Agency performance

Delivering safe, high-quality care

Our commitment to quality improvement and learning from clinical incidents continues to identify key priorities for the development of safe systems and practice at CAHS.

Quality improvement activities at CAHS

CAHS has a strong commitment to undertaking quality improvement activities to address clinical risks and improve existing processes.

Quality improvement is the combined efforts of the workforce and others (such as parents, patients and families; researchers; clinicians and educators) to make changes that will lead to better care and patient health outcomes.

During the reporting period, 281 proposals were approved in the CAHS Governance Evidence Knowledge (GEKO) system, the database used to register information relating to all quality improvement activities within CAHS.

Following a review in March 2022, a single committee was established to replace the numerous GEKO committees across CAHS, ensuring improved assessment of all submissions, improved timeliness of reviews and the removal of conflict of interest. The new committee also assesses whether projects are able to answer their objectives and have impact on care for children and families.

Some notable quality improvement activities during the 2021-2022 period were:

Audit and evaluation of clinical supervision for Child Development Service allied health clinicians

Child Development Service (CDS) allied health clinicians' compliance with clinical supervision procedures was evaluated, with staff feedback obtained to inform revision of policy, processes and training. Staff reported clinical supervision had improved the quality of clinical care they provide, and clinical supervision supported them to practice according to CDS-specific operational and clinical guidelines.

Follow up of children not completing their two-year child health assessment at risk of poor developmental outcomes

A tool to systematically identify children at increased risk of developmental delay through their health record was developed and trialled, with local strategies implemented to invite families to book a two-year-old child health check if not scheduled by 27 months. Consumer and staff focus groups were held to assist in development of the tool and engagement strategies.

This pilot was the first phase to operationally test the summed risk index tool and led the development of a partnership between the research and evaluation team and Telethon Kids Institute to externally validate the tool. Funding is being sought to progress the research.

Independent second checking to reduce medication-related errors

An internationally recognised key safety mechanism for reducing medication-related errors is the practice of independent second checking wherein two clinicians separately check the 6 rights of medication administration, 'right patient, right medication, right dose, right time, right route and right documentation', without cues from each other, then compare the results.

Quality improvement plans to enhance compliance with independent second checking include education, observational auditing and feedback of results to staff.

In-service sessions on independent second checking for high risk medications were conducted for staff at Perth Children's Hospital. A subsequent practice audit conducted over a six week period demonstrated that:

- 100 per cent compliance for staff observed checking the prescription on the medication chart independently of the other staff member.
- 88 per cent compliance was demonstrated for both staff observed to check the medication label independently of the other staff member.
- 92 per cent compliance of both staff observed to independently check complete dosage calculations on paper or calculator or other method.
- 100 per cent compliance of both staff observed to check medication/prescription and patient identification matching (ID bands) to the patient comparing prescription ID with patient ID at the bedside.

Quarterly auditing continues and actions resulting from these are being implemented.

Clinical incident management

The delivery of healthcare occurs in complex and dynamic systems, and therefore is not without risk. In our quest to be a high reliability organisation, we are vigilant about safety. This means that we seek to identify and investigate all reported clinical incidents. Once we understand why an incident occurred, we seek not only to address the causes but also to share lessons learnt between clinical teams to reduce the risk of further harms.

At CAHS, a Lessons Learnt Model is the foundation for the approach to manage clinical incidents. This model provides a focus on the identification of lessons, sharing and applying lessons, and their evaluation. At the core of the Lessons Learnt Model is the imperative to learn from system issues and error, to identify and apply improvement strategies for safer systems and practice.

The clinical incident management program and staff continues to be developed to enable effective analysis of reported incidents, identification and development of focused and robust recommendations. This program of improvement has three arms: 1) training and education of staff; 2) process and tools, and 3) improvement.

