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

ANNUAL REPORT 2024–25

For their best health and wellbeing, now and into the future

STATEMENT OF COMPLIANCE

FOR THE YEAR ENDED 30 JUNE 2025

Hon. Meredith Hammat MLA

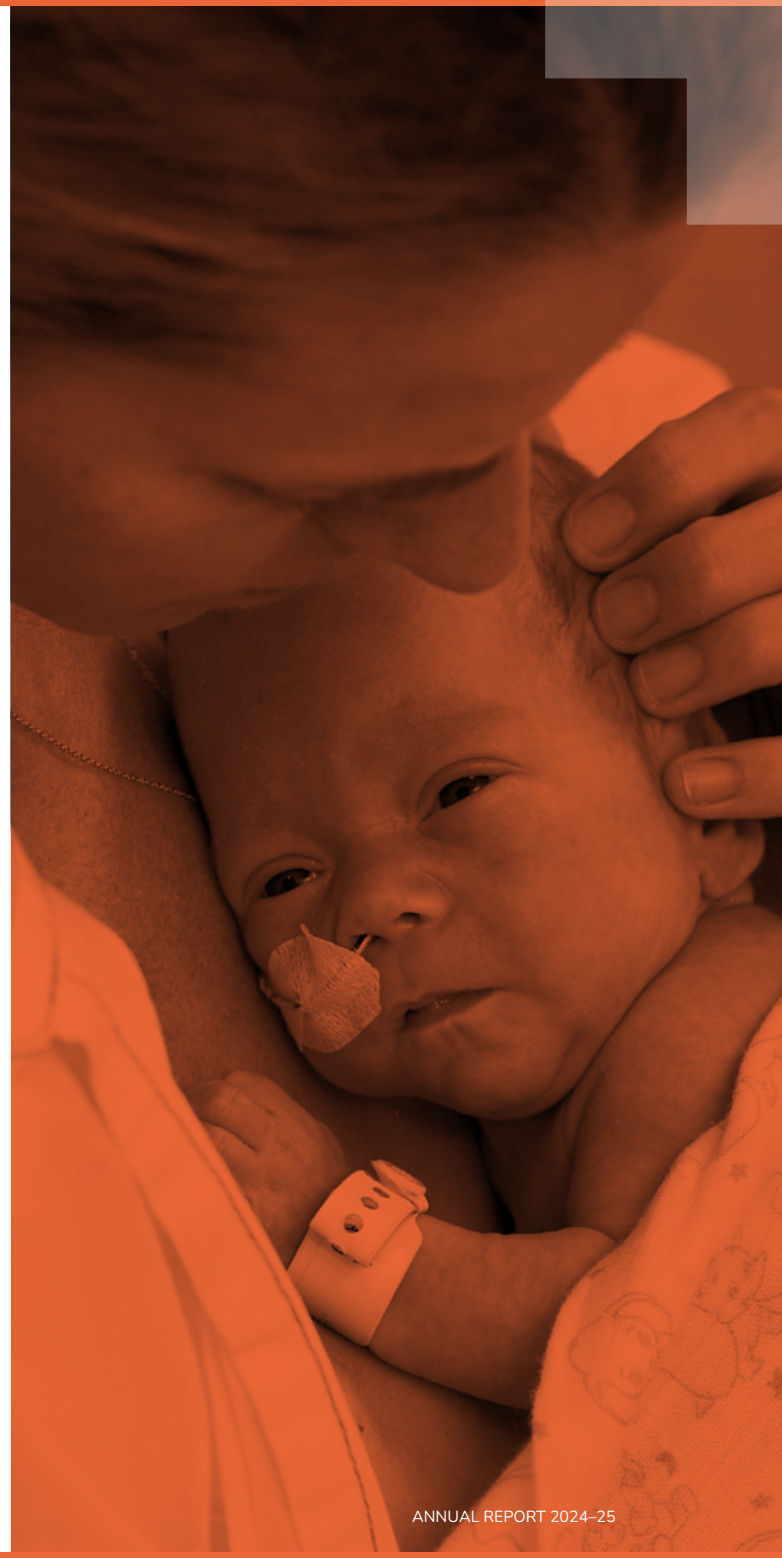
MINISTER FOR HEALTH; MENTAL HEALTH

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 financial year ended 30 June 2025.

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

Ms Pamela Michael
CHAIR, CAHS BOARD
Child and Adolescent Health Service
23 September 2025

Dr Alexius Julian
CHAIR, CAHS FINANCE COMMITTEE
Child and Adolescent Health Service
23 September 2025



ACKNOWLEDGEMENT OF COUNTRY

The Child and Adolescent Health Service (CAHS) acknowledges the Whadjuk and Binjareb people of the Noongar Nation as the Traditional Custodians of the land, sea and waters on which we work and live. We pay our respects to the Elders past and present.

Aboriginal people, as the First Peoples, have cared for this land for at least 65,000 years. We recognise and value their continuing cultural and spiritual connections to this land. CAHS acknowledges the diversity of Aboriginal people from across Western Australia who access the health services provided within CAHS.

CAHS recognises that the colonisation of this Country has come at a great cost to Aboriginal peoples and communities and the continued effects of colonisation impact on health and wellbeing today. We pay tribute to the strength, resilience, and courage of Aboriginal people who have survived the devastation of the recent past, to stand strong and proud today.

CAHS is committed to working towards a better future, where all cultures are respected and valued, and Aboriginal people take their rightful place as the First Australians.

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.

CONTENTS

WELCOME TO OUR ANNUAL REPORT

The Child and Adolescent Health Service Annual Report 2024–25 outlines our achievements, challenges, performance results and financial outcomes for the financial year ended 30 June 2025.

Our achievements have been aligned against our 8 strategic priorities, demonstrating how we support Western Australian children, young people and families.

The report summarises our performance against mandated key performance indicators. We have reported in line with the *Financial Management Act 2006* and the Public Sector Commission's Annual Reporting Information 2024–25.

CAHS is trusted by families for our expert care, pioneering research and unwavering focus on placing children, young people and families at the centre of everything we do.

EXECUTIVE SUMMARY

MESSAGE FROM THE BOARD CHAIR

Ms Pamela Michael

> **At CAHS, our purpose is clear: to help children and young people across Western Australia live their healthiest, happiest lives – today and for generations to come.**

On behalf of the Board, I am honoured to deliver the Child and Adolescent Health Service 2024–25 Annual Report which reflects the achievements, challenges and aspirations that have shaped our service over the past year.

At the Child and Adolescent Health Service (CAHS), our purpose is clear: to help children and young people across Western Australia live their healthiest, happiest lives – today and for generations to come. Every decision we make and every service we deliver is grounded in this commitment.

We are proud to be a trusted and respected leader in child and adolescent health – a service dedicated to delivering exceptional care in genuine partnership with children, young people and their families. Their voices guide us, their needs shape us, and together we work to ensure that every child and young person is supported to thrive.

The CAHS Board provides governance and strategic oversight across all our services and activities, ensuring excellence in paediatric health care and research remains at the heart of everything we do.

We are unwavering in our commitment to providing an equitable and comprehensive service, ensuring that every child and young person and their families has access to the right care, at the right time, no matter their circumstances.

This year, our progress has been guided by the CAHS values of accountability, equity, respect, excellence, compassion and collaboration. These values underpin our strategic priorities and shape the culture of our service.

A highlight of the year was CAHS becoming the first Western Australian public health service provider to undergo a Short Notice Accreditation Assessment Pathway (SNAAP) assessment. I am delighted that the national assessors provided exceptional feedback, a true reflection of the professionalism, dedication and compassion of our staff, as well as our steadfast commitment to continuous improvement and the highest standards of care.

We continue to embrace reform to meet the growing demand for mental health and child development services, and to strengthen our capacity through investment in health facilities, infrastructure, and our workforce. These changes are critical to ensuring CAHS remains responsive and resilient in the face of emerging needs.

Working in paediatric health care is a profound privilege and great responsibility. It requires not only technical excellence and expertise, but also deep empathy, resilience, and at times, extraordinary grace under pressure. None of our achievements would be possible without the dedication of our exceptional staff and volunteers, who give so much of themselves in the service of children, young people and their families. To each of you, I extend my deepest gratitude.

I also thank our community, consumers, partners and stakeholders for their collaboration and shared commitment to improving health outcomes for children and young people in Western Australia. Together, we are stronger.

I wish to acknowledge Dr Rosanna Capolingua AM, the outgoing Board Chair, for her outstanding leadership, professionalism and unwavering commitment to CAHS.

I also extend my thanks to my fellow Board members for their leadership, collective wisdom and guidance throughout the year.

And finally, to the children and young people we serve, you are at the heart of all that we do. You inspire us every day, and are the reason we are driven to deliver the very best health care for you and future generations.

MESSAGE FROM THE CHIEF EXECUTIVE

Mrs Valerie Buić (née Jovanovic)

> **Our vision is a future where every child has access to the care and support they need to reach their full potential.**

I am delighted to present the 2024–25 Annual Report for the Child and Adolescent Health Service (CAHS). It is a privilege to be part of an organisation so deeply committed to supporting children and young people across Western Australia in living happy, healthy lives.

As the state's only dedicated paediatric health service, CAHS is trusted by families for our expert care, pioneering research and unwavering focus on placing children, young people and families at the centre of everything we do.

Over the past year, CAHS supported more than 1.2 million interactions with children and young people. These included child health checks, school assessments, Emergency Department visits, surgeries and mental health care. Each interaction reflects the scale of our service, and the trust placed in us by families across the state.

To improve access to essential services for families, we opened the Midland and Murdoch Community Hubs, creating welcoming spaces where a variety of child health services are available in one convenient location. We have also expanded our child development services to support earlier assessment and intervention, helping children with developmental challenges get the best possible start in life.

Mental health care has also continued to progress through the introduction of Acute Care and Response Teams, the rollout of Crisis Connect, and broader reform efforts. Virtual and home-based services have expanded, including telehealth, Hospital in the Home, and the Hospital Anywhere Physiotherapy Initiative, bringing care directly into homes and communities.

Building on this momentum, theatre capacity at Perth Children's Hospital has been increased to help reduce surgical wait times, and innovative new pathways and resources have been developed to improve the ADHD assessment process and provide tailored support for neurodivergent children and their families.

We have strengthened our collaboration with consumers, drawing on their lived experiences to shape more responsive and inclusive services. This year, we introduced the Community Ambassador Program and launched targeted initiatives to promote Aboriginal health equity, including a pilot in the Emergency Department and a new model of care delivered within the community.

All of our achievements at CAHS are made possible by the remarkable people who make up CAHS. Across every service area, our workforce brings together expertise, compassion and a deep commitment to the wellbeing of children and families.

With internationally recognised clinical excellence and a workplace culture that fosters collaboration and care, we continue to attract and retain outstanding professionals who bring our values to life.

We are also supported by dedicated volunteers whose generosity and spirit enrich our services and bring comfort and joy to those we care for. To our internal and external partners, thank you for your collaboration, insight and ongoing support. Your contributions are essential to our success.

CAHS remains committed to building on our achievements, embracing innovation and working together to create a lasting impact.

Our vision is a future where every child has access to the care and support they need to reach their full potential.

Together, we are making that future a reality.

CAHS strives to bring the voice of our children, young people, their families and caregivers to the forefront of everything we do.

OVERVIEW

WHO WE ARE

The Child and Adolescent Health Service (CAHS) is Western Australia's only dedicated health service provider for infants, children and young people. CAHS is made up of 3 service areas.

Child and Adolescent Community Health

Child and Adolescent Community Health (CACH) provides a comprehensive range of community-based early identification and intervention services to children, young people and their families across metropolitan Perth.

Child and Adolescent Mental Health Services

Child and Adolescent Mental Health Services (CAMHS) provides specialist public mental health services for children and adolescents with moderate to severe and complex mental health conditions. Inpatient and specialised services are based in Perth and accessible to children and young people throughout WA.

Community CAMHS offers catchment-based outpatient services in metropolitan Perth.

Perth Children's Hospital and Neonatology

Perth Children's Hospital (PCH) is WA's only specialist paediatric hospital and trauma centre. PCH provides medical care to children and adolescents 15 years of age or under.

Our neonatology service provides focused neonatal care to newborn babies and infants who need specialised treatment in the first few months of life through intensive care units at PCH and King Edward Memorial Hospital (KEMH), and the mobile Newborn Emergency Transport Service.

CAHS offers services that support children from birth to young adulthood – from caring for them when they are sick, to helping them to have their best health possible. Our services are delivered at PCH and KEMH, and at more than 170 community clinics in schools and homes across metropolitan Perth. This ensures that many of our services are accessible wherever children and families live.

We are proud to support a diverse WA community. Our workforce, and many of the children and young people to whom we provide care, come from different backgrounds and places. We respect, value and embrace this diversity, and see it as a key strength of our health service. As we look to the future, we will continue to work towards building a better and more united CAHS for children, young people and the WA community.

Why we exist

We serve all children and young people across WA so they can achieve their best health and wellbeing, now and into the future.

Child safe organisation

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

CAHS has committed to becoming a child safe organisation by implementing the National Principles for Child Safe Organisations. 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.

OUR VALUES

Our values are the promises we make to our consumers, our colleagues, our partners and the broader community. They define who we are, what we stand for and how we behave.

Accountability: We take responsibility for our actions and do what we say we will.

Equity: We are inclusive, respect diversity and aim to overcome disadvantage.

Respect: We value others and treat others as we wish to be treated.

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

Compassion: We treat others with empathy and kindness.

Collaboration: We work together with others to learn and continuously improve our service.

OUR STRATEGIC DIRECTION

We are guided by our CAHS Strategic Plan 2023–25, which sets out 8 strategic priorities of equal importance, and by the CAHS Strategic Action Plan, which outlines our approach to meeting the objectives of the Strategic Plan.

See the Strategic plan performance section (page 33) for detail about some of our key achievements in delivering on our strategic priorities.

Our strategic priorities

Person-centred care

We will meaningfully engage and partner with children, young people and their families. We will place them at the centre of every decision and provide care that is based on their needs and preferences.

Inclusivity, diversity and equity

We will respect, embrace and champion the diversity of our community. We will uphold equal opportunity and we will not tolerate racism or discrimination. Our care will be culturally safe and inclusive for people who are Aboriginal, culturally and linguistically diverse, LGBTIQA+SB or who have disability, and we will work towards equal health outcomes.

Organisational culture

We will continue to shape our culture so we live our values, realise our aspirations, and create a workplace where our people feel safe, included, respected and valued.

High performance

We will continuously improve how we work by setting clearer expectations, strengthening our clinical governance, and better using data, benchmarking and performance reporting.

Prevention and early intervention

We will lead and deliver integrated, multi-disciplinary and cross-sector initiatives that target prevention and early intervention for all children and young people, and particularly in Aboriginal health and mental health.

Contemporary models of care

We will plan and implement models of care that are informed by children, young people and their families, and are grounded in leading practice, research, evidence and data.

Workforce capability, capacity and development

We will plan for and grow a sustainable workforce whose skills and experiences are harnessed in the best possible way, and create an environment where our people can sustain a balanced work and personal life.

External partnerships

We will develop and maintain mutually beneficial external partnerships to collectively achieve better health outcomes for children and young people.

OUR CHILDREN AND YOUNG PEOPLE AT A GLANCE

Child and Adolescent Community Health

Child health assessments	**121,224**	financial year
School entry health assessments	**26,188**	school year
Unique children received services from the Child Development Service	**41,781**	financial year
Immunisations	**124,124**	calendar year
New babies welcomed	**25,304**	financial year
Families who accepted offer of universal postnatal visit	**24,268**	financial year

Child and Adolescent Mental Health Services

Service contacts	**129,394**	financial year
Young people seen	**5,893**	financial year
Mental health Emergency Department (ED) presentations	**2,283**	financial year
Inpatient unit separations	**427**	financial year
Crisis Connect calls responded to	**9,790**	financial year
Crisis Connect calls average per day	**16**	financial year
Crisis Connect mental health assessments in the ED or via telehealth	**1,368**	financial year
Crisis Connect follow-up calls after a mental health assessment	**1,438**	financial year

Perth Children's Hospital and Neonatology

Neonatal hospital admissions	**2,918**	financial year
Neonatal days average length of stay	**11.3**	financial year
Neonatal emergency transports	**950**	financial year
Number of pre-term infants	**335**	financial year
Litres of donor milk	**880**	financial year
ED attendances	**69,672**	financial year
Hospital admissions	**33,173**	financial year
Surgeries performed	**16,027**	financial year
Outpatient appointments	**296,023**	financial year
Outpatient patients	**66,626**	financial year
Number of appendicectomies	**400**	calendar year
Number of tonsillectomies	**1,187**	calendar year

1,253,483

CAHS interactions with children and young people in 2024–25

OUR PEOPLE

As WA's only dedicated health service provider for children and young people, CAHS is committed to putting children, young people and their families first in everything we do.

We have more than 7,000 employees who work with dedication, compassion and professionalism to support children, young people and their families.

Our people are located across 171 sites, and serve families across 3 areas:

- Perth Children's Hospital and Neonatology
- Child and Adolescent Community Health
- Child and Adolescent Mental Health Services.

7,213
Number of employees

3,784
Full-time employees

3,429
Part-time employees

33 (82.5%)
Senior leadership roles held by women

125 (1.7%)
Aboriginal people

74 (1%)
Employees with disability

982 (13.6%)
Culturally and linguistically diverse people

523 (7.3%)
Young people aged 18–24 years

Table 1: Total full-time equivalent roles by category

Category	Description	2023–24	2024–25
Administration and clerical	All clerical occupations, together with patient-facing (ward) clerical support staff. Board members	1,043.9	**1,149.2**
Agency	Administration and clerical, medical support, hotel services, site services, medical salaried (excludes visiting medical practitioners) and medical sessional	43.4	**43.6**
Agency nursing	Workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest	4.6	**7.8**
Assistants in nursing	Workers who support registered nurses and enrolled nurses in the delivery of general patient care	53.8	**61.8**
Dental nursing	Dental nurses and dental clinic assistants	8.2	**9.4**
Hotel services	Catering, cleaning, stores/supply, laundry and transport occupations	233.9	**248.0**
Medical salaried	All salary-based medical occupations, including interns, registrars and specialist medical practitioners	562.2	**594.7**
Medical sessional	Specialist medical practitioners who are engaged on a sessional basis	91.9	**98.6**
Medical support	All allied health and scientific/technical related occupations	784.4	**834.7**
Nursing	All nursing occupations. Does not include agency nurses	1,999.3	**2,051.6**
Site services	Engineering, garden and security-based occupations	21.5	**26.4**
Other roles	Aboriginal and culturally and linguistically diverse roles	26.0	**26.9**
Total		**4,873.2**	**5,152.6**

OUR VOLUNTEERS

Every day our volunteers make an incredible contribution to the children, young people and families we serve. In their signature orange attire, the 'team in tangerine' donate their time to make everyone's CAHS experience positive and warm.

Our more than 440 volunteers generously give over 700 hours every week to support the care of WA's children, young people and families. From comforting kids in the PCH Emergency Department to offering a helping hand across 38 service areas – including wards, outpatient clinics, special education settings, the neonatal unit and the Stitches Shuttle – our volunteers are an important part of our team.

Our volunteers are as diverse as the community we serve. Seventy-five years separates our oldest and youngest volunteers. More than 45 different languages are spoken. One in 4 of our volunteers is studying – many of them in health disciplines. An increasing number of the team identify as having additional needs.

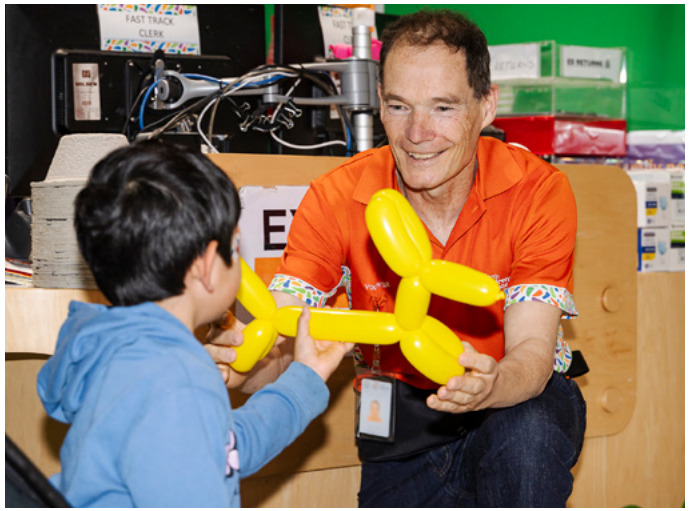
We're delighted that our volunteering partnership with the University of Western Australia's University Hall is flourishing. The partnership gives international students unique opportunities for community participation by volunteering at PCH.

New for this year are our volunteer-led mobile activity carts, chock full of stationery, craft and other fun activities to keep children busy while they wait at PCH.

Our popular animal therapy program continues to grow via our partnership with Animal Companions. The furry team has increased to 8 therapy dogs – Luna, Ludo, Winston, Mars, Shimma, Merlin, Karri and Murphy – who visit PCH regularly and bring comfort and joy to PCH families. The program has been expanded so that even staff get regular visits from our 4-legged volunteers.

Community donations continue to demonstrate the generosity of Western Australians. CAHS regularly receives a range of donated goods, such as new toys, school supplies, crafts and musical instruments, and our volunteers help to sort and distribute these donations across CAHS for the benefit of those in need.

We celebrated the achievements of our volunteers at our annual Christmas lunch and recognised every volunteer for their invaluable service.



OUR AWARD WINNERS

Our staff do extraordinary work across CAHS serving children, young people and their families every day of the year.

We are immensely proud of all our people who have been recognised through this reporting year for their achievements via formal awards and recognition programs.

The following are highlights of some of our award-winning staff.

Jemma Weidinger (left), Maria Xavier (right)

WA Health Nursing and Midwifery Excellence Awards

- Maria Xavier, clinical nurse
  – Excellence in Aboriginal Health
- Jemma Weidinger, nurse practitioner
  – Excellence in Leadership - Established Leader

WA Health Awards

- WA Respiratory Syncytial Virus (RSV) Infant Immunisation Program
  – Excellence in Preventative Health (joint winners CAHS, Department of Health and WA Country Health Service)

King's Birthday Honours List

- Professor Tim Jones, Director Research
  – Member of the Order of Australia, for significant service to medical research, particularly to paediatric endocrinology and diabetes.
- Professor Britta Regli-von Ungern-Sternberg, consultant anaesthetist
  – Member of the Order of Australia, for significant service to medicine as a paediatric anaesthetist and researcher.

Parvan Gill (left), Dr Pamela Laird (right)

WA Health Excellence in Allied Health Awards

- Parvan Gill, nutritional feeds officer
  – Allied Health Assistant Award
- Dr Pamela Laird, senior physiotherapist
  – Allied Health Researcher Award

Prime Minister's Prizes for Science

- Professor Britta Regli-von Ungern-Sternberg, consultant anaesthetist
  – Frank Fenner Prize for Life Scientist of the Year

Premier's Science Awards

- Dr Pamela Laird, senior physiotherapist
  – Early Career Scientist of the Year

WA Women's Hall of Fame

- Professor Michaela Lucas, clinical immunologist
  – inducted to WA Women's Hall of Fame

Western Australian Science Hall of Fame

- Winthrop Professor Fiona Wood AO
  – inducted to Western Australian Science Hall of Fame

CAHS Annual Excellence Awards

- Professor Rishi Kotecha, consultant (oncology and haematology)
  – Researcher of the Year Award
- PCH Emergency Department Live Project Team
  – Innovation Award
- Dr Natasha Epari and Dr Justin Hii, consultants (anaesthesia and pain medicine)
  – Sustainability Award
- Anna Moore, clinical nurse specialist
  – Aboriginal Health Award
- Frank Melia, volunteer – Volunteer Award
- Dr Andrew Wilson, Head of Department Respiratory Medicine
  – Culture and Inclusion Award
- Renée Deleuil, Acting Coordinator of Nursing
  – Values in Action Award, PCH and Neonatology
- Maria Mitchell, child health nurse
  – Values in Action Award, CACH
- Amy Bell, facilities manager
  – Values in Action Award, CAHS-wide services
- Alison Parkinson, lived experience coordinator
  – Values in Action Award, CAMHS
- Professor Chris Blyth, professor infectious diseases, and the CAHS Sepsis Working Group
  – Safety and Quality Award
- Professor Lakshmi Nagarajan, paediatric neurologist and epileptologist
  – Excellence in Child Clinical Care Award
- Kerrie Graham, clinical nurse specialist (oncology)
  – Consumer Experience Award
- Alix Lincoln, senior occupational therapist
  – Rising Star Award
- Matthew Holmes, Director Consumer Engagement
  – Chief Executive Award

CONSUMER ENGAGEMENT

Children, young people and their families are at the heart of our work. They are the reason we do what we do.

CAHS strives to bring the voice of our children, young people, their families and caregivers to the forefront of everything we do, and to ensure we do this in a safe and accessible way.

CAHS has made significant steps forward in truly listening and actively responding to the needs of our consumers and to make them feel valued as partners in designing and improving our services.

Guided by the CAHS Consumer Engagement Strategy 2023–2026, 'Trusting the Partnership', CAHS has expanded the ways consumers can engage with us, particularly those from diverse communities. We have taken steps to minimise language and access barriers.

In 2024–25 we established the new CAHS Community Ambassador Program, which created formal connections with established and trusted community leaders and advocates. The program seeks to better understand the unique social factors that influence how young people and families interact and engage with us, the barriers they face and what they may find helpful when navigating our health service.

Launched in December with 11 ambassadors from a variety of multicultural and youth communities across WA, the program facilitates safe and inclusive two-way information sharing between CAHS and the wider community.

One of the first key initiatives of our multicultural Community Ambassadors is working with us to co-design a cultural safety indicator for multicultural communities who use children's health services.

Our youth Community Ambassadors are mentoring high school students and looking at how we can enhance social inclusion for neurodivergent young people to improve their mental health.

CAHS' other key achievements this year:

- an Aboriginal Consumer Engagement Action Plan to improve engagement with Aboriginal families to inform health service design and delivery
- a staff education and training package on co-design approaches and safe engagement
- engagement with a broad range of consumers on improvements to PCH meal services
- children's art and crafts activities in the PCH Atrium during celebration days and weeks to help engage children and young people
- the opportunity for consumer representatives and Community Ambassadors to undertake a wide variety of face-to-face training sessions
- a consumer engagement project register to capture all of the consumer engagement initiatives occurring across CAHS
- expanding the CAHS Engage Online Consumer Network to include more than 1,000 young people, parents and carers and key partners

- a Cultural Conversation forum with members of the broader multicultural community to learn about the best ways to engage them to access mental health services
- sharing the results of the consumer representative evaluation survey with consumer representatives at the annual CAHS Consumer Representative Network Forum, and providing training to help consumers share their story safely
- new consumer advisory groups for clinical services: Oncology and Haematology Consumer Advisory Group, Differences in Sexual Differentiation Consumer Advisory Group, Paediatric Critical Care Consumer Advisory Group and Hospital in the Home Remote Monitoring Consumer Advisory Group.

CONSUMER FEEDBACK

We want to know more about people's experiences of CAHS and how we can do better to meet their needs.

CAHS proactively seeks consumer feedback to understand and improve our care and services.

We received more consumer feedback this year compared to 2023–24, which demonstrates our continuing efforts to seek the opinions of children, young people and their families.

During the 2024–25 period:

- 700 compliments were received through formal feedback processes
- 348 contacts were received through the Child and Family Liaison Service
- 892 complaints were received through formal feedback processes.

From these:

- 99 per cent of complaints were acknowledged within 5 working days
- 93.6 per cent of complaints were resolved within 30 working days.

CAHS values the feedback from children, young people, families and carers and recognises the positive effect our staff have on those in their care. The feedback shows that CAHS staff are delivering care to children, young people and families with compassion and kindness in accordance with the CAHS values.

This year, the following improvements have been made to the way we manage complaints.

- Most complaints were acknowledged within 5 working days.
- More than 90 per cent of complaints were resolved within 30 working days, in line with the WA Complaints Management Policy timeframe.
- We increased the number of staff at the Child and Family Liaison Service so that we can manage complaints more quickly.
- We continued to improve the way we manage complex complaints. This included triaging consumer feedback and facilitating family meetings, where appropriate, so that families can discuss their concerns in detail and partner with clinicians to improve how we deliver our services.

MEASURING THE CONSUMER EXPERIENCE

How we measure the consumer experience

CAHS uses a range of surveys that produce a Net Promoter Score (NPS), which is an internationally recognised measure of overall consumer experience, a consumer's willingness to use a service again and whether they would promote the service to others.

What is a good NPS score?

- below 0 requires improvement
- between 0 and 50 is good
- between 50 and 70 is excellent
- 70 or greater is world class.

Perth Children's Hospital and Neonatology

A link to the MySay or MyVisit survey is sent to all families of admitted patients, patients who visited the PCH Emergency Department or outpatients, and patients of the Neonatology wards at PCH and KEMH.

75	Inpatient
70	Outpatient
56	Emergency Department

Key themes that emerged:

- Staff deliver a high standard of care which often exceeds consumer expectations; children, young people and families feel very well cared for.
- There is strong engagement from staff. Families are kept informed and involved in care, thereby reducing anxiety and fostering collaboration.
- Staff show attention to detail and respect towards the individual needs of children and young people. They demonstrate compassion, kindness and a focus on reducing anxiety during hospital experiences.
- Staff and volunteers display professionalism, empathy and warmth.

A key area for improvement was communication between teams and with consumers, particularly during periods of high activity in the hospital.

Child and Adolescent Mental Health Services

The Your Experience of Service (YES) survey and Carer Experience of Service (CES) survey were implemented in 2020. These surveys report an overall experience score. CAMHS staff offer the survey at key assessment points.

87	Overall experience score for young people
86	Overall experience score for parent/carers

Key themes that emerged:

- Care was delivered in a welcoming and safe environment, with fun activities to participate in.
- Consumers and carers felt listened to and supported.
- CAMHS has dedicated staff who consistently demonstrate openness, kindness and respect for privacy.

Child and Adolescent Community Health

The Community Health Consumer Experience survey is sent as a text message to parents and carers of children 5 days after attending the 4-month child health nurse appointment, and 5 days after attending a Child Development Service appointment.

