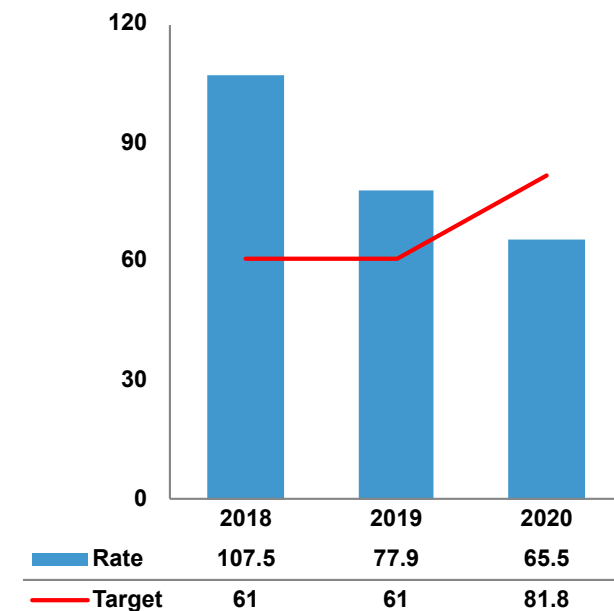
The 2020 targets are based on the total child and adult population, and for each procedure is:

Surgical Procedure	Target (per 1,000)
Tonsillectomy & Adenoidectomy	≤81.8
Appendicectomy	≤25.7

Results**Tonsillectomy & Adenoidectomy**

The rate of unplanned readmission for tonsillectomy and adenoidectomy was 65.5 per 1,000, which is lower than previous years and below the target of 81.8 per 1,000. (Figure 5).

Figure 5: Rate of unplanned hospital readmissions for patients within 28 days for tonsillectomy and adenoidectomy, 2018 to 2020

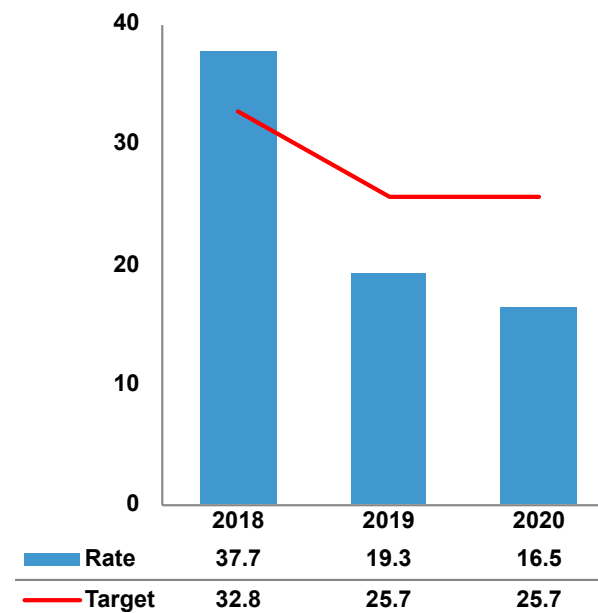


Data sources: Hospital Morbidity Data Collection, WA Data Linkage System.

Appendicectomy

The rate of unplanned readmissions for appendicectomy was 16.5 per 1,000, which is lower than previous years and below the target of 25.7 per 1,000 (Figure 6).

Figure 6: Rate of unplanned hospital readmissions for patients within 28 days for appendicectomy, 2018 to 2020



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

EFFECTIVENESS KPI – OUTCOME 1:**PUBLIC HOSPITAL BASED SERVICES THAT ENABLE EFFECTIVE TREATMENT AND RESTORATIVE HEALTH CARE FOR WESTERN AUSTRALIANS****Percentage of elective wait list patients waiting over boundary for reportable procedures****Rationale**

Elective surgery refers to planned surgery that can be booked in advance following specialist assessment that results in placement on an elective surgery waiting list.

Elective surgical services delivered in the WA health system are those deemed to be clinically necessary. Excessive waiting times for these services can lead to deterioration of the patient's condition and/or quality of life, or even death¹¹. Waiting lists must be actively managed by hospitals to ensure fair and equitable access to limited services, and that all patients are treated within clinically appropriate timeframes.

Patients are prioritised based on their assigned clinical urgency category:

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

Target

The 2020–21 target is zero per cent for each urgency category. Performance is demonstrated by a result that is equal to the target.

