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

2021–2022

Annual Report

Acknowledgement of Country

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

Using the term Aboriginal

Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. Aboriginal and Torres Strait Islander may be referred to in the national context and Indigenous may be referred to in the international context. No disrespect is intended to our Torres Strait Islander colleagues and community.

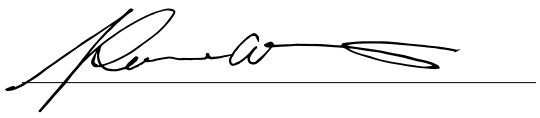
Statement of compliance

FOR THE YEAR ENDED 30 JUNE 2022

Hon Amber Jade Sanderson BA 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 reporting period ended 30 June 2022.

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



Dr Rosanna Capolingua
Board Chair
Child and Adolescent Health Service
1 September 2022

Dr Alexius Julian
Board Member
Child and Adolescent Health Service
1 September 2022

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Copies of this publication are available in alternative formats upon request.

Executive Summary

Locations and contact information

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Some of the images featured in this report were taken prior to physical distancing measures put in place during the COVID-19 pandemic, or at a time when they were not required.

Message from the Board Chair

Dr Rosanna Capolingua
Board Chair

The focus of my first 12 months as Board Chair of the Child and Adolescent Health Service (CAHS) was to support the Executive to implement significant and tangible improvements to ensure we excel in delivering safe, high-quality care, to children, young people and families.

We have seen an enormous amount of change across our health service during the past year, faced challenges that we have embraced and continue to embrace as genuine opportunities for growth and improvement. We are on a journey of cultural transformation.

I am continuously humbled and touched by the experiences of infants, children, young people and families whose lives intersect with the need for our care. I know they are often at their most vulnerable when they come seeking care and support. We must always connect with compassion and generosity of heart, along with professionalism, skills and commitment. We must always provide comfort, hope and safety to those who pass through any portal of CAHS.

I acknowledge that whilst we undoubtedly make significant and very positive contributions in the lives of many, sometimes we do not achieve the desired outcome. The privilege we have in caring for children and families comes with the enormous responsibility to reflect and learn from those occasions when we fail to achieve the standards of care or interaction to which we aspire.

This collective responsibility and accountability to ensure every child in our care is the absolute focus of every decision we make sits with each and every one of us at CAHS. For the Board, it is also critical that we ensure that our staff are supported and acknowledged for the excellent care they deliver. This commitment extends to all staff groups, as we recognise everyone at CAHS has a role which ultimately contributes to clinical care. The responsibility for quality care rests with all of us.

Clear and good governance at all levels creates a workplace that is transparent and effective for all who serve in it and for those who are served by it. Accountability and a focus on the needs of those in our care underpins the work of the Board and the Executive.

This year we established a new structure which ensures that all service areas are represented with accountability and advocacy at the highest level. This has meant establishing dedicated Executive Director roles for Perth Children's Hospital and Neonatology services, for Child and Adolescent Mental Health Services and for Community Health.

I believe that the rigour of the Board in clinical governance is a priority. To fulfil our governance responsibilities effectively, it is essential that the Board is alive to the challenges at the coal face, where staff interact with those in our care.

My thanks to outgoing Board Members; Ms Miriam Bowen, Ms Kathleen Bozanic, Professor Geoff Dobb and Ms Anne Donaldson for their dedicated commitment to CAHS and their contributions during their terms on the CAHS Board. Welcome to our new Board members; Mr John McLean who joined during the year and from 1 July 2022 we welcomed Dr Shane Kelly, Ms Nicole Lockwood and Ms Pamela Michael.

Significant work has taken place since the report following the Independent Inquiry into PCH was released in November 2021. Many of the 30

recommendations from the Inquiry built on the changes and focus that we had already put in place. We committed to implement and embed as working practice the recommendations and the implementation of all of these has been a critical focus for our health service.

All recommendations provide the foundation for cultural, clinical and system-wide changes. We are focused on extending the scope and intent of all recommendations to embed and ensure real change. These recommendations are, and will always be, part of how we work, each and every day. This is not a process that starts and finishes – it is a journey of continuous improvement and milestone evaluation of that change. This is required to embed lasting change in governance and the safety culture at CAHS.

Changes within our Emergency Department have been a significant priority. Changes include more doctors and nurses, including nurses in waiting areas, and structural changes in the Emergency Department that have improved line of sight of families waiting. I know that no one knows their child better than the parent, and this message has been reinforced in recognition of parental concern, active engagement with parents and carers, and the introduction of Aishwarya's CARE Call. We are also improving processes to move patients into and across our hospital more quickly, with a priority focus on those waiting in the Emergency Department.

This year we also underwent Australian Council on Healthcare Standards accreditation with a focus on staff training, and quality and safety, and have been accredited against these Standards. We have learnt a great deal and have implemented a lot of change that must be embedded and reviewed across all our services.

We know that the mental health and wellbeing of children and young people is a national crisis and has been exacerbated by the pandemic. Those affected and their loved ones need much more in support and access to care, and this growing pressure has been felt on the frontline. Following the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents, we are working closely with the Mental Health Commission to look at what we need to do to bring the Taskforce report to life, to redesign the provision of care across WA so that children and families are better supported.

At CAHS, we celebrate the diversity of our community and strive to foster a welcoming and accessible environment where consumers and staff feel respected, safe, and included.

We must reach in and be alive to the needs of our First Nations peoples so they can feel confident and safe in our spaces and places. We have a new Reconciliation Action Plan and we must demonstrate respect to our First Australians with real adaptation to meet their needs.

We must also be open to the different experiences of children, families and staff from culturally and linguistically diverse backgrounds. Across Australia this is a focus and we know we can do better. Refreshed training programs for cultural competency have started and will help increase cultural awareness of the unique needs of our diverse communities. We have also developed our second Multicultural Action Plan and we have explicitly called out the need to address any discrimination.

We must always reflect on what we do, how we do it, and how our consumers are experiencing our care. We are committed to deliver the changes required to continuously improve care and the experience children and families have with us.

We have reinforced measures to ensure an ongoing culture of accountability and transparency. The CAHS Board is actively engaged in reviewing both the data and the personal stories, where the experience of staff and or families could, or should, have been better. We have a responsible culture of reporting of incidents, near misses, complaints and concerns. We actively encourage reporting and engagement by our staff and from families. While this may appear to increase reported incidents, this transparency is central to our goal to ensure that a culture of learning and improvement becomes firmly embedded. The evidence that such an approach in fact translates to better, safer care is overwhelming. We are also sharing these stories across our health service so that we can all learn together and prevent harm.

The CAHS Executive and Board have committed to producing a biannual Quality Account for the people of WA. In this, we will report on metrics that are not just the expected key performance indicators but will transparently tell the story of striving for improvement at CAHS so that the community can be confident in the excellence of the care we provide.

The Board has focused on finalising our strategic planning process that will set the path for continued growth and renewal of our health service over the next three years. Staff, consumers and our key partners have been involved in this planning and have had the opportunity to inform our renewal.

We know that COVID-19 has continued to impact all of us, and throughout the pandemic our staff have demonstrated a commitment that is beyond words of thanks and respect. Everyone in healthcare has been working so hard over the period of the pandemic, and we know we are not through it, and yet they continue to give above and beyond.

Looking ahead, we will continue to work together to deliver a legacy of lasting change which will inform and improve our health service for decades to come. While I am in the privileged position of being the Chair of the Child and Adolescent Health Service, I make that commitment to the people of Western Australia.

Message from the Chief Executive

Valerie Jovanovic
Acting Chief Executive

Over this reporting period, I have been a part of the Child and Adolescent Health Service Executive, as Executive Director, People, Capability and Culture, appointed as Acting Chief Executive in mid-August 2022. It is a privilege to step in to lead the health service, together with the Board and the Executive team.

It is my honour to acknowledge our former Chief Executive, Dr Aresh Anwar, who has ably led the transformation of CAHS since his appointment to the role in 2018. Dr Anwar worked tirelessly to lead our health service through a journey of cultural transformation, and during unprecedented times for CAHS and WA Health, resigning from the role in August 2022.

On reflection of our work this year, I am inspired by the commitment and dedication of our staff and volunteers, and the resilience of the children and families we serve, as we continued to provide safe and high-quality care against the ever-changing backdrop of the COVID-19 pandemic.

CAHS has moved quickly to respond to the changing COVID-19 environment during the year, with a focus on keeping children, families and staff safe. We have continued to provide safe care across all our services, with adaptations to meet infection prevention guidelines and COVID-19 related directions.

Simultaneous to this, we have continued to build and improve safety and quality at CAHS. We have maintained a focus on ensuring the recommendations from the Independent Inquiry into Perth Children's Hospital conducted by the Australian Commission on Safety and Quality in Health Care are implemented robustly, to bring about enduring changes to the health service and the broader health system.

Building on our foundations, we have also continued to work toward improving the culture at CAHS, as we recognise and fulfil our obligation to support our staff so that they can continue their work, caring for children, young people and families.

I would like to thank the 6,500 staff who choose to work in our health service for their role in the provision of safe, high-quality, compassionate care. I would also like to thank our team of more than 400 volunteers who make an incredible contribution to the care we provide approximately 800 hours each week and we thank them for their incredible contribution. I would also like to acknowledge our many partner organisations for the role they play in supporting children and families across Western Australia.

On behalf of the Executive team at CAHS, we commit to continue to place the child at the centre of everything we do and to demonstrate our values of respect, equity, collaboration, accountability, excellence and compassion to every child and family, and to each other.

About the Child and Adolescent Health Service

The Child and Adolescent Health Service (CAHS) is Western Australia's (WA) only dedicated health service for infants, children and young people.

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

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

Neonatology provides state-wide specialised neonatal services to meet the needs of newborn babies and infants who need specialist treatment in the first months of life. Neonatology operates two neonatal intensive care units at PCH and King Edward Memorial Hospital.

Community Health offers child health assessments, screening, immunisation, support and advice to every child born in the Perth metropolitan area, with a focus on prevention and early intervention.

CAMHS provides specialist public mental health community services across the Perth metropolitan area, and state-wide inpatient and specialised services for children and adolescents with moderate to severe and complex mental health conditions.

PCH is WA's only dedicated paediatric hospital, providing medical care to children and adolescents who are 15 years old or under. The hospital provides inpatient, ambulatory, and outpatient services, and is WA's only paediatric trauma centre. PCH is also home to the Stan Perron Immunisation Centre.

Our year at a glance

Neonatology

2,979
neonatal admissions

12
days average length of stay

1,224
neonatal emergency transports

354 pre-term infants received
923 litres of donor milk

Community Health

144,632
child health assessments

24,154
school health assessments (2021)

32,982
unique children received services from the Child Development Service

118,195
immunisations (2021)

CAMHS

138,681
service contacts

7,956
young people seen

415
inpatient unit separations

2,629
mental health ED presentations

PCH

69,745
Emergency Department attendances

30,398
hospital admissions

14,850
surgeries performed

258,588 outpatients

Vision, values and objectives

Our vision

Healthy kids, healthy communities

Our objectives

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

Our values drive us

Accountability

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

Respect

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

Compassion

We treat others with empathy and kindness

Equity

We are inclusive, respect diversity and aim to overcome disadvantage

Excellence

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

Collaboration

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

The Child and Adolescent Health Service (CAHS) values of accountability, respect, compassion, equity, excellence and collaboration are enduring foundations of everything we do in our health service.

We aspire to demonstrate these values in our interactions with children and families and with our colleagues. This year has brought unprecedented challenges and opportunities to our health service and as we have navigated these, our values have never been more important.

Accountability

To deliver improved accountability and ensure dedicated oversight of each clinical service, the organisational structure was expanded to include an Executive Director, Perth Children's Hospital and Neonatology, Executive Director, Community Health and Executive Director, Child and Adolescent Mental Health Services. This ensures that all service areas are now represented with accountability and advocacy at the highest level. These new roles report directly to the Chief Executive and work collaboratively with other members of the Executive.

CAHS continuously strives for better outcomes and experiences for our patients, families and clients, ensuring every child in our care is at the centre of every decision we make, for the best possible patient outcomes.

Respect

We recognise the diversity of Aboriginal and Torres Strait Islander people and value their strength, resilience and capacity. Providing just and equitable opportunities and outcomes for our Aboriginal and Torres Strait Islander staff, children and their families is a key priority at CAHS.

The **CAHS Reconciliation Action Plan**, launched during Reconciliation Week in May 2022, reinforces our ongoing commitment to reconciliation, and provides a framework for CAHS to consciously and deliberately deliver tangible and substantive benefits for Aboriginal and Torres Strait Islander people. It sets out our commitments to increasing our awareness about Aboriginal culture and protocols through cultural awareness training, the land our services are placed on and developing an understanding of the local Traditional Owners or Custodians of those lands.

CAHS recognised the need to better communicate health information with Aboriginal families to ensure that they understand the medical condition of their child, the treatment to be undertaken and the overall care necessary for recovery. **Keeping our Mob Healthy Health Facts sheets** are now available on the Perth Children's Hospital website thanks to a Perth Children's Hospital Foundation grant. Over 120 culturally appropriate fact sheets have been developed for Aboriginal families, illustrated by local Noongar and Saibai Islander artist Tyrown Waigana.

> "Over 120 culturally appropriate fact sheets have been developed for Aboriginal families, illustrated by local Noongar and Saibai Islander artist Tyrown Waigana."

Bringing the voice of Aboriginal consumers and the wider Aboriginal community to help guide and shape our decision making, services, policies and practices at CAHS was also advanced during this period, with the new **CAHS Aboriginal Community Advisory Group** engaged and contributing in a meaningful way to our health service, including representation as a voting member of the CAHS Executive Committee meetings.

Compassion

We recognise that children and families are often at their most vulnerable when they access our services, and it is our responsibility to ensure that we approach every interaction with genuine compassion.

Our staff are privileged to stand alongside families to provide end of life care and recognise compassionate bereavement support as a critical component of that care. Opportunities for improvement were identified in response to consumer feedback, and consultation with clinical staff. CAHS has established a dedicated **Bereavement Coordinator** to enhance our care and support to families who experience the tragic loss of a child. An enhanced service will include:

- Psychological support tailored to each situation and the needs of each individual family.
- Identifying and promoting the experience and needs of Aboriginal and Torres Strait Islander families, and families from a culturally and linguistically diverse backgrounds.
- Expert clinical advice to support all clinicians engaging in bereavement care.

- Development of a broader suite of supports and resources for children, siblings, parents and extended families.

Equity

We celebrate the diversity of our community and strive to foster a welcoming and accessible environment where consumers and staff feel respected, safe, and included. We will measure ourselves against national and international benchmarks in order to identify scope for better delivery to those in our care, and strive to be leaders in what we do.

The **CAHS Multicultural Action Plan** provides a systematic approach to guide the way we work to promote the benefits of cultural and linguistic diversity and celebrate the achievements of people from culturally and linguistically diverse backgrounds. It drives us to deliver on our commitment to deliver health services that are welcoming, inclusive and equitable for the children, adolescents and families of WA's diverse communities.

On 3 December 2021 CAHS celebrated the International Day of People with Disability with the launch of a new disability access and inclusion e-learning package, customised for our health service. This resource was developed with input from consumers and staff on our Disability Access and Inclusion Committee and is set to be introduced as an essential part of CAHS staff induction.

Consumer feedback had highlighted a lack of accessible toilets and changing facilities for families at Perth Children's Hospital after hours, overnight, on weekends and public holidays. Perth Children's Hospital has now introduced a **'Changing Places'** facility, open 24 hours providing suitable amenities for people who cannot use standard toilets, for example including a height-adjustable adult-sized change table; a constant-charging ceiling track hoist system; an automatic door; and a privacy screen.

Excellence

CAHS is committed to continuous improvement to ensure excellence across its services and is internationally recognised for the work it does. We will measure ourselves against national and international benchmarks in order to identify scope for better delivery to those in our care, and strive to be leaders in what we do.

The Child Development Service made a significant contribution to a major **international study on autism** in partnership with the Telethon Kids Institute. The study demonstrated a reduction in clinical autism diagnosis due to a parent-led therapy for babies displaying signs of autism. The findings provided the first evidence worldwide that a pre-emptive intervention during infancy could lead to such a significant improvement in children's social development that they fell below the threshold for a clinical diagnosis of autism.

Collaboration

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

CAHS recognises that strong partnerships contribute to better health outcomes and a more sustainable health care system.

In 2021–22, **CAHS partnered with more than 49 non-government organisations** through a range of contractual arrangements, including:

- Nine NGOs who have a licence agreement or service level agreement for the occupancy of a dedicated space at Perth Children's Hospital. These organisations provide services to children and families without remuneration from CAHS.
- Forty visiting non-government organisations who have an access agreement with CAHS, enabling them to visit PCH to provide advocacy, support and education to children and parents without remuneration from CAHS.

Those with whom CAHS has a formal contract, awarded after a procurement process, and are funded to provide a range of health-related services in the community.


GLIDE

Significant Issues and Strategic Highlights

Significant Issues

Staff at Rapid Antigen Testing tents outside Perth Children's Hospital

COVID-19

The COVID-19 pandemic has continued to heavily shape the provision of health care in Western Australia. The Child and Adolescent Health Service (CAHS) has remained agile in responding to the changing COVID-19 environment, with a focus on keeping children, families and staff safe particularly during periods of heightened community transmission. We have continued to provide safe care across all our services, with adaptations to meet infection prevention guidelines and COVID-19 related directions set through the WA Health Framework for System Alert Response.

The CAHS Emergency Command Centre and Executive Oversight Committee has been operating to provide organisational oversight, facilitate rapid decision making and continued monitoring across all service areas, in conjunction with WA Health and the State Incident Command Centre.

Periods of high community transmission

During periods of high community transmission, all health services were required to reduce face-to-face outpatient appointments to help reduce the risk of transmission. When clinically appropriate, telehealth and virtual appointments were conducted, with essential face-to-face appointments going ahead across all CAHS services. Visitor restrictions were also adjusted during the year to enable physical distancing and reduce potential COVID-19 exposure at all sites.

As community transmission of COVID-19 increased, significant numbers of CAHS staff and volunteers were required to isolate, for varying lengths depending on the guidelines at the time. A dedicated contact tracing centre was established in March 2022, providing a call centre service 12 hours a day, seven days a week for CAHS staff who were COVID-19 positive, a close contact or symptomatic. Rapid Antigen Testing kits were also distributed to enable regular voluntary testing.

The Emergency Department consistently recorded 12 per cent of presentations as being COVID-19 positive during March, April and May, with two peaks of 21 per cent in late March and 21 per cent in mid-May. This translated into a hospitalisation rate for COVID-19 positive children of approximately one in

four, with the majority of these children having a length of stay between 24 and 48 hours. The main management for COVID-19 positive children was treatment of the symptoms, observation, and administration of fluids.

