CAHS clinicians and support staff bring a high level of expertise and commitment to every patient, at every moment of care.

AGENCY PERFORMANCE

SUMMARY OF KEY PERFORMANCE INDICATORS

Key performance indicators (KPIs) help us monitor and assess how we are progressing toward achieving State Government outcomes. KPIs 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. Efficiency indicators monitor the relationship between the services delivered and the resources used to provide the service.

A summary of the CAHS KPIs and variation from the 2024–25 targets is given in Table 2.

Table 2: Actual results versus KPI targets

Key performance indicator		2024–25 Target	2024–25 Actual
Unplanned hospital readmissions for patients within 28 days for selected surgical procedures	Tonsillectomy & Adenoidectomy	≤84.4	40.4
	Appendicectomy	≤29.7	17.5
Percentage of elective wait list patients waiting over boundary for reportable procedures	**Category 1** (≤30 days)	0%	4.6%
	Category 2 (≤90 days)	0%	18.8%
	Category 3 (≤365 days)	0%	26.1%
Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days		≤1.0	0.55
Percentage of admitted patients who discharged against medical advice (DAMA): a) Aboriginal patients; and b) non-Aboriginal patients	Aboriginal	≤2.78%	0.11%
	non-Aboriginal	≤0.99%	0.06%
Readmissions to acute specialised mental health inpatient services within 28 days of discharge		≤12.0%	18.5%
Percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services		≥75%	83.6%
Average **admitted** cost per weighted activity unit		$7,899	$9,136
Average **Emergency Department** cost per weighted activity unit		$7,777	$11,211
Average **non-admitted** cost per weighted activity unit		$7,903	$9,304
Average cost per bed-day in **specialised mental health inpatient services**		$2,553	$8,025
Average cost per treatment day of **non-admitted care provided by mental health services**		$868	$933
Average cost per person of **delivering population health programs by population health units**		$314	$323

FINANCIAL SUMMARY

Table 3: Financial summary

	2024–25 target[1] ($000)	2024–25 actual ($000)	Variation[7] ($000)
Total cost of services (expense limit) (sourced from Statement of Comprehensive Income)	1,033,902	1,197,394	163,492[2]
Net cost of services (sourced from Statement of Comprehensive Income)	938,514	1,085,613	147,099[3]
Total equity (sourced from Statement of Financial Position)	1,648,061	1,819,687	171,626[4]
Net increase in cash held (sourced from Statement of Cash Flows)	(5,278)	2,859	8,137[5]
Approved salary expense level	715,971	845,124	129,153[6]

Notes

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

[2] The major causes for the variation of $163.492 million in total cost of services are the lower funding base in the initial budget estimates, cost escalations, award salary increases, enhanced support to Emergency Department, resourcing to support the reforms arising from the Ministerial Taskforce into Public Mental Health Services and the associated increases in patient support costs, other supplies and services.

[3] As a result of the higher than budgeted patient charges ($11.234 million), grants and contributions from charitable organisations ($1.895 million), and donation revenue ($1.519 million), the variation in net cost of services is $16.393 million less than the variance in total cost of services.

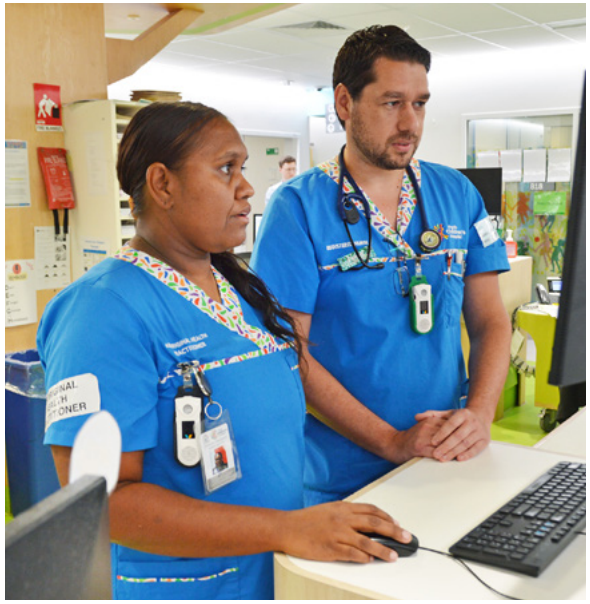
[4] The asset revaluation increments of $196.914 million for buildings have contributed to the increase in total equity. Conversely, the equity increase has been lessened by the operating deficit of $21.721 million. The details are set out in Note 9.13 'Equity'.

[5] The higher than budgeted cash held (+$8,137 million) is mainly caused by additional State and Mental Health Commission funding received in June 2025, and the deferment of payment to accrued salaries account to 2025-26.

[6] Salaries and superannuation costs are above budget partly because of the lower funding base in the initial estimates and partly as a result of pay increases awarded to employees under the new industrial agreements and additional staffing resourcing engaged to address essential service needs, to enhance support to the Emergency Department, and to maintain safety and quality measures within the Perth Children's Hospital.

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

EMERGENCY DEPARTMENT



The 2024–25 financial year saw 69,691 patients attend the PCH ED for assessment and treatment. Consistent with previous years, 21.68 per cent required inpatient admission following initial treatment in the ED.

Percentage of Emergency Department patients seen within recommended times

The Australasian Triage Scale (ATS) category review time targets are supportive indicators. They measure the time to first review by an ED doctor or nurse practitioner, or the start of treatment. The triage system aims to provide a balance between the need to provide immediate care to those at highest risk and the clinical resources in the ED.