85	Nursing
82	Child Development Service

Key themes that emerged:

- Family values are respected, and views and concerns are always listened to.
- Staff work with families, and give them various options for supports and resources so that they can make informed choices.
- Care is flexible and responsive and helps families to achieve their goals and priorities.

CONSUMER REPRESENTATIVES

Message from the Co-Chairs of the CAHS Consumer Leadership Council

The CAHS Consumer Leadership Council (CLC) has continued to grow in strength, connection and impact. As Co-Chairs, we are proud to lead a group that brings together the voices of consumer representatives from across CAHS, ensuring lived experience is at the heart of how services are designed, delivered and improved.

This year, the CLC has focused on deepening collaboration – both within the Council and with the broader CAHS community. We've strengthened communication channels between the consumer networks we represent and the CAHS Executive and Board, and worked to ensure that key consumer priorities are reflected in service planning and strategic decision-making.

We are grateful for the ongoing support from CAHS leaders and staff, and look forward to continuing to build a strong culture of partnership where consumers are respected as essential contributors to health services for infants, children and young people.

Amber Bates and Amelie Farrell

Co-Chairs, Consumer Leadership Council

CONSUMER ADVISORY GROUPS

The CLC is made up of the consumer Chairs from the following 6 CAHS consumer advisory groups.

Aboriginal Community Advisory Group (ACAG)

The ACAG brings the voices of Aboriginal consumers and community representatives to the forefront, helping CAHS to deliver culturally appropriate approaches to improve the health of Aboriginal children, young people and families.

This year the ACAG provided expert advice on improving Aboriginal person-centred care approaches at CAHS, identified key elements of consumer experience for Aboriginal families and ensured that CAHS is meeting its responsibilities under the WA Aboriginal Health and Wellbeing Framework 2015–2030.

Multicultural Access and Inclusion Advisory Group (MAIAG)

The MAIAG oversees the implementation of the CAHS Multicultural Action Plan 2022–2027 to ensure that our services respond to the diverse needs of multicultural children, young people, families and staff. The group supports improvements to accessibility, cultural inclusivity and equitable health care experiences across CAHS.

This year the MAIAG welcomed new staff members from CAMHS, which strengthened the group's capacity to advise on culturally safe and informed mental health care.

Parent and Carer Advisory Group (PCAG)

The PCAG represents the interests of parents and carers of infants, children and young people who use PCH, Neonatology and CACH services.

This year the PCAG began developing its own consumer-led improvement initiative by exploring the creation of a parent information hub to help families access service information more easily.

The PCAG participated in the first 'consumer buddy' trial at CAHS. In the successful trial, a group member formally partnered with one of the participating clinical services to bring a direct consumer voice to inform service changes and provide a stronger link to families using those services. Group members also advocated for the ongoing strengthening of bereavement services to better support parents and carers through the loss of a child.

Youth Advisory Group (YAG)

The YAG is the key consumer advisory group for young people who use services at PCH and CACH. Its members offer diverse perspectives and lived experience, and play a crucial role in enhancing health services for children and young people.

This year the YAG was honoured with The Y WA Collective Action Award at the 25th WA Youth Awards. The award recognises the group's dedication and commitment to fostering positive and meaningful change for the youth of WA. The YAG strongly advocated for the improvement of inpatient food options at PCH to address the diverse dietary and cultural expectations of the children and young people using inpatient services.

CAMHS Lived Experience Advisory Group (LEAG)

Made up of young people, parents and carers who have lived experience of CAMHS services, the LEAG is passionate about improving mental health care delivery. The group provides feedback on service development, reform, policy, communications and consumer resources. This year the LEAG welcomed 2 new Aboriginal representatives, a young person and a parent, to strengthen the group's cultural perspectives.

This year the LEAG co-facilitated staff training on the importance of gathering consumer feedback, co-developed information resources for young people being admitted to the ward, reviewed clinical resources and continued to advocate for youth mental health reform. The LEAG secured funding to develop a series of youth-designed short videos about what to expect from community CAMHS.

Disability Access and Inclusion Advisory Group (DAIAG)

The DAIAG advises on and advocates for improved disability access and inclusion across CAHS services and monitors the implementation of the CAHS Disability Access and Inclusion Plan 2022–2025.

This year the DAIAG focused on increasing staff knowledge and skills in caring for people with disability, increasing awareness of barriers faced by people with disability, and advising on disability access and inclusion for staff and consumers.

The DAIAG strengthened its collaboration with key partners, such as Carers WA, Carers Council of WA and Kiind, and explored ways CAHS can better recognise and meaningfully support carers. The DAIAG's advocacy has helped CAHS initiate positive changes to services and support for neurodivergent children and young people.

COMPLIMENTS

We immediately felt looked after

From the first interaction with the triage nurse to the doctor on duty and the rest of the team, we immediately felt looked after. Everyone was very kind and gentle especially to our little one who was very flat and scared. When our 21 month old son had some blood taken and an x-ray done, both doctor and nurses always made it less scary and quick every time, which was very reassuring for us parents.

Both my husband and I went home last night knowing that our little guy will be ok, and we made the right decision to take him to the ED. We were never made to feel that we were just 2 parents that were being paranoid, because their son was having a fever.

Incredible neonatal nurses

The nurses on the ward were incredible. They were very loving with our baby, lifting and holding her gently while singing to her. The nurses were very helpful to the family, advocating for them to be in a room where they could all be together.

The nurses were very lovely to talk to, listened to her story and provided comfort. The doctor and his team were also amazing, he took his time to explain everything clearly and didn't make them feel rushed, he actively encouraged questions.

Diabetes team were fantastic

My son was newly diagnosed with type 1 diabetes and transferred from a regional hospital to PCH. The Diabetes team have been fantastic in their delivery of care and training in this life-changing transition for my son and our family.

In particular, we would like to acknowledge our nurse for her kindness, care and encouragement. She has been outstanding in her delivery of care. She has also gone above her usual check-ins to enquire about alternative options for care delivery by the PCH Technology Team for our family as we live in a regional town and travelling to PCH can be difficult. We appreciate our nurse's care through this newly diagnosed period, her encouragement has been uplifting and a great acknowledgement of how well our son is doing in his new diagnosis.

Child health nurse helped me seek and find support

Just wanted to pass on some compliments to the lovely child health nurses at the Leeming centre, who are doing a fantastic job supporting the new mums in their area. We have seen one of them over the past few years and always had such a positive experience. She is patient, thorough, and has a wealth of knowledge and advice to share. She encouraged me to seek support (and helped me to find it) for my post-natal depression and anxiety with my oldest. She never fails to check in on these when we speak.

Child health nurse was my rock

My son was premature and had extreme reflux. The child health nurse was my rock, there were never any stupid questions, and she was always there for me whenever I needed her and even if I didn't realise I did.

She would follow up with me to make sure I was ok. I remember that so vividly as it's a time when a lot of people are focused on the baby and not so much on how the mum is doing. She monitored my child, making sure he was thriving with his reflux and reassured me that what I was doing was amazing and slowly my confidence grew. Two years later we have an amazing 2-year-old who has incredible verbal skills and all round a very healthy and happy little guy.

Support, gratitude and guidance from CAMHS

I wanted to express my deepest gratitude for all the support, gratitude and guidance you have provided me. Your insights, patience and encouragement have been invaluable throughout our time together. Your dedication has not only helped me get through challenging moments but has also empowered me to grow. I appreciate the safe space you create. As I move forward I will carry with me the tools and wisdom you have shared. Thank you for your support and for being a significant part of my journey.

PCH's awesome service

Huge shout-outs to the Nurses and Ward Clerks in Ward 1B and the Physio. My son broke his femur and was in a lot of pain and very distressed – as was I – and every single person made us feel heard and cared for. We were tended to with compassion and always in a timely manner, and we were consistently impressed with how fantastic everyone was. The doctors, nurses, physio, OTs, volunteers and Starlight team members all combined to make our stay as smooth as possible.

We feel so incredibly lucky to have access to such an awesome service in PCH. Even though we live about 3.5 hours away, knowing you're all there gives us great solace. Thank you to all of you, and thank you Ward 1B team for all you do. Your hard work, tenacity and compassion did not go unnoticed.

CARE OPINION

Care Opinion is an online platform where consumers can share their healthcare experiences.

Care Opinion is independent from service providers and supplements existing feedback and complaint management systems. It is an anonymous platform where consumers can share stories with healthcare providers to acknowledge exceptional care that was received or to highlight the need for change. CAHS received 39 stories over the past year. Of these, 14 were complimentary and 4 had both positive and improvement elements. All Care Opinion stories were shared with staff to highlight areas for improvement and to celebrate achievements.

Standing ovation deserved

I wanted to express our heartfelt gratitude to everyone who made our journey through your services so positive. Your Orthopaedics Department deserves a standing ovation ...The MRI team turned what could have been a daunting experience into a fun-filled adventure.

In Clinic C (especially nurse Madi and doctor Madi) the kindness and efficiency of your team shone brightly, even in the midst of your busiest moments. To the nurses in the plaster room, thank you for the steady stream of smiles—it made all the difference. Theatres worked their magic with dressing perfection, and PACU nailed the art of the post-surgery pick-me-up with icy poles.

I didn't get to witness the theatre magic firsthand (thankfully!) but it's clear from the meticulous care my son received that your surgeons and anaesthetists are at the top of their game (thank you so much Mr. Honey and fabulous team Georgie and Madi). Their direct and child-friendly communication was a true standout.

A huge thank you to Ward 3C, where Abbey, Kylie, and the highly skilled graduate nurse were all incredibly caring, kind and comforting to our boy. Special thanks to Amy, the Upper Limb OT, who transformed the anxious nerves into excitement about his "robot arm".

The Starlight Captains were nothing short of heroic. Our boy (and us parents) hugely appreciated your magical touch. To the PCH volunteers – guiding many lost people with energy, patience and generosity. You make the hospital feel like a welcoming community, thank you.

And a shout out to the Communications team for the wonderful video featuring Amelia and Pranay. It's a great reflection of the incredible work being done to make this a truly child and family welcoming experience.

Amazing staff

Our son had to be air lifted to PCH from Busselton Hospital after he was born. I just wanted to say thank you to the amazing staff we saw at PCH who kept him alive and helped nurse him back to health. We really appreciated all the staff, facilities and care he received.

Our son is about to turn 1 and if it was not for the incredibly talented staff and facilities afforded to us, we would not have him to celebrate it with. We are incredibly grateful and humbled by the experience and want to say thank you.

Made my child feel at ease

Coming to hospital is a stressful time but when we went through to PCH ED, I knew that was not going to be the case. The Triage Nurse listened and asked questions intently. The Emergency Doctor went over and beyond my expectations. She knew that we were from out of town and organised referrals on the day. She also took a great interest in our case, and I believe did everything in her power to get answers.

The ED nurse who found my other child upset and gave her a teddy was godsent. The general Paediatrics Team made my child feel at ease and even made her laugh in the tough situation. They kept me up to date with the plan regularly. Nurses on ward 1B were great and made my child feel at 'home'. Thank you all from the bottom of my heart.

Photo courtesy of Perth Children's Hospital Foundation

OUR RESEARCH

CAHS' pursuit of research excellence reflects an enduring commitment to provide Western Australia's children and young people with the highest level of evidence-based care.

This includes local access to cutting-edge treatments and therapies through national and international clinical trials and clinical investigations.

Investing in our researchers and research infrastructure is a cornerstone of creating these opportunities for our patients.

In 2024–25 we continued to find new ways of strengthening and supporting our research community through initiatives that included:

- a Consumer and Community Involvement program that provided scholarships to researchers to assist them with the recruitment and engagement of consumers. In 2025, 10 researchers were awarded scholarships in 2 rounds of the program
- a new funding opportunity – Stan Perron Charitable Foundation Seeding Grants – open to early-career researchers from all clinical disciplines for short-term projects. With substantial funding generously provided in its first year, the program provided grants of $20,000 to 8 researchers
- a service-wide research capability and culture survey to obtain a baseline measure of the skills, engagement and research readiness of CAHS' workforce. The results of the survey will help design further initiatives that support and develop prospective researchers and enable established researchers to remain active in the field.

The collective efforts of our committed staff continue to enhance our research credentials. Highlights from the year include:

- CAHS' Research department emerged from its first assessment under the Australian Commission on Health Care Safety and Quality in Healthcare Short Notice Accreditation Assessment Pathway with a maturity rating of 2.92 out of a possible 3 – the highest rating in Australia at the time.
- CAHS received a High Commendation from the Australian Council on Healthcare Standards at its 27th Annual Quality Improvement Awards.
- CAHS staged another successful research symposium, *Empowering Futures: Advancing Child Health*.

We remain grateful for our partnerships with, and support from, The Kids Research Institute Australia, Perth Children's Hospital Foundation and Channel 7 Telethon Trust (Telethon). Our commitment to world class research is driven by our staff's passion for improving the current and future health outcomes for the children of Western Australia.

The CAHS Strategic Plan 2023–2025 sets out our vision for where we expect to be in the future and the actions we will take to get there.

Underpinned by our 8 strategic priorities, the plan describes our approach to investment and focus in the communities we serve, in our workforce, and in our capabilities as a health service.

This section is a summary of our key achievements this year.

STRATEGIC PLAN PERFORMANCE

Strategic priority

PERSON-CENTRED CARE

We will meaningfully engage and partner with children, young people and their families. We will place them at the centre of every decision and provide care that is based on their needs and preferences.

We place children, young people and families at the centre of care. By listening and partnering with them, we deliver flexible, tailored services that support informed choices and better outcomes.

We have succeeded when

- ✔ our consumers report their experience and satisfaction as high
- ✔ children, young people and their families are always connected to services when needed.

Real talk: Youth-led videos break down mental health support at CAMHS

A new video series is helping young people feel more confident and informed about accessing mental health support at CAMHS.

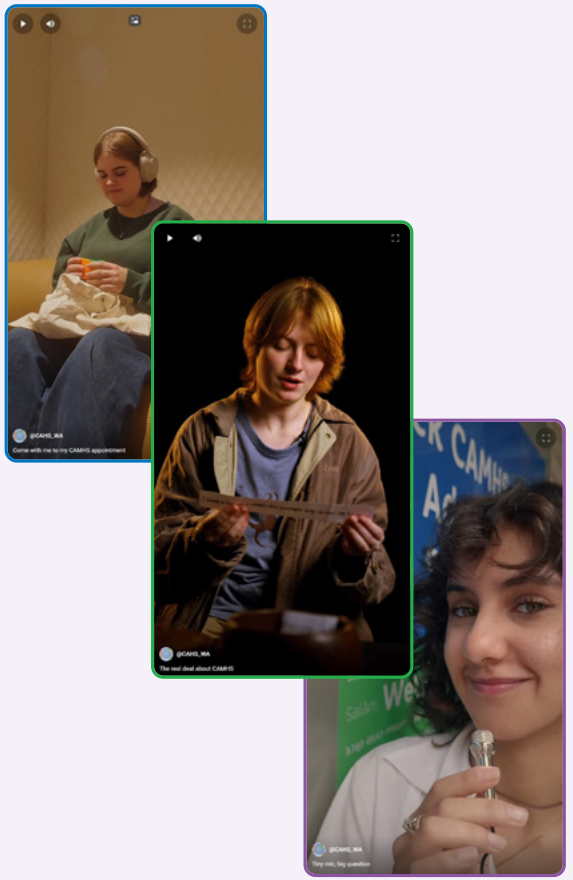
Inforeels is a creative, youth-led project designed for 14–17-year-olds referred to CAMHS community services. Funded by the CAHS Innovation Challenge, the project was co-designed with 6 young people and supported by passionate CAMHS staff.

The result has been a series of short, social media-style videos that speak directly to young people answering common questions, showing real CAMHS spaces, and breaking down the stigma around seeking help.

Filmed at Warwick CAMHS and Midland Community Hub, the videos include:

- The real deal about CAMHS: Honest insights into what CAMHS is really like
- Come with me to my CAMHS appointment: A walk-through of what to expect
- Tiny mic, big question: Quick-fire Q&As with a youth twist.

Because they were made by young people, for young people, these videos feel real, relatable and inclusive. They're helping to make mental health support feel less scary and more accessible.



Scan the QR code to watch the Inforeels

New video resource welcomes families to the neonatal unit

CAHS has launched a new video to help parents feel more informed and supported as they begin their journey in the neonatal unit at KEMH.

This short, engaging video was developed in collaboration with parents, neonatal staff and the CAHS Communications team. It provides a clear overview of what families can expect, the services available and the support offered during their time in the unit.

The video is designed to offer reassurance and practical guidance, helping families feel more confident and prepared and reflects our commitment to improving the experience of care through accessible, family-centred communication.

Scan the QR code to watch the Welcome to the Neonatal Unit video

Hospital in the Home: Bringing care to families

The CAHS Hospital in the Home (HiTH) program continues to grow bringing hospital-level care directly to children in the comfort of their own homes.

HiTH provides acute care and clinical interventions for children who would otherwise need to stay in hospital. This year, the program expanded with 3 new pilot initiatives in respiratory physiotherapy, pharmacy and remote monitoring, making it easier for more families to access care at home.

Highlights from the year:

- The respiratory physiotherapy pilot reduced hospital stays by 25 per cent in its first year and received high praise from patients and families.
- The pharmacy and remote monitoring pilots are already showing promising results, improving patient flow and easing demand at PCH.
- More than 740 children received care through HiTH this year — reflecting its growing popularity and impact.

To meet rising demand, CAHS has also adapted existing spaces to support more telehealth and home-based consultations, ensuring families continue to receive safe, timely and effective care, right where they need it most.

HAPI expands physiotherapy access for regional youth

Children and young people in regional WA are receiving physiotherapy care closer to home thanks to the Hospital Anywhere Physiotherapy Initiative (HAPI), a CAHS outreach program designed to reduce barriers to specialist care.

HAPI delivers physiotherapy through a flexible model that includes virtual consultations, treatment at local hospitals and home-based care via CAHS' Hospital in the Home service. This approach ensures families in remote areas can access high quality care without the burden of long-distance travel to Perth.

Since its launch, HAPI has:

- supported 11 admissions
- delivered 117 days of care
- provided 182 physiotherapy sessions, including 24 sessions in collaboration with WA Country Health Service therapists.

The program has reached families across the Pilbara, Kimberley, Wheatbelt and Goldfields regions, with strong feedback from families who value the convenience, continuity and quality of care.

HAPI is helping to improve patient flow, reduce pressure on metropolitan services and ensure that regional children receive timely, effective physiotherapy support – right where they live.

Stepping up Virtual Care at CAHS

At CAHS, we're always looking for innovative, accessible and patient-centred ways to deliver care so families can get the support they need, wherever they are.

One area making a big impact is virtual health care, and CAHS is proud to be leading the way.

Currently, around one-third of our outpatient services are delivered virtually, helping families across WA access care more easily and conveniently.

CAHS Virtual Care (telehealth) connects patients with health professionals safely and efficiently, helping to reduce travel, avoid unnecessary in-person visits and improve overall access to care.

Highlights from this year:

- Virtual outpatient delivery has grown significantly with 30 per cent of appointments conducted virtually.
- New digitally-enabled and family-friendly autism assessment suites have opened at Murdoch, Midland and Gosnells.
- Digital appointment reminders have helped reduce Did Not Attend rates, allowing more children to be seen and improving service efficiency.
- Culturally responsive design: Aboriginal artist Tyrown Waigana's artwork brightens PCH telehealth clinic rooms, creating a welcoming atmosphere.
- Repurposed spaces: Meeting rooms at PCH have been converted to meet growing demand for telehealth consultations.

> *Around one-third of our outpatient services are delivered virtually, helping families across WA access care more easily and conveniently.*

BIG BOOST FOR CHILD DEVELOPMENT SERVICES

Exciting changes are underway for the metropolitan Child Development Service (CDS), which supports children with developmental delays or difficulties through assessment and early intervention.

This year, the State Government has committed $30.4 million to expand and reform the CDS, meaning more children will be able to access services faster, with shorter wait times and more time spent with clinicians.

These reforms are part of CAHS' response to the Select Committee into Child Development Services recommendations. The CDS team is working closely with families, the WA Country Health Service, the Department of Health, and other partners to co-design improvements that make services more accessible, equitable and family-friendly.

Families will benefit from:

- easier access to services, no matter where they live
- practical strategies and information they can use while waiting for assessment or intervention
- a more efficient and responsive service experience.

This is a major step forward in supporting the developmental needs of WA children – and we're proud to be part of the journey.

MORE TASTY CHOICES ON THE MENU

From sensory meals to bedside delivery and traditional foods, PCH is making mealtimes more inclusive, comforting, and culturally responsive for every family.

Sensory meals support neurodivergent patients

Mealtimes in hospital can be challenging – especially for neurodivergent children and young people with heightened sensory sensitivities. That's why PCH has introduced sensory meal options designed to make eating less stressful and more enjoyable.

These new meals were developed in response to feedback from families and nursing staff, and created through a collaboration between PCH Food Services, Dietetics and members of the community.

Many neurodivergent patients experience challenges such as limited food preferences, difficulty trying new foods and discomfort when different foods touch on the plate.

The new sensory meals are designed with these needs in mind. These meals are nutritious, tasty and served with each component separated, so children can enjoy food in a way that feels right for them.

Early feedback from families has been overwhelmingly positive, indicating less mealtime stress and more comfort. The result is better support for health and wellbeing.

Meal delivery trial at PCH

PCH is trialling a meal delivery service to support parents and carers who are unable to leave their child's bedside.

The initiative, currently running on 2 wards, was developed in response to feedback from families who shared how difficult it can be to access food while staying close to their child. In collaboration with hospital food vendors, PCH explored ways to offer more compassionate and convenient food options on the wards.

Using a QR code included in patient admission packs, families can order a variety of meals such as sushi, salads, sandwiches, hot dishes and drinks through the food vendor online platform. Once the order is ready, a mobile notification is sent and meals are delivered directly to the ward entrance for easy collection.

Early feedback has been very positive, with families appreciating the ease and comfort the service provides. PCH is now reviewing the pilot with a view to expanding it to additional wards.

This trial reflects our ongoing efforts to improve the hospital experience for families.

Enhancing cultural inclusion through food

PCH has introduced culturally appropriate food options for Aboriginal children and young people, following a review of the hospital's inpatient menu.

In collaboration with Aboriginal Liaison Officers and Edith Cowan University dietetics students, PCH conducted yarning sessions with Aboriginal families to better understand their experiences and preferences around hospital food. These conversations highlighted the need for more culturally relevant and familiar meal options. The menu now includes traditional Aboriginal foods – most notably, kangaroo stew – now available as a daily option.

The meals are designed to be both nutritious and culturally meaningful, supporting a more welcoming and inclusive hospital environment.

This initiative aligns with the broader efforts throughout all of CAHS to improve the experience of care for Aboriginal children, young people, and families.

Early feedback has been very positive. More recipes are being developed based on community input.

CAHS 2024 Diwali celebrations

Strategic priority

INCLUSIVITY, DIVERSITY AND EQUITY

We will respect, embrace and champion the diversity of our community. We will uphold equal opportunity and we will not tolerate racism or discrimination. Our care will be culturally safe and inclusive for people who are Aboriginal, culturally and linguistically diverse, LGBTIQA+SB* or who have disability, and we will work towards equal health outcomes.

We provide culturally safe, inclusive care and do not tolerate discrimination. By embracing diversity and listening to our community, we create welcoming services and work toward equal health outcomes for all.

We have succeeded when

- ✔ there is greater diversity in our workforce
- ✔ we better understand the diversity of our consumers and improve the cultural safety of our health service
- ✔ Aboriginal children and young people report a high level of cultural safety and inclusivity with our services.

*Lesbian, gay, bisexual, transgender, intersex, queer, asexual, Sistergirl and Brotherboy.

Building on success: new Social Stories developed

Following the strong uptake and positive feedback from our initial Social Stories resources we've expanded our collection with 6 new topics designed to support neurodivergent children and young people during visits to the PCH ED.

These new Social Stories cover:

- ear and throat examinations
- immunisations
- nitrous gas sedation
- why there might be a wait in the ED
- meeting ED staff
- having an x-ray.

Each resource is photo-based and highly visual, offering step-by-step guidance to help children better understand what to expect in the ED. By making hospital procedures more familiar, these tools aim to reduce anxiety and empower young patients to feel more at ease.

Social Stories – which were downloaded nearly 3,000 times from the PCH website over the past year – are created especially for children with autism, other forms of neurodivergence, and those who speak English as an additional language. Social Stories are part of the Neurodiversity Care Program, a collaboration between the PCH ED and KKIND (Keeping Kids in No Distress).

Scan the QR code to see our Social Stories library

Celebrating Wear it Purple Day at CAHS

CAHS proudly celebrated Wear it Purple Day, showing our ongoing support for LGBTIQA+SB young people and reinforcing our commitment to creating a safe, respectful and inclusive environment.

As Western Australia's lead health agency for young people, we have a responsibility to champion the rights of LGBTIQA+SB youth. When young people and their families feel safe and supported, they are more likely to access our services and experience better health outcomes.

This year's celebrations included staff morning teas, information sessions, welcoming signage and plenty of purple. Staff were encouraged to wear purple as a visible show of support and solidarity.

In the lead-up to the day, CAHS staff and consumer representatives from the LGBTIQA+SB community generously shared their lived experiences. Their stories helped raise awareness and deepen understanding of the challenges and strengths within the community.

Wear it Purple Day is more than a celebration. It is a reminder of the importance of visibility, inclusion and empowerment for young LGBTIQA+SB people across our health services.

Recognising Aboriginal significant dates across CAHS

Throughout the year, CAHS has proudly taken part in a range of Aboriginal significant dates and events. These moments have provided meaningful opportunities to celebrate the culture and contributions of Aboriginal peoples, while continuing to foster a culturally safe and inclusive workplace.

National Sorry Day and National Reconciliation Week

Under the theme *Bridging Now to Next*, staff across CAHS came together for a series of powerful and reflective activities. Highlights included a Welcome to Country, a water ceremony, a screening of *We Were Just Little Boys* followed by a panel discussion, cultural displays and stalls at PCH, shared staff lunches, choir performances and Noongar language lessons.

NAIDOC Week

This year's celebrations were vibrant and community focused. Events included a Kids' Rainbow Bridge Walk, weaving and language workshops, community stalls, a panel session and choir performances.

At KEMH, staff enjoyed a damper cook-off, Welcome to Country, smoking and flag raising ceremonies, NAIDOC awards and a performance by the Mungart Yongah Dance Group.

National Aboriginal and Torres Strait Islander Children's Day

PCH hosted a joyful event in the hospital atrium featuring visitor displays and interactive activities. The day celebrated togetherness and highlighted the importance of supporting Aboriginal children to feel proud and connected to their culture, stories, kin and communities.

These events continue to strengthen our commitment to reconciliation and cultural safety across CAHS.

BOOSTING ABORIGINAL HEALTH EQUITY

A new pilot program at PCH is helping improve cultural safety and health equity for Aboriginal families by employing Aboriginal Health Practitioners (AHPs) in the ED.

AHPs work alongside clinical teams to provide culturally safe care, conduct health assessments, share health information and support referrals. Their presence builds trust, strengthens cultural understanding and improves patient experiences.

The impact has been clear. Patients, families and staff have praised the empathy, dedication and cultural insight AHPs bring to their roles.

Since the pilot began, AHPs have supported care for more than 400 Aboriginal children, as well as non-Aboriginal patients. Consumer consultation is now underway to guide future development and strengthen service delivery.

Strategic priority

ORGANISATIONAL CULTURE

We will continue to shape our culture, so we live our values, realise our aspirations, and create a workplace where our people feel safe, included, respected and valued.

We are building a values-driven culture where staff feel safe, respected and supported. United by our focus on children, we foster a positive environment that delivers compassionate, high quality care.

We have succeeded when

- ✔ we live our values consistently
- ✔ there is an increase in staff engagement, satisfaction and wellbeing.

Creating a safe and positive workplace

CAHS has launched the Safe and Positive Workplace Behaviours program to support a culture where all staff feel safe, respected and valued.

The program defines what safe and respectful behaviours look like, how to give and receive constructive feedback, and how to address concerning behaviours early. It also provides clear guidance and pathways for support and formal resolution when needed.

Staff and managers have access to practical toolkits and interactive workshops. The program is adapted from a successful initiative at Melbourne's Royal Children's Hospital.

Supporting trauma-informed care

To strengthen our ability to support people experiencing trauma, CAHS delivered specialist training in Psychological First Aid to managerial staff.

Psychological First Aid is an evidence-based approach that helps reduce distress after a traumatic event. It focuses on connection, calmness and recovery, encouraging support from colleagues, family and friends.

Facilitated by the Work Health, Safety and Wellbeing team with a clinical psychologist, the training equipped 154 of our managers with practical tools to respond with empathy and confidence.

Celebrating our people

We are proud to recognise and celebrate the exceptional contributions of our staff and volunteers through our expanded Stars of CAHS recognition and reward program.

The program highlights individuals and teams who go above and beyond in delivering outstanding care and service, reflecting our core values of compassion, collaboration, equity, respect, excellence and accountability.

Dr Melanie Yeoh, winner of the Stars of CAHS Consumer Award this Bunuru season

Stars of CAHS – Bimonthly recognition

To provide more frequent opportunities for recognition, the program has transitioned from a quarterly to a bimonthly format, aligning with the 6 Noongar seasons. This culturally significant change allows us to celebrate achievements in a way that resonates with our local context.

Nominations can now be submitted by peers or consumers, across a range of categories, ensuring a broad and inclusive approach to recognising excellence.

Dr Arne Speidel and Dr James Wiffen, winners of the Stars of CAHS Consumer Award this Djeran season

CAHS Annual Excellence Awards

In June 2025, we launched the inaugural CAHS Annual Excellence Awards, celebrating outstanding service and achievement across 12 categories. This event honoured those who consistently demonstrate excellence and embody the values that define CAHS. See page 21 for the full list of winners.

Everyday Peer Recognition

In addition to formal awards, the Everyday Peer Recognition tier remains open year-round. This initiative empowers staff and managers to acknowledge the daily efforts and positive impact of colleagues, fostering a culture of appreciation and continuous recognition.

Together, these initiatives reflect our ongoing commitment to valuing and celebrating the people who make CAHS a place of excellence and compassion.