To ensure COVID-19 suspected or positive children received essential hospital care new arrangements were implemented including strict patient transfer arrangements, the addition of HEPA filters, and a range of other approaches guided by COVID-19 specific policies and guidelines.

Community Health established a dedicated child health clinic in East Perth to facilitate child health checks of positive and suspected COVID-19 positive children, or those whose parents and guardians were COVID-19 positive. A second COVID-19 Safe clinic opened in Duncraig in May 2022.

COVID-19 Vaccination

The CAHS COVID-19 Vaccination Team made a significant contribution to the delivery of COVID-19 vaccinations in WA as part of the WA COVID-19 Vaccination Program.

Over the past year the program managed eight fixed community vaccination clinics in the Perth metropolitan area, providing high volume vaccinations to the community.

The team was responsive to the evolution of vaccination mandates and recommendations, including workforce mandates, the introduction of booster doses and expanding eligibility.

The CAHS COVID-19 Vaccination Team played a key role in diversifying vaccination opportunities for the community. To allow for convenient and opportunistic access, pop-up clinics at community events and in shopping centres in both high volume and low uptake local areas were held regularly.

The team also provided in-reach and outreach opportunities for school children to be vaccinated. In terms three and four in 2021, the program attended a number of high schools to vaccinate students from vulnerable cohorts. In 2022, the team led a series of small pop-up clinics in primary schools located in low uptake areas to support primary school aged children (aged five to 11 years) to be vaccinated in a convenient and familiar environment using a parent present model.

The CAHS COVID-19 Vaccination Team supported the WA COVID-19 Vaccination Program strategy in providing equitable access to priority populations and hard to reach cohorts. The team has partnered with trusted service providers to deliver culturally safe and socially secure vaccination opportunities to Aboriginal people, people experiencing homelessness and rough sleepers, culturally and linguistically diverse communities, people in residential care including aged care and disability settings, those in congregate living and social housing, people with medical complexities and people with disability and neurodiversity.

The team also supported vaccination efforts in the regions including bus tours to remote and very remote communities, as well as meeting the demand of large scale vaccination clinics and bespoke person centred services such as in home vaccination and vaccination under sedation (in partnership with a private provider).

CAHS clinics (community vaccination clinics, pop-ups, in-reach and outreach) have delivered 1,365,271 COVID-19 vaccinations in 2021-2022.

Community vaccination clinics in the 2021-22 reporting period were held in Joondalup, Carramar, Ellenbrook, Midland, Mirrabooka, Perth Airport, Perth Convention and Exhibition Centre and Claremont.

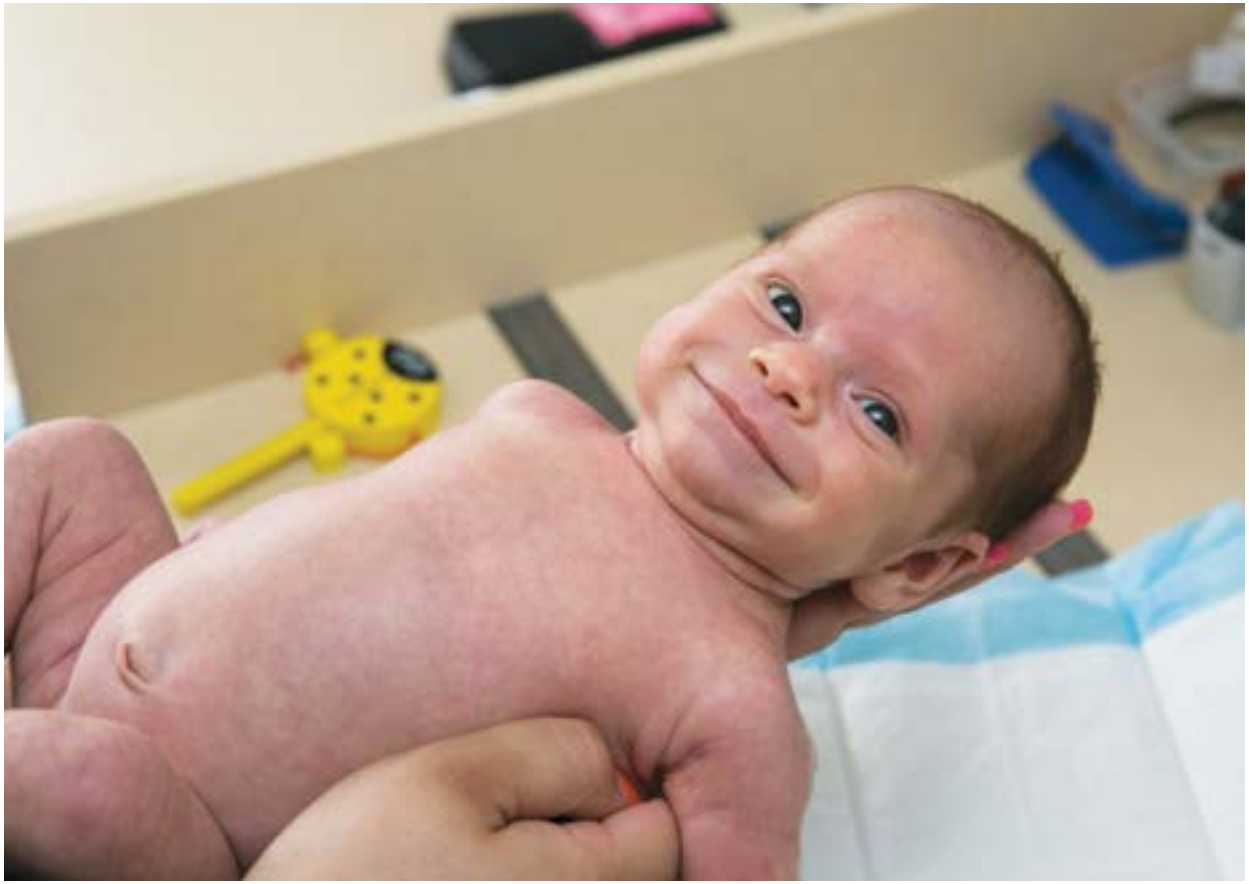
More than 10,000 high school students were transported to vaccinations clinics in 2021; and the CAHS team provided 24 primary school pop-up clinics in term two, 2021.

The CAHS vaccination team delivered 160 long-term and short-term clinics in 2021-22, including large scale vaccination clinics, pop-up clinics, in-reach and outreach clinics, school clinics, shopping centre clinics, door-to-door, in-home, and sedation clinic vaccinations.

Statewide Paediatric and Adolescent Remote Care COVID-19 service

As a part of preparation for COVID-19, the State-wide Paediatric and Adolescent Remote Care (SPARC) Service was established to help support COVID-19 positive children with chronic conditions and their families across WA, who have an elevated risk of an increased burden of disease.

The SPARC multidisciplinary team consists of nursing, medical, social work, Aboriginal health



> The SPARC team provides 24 hours a day, seven days a week access to clinical care, with the purpose of reducing unnecessary Emergency Department presentations and hospital admissions.

workers and clerical support to remotely care for families affected by COVID-19. By supporting these families, children can remain in isolation and avoid the stress sometimes associated with visiting a hospital. The remote virtual care service also enables the team to support children from all over the state, and link patients with local treating teams if required. The SPARC team provides 24 hours a day, seven days a week access to clinical care, with the purpose of reducing unnecessary Emergency Department presentations and hospital admissions. The SPARC service has cared for almost 400 patients since starting in early 2022.

Child Development Service demand

The Child Development Service (CDS) provides an essential service for children with developmental concerns and their families across the Perth metropolitan area through a range of assessment, diagnostic and early intervention services. Early detection of child development concerns and access to interventions before school entry is paramount to reduce the likelihood of a range of long-term negative outcomes that may impact a child's education and social achievements.

The CDS is a unique service that combines a metropolitan-wide developmental paediatric diagnostic and management service, with a comprehensive allied health service. The service operates in a broader context that intersects with education, disability, mental health and the private sector.

There has been a 59 per cent growth in demand for CDS services over the last 10 years, with an increase in demand of 43 per cent noted in the last 5 years. There has been increasing demand for all CDS services (excluding Audiology) with the highest increases noted for Paediatric services (109 per cent), Occupational Therapy (103 per cent) and Clinical Psychology (85 per cent).

During this time the CDS has undergone significant change to improve service delivery models and standardise clinical care pathways. The service has also adapted to accommodate changes to the broader service delivery landscape, such as the introduction of the National Disability Insurance Scheme (NDIS) and the impact of COVID-19. The CDS has a wide range of strengths as a service but also operates with significant facility and resource constraints.

In 2021, CAHS funded an additional 11.5FTE to help address wait times to access a paediatrician and autism diagnostic assessment services. CAHS has also continued to implement a range of strategies to ensure the most efficient use of clinical resources, including reviewing waitlists to identify children no longer needing services, the use of video consultations and online questionnaires, expanding inter-disciplinary work and operating a weekly rapid response medication review clinic to manage referrals for children on medication who no longer have access to their non-CDS specialist prescriber.

Information, Communication and Technology

Information, Communication and Technology (ICT) asset investment in CAHS has historically been opportunistic and driven by demand for health and for community mental health.

Perth Children's Hospital had significant investment during its opening, however ICT infrastructure, such as computer devices and audio-visual equipment will require significant ongoing investment to ensure continuing digital performance and the ability to deliver an electronic medical record into the future.

ICT community infrastructure across community sites has faced funding challenges for many years.

To assist with informing current and future needs, CAHS is developing an ICT Asset Management Plan which will focus on the management of various ICT assets including End User Computing (EUC), Audio visual (AV) and Network and Server Infrastructure. This will be provided as an addendum to the annual review of the CAHS Strategic Asset Plan. CAHS ICT Server and Network asset replacement is managed by Health Support Services.

The Perth Children's Hospital (PCH) Project procured a significant amount of new medical technology. There was a transfer of 6,953 individual medical devices valued at $27.94 million from Princess Margaret Hospital. As a result of ongoing procurement (replacement and expansion), CAHS is currently equipped with approximately 23,000 individual medical devices worth a total value of $102 million. Timely replacement requires a $10 million annual Medical Equipment Replacement Program (MERP) budget. Post PCH opening, each annual MERP budget has been less than $2 million. As a result, the current MERP backlog is $26.7 million and is expected to grow over the next five years to approximately $75 million as the majority of equipment purchased by the Perth Children's Hospital Project reaches end of life.

Ageing community facilities

CAHS uses a total of 169 community facilities; 154 are leased and 15 owned and operated. A recent CAHS Building Compliance Audit reviewed the community facilities owned by CAHS and made recommendations for rectification works, ongoing maintenance and other buildings and regulatory compliance considerations.

The audit found that CAHS community facilities need significant refurbishments and upgrades to rectify critical risks and meet service delivery requirements now and into the future. CAHS continues to work within its budget environment to address issues including building and structural issues, accessibility compliance with the Disability Discrimination Act, fire safety compliance, and occupational safety and health issues over the previous decade.

CAHS continues to develop business cases for community facilities, medical and ICT equipment replacement, outlined in a detailed capital investment plan within its Strategic Asset Plan to government for consideration on an annual basis.

Independent Inquiry into Perth Children's Hospital conducted by the Australian Commission on Safety and Quality in Health Care

The WA Health Director General initiated an Independent Inquiry into Perth Children's Hospital under Part 14, section 183 of the Health Services Act 2016 (WA) (Act), following the tragic death of Aishwarya Aswath in April 2021, and the subsequent internal clinical incident investigation. The Inquiry was undertaken by the Australian Commission on Safety and Quality in Health Care which released its final report in November 2021, outlining 30 recommendations.

The CAHS Board accepted all recommendations. The Chief Executive established an Independent Inquiry Oversight Committee to build and improve safety and quality at CAHS and to oversee implementation of the recommendations.

A phased approach has been adopted to progress and implement recommendations, and to ensure ongoing monitoring and evaluation. CAHS are determined that implementation of the recommendations will go beyond a transactional focus, and genuinely build a lasting foundation for cultural, clinical and system-wide changes. Embedding the recommendations will be ongoing, reflecting the genuine and lasting change intended by the Independent Inquiry team.

The Department of Health is overseeing implementation of the recommendations by CAHS and across all health service providers where relevant.

Supporting children and young people experiencing mental health issues

Supporting children and young people experiencing mental health issues has remained a critical focus at CAHS with continued high demand across Child and Adolescent Mental Health Services with high acuity and risk associated with a complex and vulnerable group of children and young people.

CAHS has continued to work closely with the Department of Health, Mental Health Commission, Child and Adolescent Mental Health Services staff and consumers to ensure every opportunity is taken to enhance services for children, young people and their families, and has remained intensely focused on this throughout the year.

Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0–18 in Western Australia

The Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents Aged 0-18-years in Western Australia (Taskforce) was established by the State Government in early 2021 to develop a system-wide plan for public specialist infant, child and adolescent mental health services. The Taskforce was a key recommendation arising from the Chief Psychiatrist's review into the treatment of Ms Kate Savage who died tragically in July 2020, triggering an intense and continued focus on mental health services for children and young people.

The final Taskforce report, delivered in March 2022, provides a comprehensive plan for securing better mental health outcomes for children and young people across WA. The Taskforce's findings, recommendations and vision have all been shaped by extensive engagement with stakeholders throughout WA, including people with lived experience, clinicians, service providers and other system leaders. Its strategy includes eight Key Actions outlining the critical reforms needed to improve outcomes and 32 recommendations to guide implementation.

The WA Government has endorsed all 32 Taskforce recommendations, and has committed to radically reshaping the State's infant, child and adolescent mental health system to deliver significantly better outcomes for them and their families and carers.

CAMHS is actively working with the Department of Health and Mental Health Commission who are responsible for the delivery of the Taskforce recommendations.

As part of the Taskforce reform, CAMHS will be reimagined to provide early intervention, prevention and a responsiveness to changing needs with accessible, more local, consistent, and integrated care.

The CAMHS Reform Program was established in August 2021 to prepare for the recommendations of the Taskforce. The Reform Program provides coordination, oversight and reporting support for the delivery of CAMHS initiatives and projects aligned to the Taskforce's vision. The CAMHS Reform Program will continue, aligned closely with the Mental Health Commission Implementation Steering Group, CAHS stakeholders and the WA Country Health Service.

During 2022-23, the CAMHS Reform Program will focus on designing a range of new, integrated models of care in partnership with system stakeholders.

CAMHS Workforce

Recruiting additional staff for CAMHS has been and continues to be an area of intense focus in response to increased demand for services. As part of the 2021-22 budget CAMHS received funding for an additional 101.3 full time equivalent (FTE) to meet the increased demand for services, with the Mental Health Commission funding 50.1 FTE of this across 2021-22 and 2022-23 budget.

Significant workforce shortages in Western Australia, across Australia, and internationally are impacting on the availability of qualified health professionals to fill positions. CAHS has commenced international recruitment to fill the additional and vacant Child Psychiatry positions.

CAHS is also leveraging off WA Health's international nursing recruitment and the Belong recruitment campaign. Active local, interstate and international recruitment, marketing, monitoring and evaluation to fill all CAMHS positions will continue to be a priority for CAHS.

As of 12 August 2022, CAMHS has successfully appointed to 36 FTE of the 101.3 FTE.

The increase in staffing has been allocated to the areas of highest need and includes an increase in psychiatrists, nurses, clinical psychologists, social workers, occupational therapists, and Aboriginal mental health workers. A number of new positions have also been created including graduate nurse and entry level allied health positions, allied health and nursing professional leads, and a National Disability Insurance Scheme Coordinator.

CAMHS has also expanded its Peer and Family Support Workers (Lived Experience) workforce. An additional four full time equivalent positions have been created with recruitment commencing across the five sites of PCH Ward 5A, Armadale and Rockingham Community CAMHS, Pathways and Touchstone day programs.

Developer's render of Murdoch Square as the location for the Murdoch Community Hub

Midland and Murdoch Community Hubs

In alignment with our Strategic Asset Plan, CAHS is establishing purpose built facilities that will offer integrated and coordinated community-based health services for children and families in both the Midland and Murdoch regions.

These hubs will offer families the convenience of accessing multiple CAHS services from a single, contemporary, safe and fit-for-purpose site, whilst some existing service sites (named spokes) will remain open and that provide care closer to home.

Midland and Murdoch are the initial two CAHS hub sites that have been selected, based on consumer demand for CAHS community-based services and population growth.

CAHS initiated the Midland Community Hub Project as the first hub project due to $7.2m funding being provided by the Department of Health from the Sustainable Health Review (recommendation 8) in 2019.

Total capital funding approved through Treasury for the Murdoch hub project is $10.94M. Following a period of negotiations and due diligence assessments, CAHS executed a lease with Hesperia in December 2021 for an approximate 2,871m^2 footprint within a new build located at Lot 1 at the intersection of Fiona Wood Road and Barry Marshall Parade in Murdoch.

CAHS has developed a new service delivery framework that underpins the delivery of integrated community based services to deliver long-term economic, social and health benefits across the community. To support the new service delivery framework, CAHS is seeking to transform their community-based assets and service delivery

approach via the Hub and Spoke Model - investing in physical infrastructure to respond to increasingly inadequate current facilities while enabling a more integrated community-based service model.

The strategic shift towards an integrated service model, focusing on effectively managing health care in the community where appropriate, is considered a critical part of the solution to ever-increasing demand for health care and the associated financial pressures. Hub and spokes will deliver contemporary, purpose built, community-based facilities that will provide integrated universal health, immunisation, developmental and mental health services for children and families that are responsive to local community need.

Children's Hospice

CAHS is partnering with Perth Children's Hospital Foundation to build Western Australia's first children's hospice, which is expected to open in late 2024.

Specialist paediatric palliative care is known to improve the quality of life for a child with a life-limiting condition, and their family and carers from the time of diagnosis and over the course of the illness. The Children's Hospice will provide the care of a hospital and the feel of a home for children living with life-limiting conditions. Respite care and support will also be provided for the families. The hospice will provide an opportunity for families to come together, to celebrate life and to connect with others in similar circumstances, while being supported by a clinical team.

The services provided by the hospice will also include support for the physical, emotional, social and spiritual support of the child and their family during their palliative care journey. The state-wide paediatric palliative care service will support the hospice, by providing holistic care to children, young people and their families across Western Australia.

The hospice will be designed to have a welcoming home-like environment. It will have seven beds and a bereavement suite as well as three family accommodation units.

The hospice project is currently in design development phase. There has been significant progress to develop the hospice design and associated model of care with construction expected to commence in 2023.

Following approval by Parliament, the Children's Hospice site has been excised from the Allen Park A Class Reserve in Swanbourne and registered with Landgate on 21 May 2021.

The construction and fit-out costs of the Children's Hospice will be funded by Perth Children's Hospital Foundation, with CAHS to provide ongoing operational funding, along with funding and operational support from the Foundation for some non-clinical areas.