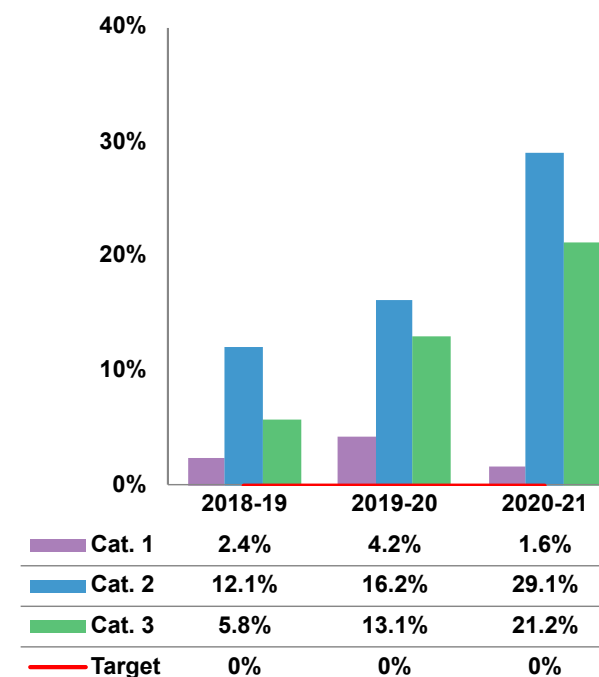
¹¹ Derrett, S., Paul, C., Morris, J.M. (1999). *Waiting for Elective Surgery: Effects on Health-Related Quality of Life, International Journal of Quality in Health Care, Vol 11 No. 1, 47-57.*

Results

In 2020–21, CAHS' performance with surgical waitlisting of patients and treating them within recommended timeframes improved for the most urgent surgeries (Category 1) but declined for those less urgent (Categories 2 and 3) when averaged across the entire year. Figure 7 shows an average of 1.6 per cent of Category 1 patients were not treated within 30 days, 29.1 per cent of Category 2 patients were not treated within 90 days, and 21.2 per cent of Category 3 patients were not treated within 365 days.

CAHS prioritises the treatment of patients with the most urgent clinical need, i.e. those awaiting elective procedures deemed Category 1, as evidenced by the very small proportion of those whose wait time exceeded the recommended period. The decline in performance for Category 2 and 3 surgeries was due to this prioritisation and the cumulative effects of instances where elective surgeries had to cease or be scaled back in 2020 and 2021 due to COVID-19 related drivers. This includes the reduction in surgical activity between 23 March and 15 June 2020 that occurred on instruction from the Director General of WA Health and the Minister for Health, and the additional impact of further instructions to reduce surgeries during lockdown periods that commenced in January, April and June 2021.

Figure 7: Percentage of elective wait list patients waiting over boundary for reportable procedures, by urgency category, 2018–19 to 2020–21



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

EFFECTIVENESS KPI – OUTCOME 1:

PUBLIC HOSPITAL BASED SERVICES THAT ENABLE EFFECTIVE TREATMENT AND RESTORATIVE HEALTH CARE FOR WESTERN AUSTRALIANS

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

Rationale

Staphylococcus aureus bloodstream infection is a serious infection that may be associated with the provision of healthcare. *Staphylococcus aureus* is a highly pathogenic organism and even with advanced medical care, infection is associated with prolonged hospital stays, increased healthcare costs and a marked increase in morbidity and mortality (SABSI mortality rates are estimated at 20–25 per cent¹² in adults and five per cent in children).

HA-SABSI is generally considered to be a preventable adverse event associated with the provision of healthcare, therefore this KPI is a robust measure of the safety and quality of care provided by WA public hospitals. A low or decreasing HA-SABSI rate is desirable, and the WA target reflects the nationally agreed benchmark.

Target

The 2020 target is ≤1.0 HA-SABSI per 10,000 occupied bed-days.

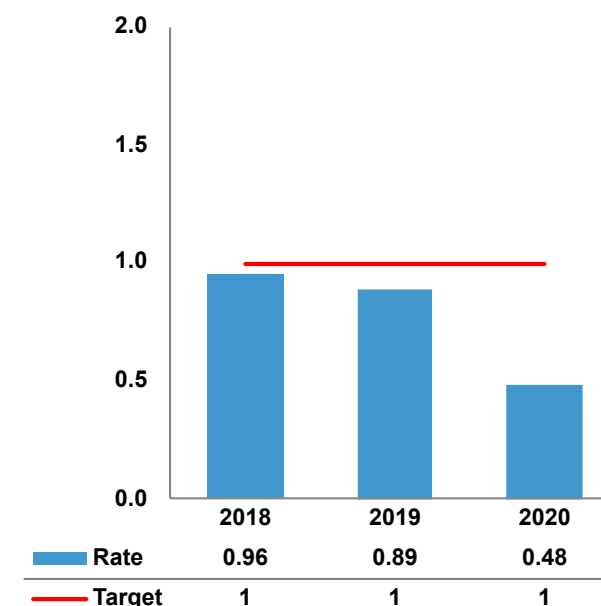
Result

CAHS provides a range of specialised services, including emergency medicine, intensive care,