Strengthening integrity at CAHS

CAHS is committed to transparency, accountability and zero tolerance for fraud and corruption. Staff are strongly encouraged to report any suspected misconduct, with clear processes in place for investigation and resolution.

This year, the CAHS Fraud and Corruption Control System was reviewed and aligned with Australian Standard AS8001-2021 to support ongoing improvements in integrity and prevention.

Key actions include:

- targeted internal audits in high-risk areas like procurement and contract management
- increased communication around mandatory declarations of gifts, benefits and interests
- continued monitoring of the Integrity and Ethics work plan.

Staff and the public can report concerns through multiple channels, including Human Resources, the Integrity and Ethics team, Public Interest Disclosure or external bodies.

CAHS also works closely with the Corruption and Crime Commission, the Public Sector Commission and the WA Health Integrity Working Group to strengthen integrity partnerships.

Staff engagement helps shape a great workplace culture

At CAHS, we know that listening to our people is key to building the kind of workplace culture we all want to be part of. When we understand what matters to our staff, we're better equipped to support each other and deliver outstanding care to children, young people and families across Western Australia.

This year, we connected with more than 500 employees and volunteers to hear their thoughts on how we can create a more positive and supportive work environment. We asked what's working, what could be better, and how we can improve the experience of working at CAHS.

The feedback we received played a big role in shaping our new Employee Voice Culture Framework. This framework lays the groundwork for co-designing our Culture Action Plan 2026–2030, which will guide us in making meaningful improvements to our workplace culture over the coming years.

CAHS connects at WA Multicultural Expo

The CAHS Talent Acquisition team proudly joined the inaugural WA Multicultural Expo at the Perth Cultural Centre to connect with culturally and linguistically diverse communities.

Hosted by the Office of Multicultural Interests, the event brought together multicultural groups, government agencies and community organisations. CAHS staff spoke with attendees about child health, community care and equitable access to health services, especially for new arrivals to Australia.

The team also promoted career pathways in health care, offering guidance and resources to those interested in joining the sector. Many attendees expressed strong interest in learning more about health services, training and employment opportunities.

> *When we understand what matters to our staff, we're better equipped to support each other and deliver outstanding care to children, young people and families.*

LIVING OUR VALUES WEEK AT CAHS

CAHS celebrated its fifth annual Living our Values Week, bringing staff together to reflect on and strengthen our shared commitment to compassion, excellence, collaboration, accountability, equity and respect.

The week sparked meaningful conversations and featured a variety of values-themed activities, including bake-offs, masterclasses, workshops, shared meals, a yarning circle and the always-popular Funky Friday dress-up day.

Living our Values Week continues to be a vibrant reminder of the culture we're building together.

Strategic priority

HIGH PERFORMANCE

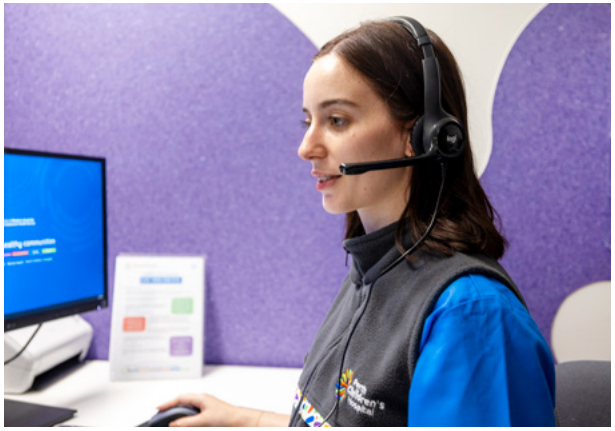
We will continuously improve how we work by setting clearer expectations, strengthening our clinical governance, and by better using data, benchmarking and performance reporting.

We drive continuous improvement through clear expectations, strong governance and data-informed decisions. Research, innovation and planning help us deliver better care and meet evolving health needs.

We have succeeded when

- ✔ there is consistent achievement of performance targets
- ✔ there is a reduction in preventable harm
- ✔ children and young people access the right services, at the right place and at the right time.

Crisis Connect to go statewide



Crisis Connect, a vital support service for children and young people facing mental health crises, is expanding beyond the Perth metropolitan area to reach communities across Western Australia.

Offering phone and online video support, Crisis Connect also provides guidance to families, carers and professionals, ensuring nobody faces a crisis alone. This statewide rollout means every child, young person, and family in WA will soon have equitable access to urgent mental health care, no matter where they live.

The expansion follows direction from the Mental Health Commission. CAHS has formed dedicated steering and working groups to drive the rollout and ensure a smooth transition.

CAHS earns national praise in landmark accreditation assessment

In a major milestone for quality care, CAHS has received glowing feedback from national health care assessors following its first ever Short Notice Accreditation Assessment Pathway (SNAAP) review in July 2024.

As the first WA health service provider to be assessed under the SNAAP model, CAHS set a high benchmark demonstrating our unwavering commitment to excellence and continuous improvement.

Over the course of a week, assessors from the Australian Council on Healthcare Standards visited more than 35 CACH and CAMHS sites, speaking with both clinical and non-clinical staff, and consumers. Assessors also inspected emergency departments, wards and clinics across PCH and the neonatology unit at KEMH.

CAHS met all 151 national accreditation actions – our strongest performance since the standards were introduced. The assessment team praised the consistently high standards across both acute and community care settings.

The assessors were particularly impressed by the CAHS culture and commitment to quality improvements, and expressed admiration for the passion, professionalism, quality focus, collaborative approach, commitment to family-centred care and genuine compassionate nature of our staff.

Research strengthens child's safety in hospital

We are always looking for ways to improve how we care for children. This year, we took a closer look at how we recognise and respond to early signs of clinical deterioration in children, and how we can do it even better.

After introducing the ESCALATION system at PCH and other paediatric facilities across WA, we led research to see how well it's working and where we can make improvements. Both health professionals and families have strongly supported this evidence-based approach.

Our research uncovered some great opportunities to refine the system, including:

- asking more targeted questions to better understand family concerns
- adding a new check for confusion or changes in behaviour
- introducing a structured framework for senior nursing reviews
- aligning with the paediatric sepsis pathway.

We have updated staff education to reflect these learnings, and over 80 per cent of nurses and doctors at PCH have completed the training. We're also working on further improvements to make sure the ESCALATION system better meets the needs of culturally and linguistically diverse and Aboriginal families.

Empowering smarter clinical decisions with the Take 2 – Think, Do Framework

CAHS clinical staff now have a powerful new tool to support decision-making in complex clinical environments. The Take 2 – Think, Do Framework, adapted from the New South Wales Clinical Excellence Commission, is designed to sharpen clinical reasoning and reduce the risk of diagnostic errors.

This framework encourages clinicians to pause and reflect, and take 2 minutes to think critically before acting. It promotes a shared language and structured approach to clinical reasoning, helping teams navigate challenging cases with greater clarity and confidence.

Clinical reasoning describes the thinking and decision-making processes associated with clinical practice. It involves gathering and analysing information to make sound clinical judgments. By strengthening this skill, the framework supports excellence in diagnosis and helps reduce the likelihood of missed, delayed, or incorrect diagnoses.

To make adoption seamless, an eLearning package is available, guiding staff on how to integrate the framework into everyday practice.

Driving innovation in health care: Clinical Service Improvement Program

The Clinical Service Improvement Program empowers our clinicians to lead bold, data-driven projects that enhance patient care. This initiative not only fosters innovation but also strengthens leadership and project management skills across medical, nursing and allied health disciplines.

The biannual program is designed to create meaningful, lasting improvements in clinical services. Each project is grounded in research and evidence being shaped by insights from consumers, staff and organisational priorities.

This year CAHS hosted 6 Clinical Service Improvement Program participants spanning medical, nursing and allied health disciplines.

Completed improvement projects:

- Smarter assessments in ED: Enhancing a digital psychosocial tool for adolescents to improve mental health screening
- Faster access to cancer treatment: Reducing wait times for anti-cancer therapy, ensuring timely and effective care
- Collaborative care for complex conditions: Designing a best practice, multi-disciplinary outpatient model for patients with tracheoesophageal fistula and oesophageal atresia.

Ongoing improvement projects:

- Clearer communication: Improving the quality and clarity of ED discharge summary reports
- Continuity of care for adolescents: Strengthening community-based follow-up for Adolescent Medicine patients
- Tech-enabled diabetes management: Exploring the use of mobile phones as medical devices for patients with type 1 diabetes.

> *The assessment team praised the consistently high standards across both acute and community care settings.*

MENTAL HEALTH SUPPORT ON THE MOVE: MOBILE SERVICE NOW METRO-WIDE

Children and young people across Perth now have greater access to mental health care, right where it is needed. Following a successful pilot, the mobile Acute Care and Response Teams are now operating metro-wide, delivering specialised support directly in the community.

Based at Midland and Murdoch Community Hubs and Warwick CAMHS, these mobile teams are made up of experienced mental health professionals who provide timely, compassionate care to young people experiencing distress without the need for a hospital visit.

The service focuses on early intervention, helping young people build coping strategies and supporting families and carers with tools to manage distress and risk at home.

Since launching in early 2025, the service has already received 167 referrals, highlighting the growing need, and the positive impact, of bringing mental health care closer to home.

Strategic priority

PREVENTION AND EARLY INTERVENTION

We will lead and deliver integrated, multi-disciplinary and cross-sector initiatives that target prevention and early intervention for all children and young people, and particularly in Aboriginal health and mental health.

We lead cross-sector efforts that promote healthy behaviours, identify risks early and support better outcomes, with a strong focus on Aboriginal health and mental health.

We have succeeded when

- ✔ the developing child and their family have the greatest opportunity to improve the child's health outcomes
- ✔ we are a leader in delivering initiatives that contribute to closing the gap targets for Aboriginal children
- ✔ we support the provision of primary care for children in local communities to reduce the need for hospital services.

2024 Infant Mental Health Forum

Jill Pascoe, Executive Director of CAMHS, Maureen Lewis, Commissioner of the Mental Health Commission, Dr Vineet Padmanabhan, Director Clinical Services of CAMHS.

The 2024 Infant Mental Health Forum marked the beginning of a new CAMHS initiative to strengthen support for infant mental health.

More than 200 professionals from government and non-government services came together to hear from leading Australian experts in the field.

As part of this broader program, CAMHS is offering foundation training in infant mental health to all clinicians through Emerging Minds, a national organisation dedicated to supporting the wellbeing of Australian infants, children and families.

Chronic pain support and school attendance

A CAHS-led study has found that access to specialist teaching at PCH plays a key role in helping children with chronic pain stay engaged in school.

The research compared support models at PCH and Stanford University Hospital, both of which use cognitive behavioural therapy and offer allied health and medical services.

PCH's model stands out for its strong focus on pain neuroscience education and its integration of a liaison teacher from the School of Special Educational Needs: Medical and Mental Health to work with the PCH Complex Pain team.

The study highlighted the effectiveness of PCH's collaborative approach, showing improved patient outcomes and efficient use of resources through close teamwork between allied health professionals and education support.

Celebrating 25 years of newborn hearing screening in WA

This year we celebrated a quarter-century of life-changing impact through the WA Newborn Hearing Screening Program. Since its introduction in 2000, the program has helped thousands of babies across the state by detecting hearing loss early and supporting their journey toward strong speech and language development.

To celebrate this achievement, a special event was held to recognise the passionate efforts of medical specialists, teachers of children with hearing loss, Princess Margaret Hospital staff and the Deafness Council.

In 2024 the program screened 98.8 per cent of eligible babies, exceeding the national target of 97 per cent. The service has also grown to include a family support facilitator at PCH, a role that has significantly improved access to early intervention for families.

This milestone is a testament to the dedication of everyone involved and the lasting impact of early hearing screening on children's lives across the state.

Establishing a research centre for rare diseases

The Rare Care Centre is progressing plans to establish a dedicated research centre focused on improving the diagnosis and treatment of children and young people in Western Australia who are living with rare and undiagnosed diseases.

Supported by a grant from the Future Health Research and Innovation Fund, the new centre will be known as the Collaborative Centre for Rare and Undiagnosed Diseases Research and Innovation. It will build on the Rare Care Centre's existing work and provide a platform for advancing clinical care and research.

The centre will aim to:

- enhance diagnostic capabilities and increase access to clinical trials and emerging treatments within Western Australia
- develop and evaluate innovative programs and services tailored to children with rare conditions
- offer professional development opportunities for staff in research and innovation.

Kids Health Matters: Trusted advice from WA's child health experts

The *Kids Health Matters* podcast, produced by CAHS, is quickly becoming a trusted source for families seeking reliable, evidence-based guidance on child health, wellbeing and development.

With more than 8,500 downloads and listeners tuning in from over 50 countries, the podcast is gaining strong momentum and a loyal following.

Hosted by broadcaster and mum of two Dani Shuey, alongside PCH doctor Adelaide Withers and nurse Danielle Engelbrecht, each episode explores topics that matter most to parents. From food allergies and sleep to ADHD and developmental milestones, the podcast delivers expert insights in a warm and accessible format.

Over 11 engaging episodes, *Kids Health Matters* helps cut through misinformation and build parents' confidence by answering commonly asked questions with trusted advice. The podcast takes a consumer-led approach, making child health information easy to understand and relevant to everyday parenting.

Listeners have responded with overwhelmingly positive feedback. The series holds a 5-star rating on Apple Podcasts and Spotify and continues to grow in popularity both locally and internationally.

Kids Health Matters is available via the CAHS website and major podcast platforms

Improving support for families: CACH Nocturnal Enuresis Service review

The CACH Nocturnal Enuresis Service helps families with children over 5 who experience night-time bedwetting.

Delivered by nurses across 10 metropolitan community health clinics, the service combines mat and alarm interventions with behavioural strategies to support children in staying dry overnight. Families receive follow-up care either in person or over the phone.

Families have consistently shared positive feedback about the service. To build on this success, CAHS is reviewing the program to improve access, simplify processes and create an even better experience for families.

Key areas of focus include:

- feedback from staff and consumers
- clinical documentation and equipment processes
- the service model
- data analysis and client journey mapping
- staff training resources
- consumer resources
- service improvement pilots.

This review will help ensure the service continues to meet the needs of families and delivers the best possible outcomes for children.

Smiling Starts dental health program

Smiling Starts is a new initiative focused on improving oral health for children under 5 in Western Australia.

Following a successful pilot in Kwinana and the Avon and Central Wheatbelt region, the program was officially launched at these sites in December 2024, delivering oral health education to families in familiar, child-friendly settings such as playgroups and Child and Parent Centres.

Children identified with oral health concerns during their 12-month health check can be referred by community health nurses. Smiling Starts therapists provide early, minimally invasive treatments to help prevent tooth decay and avoid extractions.

Consumer feedback has been overwhelmingly positive, and plans are underway to expand the program.

Smiling Starts is a collaboration between CAHS, the Dental Health Service (North Metropolitan Health Service), WA Country Health Service and the Office of the Chief Dental Officer.

Scan the QR code to visit the Smiling Starts website

The Kids Health Matters podcast … is quickly becoming a trusted source for families seeking reliable, evidence-based guidance on child health, wellbeing and development.

PCH LEADS THE WAY IN GLOBAL PNEUMOCOCCAL VACCINE TRIAL

PCH is playing a key role in an international clinical trial testing a new pneumococcal vaccine designed to protect against 21 strains of the bacteria responsible for serious illnesses such as pneumonia, meningitis, sinusitis and bloodstream infections.

In partnership with The Kids Research Institute Australia, PCH is one of 6 Australian sites involved in the study, which aims to enrol more than 1,600 infants worldwide. The new vaccine has already shown promising results in earlier studies and could offer broader protection than the current vaccine, which covers 13 strains.

Four-month-old Eric became the first baby in the world to receive the vaccine as part of the global phase 3 trial.

The large-scale study will compare the new vaccine to a placebo to assess its safety and effectiveness.

PILOT ADHD ASSESSMENT SUPPORTING FAMILIES

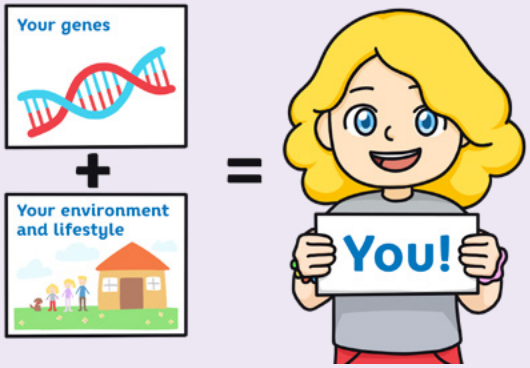
The Attention, Regulation and Concentration (ARC) project is helping children with attention deficit hyperactivity disorder (ADHD) and their families through a new assessment pathway, delivered in collaboration between nurses and paediatricians.

Piloted at the Armadale Child Development Service, the ARC project involves a senior nurse working alongside a paediatrician to deliver coordinated care.

The pilot was designed to trial an alternative assessment pathway and meet the needs of families of children who experience difficulties with attention, regulation and concentration. Since its launch in January 2024, more than 200 children have been assessed and managed through the pathway.

To further support families, a range of educational resources is being developed to help them better understand and support their child at home, work with schools and help their child with other aspects of development and learning.

These resources were shaped by clinicians with consumer feedback, ensuring they reflect the real needs of families. Plans are in place to translate the materials into multiple languages, making them accessible to a wider community.



Strategic priority

CONTEMPORARY MODELS OF CARE

We will plan and implement models of care that are informed by children, young people and their families, and are grounded in leading practice, research, evidence and data.

We design care models informed by families, evidence and lived experience. By delivering the right care at the right time, we respond to changing needs and improve outcomes for children and young people.

We have succeeded when

- ✔ we provide infant, child and adolescent health services that are responsive to the changing needs of the community we serve
- ✔ research and innovations are successfully translated to improve the services and care we provide.

New theatre suite boosts surgery capacity at PCH

Elective surgery capacity at PCH has increased following the opening of a new theatre suite last year and the recruitment of additional clinical staff.

PCH now operates with 10 general theatres, 2 specialised theatres and an intraoperative MRI. To support the expanded capacity, more nurses, surgeons, anaesthetists and anaesthetic technicians have joined the team.

This expansion is contributing to a gradual reduction in surgery wait list pressures, helping improve access to care for children and families across WA.

New program empowers children to move, heal and grow

Photos courtesy of Perth Children's Hospital Foundation

A new service at PCH is helping children and young people with ongoing health conditions unlock the benefits of physical activity. Move to Improve, launched in August 2024, is an individualised program designed to support children with type 1 diabetes, cerebral palsy, burn injuries and cancer.

The program helps participants overcome barriers to movement through tailored, family-friendly sessions delivered at PCH and in the community.

Children involved in the program have reported increased strength and confidence, reduced fatigue and improved mental wellbeing. Many families have also built lasting connections with local sporting clubs.

With plans to expand the service to include other health conditions, a research project is now underway to explore the program's impact on health and wellbeing outcomes.

Breaking barriers in nut allergy care for young children

Two new pilot programs are offering fresh hope to families of young children with nut allergies, with exciting work happening at PCH.

The ADAPT Oral Immunotherapy (OIT) Program helps babies with peanut allergies build tolerance through small, carefully monitored doses. It's already running in 10 children's hospitals across Australia, including PCH.

PCH is also leading an Australian-first clinical trial for preschoolers with multiple nut allergies. The Low-dose Multi-nut Oral Immunotherapy trial allows children to be treated for up to 6 nut allergies at once, including peanuts, using a gentle and safe approach.

The goal of both programs is to help children achieve remission from nut allergies early in life, ideally before they start school. This can ease the stress and worry for families when their children start school.

So far, more than 100 children have taken part in nut OIT at PCH, and there are plans to expand the program across WA. Parents have shared glowing feedback, saying the experience has helped them feel more confident and in control of their child's allergy journey.

These programs mark a big step forward in allergy care, offering not just medical innovation but real peace of mind for families.

New framework enhances mental health journey

A new framework has been introduced on Ward 5A at PCH to strengthen collaboration between staff, children, young people and families during their mental health care journey.

The Working with Children, Young People and Families Framework encourages open communication and shared decision-making. It provides clear information about the model of care and helps families understand what to expect during admission and treatment.

Co-designed by Ward 5A staff, consumers, carers and the WA Mental Health and Advocacy Service, the framework reflects a shared commitment to delivering respectful, inclusive and family-centred care.

Transforming mental health care for young people

Significant reform is underway at CAMHS. A new model of care is set to reshape how mental health services are delivered for children and young people across WA.

The reform responds to recommendations from the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents, and follows extensive consultation with young people, families, staff and key partners.

Community teams are transitioning into area networks that will deliver more consistent, integrated and localised care. Each network will have a centralised intake and assessment process, making it easier for families to access the right support at the right time.

The new model also introduces updated approaches to care coordination and continuing care, along with evidence-based interventions for young people with personality difficulties.

Integrated stepped care will be delivered in partnership with specialist mental health teams.

Throughout this transformation, CAMHS remains focused on ensuring smooth transitions between crisis, inpatient, community and specialised care.

CAHS continues to strengthen partnerships with organisations such as the Mental Health Commission, Youth Focus, Holyoake and Orygen to improve outcomes for young people and their families.

Embedding peer support at CAMHS

CAMHS is continuing to strengthen the role of peer support and lived experience in mental health care, helping to create more meaningful connections between staff, young people and families.

This year, CAMHS has led several initiatives to embed peer support across services.

Highlights include:

- a new guideline to help staff and consumers better understand the role of peer support workers
- a formal review and definition of peer worker roles
- a reflective practice policy tailored for peer workers
- an online resource hub with lived experience workforce information
- peer supervision and a Community of Practice to support peer workers
- a pilot peer-led parent and family skills group at Rockingham CAMHS
- the launch of a Lived Experience Workforce Allies Network to strengthen peer work across CAMHS.

Peer support workers also shared their insights at the WA Mental Health Conference and the WA Peer Support Network Conference, highlighting the powerful impact of lived experience in shaping compassionate, person-centred care.

Celebrating strengths in Aboriginal community health care

A new approach to community-based health care is making a real difference for Aboriginal families, focusing on strengths, culture and connection.

The CACH model of care for Aboriginal children has been thoughtfully revised after extensive consultation with families and community stakeholders. These conversations helped identify barriers and shape a model that truly reflects the needs and values of Aboriginal communities.

This updated model takes a trauma-informed and culturally holistic approach, drawing on the deep strengths of Aboriginal peoples' connections to culture, community, Country and family.

At its heart, it is a commitment to supporting and encouraging responsive, nurturing parenting.

When families leave maternity services, their first contact is now with the CACH Aboriginal Health Team. Parents can choose to continue with this team, connect with their local child health nurse or access another service that suits them best.

So far, 73 per cent of families have chosen to stay with the Aboriginal Health Team, showing just how valued and trusted this new approach is.

This model is more than just a change in service delivery. It emphasises the importance of putting culture at the centre of child health services for Aboriginal families. It's a step forward in creating culturally safe, supportive spaces for Aboriginal children and their families.

Spotlight on neonatal sepsis in leading medical journal

A new academic paper is drawing global attention to the challenges of neonatal sepsis, one of the leading causes of death in newborns.

Professor Tobias Strunk, consultant neonatologist at KEMH, was lead author of the article 'Neonatal bacterial sepsis', published in the prestigious journal *The Lancet*.

Co-authored with internationally recognised experts, the paper explores the latest developments in understanding, diagnosing and treating neonatal sepsis.

Alongside pre-term birth, neonatal sepsis is responsible for the highest number of deaths in the first month of life. The paper highlights the difficulties in diagnosing and managing the condition, especially in low and middle-income countries, and points to the lack of a universal definition as a major barrier to research and treatment.

The paper also discusses promising approaches to preventing sepsis in vulnerable newborns, offering insights that could help improve outcomes for infants worldwide.

SEPSIS PROGRAM GAINS MOMENTUM ACROSS WA

The CAHS Sepsis Program is making great strides in improving care for children throughout Western Australia, successfully rolling out the paediatric sepsis pathway and education program in every WA public hospital, with fantastic results.

By 30 June 2025, nearly 2,500 CAHS clinical staff had completed the training. A study is now underway to see how well the pathway is being used and where we can make it even better.

Community involvement has been a big part of the program's success. Thousands of Western Australians have taken part in sepsis awareness events and education activities, especially during Paediatric Sepsis Week, which shines a light on the early signs of sepsis in children.

Supporting families after sepsis

The Post-Sepsis Care Program is an Australian-first initiative that offers ongoing support to children and families after a sepsis diagnosis.

Developed through a co-design process involving researchers, clinicians and families, the program helps identify and address gaps in post-sepsis care.

Delivered by a team of multi-disciplinary clinicians, the program includes:

- discharge support
- virtual follow-ups at key intervals for up to 12 months
- monitoring to support long-term recovery.

This innovative approach ensures families feel supported every step of the way.

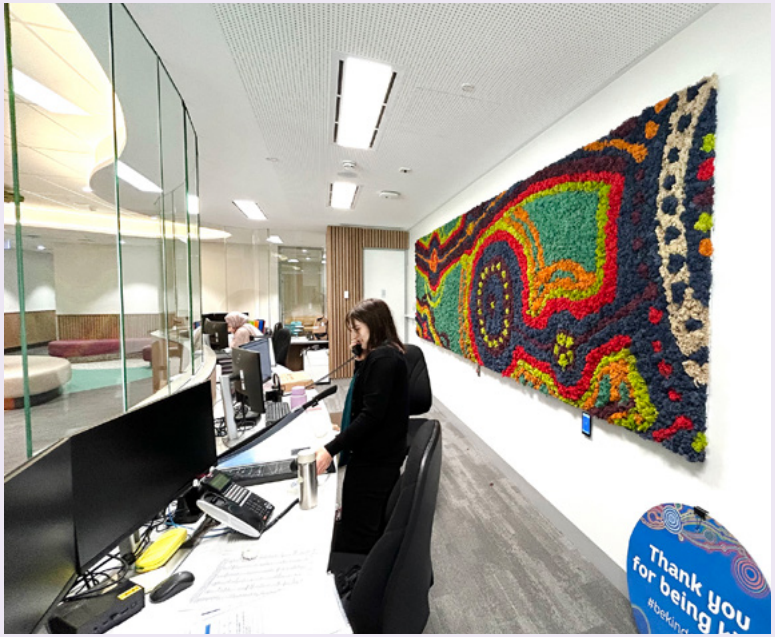
MIDLAND AND MURDOCH HUBS OPEN DOORS FOR CHILD-CENTRED CARE

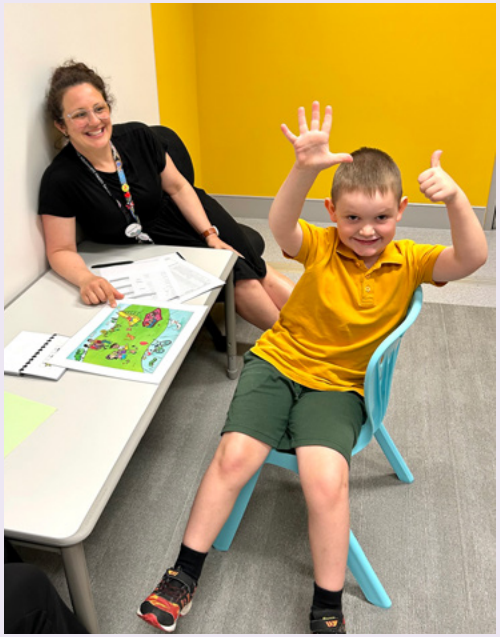
CAHS has opened 2 purpose-built Community Health Hubs in Midland and Murdoch, making it easier for families to access child health, development, immunisation and mental health services in one welcoming location.

Designed as a one-stop shop, the hubs bring together a range of community-based services under one roof, supporting collaborative, child-centred care that helps children and young people thrive.

Each hub has been thoughtfully designed to be inclusive and welcoming for Aboriginal children and families, featuring site-specific artwork, Noongar naming of clinical spaces and in-language welcomes that reflect the stories and culture of the local area.

These new hubs are a big step forward in making care more accessible, connected and culturally safe for families across WA.





Strategic priority

WORKFORCE CAPABILITY, CAPACITY AND DEVELOPMENT

We will plan for and grow a sustainable workforce whose skills and experiences are harnessed in the best possible way, and create an environment where our people can sustain a balanced work and personal life.

We are building a skilled, supported workforce through strong planning and investment. By fostering growth and leadership, we enable high quality care and create a workplace where people thrive.

We have succeeded when

- ✔ there is a stable and sustainable workforce
- ✔ all staff are supported to participate in training and professional development programs
- ✔ CAHS is recognised as an employer of choice by current and prospective staff.

Strengthening our commitment to Aboriginal health

The Aboriginal Health Champions program continues to grow, helping to improve health outcomes and consumer experiences by building cultural understanding across the CAHS workforce.

The program educates staff on cultural safety and how to deliver care that is respectful, responsive and appropriate for Aboriginal children and families.

This year, CAHS proudly welcomed its 69th Aboriginal Health Champion, marking a significant milestone since the program began in 2023.

To further strengthen the program, Aboriginal Health Ambassador roles were introduced. These ambassadors provide leadership, facilitate Yarning Circles, and offer cultural guidance and education to non-Aboriginal staff.

Yarning Circles are safe, inclusive learning spaces that help staff deepen their cultural competency and deliver more culturally responsive and equitable care to the communities we serve.

Creating a better experience for our junior doctors

CAHS is committed to supporting junior medical officers (JMOs) and creating a workplace where they feel safe, valued and empowered.

A range of new initiatives has been introduced to improve wellbeing, safety and training, including easier access to leave, a dedicated doctors' support guide and a refreshed JMO Orientation Program that now includes health and wellbeing.

CAHS also celebrated JMO Wellbeing Week, reinforcing our focus on building a positive and supportive culture for our medical workforce.

These initiatives are part of the CAHS JMO Action Plan, which aims to ensure junior doctors have the support they need to thrive and continue delivering high quality care to children and families.

Working Together, Thriving Together

To further enhance support, CAHS has launched Doctors' HQ, an online hub offering information on wellbeing, training and leave, along with a secure portal for staff feedback.

Future nurses explore careers at CAHS expo

Hundreds of aspiring nurses visited PCH for the CAHS Nursing Careers Expo, eager to learn more about the rewarding world of paediatric nursing.

Attendees connected with CAHS staff and explored career pathways across our service streams. Information stalls showcased graduate nursing programs, clinical specialisations and resources for those considering a career supporting children, young people and their families.