WA Treasury approved funding for $3.2 million of additional expenditure and funding for WA Health over the period 2021-22 to 2023-24 for planning, equipment, public art, and preparatory site works for the new Children's Hospice as well as support an immediate uplift to the current service capacity of the WA Paediatric Palliative Care Service.

> The services provided by the hospice will also include support for the physical, emotional, social and spiritual support of the child and their family during their palliative care journey.

Architect Concepts by Hassell / Children's Hospice Project

Strategic Highlights

Care for children, young people and families

Community Pharmacy

In February 2021, a CAHS Community Pharmacy Pilot Project commenced, which involved the PCH Pharmacy Department working collaboratively with Community Health and CAMHS to optimise the delivery of medicine services for CAHS' community patients and families. This has seen the establishment of two new pharmacist positions which will enable the PCH Pharmacy Department to continue to work closely with community-based CAHS doctors, nurses and families to ensure safe, appropriate and timely access to medications.

CAHS Disability Access and Inclusion Plan 2022-2026

People with disability often experience a significant health disparity gap when compared to those without a disability. CAHS is committed to ensuring that people with a disability, their families and carers are able to fully access the range of services, information and facilities by being responsive and innovative in continual improvement opportunities, and by encouraging all employees, contractors and volunteers to drive an inclusive health environment

To guide this work, CAHS has developed a new Disability Access and Inclusion Plan for the 2022 to 2026 period.

Environmental Sustainability

Working alongside the State Government and the Department of Health Sustainable Development Unit, CAHS is actively pursuing a greener future.

CAHS is a member of the Global Green and Healthy Hospitals Network – the framework of which paves the way for the industry to address and promote greater sustainability and environmental health.

Greenhouse gas reduction initiatives are being implemented across CAHS to achieve net zero emissions in accordance with State Government targets. Key environmental projects include:

- PCH Surgical Theatres have eliminated the use of the potent greenhouse gas desflurane used in anaesthetic procedures, and the use of nitrous oxide has also been reduced by 73 percent.
- PVC and single use metal instrument recycling was introduced across PCH.
- CAHS is also working with the Department of Health to develop a whole of health emissions data reporting system.

Value and respect our people

Accreditation

The National Safety and Quality Health Service (NSQHS) Standards define the level and consistency of healthcare that consumers should expect. The Standards help to ensure that robust systems and processes are in place to minimise the risk of harm to patients and clients, and improvements are continually made to the quality of health service provision.

In November 2021, CAHS was assessed against the Standards by the Australian Council on Healthcare Standards (ACHS) and in February 2022, was successful in obtaining accreditation for a further three-year period. This is a credit to the hard work of all staff and our ongoing commitment to providing safe and high-quality care.

Stars of CAHS

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

There are three categories of awards:

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

In 2021-22 there were 14 winners from 181 nominations.

CAHS gratefully acknowledges the ongoing support of award sponsors HESTA and the Perth Children's Hospital Foundation.

Volunteers

CAHS is privileged to be supported by a team of over 400 volunteers who provide approximately 800 hours a week. During 2021-22 CAHS recruited 150 new volunteers. Our volunteer group is increasingly diverse, with more than 55 languages spoken collectively.

Transition to Practice (Graduate Nurse) orientation

Promote teaching, training and research

Postgraduate Nursing Education

In collaboration with the Chief Nursing and Midwifery Office and Edith Cowan University, CAHS Paediatric Nursing Education facilitated an opportunity for 27 registered nurses to complete a Graduate Certificate in Children and Young People's Nursing. This course provides an opportunity to advance knowledge in theoretical principles of children and young people's nursing, enabling nurses to develop skills towards becoming a specialist paediatric nurse.

Simulation Education

Simulation Education at PCH has continued to develop across many areas of the hospital, with a year-on-year increase in CAHS employees attending training sessions.

Over the past three years, several new high-fidelity simulation courses have been designed and delivered, including crisis resource management, adolescent medicine, and paediatric cardiology to CAHS staff, WA Health staff, and interstate participants. Some of these courses have been the first of their kind in Australia.

PCH is now delivering simulation training onsite in wards and outpatient departments on a weekly basis, as well as supporting the weekly sessions in the Paediatric Intensive Care Unit and the Emergency Department. During the pandemic, the team developed COVID-19-based scenarios for clinical areas, which have proven critical to support clinical practice in the context of increased COVID-19 positive inpatient admissions to PCH.

Neonatology

In collaboration with colleagues from health services across the State, the Neonatology education team designed, developed, and launched a new hospital-based neonatal care course for nurses and midwives who work in hospitals across the State caring for newborns.

The program, which commenced in February 2022, takes a blended learning approach with 28 hours theory, learning through tutorials, interactive workshops, and case studies. This is followed by 80 hours clinical practice placement at the KEMH Neonatal Unit to consolidate skills before returning to metropolitan, rural, and remote locations with enhanced skills and knowledge.

Appointment of the inaugural Associate Professor Community Child Health

Dr Yvonne Anderson

In January 2022, Dr Yvonne Anderson was appointed to the newly established role of Associate Professor Community Child Health. This is a joint appointment between CAHS and Curtin University, in partnership with the Telethon Kids Institute.

This position will drive the research program in community child health, and foster collaboration with Community Health teams, Curtin University and families, with a focus on research that can be translated into Community Health service delivery and improvements.

Collaborate with our key support partners

Rare Care Centre

Western Australia is taking a global, leading role in establishing a Rare Care Centre that will provide a holistic model of care for children with rare and undiagnosed diseases. Its aim is to improve the lives of children and young people living with a rare disease and their families by providing an integrated, coordinated and globally connected model of care. The Centre has secured funding from leading WA philanthropists – the Angela Wright Bennett Foundation, the McCusker Charitable Foundation via the Channel 7 Telethon Trust, the Stan Perron Charitable Foundation and Perth Children's Hospital Foundation via a significant contribution from Mineral Resources Limited. Together they have provided a total commitment of $10 million over five years, and we thank them for their generous support.

The Centre, with staff based at PCH, will improve awareness and support in the early identification of children with potential rare diseases while also providing improved support, care coordination and access to community resources, clinical trials, and research. With a statewide clinical service, the Centre will develop an education centre, digital platform, and global partnerships. It will champion research collaborations, increase workforce capacity, raise awareness, create peer support programs, and advocate for disease recognition.

The Rare Care clinical lead and patient

New 'Fun on Four' Family Room in partnership with Ronald McDonald House Charities WA.

A new Ronald McDonald Family Room opened in August 2021 within the PCH 'Fun on Four' precinct.

The newly refurbished space provides quality play and learning experiences for young patients and siblings, while offering a comforting and uplifting environment for parents and carers and is managed as part of a new partnership between CAHS and Ronald McDonald House Charities WA.

It features a parent's retreat with tea and coffee facilities, arts and crafts zone, teen den fully equipped with the latest video and arcade games, cinema room, reading retreat with enjoyable lounge area, soft play and toddler zone, and an explorer's zone with sensory, construction and imaginative play areas.

The new 'Fun on Four' Ronald McDonald Family Room

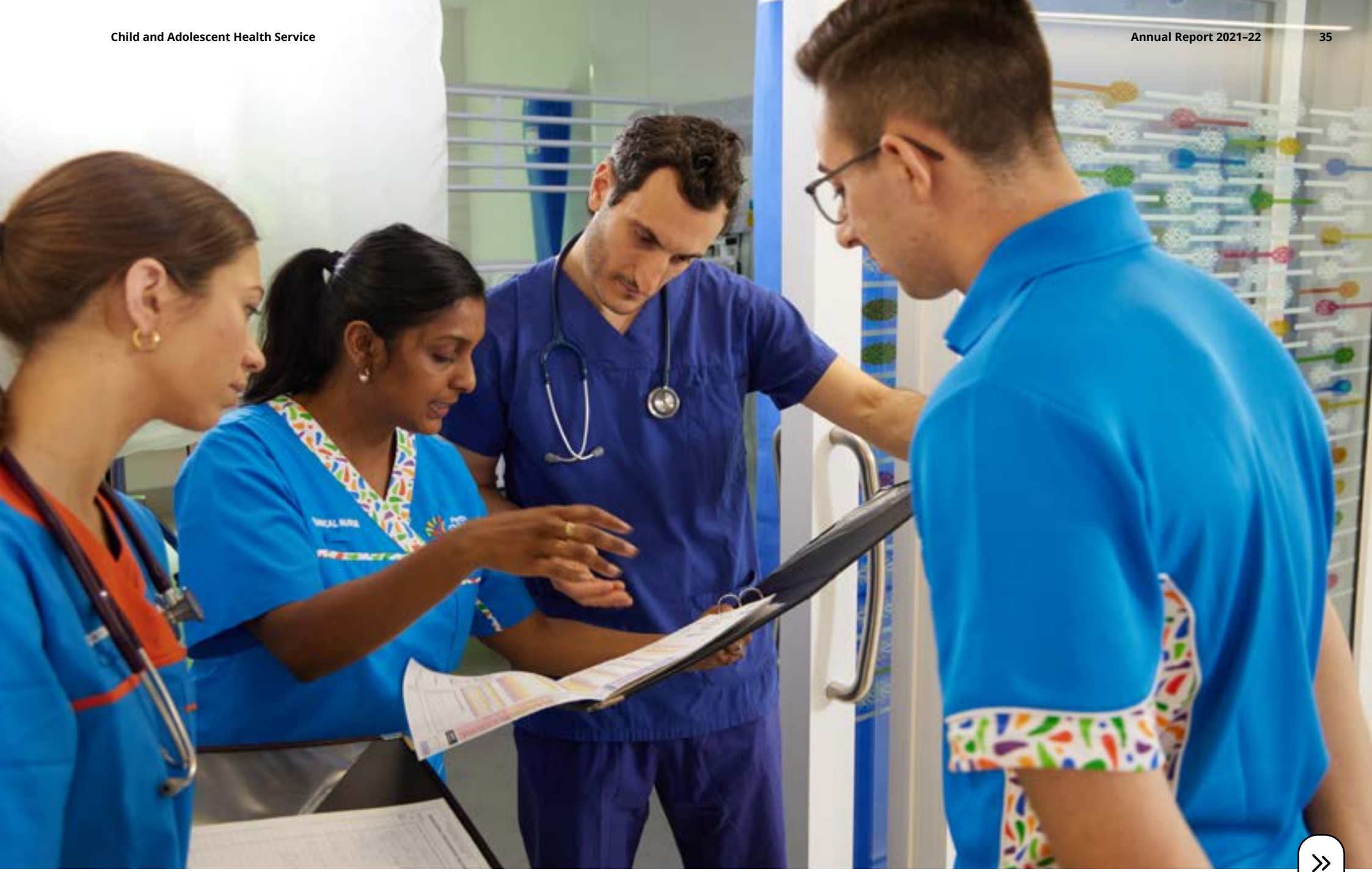
Early Phase Clinical Trials Program

The Oncology and Haematology Department expanded its early phase clinical trials capabilities to ensure that all children with cancer in WA have an opportunity to access the latest cutting-edge therapies, such as molecularly targeted therapy and immunotherapy using precision medicine testing.

The Department established an Early Phase Clinical Trials Unit in 2017. Since inception, a total of 33 new early phase clinical trials have been opened, with 67 patients enrolled, some of which have participated from other countries.

In collaboration with the Telethon Kids Institute Cancer Centre, the Oncology and Haematology Department has translated home grown research into an international clinical trial called SJ-ELIOT, in partnership with the world-renowned St Jude Clinical Research Hospital in Memphis, United States of America, for patients with relapsed medulloblastoma (a common type of cancerous brain tumour in children).

In 2019, PCH joined several international clinical trials consortia including the COllaborative Network for NEuro-oncology Clinical Trials (CONNECT), Pacific Pediatric Neuro-Oncology Consortium (PNOC) and the Innovative Therapies for Children with Cancer (ITCC)-Brain. The Oncology and Haematology Department have built strong collaborations with numerous pharmaceutical companies, allowing us to offer families access to novel treatments not otherwise available.



Performance highlights

Community Health

Child Health Nursing

The Community Child Health Nursing services provide primary prevention and early intervention programs focused on the health, development, and wellbeing of children between birth and school entry. Services are offered at more than 160 sites across the metropolitan area, including the universal program, consisting of five high quality health and developmental assessments at scheduled checks, as well as a range of group-based and one-on-one support services.

In response to the COVID-19 pandemic, child health appointments were divided into two components; a phone call to discuss progress and concerns, followed by a short face-to-face visit for nurses to complete the physical child health check. Drop-in sessions were also suspended in 2021 and 2022, with parents offered phone consultation or the option to make a booked appointment as needed. Usual appointment processes recommenced in May 2022.

During the 2021-22 reporting period, 26,245 new babies were welcomed into the Universal Child Health Program from birth, with 25,888 (99 per cent) accepting the offer of a postnatal home visit in the early postnatal period.

Community child health nurses provided a total of 144,632 individual child health contacts during the year in clinic appointments and home visits, including 53,137 'Universal Plus' contacts for families needing additional support.

In addition to individual contacts, child health nurses delivered 3,236 parenting group sessions to 15,040 parents and saw 14,896 families at drop-in sessions throughout the year.

School Health Nursing

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

Throughout the year, in collaboration with the WA Country Health Service and the Department of Education, CAHS has continued to implement recommendations from the Review of School Aged Health Services. These recommendations relate to key aspects of the service delivery model, the role of community nurses working with children and young people, and workforce utilisation and supports.

School Entry Health Assessments were paused in 2021-22 to divert school community nurses to support COVID-19 contact tracing and vaccinations, resulting in families being offered a School Entry Health Assessment during school holidays.

During the 2021 school year, 24,154 (95 per cent) of all children enrolled in kindergarten received a School Entry Health Assessment, with 1,246 provided during the school holidays.

School community health nurses also provided 60,802 occasions of service to secondary students and 45,642 occasions of service to students in education support facilities.

Child Development Service

The multidisciplinary metropolitan Child Development Service (CDS) provides assessment, early intervention and treatment services to children with developmental delay difficulties that impact on function, participation in daily life, or parent-child relationships. CDS works with families to plan and set goals for the child and to address parents' concerns and priorities for their child.

Families referred to the service are generally invited to attend a service planning appointment, within eight weeks of referral. Service options include parent workshops, group interventions, home or school visits and assessment and individual treatment.

Demand for CDS continues to grow, with 32,960 referrals accepted during 2021–22. This is an increase of eight per cent on the previous year, and a 24 per cent increase over the past three years.

Children aged three to seven years account for the most children seen, which is in line with the focus on early intervention.

The CDS Telehealth service continued to be important due to COVID-19, with CDS providing a total of 28,040 individual telehealth appointments.

The demand for an Autism Spectrum Disorder (ASD) assessment continues to grow, with 550 formal referrals received in 2021–22; a 12 per cent increase on the previous year, and an 82 per cent increase in the past five years. CDS has begun to implement a revised clinical pathway for assessment of ASD, to align with the National Guidelines for the Assessment of Autism. In addition, the Child Development Service provides a range of assessment, early intervention and treatment services to children with developmental delay or difficulty.

Immunisation

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

During 2021-22, community health nurses delivered 118,195 vaccinations through the Childhood and School Based Immunisation Programs. Childhood immunisations were provided from more than 50 community-based facilities across metropolitan Perth, with 52,699 vaccinations delivered to 15,668 children. Through the school-based program, Community Health delivered 65,496 vaccinations to 37,758 students at 189 schools across metropolitan Perth.

26,245
New babies welcomed into the Universal Child Health Program

144,632
Child health contacts

53,137
'Universal Plus' contacts

3,236
Group sessions

25,2810
School entry health assessments

60,802
Secondary student occasions of service

45,642
Education support occasions of service

118,195
Vaccinations administered (2021)

15,668
Children immunised (2021)

37,758
Students immunised (2021)

32,960
CDS referrals accepted

10,489
CDS service planning appointments within 8 weeks

32,982
Children seen by CDS

Child and Adolescent Mental Health Services

Child and Adolescent Mental Health Services (CAMHS) provide support, advice and treatment to young people and their families who are experiencing mental health issues.

CAMHS has several streams of service delivery including:

- 10 specialist community outpatient services across the metropolitan area known as Community CAMHS.
- Four specialised programs:
  - Complex Attention and Hyperactivity Disorder Service - for children and young people experiencing persistent and severe attention difficulties.
  - Multisystemic Therapy - for families with young people experiencing serious behavioural and mental health problems.
  - Pathways - assessment, treatment and support for young people with complex mental health issues.
  - Touchstone - a day program for young people struggling with self-harm behaviours and associated mental illnesses.
- A mental health inpatient unit (PCH Ward 5A) and associated services:
  - Paediatric Consultation Liaison which provides mental health and wellbeing support for inpatients and outpatients (and their families) who are receiving treatment for physical health issues.
  - Eating Disorders Service which provides assessment and treatment of young people with eating disorders, and their families.
  - Gender Diversity Service which is a specialist state-wide outpatient service for the assessment and care of children and adolescents experiencing gender diversity issues.

CAMHS Crisis Connect

On 1 November 2021 the CAMHS Emergency Telehealth Service officially changed its name to **CAMHS Crisis Connect** reflecting an expansion of the service, including a shift to operate seven days a week, 24 hours a day.

During this reporting period, the service provided 2,936 episodes of care.

The service provides urgent mental health support, crisis management, brief intervention or assessment as an alternative to presenting to an Emergency Department. It also provides face-to-face mental health assessment at the PCH Emergency Department or via Telehealth to other metropolitan Emergency Departments. Paediatric psychiatrists and specialist mental health clinical nurses also provide consultation, liaison, and crisis management support to general practitioners, schools and families.

Table 1: CAMHS Crisis Connect service

	Not Seen within 4 Hours	Seen within 4 hours	Total presentations	Median Length of Episode
2019-20	774	1,136	1,910	218
2020-21	1,057	1,195	2,252	237
2021-22	**1,743**	**1,193**	**2,936**	**283**

Eating Disorders Service

Demand for eating disorder services has increased in recent years and became even more pronounced during the earlier stages of the COVID-19 pandemic, with the number of referrals per month peaking in December 2020. Demand for the service has decreased with 196 referrals received in this period compared to 244 in 2020-21, which is a decrease of 20 per cent.

CAMHS are committed to providing a comprehensive service including outpatient care for young people and minimising the need for hospital admissions, whilst also working to ensure that there is adequate hospital capacity for those who require inpatient treatment.

A new model of care has been developed, with input from consumers. The model outlines the delivery of a suite of services involving outpatient, day treatment and inpatient care, designed to support smooth and supported transition of patients between the services. The services will be delivered in a multidisciplinary manner involving collaboration between psychiatry, adolescent medicine, nursing, allied health and peer support.