cardiothoracic surgery and oncology. Many patients are therefore at higher risk of *Staphylococcus aureus* (*S. aureus*) infection than those at hospitals providing less specialised services. Despite this, CAHS reduced its *S. aureus* bloodstream infection rate in 2020 to 0.48 per 10,000 occupied bed-days, which is almost half last year’s result and well below the WA health system target of 1.0 per 10,000 bed-days (Figure 8).

The favourable result is due to a number of initiatives CAHS has in place to prevent *S. aureus* infection, particularly the dedicated central venous access device (CVAD) insertion and management service. New to 2020 was the introduction of CVAD bundles, which are evidence-based practices that cause significant improvement in outcomes for patients with CVADs in place.

Figure 8: Healthcare associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days, 2018 to 2020



Data source: Healthcare Infection Surveillance Western Australia Data Collection.

¹² van Hal, S. J., Jensen, S. O., Vaska, V. L., Espedido, B. A., Paterson, D. L., & Gosbell, I. B. (2012). Predictors of mortality in *Staphylococcus aureus* Bacteremia. *Clinical microbiology reviews*, 25(2), 362–386. doi:10.1128/CMR.05022-11

EFFECTIVENESS KPI – OUTCOME 1:**PUBLIC HOSPITAL BASED SERVICES THAT ENABLE EFFECTIVE TREATMENT AND RESTORATIVE HEALTH CARE FOR WESTERN AUSTRALIANS****Percentage of admitted patients who discharged against medical advice: a) Aboriginal patients; and b) Non-Aboriginal patients****Rationale**

Discharge against medical advice (DAMA) refers to patients leaving hospital against the advice of their treating medical team or without advising hospital staff (e.g. absconding or missing and not found). Patients who do so have a higher risk of readmission and mortality¹³ and have been found to cost the health system 50 per cent more than patients who are discharged by their physician.¹⁴

Between July 2013 and June 2015, Aboriginal patients in WA were almost 12.7 times more likely than non-Aboriginal patients to discharge against medical advice, compared with seven times nationally¹⁵. 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

¹³ Yong et al. *Characteristics and outcomes of discharges against medical advice among hospitalised patients. Internal medicine journal* 2013;43(7):798-802.

¹⁴ Aliyu ZY. *Discharge against medical advice: sociodemographic, clinical and financial perspectives. International journal of clinical practice* 2002;56(5):325-27.

¹⁵ Commonwealth of Australia. (2017). *Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report*, Commonwealth of Australia, Canberra.

treatment outcomes for Aboriginal patients. While the aim is to achieve equitable treatment outcomes for Aboriginal patients, the targets reflect the need for a long-term approach to progressively closing the gap between Aboriginal and non-Aboriginal patient cohorts.

Target

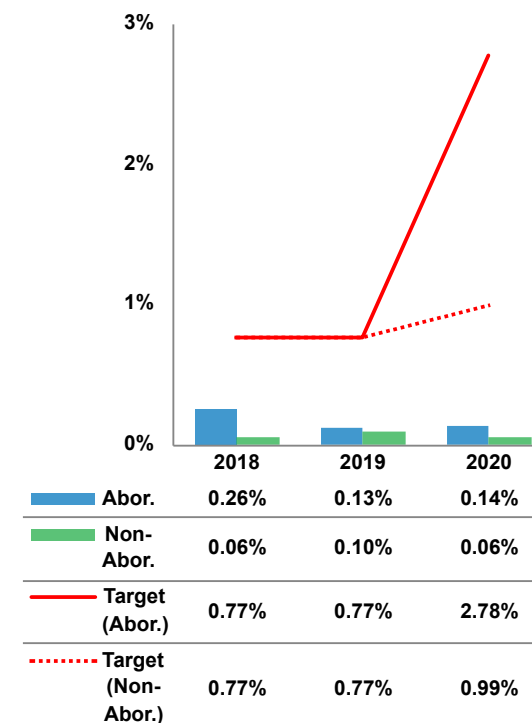
The 2020 targets are based on the total child and adult population:

	Target
Aboriginal patients	≤2.78%
Non-Aboriginal patients	≤0.99%

Results

In 2020, CAHS recorded a rate of discharge against medical advice of 0.14 per cent for Aboriginal patients, which is similar to last year and well below the target of 2.78 per cent. For non-Aboriginal patients, the rate was 0.06 per cent, which is lower than last year and also well below the target of 0.99 per cent (Figure 9). A contributing factor to the favourable result for Aboriginal patients is the Kooringly Moort (Walking with Families) program, which engages with Aboriginal people early and improves communication between health care services in and out of hospital.

Figure 9: Percentage of admitted patients who discharged against medical advice, 2018 to 2020



Data source: Hospital Morbidity Data Collection.

EFFECTIVENESS KPI – OUTCOME 1:

PUBLIC HOSPITAL BASED SERVICES THAT ENABLE EFFECTIVE TREATMENT AND RESTORATIVE HEALTH CARE FOR WESTERN AUSTRALIANS

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

Rationale

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

While multiple hospital admissions over a lifetime may be necessary for someone with ongoing illness, a high proportion of readmissions shortly after discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was not adequate to maintain the patient's recovery out of hospital.¹⁶ These readmissions mean that patients spend additional time in hospital and utilise additional resources. A low readmission rate suggests that good clinical practice is in operation.

Readmissions are attributed to the facility at which the initial separation (discharge) occurred rather than the facility to which the patient was readmitted. By monitoring this indicator, key areas for improvement can be identified. This can facilitate the development and delivery of targeted care pathways and interventions aimed at improving the mental health and quality of life of Western Australians.

¹⁶ Australian Health Ministers Advisory Council Mental Health Standing Committee (2011). *Fourth National Mental Health Plan Measurement Strategy*. Available at: <https://www.aihw.gov.au/getmedia/d8e52c84-a53f-4eeef-a7e6-f81a5af94764/Fourth-national-mental-health-plan-measurement-strategy-2011.pdf.aspx>

Target

The 2020 target is ≤12 per cent.¹⁷

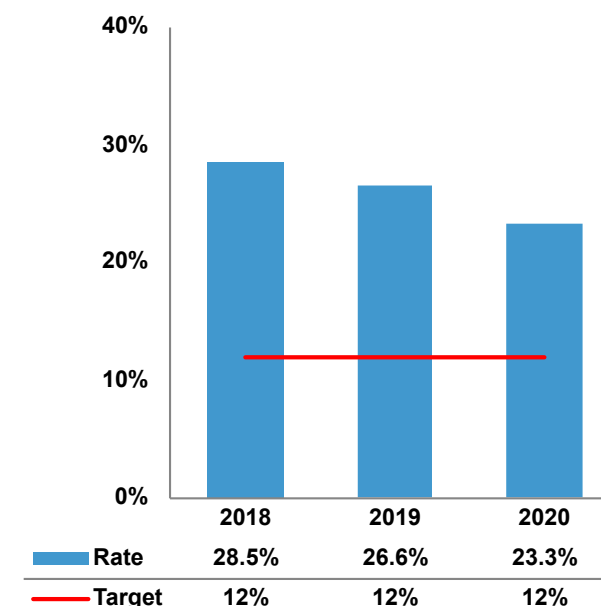
Result

Although above the target of 12 per cent, the rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit in 2020 improved for the second successive year to 23.3 per cent (Figure 10). The reduction is in part due to the commencement of the Emergency Telehealth Service to provide mental health assessments within the home.

It should be noted that this indicator does not distinguish between planned and unplanned readmissions. Child and Adolescent Mental Health Services provide planned admissions for those who require frequent inpatient admissions and non-acute interventions as part of their care. The record high bed occupancy of the mental health ward in 2020 also contributed to a reduction in planned readmissions.

¹⁷ The source of this target was the *Fourth National Mental Health Measurement Strategy (May 2011)* produced by the *Mental Health Information Strategy Subcommittee*, Australian Health Ministers' Advisory Council, Mental Health Standing Committee. [http://www.health.gov.au/internet/main/publishing.nsf/content/1ED20240320A3A11CA257D9B007B31C6/\\$File/meas.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/1ED20240320A3A11CA257D9B007B31C6/$File/meas.pdf)

Figure 10: Readmissions to acute specialised mental health inpatient services within 28 days of discharge, 2018 to 2020



Data source: Hospital Morbidity Data Collection

EFFECTIVENESS KPI – OUTCOME 1:**PUBLIC HOSPITAL BASED SERVICES THAT ENABLE EFFECTIVE TREATMENT AND RESTORATIVE HEALTH CARE FOR WESTERN AUSTRALIANS****Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services****Rationale**

In 2017–18, one in five (4.8 million) Australians reported having a mental or behavioural condition.¹⁸ Therefore, it is crucial to ensure effective and appropriate care is provided not only in a hospital setting but also in the community.