Guided tours of PCH gave visitors a behind-the-scenes look at WA's only dedicated paediatric hospital, offering a real-world glimpse into the dynamic and compassionate environment our nurses work in every day.

Supporting nurse-led research for better care

In 2024, CAHS launched its first Nursing Research Fellowship, a major step toward strengthening evidence-based, research-led nursing care.

Funded through a 3-year commitment from Telethon, the fellowship gives nurses the opportunity to lead research projects that directly impact their field of practice.

The inaugural fellowship was awarded to Arielle Jolly, Paediatric Critical Care Clinical Nurse, whose FOOTPRINTS project is designing and testing a bereavement service for families who have experienced the unexpected loss of a child in the Intensive Care Unit.

The 2025 fellowship was awarded to Maria Garland, CAMHS Clinical Nurse Consultant. Her research focuses on co-designing a therapeutic intervention for adolescents with anorexia nervosa, targeting alexithymia, also known as emotional blindness.

These fellowships are helping to shape the future of nursing care by supporting frontline clinicians to lead meaningful, practice-based research.

Welcoming the next generation of nurses

CAHS welcomed 112 graduate nurses this year through its Transition to Practice Program, designed to support new registered nurses as they begin their careers.

Graduates joined nursing teams across PCH, Neonatology, Community Nursing and CAMHS, with access to tailored program streams that match their area of interest. The program provides a supportive learning environment that helps build resilience, adaptability and professional skills.

Participants benefit from opportunities to collaborate, share experiences and build networks, setting them up for success as they begin their career in paediatric nursing.

> *CAHS is committed to supporting junior medical officers and creating a workplace where they feel safe, valued and empowered.*

PCH LEADS THE WAY IN ALLIED HEALTH CAREER DEVELOPMENT

This year, PCH introduced the Transition to Practice program for allied health professionals – the first of its kind at a tertiary paediatric hospital in Australia.

The program is designed to support early career allied health clinicians as they grow into confident, capable and reflective practitioners. The first intake welcomed 14 graduates from a range of allied health disciplines, offering structured opportunities to build skills, gain experience and strengthen their professional foundations.

Graduates have described the program as highly valuable. After this early success, CAHS is now planning to expand the initiative across the organisation to support even more allied health professionals in their career journey.

Clown Doctors Australia support PCH patients, families and staff.

Strategic priority

EXTERNAL PARTNERSHIPS

We will develop and maintain mutually beneficial external partnerships to collectively achieve better health outcomes for children and young people.

We build strong partnerships to improve health outcomes for children and young people. By working with others in research, innovation and care, we create meaningful collaborations that benefit families across WA.

We have succeeded when

- ✔ our partners have improved experiences when collaborating on common objectives with CAHS
- ✔ we have established closer working practices with health service providers, health providers, child protection and youth justice services and schools.

Our valued partners

We are proud to work with a wide network of partners who help us support the health and wellbeing of children, young people and families across WA.

In 2024–25, we strengthened relationships with non-government organisations, research institutions and funding bodies.

These partnerships are built on shared values and a commitment to improving health and wellbeing. They support new models of care, modern equipment, play spaces and emotional support, enhancing the experience of care for families.

These contributions complement our clinical services and help create a more holistic and supportive environment.

Our partnerships with research institutions such as The Kids Research Institute Australia, Curtin University, the University of Western Australia (UWA) and Edith Cowan University continue to drive innovation. These collaborations enable our clinical teams to engage in research that informs and improves practice, ensuring we remain at the forefront of paediatric care.

We're incredibly grateful for the generous support of our funding partners, whose contributions help us continue delivering world-class care and innovation.

The Perth Children's Hospital Foundation remains a vital supporter of research and equipment funding, playing a key role in advancing paediatric health care.

We also gratefully acknowledge the ongoing support of the Stan Perron Charitable Foundation and Channel 7 Telethon Trust, whose commitment helps us provide high quality services and improve outcomes for children and families across WA.

Together, these partnerships form a strong foundation for everything we do. We are proud of the relationships we've built and thankful for the trust and support that allows us to continue making a difference to the lives of WA families.

> *These partnerships are built on shared values and a commitment to improving health and wellbeing.*

Students help build culturally safe care

CAHS welcomed enrolled nursing students from Marr Mooditj Training for clinical placements at PCH. These placements give students valuable experience in paediatric care while supporting the health and wellbeing of Aboriginal families.

The partnership with Marr Mooditj reflects our commitment to creating a culturally safe and inclusive health system. It also helps build a workforce that better represents and understands the communities we serve.

Looking ahead, CAHS is exploring graduate employment opportunities and future placements for Aboriginal Health Practitioners to continue strengthening this important partnership.

WA's first children's hospice takes shape

Render courtesy of Perth Children's Hospital Foundation

Construction is underway on WA's first paediatric hospice, a collaboration between CAHS and the Perth Children's Hospital Foundation. Hospice construction started in November 2024 and is expected to be completed in 2026.

This year, the focus has been on shaping the model of care with input from families and other children's hospices across Australia. More consultation will follow as the hospice moves closer to opening.

The hospice will offer 7 beds, 3 family suites, therapy and playrooms, a bereavement suite, communal living spaces and a hydrotherapy pool. Families will be welcomed into a warm, home-like space, supported by a dedicated clinical team.

Children will receive round-the-clock care, giving families time to rest. Bereavement support will also be available to families across WA after the loss of a child.

It is our vision and hope that the hospice will be a place of comfort, care and connection for families during some of life's most difficult moments.

Working together to support children in care

CAHS is partnering with the Department of Communities to improve mental health support for children in care. This collaboration is part of a broader effort to update the bilateral agreement between the two organisations.

As part of this work, CAHS has joined forces with the Department of Health and WA Country Health Service to develop an operational escalation pathway. This pathway helps ensure children in care can access the right support when they need it most.

By working together, we're helping create a more responsive and coordinated system for some of WA's most vulnerable children.

New fellowship supports nutrition research in intensive care

Allied health research at CAHS is advancing through the launch of a Telethon-funded fellowship.

As part of the inaugural Allied Health CAHS Research Fellowship, PCH dietitian Tamara Farrell is leading a study into how nutrition affects recovery for critically ill children in paediatric intensive care.

Her research aims to improve outcomes by exploring how targeted nutritional care can support healing during intensive treatment.

MERLIN supercharges AI research at PCH

One of Western Australia's most powerful computers has arrived at PCH, opening new frontiers in child health research.

Named MERLIN, the supercomputer is the result of a collaboration between CAHS and UWA, made possible through funding from the Stan Perron Charitable Foundation.

MERLIN provides researchers with access to a secure artificial intelligence platform and is managed by the Anaesthesia Research team at PCH. It's built to handle complex machine learning projects while safeguarding sensitive medical data.

This cutting-edge technology is already making an impact. MERLIN's first task involves analysing data from more than 10,000 children to identify risk factors for common anaesthesia complications.

Researchers from other CAHS teams including Burns, Rare Diseases, Emergency Medicine and Skin Health, are now launching their own AI-enhanced projects.

Beyond research, MERLIN is helping build AI literacy and capability across CAHS and UWA, empowering teams with dual expertise in medicine and programming to push the boundaries of paediatric care.

Supporting patients with legal challenges

Sometimes legal issues need attention even while someone is in hospital or accessing our services. For vulnerable patients, accessing legal support can be especially difficult. A new initiative is helping bridge that gap.

The Health Justice Partnership brings together CAHS Social Work, Legal Aid WA and the Department of Justice to provide legal services to families within CAHS.

Lawyers are available one day a week at PCH. The Social Work team works alongside Health Justice Partnership lawyers to support families dealing with legal issues that may affect their health and wellbeing.

The initiative was recently recognised with a Silver Award for Best Practice in Collaboration by the Institute of Public Administration Australia WA, highlighting its success in bringing together government agencies to support those in need.

TRANSFORMATIONAL FUNDING BOOST FOR CHILDHOOD CANCER RESEARCH AND TREATMENT

A major step forward in childhood cancer care is underway, thanks to a $135.5 million commitment from the Stan Perron Charitable Foundation.

Over the next decade, this funding will support research and treatment through a powerful collaboration between PCH, The Kids Research Institute Australia (The Kids), the Perth Children's Hospital Foundation (PCHF) and UWA.

This landmark donation, along with additional support from PCHF, will help establish the WA Comprehensive Kids Cancer Centre. The centre will bring together world-class clinical care at PCH with cutting-edge research from The Kids and UWA.

The vision is bold and clear: to ensure every child with cancer not only survives but thrives.

FLYING FORWARD: IMPROVED NEONATAL TRANSPORT FOR REGIONAL WA

Newborns in regional Western Australia now have improved access to specialist care, thanks to a collaboration between the Royal Flying Doctor Service (RFDS), Telethon, and the CAHS Newborn Emergency Transport Service WA (NETS WA).

With support from the Telethon, RFDS helicopters have been upgraded to safely carry neonatal cots. These modifications make it easier for NETS WA to transport vulnerable newborns, including premature babies, from regional hospitals to neonatal units at PCH and KEMH.

The new cot setup is helping reduce transfer times and ensures that families can reach expert neonatology care in Perth more quickly. It's a vital step forward in supporting the health of some of our tiniest regional patients.

HEALTHY PLANET, HEALTHY KIDS

Embedding sustainability for a healthier future

Environmental sustainability is a guiding principle at CAHS. It shapes how we plan, make decisions and carry out our work.

CAHS has set a target of net zero emissions by 2040. Our Environmental Sustainability Strategy and Action Plan 2023–27 is already driving meaningful progress.

This strategy details how CAHS will meet its climate and sustainability targets including requirements set out by the National Health and Climate Strategy, the Western Australian Climate Policy and the WA Emissions Reduction Framework.

Guiding principle

SUSTAINABILITY

We use all our resources wisely and are committed to embedding financially and environmentally sustainable work practices for the benefit of future generations.

What we have achieved this year

Building climate-smart capability

- Expanded climate and environmental training for staff
- 8 team members received scholarships for carbon literacy training at Edith Cowan University
- Regular presentations helped staff understand the connection between climate change and health.

Driving research and innovation

- Partnered with the Department of Health to advocate for climate-health research
- The Future Health Research and Innovation Fund now includes climate change in its funding priorities.

Engaging our community

- Partnered with Doctors for the Environment and the Conservation Council of WA
- Hosted an event at PCH for staff, children, young people, and families to raise awareness about the link between environment and health.

Strengthening leadership and governance

- Introduced a Climate and Sustainability Oversight Committee
- Expanded the Sustainability Working Group to support implementation of the strategy.

Greening our transport

- Installed electric vehicle charging stations at the CAHS Midland Community Hub
- Ordered our first electric fleet vehicle to support the WA Electric Vehicle Strategy.

Measuring what matters

- Continued participation in the Department of Water and Environmental Regulation's emissions project
- Our emissions data is helping shape smarter, more targeted climate action.

Innovating for impact

- The CAHS Sustainability team won the CAHS Innovation Challenge
- Their project focuses on developing an asset reuse program to reduce waste and cut emissions.

Rethinking waste

- Repurposed large volumes of COVID-era personal protective equipment across community health clinics
- PCH joined the Pharmacycle blister pack recycling program
- Over the past 3 years, recycled more than 36,000 containers through the Containers for Change program.

BURNS CLINIC CHAMPIONS GREEN THINKING

How one team turned small steps into big change

At the PCH Burns Clinic, a quiet revolution has been taking place. Led by passionate nurse Michelle Adamson (pictured right), a team of staff set out to answer a powerful question:

Can simple, low-cost changes spark a culture of sustainability in a busy clinical setting?

The answer was a resounding yes.

Over 14 weeks, the clinic rolled out a sustainability improvement project that was as practical as it was inspiring. The goal? To boost staff awareness and shift attitudes toward environmental responsibility. All without breaking the budget.

Three simple actions made a big impact:

- A Green Team was formed, bringing together staff from across disciplines to champion eco-friendly ideas.
- Face-to-face education sessions helped connect the dots between climate change and children's health.
- A vibrant visual display board shared tips, facts, and inspiration to reduce the clinic's environmental footprint.

At the start, staff already cared deeply about sustainability, but many weren't sure how to apply it in their day-to-day roles. The project changed that. With support and practical tools, the team began to see real opportunities for change.

The results spoke for themselves:

- Knowledge and confidence around sustainability increased.
- Single-use plastics were significantly reduced.
- Recycling increased, including new efforts to recycle single-use metals.
- Plastic blueys (absorbent sheets) were swapped for more sustainable alternatives.
- Paper handouts were replaced with QR codes, cutting down on printing.

What started as a small experiment has now become part of the clinic's identity. The Burns Clinic is proving that when staff are empowered and supported, sustainability becomes more than a goal. It becomes a way of working.

LOOKING AHEAD

We are proud of what we've achieved this year, but we are just getting started. From reducing emissions to rethinking waste, CAHS is committed to building a future where healthy kids thrive on a healthy planet.

Together, we're turning sustainability into action, and action into impact.

Through compassionate leadership and accountable governance, the CAHS Board ensures that care is safe, high quality and tailored to individual needs.

GOVERNANCE

OUR MINISTER, ENABLING LEGISLATION AND OPERATIONS

Responsible Minister

CAHS is responsible to the Minister for Health; Mental Health, and the Director General of the Department of Health, as System Manager, for the efficient and effective management of the organisation.

Enabling legislation

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*.

Accountable authority

Under section 70 of the Act, CAHS is a Board-governed health service provider, responsible to the Minister for Health; Mental Health, the Honourable Meredith Hammat MLA.

The Minister appoints the CAHS Board Chair and Board members.

The Director General of the Department of Health, as System Manager, is responsible for strategic leadership, systemwide planning, policy and performance, and provision of services for health service providers. The System Manager is the employing authority of the CAHS Chief Executive.

The Board works closely with the Chief Executive, who manages the day-to-day operations of CAHS to deliver safe and high quality health services.

CHILD AND ADOLESCENT 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 monthly. During 2024–25, the Board met on 12 occasions. In this period, there were 4 standing committees of the Board:

- Finance
- Audit and Risk
- Safety and Quality
- People, Capability and Culture.

Board members absent: Mrs Meghan Maor and Mr James Jegasothy

The Child and Adolescent Health Service Board is dedicated to improving the health and wellbeing of children and young people across Western Australia.

With a strong commitment to person-centred care, the CAHS Board places children, young people, and their families at the heart of every decision. Through compassionate leadership and accountable governance, the CAHS Board ensures that care is safe, high quality and tailored to individual needs. Guided by a vision of equity, excellence, and continuous improvement, the Board helps shape a child health system that listens to families, responds to community needs, and evolves to support every child in living their healthiest life.

BOARD MEMBERS

As at 30 June 2025

Ms Pamela Michael

Board Chair

Dip HSc (Nursing), BHSc (Nursing), LLB, Postgraduate Management, GAICD

Ms Pamela Michael is a senior solicitor and former registered nurse with more than 30 years of experience in the health, legal, and management sectors. She brings a unique and extensive blend of expertise in legal, insurance, health, corporate governance and executive leadership.

A former managing partner and director of a leading medical defence law firm, Ms Michael is a recognised legal specialist in medical negligence, civil litigation, and regulatory and professional conduct matters. Most recently practising in New South Wales, she has provided strategic legal counsel across complex medico-legal issues.

Earlier in her career, Ms Michael practised as a registered nurse. She also holds postgraduate qualifications in management and is a Graduate of the Australian Institute of Company Directors (GAICD), reflecting her strong commitment to governance and board leadership.

Professor Daniel McAullay

Chair, People, Capability and Culture Committee

PhD, M AppEpi, BSc

Professor Daniel McAullay is a health professional with extensive experience as a member of health boards and committees. Professor McAullay is the Dean of Kurongkurl Katitjin and Director of Aboriginal Research at Edith Cowan University. He is a health services researcher with experience in maternal, infant and child health, primary health care and Aboriginal health.

Dr Shane Kelly

Board Member

MBBS, MBA, MPH, Grad Cert L&CC, FRACMA, FCHSM, CHE, FAICD

Dr Shane Kelly is a highly experienced health executive with an extensive career spanning more than 38 years in the public and private hospital and health system in Australia, including more than 23 years in CEO roles.

Prior to his retirement in June 2025, Dr Kelly was State Manager (WA) for Ramsay Health Care. His other previous roles include Group CEO of St John of God Health Care, Group CEO of Mater Ltd in Queensland, CEO of St John of God Subiaco Hospital and Chief Executive of public hospitals and health services in WA.

Dr Kelly has extensive board experience including previously as a Director on the St John of God Health Care Inc Board, Australian Clinical Laboratories Board, Mater Medical Research Institute Board and Telethon Speech and Hearing Board.

Professor Karen Strickland

Chair, Safety and Quality Committee

RN, PhD, MSc, PGCert, BSC, FHEA, FEANS

Professor Karen Strickland has significant clinical, academic and research experience across the health, higher education and social service sectors, most notably as Executive Dean, School of Nursing and Midwifery at Edith Cowan University and Head of School, Nursing and Midwifery, University of Canberra.

Professor Strickland has consulted internationally in education and health-related curriculum development and is a Registered Nurse Academic Accreditation Assessor with the Australian Nursing and Midwifery Accreditation Council.

Professor Strickland is acknowledged as an expert in the fields of cancer, palliative and aged care, with 3 Visiting Professor appointments at international universities in New Zealand and Scotland. She is an experienced board member at local, Commonwealth and international levels, including Chair of the Council of Deans of Nursing and Midwifery in Australia and New Zealand, and Ovarian Cancer Australia.

Mrs Meghan Maor

Board Member

MBA, BSc

Mrs Meghan Maor is the co-founder and Director of Operations of Tikva Medicolegal. Mrs Maor is an experienced leader with a clinical background, having worked locally and internationally across government and non-government organisations, projects and programs. She has a background in the paediatric critical care setting at CAHS prior to moving into hospital commissioning.

Following a move to London in 2017, Mrs Maor worked as a project manager for 2 national health data web-based clinical audit programs. This work spanned 177 hospitals across the National Health Service, culminating in several publications which led to the change of national guidelines in the rehabilitation of hip fracture patients across the United Kingdom.

After returning to Perth, Mrs Maor has worked in health consulting, risk and audit in corporate and government settings. She has worked with a diverse range of stakeholders, including the Australian Government Department of Health, WA Department of Health, the Chief Medical Officer of Western Australia, East Metropolitan Health Service, Women and Newborn Health Service and St John Ambulance.

Dr Alexius Julian

Chair, Finance Committee

MBBS GAICD

Dr Alexius Julian is a highly skilled clinician with significant experience in information and communications technology (ICT) across health care. He 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.

Dr Julian has a strong interest in technology, start-up and business. He is a self-employed clinician and works on several commercial interests.

Mr James Jegasothy

Board Member

LLB, BA (Politics)

Mr James Jegasothy has strategic and governance experience across government, for-purpose and community sectors. In his role as Deputy CEO of Multicultural New South Wales, Mr Jegasothy advises State Government on policies and programs to achieve the full potential of multiculturalism. Prior to this he was the Executive Director at the Western Australian Office of Multicultural Interests.

Mr Jegasothy is committed to ensuring equitable outcomes for people from vulnerable groups. His previous roles include Chair of Rise Network; member of the Anglican Social Responsibilities Commission; Vice Chair of the Centre for Asylum Seekers, Refugees and Detainees; Secretary of the Ethnic Communities Council of Western Australia and State Manager for Welcome to Australia. He has led local asylum seeker programs for Australian Red Cross. As Senior Reviewer, he has recently completed the Agency Capability Review of the Department of Fire and Emergency Services with the WA Public Sector Commission.

Mr John McLean

Chair, Audit and Risk Committee

BSc (Econ) Hons, CA (ANZ), F.FINSIA, GAICD

Mr John McLean is a Chartered Accountant and experienced non-executive director.

After qualifying as a Chartered Accountant with Deloitte in London, he transferred to Africa, handling audits for a range of listed, non-listed and government clients. He spent 6 years as Staff Partner at Deloitte and retains a particular interest in staff development. He joined Coopers and Lybrand in Perth (now PwC) from Africa, initially in its audit division, transitioning to management in the Perth office before joining law firm Jackson McDonald, where he spent 15 years as CEO.

Over the past 12 years, Mr McLean has held a range of non-executive roles, mainly in the not-for-profit sector, and has worked as a business consultant specialising in financial reviews, strategic planning, policy reviews and procurement. He has worked with a range of Aboriginal entities in Western Australia in both Board and consultancy roles. He is a qualified financial counsellor.

Mr McLean holds Board roles with Red Jacket Consulting Pty Ltd and Martu United Pty Ltd.

CAHS EXECUTIVE

As at 30 June 2025

Valerie Buić

Chief Executive
Child and Adolescent Health Service

Dr Clare Matthews

A/Executive Director
Medical Services

Judith Stewart

Executive Director
Child and Adolescent Community Health

Tony Dolan

Executive Director
Perth Children's Hospital and Neonatology

Michael Hutchings

Executive Director
Finance and Corporate Services

Ali Devellerez

A/Executive Director
Contracting, Infrastructure, Digital Health and Patient Support Services

Jill Pascoe

Executive Director
Child and Adolescent Mental Health Services

Clare Dobb

Executive Director
People, Capability and Culture

Sam Campanella

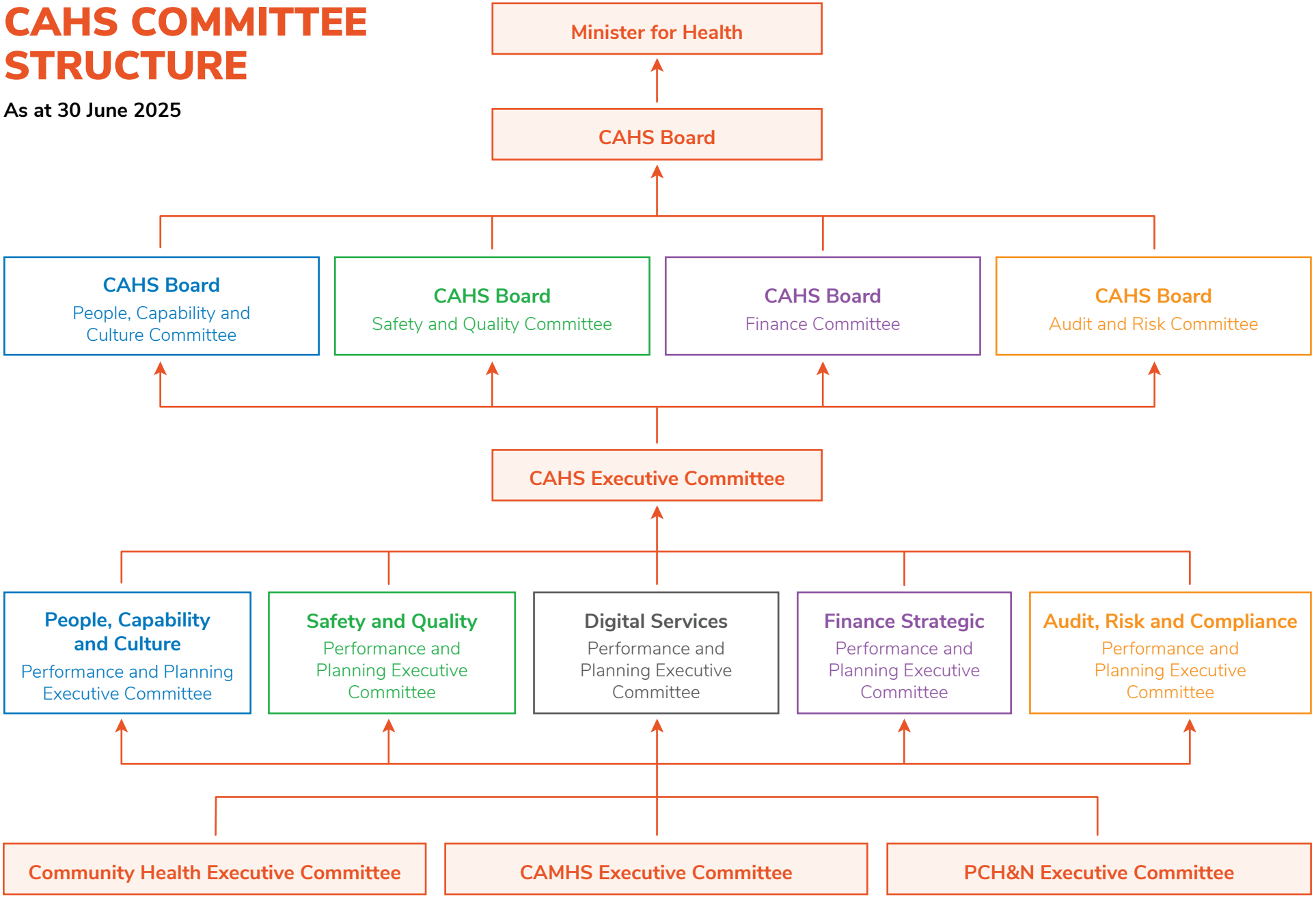
Executive Director
Safety, Quality and Innovation

Marie Slater

Executive Director
Nursing Services

CAHS COMMITTEE STRUCTURE

As at 30 June 2025



PERFORMANCE MANAGEMENT FRAMEWORK

To comply with its legislative obligations, CAHS operates under the WA Health Outcome Based Management Framework, as determined by the Department of Health.

This framework describes how outcomes, services and key performance indicators (KPIs) are used to measure agency performance towards achieving the relevant overarching whole-of-government goals.

There were no changes to the Outcome Based Management Framework for 2024–25.

The KPIs measure the effectiveness and efficiency of CAHS in achieving the following outcomes:

- **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.

Government goal

Strong Communities: Safe communities and supported families.

WA Health goal

Delivery of safe, quality, financially sustainable and accountable health care for all Western Australians.

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

Effectiveness KPIs

- 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 7 days following discharge from acute specialised mental health inpatient service

Efficiency KPIs

Service 1: Public hospital admitted services	• Average admitted cost per weighted activity unit
Service 2: Public hospital emergency services	• Average ED cost per weighted activity unit
Service 3: Public hospital non-admitted services	• Average non-admitted cost per weighted activity unit
Service 4: Mental health services	• Average cost per bed-day in specialised mental health inpatient services • Average cost per treatment day of non-admitted care provided by mental health services

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

Efficiency KPIs

Service 6: Public and community health services	Average cost per person of delivering population health programs by population health units

SHARED RESPONSIBILITIES WITH OTHER AGENCIES

External partnerships

CAHS continues to develop and maintain mutually beneficial external partnerships to improve and support the overall health and wellbeing of children and young people.

In 2024–25 CAHS partnered with 59 non-government agencies and community and not-for-profit organisations to deliver support and health-related services to children, young people and their families.

These partnerships have enabled CAHS to build connections throughout our community so that children, young people and their families have the support when and where they need it.

Services were provided through 134 arrangements:

- 5 licence agreements to use a dedicated PCH space
- 26 agreements for partner agencies to deliver support, advocacy and education at PCH at no cost to CAHS
- 78 incoming grant and sponsorship agreements for equipment, programs and services to help CAHS improve and support the overall health and wellbeing of children, young people and their families
- 25 contracts to deliver health-related services for children, adolescents and their families in the community.


Perth Children's Hospital
The KIDS
RESEARCH INSTITUTE
AUSTRALIA

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.

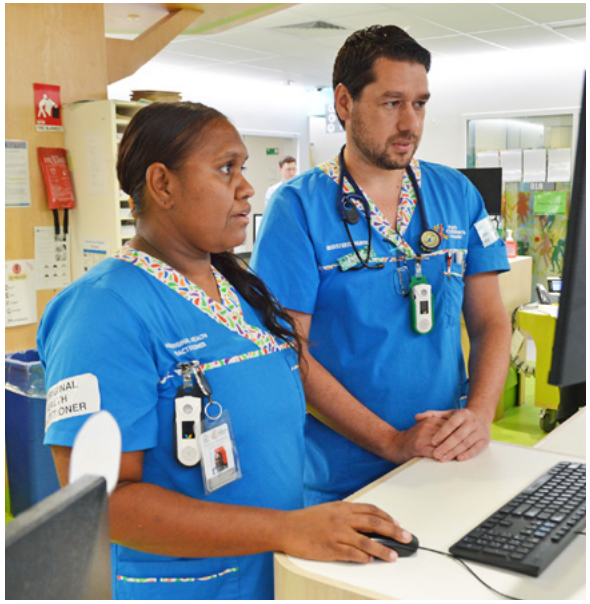
[4] The asset revaluation increments of $196.914 million for buildings have contributed to the increase in total equity. Conversely, the equity increase has been lessened by the operating deficit of $21.721 million. The details are set out in Note 9.13 'Equity'.

[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**

CAHS is focused on attracting and retaining the best talent … to uphold our commitment to delivering high quality care for children and young people across WA.

SIGNIFICANT CHALLENGES

ACCESS TO ELECTIVE SURGERY

While demand for elective surgery at PCH remains an ongoing challenge, average wait times and the number of children waiting for surgery have declined.

In the 12 months to 30 June 2025, the CAHS elective surgery wait list dropped 24 per cent from 4,767 to 3,622 children and young people awaiting surgery.

Average wait times as at 30 June 2025 based on surgery category were:

- **Category 1** (procedures clinically indicated within 30 days) – 18.2 days
- **Category 2** (procedures clinically indicated within 90 days) – 91.7 days
- **Category 3** (procedures clinically indicated within 365 days) – 197.7 days.

The most notable improvements to wait times were in ear, nose and throat surgery and general surgery.

Much of the improvement is attributed to greater theatre capacity following the opening of a new theatre suite. CAHS is continuing to look at future initiatives to meet this demand.

WORKFORCE ATTRACTION AND RETENTION

Global workforce shortages continue to place pressure on competition for talent across medical, nursing and allied health professions. At the same time, emerging developments in artificial intelligence, robotics and other technologies require new skills and present opportunities for improving processes, advancing approaches to training and models of care, and managing data and administration.

CAHS is focused on attracting and retaining the best talent to respond to these opportunities and to uphold our commitment to delivering high quality care for children and young people across WA.

The CAHS-wide Strategic Workforce Plan is helping us to identify and address our most critical workforce risks across all service areas. The plan complements our workforce planning across CAHS' service areas and professions.