To progress the implementation of the model of care, the Eating Disorders Day Program, which had been temporarily paused in response to high inpatient demand, has been re-established. The day program, which has been revised to align with international best practice, is a group-based day treatment for young people who need intensive therapy and support to help them in their recovery from an eating disorder. The aim of the program is to help young people successfully re-engage in treatment within outpatient services. The weekday program offers group therapy, meal support, parent and carer support, peer support and school and is open to eight patients at any one time.

138,681
service contacts

7,956
young people seen

415
inpatient unit separations

2,629
Mental Health Emergency Department presentations

2,936
CAMHS Crisis Connect presentations

Perth Children's Hospital

Perth Children's Hospital (PCH) provides clinical care through emergency, inpatient, outpatient and ambulatory settings. PCH also provides state-wide outreach and mental health services, in addition to being home to one of the neonatology intensive care units.

There were 258,588 outpatient appointments attended at PCH during 2021-22, an increase on the 236,671 appointments in the previous year.

Emergency Department

The PCH Emergency Department provides a tertiary level emergency service for paediatric patients including resuscitation, assessment, diagnosis and treatment for patients with a range of conditions including trauma, medical, surgical and psychiatric presentations.

The 2020-21 financial year was the busiest on record for the PCH Emergency Department, with 69,745 patients presenting for assessment and treatment. The admission rate for patients presenting to the Emergency Department has remained steady at around 20 per cent.

There have been many changes made within the Emergency Department in response to high demand, COVID-19 infection prevention and control requirements, and following the reviews and inquiries arising from the tragic death of Aishwarya Aswath on 3 April 2021.

- On arrival parents are met by large signs welcoming them to the Emergency Department displayed in multiple different languages.
- The triage desk has been modified to allow the triage nurse to physically touch a patient without leaving the triage station.
- An additional clerical officer role has been introduced at triage to facilitate access for parents and answer queries, reducing the number of interruptions and disruptions to workflow for the triage nurse.
- A triage support nurse role has been introduced, to assist with escorting patients to their destination within the ED. This ensures that the triage desk is always staffed.
- A PCH specific triage policy has been developed to document the process to ensure children presenting to the department are clinically assessed and allocated to the most appropriate assessment and treatment area based on urgency.
- After triage, caregivers receive a text message directing them to the PCH website and information on what to expect during their visit including information on interpreters, waiting times, Emergency Department processes, how to identify different staff members, escalation of care (Aishwarya's CARE call), available amenities, and information on safety and security. This information is available in languages other than English and can also be accessed directly at any time via links on the website.
- The same information is also displayed on screens located within the Emergency Department waiting area, in addition to waiting room screens which convey real time data indicating the current longest waiting patient in the department.
- The existing hospital Care Call system, in place at PCH was expanded to all areas of the Emergency Department. In October 2021, the expanded Care Call system was recognised and named as Aishwarya's CARE Call, featuring dedicated phones with clear instructions for caregivers if they feel their child's health is deteriorating. A work instruction has also been

developed for all Emergency Department staff, outlining the role specific actions to take when parents escalate concerns while they are in an Emergency Department waiting room.

- A dedicated senior nurse has been introduced to monitor patients in the waiting room, with a workstation which allows a clear line of site to patients.

Paediatric Acute Recognition and Response Observation Tool (PARROT) chart

The PARROT chart is a paediatric early warning score observation chart that assists staff to recognise and respond to clinical deterioration. The addition of parental concern to the scoring system, in addition to nine other elements in the tool, reflects the importance of parental observations about changes in their child's condition compared to their usual selves. The PARROT is one part of a group of policies, procedures and guidelines which provide guidance to clinical staff in the recognition and response to clinical deterioration in hospitalised patients.

In April 2021, the PARROT chart was formally implemented across PCH inpatient areas, the Post Acute Care Unit, Hospital in the Home and the Emergency Department. An online learning package and training support for the PARROT chart has been implemented at CAHS. This online learning package is now essential training for PCH nursing and medical staff to complete within three months following commencement of employment. In addition, this online learning package and training support has been implemented across WA Health hospitals using the PARROT chart as part of a state-wide roll out led by the Department of Health

Surgical Services

In March 2020, the temporary cessation of non-urgent elective surgery during the early phase of the COVID-19 pandemic exacerbated an already growing list of over boundary cases. Further curtailing of category 3 and non-urgent category 2 surgery in March 2022 also due to COVID-19, has resulted in over boundary cases increasing to 1,382 as of 30 June 2022, which is an increase of 56.7 per cent from the last financial year. This increase was largely in category 3 cases.

Pre-operative screening, increased theatre cleaning, and recovery of COVID-19 positive patients within the operating theatre has had significant impact on theatre lists. The hard work of patient support, nursing, anaesthesia and surgical teams has meant that these additional requirements have had minimal impact on patients and their families when attending PCH for surgery.

Medical Services

Medical Services encompasses a range of services across 24 departments, including the Emergency Department, and is responsible for four wards within PCH. With nearly 1,300 staff, Medical Services has embraced Telehealth and videoconferencing during the COVID-19 pandemic to ensure patients were able to be seen for appointments, which as a result decreased the rate of appointment non-attendance.

Throughout the year Medical Services has introduced new and innovative approaches to delivering on our vision of providing amazing care. The Complex Pain Service was established as a

Table 2: Triage categories

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

new department, and the Diabetes department has been the national leader on introducing automatic insulin delivery systems with a comprehensive model of care for education, enabling widespread use by children with diabetes in Western Australia. Kids Rehab have successfully implemented the international guidelines for the early detection of Cerebral Palsy into their clinical service, ensuring a comprehensive coordinated care pathway for children with Cerebral Palsy as young as three months.

Percentage of Emergency Department patients seen within recommended times

When patients first enter the Emergency Department, they are assessed on how urgently treatment should be provided. A patient is allocated a triage category between 1 (immediate) and 5 (less urgent) that indicates their clinical acuity (see Table 2). Treatment should commence within the recommended time of the triage category allocated.

Monitoring performance against these recommended response times and targets is a key indicator of how effective an emergency department is operating from the beginning of the care journey.

During this reporting period, CAHS has continued to exceed performance expectations for Triage categories 1 and 2, and performance in Triage categories 3 and 4 has improved slightly compared with last year (Table 3). Triage category 5 access sits well above target and comprises low acuity cases that represent a small percentage of presentations that can either be treated by a wider multi-disciplinary team or be directed to other providers through the triage process.

The majority of presentations are assessed as Triage categories 3 and 4. While the data shows that waiting time targets for categories 3 and 4 are underperforming, the presence of nursing staff in the Emergency Department waiting room has led to earlier nursing assessment, nurse-initiated care for patients in the waiting room and facilitates escalation of care when required.

Table 3: Percentage of Emergency Department patients seen within recommended times, by triage category, 2019-20 to 2021-22

Triage category	2019-20	2020-21	2021-22	Target
1	100%	100%	**100%**	100%
2	87.6%	81.0%	**84.30%**	≥80%
3	61.5%	46.63%	**51.80%**	≥75%
4	64.7%	53.6%	**62.60%**	≥70%
5	95.0%	81.0%	**93.90%**	≥70%

Favourable performance **Unfavourable performance**


Welcome to Perth Children's Hospital
Emergency Department
Ni hao
Tālofa
Zdravo
Selamat
Dia dhuit
Welcome
Salām
добродошли
Welkom
dobrodošli
Mile widziany
Kaya
Croeso
Xin chào
Привет
Hola
Bonjour
नमस्कार
Kia Ora
Καλώς ήρθες
سلام
환영
eat or drink

Neonatology

Neonatology encompasses a range of services, including Neonatal Intensive Care Units (NICU) at PCH and King Edward Memorial Hospital (KEMH), Special Care Nurseries, Newborn Emergency Transport Service (NETS WA) and the Perron Rotary Express Milk Bank. Neonatology services are delivered at KEMH and PCH.

Neonatal Intensive Care Units

The NICU at KEMH has 94 beds and cares for babies who are born early or are unwell after birth and need intensive care. The unit cares for all babies born in WA more than 12 weeks early, and the majority of those born between eight and 12 weeks early in WA. The PCH NICU has 30 beds and cares for all babies who require surgery or the specialist medical services at PCH. Babies are transferred to PCH by NETS WA.

In 2021-22 there were 3,342 patients admitted into the NICUs at KEMH and PCH, with a 99 per cent survival which is comparable to other NICUs nationally. The length of stay in the NICUs ranges from one to 156 days, with the average length of stay being 11 days.

Neonatal Emergency Transport Service (NETS) in WA

NETS WA is a mobile intensive care unit for sick newborn and young infants in need of our neonatal care, servicing the largest transport area of any similar service in the world. This specialised team of doctors and nurses provide neonatal intensive care during transport, working closely with other service providers, including St John Ambulance WA, the Royal Flying Doctor Service (RFDS), and Medical Air.

The NETS WA team also provides expert neonatal advice through a 24/7 hotline for clinical staff who are caring for sick newborn babies across the State. In 2021-22 there were 1,193 transport transfers for unwell babies needing specialist neonatal care.

A new NETS patient transfer vehicle was commissioned in February 2022, with help from donations made to Perth Children's Hospital Foundation. The vehicle transfers unwell babies and infants between hospitals and centres as they progress on their journeys to good health and going home.

There has been an increase in demand for NETS WA over the past 10 years with the total transports increasing from 776 in 2011 to almost 1,200 in 2021. Acute retrievals have increased from 66 per cent to 83 per cent of all NETS WA transfers during the same period, with increasing acuity and complexity of patients requiring transfer to a tertiary hospital.

Part of this demand is a result of an increase in very preterm babies born outside of KEMH requiring retrieval and transport after birth and requests to attend high-risk births. In response to increasing demand, a review was completed to determine

how the service can ensure consistent, high-quality care in every corner of the state. A framework was developed based on the review's recommendations, and NETS WA successfully received additional funding in the May 2022 State budget which will allow for increased staffing.

An interagency working group has been established to provide governance and oversight to the end-to-end journey of critically ill neonates from regional areas of Western Australia. It provides a forum for oversight of clinical issues and a high-level forum to escalate, discuss and resolve issues. Membership is made up of representatives from CAHS, the WA Country Health Service, Royal Flying Doctor Services, Department of Fire and Emergency Services and St John Ambulance.

Aboriginal Health at CAHS

CAHS is committed to equity in health care for children, young people and their families.

We recognise the diversity of Aboriginal and Torres Strait Islander people and value their strength, resilience and capacity. Providing just and equitable opportunities and outcomes for our Aboriginal and Torres Strait Islander staff, children and their families is a key priority at CAHS.

The Director, Aboriginal Health continues to provide leadership and guidance to ensure that both operational and strategic priority setting across CAHS remains focused on our commitments to Aboriginal health.

Community Health Aboriginal Health Team

The Community Health Aboriginal Health Team provides culturally secure multidisciplinary services to Aboriginal children in the newborn to six years age group. This team includes Aboriginal health workers, nurses, a medical officer and allied health staff. In addition, health promotion staff help to promote child health, ear health, nutrition and playgroups.

Moordidjadbiny (Becoming Strong) Mentoring Program - Leeanne Loo, Gina Whitby, Mel Robinson, Alanan Colbung and Deborah Jacobs

The Aboriginal Health team provides the services of a General Practitioner for Aboriginal children, ear screening in primary schools, and supporting parents and carers to access appointments in community health, including the Child Development Service.

Allied health staff deliver one-to-one assessments to address any concerns before referral to the Child Development Service. The Aboriginal Health Team also offers playgroups in Bentley, Hilton and Joondalup, ear nose and throat clinics in Armadale and Padbury and immunisation clinics in Bentley and Maddington.

PCH Aboriginal Liaison Service

Two Aboriginal Liaison Officers at PCH work in partnership with the Social Work department to meet the needs of Aboriginal children who visit PCH from across Western Australia. Due to COVID-19 restrictions on visitors in the hospital, it has been particularly difficult for Aboriginal families who prefer more than one visitor or carer to provide support to their child or young person, and the Aboriginal Liaison Service has provided critical support to families.

The Aboriginal Liaison Officers continue to provide cultural support and advocacy for Aboriginal children, young people and families, creating a welcoming familiar presence and supporting cultural education for clinical staff

CAHS Aboriginal Workforce Strategy 2018-2026

CAHS is committed to building a sustainable, skilled Aboriginal workforce, from entry level to leadership positions, using a variety of attraction, appointment and retention strategies.

CAHS has an Aboriginal Workforce Strategy 2018-2026 which outlines the activities, priorities,

oversight, and monitoring of this commitment, which are aligned with the WA Aboriginal Health and Wellbeing Framework 2015- 2030.

As part of this commitment, CAHS will apply section 51 (s.51) of the EO Act to all of its Jobs WA adverts, enabling a recruiting manager to identify and employ an Aboriginal person before someone else in a competitive process.

We have demonstrated our commitment to increasing our Aboriginal workforce to two per cent as of 30 June 2022. Our target is 3.2 per cent by 2026.

Aboriginal employee retention has been a major focus, with the Moordidjadbiny (staying strong) Aboriginal nurses mentor program delivered, and events held for Aboriginal staff such as the Aboriginal staff BBQ at Kaarta Koomba, and a NAIDOC morning tea with the Kulunga team at Telethon Kid's Institute.

Two new cadets were welcomed into the Aboriginal cadetship program, adding to the three existing cadets. CAHS has also continued to develop new employment opportunities within WA Health and CAHS, including the creation of the Aboriginal Health Practitioner role.

Koorliny Moort - 'Walking with Families'

The Koorliny Moort team at PCH provides care coordination services for Aboriginal children with complex needs from across WA. In addition, the team provides paediatrician outreach clinics across the metropolitan area with the Aboriginal Health Team, Derbarl Yerrigan Health Service, Babbingar Mia and at Armadale CAMHS.

The Koorliny Moort team adopted an Aboriginal design on their shirts to create recognition and improve engagement. The Koorliny Moort team has also begun building partnerships with various internal and external stakeholders including neurosciences, the Healthy Weight Service at PCH, and the Department of Justice. The aim of these partnerships is to strengthen and improve health outcomes for Aboriginal children and young people.

Aboriginal cultural security across CAMHS

With the support of the Mental Health Commission, the service employs a Coordinator of Aboriginal mental health and Aboriginal mental health workers in Community CAMHS teams to support engagement and build workforce capacity. The Aboriginal Mental Health workers support families to engage with CAMHS, providing cultural guidance to non-Aboriginal clinicians and develop links with external agencies to support Aboriginal children and families.

CAMHS aspires to provide a safe and culturally secure mental health service for Aboriginal children, young people, families and staff. An Aboriginal Cultural Security Review was undertaken in collaboration with elders, community members, young people and carers, Aboriginal and non-Aboriginal staff members. The review was initiated to establish baseline levels of cultural security and to determine to what extent consideration of the cultural needs of Aboriginal people are embedded within policy, practices and system functions.

Online surveys were developed and disseminated across CAMHS for Aboriginal and non-Aboriginal staff, stakeholders, consumers and carers.
The project also included a review of relevant policy documents and the completion of a Welcoming Environment Checklist across CAMHS sites.
The report details findings, recommendations and directions to ensure CAMHS provide a safety and culturally secure service.

Refugee Health at CAHS

The CAHS Refugee Health Service works across the organisation to provide care to children, young people and families from refugee-like backgrounds.

The two service streams include the multidisciplinary PCH Refugee Health Service and the Community Health Refugee Health Team.

The Community Health team provides services across the Perth metropolitan area, assisting families to navigate the health system, complete catch-up immunisations, identify their health concerns and priorities, support to manage chronic and complex conditions, and link them to appropriate providers for continuing health care, including the PCH Refugee Health Service. The PCH team provides a multidisciplinary service, enabling flexible comprehensive assessments to be undertaken in conjunction with colleagues in education, primary care, wider health organisations, social services and non-government organisations. The team is actively supported by CAHS Language Services, interpreters, pharmacy staff and PCH Foundation volunteers.

The past year has provided additional challenges in care and service delivery related to the complexities of community COVID-19 transmission, the crisis in Afghanistan and the re-opening of state and international borders.

The Afghanistan crisis highlighted the capacity of our Refugee Health Service to respond rapidly and work collaboratively, with Perth being the initial evacuation hub. The Refugee Health Service team worked closely with the other providers including the Department of Communities, Australian Red Cross, State Health Incident Coordination Centre and Hotel Quarantine Medical teams to provide paediatric oversight of new arrivals and provide immediate care.

All evacuated Afghani children and adolescents in hotel quarantine were also provided "Welcome Backpacks" which included basic supplies, educational supports, toys and activities, providing comfort and compassion at a time of great upheaval.

Strengthening Multicultural Services Project

A 2021 State Government election commitment of $4.1 million over four years has provided CAHS with an opportunity to strengthen community-based multicultural services that are delivered to children and adolescents from refugee-like backgrounds. The project aims to improve the health and social-emotional outcomes of refugee children.

“A 2021 State Government election commitment of $4.1 million over four years has provided CAHS with an opportunity to strengthen community-based multicultural services that are delivered to children and adolescents from refugee-like backgrounds.”

A project being led by the CAHS Strategy, Planning and Innovation team in collaboration with the CAHS Refugee Health Service has undertaken a comprehensive health and socio-emotional needs assessment to identify priority health needs, gaps in services and establish opportunities to better support newly arrived refugee children. Commissioning of services, informed from the needs assessment, will start in the second half of 2022, with service delivery and evaluation to follow.

The Refugee Health Service Grand Round in June 2022

The crisis in Ukraine brought new arrivals with profound trauma experiences, reinforcing the need for flexible capacity at times of international disasters. There is a need for enhanced early mental intervention and mental health education for all patients from ethnolinguistically and refugee-like backgrounds, which is culturally appropriate, trauma-informed and acknowledges the interrelated complex socio-economic and family factors experienced by our families.

The Strengthening Multicultural Communities project team collaborated with the Ishar Multicultural Women's Health Services, Healthway and the Refugee Health Service to develop and deliver targeted culturally nuanced nutritional modules to new arrivals, health professional and community service providers overthe next three years.

Research at CAHS

CAHS Research strategic intent

The CAHS Research Strategy 2021-2023 outlines the approach to build a strong research culture based on high quality and impactful research that will save and change lives, improve clinical care, and enhance the health service, leading to further advancements in patient experience, clinical outcomes and efficiency.

CAHS aims to establish itself as one of the world's great academic paediatric health services with teaching, training and research integrated into all aspects of clinical service delivery, service areas and disciplines to ensure evidence-based and best practice treatments and clinical care are available to children and young people.

By establishing opportunities for meaningful consumer involvement at all stages of the research process, genuine improvements in health and wellbeing will be realised for children and young people now and for future generations.

Our research strategy provides the framework to achieve our overall intentions – save and change lives, improve clinical care, and enhance health service and delivery.

Save and change lives

Peanut allergy trial launches at PCH

A PCH research team is leading an investigation into the efficacy, safety and tolerability of adding inexpensive off-the-shelf peanut flour to home meals under medical direction to desensitise pre-schoolers with peanut allergy.