Discharge from hospital is a critical transition point in the delivery of mental health care. People leaving hospital after an admission for an episode of mental illness have increased vulnerability and, without adequate follow up, may relapse or be readmitted.

The standard underlying this measure is that continuity of care requires prompt community follow-up in the period following discharge from hospital. A responsive community support system for persons who have experienced a psychiatric episode requiring hospitalisation is essential to maintain their clinical and functional stability, and to minimise the need for hospital readmissions. Patients leaving hospital after a psychiatric admission with a formal discharge plan that includes links with public community based services and support are less likely to need avoidable hospital readmissions.

¹⁸ <https://www.abs.gov.au/ausstats/abs@.nsf/mf/4364.0.55.001>

Target

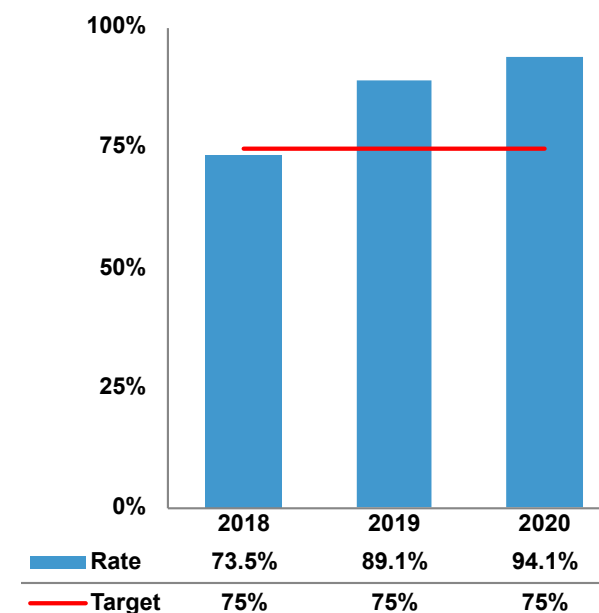
The 2020 target is ≥ 75 per cent.

Result

In 2020, 94.1 per cent of young people who were admitted to CAHS acute specialised mental health inpatient services or their carers were contacted by a community-based public mental health non-admitted health service within seven days of discharge, which is well above the target of 75 per cent (Figure 11). The creation of the Emergency Telehealth Service in 2020 contributed to this improvement by establishing a formal process of follow up for those young people discharged to private and not-for-profit care providers.

The improvement in performance since 2018 is also partly due to revision to the methodology in accordance with the national definition to include contacts with carers. This is considered particularly appropriate and relevant where, for example, the patient is a minor.

Figure 11: Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services, 2018 to 2020



Data source: Mental Health Information Data Collection, Hospital Morbidity Data Collection.

**EFFICIENCY KPI – OUTCOME 1 – SERVICE 1:
PUBLIC HOSPITAL ADMITTED SERVICES**

Average admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per weighted activity unit (WAU) compared with the State (aggregated) target, as approved by the Department of Treasury and published in Volume 1 of the 2020–21 Budget Paper No. 2.

The measure ensures a consistent methodology is applied to calculating and reporting the cost of delivering inpatient activity against the State's funding allocation. As admitted services received nearly half of the overall 2020–21 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

Target

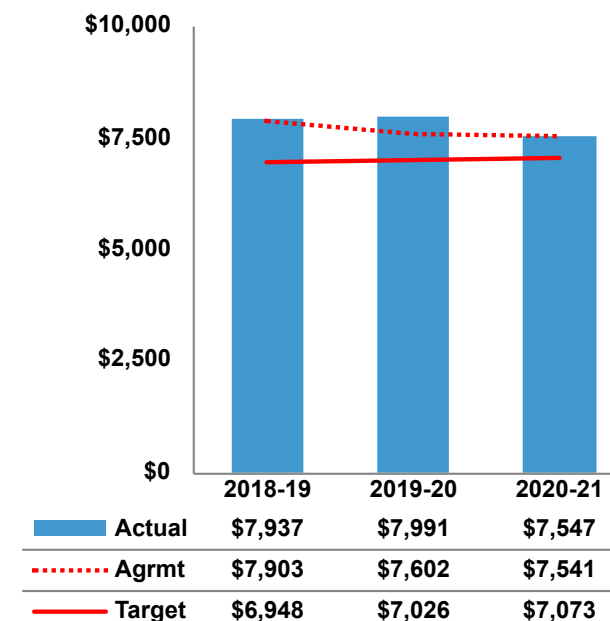
The 2020–21 target is ≤\$7,073 per weighted activity unit.