Our Talent Acquisition team continued to implement forward-thinking approaches to attract and engage high calibre local, national and international talent. Significant efforts have been made to strengthen talent pipelines across clinical and non-clinical disciplines, including recruitment for the CAMHS-led Acute Care Response Teams and the CACH-led Child Development Services.

Throughout the year the team attended a wide range of career fairs and networking events, including participating in LGBTIQA+SB and multicultural events, to promote career opportunities and health services to a broad and diverse audience.

CAHS continued to support employee development with increased professional development training opportunities through the CAHS Learning Academy online learning system. The training includes leadership development, staff performance development and mandatory safety skills training to strengthen compliance.

We maintained our strong focus on developing our future workforce through educational placements of students from medical, nursing, allied health and other health disciplines.

Improving the experience of our junior doctors remains a key focus at CAHS. Underscoring our progress in this area, CAHS achieved positive results in the 2025 Australian Medical Association Hospital Health Check, testament to the efforts of all involved in implementing the CAHS Junior Medical Officer Action Plan.

CAHS aims to be an employer of choice, and to be recognised for the development and training of the next generation of paediatric medical officers.

DEMAND FOR CHILD DEVELOPMENT SERVICES

Referrals for child development services have increased significantly over the last 10 years in line with global trends.

This year the State Government committed $30.4 million to expand the CAHS metropolitan Child Development Service (CDS). This investment will enable more children to receive developmental services and reduce wait times.

To meet this expansion, CAHS is stepping up workforce recruitment with an increase in paediatric and allied health clinicians and other support roles to enable a more flexible workforce and facilitate innovative models of care.

The addition of health care navigators, Aboriginal health liaison officers and allied health assistants aims to improve the overall client experience, boost engagement, increase client–clinician contact and improve operational efficiency.

Initiatives that improve access and convenience for families have been introduced, such as trialling Saturday opening hours at the Joondalup and Rockingham sites and the opening of a new site in Kwinana.

A suite of e-learning packages is being developed for parents and carers to encourage early engagement and to empower families following a CDS referral. These resources aim to provide practical strategies for families to implement while awaiting assessment.

CAHS is working with the WA Country Health Service and the Department of Health on the Child Development Service System Reform Program and has established a dedicated team to focus on implementing recommendations. Consumer engagement will be embedded as a principle underpinning key reforms.

SUPPORTING NEURODIVERGENT CHILDREN

We continued to see an increase in children and young people with neurodevelopmental conditions presenting to the PCH Emergency Department and CAHS community services.

Supporting the needs of neurodivergent children and their families is a priority for CAHS and we are working towards providing a more coordinated approach to supporting the health needs of neurodivergent children and young people, and their families.

A lived experience consumer reference group, including young people and their caregivers, has been established to advise CAHS in co-designing clinical service initiatives and models of care.

A new process is being implemented to support young people who present to PCH ED in crisis, including those with neurodevelopmental conditions. The process includes a multi-disciplinary team who provides wraparound care and a clear pathway for follow-up care.

The Social Work and Occupational Therapy teams also ran a pilot rapid access clinic, supporting young people and their families who presented to PCH ED in crisis.

The pilot was well received by consumers and helped to avoid further ED presentations in the 6 months after the initial clinic visit.

This year CAHS ran the first Youth Innovation Challenge, bringing together 50 students from 6 high schools with education support programs for neurodivergent students. Working in collaboration with CAHS staff and youth mentors, teams developed innovative solutions to the challenge: ‘How might we enhance social inclusion for neurodivergent young people to improve their mental health?’ Solutions were presented to a panel of senior leaders, and concepts will be incorporated into a CAHS-led innovation project.

Other initiatives to support neurodivergent children include the introduction of sensory meal options at PCH where foods are separated on the plate, and the Attention Regulation and Concentration project, piloting an alternative assessment and management pathway for children and families dealing with attention, regulation and concentration concerns.

DEMAND FOR MENTAL HEALTH SERVICES

As demand for mental health services continues to grow, CAHS is committed to providing access to services that meet the needs of children, young people and their families.

CAHS is reforming the way we deliver mental health services in response to the recommendations of the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents. Reform includes the introduction of a new model of care for our community services and planned expansion to infant mental health services.

The recruitment of specialist child and adolescent psychiatrists remains a global challenge, and facilities infrastructure also affects our capacity to meet rising demand, particularly in areas of high population growth.

We continue to monitor the impact of the Health Services Union work bans, which limit community clinician case numbers.

FACILITIES AND INFRASTRUCTURE

CAHS delivers vital community-based services across 171 facilities, of which 155 are leased and 16 are owned. As demand for our services grows in volume and complexity, we are reviewing our ageing infrastructure to ensure it remains safe and suitable for delivering contemporary models of care.

CAHS is focused on shifting care from acute hospital settings to the community, providing services closer to where people live, and improving outpatient, early intervention and prevention services.

To deliver on these priorities, CAHS is developing a plan for the future of our community facilities, based on service need and community demand. This aims to deliver the necessary infrastructure to support integrated, collaborative care closer to home across CACH, CAMHS and PCH and Neonatology, ensuring high quality, accessible services for all CAHS consumers.

Further work is being done on identifying and mitigating infrastructure-related risks, including those associated with building condition, fire safety, occupational health and safety, and accessibility requirements.

DIGITAL HEALTH

CAHS is committed to delivering safe and sustainable clinical services through the enhancement of digital health capabilities. Our ongoing efforts to align clinical needs with digital infrastructure and equipment, as outlined in the Strategic Asset Plan, assist with ensuring a future-proof digital footprint and sustainable funding.

We are advancing inter-operability and preparing for future electronic medical record (EMR) initiatives by collaborating with the WA Health EMR Program and exploring innovative solutions such as ambient artificial intelligence. Our involvement with WA Health's Critical Health ICT Infrastructure Program strengthens our technical readiness and resilience for future EMR implementation.

This year we have matured our cyber and digital resilience through various initiatives, including enhanced cybersecurity measures and comprehensive disaster recovery testing. With the successful implementation of EMR Stage 1 and progress towards implementing the Intensive Care Unit EMR, CAHS is positioned to support statewide EMR adoption, particularly for our most vulnerable children and young people.

KEY PERFORMANCE INDICATORS

CERTIFICATION OF KEY PERFORMANCE INDICATORS

CHILD AND ADOLESCENT HEALTH SERVICE

Certification of key performance indicators for the year ended 30 June 2025

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 financial year ended 30 June 2025.

Ms Pamela Michael
CHAIR, CAHS BOARD
Child and Adolescent Health Service
23 September 2025

Dr Alexius Julian
CHAIR, CAHS FINANCE COMMITTEE
Child and Adolescent Health Service
23 September 2025

EFFECTIVENESS KPIs

Effectiveness KPI – Outcome 1

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.[1] These readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

Readmission reduction is a common focus of health systems worldwide as they seek to improve the quality and efficiency of healthcare delivery, in the face of rising healthcare costs and increasing prevalence of chronic disease.[2]

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 Healthcare Agreement Unplanned Readmission performance indicator (NHA PI 23).[3]

Target

The 2024 targets are based on the total child and adult population, and for each procedure is:

Surgical Procedure	Target (per 1,000)
Tonsillectomy & Adenoidectomy	≤84.4
Appendicectomy	≤29.7

Result

Tonsillectomy & Adenoidectomy

Figure 1: Rate of unplanned hospital readmissions for patients within 28 days for tonsillectomy and adenoidectomy, 2022 to 2024

2022	2023	**2024**	Target
50.6	56.6	**40.4**	≤84.4

CAHS has continued to reduce readmission rates for tonsillectomy and adenotonsillectomy procedures. The rate of unplanned readmission was 40.4 per 1,000, which is below the target of 84.4 per 1,000.

This achievement reflects CAHS' proactive approach to patient care, before, during and after surgery. Pre-operative telehealth and virtual care helps prepare patients and families for surgery and the recovery process. This has proven effective in alleviating pre-surgery anxiety and setting clear expectations for post-operative care.

Following surgery, CAHS provides comprehensive education to parents and carers at the time of discharge. This includes post-operative information accessible in multiple languages.

Additionally, CAHS proactively contacts parents and carers to offer support for post-operative pain management and address any concerns during the recovery period.

Appendicectomy

Figure 2: Rate of unplanned hospital readmissions for patients within 28 days for appendicectomy, 2022 to 2024

2022	2023	**2024**	Target
15.0	14.8	**17.5**	≤29.7

The rate of unplanned readmissions was 17.5 per 1,000, significantly below the target of 29.7 per 1,000. CAHS' ongoing commitment to timely access to emergency surgery, has helped to reduce the risk of complications and shortened hospital stays. Other factors include providing comprehensive education and information to parents and carers, before and after surgery. Our Acute Pain Service provides effective pain relief for children, supporting successful discharge home and enhancing patient comfort.

Reporting period: Calendar year, to account for lags in reporting due to time difference between index episode discharge date and clinical coding completion of readmission episode

Data source: Hospital Morbidity Data Collection; WA Data Linkage System

[1] 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/summary

[2] Australian Commission on Safety and Quality in Health Care. Avoidable Hospital Readmissions: Report on Australian and International indicators, their use and the efficacy of interventions to reduce readmissions. Sydney: ACSQHC; 2019. Available at: https://www.safetyandquality.gov.au/publications-and-resources/resource-library/avoidable-hospital-readmission-literature-review-australian-and-international-indicators

[3] https://meteor.aihw.gov.au/content/742756

Effectiveness KPI – Outcome 1

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.[4] 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 statewide performance target for the provision of elective services. For reportable procedures, the target requires that no patients (0%) on the elective waiting lists wait longer than the clinically recommended time for their procedure, according to their urgency category.

Target

The 2024–25 target is 0% for each urgency category. Performance is demonstrated by a result that is equal to the target.

Result

Figure 3: Percentage of elective wait list patients waiting over boundary for reportable procedures, by urgency category, 2022–23 to 2024–25

	2022–23	2023–24	**2024–25**	Target
Category 1	9.9%	8.7%	**4.6%**	0%
Category 2	28.7%	26.3%	**18.8%**	0%
Category 3	39.6%	34.7%	**26.1%**	0%

In the 2024–2025 year, there has been a decrease in the percentage of reportable patients over boundary on the surgical wait list across all categories.

As of 30 June 2025, 4.6 per cent of Category 1 patients were not treated within 30 days, 18.8 per cent of Category 2 patients were not treated within 90 days, and 26.1 per cent of Category 3 patients were not treated within 365 days. CAHS remains committed to improving service delivery and clinical management to ensure patients with the most critical clinical need are prioritised and treated as soon as possible.

CAHS has implemented a range of initiatives to improve access to elective surgery and reduce wait lists. A key development was the opening of an additional operating theatre in December 2024 which has added surgical capacity. We continued to partner with the Western Australian Country Health Service, to deliver dental surgery in the South West and Great Southern regions.

We have maintained a strong focus on theatre management, efficiency and performance monitoring. For example, an improved approach to low complexity procedures in identified specialities has helped to maximise theatre efficiency.

Note: The result is based on an average of weekly census data for the financial year.

Reporting period: Financial year.
Data source: Elective Services Wait List Data Collection.

[4] 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.

Effectiveness KPI – Outcome 1

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 health care. *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%[5]).

HA-SABSI is generally considered to be a preventable adverse event associated with the provision of health care. 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 2024 target is ≤1.0 infections per 10,000 occupied bed-days and is the agreed benchmark utilised for National Health Performance Reporting.

Result

Figure 4: Healthcare associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days, 2022 to 2024

2022	2023	**2024**	Target
0.92	0.70	**0.55**	≤1.0

CAHS reduced the *Staphylococcus aureus* (*S. aureus*) bloodstream infection rate in 2024 to 0.55 per 10,000 occupied bed-days, which is below the WA health system target of 1.0 per 10,000 bed-days. This reflects initiatives such as *S. aureus* decolonisation of all children undergoing high-risk procedures, a strong focus on hand hygiene and aseptic technique compliance, and the role of the dedicated central venous access device insertion and management service.

Reporting period: Calendar year, to account for lag in reporting in clinical coding completion.

Data source: Healthcare Infection Surveillance Western Australia Data Collection.

[5] 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

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

Rationale

Discharged against medical advice (DAMA) refers to patients leaving hospital against the advice of their treating medical team or without advising hospital staff (e.g. take own leave, left without notice, missing and not found, or discharge at own risk). Patients who do so have a higher risk of readmission and mortality[6] and have been found to cost the health system 50% more than patients who are discharged by their physician.[7]

The national Aboriginal and Torres Strait Islander Health Performance Framework reports discharge at own risk under the heading 'Self-discharge from hospital'. Between July 2019 and June 2021 Aboriginal patients (4.4%) in WA were 7.5 times more likely than non-Aboriginal patients (0.6%) to discharge at own risk, compared with 5.2 times nationally (3.8% and 0.7% respectively).[8] This statistic indicates a need for improved responses by the health system to the needs of Aboriginal patients. This indicator is also being reported in the Report on Government Services 2024 under the performance of governments in providing acute care services in public hospitals.[9]

This indicator provides a measure of the safety and quality of inpatient care. Reporting the results by Aboriginal status measures the effectiveness of initiatives within the WA health system to deliver culturally secure services to Aboriginal people. While the aim is to achieve equitable treatment outcomes, the targets reflect the need for a long-term approach to progressively closing the gap between Aboriginal and non-Aboriginal patient cohorts.

Discharge against medical advice performance measure is also one of the key contextual indicators of Outcome 1 "Aboriginal and Torres Strait Islander people enjoy long and healthy lives" under the new National Agreement on Closing the Gap, which was agreed to by the Coalition of Aboriginal and Torres Strait Islander Peak Organisations and all Australian Governments in July 2020.[10]

Target

The 2024 targets are based on the total child and adult population:

	Target
a) Aboriginal patients	≤2.78%
b) Non-Aboriginal patients	≤0.99%

Result

Figure 5: Percentage of admitted patients who discharged against medical advice, 2022 to 2024

	2022	2023	**2024**	Target
Aboriginal patients	0.25%	0.24%	**0.11%**	≤2.78%
Non-Aboriginal patients	0.05%	0.10%	**0.06%**	≤0.99%

In 2024, CAHS recorded a DAMA rate of 0.11 per cent for Aboriginal patients, which is below the target of 2.78 per cent. For non-Aboriginal patients, the rate was 0.06 per cent, which is also below the target of 0.99 per cent.

CAHS continues to consistently achieve low DAMA rates. A range of support services including those provided by Aboriginal Liaison Officers, social workers and clinical teams have contributed to the lower DAMA rates.

We continue to work towards creating more culturally safe and inclusive spaces for Aboriginal families who access our services. We educate staff on how to deliver culturally safe clinical care and are committed to meaningful engagement with Aboriginal families to build and maintain trust in the health services.

Reporting period: Calendar year, to account for lag in reporting due to clinical coding completion.

Data source: Hospital Morbidity Data Collection

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

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

[8] See Table D3.09.3 https://www.indigenoushpf.gov.au/measures/3-09-self-discharge-from-hospital/data#DataTablesAndResources

[9] For more information see 12 Public hospitals - Report on Government Services 2024 – Productivity Commission (pc.gov.au)

[10] www.closingthegap.gov.au/national-agreement

Effectiveness KPI – Outcome 1

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

Rationale

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

While multiple hospital admissions over a lifetime may be necessary for someone with ongoing illness, a high proportion of readmissions shortly after discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was not adequate to maintain the patient's recovery out of hospital.[11] Rapid readmissions place pressure on finite beds and may reduce access to care for other consumers in need.

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.

Target

The 2024 target is ≤12%.

Result

Figure 6: Readmissions to acute specialised mental health inpatient services within 28 days of discharge, 2022 to 2024

2022	2023	**2024**	Target
24.9%	24.3%	**18.5%**	≤12%

The rate of total hospital readmissions for 2024 is above the target of 12 per cent. It should be noted that this indicator does not distinguish between planned and unplanned readmissions. CAHS provides clinically appropriate planned admissions for young people who would benefit from an additional inpatient stay.

CAHS is working to better understand unplanned readmissions to identify opportunities to make improvements. CAHS is considering the impact that overnight leave may have on the success of transition from inpatient to community-based services and continues to focus on improving the mental health care provided in the community. CAHS will always prioritise the safety of young people and their families through admission to an inpatient mental health service when required.

Reporting period: Calendar year, to account for lag in reporting due to time difference between index episode discharge date and clinical coding completion of readmission episode.

Data source: Hospital Morbidity Data Collection (Inpatient Separations).

[11] 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

Effectiveness KPI – Outcome 1

Percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services

Rationale

In 2022, one in four (6.6 million) Australians reported having a mental or behavioural condition.[12] 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.

Target

The 2024 target is ≥75%.

Result

Figure 7: Percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services, 2022 to 2024

2022	2023	**2024**	Target
78.8%	78.5%	**83.6%**	≥75%

In 2024, 83.6 per cent of young people who were admitted to the CAHS acute specialised mental health inpatient services were contacted by a CAHS mental health service team member within 7 days of discharge, which is above the target of 75 per cent. CAHS reviews all cases where a follow-up did not occur within 7 days of discharge to identify opportunities for improvement. CAHS is committed to supporting safe transitions of care from hospital to the community for our young people and will consider additional strategies to support this improving trend.

Reporting period: Calendar year, to account for reporting delays caused by time difference between episode discharge date and clinical coding completion of non-admitted post-discharge episode.

Data source: Mental Health Information Data Collection, Hospital Morbidity Data Collection (Inpatient separations).

[12] National Health Survey, 2022 | Australian Bureau of Statistics

EFFICIENCY KPIs

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 compared with the State target, as approved by the Department of Treasury, and published in the 2024–25 Budget Paper No. 2, Volume 1.

The measure ensures a consistent methodology is applied to calculating and reporting the cost of delivering inpatient activity against the State's funding allocation. As admitted services received nearly half of the overall 2024–25 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

Target

The 2024–25 target is ≤$7,899 per weighted activity unit.

Result

The average admitted cost per weighted activity unit was $9,174 in 2024–25, which is a 16.1 per cent unfavourable outcome relative to target. The target was developed at a whole of WA health system level and the same target applies to all Health Service Providers.

In 2024–25 CAHS delivered considerably more admitted activity than the prior year, which was achieved at a higher cost profile in comparison to 2023–24. This indicator shows an improvement from the prior year outcome. The higher cost profile that contributed to the higher than target outcome in 2024–25 was as a result of the higher-than-expected Enterprise Bargaining Award increases from the Government's Wages Policy, and escalating costs for goods and services.

In addition, admitted service provision has increased due to the opening of the new theatre in response to clinical demand.

Figure 8: Average admitted cost per weighted activity unit, 2022–23 to 2024–25

2022–23 Actual	2023–24 Actual	**2024–25 Actual**	2024–25 Target
$8,297	$9,199	**$9,174**	$7,899

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.

Reporting period: Financial year.

Comparative data for 2022–23 and 2023–24 have been restated due to a change in methodology for some cost distribution.

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 compared with the State target as approved by the Department of Treasury, which is published in the 2024–25 Budget Paper No. 2, Volume 1.

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

Target

The 2024–25 target is ≤$7,777 per weighted activity unit.

Result

The average Emergency Department cost per weighted activity unit was $11,259 in 2024–25 which is 44.8 per cent higher than the target. The target was developed at a whole of WA health system level and the same target applies to all Health Service Providers.

The higher cost profile, which caused the indicator to exceed the target, is primarily due to specialist paediatric services, increased staffing costs due to higher than expected Enterprise Bargaining Award increases from the Government's Wages Policy, and an increase in staffing. The staffing cost profile includes nurse-to-patient ratios and the dedicated resuscitation team in the Emergency Department. Notwithstanding the expenditure profile, the Child and Adolescent Health Service supported a larger number of presentations through its Emergency Department, which improved the 2024–25 Actual outcome.

Figure 9: Average Emergency Department cost per weighted activity unit, 2022–23 to 2024–25

2022–23 Actual	2023–24 Actual	**2024–25 Actual**	2024–25 Target
$9,768	$11,388	**$11,259**	$7,777

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.

Reporting period: Financial Year.

Comparative data for 2022–23 and 2023–24 have been restated due to a change in methodology for some cost distribution.

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 compared with the State (aggregated) target, as approved by the Department of Treasury, which is published in the 2024–25 Budget Paper No. 2, Volume 1.

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 2024–25 target is ≤$7,903 per weighted activity unit.

Result

The average non-admitted cost per weighted activity unit was $9,334 in 2024–25, which is 18.1 per cent above target. The target was developed at a whole of WA health system level and the same target applies to all Health Service Providers.

In 2024–25, the higher cost profile for non-admitted services is due to the higher than expected Enterprise Bargaining Award increases from the Government's Wages Policy and inflationary cost pressures. The increased target has also contributed to this indicator reducing the unfavourable outcome. Compared to the prior year, the Child and Adolescent Health Service has delivered significantly more non-admitted services, which improved the 2024–25 Actual.

Figure 10: Average non-admitted cost per weighted activity unit

2022–23 Actual	2023–24 Actual	**2024–25 Actual**	2024–25 Target
$8,820	$9,430	**$9,334**	$7,903

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.

Reporting period: Financial year.

Comparative data for 2022–23 and 2023–24 have been restated due to a change in methodology for some cost distribution.

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. 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 costs of providing mental health care and enable the reallocation of funds to appropriate alternative non-admitted care.

Target

The 2024–25 target is ≤$2,553 per bed-day.

Result

In 2024–25, the average cost per bed-day in specialised mental health inpatient services rose significantly to $8,021, representing a 214.2 per cent increase above the target. This variance was driven by a combination of factors, including the allocation of additional staffing to support reforms arising from the Ministerial Taskforce into Public Mental Health Services and a reduction in the target in 2024–25.

The significant increase in cost profile includes the temporary increase in workforce to support the commissioning, and operations and licensing costs of the Nickoll Ward at the Hollywood Hospital. The Nickoll Ward is being used as a decant facility whilst the inpatient mental health ward at the Perth Children's Hospital undergoes refurbishment.

Figure 11: Average cost per bed-day in specialised mental health inpatient units, 2022–23 to 2024–25

2022–23 Actual	2023–24 Actual	**2024–25 Actual**	2024–25 Target
$4,740	$5,533	**$8,021**	$2,553

Reporting period: Financial year.

Comparative data for 2022–23 and 2023–24 have been restated due to a change in methodology for some cost distribution.

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.

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.

Efficient functioning of public community mental health services is essential to ensure that finite funds are used effectively to deliver maximum community benefit. This indicator provides a measure of the cost-effectiveness of treatment for public psychiatric patients under public community mental health care (non-admitted/ambulatory patients).

Target

The 2024–25 target is ≤$868 per treatment day.

Result

In 2024–25, the average cost per treatment day for non-admitted care provided by public clinical mental health services increased to $932, exceeding the target by 7.4 per cent. This outcome was influenced by a range of cost pressures, including increased employment costs arising from higher than expected Enterprise Bargaining Award increases from the Government's Wages Policy, and inflationary cost impacts.

Figure 12: Average cost per treatment day of non-admitted care provided by mental health services, 2022–23 to 2024–25

2022–23 Actual	2023–24 Actual	**2024–25 Actual**	2024–25 Target
$848	$876	**$932**	$868

Reporting period: Financial year.

Comparative data for 2022–23 and 2023–24 have been restated due to a change in methodology for some cost distribution.

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 2022–2026.[13] This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

The 2024–25 target is ≤$314 per person.

Result

In 2024–25, the average cost per person for delivering population health programs through Population Health Units was $322, which is 2.5 per cent unfavourable against the target. The higher cost profile which contributed to the indicator being above target is attributed to increased employment costs related to higher than expected Enterprise Bargaining Award increases from the Government's Wages Policy, and inflationary pressures.

Figure 13: Average cost per person of delivering population health programs by population health units 2022–23 to 2024–25

2022–23 Actual	2023–24 Actual	**2024–25 Actual**	2024–25 Target
$263	$281	**$322**	$314

Reporting period: Financial year.

Comparative data for 2022–23 and 2023–24 have been restated due to a change in methodology for some cost distribution.

Data sources: Health Service financial system, Estimated Resident Populations for 2019–2023 as provided by Epidemiology Directorate, Public and Aboriginal Health Division, WA Department of Health

[13] WA Health Promotion Strategic Framework 2022–2026
WA Health Promotion Strategic Framework

FINANCIAL STATEMENTS

Auditor General

INDEPENDENT AUDITOR'S REPORT

2025

Child and Adolescent Health Service

To the Parliament of Western Australia

Report on the audit of the financial statements

Opinion

I have audited the financial statements of the Child and Adolescent Health Service (Health Service) which comprise:

- the statement of financial position as at 30 June 2025, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended
- notes comprising a summary of material accounting policies and other explanatory information.

In my opinion, the financial statements are:

- based on proper accounts and present fairly, in all material respects, the operating results and cash flows of the Health Service for the year ended 30 June 2025 and the financial position as at the end of that period
- in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions.

Basis for opinion

I conducted my audit in accordance with the Australian Auditing Standards. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my report.

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

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

Responsibilities of the Board for the financial statements

The Board is responsible for:

- keeping proper accounts
- preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions
- such internal control as it 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
- 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 responsibilities 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. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal control.

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

Report on the audit of controls

Opinion

I have undertaken a reasonable assurance engagement on the design and implementation of controls exercised by the Health Service. The controls exercised by the Health Service are those policies and procedures established 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 the State's financial reporting framework (the overall control objectives).

In my opinion, in all material respects, the controls exercised by the Health Service are sufficiently adequate to provide reasonable assurance that the controls within the system were suitably designed to achieve the overall control objectives identified as at 30 June 2025, and the controls were implemented as designed as at 30 June 2025.

Other Matter

The Health Service has made payments using the direct payments to third parties pathway throughout the year. The Department of Health has approved this pathway to be used in limited circumstances as expenditure is not subject to levels of approval required under Treasurer's Instruction 5 Expenditure and Payments.

While this is not a primary pathway for expenditure for the Health Service, we have identified weaknesses in how this pathway is used and the types of transactions processed using this pathway, which increases the risk of fraud.

To allow for more detailed reporting of these concerns, the Auditor General has decided to report these matters separately as a performance audit tabled in Parliament.

My opinion is not modified in respect of this matter.

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 involves performing procedures to obtain evidence about the suitability of the controls design to achieve the overall control objectives and the implementation of those controls. The procedures selected depend on my judgement, including an 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 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 audit of the key performance indicators

Opinion

I have undertaken a reasonable assurance engagement on the key performance indicators of the Health Service for the year ended 30 June 2025 reported in accordance with the *Financial Management Act 2006* and the Treasurer's Instructions (legislative requirements). 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 report of the Health Service for the year ended 30 June 2025 is in accordance with the legislative requirements, and the key performance indicators are relevant and appropriate to assist users to assess the Health Service's performance and fairly represent indicated performance for the year ended 30 June 2025.

The Board's responsibilities 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 controls 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 3 Financial Sustainability – Requirement 5: Key Performance Indicators.

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 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 3 - Requirement 5 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 management relating to the report on financial statements, 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 ASQM 1 *Quality Management for Firms that Perform Audits or Reviews of Financial Reports and Other Financial Information, or Other Assurance or Related Services Engagements,* the Office of the Auditor General maintains a comprehensive system of quality management including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Other information

Those charged with governance are responsible for the other information. The other information is the information in the entity's annual report for the year ended 30 June 2025, but not the financial statements, key performance indicators and my auditor's report.

My opinions on the financial statements, controls and key performance indicators do not cover the other information and accordingly I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial statements, controls and key performance indicators my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements and key performance indicators or my knowledge obtained in the audit or otherwise appears to be materially misstated.

If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I did not receive the other information prior to the date of this auditor's report. When I do receive it, I will read it and if I conclude that there is a material misstatement in this information, I am required to communicate the matter to those charged with governance and request them to correct the misstated information. If the misstated information is not corrected, I may need to retract this auditor's report and re-issue an amended report.

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 2025 included in the annual report 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, controls and key performance indicators described above. It does not provide an opinion on any other information which may have been hyperlinked to/from the annual report. 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.

Grant Robinson
Assistant Auditor General Financial Audit
Delegate of the Auditor General for Western Australia
Perth, Western Australia
24 September 2025

CERTIFICATION OF FINANCIAL STATEMENTS

CHILD AND ADOLESCENT HEALTH SERVICE

Certification of financial statements for the year ended 30 June 2025

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 financial year ended 30 June 2025 and the financial position as at 30 June 2025.

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.