The oral immunotherapy randomised controlled trial, called Early Peanut Immunotherapy in Children, is the first-of-its kind in Australia and is focusing on utilising a possible early window of opportunity to safely and gradually reintroduce a small amount of peanuts to desensitise and build up a degree of tolerance.

The aim is to prevent and limit severe allergic reactions and potentially life-threatening anaphylaxis that occur when there is accidental exposure. The trial has been funded by a grant from the WA Child Research Fund, jointly established by the WA Department of Health and Channel 7 Telethon Trust.

Improve clinical care

CAMHS and PCH staff are part of a collaborative research team aiming to reduce the rate of youth suicide, by examining ways to improve the experience that children and young people have when they present to hospital emergency departments for an acute mental health crisis.

The project team includes researchers from Telethon Kids Institute, PCH, the WA Country Health Service, the Geraldton Regional Aboriginal Medical Service and Youth Focus. This project builds on 'EXPAAND', a research project currently being conducted at PCH which aims to achieve better outcomes by making the assessment of children and adolescents at the time of an acute mental health crisis more therapeutic.

Enhance health service delivery

Researchers find weight gain could be key to predicting common eye condition that can cause blindness in premature babies

A joint neonatology and ophthalmology research project has found a simple method, based on a postnatal weight gain model, can predict a common eye condition in premature babies.

The finding, which evaluated the performance of algorithms, provides strong evidence for reviewing the screening protocols for retinopathy of prematurity which is the leading cause of blindness in premature babies. These findings could have a huge impact globally by prompting a review of screening protocols which in turn could reduce the number of premature babies who are screened for retinopathy of prematurity.

Research study numbers and participation at CAHS

Research studies

The following is based on data entered by researchers into the current reporting system.

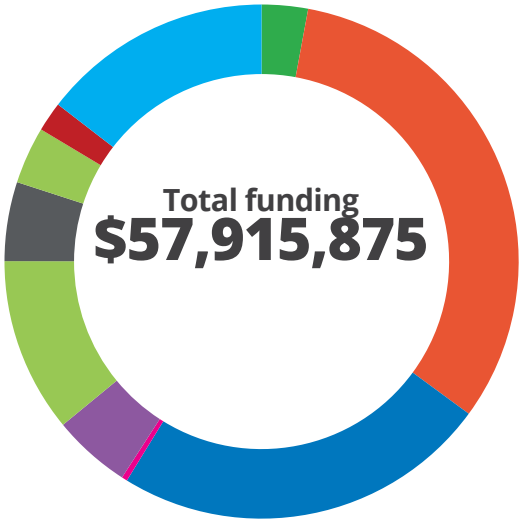
New studies with CAHS site approval	80
New studies approved by CAHS Human Research Ethics Committee (HREC)	61

Research funding

The following is based on data provided by the Centre for Child Health Research which captures research funding awarded to projects from across PCH.

Funding awarded directly to CAHS was $9,520,757 including awards received from the Perth Children's Hospital Foundation, Channel 7 Telethon Trust and the Raine Medical Research Foundation.

The total research funding outlined below includes the $9.52m of direct research funding to CAHS and funding received by the University of Western Australia Centre for Child Health Research (affiliated with the Telethon Kids Institute), where staff are involved in research, however funding is not directly awarded to CAHS.



Cancer research funding sources	$1,683,202
Australian Commonwealth Government	$18,635,111
International research sources	$13,723,605
Local NGO	$205,965
National NGO	$2,846,356
Perth Children's Hospital Foundation	$6,358,526
Perron Foundation Trust	$2,879,368
Raine Medical Research Foundation	$2,080,039
Telethon Trust	$1,082,192
WA Dept of Health	$8,421,511

Move to Improve

A new multidisciplinary research project, 'Move to Improve' was announced in April 2022 thanks to funding from the Stan Perron Charitable Foundation and Perth Children's Hospital Foundation. The project will inform Australia's first clinical exercise service at PCH which is available for children with a range of conditions.

This ground-breaking service prescribes personalised physical exercise and health promotion advice as part of clinical care, aligning with the service's 'exercise as medicine' ethos.

After an initial pilot study which explored the effectiveness of surfing as a form of therapy in a multi-pronged approach to care, a larger surfing intervention program is now part of the project.

A Move to Improve participant

Consumer experience and partnerships

Partnering with our consumers and the broader community is a critical component of achieving our vision of *healthy kids, healthy communities*.

In 2021-22, CAHS delivered a number of initiatives to demonstrate our commitment to meaningfully embed the consumer voice across the health service.

CAHS Consumer Engagement Strategy

Throughout the year we continued to implement our CAHS Consumer Engagement Strategy 2020-2022, with 27 of the 43 major actions completed.

Throughout the year, we engaged with a large number of consumers on a number of initiatives including the CAHS Community Hub Project, the Children's Hospice Project, responses to the Independent Inquiry into Perth Children's Hospital, and policy and publication development.

Consumers participated in the development of a new CAHS Strategic Plan, through focus groups and the Chair and Deputy Chairs of our Consumer Advisory Council and Youth Advisory Council taking part in a Strategic Planning Day with the CAHS Board and Executive. They also contributed to the development of a staff training module for the delivery of child and family-centred care across all services.

There has been a significant shift in departments across CAHS recognising the need to provide access to information in a range of media that reflect the diverse needs of CAHS consumers. A new Consumer Engagement Activity Record was established to support the centralised reporting of activities and initiatives where consumers have been involved.

Consumer feedback

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

CAHS introduced a dedicated role in February 2022 to improve the management of consumer feedback, to enhance our interactions with consumers who provide feedback on their experiences, and to

identify and implement service improvements as a result of consumer feedback.

The CAHS Service Lead – Complaints has strengthened the way we work collaboratively with families and clinicians to facilitate opportunities to discuss their feedback and concerns. We have increasingly engaged consumers in family meetings to provide the opportunity to reflect and learn from those occasions when we have not met the standards of care to which we aspire, in preference or to compliment written complaint responses.

MySay Healthcare Survey

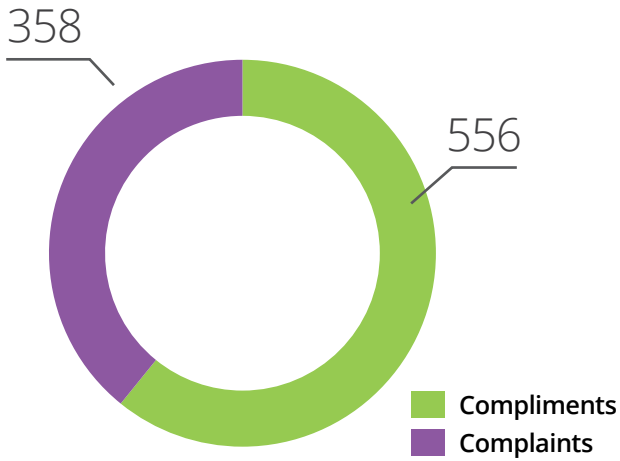
A paediatric version of the MySay Healthcare Survey was implemented at PCH this year. This is a validated, standardised patient experience survey sent via text message to parents and carers of inpatients after discharge. CAHS received an 'excellent' ranking from parents and carers, based on 4,000 MySay Healthcare survey responses, including to the question '*How likely are you to recommend Perth Children's Hospital to family or friends?*'.

New consumer experience surveys were also introduced for our Emergency Department, Community Health Nursing and the Child Development Service, receiving feedback from more than 10,000 consumers. The information has been used to drive improvements to services and inform the development of new training and education packages for staff.

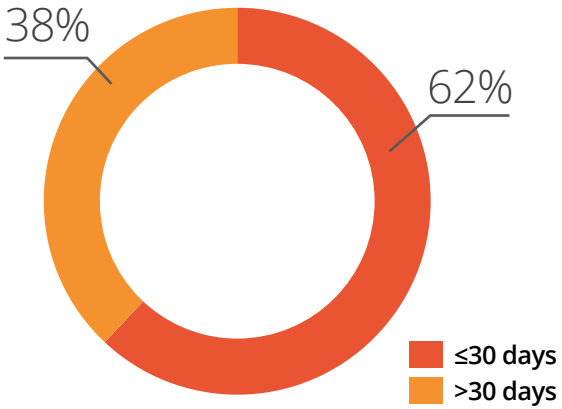
In response to a new question to identify how well hospital staff respected cultural values and practices of consumers from culturally and/or linguistically diverse backgrounds, 97 per cent of more than 200 multicultural families advised that staff respected their cultural values and practices during their Emergency Department visit always or mostly.

In 2021-22, through our formal processes, CAHS received the following feedback:

Feedback type



Complaint response timeframes



Care Opinion

Care Opinion is an independent, online consumer feedback platform that enables members of the public to share stories about their health care experience. The platform is independently moderated and supplements existing feedback and complaints systems by providing a real time and anonymous process for consumers to be heard and for health services to respond.

CAHS received 52 stories over the past year, with 23 of these providing positive and complimentary details. All Care Opinion stories have been shared with staff to highlight areas of improvement and celebrate achievements and positive behaviours.

During Patient Experience Week in April 2022, the Perth Children's Hospital Emergency Department was awarded the *Care Opinion Patient's Champion Award* by CAHS after the department received a series of compliments on Care Opinion from consumers.

"We presented at PCH Emergency Department with our 16-month-old daughter who had laboured breathing. We had already been to another hospital's Urgent Care service and were asked to take her to be seen at emergency."

"We ended up staying overnight, and again the nurses were amazing. It was reassuring that the nurses also explained that there were options to escalate any concerns we may have if we felt unheard. Not that this was required as the staff were attentive, communicative and responsive from the moment we were triaged.

"I am unbelievably grateful for the care our daughter received at PCH. Across the board, our experience was positive. I particularly appreciated the clear communication and care plan and the care and effort taken to build rapport with my young daughter who was at times, a little distressed in an unfamiliar environment."

"The orderly/ward clerk (who delivered breakfast and changed the bins) on the short term/overnight stay ward on a Tuesday morning was engaging and warm. I appreciated her help in showing me where I could find an extra bag to dispose of my daughter's soiled nappy. We were seen by the doctors early the next morning, given a clear and succinct care plan and appropriately discharged to cuddle up and recoup at home!

"I cannot speak more highly of the care we received at PCH. The staff were fully gowned which was necessary but at times, a bit frightening for our daughter. The nurses, in particular Caitlin who called the Wiggles over her pager and played music, and the doctors, in particular Matti, were amazing with our daughter and really made an effort to engage with her and make her feel at ease. Although our daughter hated receiving Ventolin, the nurses and doctors had built such good rapport that she gave them claps and blew kisses once it was over.

Statement from the Consumer Advisory Council Chairperson

The opportunity to be a part of the Consumer Advisory Council (CAC) is a privilege that I have been afforded for the last six years.

I became the Chair over a year ago and have been a part of a vibrant and diverse group of parents, carers and community members who all work to ensure the voices and perspectives of children and families are at the centre of CAHS.

The last 12 months have been a very busy time for the CAC, and for the health service. The focus from the service on better engagement and involvement with their consumers and families has meant that the members of the CAC and consumers more widely have been involved in many activities, workshops, planning days and committees.

The CAC has held 10 meetings over the last 12 months, and the Chair has also attended a number of CAHS Executive Committee meetings and had the opportunity to be involved in health service decision making. More broadly, our members have attended and provided a consumer voice at CAHS Board Meetings, strategic planning days, diversity workshops, piloting of training, accreditation meetings, the Implementation Oversight Committee following the Independent Inquiry into PCH, and various recruitment panels among other things.

We have spent time this year focusing on how the service can continue to build meaningful ways of working with consumers and families. We are also starting to look to building networks and relationships with consumers from other health services that also provide services to children and young people, to help support our broad understanding of the experiences of our consumers. We also want to build relationships with the Consumer Advisory Councils at our other hospitals and health services to help those services understand the needs of our young people and families as they transition out of paediatric services into adult services. CAHS also implemented a consumer induction process for all of our consumer representatives to ensure they feel safe and supported in their role when partnering with our health service.

There is a lot of work happening with consumers and families at CAHS, and we are happy to welcome new people to our committee and keep our longstanding members with us. We look forward to the next 12 months and seeing how we can continue to help CAHS provide excellent care to our children into the future.

Tania Harris
Chair
CAHS Consumer Advisory Council

Statement from the Youth Advisory Council Chairperson

This year, we had a focus on organisational governance, whereby the group provided input on a series of policies such as the Consumer Representative Recruitment and Management Policy and Guideline, the CAHS Consumer Consultation Policy, and some upcoming customer service training.

The Youth Advisory Council (YAC) participated in the accreditation process, reviewed the CAHS Quarterly Consumer Feedback Update, and received updates on strategies such as the CAHS Consumer Engagement Strategy, and the Multicultural Action Plan. Additionally, our co-chairs were invited to attend the CAHS strategic planning day.

We continue to strengthen our relationship with the organisation and improve communication processes between YAC and CAHS staff, Executive, and Board members so that we can impact real change within the organisation. Our Chair represents the group at the weekly CAHS Executive Committee meetings, fortnightly Inquiry Implementation Oversight Committee meetings, quarterly Board meetings, and other events as required. This provides the YAC with the opportunity to better escalate issues pertinent to young people and gives young people a seat at the table where decisions are made. Importantly, our YAC meeting minutes are escalated to both the CAHS Executive Committee and the Board to keep them fully informed.

A recent addition to our meetings is the Consumer Experience Moment, in which we receive a complaint about the service and the response from CAHS, which will later be shared with the Board. YAC has the opportunity to voice compliments or concerns regarding the quality of service described, as well as the quality of the complaint responses. This has allowed for consumer issues and trends to be recognised more easily and voiced efficiently. It gives YAC the opportunity to advocate for patient-wellbeing and consumer-focused care. We continue to welcome and provide input on a myriad of projects, such as the development of a youth-specific version of the Australian Hospital Patient Experience Question Set, the What Matters to Me Poster and the Child Protection Unit redesign. Members are also provided opportunities outside of meetings - for example, our consumer representative Rana provided some brilliant insights into the experience of consumers from culturally and linguistically diverse backgrounds on the Harmony Week panel entitled CAHS Conversations on Culture.

We continue to aim to develop consumer-run initiatives and have a particular interest in connecting more with consumers and other organisations. Keep an eye on the socials! You might be seeing some familiar faces soon. We will soon be starting a recruitment drive again to reach full capacity and increase our diverse membership, as a longstanding goal of the YAC is - and will continue to be - to advocate for marginalised communities.

Over the next year, we will continue to represent young people in spaces where they are at the centre by *sharing our voices to shape your care*.

Amelie Farrell
Chair
CAHS Youth Advisory Council

Agency performance

Delivering safe, high-quality care

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

Quality improvement activities at CAHS

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

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

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

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

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

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

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

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

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

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

Independent second checking to reduce medication-related errors

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

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

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

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

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

Clinical incident management

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

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

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

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

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

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

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

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

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

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

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

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

Confirmed with patient outcome

Clinical safety indicators

Hand hygiene

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

People, Capability and Culture

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

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

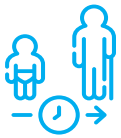
- An irresistible employee experience.
- Proactive health, safety, wellbeing and support.
- Clear, reliable and collaborative communication.
- Courageous, inspiring and inclusive leaders.
- Meaningful, dynamic learning and growth experiences.
- A culture in which our people can thrive.

Our people – employee profile

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

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

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

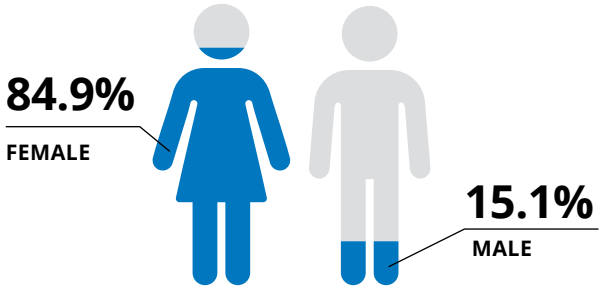


40 years
Median age

52.8 hours
Average hours paid per fortnight

9.6 years
Average length of service

1.4%
Aboriginal Employees



13.1%
Cultural and linguistically diverse

1.2%
Employees with disability

Table 5: Total full-time employees, by category

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

Workforce Planning

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

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

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

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

CAHS Transition to Practice Programs (Graduate Nursing Programs)

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

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

Supported Introduction to Infants, Paediatric and Adolescent Nursing program

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

Strategic Talent Acquisition

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

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

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

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

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

Our culture - shaping our future

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

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

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

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

Compliance with public sector standards and ethical codes

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

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

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

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

Compliance monitoring

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

A total of 94 reports or complaints alleging noncompliance with the Code of Conduct (breaches of discipline) were lodged (Table 6). Suspected breaches of discipline, including matters of reportable misconduct, were dealt with through the WA Health Disciplinary processes,

and where appropriate, reported to the Public Sector Commission (15) or the Corruption Crime Commission (30) as required under the *Corruption, Crime and Misconduct Act 2003*. Where breaches were substantiated, the decision maker determined the appropriate action in accordance with the *Health Services Act 2016*.