Result

The average admitted cost per weighted activity unit fell to \$7,547 in 2020–21, which is 6.7 per cent above the target. It is important to note that the target was developed at a whole of WA health system level, and it applies to all Health Service Providers (HSPs), despite each having a different cost structure dependent on the nature of their operations and the facilities they work from. For instance, CAHS provides specialist paediatric services and operates a new, state of the art hospital, whereas other HSPs cater primarily to adults from older facilities subject to less depreciation.

CAHS has a Service Agreement with the Department of Health that specifies the funding it has been allocated to meet the services it delivers. This effectively set a CAHS-specific performance expectation that is higher than the Annual Report target. By that standard, CAHS performed at expectation by being less than 0.1 per cent above the value determined by the Service Agreement (Figure 12).

Figure 12: Average admitted cost per weighted activity unit, 2018–19 to 2020–21



Note: Weighted activity units adjust raw activity data to reflect the complexity of services provided to treat various conditions. WA health system hospitals utilise the Australian Refined Diagnosis Related Groups classifications to assign cost weights to each diagnostic group.

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

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

Average Emergency Department cost per weighted activity unit

Rationale

This indicator is a measure of the cost per weighted activity unit (WAU) compared with the State (aggregated) target as approved by the Department of Treasury and published in Volume 1 of the 2020–21 Budget Paper No. 2.

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

Target

The 2020–21 target is ≤\$6,853 per weighted activity unit.

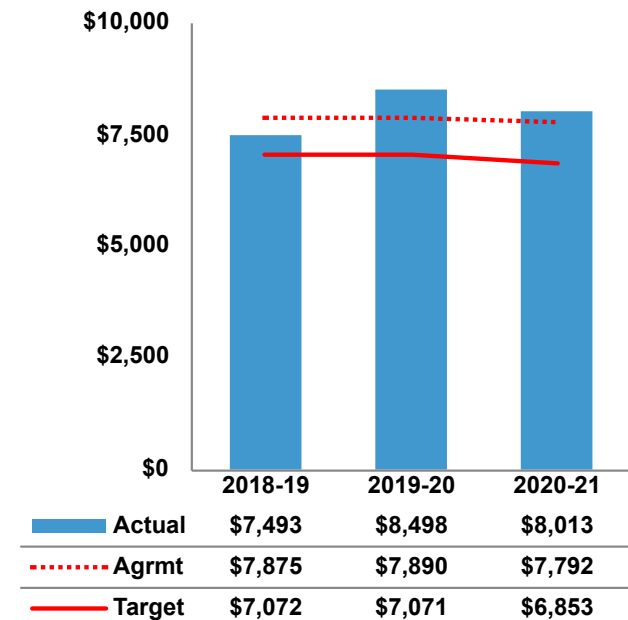
Result

The average Emergency Department cost per weighted activity unit fell to \$8,013 in 2020–21, which is 16.9 per cent above the target. It is important to note that the target was developed at a whole of WA health system level, and it applies to all Health Service Providers (HSPs), despite each having a different cost structure dependent on the nature of their operations and the facilities they work from. For instance, CAHS provides specialist paediatric services and operates a new, state of the art hospital,

whereas other HSPs cater primarily to adults from older facilities subject to less depreciation.

CAHS has a Service Agreement with the Department of Health that specifies the funding it has been allocated to meet the services it delivers. This effectively set a CAHS-specific performance expectation that is higher than the Annual Report target. By that standard, CAHS' performance was slightly unfavourable in 2020–21, being 2.8 per cent above the value determined by the Service Agreement (Figure 13).

Figure 13: Average Emergency Department cost per weighted activity unit, 2018–19 to 2020–21



Note: Weighted activity units adjust raw activity data to reflect the complexity of services provided to treat various conditions. WA health system hospitals utilise the Australian Refined Diagnosis Related Groups classifications to assign cost weights to each diagnostic group.