Mr Michael Hutchings
CHIEF FINANCE OFFICER
Child and Adolescent Health Service
23 September 2025

Ms Pamela Michael
CHAIR, CAHS BOARD
Child and Adolescent Health Service
23 September 2025

Dr Alexius Julian
CHAIR, CAHS FINANCE COMMITTEE
Child and Adolescent Health Service
23 September 2025

Statement of comprehensive income for the year ended 30 June 2025

	Notes	2025	2024
		$000	$000
COST OF SERVICES			
Expenses			
Employee benefits expense	3.1(a)	845,124	753,206
Fees for visiting medical practitioners		4,582	4,053
Contracts for services	3.2	8,778	8,785
Patient support costs	3.3	139,483	134,505
Finance costs	7.2	1,708	421
Depreciation and amortisation expenses	5	52,544	51,363
Loss on disposal of non-current assets	5.1.2	-	205
Repairs, maintenance and consumable equipment	3.4	30,014	27,551
Other supplies and services	3.5	65,695	62,904
Other expenses	3.6	49,466	44,528
Total cost of services		**1,197,394**	**1,087,521**
INCOME			
Patient charges	4.2	37,095	28,476
Other fees for services	4.2	46,174	48,615
Grants and contributions	4.3	19,115	15,563
Donation revenue	4.4	1,539	1,821
Gain on disposal of non-current assets	5.1.2	103	-
Asset revaluation increments	5.1	920	2,375
Other income	4.5	6,835	6,432
Total income		**111,781**	**103,282**
NET COST OF SERVICES		**1,085,613**	**984,239**

	Notes	2025	2024
		$000	$000
INCOME FROM STATE GOVERNMENT			
Service agreement funding - State	4.1	697,500	626,677
Service agreement funding - Commonwealth	4.1	197,838	188,238
Grants from other state government agencies	4.1	101,003	89,962
Services provided to other government agencies	4.1	3,945	4,060
Assets (transferred)/assumed	4.1	268	(20)
Resources received free of charge	4.1	63,338	60,689
Total income from State Government		**1,063,892**	**969,606**
DEFICIT FOR THE PERIOD		**(21,721)**	**(14,633)**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.13	196,914	74,488
Total other comprehensive income		196,914	74,488
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**175,193**	**59,855**

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

Statement of financial position as at 30 June 2025

	Notes	2025 $000	2024 $000
ASSETS			
Current Assets			
Cash and cash equivalents	7.3	17,730	17,152
Restricted cash and cash equivalents	7.3	28,102	25,821
Receivables	6.1	16,419	13,648
Inventories	6.3	4,980	5,359
Other current assets	6.4	1,119	1,209
Total Current Assets		68,350	63,189
Non-Current Assets			
Receivables	6.1	18,872	15,372
Amounts receivable for services	6.2	628,351	581,135
Property, plant and equipment	5.1	1,368,464	1,192,637
Right-of-use assets	5.2	26,486	10,040
Intangible assets	5.3	6,888	9,822
Total Non-Current Assets		2,049,061	1,809,006
TOTAL ASSETS		**2,117,411**	**1,872,195**

	Notes	2025 $000	2024 $000
LIABILITIES			
Current Liabilities			
Payables	6.5	51,801	47,562
Contract liabilities	6.6	796	472
Capital grant liabilities	6.7	1,245	101
Lease liabilities	7.1	2,914	2,132
Employee benefits provisions	3.1 (b)	174,883	157,424
Other current liabilities	6.8	100	104
Total Current Liabilities		231,739	207,795
Non-Current Liabilities			
Lease liabilities	7.1	29,444	8,830
Employee benefits provisions	3.1 (b)	36,541	26,777
Total Non-Current Liabilities		65,985	35,607
TOTAL LIABILITIES		**297,724**	**243,402**
NET ASSETS		**1,819,687**	**1,628,793**
EQUITY			
Contributed equity	9.13	1,505,238	1,489,537
Reserves	9.13	424,718	227,804
Accumulated deficit		(110,269)	(88,548)
TOTAL EQUITY		**1,819,687**	**1,628,793**

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

Statement of cash flows for the year ended 30 June 2025

	Notes	2025 $000	2024 $000
CASH FLOWS FROM STATE GOVERNMENT			
Service agreement funding - State		650,284	574,884
Service agreement funding - Commonwealth		197,838	188,238
Grants from other state government agencies		101,003	89,962
Services provided to other government agencies		3,945	4,060
Capital appropriations administered by Department of Health		15,701	16,236
Net cash provided by State Government	7.3.3	**968,771**	**873,380**
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(813,131)	(734,300)
Supplies and services		(232,114)	(218,825)
Finance costs		(1,688)	(413)
Receipts			
Receipts from customers		36,831	28,255
Grants and contributions		20,583	15,447
Donations received		723	364
Other receipts		50,271	54,615
Net cash used in operating activities	7.3.2	**(938,525)**	**(854,857)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Purchase of non-current assets		(25,634)	(7,883)
Receipts			
Proceeds from sale of non-current assets	5.1.2	210	13
Net cash used in investing activities		**(25,424)**	**(7,870)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Principal elements of lease payments		(2,861)	(2,321)
Payment to accrued salaries account		(3,500)	-
Receipts			
Lease incentive received		4,398	-
Net cash used in financing activities		**(1,963)**	**(2,321)**
Net increase in cash and cash equivalents		2,859	8,332
Cash and cash equivalents at the beginning of the period		42,973	34,641
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.3	**45,832**	**42,973**

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

Statement of changes in equity for the year ended 30 June 2025

	Notes	Contributed equity $000	Reserves $000	Accumulated deficit $000	Total equity $000
Balance at 1 July 2023		1,473,301	153,316	(73,915)	1,552,702
Deficit		-	-	(14,633)	(14,633)
Other comprehensive income	9.13	-	74,488	-	74,488
Total comprehensive income for the period		-	74,488	(14,633)	59,855
Transactions with owners in their capacity as owners:					
Capital appropriations administered by Department of Health	9.13	16,236	-	-	16,236
Total		16,236	-	-	16,236
Balance at 30 June 2024		**1,489,537**	**227,804**	**(88,548)**	**1,628,793**
Balance at 1 July 2024		1,489,537	227,804	(88,548)	1,628,793
Deficit		-	-	(21,721)	(21,721)
Other comprehensive income	9.13	-	196,914	-	196,914
Total comprehensive income for the period		-	196,914	(21,721)	175,193
Transactions with owners in their capacity as owners:					
Capital appropriations administered by Department of Health	9.13	15,701	-	-	15,701
Total		15,701	-	-	15,701
Balance at 30 June 2025		**1,505,238**	**424,718**	**(110,269)**	**1,819,687**

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

1. Basis of preparation

The Child and Adolescent Health Service (The Health Service) is a statutory authority established under the *Health Services Act 2016* 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 23 September 2025.

Statement of compliance

The financial statements constitute general purpose financial statements that have been prepared in accordance with Australian Accounting Standards, the Framework, Statement of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board as applied by Treasurer's instructions. Several of these are modified by Treasurer's instructions to vary application, disclosure, format and wording.

The Act and Treasurer's instructions are legislative provisions governing the preparation of financial statements and take precedence over Australian Accounting Standards, the Framework, Statement of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board. 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.

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 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 8 – Requirement 8.1(i) and will be 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.

2.1 Health Service objectives

Vision and objectives

The Health Service's 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. The objectives are to care for children, young people and families, provide high value healthcare, collaborate with key support partners, value and respect staff, and promote teaching, training and research.

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, oncology services and neonatology services.

2.1 Health Service objectives (cont.)

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.

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. Comparative figures have been reclassified to be comparable with the figures presented in the current financial year.

(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	
	2025	2024	2025	2024	2025	2024	2025	2024
COST OF SERVICES	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
Expenses								
Employee benefits expense	399,905	360,020	78,022	67,745	123,641	108,767	91,028	84,911
Fees for visiting medical practitioners	1,142	1,016	2,525	2,225	915	812	-	-
Contracts for services	7,086	7,117	4	4	10	12	25	13
Patient support costs	80,844	77,789	9,500	9,161	34,930	34,172	3,248	2,659
Finance costs	53	49	8	9	17	17	128	106
Depreciation and amortisation expenses	29,216	29,525	6,024	5,884	9,053	9,144	3,327	3,266
Loss on disposal of non-current assets	-	93	-	91	-	17	-	4
Repairs, maintenance and consumable equipment	15,172	14,952	3,185	2,818	5,094	4,675	2,002	2,074
Other supplies and services	31,058	29,951	4,514	4,412	9,574	8,993	7,374	7,184
Other expenses	15,947	16,827	2,369	2,414	4,756	4,766	8,260	6,446
Total cost of services	580,423	537,339	106,151	94,763	187,990	171,375	115,392	106,663
Income								
Patient charges	32,758	24,308	1,247	1,084	2,570	2,512	520	572
Other fees for services	29,962	32,049	5,683	5,772	10,071	10,408	128	43
Grants and contributions	7,970	7,149	1,101	838	6,909	4,708	614	575
Donation revenue	1,010	1,265	188	194	332	352	-	-
Gain on disposal of non-current assets	130	-	4	-	(3)	-	-	-
Asset revaluation increments	118	164	22	30	39	54	(80)	(30)
Other income	4,353	4,130	802	731	1,424	1,319	20	5
Total income	76,301	69,065	9,047	8,649	21,342	19,353	1,202	1,165
NET COST OF SERVICES	**504,122**	**468,274**	**97,104**	**86,114**	**166,648**	**152,022**	**114,190**	**105,498**
INCOME FROM STATE GOVERNMENT								
Service agreement funding - State	334,433	307,824	68,011	55,635	102,880	100,567	6,099	6,661
Service agreement funding - Commonwealth	125,407	121,876	21,757	24,837	49,097	39,974	-	21
Grants from other state government agencies	272	329	58	85	797	198	99,845	88,981
Services provided to other government agencies	3,353	3,471	263	242	322	354	5	(3)
Assets (transferred)/assumed	190	(14)	28	(2)	49	(4)	-	-
Resources received free of charge	29,871	28,873	4,339	4,197	8,981	8,683	7,431	6,987
Total income from State Government	493,526	462,359	94,456	84,994	162,126	149,772	113,380	102,647
SURPLUS / (DEFICIT) FOR THE PERIOD	**(10,596)**	**(5,915)**	**(2,648)**	**(1,120)**	**(4,522)**	**(2,250)**	**(810)**	**(2,851)**

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

	Aged and Continuing Care Services [a]		Public and Community Health Services		Total	
	2025	2024	2025	2024	2025	2024
COST OF SERVICES	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
Expenses						
Employee benefits expense	3,884	3,363	148,644	128,400	845,124	753,206
Fees for visiting medical practitioners	-	-	-	-	4,582	4,053
Contracts for services	1	3	1,652	1,636	8,778	8,785
Patient support costs	688	1,138	10,273	9,586	139,483	134,505
Finance costs	-	-	1,502	240	1,708	421
Depreciation and amortisation expenses	9	8	4,915	3,536	52,544	51,363
Loss on disposal of non-current assets	-	-	-	-	-	205
Repairs, maintenance and consumable equipment	84	56	4,477	2,976	30,014	27,551
Other supplies and services	158	148	13,017	12,216	65,695	62,904
Other expenses	210	194	17,924	13,881	49,466	44,528
Total cost of services	5,034	4,910	202,404	172,471	1,197,394	1,087,521
Income						
Patient charges	-	-	-	-	37,095	28,476
Other fees for services	270	291	60	52	46,174	48,615
Grants and contributions	246	65	2,275	2,228	19,115	15,563
Donation revenue	9	10	-	-	1,539	1,821
Gain on disposal of non-current assets	-	-	(28)	-	103	-
Asset revaluation increments	1	2	820	2,155	920	2,375
Other income	37	37	199	210	6,835	6,432
Total income	563	405	3,326	4,645	111,781	103,282
NET COST OF SERVICES	**4,471**	**4,505**	**199,078**	**167,826**	**1,085,613**	**984,239**
INCOME FROM STATE GOVERNMENT						
Service agreement funding - State	2,760	3,258	183,317	152,732	697,500	626,677
Service agreement funding - Commonwealth	1,267	973	310	557	197,838	188,238
Grants from other state government agencies	1	1	30	368	101,003	89,962
Services provided to other government agencies	-	-	2	(4)	3,945	4,060
Assets (transferred)/assumed	1	-	-	-	268	(20)
Resources received free of charge	172	161	12,544	11,788	63,338	60,689
Total income from State Government	4,201	4,393	196,203	165,441	1,063,892	969,606
SURPLUS / (DEFICIT) FOR THE PERIOD	**(270)**	**(112)**	**(2,875)**	**(2,385)**	**(21,721)**	**(14,633)**

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	2025 $000	2024 $000
Employee benefits expense	3.1(a)	845,124	753,206
Contracts for services	3.2	8,778	8,785
Patient support costs	3.3	139,483	134,505
Repairs, maintenance and consumable equipment	3.4	30,014	27,551
Other supplies and services	3.5	65,695	62,904
Other expenses	3.6	49,466	44,528

Liabilities incurred in the delivery of services

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

	Notes	2025 $000	2024 $000
Employee benefits provisions	3.1(b)	211,424	184,201

3.1(a) Employee benefits expense

	2025 $000	2024 $000
Employee benefits	762,823	682,241
Termination benefits	290	-
Superannuation - defined contribution plans	82,011	70,965
	845,124	753,206

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 administers the 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.

	2025 $000	2024 $000
Current		
Employee benefits provisions		
Annual leave [a]	83,779	76,517
Time off in lieu leave [a]	20,375	18,447
Long service leave [b]	69,551	61,518
Deferred salary scheme [c]	1,178	942
	174,883	157,424
Non-Current		
Employee benefits provisions		
Long service leave [b]	36,541	26,777
	36,541	26,777
Total employee benefits provisions	211,424	184,201

(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:

	2025 $000	2024 $000
Within 12 months of the end of the reporting period	58,598	66,863
More than 12 months after the end of the reporting period	45,556	28,101
	104,154	94,964

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:

	2025 $000	2024 $000
Within 12 months of the end of the reporting period	22,746	16,335
More than 12 months after the end of the reporting period	83,346	71,960
	106,092	88,295

The provision of the long service leave liabilities is 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:

	2025 $000	2024 $000
Within 12 months of the end of the reporting period	231	221
More than 12 months after the end of the reporting period	947	721
	1,178	942

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.

The employee retention rates were based on an analysis of the historical turnover rates exhibited by employees in the Health Service.

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

	2025 $000	2024 $000
Neonatal services [a]	7,065	7,065
Community and primary health	1,658	1,645
Other contracts	55	75
	8,778	8,785

Contracts 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) The neonatal services at the King Edward Memorial Hospital (KEMH) site formally became part of the Child and Adolescent Health Service on 1 February 2020. A purchasing arrangement has been in place with the North Metropolitan Health Service to continue the provision of support services.

3.3 Patient support costs

	2025 $000	2024 $000
Medical supplies and services [a] [b]	118,262	114,240
Domestic charges	9,996	9,295
Food supplies	1,992	1,817
Power and water charges	7,395	7,233
Patient transport costs	1,431	1,532
Research, development and other grants	407	388
	139,483	134,505

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 $7.530 million from PathWest Laboratory Medicine WA (2024: $6.715 million). See Note 4.1 'Income from State Government'.

(b) In 2024, the Health Support Services has provided the Rapid Antigen Test kits free of charge amounting to $0.174 million to the Health Service In accordance with the WA Health COVID-19 Framework. See Note 4.1 'Income from State Government'.

3.4 Repairs, maintenance and consumable equipment

	2025 $000	2024 $000
Repairs and maintenance	23,963	21,897
Consumable equipment	6,051	5,654
	30,014	27,551

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

	2025 $000	2024 $000
Facility management services	2,795	2,648
Administrative services	3,944	3,749
Interpreter services	1,632	1,262
Shared services for accounting [(a)]	935	933
Shared services for human resources [(a)]	6,284	6,277
Shared services for information technology [(a)]	43,942	41,812
Shared services for supply [(a)]	4,055	4,112
Other	2,108	2,111
	65,695	62,904

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

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

3.6 Other expenses

	2025 $000	2024 $000
Workers compensation insurance	8,546	10,029
Other insurances	11,473	11,356
Computer services	3,799	3,438
Printing and stationery	3,011	2,809
Consultancy fees	1,960	2,087
Rental expenses [(a)]	3,672	1,932
Expected credit losses expense [(b)]	630	581
Other employee related expenses	3,110	2,663
Communications	1,985	1,667
Other accommodation expenses [(c)]	2,818	1,713
Audit expenses	490	667
Legal expenses	399	511
Freight and cartage	555	598
Motor vehicle expenses	553	511
Periodical subscription	761	624
Write-off of plant and equipment (Note 5.1)	31	256
Other	5,673	3,086
	49,466	44,528

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

(a) **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.

(b) **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'.

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	2025 $000	2024 $000
Income from State Government	4.1	1,063,892	969,606
Patient charges and other fees for services	4.2	83,269	77,091
Grants and contributions	4.3	19,115	15,563
Donation revenue	4.4	1,539	1,821
Other revenue	4.5	6,835	6,432

4.1 Income from State Government

	2025 $000	2024 $000
Service agreement funding received during the period:		
Department of Health - Service agreement - State component	697,500	626,677
Department of Health - Service agreement - Commonwealth component [(i)]	197,838	188,238
Total service agreement funding	**895,338**	**814,915**
Grants from other state government agencies during the period:		
Mental Health Commission - Service delivery agreement	99,845	88,652
Mental Health Commission - Specific project	-	307
Department of Health - Research development grant	675	192
Department of Health - Implementation of ARC Pathway	-	326
Department of Health - Institute of Health Leadership program	100	100
Department of Health - Aboriginal cadetship program	12	24
Department of Health - Graduate Transition to Practice Support Program	327	336
Department of Health - Other grants	44	25
Total grants from other state government agencies	**101,003**	**89,962**
Services provided to other state government agencies during the period:		
North Metropolitan Health Service - various clinical services	3,275	3,286
WA Country Health Service - various clinical services	545	480
Pathwest - infectious diseases program	68	262
Other	57	32
Total services provided to other state government agencies	**3,945**	**4,060**
Assets transferred from other State government agencies during the period:		
Transfer of medical equipment from/(to) other Health Services	268	(20)
Net assets transferred	**268**	**(20)**

4.1 Income from State Government (cont.)

	2025 $000	2024 $000
Resources received free of charge from other State government agencies during the period:		
Health Support Services - accounting, human resources, information technology and supply services	55,216	53,134
Health Support Services - supply of Rapid Antigen Test Kits	-	174
State Solicitor's Office - legal services	328	482
Department of Education - uses of Child Parent Centres on school sites and other facilities	167	131
Department of Finance - leasing of accommodation service	97	53
PathWest Laboratory Medicine WA - pathology services	7,530	6,715
Total resources received free of charge	**63,338**	**60,689**
Total income from State Government	**1,063,892**	**969,606**

(a) **Service agreement funding** is recognised as income at fair value in the period in which the Health Service gains control of the funds as appropriated under the Service Agreement with the Department of Health. The Health Service gains control of the 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.

Being the major income source to fund the net cost of services delivered (as set out in Note 2.2), service agreement funding comprises a cash component and a receivable (asset) component. See Note 6.2 'Amounts Receivable for Services'.

(i) Included in the Commonwealth component of the service agreement funding are activity based funding and block grant funding 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.

(b) **Grants from other state government agencies** are recognised as revenue when the Health Service has satisfied its performance obligations under the grants agreement. If there is no performance obligation, revenue will be recognised when the grant is received or receivable.

(c) **Transfer of assets:** Discretionary transfers of assets 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 Treasurer's Instruction 8 are also recognised directly to equity.

(d) **Resources 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

	2025 $000	2024 $000
Patient charges [(a)]		
Inpatient charges	33,276	24,880
Outpatient charges	3,819	3,596
	37,095	28,476
Other fees for services		
Recoveries from the Pharmaceutical Benefits Scheme [(b)]	42,090	43,684
Clinical services to other health organisations [(c)]	3,401	3,624
Non clinical services to other health organisations [(c)]	683	1,307
	46,174	48,615
	83,269	77,091

(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 resources consumed in the service delivery.

4.3 Grants and contributions

	2025 $000	2024 $000
Perth Children's Hospital Foundation Ltd	4,196	4,266
Channel 7 Telethon Trust	3,782	2,346
Stan Perron Charitable Foundation	2,764	1,879
The Kids Research Institute Australia	1,427	1,358
Children's Cancer Institute	729	81
Raine Medical Research Foundation	594	420
Syneos Health Australia Pty Ltd	579	140
Parexel International Pty Ltd	524	192
Murdoch Children's Research Institute	365	510
Diabetes Australia	327	266
Children's Health Queensland Hospital & Health Service	300	45
Fiona Wood Foundation	298	-
University of WA	223	64
Monash University	199	218
The Royal Australasian College Of Physicians	196	498
Curtin University	174	3
Angela Wright Bennett Foundation	167	333
Camp Quality	161	77
Rare Voices Australia Ltd	160	160
Edith Cowan University	154	-
Queensland University of Technology	136	38
Children's Oncology Group	135	38
Alexion Pharmaceuticals Australasia Pty Ltd	104	7
Public Health Institute	103	134
Other	1,318	2,490
	19,115	15,563

Where the arrangements are not classified as contracts with customers, operational grants are recognised as income when the Health Service obtains control over the assets comprising the contribution, usually when cash is received. For contracts with customers, operational grants are recognised as revenue either over time or at a point in time, when the specific performance obligations are satisfied. 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

	2025 $000	2024 $000
Perth Children's Hospital Foundation - donations of equipment	816	1,457
Other	723	364
	1,539	1,821

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

4.5 Other revenue

	2025 $000	2024 $000
Pharmaceutical manufacturing activities	2,283	2,345
Rent from commercial tenants	588	570
Expense recoupment from tenants	3,099	2,807
RiskCover insurance premium rebate	-	30
Immunisation services	175	180
Use of hospital facilities by medical practitioners	14	8
Other	676	492
	6,835	6,432

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.

5. Key assets

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	2025 $000	2024 $000
Property, plant and equipment	5.1	1,368,464	1,192,637
Right-of-use assets	5.2	26,486	10,040
Intangible assets	5.3	6,888	9,822
Total key assets		1,401,838	1,212,499

Depreciation and amortisation expense	Notes	2025 $000	2024 $000
Property, plant and equipment	5.1.1	46,349	45,818
Right-of-use assets	5.2	3,261	2,573
Intangible assets	5.3.1	2,934	2,972
		52,544	51,363

5.1 Property, plant and equipment

Year ended 30 June 2025	Land $000	Buildings [b] $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 2024											
Gross carrying amount	29,295	1,070,389	20,380	6,403	76,777	11,358	116,470	24,249	7,176	5,072	1,367,569
Accumulated depreciation	-	-	(3,120)	(2,237)	(75,233)	(4,446)	(73,012)	(15,064)	-	-	(173,112)
Accumulated impairment losses	-	-	-	-	-	-	-	-	-	(1,820)	(1,820)
Carrying amount at start of period	**29,295**	**1,070,389**	**17,260**	**4,166**	**1,544**	**6,912**	**43,458**	**9,185**	**7,176**	**3,252**	**1,192,637**
Additions	-	-	-	-	2,459	-	5,105	338	16,502	5	24,409
Transfer from other Health Services	-	-	-	-	-	-	71	-	-	-	71
Disposals (Note 5.1.2)	-	-	-	-	-	-	(107)	-	-	-	(107)
Transfer between asset classes	-	4,298	-	12,984	897	-	(39)	61	(18,201)	-	-
Revaluation increments [a] [b]	920	196,914	-	-	-	-	-	-	-	-	197,834
Depreciation (Note 5.1.1)	-	(25,319)	(479)	(1,254)	(1,709)	(716)	(14,748)	(2,124)	-	-	(46,349)
Write-offs (Note 3.6)	-	-	-	-	-	-	(31)	-	-	-	(31)
Carrying amount at 30 June 2025	**30,215**	**1,246,282**	**16,781**	**15,896**	**3,191**	**6,196**	**33,709**	**7,460**	**5,477**	**3,257**	**1,368,464**
Gross carrying amount	30,215	1,246,282	20,380	19,387	80,133	11,358	121,088	24,641	5,477	3,257	1,562,218
Accumulated depreciation	-	-	(3,599)	(3,491)	(76,942)	(5,162)	(87,379)	(17,181)	-	-	(193,754)
Accumulated impairment losses	-	-	-	-	-	-	-	-	-	-	-

(a) 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 class of assets. In 2024-25, revaluation increment of $0.920 million for land is recognised as an income and revaluation increment of $196.914 million for buildings is recognised in the asset revaluation reserve.

(b) Of this amount, $133.643 million relates to professional and project management fees, which are now included in the value of current use building assets under the current replacement cost basis as required by the prospective application of AASB 2022-10 *Amendments to Australian Accounting Standards – Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities*.

5.1 Property, plant and equipment (cont.)

Year ended 30 June 2024	Land	Buildings	Site infra-struc-ture	Lease-hold improve-ments	Com-puter equip-ment	Furni-ture & fittings	Medical equip-ment	Motor vehicles, other plant & equip-ment	Work in progress	Art-works	Total
	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
1 July 2023											
Gross carrying amount	26,920	1,019,413	20,380	6,403	76,815	11,380	114,388	24,174	2,014	5,067	1,306,954
Accumulated depreciation	-	-	(2,641)	(1,571)	(69,131)	(3,736)	(63,329)	(12,979)	-	-	(153,387)
Accumulated impairment losses	-	-	-	-	-	-	-	-	-	(1,820)	(1,820)
Carrying amount at start of period	**26,920**	**1,019,413**	**17,739**	**4,832**	**7,684**	**7,644**	**51,059**	**11,195**	**2,014**	**3,247**	**1,151,747**
Additions	-	-	-	-	20	3	5,037	112	5,162	5	10,339
Transfer from/(to) other Health Services (Note 4.1)	-	-	-	-	-	-	(20)	-	-	-	(20)
Disposals (Note 5.1.2)	-	-	-	-	-	-	(218)	-	-	-	(218)
Transfer between asset classes	-	-	-	-	-	(11)	-	11	-	-	-
Revaluation increments [(a)]	2,375	74,488	-	-	-	-	-	-	-	-	76,863
Depreciation (Note 5.1.1)	-	(23,512)	(479)	(666)	(6,160)	(717)	(12,177)	(2,107)	-	-	(45,818)
Write-offs (Note 3.6)	-	-	-	-	-	(7)	(223)	(26)	-	-	(256)
Impairment losses (Note 5.1.1.) [(b)]	-	-	-	-	-	-	-	-	-	-	-
Carrying amount at 30 June 2024	**29,295**	**1,070,389**	**17,260**	**4,166**	**1,544**	**6,912**	**43,458**	**9,185**	**7,176**	**3,252**	**1,192,637**
Gross carrying amount	29,295	1,070,389	20,380	6,403	76,777	11,358	116,470	24,249	7,176	5,072	1,367,569
Accumulated depreciation	-	-	(3,120)	(2,237)	(75,233)	(4,446)	(73,012)	(15,064)	-	-	(173,112)
Accumulated impairment losses	-	-	-	-	-	-	-	-	-	(1,820)	(1,820)

(a) 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 class of assets. In 2023-24, revaluation increment of $2.375 million for land is recognised as an income and revaluation increment of $74.488 million for buildings is recognised in the asset revaluation reserve.

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 (Landgate). The effective date is at 1 July 2024, with the valuations performed during the year ended 30 June 2025 and recognised at 30 June 2025.

In addition, for buildings under the current replacement cost basis, estimated professional and project management fees are included in the valuation of current use assets as required by AASB 2022-10 *Amendments to Australian Accounting Standards – Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities*.

In undertaking the revaluation, fair value was determined by reference to market values for land: $0.870 million (2024: $0.740 million) and buildings: $0.250 million (2024: $0.090 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). These valuations are undertaken annually to ensure that the carrying amount of the assets does not differ materially from their fair value at the end of the reporting period.

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.

5.1 Property, plant and equipment (cont.)

(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).

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	2025	2024
Depreciation		$000	$000
Buildings	5.1	25,319	23,512
Site infrastructure	5.1	479	479
Leasehold improvement	5.1	1,254	666
Medical equipment	5.1	14,748	12,177
Computer equipment	5.1	1,709	6,160
Furniture and fittings	5.1	716	717
Motor vehicles, other plant and equipment	5.1	2,124	2,107
Total depreciation for the period		**46,349**	**45,818**

As at 30 June 2025, there were no indications of impairments.

5.1.1 Depreciation and impairment charges for the period (cont.)

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.

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	4 to 8 years
Furniture and fittings	5 to 20 years
Motor vehicles	8 to 10 years
Medical equipment	3 to 15 years
Other plant and equipment	4 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 are 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 charges for the period (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:

	2025 $000	2024 $000
Carrying amount of non-current assets disposed:		
Property, plant and equipment	(107)	(218)
Proceeds from disposal of non-current assets:		
Property, plant and equipment	210	13
Net gain/(loss) on disposal of non-current assets	**103**	**(205)**

Realised and unrealised gains are usually recognised on a net basis.

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.

5.2 Right-of-use assets

Year ended 30 June 2025	Buildings $000	Vehicles $000	Total $000
1 July 2024			
Gross carrying amount	15,322	2,518	17,840
Accumulated depreciation	(6,494)	(1,306)	(7,800)
Carrying amount at start of period	**8,828**	**1,212**	**10,040**
Additions	19,008	603	19,611
Adjustments	-	96	96
Depreciation	(2,749)	(512)	(3,261)
Carrying amount at 30 June 2025	**25,087**	**1,399**	**26,486**
Gross carrying amount	33,334	2,772	36,106
Accumulated depreciation	(8,247)	(1,373)	(9,620)

Year ended 30 June 2024	Buildings $000	Vehicles $000	Total $000
1 July 2023			
Gross carrying amount	14,306	2,347	16,653
Accumulated depreciation	(5,263)	(1,009)	(6,272)
Carrying amount at start of period	**9,043**	**1,338**	**10,381**
Additions	1,876	296	2,172
Adjustments	-	60	60
Depreciation	(2,091)	(482)	(2,573)
Carrying amount at 30 June 2024	**8,828**	**1,212**	**10,040**
Gross carrying amount	15,322	2,518	17,840
Accumulated depreciation	(6,494)	(1,306)	(7,800)

5.2 Right-of-use assets (cont.)

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

The Health Service has also entered into 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.

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 7.1.

Initial recognition

At the commencement date of the lease, the Health Service 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.

5.2 Right-of-use assets (cont.)

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	2025 $000	2024 $000
Depreciation expense of right-of-use assets	5.2	3,261	2,573
Lease interest expense	7.2	1,708	421
Short-term leases		-	-
Low-value leases		1	5
Total amount recognised in the Statement of Comprehensive Income		**4,970**	**2,999**

The total cash outflow for leases in 2025 was $4.402 million (2024: $2.734 million). As at 30 June 2025, there were no indications of impairment to right-of-use assets.

5.3 Intangible assets

Computer software	**2025 $000**	**2024 $000**
Carrying amount at start of period	9,822	12,794
Amortisation expense (Note 5.3.1)	(2,934)	(2,972)
Carrying amount at 30 June	**6,888**	**9,822**
Gross carrying amount	55,638	55,638
Accumulated amortisation	(48,750)	(45,816)
	6,888	**9,822**

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.

Acquired and internally generated intangible assets costing $5,000 or more that comply with the recognition criteria of AASB 138.57 *Intangible Assets*, are capitalised.

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

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

	2025	2024
Amortisation	$000	$000
Computer software	2,934	2,972
Total amortisation for the period	**2,934**	**2,972**

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)]	8 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 2025, 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	2025 $000	2024 $000
Receivables	6.1	35,291	29,020
Amount receivable for services	6.2	628,351	581,135
Inventories	6.3	4,980	5,359
Other current assets	6.4	1,119	1,209
Payables	6.5	51,801	47,562
Contract liabilities	6.6	796	472
Capital grant liabilities	6.7	1,245	101
Other liabilities	6.8	100	104

6.1 Receivables

	2025 $000	2024 $000
Current		
Patient fee debtors	6,958	5,458
GST receivable	668	807
Receivable from North Metropolitan Health Service	1,426	788
Other receivables	6,560	4,980
Allowance for impairment of receivables	(3,463)	(3,891)
Accrued revenue	4,270	5,506
	16,419	**13,648**
Non-current		
Accrued salaries account [(a)]	18,872	15,372
	18,872	**15,372**
Total Receivables	**35,291**	**29,020**

(a) Funds transferred to Treasury for the purpose of meeting the 27th pay in a reporting period that generally occurs every 11 years. This account is classified as non-current except for the year before the 27th pay year.