Table 6: Complaints alleging non-compliance with the Code of Conduct, by area of compliance

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

Work Health Safety and Wellbeing at CAHS

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

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

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

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

Injury management

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

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

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

Workers Compensation

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

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

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

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

Table 8: Workers compensation claims in 2021-22

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

Financial targets

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

Notes:

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

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

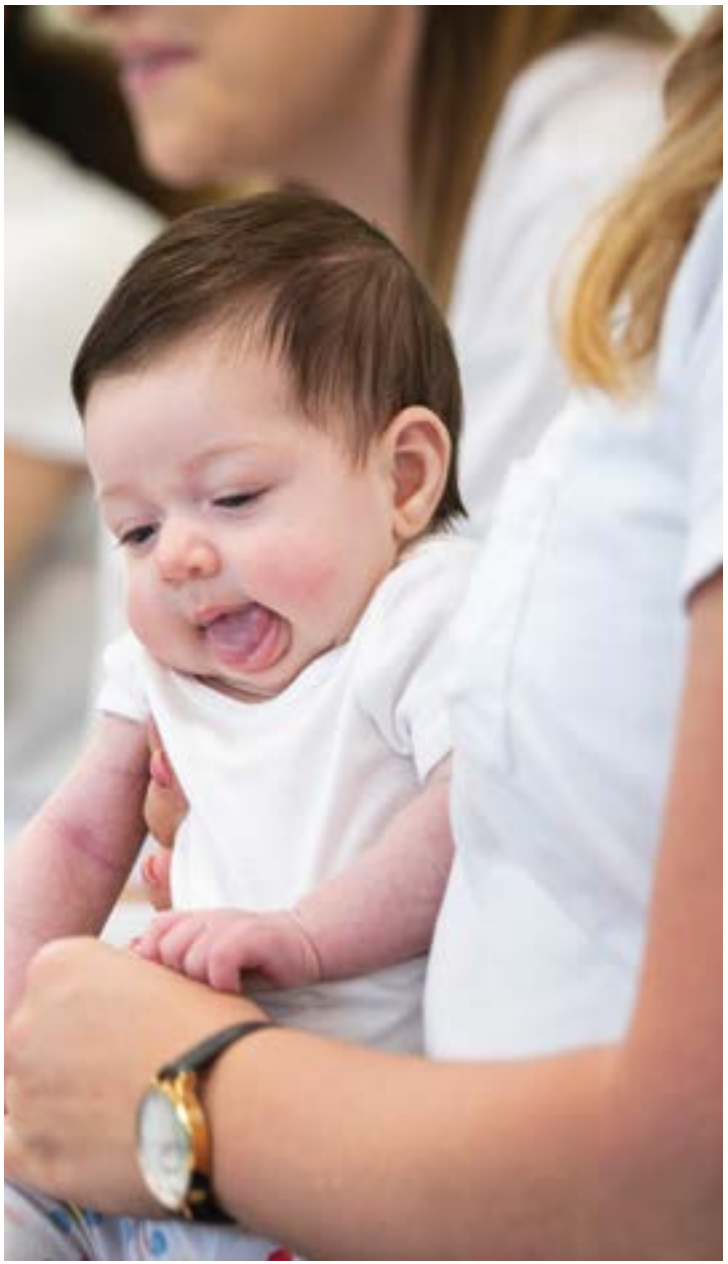
[3] As a result of recording the asset revaluation increments of $1.070 million for land and $4.941 million for buildings as revenue, the variation in net cost of services is less than the variance in total cost of services.

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

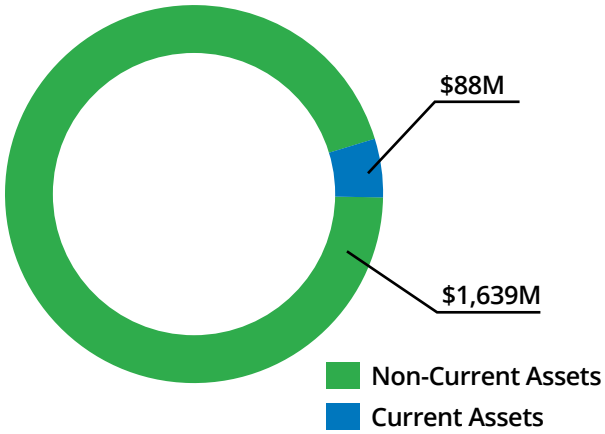
[5] The higher than budgeted decrease (-$12.926 million) in cash held was mainly caused by the $18.041 million of service agreement funding for the 2021-22 expenditures being received in the previous financial year, rather than in the current financial year.

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

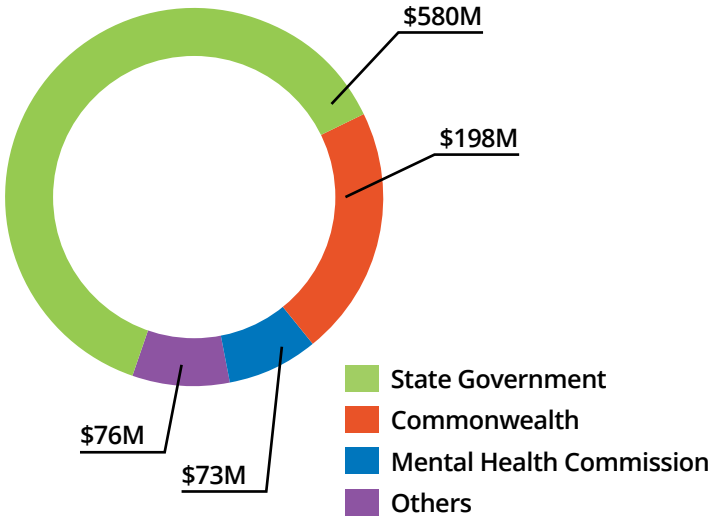
[7] Further explanations are contained in Note 9.14 'Explanatory Statement' to the financial statements.



Total assets



Income



Total assets

The Child and Adolescent Health Service finished the 2022 year with a total asset value of $1,727 million, which represents an increase of $83 million over the previous year. The major components of assets are Property plant and equipment totalling $1,125 million and Cash and cash equivalents totalling $82 million. Further details of the breakdown by asset category can be found within the statement of financial position in the annual financial statements presented as at 30 June 2022.

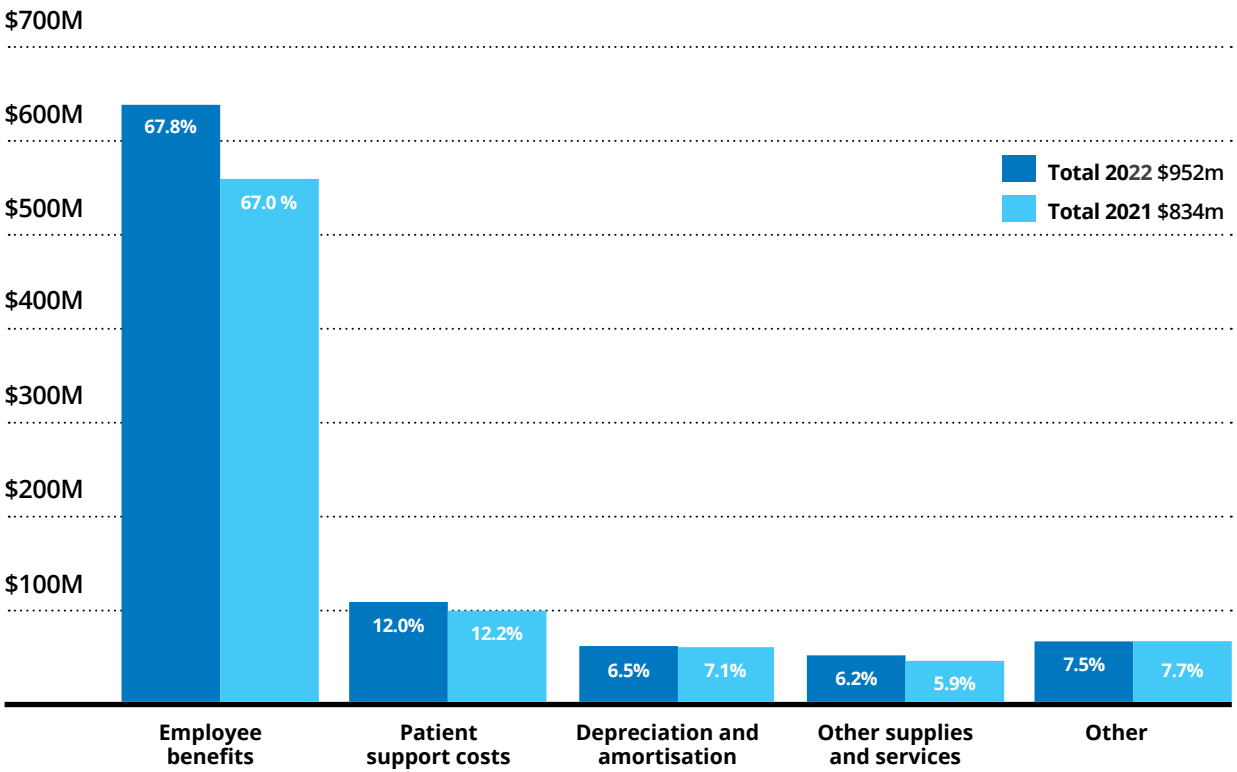
Income

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

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

A further $59 million in income was received via services received free of charge from State Government entities and $73 million from the Mental Health Commission towards the cost of providing child and adolescent mental health services. Further details of the breakdown by income category and comparison to the previous year can be found within the statement of comprehensive income in the annual financial statements presented for the year ended 30 June 2022.

Expenditure by type



Employee benefits capture the costs of staff providing services within the Child and Adolescent Health Service and represent the major component of expenditure for the 2022 year. Further details of the breakdown by expense category and comparison to the previous year can be found within the statement of comprehensive income in the annual financial statements presented for the year ended 30 June 2022.

Summary of key performance indicators

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

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

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

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

Table 9: Actual results versus KPI targets

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

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

Favourable performance **Unfavourable performance**

Governance

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.

Responsible Minister

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

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 Amber-Jade Sanderson 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, system-wide 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, high quality and efficient health services to sick and vulnerable children and families in Western Australia.

The Health Service Board

The Child and Adolescent Health Service Board is the governing body of CAHS. Appointed by the Minister for Health, Board members have experience across the fields of medicine and health care, finance, law, and community and consumer engagement.

The Board meets on a monthly basis and met on 11 occasions during 2021–22.

There are four standing committees of the Board:

Monthly committees:

- Finance
- Safety and Quality

Bi-monthly committees:

- Audit and Risk
- People, Capability and Culture

Board Chair, Dr Rosanna Capolingua
MBBS FAMA FAICD

Dr Rosanna Capolingua is a General Practitioner with broad experience across health care delivery, serving as the Australian Medical Association WA President and Federal AMA President. A member of the Federal AMA Executive for six years, she chaired the Ethics and Medico- Legal committee, Finance committee and Taskforce on Indigenous Health. She has extensive Board experience, including the Medical Board of WA, Professional Services Review Committee, Healthway and the Board of MercyCare. She was Chair of the Governing Council for the Child and Adolescent Health Service, Deputy Chair of the North Metropolitan Health Service, and a member of the WA Mental Health Commission's Alcohol and Other Drugs Advisory Board. She continues as Medical Director of the AMA (WA) Foundation, Chair of the Board of AMA, Chair of the WA Immunisation Strategy Committee, and member of the AMA Indigenous Scholarship Foundation and St John of God Healthcare Australia Boards.

Board Member, Dr Alexius Julian
MBBS

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

Board Member, Dr Daniel McAullay

Ph.D, M AppEpi, B.Sc.

Dr Daniel McAullay is a health professional and a past member of the CAHS Governing Council and has extensive experience as a member on health boards and committees. Dr McAullay currently works as the Director of Aboriginal Research at Edith Cowan University and is an Associate Professor with the Centre for Improving Health Services for Aboriginal Children and Families. Dr McAullay is a health services researcher with expertise in maternal, infant and child health, primary health care and Aboriginal health.

Board Member, Mr John McLean

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

CAHS welcomed Mr John McLean in November 2021 as a member of the Board, Finance Committee, and Chair of the CAHS Audit and Risk Committee. Mr McLean is a Chartered Accountant and experienced non-executive director. He is currently a director of Red Jacket Consulting. Over the past eight years Mr McLean has held a range of non- executive roles, mainly in the not-for-profit sector, and worked as a business consultant specialising in financial reviews, strategic planning, policy reviews, and procurement. After qualifying as a Chartered Accountant with Deloitte in London he transferred to Africa, handling audits for a range of listed and non-listed clients. He joined Coopers and Lybrand in Perth (now PWC) from Africa, initially in their audit division, transitioning to management in the Perth office before joining law firm Jackson McDonald, where he spent 15 years as their CEO. Mr McLean currently holds board roles with the Neurological Council of Western Australia, the Aboriginal Arts Centre Hub of Western Australia, Martu United Pty Ltd and the SwanCare Group.

Board Member, Mr Peter Mott

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

Mr Peter Mott has four decades of health, executive management and CEO experience. Mr Mott was appointed Ramsay Health Care WA State Manager in May 2022. Prior to his appointment Peter was CEO of Hollywood Private Hospital for nine years He is Vice President of the Australian Private Hospitals Association and Chair of the APHA Workforce Taskforce, a member of the University of Western Australia (UWA) Business School Ambassadorial Council and a member of the Young Lives Matter Foundation UWA Board. Peter is a former Deputy President of the Australian College of Health Service Management WA Branch Council, past President of the Australian Institute of Management (AIM) WA, past Chairman of the AIM WA UWA Business School Executive Education Advisory Board, and past Chairman of Lifeline WA.

Board Member, Ms Maria Osman
M. Ed GAICD

Ms Maria Osman has been leading policy reform, service delivery and community development across government, community and university sectors for more than 40 years. Ms Osman's constant focus has been on human rights, cultural diversity and gender equality in all sectors. Ms Osman has held executive positions in government, was an Australian delegate to the United Nations Commission on the Status of Women and the UN Conference on Racism. Ms Osman is Non-Executive Director of Circle Green Community Legal Centre, the International Advisory Board of the UWA Public Policy Institute and the WA Voluntary and Assisted Dying Board.

Board Member, Emeritus Professor Di Twigg
AM PhD, MBA, B.HlthSc. (Nsg) Hons, RN, RM, FACN, FACHSM

Professor Twigg has more than 45 years' experience in health and education, most notably as Executive Dean, School of Nursing and Midwifery at ECU and Executive Director of Nursing, SCGH. She combined her extensive experience in health service leadership with more recent research and policy development to contribute to issues related to nursing workforce, patient outcomes and cost-effective care. She was awarded the Lifetime Achievement Honour in 2017, was made a Member of the Order of Australia for significant service to nursing through a range of leadership, education and advisory roles in 2019, and was made an Emeritus Professor of Edith Cowan University in 2021.

CAHS acknowledge the following outgoing members of the CAHS Board for their dedicated service.

Former Deputy Board Chair, Professor Geoffrey Dobb

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

As an inaugural Board member, Deputy Board Chair and Chair of the Board Safety and Quality Committee, Professor Geoff Dobb's passion for safety and quality in healthcare has been a constant driving force. Professor Dobb has made an enormous contribution and leaves our health service a lasting legacy with patient and client safety as our priority.

Former Board Member, Ms Kathleen Bozanic

B.Com., ACA, GAICD

Ms Kathleen Bozanic stepped down from her position as Board member and Chair of the CAHS Audit and Risk Committee in September 2021 after five years of service. Ms Bozanic brought extensive experience in financial management, governance and compliance, risk management, business planning and strategic transformation to the Board.

Former Board Member, Ms Miriam Bowen

LLB

Ms Miriam Bowen has provided strong leadership and advocacy for children and families throughout her tenure. She has provided the Board with invaluable governance and legal compliance support and advice.

Former Board Member, Ms Linley (Anne) Donaldson

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

Ms Donaldson is a professional Non-Executive Director with over 15 years' experience on Boards and committees. Current board membership includes GP DownSouth, Mental Health Foundation Australia, Member (Trustee) RUAH, and ECU Human Research Ethics Committee. Ms Donaldson brings over 35 years' experience in Health and Human Services in metropolitan and regional Western Australia in senior executive, and CEO positions. She has successfully led organisations through major change, project management and commissioning of capital works, financial and operational governance. This experience includes extensive knowledge in community and stakeholder engagement effectively achieving consensus in program delivery.

Committee meeting attendance July 2021 to June 2022

Name	Number of meetings	Meetings attended
Full CAHS Board Meeting		
Dr Rosanna Capolingua (Chair)	11	11
Professor Geoffrey Dobb (Deputy Chair)	11	11
Professor Di Twigg	11	11
Ms Miriam Bowen	11	11
Ms Kathleen Bozanic	3	3
Ms Anne Donaldson	11	11
Dr Alexius Julian	11	10
Dr Daniel McAullay	11	10
Mr Peter Mott	11	11
Ms Maria Osman	11	10
Mr John McLean	6	6
Finance Committee		
Dr Alexius Julian (Chair)	10	10
Mr John McLean	6	6
Professor Geoffrey Dobb	10	10
Ms Linley (Anne) Donaldson	10	10
Mr Peter Mott	10	9

Name	Number of meetings	Meetings attended
Audit and Risk Committee		
Mr John McLean (Chair)	3	3
Dr Alexius Julian (former acting Chair)	5	5
Ms Kathleen Bozanic (former Chair)	1	1
Professor Geoffrey Dobb	5	5
Ms Anne Donaldson	5	5
Professor Di Twigg	5	5
Safety and Quality Committee		
Professor Geoffrey Dobb (Chair)	11	11
Ms Miriam Bowen	11	10
Dr Daniel McAullay	11	8
Ms Maria Osman	11	10
People, Capability and Culture Committee		
Professor Di Twigg (Chair)	6	6
Ms Miriam Bowen	6	6
Ms Maria Osman	6	5
Dr Daniel McAullay	6	5
Mr Peter Mott	6	6

Note:

Ms Kathleen Bozanic was the Chair of the Audit and Risk Committed up to September 2020. Dr Alexius Julian became interim chair until the appointment of current Chair, Mr John McLean.

Performance management framework

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

This framework describes how outcomes, services and key performance indicators are used to measure agency performance towards achieving the relevant overarching whole-of-government goal "strong communities, safe communities and supported families".

Key performance indicators measure the effectiveness and efficiency of services provided by the WA health system in achieving the stated desired outcomes.

All WA health system reporting entities contribute to achieving the outcomes through health services delivered either directly by the entities or indirectly through contracts with non-government organisations.

The WA health system's outcomes and key performance indicators for 2021–22 are aligned to the State Government goal of strong communities: safe communities and supported families.