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

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

Average non-admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per weighted activity unit (WAU) compared with the State (aggregated) target, as approved by the Department of Treasury and published in Volume 1 of the 2020-21 Budget Paper No. 2.

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

Target

The 2020-21 target is ≤\$7,025 per weighted activity unit.

Result

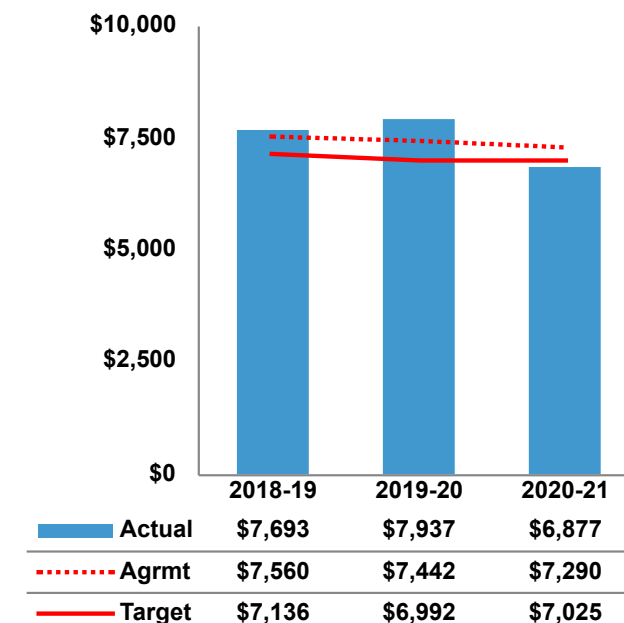
The average non-admitted cost per weighted activity unit fell significantly in 2020-21 to \$6,877. This is 2.1 per cent below the target developed at a whole of WA health system level that applies to all Health Service Providers (HSPs), despite each having a different cost structure dependent on the nature of their operations and the facilities they work from. For instance, CAHS provides specialist paediatric services and operates a new, state of the art hospital,

whereas other HSPs cater primarily to adults from older facilities subject to less depreciation.

CAHS has a Service Agreement with the Department of Health that specifies the funding it has been allocated to meet the services it delivers. This effectively set a CAHS-specific performance expectation that is higher than the Annual Report target. By that standard, CAHS’ performance remained favourable, being 5.7 per cent lower than the value determined by the Service Agreement (Figure 14).

Improved financial performance in 2020-21 is attributable to both higher activity and a revision to how the Independent Hospital Pricing Authority weights activity to account for paediatric patients.

Figure 14: Average non-admitted cost per weighted activity unit, 2018-19 to 2020-21



Note: Weighted activity units adjust raw activity data to reflect the complexity of services provided to treat various conditions. WA health system hospitals utilise the Australian Refined Diagnosis Related Groups classifications to assign cost weights to each diagnostic group.

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

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

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

Rationale

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

Target

The 2020–21 target is ≤\$3,815 per bed-day.

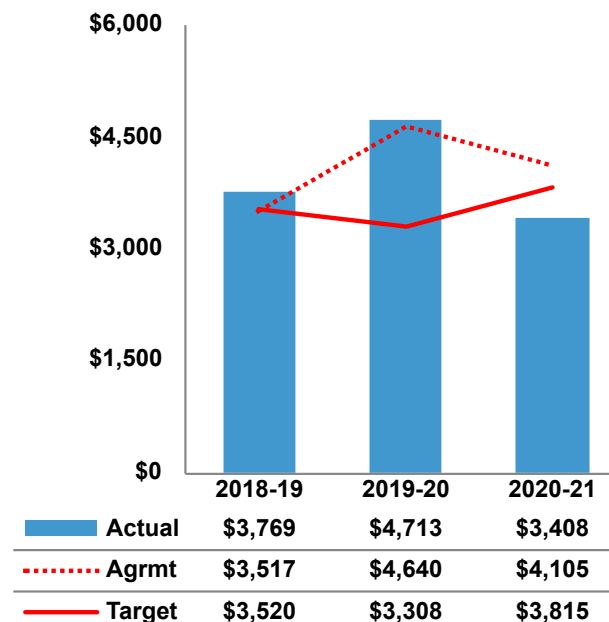
Result

The average cost per bed-day in specialised mental health inpatient services fell significantly in 2020–21 to \$3,408 which is 10.7 per cent below the target.