Training and education include 'learning labs' for the conduct of serious clinical incident review, interviewing, and the effective use of the electronic reporting system. A practical guide for reviewing serious clinical incidents and developing better recommendations have been implemented. Education for consumers has been conducted to provide an overview of how clinical incidents are conducted.

The clinical incident management policy has been reviewed to ensure it reflects best practice. A suite of tools has been developed and is in use for guiding the conduct of a serious clinical incident. Included is a guide for the development and evaluation of recommendations. Recommendations are key to mitigating risk and improving care and outcomes for our patients and clients.

How we conduct clinical incident management is driven by the need to continually do better. Two important initiatives are planned. We will be training consumers in the theory and practice of conducting a clinical incident review. We are eager to have consumers participate in this process (to the extent that they would like to) in order to bring the important consumer lens to learning and sharing lessons.

With the aim of improving the quality and robustness of clinical incident reviews we will be training senior clinicians from all disciplines to chair the review panel. This cohort of panel chairs with specialised knowledge and skill will lead the panel to analyse system issues and errors more confidently. These panels will be better prepared to identify and develop better recommendations.

The sharing of lessons learnt is done through several ways including summaries of the findings of the incident review, our staff Lessons Learnt Bulletin and through communiques. We are developing a community of practice where clinicians and consumers will co-lead the clinical incident management program for safe systems and practice.

Table 4 lists the Severity Assessment Code (SAC) 1 clinical incidents for 2021-22.

Table 4: SAC 1 incidents (1 July 2021 – 30 June 2022)

SAC 1 Incident	
Total notified	36
Investigated	21
Ongoing investigation*	11
Declassified^	4
Total confirmed	**32**

^ Declassification occurs when there are no health care related contributing factors identified. These are approved upon review by the Department of Health Patient Safety Surveillance Unit.

Confirmed with patient outcome

Clinical safety indicators

Hand hygiene

Effective health care worker hand hygiene is imperative for the prevention of healthcare-associated infections. CAHS participates in the National Hand Hygiene Initiative which involves quarterly audits. Our results for the past 12 months show overall compliance is 85 per cent which is above the required National KPI of 80 per cent and is comparable to the Statewide average.

People, Capability and Culture

Valuing and respecting our people is a key strategic priority for CAHS. The People, Capability and Culture directorate has continued to work together with staff across CAHS to create a positive workplace environment that values, respects, engages and supports individual contributions and collective strength.

All actions are aligned with our vision strategy and framework, and six key themes:

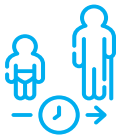
- An irresistible employee experience.
- Proactive health, safety, wellbeing and support.
- Clear, reliable and collaborative communication.
- Courageous, inspiring and inclusive leaders.
- Meaningful, dynamic learning and growth experiences.
- A culture in which our people can thrive.

Our people – employee profile

The expansion of the CAHS workforce in response to service requirements and the pandemic response now sees CAHS employee more than 6,500 staff – many are part time employees, or the equivalent of 4,670 Full Time Equivalent (FTE). This is an increase of more than 600 FTE from last financial year and more than 1,200 compared to 2019-20.

The rapid growth in employee numbers has changed the profile of the CAHS workforce. The proportion of employees aged below 25 years now makes up 8.8 per cent of the workforce, compared to less than 4 per cent of the total workforce previously.

The large FTE increase compared to the preceding financial year is mainly due to increased capacity for COVID-19 response, management and vaccination program. As part of the Government's announcement to increase staffing capacity, CAHS has also expanded its nursing capacity within the Emergency Department and additional FTEs to manage patient flow, support patient experience and for safer delivery of health-care.