CAHS reports performance for:

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 healthcare for all Western Australians

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

Services

1. Public hospital admitted services
2. Public hospital emergency services
3. Public hospital non-admitted services
4. Mental health services

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 seven days following discharge from acute specialised mental health inpatient service

Efficiency KPIs

- Average admitted cost per weighted activity unit
- Average Emergency Department cost per weighted activity unit
- Average non-admitted cost per weighted activity unit
- 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

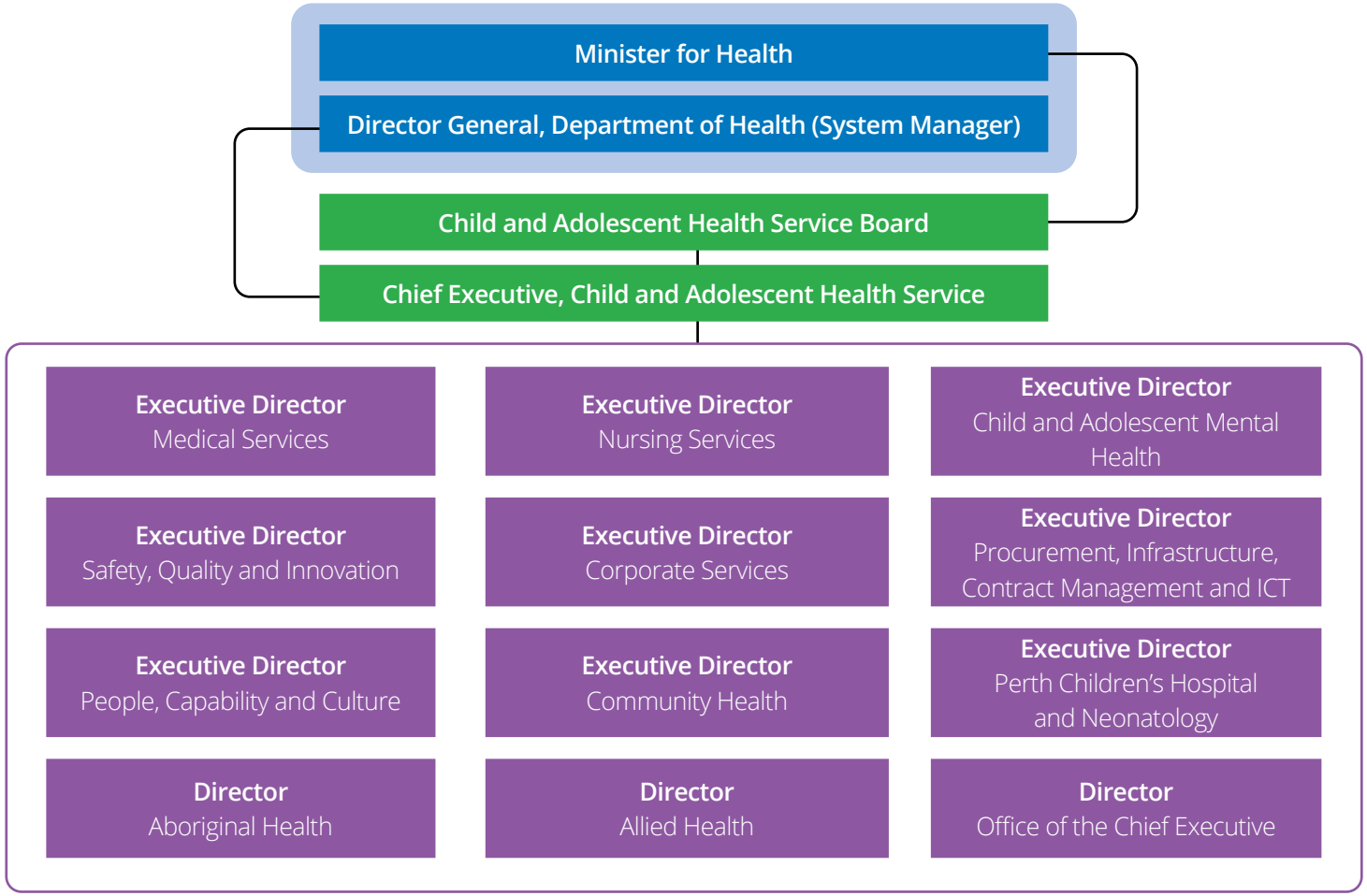
Services

5. Public and community health services

Efficiency KPIs

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

CAHS Management Structure 2021-22



Senior officers

Child and Adolescent Health Service
Chief Executive
Aresh Anwar
1 July 2021 – 30 June 2022

Medical Services, CAHS Perth Children's Hospital and Neonatology
Executive Director
Simon Wood
1 July 2021 – 30 June 2022

Nursing Services
Executive Director
Katie McKenzie
1 July 2021 – 11 March 2022*

Nursing Services
Executive Director
Terri Barrett
1 July 2021 – 30 June 2022

Safety, Quality and Innovation
Executive Director
Mary Miller
1 July 2021 – 1 April 2022

Safety, Quality and Innovation
Executive Director
Valerie Jovanovic
2 April 2022 – 25 April 2022

People, Capability & Culture
Executive Director
1 July 2021 – 30 June 2022

Safety, Quality and Innovation
Executive Director
Audrey Koay
26 April 2022 – 30 June 2022

Corporate Services
Executive Director
Tony Loiacono
1 July 2021 – 30 June 2022

Community Health
Executive Director^
Sue Kiely
11 April 2022 – 30 June 2022

Child and Adolescent Mental Health Services
Executive Director^
Maureen Lewis
11 April 2022 – 30 June 2022

Procurement, Infrastructure, Contract Management and ICT
Executive Director
Danny Rogers
1 July 2021 – 30 June 2022

People, Capability and Culture
Executive Director
Richard Prunster
2 April 2022 – 25 April 2022#

Aboriginal Health
Director
Mel Robinson
1 July 2021 – 30 June 2022

Allied Health
Director
Emma Davidson
1 July 2021 – 30 June 2022^^

Office of the Chief Executive
Director
Joanne Mizen
1 July 2021 – 30 June 2022

*During this time, Ms Katie McKenzie was responsible for Community Health and Child and Adolescent Health Services as Executive Lead, pending the determination to formally establish dedicated Health Executive Service roles. Ms Terri Barrett was responsible for Nursing Services. ^ Newly established positions # Cover temporary deployment of Ms Jovanovic. ^^ For the period of 1 July 2021 to 26 January 2022, Ms Jennifer Mace was responsible for Allied Health.

Disclosures and legal compliance

Auditor General

INDEPENDENT AUDITOR'S REPORT
2022
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 at 30 June 2022, and 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 significant 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 Child and Adolescent Health Service for the year ended 30 June 2022 and the financial position 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 am independent of the Health Service in accordance with the Auditor General Act 2006 and the relevant ethical requirements of the Accounting Professional & Ethical Standards Board's APES 110 Code of Ethics for Professional Accountants (including Independence Standards) (the Code) that are relevant to my audit of the financial statements. I have also fulfilled my other ethical responsibilities in accordance with the Code.

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

Emphasis of Matter – Restatement of Comparative Balances

I draw attention to Note 9.15 to the financial statements which states that the amounts reported in the previously issued 30 June 2021 financial report have been restated and disclosed as comparatives in this financial report. My opinion is not modified in respect of this matter.

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 Child and Adolescent Health Service. The controls exercised by the Board 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 legislative provisions (the overall control objectives).

In my opinion, in all material respects, the controls exercised by the Child and Adolescent Health Service are sufficiently adequate to provide reasonable assurance that the receipt, expenditure and investment of money, the acquisition and disposal of property and the incurring of liabilities have been in accordance with legislative provisions during the year ended 30 June 2022.

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 Child and Adolescent Health Service for the year ended 30 June 2022. The key performance indicators are the Under Treasurer-approved key effectiveness indicators and key efficiency indicators that provide performance information about achieving outcomes and delivering services.

In my opinion, in all material respects, the key performance indicators of the Child and Adolescent Health Service are relevant and appropriate to assist users to assess the Health Service's performance and fairly represent indicated performance for the year ended 30 June 2022.

The Health Service'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 control as the Board determines necessary to enable the preparation of key performance indicators that are free from material misstatement, whether due to fraud or error.

In preparing the key performance indicators, the Health Service is responsible for identifying key performance indicators that are relevant and appropriate, having regard to their purpose in accordance with Treasurer's Instruction 904 *Key Performance Indicators*.

Auditor General's 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 904 for measuring the extent of outcome achievement and the efficiency of service delivery. The procedures selected depend on my judgement, including the assessment of the risks of material misstatement of the key performance indicators. In making these risk assessments I obtain an understanding of internal control relevant to the engagement in order to design procedures that are appropriate in the circumstances.

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

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

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 2022, but not the financial statements and my auditor's report.

My opinion on the financial statements does 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, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements 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 2022 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.

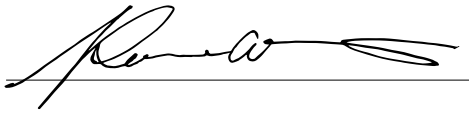
Sandra Labuschagne
Deputy Auditor General
Delegate of the Auditor General for Western Australia
Perth, Western Australia
1 September 2022

Certification of financial statements

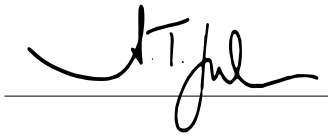
CHILD AND ADOLESCENT HEALTH SERVICE

CERTIFICATION OF FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2022

The accompanying financial statements of the Child and Adolescent Health Service have been prepared in compliance with the provisions of the *Financial Management Act 2006* from proper accounts and records to present fairly the financial transactions for the reporting period ended 30 June 2022 and the financial position as at 30 June 2022. NEXT LINE At the date of signing we are not aware of any circumstances which would render the particulars included in the financial statements misleading or accurate.



Dr Rosanna Capolingua
Board Chair
Child and Adolescent Health Service
1 September 2022



Dr Alexius Julian
Board Member
Child and Adolescent Health Service
1 September 2022

Jacqueline Shervington
Chief Finance Officer
Child and Adolescent Health Service
1 September 2022

Child and Adolescent Health Service
Statement of comprehensive income
For the year ended 30 June 2022

	Notes	2022 $000	2021 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	3.1(a)	645,719	558,987
Fees for visiting medical practitioners		2,859	2,693
Contracts for services	3.2	9,408	9,453
Patient support costs	3.3	114,768	101,975
Finance costs	7.2	268	255
Depreciation and amortisation expense	5	61,543	59,601
Asset revaluation decrements	5.1	-	3,723
Loss on disposal of non-current assets	5.1.2	659	141
Repairs, maintenance and consumable equipment	3.4	29,006	23,214
Other supplies and services	3.5	59,023	49,390
Other expenses	3.6	29,226	24,337
Total cost of services		**952,479**	**833,769**
INCOME			
Patient charges	4.2	21,672	21,787
Other fees for services	4.2	32,046	30,470
Grants and contributions	4.3	9,849	13,828
Donation revenue	4.4	1,161	2,096
Asset revaluation increments	5.1	6,011	605
Other revenue	4.5	5,683	5,211
Total income other than income from State Government		**76,422**	**73,997**
NET COST OF SERVICES		**876,057**	**759,772**

	Notes	2022 $000	2021 $000
INCOME FROM STATE GOVERNMENT			
Service agreement funding - State	4.1	516,575	492,775
Service agreement funding - Commonwealth	4.1	197,851	159,824
Grants from other state government agencies	4.1	73,736	68,828
Services provided to other government agencies	4.1	4,036	3,981
Assets (transferred)/assumed	4.1	-	863
Resources received free of charge	4.1	58,858	42,368
Total income from State Government		**851,056**	**768,639**
SURPLUS / (DEFICIT) FOR THE PERIOD		**(25,001)**	**8,867**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.12	80,360	-
Total other comprehensive income		80,360	-
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**55,359**	**8,867**

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

Child and Adolescent Health Service
Statement of financial position
For the year ended 30 June 2022

	Notes	2022 $000	Restated* 2021 $000
ASSETS			
Current Assets			
Cash and cash equivalents	7.3	50,219	67,836
Restricted cash and cash equivalents	7.3	19,012	17,374
Receivables	6.1	11,962	11,490
Inventories	6.3	5,551	3,580
Other current assets	6.4	1,033	909
Total Current Assets		87,777	101,189
Non-Current Assets			
Restricted cash and cash equivalents	7.3	12,672	9,972
Amounts receivable for services	6.2	470,279	408,937
Property, plant and equipment	5.1	1,125,366	1,084,908
Right-of-use assets	5.2	9,706	9,768
Intangible assets	5.3	20,851	29,370
Total Non-Current Assets		1,638,874	1,542,955
TOTAL ASSETS		**1,726,651**	**1,644,144**
LIABILITIES			
Current Liabilities			
Payables	6.5	32,213	29,999
Contract liabilities	6.6	119	89
Lease liabilities	7.1	1,760	1,858
Employee benefits provisions	3.1 (b)	138,146	123,317
Other current liabilities	6.8	125	83
Total Current Liabilities		172,363	155,346
Non-Current Liabilities			
Lease liabilities	7.1	8,403	8,214
Employee benefits provisions	3.1 (b)	24,486	26,365
Total Non-Current Liabilities		32,889	34,579
TOTAL LIABILITIES		**205,252**	**189,925**
NET ASSETS		**1,521,399**	**1,454,219**
EQUITY			
Contributed equity	9.12	1,465,947	1,454,126
Reserves	9.12	80,360	-
Accumulated surplus/(deficit)		(24,908)	93
TOTAL EQUITY		**1,521,399**	**1,454,219**

* Refer to Note 9.15 ‘Correction of prior period error’.

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

Child and Adolescent Health Service
Statement of cash flows
For the year ended 30 June 2022

	Notes	2022 $000	2021 $000
CASH FLOWS FROM STATE GOVERNMENT			
Service agreement funding - State		455,233	430,195
Service agreement funding - Commonwealth		197,851	159,824
Grants from other state government agencies		73,736	68,828
Services provided to other government agencies		4,036	3,981
Capital appropriations administered by Department of Health		11,821	11,769
Net cash provided by State Government	7.3.3	**742,677**	**674,597**
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(630,710)	(544,132)
Supplies and services		(186,032)	(178,529)
Finance costs		(266)	(253)
Receipts			
Receipts from customers		19,946	21,451
Grants and contributions		9,887	12,919
Donations received		106	123
Other receipts		37,991	35,437
Net cash used in operating activities	7.3.2	**(749,078)**	**(652,984)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Purchase of non-current assets		(4,771)	(8,239)
Receipts			
Proceeds from sale of non-current assets	5.1.2	-	11
Net cash used in investing activities		**(4,771)**	**(8,228)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Principal elements of lease payments		(2,107)	(1,853)
Net cash used in financing activities		**(2,107)**	**(1,853)**
Net increase / (decrease) in cash and cash equivalents		(13,279)	11,532
Cash and cash equivalents at the beginning of the period		95,182	83,650
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.3	**81,903**	**95,182**

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

Child and Adolescent Health Service
Statement of changes in equity
For the year ended 30 June 2022

	Notes	Contributed equity $000	Reserves $000	Accumulated surplus/(deficit) $000	Total equity $000
Balance at 1 July 2020		1,439,357	-	(8,774)	1,430,583
Surplus		-	-	8,867	8,867
Total comprehensive income for the period		-	-	8,867	8,867
Transactions with owners in their capacity as owners:					
Capital appropriations administered by Department of Health	9.12	11,769	-	-	11,769
Other contributions by owners	9.12	3,000	-	-	3,000
Total		14,769	-	-	14,769
Balance at 30 June 2021		**1,454,126**	**-**	**93**	**1,454,219**
Balance at 1 July 2021		1,454,126	-	93	1,454,219
Deficit		-	-	(25,001)	(25,001)
Other comprehensive income	9.12	-	80,360	-	80,360
Total comprehensive income for the period		-	80,360	(25,001)	55,359
Transactions with owners in their capacity as owners:					
Capital appropriations administered by Department of Health	9.12	11,821	-	-	11,821
Other contributions by owners	9.12	-	-	-	-
Total		11,821	-	-	11,821
Balance at 30 June 2022		**1,465,947**	**80,360**	**(24,908)**	**1,521,399**

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

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

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 1 September 2022.

Statement of compliance

These general purpose financial statements have been prepared in accordance with:

1) The Financial Management Act 2006;

2) The Treasurer's Instructions;

3) Australian Accounting Standards including applicable interpretations;

4) Where appropriate, those AAS paragraphs applicable for not for profit entities have been applied.

The *Financial Management Act 2006* and the Treasurer's Instructions (TI) take precedence over Australian Accounting Standards (AAS). Several AAS are modified by the TI to vary application, disclosure, format and wording. Where modification is required and has 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.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

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 955 *Contributions by Owners made to Wholly Owned Public Sector Entities* 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.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

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.

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.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

2.1 Health Service objectives (cont.)

Public Hospital Non-admitted Services

Medical officers, nurses and allied health staff provide non-admitted (out-patient) care services and include clinics for pre- and post-surgical care, allied health care and medical care.

Mental Health Services

Contracted mental health services describe inpatient care in an authorised ward and community mental health services provided by the Health Service under an agreement with the Mental Health Commission for specialised admitted and community mental health.

Aged and Continuing Care Services

The provision of continuing care services includes the programs that provide functional interim care or support for children with disabilities to continue living with their families.

Public and Community Health Services

Community Health provides services and programs delivered to increase optimal health and wellbeing, encourage healthy lifestyle, reduce the onset of disease and disability, reduce the risk of long-term illness as well as detect, protect and monitor the incidence of disease in the population. These include child health services, school health services, child development services, public health programs and Aboriginal health programs.

2.2 Schedule of income and expenses by service

The Schedule of Income and Expenses by Service should be read in conjunction with the accompany notes. 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.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

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	
	2022	2021	2022	2021	2022	2021	2022	2021
COST OF SERVICES	$000	$000	$000	$000	$000	$000	$000	$000
Expenses								
Employee benefits expense	289,528	262,357	53,030	40,742	96,547	81,799	65,895	61,143
Fees for visiting medical practitioners	1,921	1,839	330	280	592	562	-	-
Contracts for services	7,121	6,654	93	32	169	129	7	8
Patient support costs	68,374	65,406	14,270	10,320	24,514	19,707	1,592	1,390
Finance costs	45	48	8	7	14	14	92	86
Depreciation and amortisation expense	38,474	36,875	6,607	5,613	11,865	11,276	2,443	3,954
Asset revaluation decrements	-	-	-	-	-	-	-	40
Loss on disposal of non-current assets	436	95	75	14	135	29	-	-
Repairs, maintenance and consumable equipment	13,177	10,863	2,572	1,715	4,757	3,441	2,059	1,933
Other supplies and services	27,975	24,613	5,066	3,765	9,237	7,563	5,153	4,510
Other expenses	10,170	8,781	1,831	1,356	3,325	2,722	3,727	2,944
Total cost of services	457,221	417,531	83,882	63,844	151,155	127,242	80,968	76,008
Income								
Patient charges	18,482	18,449	632	581	1,862	1,940	696	817
Other fees for services	21,294	20,652	3,656	3,143	6,566	6,315	311	168
Grants and contributions	6,480	9,197	1,113	1,400	1,998	2,812	182	337
Donation revenue	779	1,431	134	218	240	438	2	-
Asset revaluation increments	2,217	(7)	381	(1)	684	(2)	347	138
Other revenue	3,671	3,449	631	525	1,132	1,055	11	21
Total income other than income from State Government	52,923	53,171	6,547	5,866	12,482	12,558	1,549	1,481
NET COST OF SERVICES	**404,298**	**364,360**	**77,335**	**57,978**	**138,673**	**114,684**	**79,419**	**74,527**
INCOME FROM STATE GOVERNMENT								
Service agreement funding - State	241,107	239,622	47,190	37,146	78,591	75,597	2,443	3,954
Service agreement funding - Commonwealth	117,761	97,295	21,878	17,793	45,542	39,040	818	3,665
Grants from other state government agencies	365	458	63	69	113	139	73,192	68,097
Services provided to other government agencies	3,589	3,652	147	92	292	216	(4)	-
Assets (transferred)/assumed	-	589	-	90	-	180	-	-
Resources received free of charge	26,675	21,201	6,768	3,520	10,907	6,048	4,556	3,990
Total income from State Government	389,497	362,817	76,046	58,710	135,445	121,220	81,005	79,706
SURPLUS / (DEFICIT) FOR THE PERIOD	**(14,801)**	**(1,543)**	**(1,289)**	**732**	**(3,228)**	**6,536**	**1,586**	**5,179**