CAHS has a Service Agreement with the Department of Health that specifies the funding it has been allocated to meet the services it delivers. This effectively set a different performance expectation that is higher than the Annual Report target. By that standard, CAHS' performance remained favourable, being 17.0 per cent lower than the value determined by the Service Agreement (Figure 15).

Improved financial performance in 2020–21 is attributable to a combination of lower operating costs and higher activity.

Figure 15: Average cost per bed-day in specialised mental health inpatient units, 2018–19 to 2020–21



Data sources: Health Service financial system, BedState

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

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

Rationale

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

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

Target

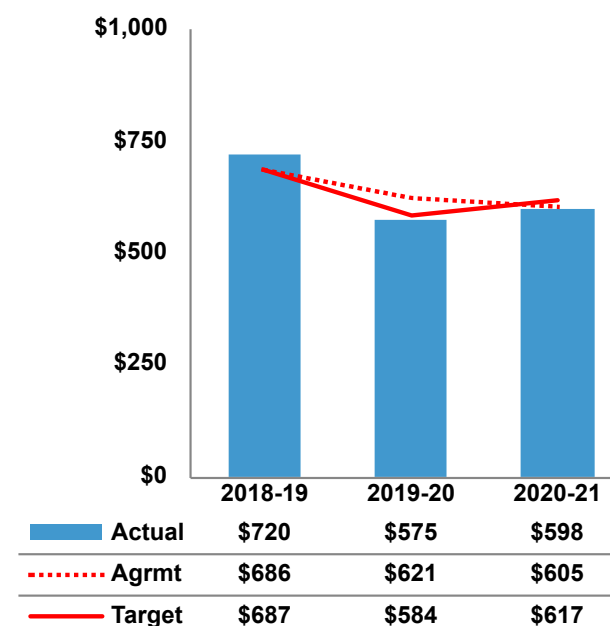
The 2020–21 target is ≤\$617 per treatment day.

Result

The average cost per treatment day of non-admitted care provided by public clinical mental health services rose slightly in 2020–21 to \$598, which is 3.0 per cent below the target.

CAHS has a Service Agreement with the Department of Health that specifies the funding it has been allocated to meet the services it delivers. This effectively set a different performance expectation that is lower than the Annual Report target. By that standard, CAHS' performance remained favourable, being 1.2 per cent lower than the value determined by the Service Agreement (Figure 16).

Figure 16: Average cost per treatment day of non-admitted care provided by mental health services, 2018–19 to 2020–21



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

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

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

Rationale

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

Population health aims to improve health by integrating all activities of the health sector and linking them with broader social and economic services and resources, as described in the WA Health Promotion Strategic Framework 2017–21. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

The 2020–21 target is ≤\$255 per person.

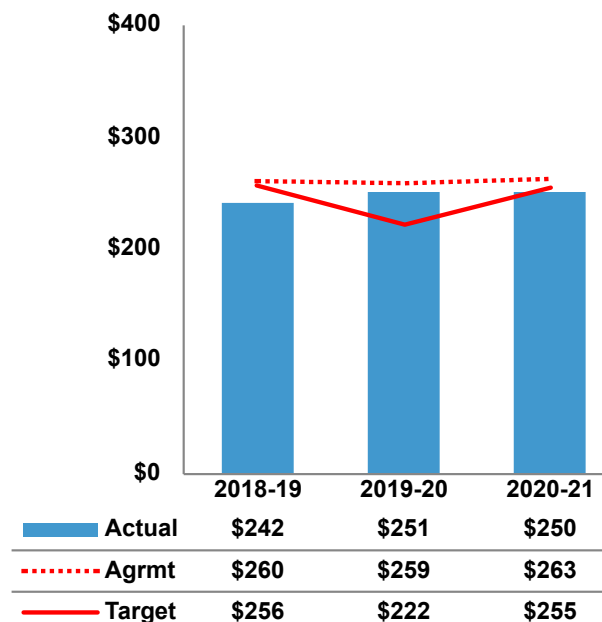
Result

The average cost per person of delivering population health programs by population health units fell slightly in 2020–21 to \$250, which is 1.8 per cent below the target.

CAHS has a Service Agreement with the Department of Health that specifies the funding it has been allocated to meet the services it delivers. This effectively set a different performance expectation that is higher than the Annual Report target. By that standard, CAHS' performance remained favourable in 2020–21, being 4.8 per cent below the value determined by the Service Agreement (Figure 17).

Favourable performance is attributable to higher estimated expenditure when setting the target.

Figure 17: Average cost per person of delivering population health programs by population health units, 2018–19 to 2020–21



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