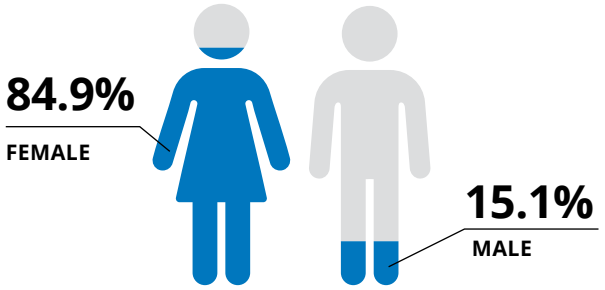


40 years
Median age

52.8 hours
Average hours paid per fortnight

9.6 years
Average length of service

1.4%
Aboriginal Employees



13.1%
Cultural and linguistically diverse

1.2%
Employees with disability

Table 5: Total full-time employees, by category

Category as per Annual Report	2020-21	2021-22
Administration & clerical	742.4	903.9
Agency	54.6	83.8
Agency nursing	1.6	1.8
Assistants in nursing	29.5	48.7
Dental nursing	7.5	7.3
Hotel services	187.4	196.4
Medical salaried	459.8	488.5
Medical sessional	77.2	86.1
Medical support	649.0	701.0
Nursing	1,673.0	1,987.8
Site services	1.3	1.1
Other	28.0	26.7
Total	**3,911.2**	**4,533.1**

Workforce Planning

At a WA Health-wide level, recommendation 26 of the Sustainable Health Review specifies the need to 'build capability in workforce planning and formally partner with universities, vocational training institutes and professional colleges to shape the skills and curriculum to develop the health and social care workforce of the future'. The development of a 10-year health and social care strategy (Workforce Strategy) was identified as an implementation priority, however work to date has not considered workforce issues specific to neonatology, paediatrics and child health.

The CAHS workforce is a complex combination of professions and service units, with distinct professional competencies, and CAHS recognises the importance of workforce planning. Following a baseline workforce assessment that included an in-depth analysis of the current clinical workforce, a four-step approach to workforce planning was developed inclusive of:

- Better understanding the existing workforce using lessons from the baseline review.
- Projecting future workforce demand.
- Projecting future workforce supply.
- Scenario modelling.

In 2021-22, the workforce planning process was applied to CAHS nursing and Community Child Health nursing.

CAHS Transition to Practice Programs (Graduate Nursing Programs)

CAHS currently offers dedicated program streams for graduate registered nurses to support transition into clinical practice and acquire skills and knowledge. The program provides a supportive learning environment to build resilience, adaptability and professional practice skills and are a nursing workforce employment strategy.

In 2022, CAHS employed a total of 128 graduate nurses with 100 graduates in the acute and specialty nursing streams, 20 graduates in Community Nursing, and eight graduates in the state-wide Mental Health Graduate Program in CAMHS.

Supported Introduction to Infants, Paediatric and Adolescent Nursing program

The Supported Introduction to Infants, Paediatric and Adolescent Nursing program was introduced as an innovative strategy aimed to assist the transition and skill development of the new workforce. It was developed to ensure nurses new to paediatric nursing would develop the knowledge and skills to safely care for children and families in the acute paediatric setting. The Supported Introduction to Infant, Paediatric and Adolescent Nursing program is a collaborative pathway of learning, underpinned by excellence in paediatric nursing practice and a strong support network of preceptorship and education. Approximately 160 participants have commenced this program since its inception in June 2021.

Strategic Talent Acquisition

Talent acquisition is the process of developing an end to end strategy to attract, recruit and retain top talent. Recruitment is just one aspect of talent acquisition, that has to do with the selection and hiring of a candidate to fit a job vacancy. Talent acquisition spans employer branding, attraction marketing, the process of recruitment, including candidate relationship management, onboarding

planning, succession planning and talent development, and continuous strategic alignment to enable strategic goals of the organisation.

CAHS took the step towards better understanding the difference between recruiting and acquiring talent which also recognised talent acquisition as an important strategy required to achieve improved patient outcomes. The opportunity to change traditional approaches and adapt recruitment practices to meet current and future challenges in the CAHS work environment has never been greater, in anticipation of challenges associated with a competitive labour market, skill shortages and the widespread impact of COVID-19.