Table 4: Triage categories

Triage category	Description	Response	Target	Achieved
1	Immediate life-threatening	Immediate (≤ 2 minutes)	100%	100%
2	Imminently life-threatening OR time-critical treatment OR very severe pain	≤ 10 minutes	≥ 80%	84.4%
3	Potentially life-threatening OR situational urgency	≤ 30 minutes	≥ 75%	27.2%
4	Potentially serious OR situational urgency OR significant complexity or severity	≤ 60 minutes	≥ 70%	46.0%
5	Less urgent	≤ 120 minutes	≥ 70%	86.8%

ATS category 1 and 2 patients remain the absolute priority for clinical assessment to ensure they receive resuscitation and emergency care for life-threatening presentations. CAHS met the target for category 1 patients and exceeded category 2 and category 5 targets.

With a 3 per cent increase in the total number of ED presentations and a continued focus on prioritising emergency care for the more urgent category patients, CAHS has not met the targets for triage categories 3 and 4.

We have implemented strategies to improve review times without affecting the performance of the more urgent categories.

These strategies include:

- more medical staff rostered in the evening and night shifts to address peak demand periods
- nurse-initiated clinical pathways to begin timely clinical care
- expansion of criteria-led discharge processes to improve patient flow
- use of additional clinical areas to maximise clinical space for assessment and treatment during peak demand in the ED
- expansion of the nurse practitioner role to 7 days per week during peak demand periods.

Achievements

Post-graduate Nursing Paediatric Emergency Course

Sixteen nurses graduated from the inaugural Post-graduate Nursing Paediatric Emergency Course in November 2024. Sixteen nurses are enrolled in this year's course.

ED Live project

The ED Live project developed a real-time digital visualisation tool that allows ED staff to track patients in real time across waiting rooms and ED cubicles.

The ED Live map provides a clear, visual snapshot of ED activity, such as available beds, how long patients have been in a cubicle and which patients are admitted. This helps staff to best manage the placement of incoming patients, track movements and allocate resources efficiently.

Clear and accurate visibility of bed availability helps ED staff to reduce delays in patient placement, reduces congestion in waiting areas and improves patient safety.

The ED Live project team won the Innovation Award at the 2025 CAHS Excellence Awards.

Quality improvements

GREATix: capturing positive ED experiences

GREATix is a reporting mechanism for capturing positive feedback about people's experiences in the ED. It aims to identify and learn from positive ED interactions to improve patient care and staff morale.

Since launching in December 2024, 461 submissions were reported via GREATix. Feedback frequently recognises our CAHS values of excellence, collaboration, accountability and compassion. Common themes included workforce professionalism and dedication to high quality care.

Improved appendicitis pain pathway

The ED's Right Iliac Fossa (RIF) pain pathway aims to improve assessment and management of children presenting with suspected appendicitis. The pathway was re-developed with collaboration between the ED clinical team, ED research team, Department of General Surgery, and the Department of Medical Imaging.

This multi-disciplinary input has been central to its success, ensuring the pathway is evidence-based, practical and realistic for implementation. It uses the paediatric Appendicitis Risk Calculator to risk-stratify patients and guide decisions about further investigations and disposition from the ED.

The pathway promotes improved patient flow, consistent decision-making and a reduction in unnecessary investigations. This helps us to deliver timely, safe and efficient care for children with RIF pain.

PATIENT SAFETY AT CAHS

CAHS is committed to the continual improvement of practice, care and service to ensure safe, high quality health care for children, young people and their families.

Learning from clinical incidents

CAHS clinicians and support staff bring a high level of expertise and commitment to every patient, at every moment of care. For the vast majority of people who interact with our services, their experience is positive. However, there are instances where this is not the case and where the interaction may have contributed to a clinical incident or unintended harm.

We take this very seriously and are committed to learning from these incidents to inform our continual improvement. The complexity of health care requires a strong patient safety culture and a robust program to identify and reduce the risk of harm to patients and clients.

We believe that every clinical incident is an opportunity to learn, understand and make changes to improve care and reduce the likelihood of a similar occurrence in the future.

We promote an open and transparent environment that encourages and enables staff to report incidents.

Our training and education help staff understand the purpose of identifying, reporting and investigating clinical incidents, and the importance of learning lessons and developing recommendations to prevent and manage the issues and risks.

CAHS takes its responsibility for children, young people, their families and the broader community seriously. The program that CAHS has in place for the investigation, learning and improvement from clinical incidents aims to build and maintain trust with the community.

All clinical incidents are categorised based on the severity and reviewed accordingly. A severity assessment code 1 (SAC 1) is the most significant clinical incident that has, or could have, contributed to serious harm or death.

The number of SAC 1 incidents reflects our strong culture of reporting. All SAC 1 clinical incidents are subject to a rigorous clinical incident investigation and the reports are reviewed by the CAHS Executive and the CAHS Board.

Through the SAC 1 clinical incident review, the range of factors that contribute to a patient's outcome are considered, including healthcare-related factors. It is important to note that the patient outcome does not necessarily arise as a direct cause of the incident.

In 2024–25 CAHS reported and reviewed 24 clinical incidents with a SAC 1 rating.

At the time of Certification of this Annual Report, 21 reviews from the 2024–25 year have been completed.

Of these, 8 incidents were approved for declassification by the Department of Health Patient Safety Surveillance Unit based on findings that there were no healthcare factors that contributed to the adverse patient outcome. Three (3) SAC 1 incident reviews are still in progress and are not yet complete.

Of the SAC 1 investigations that were completed or remain in progress, the patient outcomes are noted in Table 5.

Note: Table 5 includes SAC 1 clinical incidents where the investigation is ongoing at the time of reporting. These numbers are subject to change following the completion of the investigations and any subsequent declassifications that may occur.

Table 5:

No harm	**0**
Minor harm	**2**
Moderate harm	**9**
Serious harm	**5**
Death	**0**