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 recognises an allowance for expected credit losses (ECLs) on patient fee debtors, 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. Please refer to Note 3.6 for the amount of ECLs expensed in this financial year.

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

Accrued salaries account contains amounts paid annually into the Treasurer's special purpose account. It is restricted for meeting the additional cash outflow for employee salary payments in reporting periods with 27 pay days instead of the normal 26. No interest is received on this account.

6.1 Receivables (cont.)

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

	2025 $000	2024 $000
Reconciliation of changes in the allowance for impairment of receivables:		
Balance at start of period	3,891	4,383
Expected credit losses expense	630	581
Amount written off during the period	(1,058)	(1,073)
Balance at end of period	3,463	3,891

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)

	2025 $000	2024 $000
Current	-	-
Non-Current	628,351	581,135
	628,351	**581,135**

The Health Service receives service appropriations from the State Government via the Department of Health, 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

	2025 $000	2024 $000
Current		
Pharmaceutical stores - at cost	4,980	5,359

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 current assets

	2025 $000	2024 $000
Current		
Prepayments	1,100	1,190
Unearned patient charges	19	19
	1,119	1,209

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

6.5 Payables

	2025 $000	2024 $000
Current		
Trade payables	8,841	9,035
Other payables	42	39
Accrued expenses	11,835	12,187
Accrued salaries	31,083	26,301
	51,801	47,562

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.

6.6 Contract liabilities

	2025 $000	2024 $000
Reconciliation of changes in contract liabilities		
Opening balance	472	280
Additions	1,359	495
Revenue recognised in the reporting period	(1,035)	(303)
Total contract liabilities at end of period	796	472
Current	796	472
Non-current	-	-

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.

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

6.7 Capital grant liabilities

	2025 $000	2024 $000
Reconciliation of changes in capital grant liabilities		
Opening balance	101	409
Additions	1,235	-
Revenue recognised in the reporting period	(91)	(308)
Total capital grant liabilities at end of period	1,245	101
Current	1,245	101
Non-current	-	-

The Health Service recognises a capital grant liability for the excess of the initial carrying amount of a financial asset received in a transfer to enable the acquisition or construction of a recognisable non-financial asset under its control.

The Health Service recognises income in profit or loss as the obligations of the capital grant liability are satisfied under the transfer. Refer to Note 4.3 for the details of revenue recognition policy.

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

6.8 Other liabilities

	2025 $000	2024 $000
Current		
Paid parental leave scheme	100	104
Others	-	-
	100	104

7. Financing

This section sets out the material balances and disclosures associated with the financing and cashflows of the Health Service.

	Notes
Lease liabilities	7.1
Finance costs	7.2
Cash and cash equivalents	7.3
Reconciliation of cash	7.3.1
Reconciliation of net cost of services to net cash flows used in operating activities	7.3.2
Reconciliation of cash flows from State Government	7.3.3
Capital commitments	7.4

7.1 Lease liabilities

	2025 $000	2024 $000
Current	2,914	2,132
Non-current	29,444	8,830
Total lease liabilities [(a)]	32,358	10,962

(a) The 2025 total lease liabilities include $30.835 million for leased buildings and $1.521 million for leased vehicles. The 2024 total lease liabilities include $9.647 million for leased buildings and $1.315 million for leased vehicles.

Initial measurement

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;
- 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.

7.1 Lease liabilities (cont.)

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.

7.2 Finance costs

	2025 $000	2024 $000
Lease interest expense	1,708	421
	1,708	**421**

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

Lease interest expense is the interest component of lease liability repayments.

7.3 Cash and cash equivalents

7.3.1 Reconciliation of cash

	2025 $000	2024 $000
Cash and cash equivalents	17,730	17,152
Restricted cash and cash equivalents		
Current		
Capital work projects	5,091	10,164
Mental Health Commission Funding [(a)]	2,302	737
Restricted cash assets held for other specific purposes [(b)]	20,709	14,920
Total restricted cash and cash equivalents	28,102	25,821
Balance at end of period	**45,832**	**42,973**

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.

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

7.3.2 Reconciliation of net cost of services to net cash flows used in operating activities

	Notes	2025 $000	2024 $000
Net cost of services (Statement of Comprehensive Income)		(1,085,613)	(984,239)
Non-cash items:			
Expected credit losses expense	3.6	630	581
Write-off of inventory		11	12
Depreciation and amortisation expenses	5	52,544	51,363
Assets received from other Health Services expensed		197	-
Asset revaluation increments	5.1	(920)	(2,375)
Loss on disposal of non-current assets	5.1.2	(103)	205
Write-off of plant and equipment	3.6	31	256
Interest capitalised		20	8
Donations of assets		(336)	(929)
Resources received free of charge	4.1	63,338	60,689
(Increase)/decrease in assets:			
Receivables		(3,401)	(851)
Inventories		368	(276)
Other current assets		222	(88)
Increase/(Decrease) in liabilities:			
Payables		5,800	8,107
Current provisions		17,459	10,536
Non-current provisions		9,764	2,217
Grant liabilities		1,144	(308)
Contract liabilities		324	192
Other current liabilities		(4)	43
Net cash used in operating activities (Statement of Cash Flows)		**(938,525)**	**(854,857)**

7.3.3 Reconciliation of cash flows from State Government

	2025 $000	2024 $000
Service agreement funding - State	697,500	626,677
Service agreement funding - Commonwealth	197,838	188,238
Grants from other state government agencies	101,003	89,962
Services provided to other government agencies	3,945	4,060
Capital appropriation credited directly to Contributed equity (refer Note 9.13)	15,701	16,236
	1,015,987	925,173
Less notional cash flows:		
Accrual appropriations	(47,216)	(51,793)
Cash Flows from State Government as per Statement of Cash Flows	968,771	873,380

At the end of the reporting period, the Health Service had fully drawn on all financing facilities, details of which are disclosed in the financial statements.

7.4 Capital commitments

	2025 $000	2024 $000
Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows:		
Within 1 year	5,389	7,400
Later than 1 year, and not later than 5 years	5,773	117
Later than 5 years	-	51
	11,162	7,568

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, lease liabilities, 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.

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 lease liabilities.

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:

	2025 $000	2024 $000
Financial Assets		
Cash and cash equivalents	17,730	17,152
Restricted cash and cash equivalents	28,102	25,821
Financial assets at amortised cost [(a)]	662,974	609,348
	708,806	**652,321**
Financial Liabilities		
Financial liabilities measured at amortised cost	84,159	58,524
	84,159	**58,524**

(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 2025							
Expected credit loss rate	24%	2%	8%	12%	31%	59%	75%
Estimated total gross carrying amount	14,406	6,601	1,673	949	1,505	721	2,957
Expected credit losses	(3,465)	(125)	(132)	(117)	(464)	(422)	(2,205)
30 June 2024							
Expected credit loss rate	37%	3%	6%	23%	28%	50%	85%
Estimated total gross carrying amount	10,473	4,002	1,041	488	616	719	3,607
Expected credit losses	(3,890)	(105)	(64)	(110)	(173)	(360)	(3,078)

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	Interest rate exposure				Maturity dates			
		Carrying amount	Fixed interest rate	Variable interest rate	Non-interest bearing	Nominal Amount	Up to 3 months	3 months to 1 year	1-5 years	More than 5 years
	%	$000	$000	$000	$000	$000	$000	$000	$000	$000
2025										
Financial Assets										
Cash and cash equivalents		17,730	-	-	17,730	17,730	17,730	-	-	-
Restricted cash and cash equivalents		28,102	-	-	28,102	28,102	28,102	-	-	-
Receivables [(a)]		34,623	-	-	34,623	34,623	15,751	-	18,872	-
Amounts receivable for services		628,351	-	-	628,351	628,351	-	-	-	628,351
		708,806	-	-	708,806	708,806	61,583	-	18,872	628,351
Financial Liabilities										
Payables		51,801	-	-	51,801	51,801	51,801	-	-	-
Lease liabilities	7.88%	32,358	32,358	-	-	51,525	1,112	3,327	14,687	32,399
		84,159	32,358	-	51,801	103,326	52,913	3,327	14,687	32,399

(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	Interest rate exposure				Maturity dates			
		Carrying amount	Fixed interest rate	Variable interest rate	Non-interest bearing	Nominal Amount	Up to 3 months	3 months to 1 year	1-5 years	More than 5 years
	%	$000	$000	$000	$000	$000	$000	$000	$000	$000
2024										
Financial Assets										
Cash and cash equivalents		17,152	-	-	17,152	17,152	17,152	-	-	-
Restricted cash and cash equivalents		25,821	-	-	25,821	25,821	25,821	-	-	-
Receivables [(a)]		28,213	-	-	28,213	28,213	12,841	-	15,372	-
Amounts receivable for services		581,135	-	-	581,135	581,135	-	-	-	581,135
		652,321	-	-	652,321	652,321	55,814	-	15,372	581,135
Financial Liabilities										
Payables		47,562	-	-	47,562	47,562	47,562	-	-	-
Lease liabilities	3.83%	10,962	10,962	-	-	12,265	650	1,683	6,695	3,237
		58,524	10,962	-	47,562	59,827	48,212	1,683	6,695	3,237

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

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

The Health Service is a registered member of a cladding class action for the Perth Children's Hospital building.

We are unable to estimate the financial effect at this stage, however disclosure of a contingent asset is deemed to be reasonable as the inflow of economic benefit is probable.

8.2.2 Contingent liabilities

Employee Benefits Provisions

The estimates of the long service leave liabilities for casual employees do not include the impact of continuity of service. At the time of reporting, the Actuary has not completed the assessment of this component of liability and consequently a reliability estimate is not available for recognition in the employee benefits provision.

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 '*Fair Value Measurement*' 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:

2025	Notes	Level 1 $000	Level 2 $000	Level 3 $000	Fair value at end of period $000
Land	5.1				
Residential		-	870	-	870
Specialised		-	-	29,345	29,345
Buildings	5.1				
Residential		-	250	-	250
Specialised		-	-	1,246,032	1,246,032
		-	1,120	1,275,377	1,276,497
2024					
Land	5.1				
Residential		-	740	-	740
Specialised		-	-	28,555	28,555
Buildings	5.1				
Residential		-	90	-	90
Specialised		-	-	1,070,299	1,070,299
		-	830	1,098,854	1,099,684

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 (Landgate) 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 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)

2025	Land $000	Buildings $000
Fair value at start of period	28,555	1,070,299
Additions	-	4,298
Revaluation increments recognised in Profit or Loss	790	-
Revaluation increments recognised in Other Comprehensive Income	-	196,752
Depreciation expense	-	(25,317)
Fair Value at end of period	**29,345**	**1,246,032**
2024		
Fair value at start of period	26,220	1,019,328
Revaluation increments recognised in Profit or Loss	2,335	-
Revaluation increments recognised in Other Comprehensive Income	-	74,483
Depreciation expense	-	(23,512)
Fair Value at end of period	**28,555**	**1,070,299**

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.

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.

8.3 Fair value measurements (cont.)

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 metre 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.

In addition, professional and project management fees estimated and added to the current replacement costs provided by Landgate for current use buildings represent significant Level 3 inputs used in the valuation process. The higher level of estimated professional and project management fees would result in higher fair value of these assets.

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

AASB 2022-10 – *Amendments to Australian Accounting Standards – Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities*

The Standard amends AASB 13 *Fair Value Measurement* to provide additional clarification on the application of the fair value measurement principles for non-financial assets of not-for-profit public sector entities that are not held primarily for their ability to generate net cash inflows. Specifically, this Standard provides guidance on the nature of costs to include in the replacement cost of a reference asset.

It is considered that valuations provided by the Western Australian Land Information Authority (Landgate) under the current replacement cost basis are consistent with the requirements of AASB 13 except for professional and project management fees (PPF). As the Standard assumes the assets be re-constructed at the measurement date, PPF would be incurred as part of the reconstruction. Accordingly, the Health Service has included PPF of $133.643 million to the valuation provided by Landgate.

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 Treasurer's Instruction (TI) 9 – Requirement 4 *Application of Australian Accounting Standards and Other Pronouncements* or by an exemption from TI 9. 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 2024-2	*Amendments to Australian Accounting Standards – Classification and Measurement of Financial Instruments* This Standard amends AASB 7 and AASB 9 as a consequence of the issuance of *Amendments to the Classification and Measurement of Financial Instruments* (Amendments to IFRS 9 and IFRS 7) by the International Accounting Standards Board in May 2024. The Health Service has not assessed the impact of the Standard.	1 January 2026
AASB 2024-3	*Amendments to Australian Accounting Standards – Annual Improvements Volume 11* This Standard amends AASB 1, AASB 7, AASB 9, AASB 10 and AASB 107 as a consequence of the issuance of *Annual Improvements to IFRS Standards - Volume 11* by the International Accounting Standards Board in July 2024. The Health Service has not assessed the impact of the Standard.	1 January 2026
AASB 18	*Presentation and Disclosure in Financial Statements (Appendix D) [for not-for-profit and superannuation entities]* This Standard replaces AASB 101 with respect to the presentation and disclosure requirements in financial statements applicable to not-for-profit and superannuation entities This Standard is a consequence of the issuance of IFRS 18 *Presentation and Disclosure in financial Statements* by the International Accounting Standards Board in April 2024. This Standard also makes amendments to other Australian Accounting Standards set out in Appendix D of this Standard. The Health Service has not assessed the impact of the Standard.	1 January 2027

9.4 Remuneration of auditors

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

	2025 $000	2024 $000
Auditing the accounts, financial statements, controls, and key performance indicators	318	292

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 ($)	**2025**	**2024**
$10,001 - $20,000	-	3
$20,001 - $30,000	2	-
$30,001 - $40,000	-	1
$40,001 - $50,000	7	6
$60,001 - $70,000	1	-
$80,001 - $90,000	-	1
Total number of members of the Accountable Authority	10	11

	2025 $000	2024 $000
Short-term employee benefits	394	394
Post-employment benefits	45	43
Total compensation of members of the Accountable Authority	**439**	**437**

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 ($)	2025	2024
$0 - $50,000	1	1
$50,001 - $100,000	1	1
$100,001 - $150,000	1	1
$200,001 - $250,000	4	5
$250,001 - $300,000	4	2
$300,001 - $350,000	1	-
$450,001 - $500,000	1	-
$500,001 - $550,000	-	2
Total number of senior officers	13	12

	2025 $000	2024 $000
Short-term employee benefits	2,439	2,333
Post-employment benefits	322	296
Other long-term benefits	292	276
Termination benefits	-	-
Total compensation of senior officers	**3,053**	**2,905**

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).

9.6 Related party transactions (cont.)

Significant transactions with Government-related entities

In conducting its activities, the Health Service is required to transact with the State and entities related to the State. These transactions are generally based on the standard terms and conditions that apply to all agencies. Such transactions include:

	Notes	2025 $000	2024 $000
Income			
Service agreement funding - State	4.1	697,500	626,677
Service agreement funding - Commonwealth	4.1	197,838	188,238
Mental Health Commission - Service delivery agreement	4.1	99,845	88,652
Department of Health - Research development grant	4.1	675	192
Department of Health grant - COVID-19 vaccination	4.1	100	100
Department of Health grant - Aboriginal Cadetship Program	4.1	12	24
North Metropolitan Health Service - various clinical services	4.1	3,275	3,286
WA Country Health Service - various clinical services	4.1	545	480
Department of Health - Auspman fitout capital project	4.1	-	25
Department of Health - Graduate Transition to Practice Support Program	4.1	327	336
Assets assumed/(transferred)	4.1	268	(20)
Services received free of charge	4.1	63,338	60,689
Expenses			
Contracts for services - North Metropolitan Health Service	3.2	7,065	7,065
Facility management services - North Metropolitan Health Service	3.5	2,795	2,648
Contracts for services - Department of Communities [(a)]		661	684
Insurance payments - Insurance Commission (RiskCover) [(a)]		20,015	21,402
Rental and other accommodation expenses - Department of Finance [(a)]		3,256	1,600
Lease interest expense - State Fleet [(a)]		87	81
Remuneration for audit services - Office of the Auditor General	9.4	318	292

(a) These transactions are included at Note 3.6 'Other expenses' and Note 7.2 'Finance costs'.

9.6 Related party transactions (cont.)

Significant transactions with Government-related entities (cont.)

	Notes	2025 $000	2024 $000
Assets			
Receivables at 30 June - North Metropolitan Health Service	6.1	1,426	788
Liabilities			
Lease liabilities at 30 June - State Fleet	7.1	1,521	1,315
Repayments of lease liabilities - State Fleet		494	462
Contributed Equity			
Capital appropriations administered by Department of Health	9.13	15,701	16,236

Material transactions with other related parties

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

	2025 $000	2024 $000
Superannuation payments to GESB	57,792	51,476
Payable to GESB	3,620	2,826

All other transactions (including normal 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:

	2025 $000	2024 $000
Department for Communities - health assessments for children in care	244	234
Department of Education - school health services	14,054	13,807
	14,298	14,041

9.10 Other statement of receipts and payments

	2025 $000	2024 $000
Commonwealth Grant - Christmas and Cocos Island		
Balance at the start of period	(82)	(83)
Receipts		
Commonwealth grant - provision of paediatric services [(a)]	82	83
Payments		
Costs of visiting specialists [(b)]	(78)	(82)
Balance at the end of period	**(78)**	**(82)**

(a) The grant to cover the costs of visiting specialists in 2023-24 has been received from Commonwealth in 2024-25.

(b) The grant to cover the costs of visiting specialists in 2024-25 will be received from Commonwealth in 2025-26.

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.*

	2025 $000	2024 $000
Balance at the start of period	737	581
Receipts		
Service delivery agreement - Commonwealth contributions	31,119	18,387
Service delivery agreement - State contributions	68,726	70,265
Specific project - Ward 5A relocation costs	-	307
	99,845	88,959
Payments	(98,280)	(88,803)
	1,565	156
Balance at the end of period [(a)]	**2,302**	**737**

(a) The closing cash balance of $2,302,384 is classified as restricted cash (2024: $737,392).

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.

	2025 $000	2024 $000
Contributed equity		
Balance at start of period	1,489,537	1,473,301
Contributions by owners		
Capital appropriations administered by Department of Health [(a)]	15,701	16,236
Balance at end of period	**1,505,238**	**1,489,537**

(a) *Treasurer's Instruction (TI) 8 – Requirement 8.1(i)* designates capital appropriations as contributions by owners in accordance with AASB Interpretation 1038 *'Contributions by Owners Made to Wholly-Owned Public Sector Entities*'.

	2025 $000	2024 $000
Assets revaluation reserve		
Balance at start of period	227,804	153,316
Net revaluation increments/(decrements) [(a) (b)]		
Buildings	196,914	74,488
Balance at end of period	424,718	227,804

(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

	2025 $000	2024 $000
Revenue and debts written off under the authority of the Accountable Authority	682	1,039
Revenue and debts written off under the authority of the Minister	587	-
Public and other property written off under the authority of the Accountable Authority	33	313
Public and other property written off under the authority of the Treasurer	1,820	-
	3,122	1,352

(b) Losses through theft, defaults and other causes

	2025 $000	2024 $000
Losses of public money and public and other property through theft or default	-	-
	-	-

(c) Gifts of public property

In the 2023-24 financial year, the Health Service donated various medical equipment to the Australian Doctors for Africa, Operation Rainbow Australia Limited, Neurospheric Pty Ltd and Royal Flying Doctor Service.

9.15 Explanatory statement

All variances between annual estimates (original budget) and actual results for 2025, and between the actual results for 2025 and 2024 are shown below. Narratives are provided for key major variances which vary more than 10% from their comparative and that the variation is more than 1% of the following:

1. Estimate and actual results for the current year
    - Total Cost of Services of the annual estimate for the Statement of comprehensive income and Statement of cash flows ($10.339 million), and
    - Total Assets of the annual estimate for the Statement of financial position ($19.009 million).
2. Actual results for the current year and the prior year actual
    - Total Cost of Services for the previous year for the Statements of comprehensive income and Statement of cash flows ($10.875 million), and
    - Total Assets for the previous year for the Statement of financial position ($18.722 million).

Treasurer's Instruction 3 – Requirement 7.2 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 2025 $000	Actual 2025 $000	Actual 2024 $000	Variance between actual and estimate $000	Variance between actual results for 2025 and 2024 $000
Expenses						
Employee benefits expense	(a) (f)	715,971	845,124	753,206	129,153	91,918
Fees for visiting medical practitioners		3,853	4,582	4,053	729	529
Contracts for services		8,351	8,778	8,785	427	(7)
Patient support costs		130,615	139,483	134,505	8,868	4,978
Finance costs		954	1,708	421	754	1,287
Depreciation and amortisation expenses		47,216	52,544	51,363	5,328	1,181
Loss on disposal of non-current assets		-	-	205	-	(205)
Repairs, maintenance and consumable equipment		26,191	30,014	27,551	3,823	2,463
Other supplies and services		59,005	65,695	62,904	6,690	2,791
Other expenses		41,746	49,466	44,528	7,720	4,938
Total cost of services		**1,033,902**	**1,197,394**	**1,087,521**	**163,492**	**109,873**

9.15.1 Statement of Comprehensive Income Variances (cont.)

	Variance note	Estimate 2025 $000	Actual 2025 $000	Actual 2024 $000	Variance between actual and estimate $000	Variance between actual results for 2025 and 2024 $000
Income						
Patient charges	(b)	25,861	37,095	28,476	11,234	8,619
Other fees for services		50,688	46,174	48,615	(4,514)	(2,441)
Grants and contributions		17,220	19,115	15,563	1,895	3,552
Donation revenue		20	1,539	1,821	1,519	(282)
Gain on disposal of non-current assets		-	103	-	103	103
Asset revaluation increments		-	920	2,375	920	(1,455)
Other income		1,599	6,835	6,432	5,236	403
Total income		**95,388**	**111,781**	**103,282**	**16,393**	**8,499**
NET COST OF SERVICES		**938,514**	**1,085,613**	**984,239**	**147,099**	**101,374**
INCOME FROM STATE GOVERNMENT						
Service agreement funding - State	(c) (g)	609,088	697,500	626,677	88,412	70,823
Service agreement funding - Commonwealth	(d)	177,288	197,838	188,238	20,550	9,600
Grants from other state government agencies	(e) (h)	89,683	101,003	89,962	11,320	11,041
Services provided to other government agencies		4,339	3,945	4,060	(394)	(115)
Assets (transferred)/assumed		-	268	(20)	268	288
Resources received free of charge		56,717	63,338	60,689	6,621	2,649
Total income from State Government		**937,115**	**1,063,892**	**969,606**	**126,777**	**94,286**
SURPLUS / (DEFICIT) FOR THE PERIOD		**(1,399)**	**(21,721)**	**(14,633)**	**(20,322)**	**(7,088)**
OTHER COMPREHENSIVE INCOME						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve		-	196,914	74,488	196,914	122,426
Total other comprehensive income		-	196,914	74,488	196,914	122,426
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**(1,399)**	**175,193**	**59,855**	**176,592**	**115,338**

9.15.1 Statement of Comprehensive Income Variances (cont.)

Major Variance Narratives

Variances between estimates and actuals

(a) Employee benefits expense – The $129.2 million variance is partly due to a lower funding base in the initial estimates, additional resourcing engaged to address essential service needs, to enhance support to the Emergency Department, and to maintain appropriate safety and quality measures. Resourcing has been deployed to support the reforms arising from the Ministerial Taskforce into Public Mental Health Services, and the commissioning of the Nickoll Ward at Hollywood Hospital, which is being used as a decant facility whilst the Perth Children's Hospital's inpatient mental health ward undergoes refurbishment. The resourcing costs have also been compounded by pay increases awarded to employees under the new industrial agreements, and by the increase in employee benefits provisions.

(b) Patient charges – The variance is mainly in regard to the increase in overseas patients and increase in the chargeable occupancy bed days at the Perth Children's Hospital (PCH) and the Neonatology services at the King Edward Memorial Hospital.

(c) Service agreement funding – State – The variance reflects the additional funding provided by State Government to support the increased costs of existing, expanded and new services in the 2024-25 financial year. These include increases from hospital activity pricing, and other non-hospital services including funding allocation for the expansion of child development service and for the operations of the Midland and Murdoch community hubs. Funding supplementation has also been received for pay increases under the new industrial agreements.

(d) Service agreement funding – Commonwealth – Compared with the initial estimates, there is a funding adjustment of $20.0 million between the State component and Commonwealth component of the initial Service Agreement Funding, as the State receives funding adjustments from the Commonwealth via the National Health Reform Agreement.

(e) Grants from other state government agencies – $10.7 million of the variance is the additional funding from the Mental Health Commission (MHC) to support the commissioning and operation of the Nickoll Ward at Hollywood Hospital (see variance note (a) above). Additional funding for pay increases has also been provided by MHC.

9.15.1 Statement of Comprehensive Income Variances (cont.)

Major Variance Narratives

Variances between actuals for 2024-25 and 2023-24

(f) Employee benefits expense – The $91.9 million increase is partly caused by the additional resourcing engaged to address essential service needs, to enhance support to the Emergency Department, and to maintain appropriate safety and quality measures. As a result of increased funding from the Mental Health Commission, the Health Service has been able to deploy resourcing to support reforms arising from the Ministerial Taskforce into Public Mental Health Services, and to support the commissioning and operation of the Nickoll Ward at Hollywood Hospital (see variance note (a) above). The additional resourcing costs have also been compounded by pay increases awarded to employees under the new industrial agreements. and by the increase in employee benefits provisions.

(g) Service agreement funding – State - The increase reflects the additional funding provided by State Government to support the increased costs of existing, expanded and new services in 2024-25. These include increases from hospital activity pricing, and other non-hospital services including funding allocation for the expansion of child development service and for the operations of the Midland and Murdoch community hubs. Funding supplementation has also been received for pay increases awarded under the new industrial agreements.

(h) Grants from other state government agencies – The increased funding from the Mental Health Commission (MHC) has been used to support the commissioning and operation of the Nickoll Ward at Hollywood Hospital (see variance note (a) above), and to address the reforms arising from the Ministerial Taskforce into Public Mental Health Services. Additional funding has also been provided by MHC for pay increases paid to employees within the Child and Adolescent Mental Health Service.

9.15.2 Statement of Financial Position Variances

	Variance note	Estimate 2025 $000	Actual 2025 $000	Actual 2024 $000	Variance between actual and estimate $000	Variance between actual results for 2025 and 2024 $000
ASSETS						
Current Assets						
Cash and cash equivalents		13,273	17,730	17,152	4,457	578
Restricted cash and cash equivalents		24,422	28,102	25,821	3,680	2,281
Receivables		15,553	16,419	13,648	866	2,771
Inventories		5,359	4,980	5,359	(379)	(379)
Other current assets		1,209	1,119	1,209	(90)	(90)
Total Current Assets		59,816	68,350	63,189	8,534	5,161
Non-Current Assets						
Receivables		20,772	18,872	15,372	(1,900)	3,500
Amounts receivable for services		628,351	628,351	581,135	-	47,216
Property, plant and equipment	(a) (b)	1,168,667	1,368,464	1,192,637	199,797	175,827
Right-of-use assets		16,432	26,486	10,040	10,054	16,446
Intangible assets		6,887	6,888	9,822	1	(2,934)
Total Non-Current Assets		1,841,109	2,049,061	1,809,006	207,952	240,055
TOTAL ASSETS		**1,900,925**	**2,117,411**	**1,872,195**	**216,486**	**245,216**

9.15.2 Statement of Financial Position Variances (cont.)

	Variance note	Estimate 2025 $000	Actual 2025 $000	Actual 2024 $000	Variance between actual and estimate $000	Variance between actual results for 2025 and 2024 $000
LIABILITIES						
Current Liabilities						
Payables		49,865	51,801	47,562	1,936	4,239
Contract liabilities		472	796	472	324	324
Capital grant liabilities		96	1,245	101	1,149	1,144
Lease liabilities		2,615	2,914	2,132	299	782
Employee benefits provisions		157,344	174,883	157,424	17,539	17,459
Other current liabilities		104	100	104	(4)	(4)
Total Current Liabilities		210,496	231,739	207,795	21,243	23,944
Non-Current Liabilities						
Lease liabilities	(c)	15,591	29,444	8,830	13,853	20,614
Employee benefits provisions		26,777	36,541	26,777	9,764	9,764
Total Non-Current Liabilities		42,368	65,985	35,607	23,617	30,378
TOTAL LIABILITIES		**252,864**	**297,724**	**243,402**	**44,860**	**54,322**
NET ASSETS		**1,648,061**	**1,819,687**	**1,628,793**	**171,626**	**190,894**
EQUITY						
Contributed equity		1,509,344	1,505,238	1,489,537	(4,106)	15,701
Reserves		227,804	424,718	227,804	196,914	196,914
Accumulated surplus		(89,087)	(110,269)	(88,548)	(21,182)	(21,721)
TOTAL EQUITY		**1,648,061**	**1,819,687**	**1,628,793**	**171,626**	**190,894**

9.15.2 Statement of Financial Position Variances (cont.)

Major Variance Narratives

Variances between estimates and actuals

(a) Property, plant and equipment – The $199.8 million variance is mainly caused by $197.8 million asset revaluation increments of which $133.6 million relating to the estimated professional and project management fees added to the carrying amounts of buildings as at 30 June 2025.

Variances between actuals for 2024-25 and 2023-24

(b) Property, plant and equipment – The $175.8 million increase is mainly due to the $197.8 million asset revaluation increments, partially offset by depreciation of $46.3 million for the current financial year.
(c) Lease liabilities – The $20.6 million increase consists of $17.9 million from the commencement of lease for the new Murdoch Community Hub in the 2024-25 financial year.