In January 2022, a Strategic Talent Acquisition and Recruitment Team was implemented to improve recruitment outcomes, with the focus initially on supporting fast track, high volume nursing recruitment and support to high priority areas, including CAMHS.

CAHS remains focused on finding efficiencies, streamlining and improving recruitment processes, and tracking and using meaningful data to ensure the right people are in the right jobs to support achieving our strategic objective of *'healthy kids, healthy communities'.*

Our culture - shaping our future

CAHS undertakes a 'Culture Assessment' every two years to measure progress toward our vision of becoming a values-based organisation. The third CAHS Culture Assessment took place in February 2022 with just over 28 per cent of CAHS employees, Board members, volunteers and consumer groups completing the assessment.

The results show that employee personal values and desired culture remain aligned with CAHS values – staff want to provide excellent care for children, adolescents and their families, and care for one another.

Consistent since the 2019 survey, patient, client and family centred care, safety and quality and accountability, feature in the top 10 of our current values. The internal and external environmental challenges faced during this period have seen values like long hours, short term focus and confusion feature in the results. These factors or "potentially limiting values" can take up our time, energy and resourcing and we need to work together to identify them and improve the way we work and interact. Better areas for focus are home/work balance, continuous improvement, open communication and employee engagement. Cultural change takes time and the results provide assurance that we must continue our focus to ensure CAHS is a great place to work.

The CAHS Culture Action Strategy 2.0 (2021-24) builds on the organisational vision, values and strategic objectives of the CAHS Strategic Plan 2018 –23.

Compliance with public sector standards and ethical codes

CAHS continues its commitment to be an ethical, transparent, and accountable public sector organisation.

Employees are made aware of their rights and responsibilities in accordance with the Public Sector Standards and ethical codes, through policies, procedures and associated guidelines communicated in various ways. Human Resources and Integrity and Ethics Officers are available to advise managers and employees.

The CAHS website informs our patients and families and the wider public about how to give compliments or make complaints in relation and notify us about non-compliance with ethical codes of conduct.

Claims of non-compliance with Public Sector Standards and ethical codes are tracked and deidentified for reporting to the Executive and Board. This series of metrics incudes the monitoring of any trends.

Compliance monitoring

During 2021–22, there were 17 claims lodged against the employment standard. Six claims were resolved internally, with 11 claims referred to the Public Sector Commission for review. Ten were subsequently declined by the Public Sector Commission and one outcome is still pending. There were seven claims lodged against the grievance standard in 2021–22.

A total of 94 reports or complaints alleging noncompliance with the Code of Conduct (breaches of discipline) were lodged (Table 6). 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 (15) or the Corruption Crime Commission (30) 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 6: Complaints alleging non-compliance with the Code of Conduct, by area of compliance

Type	
Communication and official information	6
Conflict of interest	2
Fraud and corrupt behaviour	14
Personal behaviour	66
Record keeping and use of information	4
Use of public resources	2
Total	**94**

Work Health Safety and Wellbeing at CAHS

CAHS recognises the vital role that the physical and psychological health of each employee plays in their own lives and those of their families. A strong focus on employee wellbeing at CAHS promotes physical and psychological health and contributes to the provision of the highest levels of care for the children and their families who attend our sites and utilise the breadth of our services.

As part of our commitment to a safe culture and the wellbeing of our staff, CAHS transitioned to a new way of supporting our staff in identifying, reporting and managing incidents and hazards with the introduction of 'Safe@CAHS'. This has enabled an easier, faster and more accessible way for all staff to ensure work health safety incidents and hazards for CAHS employees, contractors and volunteers are captured via an online portal also accessible via smart devices.

The Staff Wellbeing Psychological Support Services and Pastoral Care teams have continued to provide support, assistance and solutions to staff at CAHS.

CAHS was a finalist in the 2021 Best Workplace Health and Wellbeing Initiative at the WA Work Health Safety Excellence Awards.

Injury management

The CAHS Board and Executive have formal mechanisms in place to fulfil their legislative role, and compliance against the requirements under the *Workers' Compensation and Injury Management Act 1981*. The *Injury Management Code of Practice (WorkCover WA)* is monitored through the CAHS People, Capability and Culture Executive Committee, which is accountable for the safety of all CAHS staff, visitors, patients, clients, carers, volunteers and contractors.

A significant initiative of the Work Health Safety and Wellbeing team this year has been the establishment of a Work Health Safety and Wellbeing Clinic with a CAHS Occupational Physician available to enable any fitness for work issues to be seen quickly and effectively by people familiar with their work environment. CAHS also appointed an Ergonomist, whose role has a specific emphasis on reducing the injuries associated with patient and equipment handling in healthcare.

Occupational safety, heath and injury performance performance is summarised in Table 7.

Workers Compensation

The number of employees sustaining a work-related injury is monitored and all cases are investigated to ensure lessons are learned to reduce the likelihood of a similar injury.

A total of 87 workers compensation claims were made in 2021-22 (see table 8).

Table 7: Occupational safety, health and injury performance, 2019-20 to 2021-22

Measure	2019-20	2020-21	2021–22	Target	Comment
Fatalities (number of deaths)	0	0	**0**	0	Target met
Lost time injury/diseases (LTI/D) incidence rate (per 100)	2.0%	1.9%	**1.2%**	0 or 10%	Target met
Lost time injury severity rate (per 100, i.e. percentage of all LTI/D)	36.4%	47.8%	**48.5%**	0 or 10%	Target not met
Percentage of injured workers returned to work within 13 weeks	77%	75%	**70%**	No target	No Target
Percentage of injured workers returned to work within 26 weeks	77%	88%	**91%**	≥80%	Target met
Percentage of managers trained in injury management and work health safety and wellbeing responsibilities	48%	80%	**57%**	≥80%	Target not met

Table 8: Workers compensation claims in 2021-22

Category	Claims
Nursing Services / Dental Care Assistants	49
Administration and Clerical	14
Medical Support	12
Hotel Services	10
Maintenance	0
Medical (salaried)	2
Total	**87**

Financial targets

	2021-22 target [1] $000	2021-22 actual $000	Variation [7] $000
Total cost of services (expense limit) (sourced from Statement of Comprehensive Income)	839,857	**952,479**	112,622[2]
Net cost of services (sourced from Statement of Comprehensive Income)	772,739	**876,057**	103,318[3]
Total equity (sourced from Statement of Financial Position)	1,477,788	**1,521,399**	43,611[4]
Net increase / (decrease) in cash held (sourced from Statement of Cash Flows)	(353)	**(13,279)**	(12,926)[5]
Approved salary expense level	593,035	**645,719**	52,684[6]

Notes:

[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 $112.622 million in total cost of services are the COVID-19 management and responses, increased workforce capacity for additional patient beds and Emergency Department, and the associated increases in patient support costs.