9.15.3 Statement of Cash Flows Variances

	Variance note	Estimate 2025 $000	Actual 2025 $000	Actual 2024 $000	Variance between actual and estimate $000	Variance between actual results for 2025 and 2024 $000
CASH FLOWS FROM STATE GOVERNMENT						
Service agreement funding - State	(a) (f)	561,872	650,284	574,884	88,412	75,400
Service agreement funding - Commonwealth	(b)	177,288	197,838	188,238	20,550	9,600
Grants from other state government agencies	(c) (g)	89,683	101,003	89,962	11,320	11,041
Services provided to other government agencies		4,339	3,945	4,060	(394)	(115)
Capital appropriations administered by Department of Health		19,807	15,701	16,236	(4,106)	(535)
Net cash provided by State Government		**852,989**	**968,771**	**873,380**	**115,782**	**95,391**
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits	(d) (h)	(713,382)	(813,131)	(734,300)	(99,749)	(78,831)
Supplies and services		(213,045)	(232,114)	(218,825)	(19,069)	(13,289)
Finance costs		(954)	(1,688)	(413)	(734)	(1,275)
Receipts						
Receipts from customers	(e)	25,508	36,831	28,255	11,323	8,576
Grants and contributions		17,220	20,583	15,447	3,363	5,136
Donations received		20	723	364	703	359
Other receipts		51,573	50,271	54,615	(1,302)	(4,344)
Net cash used in operating activities		**(833,060)**	**(938,525)**	**(854,857)**	**(105,465)**	**(83,668)**

9.15.3 Statement of Cash Flows Variances (cont.)

	Variance note	Estimate 2025 $000	Actual 2025 $000	Actual 2024 $000	Variance between actual and estimate $000	Variance between actual results for 2025 and 2024 $000
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Purchase of non-current assets	(i)	(17,134)	(25,634)	(7,883)	(8,500)	(17,751)
Receipts						
Proceeds from sale of non-current assets		-	210	13	210	197
Net cash used in investing activities		**(17,134)**	**(25,424)**	**(7,870)**	**(8,290)**	**(17,554)**
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Principal elements of lease		(2,673)	(2,861)	(2,321)	(188)	(540)
Payment to accrued salaries account		(5,400)	(3,500)	-	1,900	(3,500)
Receipts						
Lease incentive received		-	4,398	-	4,398	4,398
Net cash used in financing activities		**(8,073)**	**(1,963)**	**(2,321)**	**6,110**	**358**
Net increase / (decrease) in cash and cash equivalents		(5,278)	2,859	8,332	8,137	(5,473)
Cash and cash equivalents at the beginning of period		42,973	42,973	34,641	-	8,332
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**37,695**	**45,832**	**42,973**	**8,137**	**2,859**

9.15.3 Statement of Cash Flows Variances

Major Variance Narratives

Variances between estimates and actuals

(a) Service agreement funding – State – see explanation in variance note (c) for the Statement of Comprehensive Income.

(b) Service agreement funding – Commonwealth - see explanation in variance note (d) for the Statement of Comprehensive Income.

(c) Grants from other state government agencies – see explanation in variance note (e) for the Statement of Comprehensive Income.

(d) Employee benefits – The $99.7 million variance is partly due to a lower funding base in the initial estimates, and partly because of payments for higher than estimated pay increases and for additional resourcing in respect of the various operational needs and initiatives mentioned in variance note (a) for the Statement of Comprehensive Income.

(e) Receipts from customers – see explanation in variance note (b) for the Statement of Comprehensive Income.

Variances between actuals for 2024-25 and 2023-24

(f) Service agreement funding – State - see explanation in variance note (g) for the Statement of Comprehensive Income.

(g) Grants from other state government agencies - see explanation in variance note (h) for the Statement of Comprehensive Income.

(h) Employee benefits – see explanation in variance note (f) for the Statement of Comprehensive Income.

(i) Purchase of non-current assets – The $17.8 million increase mainly consists of new operating theatres in the Perth Children's Hospital and leasehold improvements for the Murdoch Community Hub and other community health centres.

CAHS is committed to promoting a positive culture of health, safety and wellbeing.

DISCLOSURES AND LEGAL COMPLIANCE

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.

There were no Ministerial directives received for 2024–25.

OTHER FINANCIAL DISCLOSURES

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)*.

Most 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.

Compensable or Medicare 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 Government. The setting of compensable and Medicare 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 Government sets these fees at a level equivalent to the Commonwealth Minimum Benefit.

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 Health Regulations through Determinations, which include the supply of surgically implanted prostheses, magnetic resonance imaging services and pathology services. The pricing for these hospital services is determined according to their cost of service.

CAPITAL WORKS

There were no capital works completed in the 2024–25 financial year.

Table 6: Capital works in progress in the 2024–25 financial year

Project name	Expected financial year of completion*	Estimated cost to complete ($'000)	Estimated total cost of project ($'000)	Variance from previous financial year** ($'000)	Explanation of variance (>=10%)
Western Australian Hospitals Central Pharmaceutical Manufacturing Facility (Auspman)	2025–26	**5,140**	**5,140**	**0**	
Child and Adolescent Health Service Community Health Hub – Murdoch	2025–26	**13,294**	**2,660**	**0**	
Perth Children's Hospital State Rectified Defects and Design Changes	2024–25	**11,164**	**11,164**	**-1,450**	Funds redirected to Theatre Shell Fit-out
Perth Children's Hospital Theatre Shell Fit-out	2025–26	**4,050**	**4,050**	**1,450**	Funds redirected from State Rectified Defects and Design Changes
COVID-19 Perth Children's Hospital 2 Intensive Care Unit Beds	2024–25	**540**	**540**	**0**	
Children's Hospice Western Australia	2026–27	**2,364**	**2,364**	**0**	
Perth Children's Hospital – Reconfiguration of Ward 5A	2027–28	**21,881**	**21,881**	**0**	

Notes of relevance as footnote to information above

- * Expected financial year of completion considers the defects liability period and project funding timeframe after practical completion.
- ** Variance represents the difference between the estimated total cost of the project in comparison to the estimated total cost in the previous reporting. The previous reporting can be found in the CAHS Annual Report 2023–24.
- The information in Table 6 represents the CAHS major capital works program, including expensed capital but excludes statewide projects.

Governance disclosures

Indemnity insurance

In 2024–25, 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 $97,005.00 (excluding GST).

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 2024–25, none of the CAHS senior officers declared a pecuniary interest.

Employee profile

This information is included in Our people.
See pages 16-17.

Unauthorised use of credit cards

In accordance with State Government policy, CAHS has issued corporate credit cards to certain employees where their functions warrant use of this facility for purchasing goods and services. These credit cards are not to be used for personal (unauthorised) purposes.

Cardholders are reminded annually of their obligations under the credit card policy. In the reporting period, 10 employees used their corporate credit card for personal expenditure on 11 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 7).

Table 7: Credit card personal use expenditure in 2024–25

Credit card personal use expenditure	Amount
Aggregate amount of personal use expenditure for the reporting period	**$784.24**
Aggregate amount of personal use expenditure settled by the due date (within 5 working days)	**$784.24**
Aggregate amount of personal use expenditure settled after the period (after 5 working days)	**$0**
Aggregate amount of personal use expenditure outstanding at the end of the reporting period	**$0**

Industrial relations

The CAHS Workplace Relations team ensures the health service is meeting its obligations under the applicable industrial instruments and fosters constructive and productive relationships with key stakeholders, including the Department of Health, unions and professional associations.

The requirement to provide accurate and timely workplace relations advice and services in a constantly changing environment remained a priority this year.

There were 17 industrial disputes or appeals in the 2024–25 period.

While most of these related to individual employee matters, others related to matters covering large groups of employees. All matters were resolved through conciliation, mediation and dispute resolution procedures. None reached the point of arbitration. Resolving matters outside of arbitration resulted in more acceptable outcomes for all parties involved and cost savings to the health service.

Throughout the reporting period, 5 WA Health Industrial Agreements were re-negotiated by the Department of Health and registered in the Western Australian Industrial Relations Commission. Staff had the opportunity to learn more about the changes to the industrial agreements via several presentations delivered to members of the Executive, management and staff.

A review is progressing for approximately 489 senior medical practitioners' fixed-term contracts to determine eligibility for permanency. The review arose from a variation to the WA Health System – Medical Practitioners – AMA Industrial Agreement 2022 which identified permanency as the preferred mode of employment. The timeframe to complete the review is October 2025.

OTHER LEGAL REQUIREMENTS

Act of grace payments

The Minister for Health has directed the Health Service Providers to disclose all gifts and act of grace payments over $100,000 made under section 36(5) of the *Health Services Act 2016* within their annual reports. In 2024–25, CAHS did not provide any gift or make any act of grace payment over $100,000.

Advertising expenses

In accordance with section 175ZE of the *Electoral Act 1907*, CAHS incurred the following advertising expenditure in 2024–25

Table 8: Summary of advertising for 2024–25

Summary of advertising	Amount
Advertising agencies	$0
Market research organisations	$0
Polling organisations	$0
Direct mail organisations	$0
Media advertising organisations	$54,388
Total advertising expenditure	**$54,388**

Compliance with public sector standards and ethical codes

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

CAHS has appropriate systems and processes in place to inform and educate employees on their obligations and rights in accordance with the Public Sector Standards and ethical codes, through policies, procedures and associated guidelines, which are communicated to staff in various ways. Human Resources and Integrity and Ethics officers are available to advise managers and employees.

The CAHS website informs our patients, families and the wider public about how to give compliments or make complaints about employees 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 de-identified for reporting to the CAHS Board and Executive. This series of metrics includes monitoring any trends.

Compliance monitoring

7 claims were lodged against the Employment Standards.

Of these:

- 6 claims were resolved internally
- 1 claim was referred to the Public Sector Commission for review
  - 1 was declined by the Public Sector Commission
  - none are pending with the Public Sector Commission.

No claims were lodged against the Termination Standards.

No claims were lodged against the Grievance Standards.

In 2024–25, 73 reports alleging non-compliance with the Code of Conduct (breaches of discipline) were lodged (see Table 9).

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 (3), the Corruption and Crime Commission (10), WA Police (12), WA Ombudsman (3), or the Australian Health Practitioner Regulation Agency (5), as required under the *Corruption, Crime and Misconduct Act 2003* or the *Parliamentary Commissioner Act 1971*.

Where breaches were substantiated, the decision-maker determined the appropriate action in accordance with the *Health Services Act 2016*.

Table 9: Complaints alleging non-compliance with the Code of Conduct, by area of compliance

Type	Amount
Communication and official information	7
Conflict of interest	2
Fraud and corrupt behaviour	7
Personal behaviour	48
Recordkeeping and use of information	8
Use of public resources	1
Total	**73**

Disability access and inclusion

CAHS works to remove barriers to accessing our services, with a focus on improving how we engage with, and respond to, the needs of people with disability.

Our Disability Access and Inclusion Advisory Group (DAIAG) has met all the objectives set out in our Disability Access and Inclusion Plan (DAIP) 2022–2025. The advisory group has played a vital role in monitoring progress, gathering and evaluating feedback from consumers and staff, identifying service gaps and championing improvements to access and inclusion.

Work has started on developing a new DAIP for 2026–28, which will include consultation with our DAIAG members, staff, consumers and other key stakeholders to ensure we continue to improve inclusion for people living with disability.

Initiatives this reporting year:

- CAHS introduced a neurodiverse health portal that gives CAHS staff information and resources to assist them to better understand and support the needs of neurodivergent people.
- The CAMHS lived experience workforce presented on the importance of peer support at the WA Peer Support Network Conference and the WA Mental Health Conference.
- The DAIAG promoted the importance of the role of carers via various forums.
- A PCH-led study explored clinician priorities when caring for children with Down Syndrome. The study was a collaboration between PCH, the University of Western Australia, The Kids Research Institute Australia and Down Syndrome WA.
- CAHS celebrated various awareness days related to disability, including Purple Day to support epilepsy awareness, Rare Diseases Day, Neurodiversity Celebration Week and Mental Health Week.

Integrity and ethics

Accountability is a key CAHS value for embedding integrity, described as ‘always acting with integrity, we take full responsibility for our actions. You can count on us’. All CAHS employees share this responsibility to act with the highest level of integrity and ethical conduct.

CAHS embeds integrity and promotes an ethical culture throughout the organisation via a range of educational and communication opportunities.

CAHS gives staff a range of additional integrity and ethics education and training programs to ensure they are aware of their responsibilities and obligations, including:

- CAHS Corporate Induction
- Accountable and Ethical Decision-Making (and refresher training)
- Conflicts of Interest
- Recordkeeping Awareness Training
- Bullying in the Workplace
- Confidentiality Training
- Discipline Process Decision-Maker Training
- Preliminary Inquiry and Investigative Assessment Training.

The CAHS Integrity and Ethical Governance Framework outlines the structures and cultural factors that guide how staff can work together to prevent, detect, respond to and report misconduct, fraud, and corruption. This framework was reviewed in 2025 to align with the Public Sector Commission Embedding Integrity Strategy objectives.

The CAHS Promoting Integrity Sub-Committee met 6 times during the reporting period. The committee provides high level governance and oversight of misconduct risks, corrective actions, related systemic improvements and strategic direction for the Integrity and Ethics program. This work aims to promote an integrity culture, and improve safety and quality outcomes, and safe systems and practice. Key achievements include the adoption of a revised discipline decision-making framework, participation in an integrity framework maturity self-assessment and an external review of CAHS’ discipline management.

Work health, safety and wellbeing

CAHS is committed to promoting a positive culture of health, safety and wellbeing, and recognises that embedding these values in the workplace supports our staff to deliver high quality care to children, young people and their families.

We continued to deliver our Work Health Safety and Wellbeing Action Plan 2024–26. The plan, which supports implementation of the Work Health and Safety (WHS) Framework, is helping us meet legislative obligations and strengthen the culture of safety at CAHS. Other focus areas include risk minimisation, continuous improvement, integration with other systems, informed decision-making and demonstrated due diligence.

The Work Health, Safety and Wellbeing (WHSW) team continued implementation of WHS legislation and continued to participate in the Department of Health’s systemwide WHS function. This includes quarterly and annual reporting on WHS Framework implementation against key indicators. This will give health service providers critical information for benchmarking and allow us to share lessons learned to better prevent injury and illness.

The WHSW team delivered the following initiatives in the reporting period:

- Led the annual CAHS Safety Forum, which was attended by all CAHS elected Safety and Health Representatives and our Wellness Warriors. The forum theme was 'ensuring a psychologically safe and healthy workplace for all'
- Delivered awareness training about psychologically healthy and safe workplaces to CAHS senior leaders
- Completed psychosocial risk assessments in line with legislated obligations, which provided valuable insights into team dynamics and risk management
- Provided information and resources to staff about workplace flexibility and reasonable adjustments, including resources to assist neurodivergent staff, those with caring commitments and older members of our workforce
- Continued roll out of Psychological First Aid training for managers
- Expanded Pastoral Care Services to include educational sessions and other services to support the emotional and spiritual health and wellbeing of patients, families and staff.

Staff health

It's important we look after the health of those who care for others. This year the CAHS Staff Health team focused on preventative health strategies, such as staff vaccination and education.

Key initiatives and achievements:

- The relocation of the Staff Health Wellness Centre has increased vaccine uptake among staff.
- We have made it easier for new staff to access health resources that promote improved health and fitness and give support for existing conditions.
- A new pre-employment health assessment has improved our awareness of the health status of our workers, allowing for more targeted health promotion initiatives across our services.
- We have created an online portal containing resources that help our staff make inclusive workplace adjustments and adopt flexible workplace practices.

Injury management and return to work

With the *Workers Compensation and Injury Management Act and Regulations* coming into effect from 1 July 2024, CAHS has worked to ensure our injury management systems, processes and resources are in place to meet the new compliance obligations.

Each day a staff member remains injury-free or returns to work early following injury equates to valuable time directly benefiting the care of children, young people and their families.

The Injury Management team continues to educate managers and supervisors and assist them to identify duties for injured workers to ensure that all staff have meaningful and productive work.

The team is also continuing to reduce barriers to staff accessing early intervention by referring workers to the Early Intervention Program. The program has helped alleviate stressors in the workplace.

The number of staff at CAHS has continued to grow. This is reflected in an increase in claim numbers and severity. See Table 10 for the impact on the performance measures.

Table 10: Work Health Safety and Injury Management performance 2022–23 to 2024–25

Measure	2022–23	2023–24	2024–25	Target	Comment
Fatalities (number of deaths)	**0**	**0**	**0**	0	Target met
Lost time injury/diseases (LTI/D) incidence rate (per 100)	**1.4%**	**1.9%**	**1.5%**	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)	**36.6%**	**47.9%**	**74.7%**	0 or 10% improvement on the previous 3 years	Target not met
Percentage of injured workers returned to work within 13 weeks	**54%**	**49.0%**	**43.8%**	No target	No target
Percentage of injured workers returned to work within 26 weeks	**68%**	**61.2%**	**56.2%**	Greater than or equal to 80%	Target not met
Percentage of managers trained in injury management and work health safety and wellbeing responsibilities	**73.1%**	**87.6%**	**85.5%**	Greater than or equal to 80%	Target met

- LTIs and severe claims lodged during the financial year as provided by RiskCover, data adjusted each year to reflect modifications to pended claims.
- Calculated from RiskCover All Claims. Report includes lost time claims with an accident date within the previous year. Calculations are based on days lost divided by days normally worked, where the worker is fit for preinjury duties and preinjury hours.

Workers compensation

All work-related injuries are monitored and incidents are investigated to ensure lessons are learned to reduce the likelihood of a similar injury occurring.

An increase in the number of staff at CAHS correlates to an increase in workers compensation claims in comparison to previous years. A total of 117 workers compensation claims were made in 2024–25 (see Table 11), compared to 113 in 2023–24 and 83 in 2022–23.

Implementation of the *Work Health Safety Act 2020* and the *Workers Compensation and Injury Management Act 2023* has resulted in increased incident reporting and claims frequency. A focus in 2024–25 was providing wraparound supports to staff with psychological claims.

Table 11: Workers compensation claims for 2024–25 (based on date of lodgement)

Category	Claims
Nursing Services/Dental Care Assistants	69
Administration and Clerical	7
Medical Support	13
Hotel Services	18
Maintenance	3
Medical (salaried)	7
Total	**117**

WA Multicultural Policy Framework

Throughout the year, CAHS continued to implement its Multicultural Action Plan (MAP) 2022–27. As part of MAP progress monitoring, we increased mental health representation on the CAHS Multicultural Access and Inclusion Advisory Group (MAIAG) to ensure meaningful implementation of actions across our services.

Policy priority 1: Harmonious and inclusive communities

- Eight community members from a range of cultural backgrounds were selected to join the new CAHS pilot Community Ambassador Program. Community Ambassadors participated in consultations that explored the main concerns in their communities, the best ways to communicate with their communities, training and development opportunities and mental health in multicultural communities.
- PCH hosted its annual Ramadan Iftaar, which was attended by Muslim and non-Muslim CAHS staff and their families. Following prayers and a moment of reflection and gratitude, the fast was broken at sunset with dates and water, followed by a shared meal.
- CAHS recognised Lunar New Year on our social media platforms and via a staff email. As part of the celebrations, CAHS Community Ambassadors and the consumer Co-Chair of the MAIAG shared stories and photos of their communities' celebrations.
- During Harmony Week, CAHS held a stall at PCH in partnership with the MAIAG and the Hazara Women's Support Network. CAHS staff hosted a 'taste of diversity' morning tea to share foods from their cultural backgrounds.
- CAHS representatives, including one of our Community Ambassadors, attended the Indian Society of WA's Naari event. We shared information about CAHS' services and highlighted the importance of community involvement in shaping health services. The event demonstrated the role of Community Ambassadors in promoting CAHS' resources and ensuring the voices of the community are heard and valued.

Policy priority 2: Culturally responsive policies, programs and services

- CAMHS established a Cultural Advocacy in Mental Health Network. The network aims to share resources and expertise, increase understanding of culturally and linguistically diverse (CaLD) mental health, and improve access, entry, retention and service provision.
- CAHS staff collaborated with the Department of Health's Information and Performance Governance and Metadata team to increase CaLD indicators for our patients and their parents and carers through our information system, webPAS, to better meet the needs of CaLD community members.
- Compliments and complaints information was made available in several languages, and an expanded library of Social Stories (photo-based information resources) was developed to better meet the needs of CaLD consumers.
- CAHS completed its Strengthening Multicultural Community-Based Services Project 2021–2025, which aimed to enhance support to refugee and humanitarian entrant families. Project outcomes included providing universal health care and assessment by CACH and the Refugee Health Service, and support with navigating the health system to complete relevant assessments and access appropriate treatment.
- PCH Departments of Refugee and Global Health and Kids Rehab WA developed an innovative multi-disciplinary pathway that expedites assessments and healthcare access for children and young people from refugee-like backgrounds. Senior allied health professionals provide rapid assessments to address disability and developmental concerns using culturally safe and trauma-informed methods, while working with Refugee Health paediatricians, nurses and a clinical psychologist.

Policy priority 3: Economic, social, cultural, civic and political participation

- The MAIAG's consumer Co-Chair was appointed as Co-Chair of the CAHS Consumer Leadership Council and as an attending member of the CAHS Executive Committee.
- More than 100 consumers were added to the Engage Online Consumer Network. The network has more than 1,000 consumers and community organisations from a wide range of cultures.
- CAHS Consumer Engagement developed staff resources on how to engage consumers of CaLD and refugee-like backgrounds, including those with limited English proficiency. Relevant policies were also updated.

Freedom of Information

The *Freedom of Information Act 1992* (the Act) provides the rights to access various documents and to ensure that personal information contained in documents is accurate, complete, up to date and not misleading.

Freedom of Information applications are managed by the Release of Information department.

CAHS reports statistics annually to the Office of the Information Commissioner (OIC), as required by section 111(3)(a) of the Act, which are published in the OIC's annual report and can be viewed on the OIC's website.

For the 2024–25 reporting period CAHS received 249 applications under the Act, compared to 111 in 2023–24.

Recordkeeping

The *State Records Act 2000* (the Act) was established to standardise statutory recordkeeping practices across all State Government agencies. Section 19 of the Act states that every government organisation is to maintain a Recordkeeping Plan approved by the State Records Commission, which oversees compliance and scrutinises agency practices.

During the reporting period, 1,238 staff participated in recordkeeping training programs (Table 12) to promote best practice. CAHS staff must complete mandatory recordkeeping training, including the Department of Health Records Awareness Training and CAHS Electronic Document and Records Management System (Records Manager or RM) training upon receiving their RM licence.

The induction and orientation program includes a session on accountability at CAHS, which provides an overview of key public sector accountabilities, such as recordkeeping, procurement, confidentiality and cyber security. The session references the Act and the WA Health Code of Conduct, and emphasises best practice for managing corporate and clinical records.

Targeted online training is available for teams transitioning to RM, offering a flexible and tailored approach to meeting the specific needs of staff and services. A dedicated records management administrator provides follow-up training, individual assistance and help desk support, remotely and in person.

The CAHS Records and Compliance intranet site serves as a central resource. It hosts training materials, quick help guides and policies to support effective recordkeeping practices.

Table 12: Number of staff who did recordkeeping training

Training	2022–23	2023–24	2024–25
One-on-one	34	35	35
MS Teams	171	194	165
Targeted	219	22	23
Recordkeeping Awareness	**729**	**1207**	**1,015**

Table 13: Records

Records registered	2022–23	2023–24	2024–25
Documents	439,663	329,134	413,092
Folders	59,607	44,023	42,676
Storage boxes	290	136	55
Total	**499,560**	**436,293**	**455,823**

APPENDIX

BOARD AND COMMITTEE MEETING ATTENDANCE

July 2024 to June 2025

Name	Number of meetings	Meetings attended
Full CAHS Board Meeting		
Dr Rosanna Capolingua AM **Chair Jul – Dec 2024**	6	6
Ms Pamela Michael **Chair Jan – Jun 2025**	12	12
Dr Alexius Julian	12	11
Mr John McLean	12	11
Dr Shane Kelly	12	10
Prof. Karen Strickland	12	10
Prof. Daniel McAullay	12	11
Mrs Meghan Maor	11	7
Mr James Jegasothy **from Aug 2024**	10	7
Ms Nicole Lockwood	3	3
Finance Committee		
Dr Alexius Julian **Chair**	10	10
Mr John McLean	10	10
Dr Shane Kelly	10	9
Ms Nicole Lockwood	3	2

Note: Dr Rosanna Capolingua on leave 1 January 2025; Mrs Meghan Maor on leave 1 June 2025; Ms Nicole Lockwood on leave 1 October 2024 - 30 January 2025, resigned 30 January 2025.

Name	Number of meetings	Meetings attended
Safety and Quality Committee		
Ms Pamela Michael **Chair Jul – Dec 2024**	7	6
Prof. Karen Strickland **Chair Feb – Jun 2025**	10	8
Prof. Daniel McAullay	10	7
Mrs Meghan Maor	10	8
Mr James Jegasothy	8	3
Dr Alexius Julian	1	1
Audit and Risk Committee		
Mr John McLean **Chair**	8	8
Ms Pamela Michael	4	4
Mrs Meghan Maor	7	5
Dr Alexius Julian	8	7
People, Capability and Culture Committee		
Ms Nicole Lockwood **Chair Jul – Nov 2024**	3	1
Prof. Karen Strickland **Chair Apr – Jul 2025**	6	5
Prof. Daniel McAullay	6	4
Mr James Jegasothy	5	4
Ms Pamela Michael	3	3

BOARD AND COMMITTEE REMUNERATION

The list at Table 14 is as per the WA Government Boards and Committees Register.

Table 14 shows Board and committee remuneration

Position	Name	Type of remuneration	2024–25 period of membership	2024–25 total remuneration[3]
Chair	Ms Pamela Michael[1]	Annual	12 months	$64,928
Member	Dr Rosanna Capolingua AM[2]	Annual	12 months	$43,666
Member	Dr Alexius Julian	Annual	12 months	$46,598
Member	Dr Shane Kelly	Annual	12 months	$46,598
Member	Prof. Daniel McAullay	Annual	12 months	$46,598
Member	Mr John McLean	Annual	12 months	$46,598
Member	Prof. Karen Strickland	Annual	12 months	$46,598
Member	Mrs Meghan Maor	Annual	12 months	$44,806
Member	Mr James Jegasothy	Annual	11 months	$23,299
Total				**$409,689**

[1] Pamela Michael has been appointed to the Board Chair position since 1 January 2025 and was previously the Deputy Board Chair.

[2] Dr Rosanna Capolingua was the Board Chair until 31 December 2024.

[3] Mrs Nicole Lockwood resigned on 30 January 2025. The total remuneration paid in the 2024–25 financial year was $29,572.

- 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 2024–25 financial year.

ABBREVIATIONS

ACAG	Aboriginal Community Advisory Group
ADHD	Attention deficit hyperactivity disorder
AHP	Aboriginal Health Practitioner
AM	Member of the Order of Australia
ARC	Attention, Regulation and Concentration
ATS	Australasian Triage Scale
CACH	Child and Adolescent Community Health
CAHS	Child and Adolescent Health Service
CAMHS	Child and Adolescent Mental Health Services
CaLD	Culturally and linguistically diverse
CDS	Child Development Service
CES	Carer Experience of Service
CLC	Consumer Leadership Council
DAIAG	Disability Access and Inclusion Advisory Group
DAIP	Disability Access and Inclusion Plan
DAMA	Discharge against medical advice
ED	Emergency Department
EMR	Electronic Medical Records
HAPI	Hospital Anywhere Physiotherapy Initiative
HA-SABSI	Healthcare-associated *Staphylococcus aureus* bloodstream infection
HiTH	Hospital in the Home
ICT	Information and communications technology
JMO	Junior medical officer
KEMH	King Edward Memorial Hospital
KKIND	Keeping Kids in No Distress
KPI	Key performance indicators
LEAG	Lived Experience Advisory Group
LGBTIQA+SB	Lesbian, gay, bisexual, transgender, intersex, queer, asexual, Sistergirl and Brotherboy
LTI/D	Lost time injury/diseases
MAIAG	Multicultural Access and Inclusion Advisory Group
MAP	Multicultural Action Plan
NETS WA	Newborn Emergency Transport Service WA
NPS	Net Promoter Score
OIC	Office of the Information Commissioner
OIT	Oral Immunotherapy Program
OT	Occupational therapy
PACU	Post Anaesthetic Care Unit
PCAG	Parent and Carer Advisory Group
PCH	Perth Children's Hospital
PCHF	Perth Children's Hospital Foundation
RFDS	Royal Flying Doctor Service
RIF	Right Iliac Fossa
RM	Records Manager
RSV	Respiratory Syncytial Virus
SAC 1	Severity Assessment Code 1
S. aureus	*Staphylococcus aureus*
SNAAP	Short Notice Accreditation Assessment Pathway
UWA	University of Western Australia
WA	Western Australia
WHS	Work health and safety
WHSW	Work Health, Safety and Wellbeing
YAG	Youth Advisory Group
YES	Your Experience of Service

LOCATIONS AND CONTACT INFORMATION

Child and Adolescent Health Service

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

Postal address
Locked Bag 2010 Nedlands WA 6909

Phone
(08) 6456 2222

Email
CAHSExecutiveOfficeofCE@health.wa.gov.au

Web
cahs.health.wa.gov.au

Child and Adolescent Community Health

Street address
Level 2, 2 Mill Street, Perth WA 6000

Postal address
Locked Bag 2010 Nedlands WA 6909

Phone
(08) 6372 4500

Email
CACHExecutiveCorrespondence@health.wa.gov.au

Web
cahs.health.wa.gov.au/Our-services/Community-Health

Perth Children's Hospital

Street address
15 Hospital Avenue, Nedlands WA 6009

Postal address
Locked Bag 2010 Nedlands WA 6909

Phone
(08) 6456 2222

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

Web
pch.health.wa.gov.au

Child and Adolescent Mental Health Services

Street and postal address
Level 2, 52–54 Monash Avenue,
Nedlands WA 6009

Phone
(08) 6389 5800

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

Web
cahs.health.wa.gov.au/Our-services/Mental-Health

Neonatology

Street address
374 Bagot Road, Subiaco WA 6008

Phone
(08) 6458 1260

Postal address
PO Box 134 Subiaco WA 6904

Web
cahs.health.wa.gov.au/Our-services/Neonatology

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

This document can be made available in alternative formats on request.