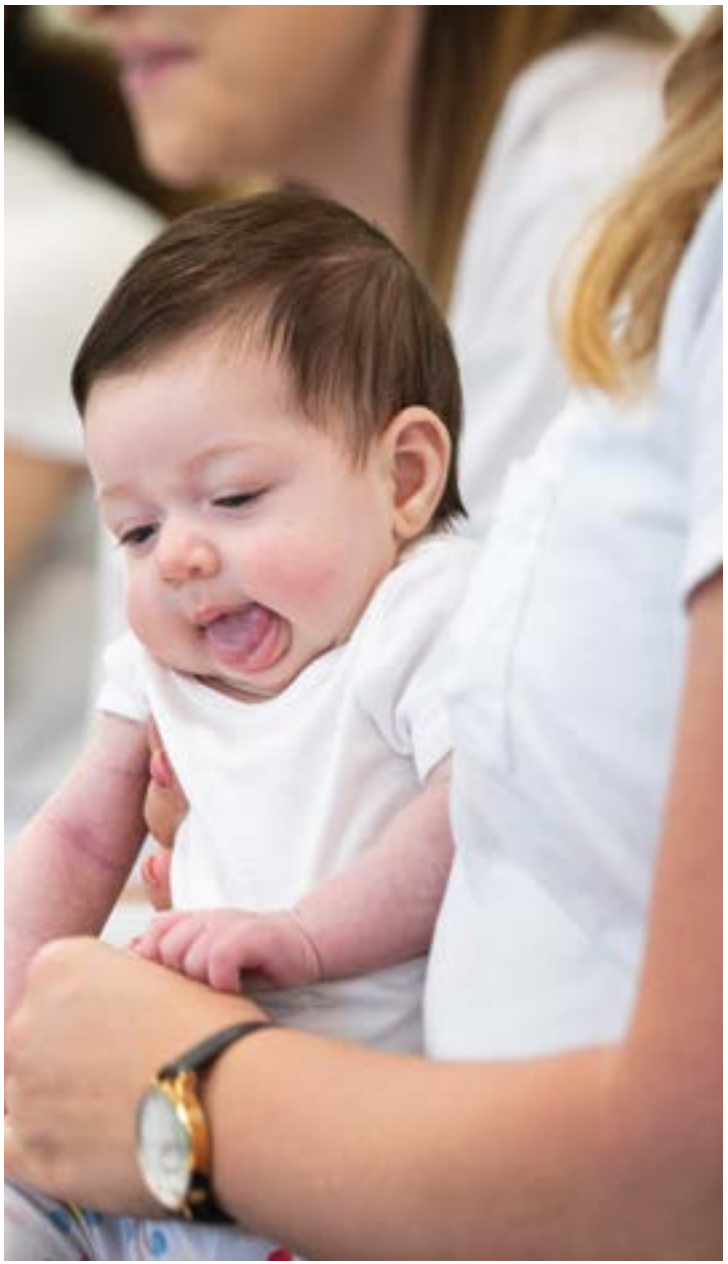
[3] As a result of recording the asset revaluation increments of $1.070 million for land and $4.941 million for buildings as revenue, the variation in net cost of services is less than the variance in total cost of services.

[4] The asset revaluation increments of $80.360 million for buildings have contributed to the increase in total equity. Conversely, the equity increase has been lessened by the operating deficit of $24.908 million and the correction of error amounting to $12.700 million with respect to the Landgate valuation of the Perth Children's Hospice site. The details are set out in Note 9.12 'Equity' and Note 9.15 'Correction of Prior Period Error' to the financial statements.

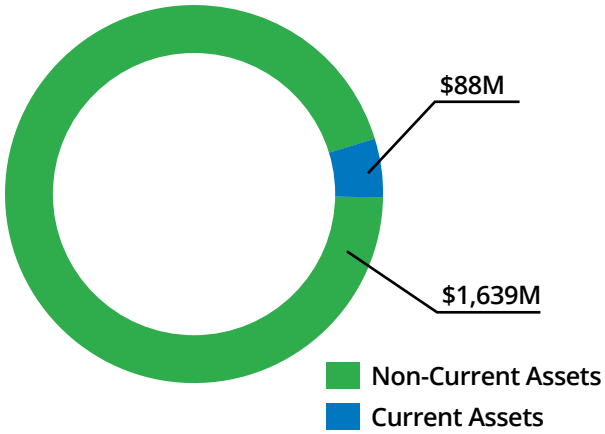
[5] The higher than budgeted decrease (-$12.926 million) in cash held was mainly caused by the $18.041 million of service agreement funding for the 2021-22 expenditures being received in the previous financial year, rather than in the current financial year.

[6] Salaries and superannuation costs are above budget largely due to increased staffing in line with the Government's announcement for Emergency Department and additional beds within PCH, and the increase in hospital workforce capacity for COVID-19 management and responses.

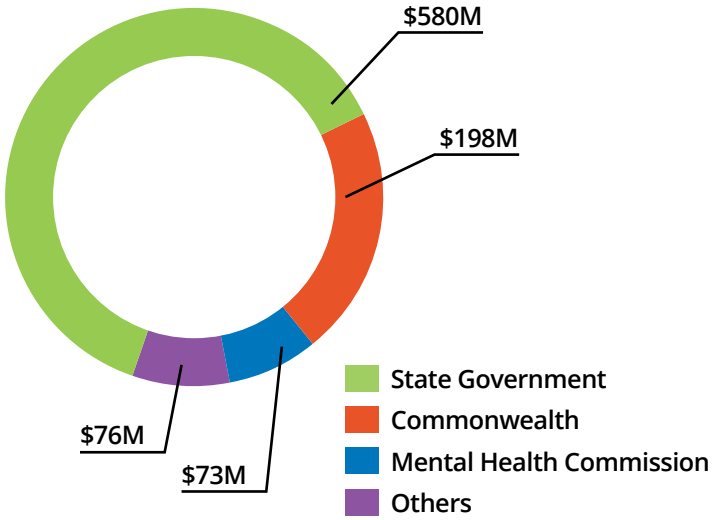
[7] Further explanations are contained in Note 9.14 'Explanatory Statement' to the financial statements.



Total assets



Income



Total assets

The Child and Adolescent Health Service finished the 2022 year with a total asset value of $1,727 million, which represents an increase of $83 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 $82 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 2022.

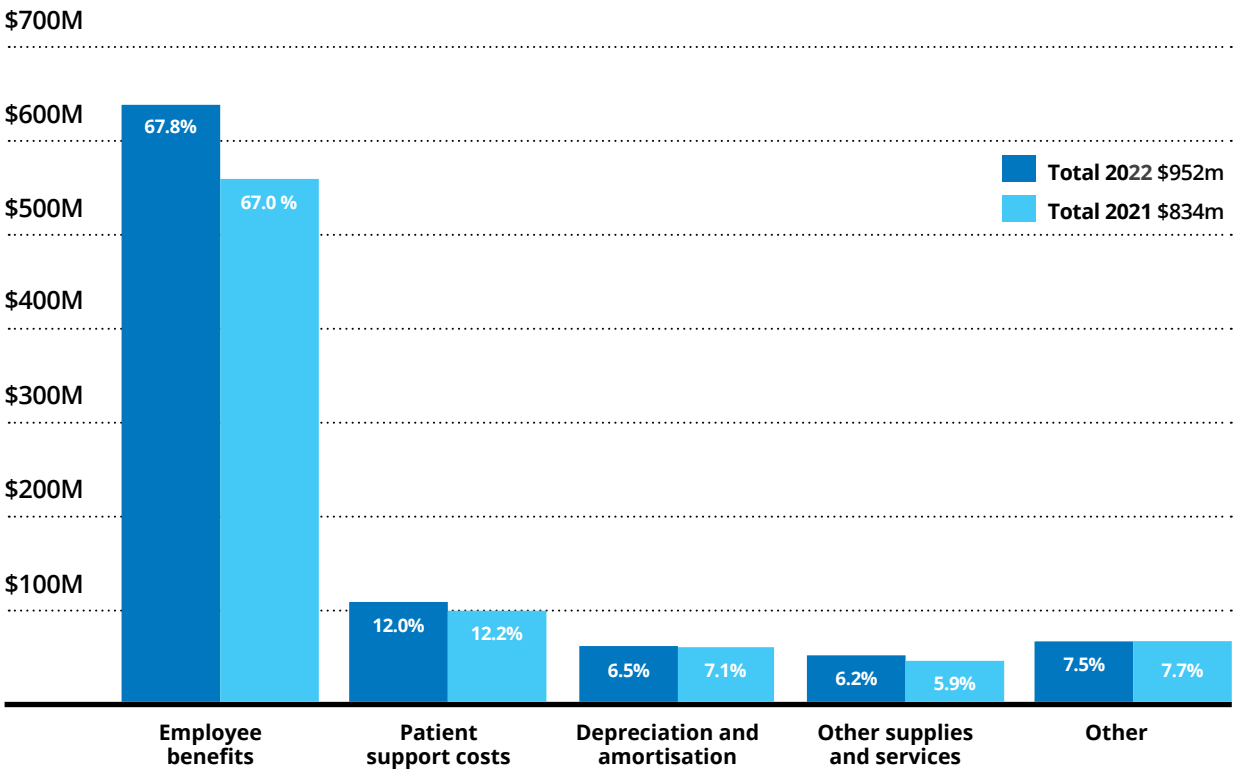
Income

The Child and Adolescent Health Service receives the majority of its income via the service agreement funding from the Department of Health.

This totalled $715 million comprising the State component of $517 million and the Commonwealth component of $198 million for the 2022 year.

A further $59 million in income was received via services received free of charge from State Government entities and $73 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 2022.

Expenditure by type



Employee benefits capture the costs of staff providing services within the Child and Adolescent Health Service and represent the major component of expenditure for the 2022 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 2022.

Summary of key performance indicators

Key performance indicators assist CAHS to assess and monitor the extent to which State Government outcomes are being achieved and help inform the community about how CAHS is performing.

Effectiveness indicators assess the extent to which outcomes have been achieved through resourcing and delivery of services to the community, while efficiency indicators monitor the relationship between the services delivered and the resources used to provide the service.

A summary of the CAHS key performance indicators and variation from the 2021–22 targets is given in Table 9.

Note: It is essential that Table 9 be read in conjunction with detailed information on each key performance indicator found in the Key Performance Indicators section of this report.

Table 9: Actual results versus KPI targets

Key performance indicator		2021-22 target	2021-22 actual	Variation	Per cent variation	Further information
Unplanned hospital readmissions for patients within 28 days for selected surgical procedures	Tonsillectomy & Adenoidectomy	≤81.8	**49.1**	32.7		page 181
	Appendicectomy	≤25.7	**11**	14.7		
Percentage of elective wait list patients waiting over boundary for reportable procedures	Cat 1 (≤30 days)	0%	**4.7%**	4.7%		page 182
	Cat 2 (≤90 days)	0%	**28.1%**	28.1%		
	Cat 3 (≤365 days)	0%	**26.8%**	26.8%		
Healthcare-associated Staphylococcus aureus bloodstream infections (HA-SABSI) per 10,000 occupied bed-days		≤1.0	**0.88**	0.12		page184
Percentage of admitted patients who discharged against medical advice (DAMA): a) Aboriginal patients; and b) Non Aboriginal patients	Aboriginal	≤2.78%	**0.33%**	2.45		page186
	Non-Aboriginal	≤0.99%	**0.04%**	0.95		
Readmissions to acute specialised mental health inpatient services within 28 days of discharge		≤12%	**13.6%**	1.6%		page 188
Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services		>75%	**87.2%**	12.2%		page 189
Average admitted cost per weighted activity unit		≤$6,907	**$7,816**	$909	13.2%	page 190
Average Emergency Department cost per weighted activity unit		≤$6,847	**$9,200**	$2,353	34.4%	page 191
Average non-admitted cost per weighted activity unit		≤$6,864	**$7,207**	$343	5.0%	page 192
Average cost per bed-day in specialised mental health inpatient services		≤ $3,209	**$3,374**	$165	5.1%	page 193
Average cost per treatment day of non-admitted care provided by mental health services		≤ $609	**$653**	$44	7.2%	page 194
Average cost per person of delivering population health programs by population health units		≤ $235	**$242**	$7	3.0%	page 195

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

Favourable performance **Unfavourable performance**