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

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

	Aged and Continuing Care Services [a]		Public and Community Health Services		Total	
	2022	2021	2022	2021	2022	2021
COST OF SERVICES	$000	$000	$000	$000	$000	$000
Expenses						
Employee benefits expense	2,516	1,751	138,203	111,195	645,719	558,987
Fees for visiting medical practitioners	16	12	-	-	2,859	2,693
Contracts for services	4	1	2,014	2,629	9,408	9,453
Patient support costs	533	386	5,485	4,766	114,768	101,975
Finance costs	-	-	109	100	268	255
Depreciation and amortisation expense	330	239	1,824	1,644	61,543	59,601
Asset revaluation decrements	-	-	-	3,683	-	3,723
Loss on disposal of non-current assets	4	-	9	3	659	141
Repairs, maintenance and consumable equipment	112	76	6,329	5,186	29,006	23,214
Other supplies and services	202	133	11,390	8,806	59,023	49,390
Other expenses	86	56	10,087	8,478	29,226	24,337
Total cost of services	3,803	2,654	175,450	146,490	952,479	833,769
Income						
Patient charges	-	-	-	-	21,672	21,787
Other fees for services	188	134	31	58	32,046	30,470
Grants and contributions	51	59	25	23	9,849	13,828
Donation revenue	6	9	-	-	1,161	2,096
Asset revaluation increments	19	-	2,363	477	6,011	605
Other revenue	32	27	206	134	5,683	5,211
Total income other than income from State Government	296	229	2,625	692	76,422	73,997
NET COST OF SERVICES	**3,507**	**2,425**	**172,825**	**145,798**	**876,057**	**759,772**
INCOME FROM STATE GOVERNMENT						
Service agreement funding - State	3,230	2,339	144,014	134,117	516,575	492,775
Service agreement funding - Commonwealth	-	-	11,852	2,031	197,851	159,824
Grants from other state government agencies	3	2	-	63	73,736	68,828
Services provided to other government agencies	8	5	4	16	4,036	3,981
Assets (transferred)/assumed	-	4	-	-	-	863
Resources received free of charge	176	114	9,776	7,495	58,858	42,368
Total income from State Government	3,417	2,464	165,646	143,722	851,056	768,639
SURPLUS / (DEFICIT) FOR THE PERIOD	**(90)**	**39**	**(7,179)**	**(2,076)**	**(25,001)**	**8,867**

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

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	2022 $000	2021 $000
Employee benefits expense	3.1(a)	645,719	558,987
Contracts for services	3.2	9,408	9,453
Patient support costs	3.3	114,768	101,975
Repairs, maintenance and consumable equipment	3.4	29,006	23,214
Other supplies and services	3.5	59,023	49,390
Other expenses	3.6	29,226	24,337

Liabilities incurred in the delivery of services

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

	Notes	2022 $000	2021 $000
Employee benefits provision	3.1(b)	162,632	149,682

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

3.1(a) Employee benefits expense

	2022 $000	2021 $000
Employee benefits	589,926	511,994
Termination benefits	-	470
Superannuation - defined contribution plans	55,793	46,523
	645,719	558,987

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.

Child and Adolescent Health Service
Notes to the financial statements
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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.

	2022 $000	2021 $000
Current		
Employee benefits provisions		
Annual leave [a]	68,122	60,603
Time off in lieu leave [a]	15,354	12,839
Long service leave [b]	52,199	48,664
Deferred salary scheme [c]	1,219	1,211
Professional development leave [d]	1,252	-
	138,146	123,317
Non-Current		
Employee benefits provisions		
Long service leave [b]	24,486	26,365
	24,486	26,365
	162,632	149,682

(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:

	2022 $000	2021 $000
Within 12 months of the end of the reporting period	58,346	51,302
More than 12 months after the end of the reporting period	25,130	22,140
	83,476	73,442

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.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

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:

	2022 $000	2021 $000
Within 12 months of the end of the reporting period	13,090	11,126
More than 12 months after the end of the reporting period	63,595	63,903
	76,685	75,029

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:

	2022 $000	2021 $000
Within 12 months of the end of the reporting period	250	176
More than 12 months after the end of the reporting period	969	1,035
	1,219	1,211

Professional development leave: Classified as current as the unused leave accrued from 1 July 2021 to 30 June 2022 will be paid out to the nurses in July 2022.

	2022 $000	2021 $000
Within 12 months of the end of the reporting period	1,252	-

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

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.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

3.2 Contracts for services

	2022 $000	2021 $000
Neonatal services [a]	6,592	6,512
Community and primary health	2,653	2,604
Other contracts	163	337
	9,408	9,453

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

	2022 $000	2021 $000
Medical supplies and services [a] [b]	95,302	83,787
Domestic charges	10,739	10,249
Food supplies	1,451	1,356
Power and water charges	5,771	5,385
Patient transport costs	1,096	985
Research, development and other grants	409	213
	114,768	101,975

Patient support costs are recognised in the reporting period in which expenses are incurred.

(a) Medical supplies and services include the pathology services received free of charge amounting to $5.695 million from PathWest Laboratory Medicine WA (2021: $5.627 million). See Note 4.1 ‘Income from State Government’.

(b) In accordance with the WA Health COVID-19 Framework, the Health Support Services has provided the Rapid Antigen Test kits free of charge amounting to $7.351 million to the Health Service in the current financial year. See Note 4.1 ‘Income from State Government’.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

3.4 Repairs, maintenance and consumable equipment

	2022 $000	2021 $000
Repairs and maintenance	22,770	19,068
Consumable equipment	6,236	4,146
	29,006	23,214

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

	2022 $000	2021 $000
Facility management services	5,925	6,065
Administrative services	4,528	3,866
Interpreter services	1,039	847
Shared services for accounting [(a)]	796	932
Shared services for human resources [(a)]	5,306	3,270
Shared services for information technology [(a)]	32,732	30,009
Shared services for supply [(a)]	6,449	2,500
Other	2,248	1,901
	59,023	49,390

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’

Child and Adolescent Health Service
Notes to the financial statements
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3.6 Other expenses

	2022 $000	2021 $000
Workers compensation insurance	5,216	2,932
Other insurances	4,213	3,302
Other employee related expenses	1,334	1,033
Communications	1,736	1,743
Computer services	1,676	1,877
Consultancy fees	3,050	2,138
Expected credit losses expense (a)	980	513
Freight and cartage	583	426
Motor vehicle expenses	622	508
Rental expenses (b)	1,456	1,392
Other accommodation expenses (c)	1,280	1,257
Periodical subscription	569	537
Printing and stationery	2,750	2,662
Write-down of assets (d)	-	991
Asset write off - stock take (d)	-	407
Other	3,761	2,619
	29,226	24,337

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

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

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

(c) **Other accommodation expenses** are for outgoing expenses only.

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

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

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	2022 $000	2021 $000
Income from State Government	4.1	851,056	768,639
Patient charges and other fees for services	4.2	53,718	52,257
Grants and contributions	4.3	9,849	13,828
Donations	4.4	1,161	2,096
Other revenue	4.5	5,683	5,211

Child and Adolescent Health Service
Notes to the financial statements
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4.1 Income from State Government

	2022 $000	2021 $000
Service agreement funding received during the period:		
Department of Health - Service agreement - State component	516,575	492,775
Department of Health - Service agreement - Commonwealth component [(i)]	197,851	159,824
Total service agreement funding	714,426	652,599
Grants from other state government agencies during the period:		
Mental Health Commission - Service delivery agreement	73,192	68,097
Department of Health - Research development grant	446	598
Department of Health - COVID-19 vaccination	62	94
Department of Health - Aboriginal cadetship program	36	39
Total grants from other state government agencies	73,736	68,828
Services provided to other state government agencies during the period:		
North Metropolitan Health Service - various clinical services	3,279	3,187
WA Country Health Service - various clinical services	478	752
South Metropolitan Health Service - training for radiology registrars	-	18
Pathwest - infectious diseases program	275	-
Other	4	24
Total services provided to other state government agencies	4,036	3,981
Assets transferred from/(to) other State government agencies during the period:		
Transfer of medical equipment from other Health Services	-	893
Transfer of plant & equipment to other Health Services	-	(30)
Net assets transferred	-	863
Resources received free of charge from other State government agencies during the period:		
Health Support Services - accounting, human resources, information technology and supply services	45,283	36,711
Health Support Services - supply of Rapid Antigen Test Kits	7,351	-
State Solicitor's Office - legal services	495	-
Department of Finance - leasing of accommodation	34	30
PathWest Laboratory Medicine WA - pathology services	5,695	5,627
Total resources received free of charge	58,858	42,368
Total income from State Government	851,056	768,639

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

4.1 Income from State Government (cont.)

(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 the following:

- Cash component; and
- A receivable (asset).

The receivable (holding account – Note 6.2) comprises the following:

- The budgeted depreciation expense; and
- Any agreed increase in leave liabilities up to the 30 June 2017.

(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 TI 955 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').

Child and Adolescent Health Service
Notes to the financial statements
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4.2 Patient charges and other fees for services

	2022 $000	2021 $000
Patient charges [a]		
Inpatient charges	19,228	19,254
Outpatient charges	2,444	2,533
	21,672	21,787
Other fees for services		
Recoveries from the Pharmaceutical Benefits Scheme [b]	28,449	27,287
Clinical services to other health organisations [c]	3,016	2,923
Non clinical services to other health organisations [c]	581	260
	32,046	30,470
	53,718	52,257

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

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

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

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

4.3 Grants and contributions

	2022 $000	2021 $000
Perth Children's Hospital Foundation	2,999	3,599
Telethon Kids Institute	1,243	1,289
Stan Perron Charitable Trust	1,224	578
Channel 7 Telethon Trust	897	4,690
Angela Wright Bennett Foundation	500	400
Raine Medical Research Foundation	355	294
Diabetes Australia	210	-
Murdoch Children's Research Institute	205	95
Rural Health West	190	107
Royal Australasian College of Physicians	158	473
ANZCHOG	145	179
Queensland Health	143	36
The Nova Institute	133	-
Curtin University	125	92
Public Health Institute	120	-
University of Western Australia	116	505
University of Melbourne	101	-
The Children's Hospital of Philadelphia	49	156
Redkite	35	100
Other	901	1,235
	9,849	13,828

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.

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4.4 Donation revenue

	2022 $000	2021 $000
Perth Children's Hospital Foundation - donations of equipment	1,055	1,883
Humpty Dumpty Foundation - donations of medical equipment	-	90
Deceased Estate	50	77
Other	56	46
	1,161	2,096

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

4.5 Other revenue

	2022 $000	2021 $000
Pharmaceutical manufacturing activities	1,863	1,749
Rent from commercial tenants	429	407
Expense recoupment from tenants	2,504	2,134
Immunisation services	126	138
Use of hospital facilities by medical practitioners	12	88
Other	749	695
	5,683	5,211

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

Rent and recoupment of outgoing expenses are received in accordance with the agreements with tenants, and are recognised as revenue on a monthly basis. Insurance premium rebate is recognised as revenue, when the cash is received from RiskCover.

Child and Adolescent Health Service
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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	2022 $000	2021 $000
Property, plant and equipment	5.1	1,125,366	1,084,908
Right-of-use assets	5.2	9,706	9,768
Intangible assets	5.3	20,851	29,370
Total key assets		1,155,923	1,124,046

Depreciation and amortisation expense	Notes	2022 $000	2021 $000
Property, plant and equipment	5.1.1	50,820	49,081
Right-of-use assets	5.2	2,204	2,001
Intangible assets	5.3.1	8,519	8,519
		61,543	59,601

Child and Adolescent Health Service
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5.1 Property, plant and equipment

Year ended 30 June 2022	Land $000	Build-ings $000	Site infra-struc-ture $000	Lease-hold improv e-ments $000	Com-puter equip-ment $000	Furni-ture & fittings $000	Medical equip-ment $000	Motor vehicles, other plant & equip-ment $000	Work in progres s $000	Art-works $000	Total $000
1 July 2021											
Gross carrying amount	23,600	902,134	20,380	1,797	76,656	11,545	108,680	23,003	4,599	5,052	1,177,446
Accumulated depreciation	-	-	(1,682)	(527)	(39,563)	(2,308)	(40,832)	(7,626)	-	-	(92,538)
Carrying amount at start of period	**23,600**	**902,134**	**18,698**	**1,270**	**37,093**	**9,237**	**67,848**	**15,377**	**4,599**	**5,052**	**1,084,908**
Additions	-	478	-	67	21	42	3,874	395	674	15	5,566
Disposals (Note 5.1.2)	-	-	-	-	-	-	(650)	(9)	-	-	(659)
Transfer between asset classes	-	283	-	4,808	-	(179)	-	178	(5,090)		-
Revaluation increments/(decrements) [(b)]	1,070	85,301	-	-	-	-	-	-	-	-	86,371
Depreciation (Note 5.1.1)	-	(19,917)	(479)	(648)	(13,881)	(733)	(12,634)	(2,528)	-	-	(50,820)
Carrying amount at 30 June 2022	**24,670**	**968,279**	**18,219**	**5,497**	**23,233**	**8,367**	**58,438**	**13,413**	**183**	**5,067**	**1,125,366**
Gross carrying amount	24,670	968,279	20,380	6,403	76,677	11,378	111,079	23,764	183	5,067	1,247,880
Accumulated depreciation	-	-	(2,161)	(906)	(53,444)	(3,011)	(52,641)	(10,351)	-	-	(122,514)

(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 classes of assets. In 2021-22, revaluation increment of $1.070 million for land is recognised as an income. For revaluation increment of $85.301 million for buildings, $4.941 million is recognised as an income and $80.360 million is credited to the asset revaluation reserve.

Child and Adolescent Health Service
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5.1 Property, plant and equipment (cont.)

Year ended 30 June 2021	Land $000	Build-ings $000	Site infra-struc-ture $000	Lease -hold improve-ments $000	Com -puter equip -ment $000	Furni -ture & fittings $000	Medical equip -ment $000	Motor vehicles, other plant & equip -ment $000	Work in progress $000	Art-works $000	Total $000
1 July 2020											
Gross carrying amount	24,323	920,689	20,380	598	77,089	11,454	106,271	22,982	777	5,052	**1,189,615**
Accumulated depreciation	-	-	(1,203)	(390)	(27,167)	(1,585)	(29,185)	(5,258)	-	-	**(64,788)**
Carrying amount at start of period	**24,323**	**920,689**	**19,177**	**208**	**49,922**	**9,869**	**77,086**	**17,724**	**777**	**5,052**	**1,124,827**
Additions	-	711	-	1,225	6	100	3,813	290	3,822	-	9,967
Transfer from other agencies [(a)]	3,000	-	-	-	-	-	-	-	-	-	3,000
Transfer from/(to) other Health Services (Note 4.1)	-	-	-	-	-	-	893	(30)	-	-	863
Disposals (Note 5.1.2)	-	-	-	-	-	-	(149)	(3)	-	-	(152)
Revaluation increments/(decrements) [(b)]	(3,723)	605	-	-	-	-	-	-	-	-	(3,118)
Depreciation (Note 5.1.1)	-	(19,871)	(479)	(137)	(12,835)	(726)	(12,556)	(2,477)	-	-	(49,081)
Asset write offs - stock take (Note 3.6)	-	-	-	-	-	(5)	(372)	(30)	-	-	(407)
Write-down of assets (Note 3.6)	-	-	-	(26)	-	(1)	(867)	(97)	-	-	(991)
Carrying amount at 30 June 2021	**23,600**	**902,134**	**18,698**	**1,270**	**37,093**	**9,237**	**67,848**	**15,377**	**4,599**	**5,052**	**1,084,908**
Gross carrying amount	23,600	902,134	20,380	1,797	76,656	11,545	108,680	23,003	4,599	5,052	1,177,446
Accumulated depreciation	-	-	(1,682)	(527)	(39,563)	(2,308)	(40,832)	(7,626)	-	-	(92,538)

(a) A crown land was transferred from the Department of Planning, Lands and Heritage for the Perth Children's Hospice. The transfer was accounted for as contributions by owners (Note 9.12 Equity). During the transfer of crown land for the Perth Children's Hospice site, there was incorrect information provided by Landgate on the land value resulting in overstatements of Property, plant and equipment and Contributed Equity by $12.700 million. See Note 9.15 for correction of prior period error on land value transferred.

(b) Revaluation increment is recorded in the asset revaluation reserve, except to the extent that any increment reverses a revaluation decrement of the same class of assets previously recognised as an expense. Revaluation decrement is recognised as an expense, except to the extent of any balance existing in the asset revaluation reserve in respect of that classes of assets. In 2020-21, revaluation decrement of $3.723 million for land is recognised as an expense and revaluation increment of $0.605 million for buildings is recognised as an income.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

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) and recognised annually to ensure that the carrying amount does not differ materially from the asset's fair value at the end of the reporting period.

Land and buildings were revalued as at 1 July 2021 by Landgate. The valuations were performed during the year ended 30 June 2022 and recognised at 30 June 2022. In undertaking the revaluation, fair value was determined by reference to market values for land: $0.675 million (2021: $0.625 million) and buildings: $0.080 million (2021: $0.080 million). For the remaining balance, fair value of buildings was determined on the basis of current replacement cost and fair value of land was determined on the basis of comparison with market evidence for land with low level utility (high restricted use land).

Revaluation model:

(a) Fair Value where market-based evidence is available:

The fair value of land and buildings is determined on the basis of current market values determined by reference to recent market transactions.

Child and Adolescent Health Service
Notes to the financial statements
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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	2022 $000	2021 $000
Depreciation			
Buildings	5.1	19,917	19,871
Site infrastructure	5.1	479	479
Leasehold improvement	5.1	648	137
Medical equipment	5.1	12,634	12,556
Computer equipment	5.1	13,881	12,835
Furniture and fittings	5.1	733	726
Motor vehicles, other plant and equipment	5.1	2,528	2,477
Total depreciation for the period		**50,820**	**49,081**

As at 30 June 2022 there were no indications of impairment to property, plant and equipment.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

5.1.1 Depreciation and impairment (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	2 to 10 years
Furniture and fittings	3 to 20 years
Motor vehicles	4 to 10 years
Medical equipment	2 to 20 years
Other plant and equipment	2 to 20 years

Land and artworks, which are considered to have an indefinite useful life, are not depreciated. Depreciation is not recognised in respect of these assets because their service potential has not, in any material sense, been consumed during the reporting period.

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

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

5.1.1 Depreciation and impairment (cont.)

Impairment (cont.)

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

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

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

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

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

	2022 $000	2021 $000
Carrying amount of non-current assets disposed:		
Property, plant and equipment	(659)	(152)
Proceeds from disposal of non-current assets:		
Property, plant and equipment	-	11
Net gain/(loss) on disposal of non-current assets	(659)	(141)

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.

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For the year ended 30 June 2022

5.2 Right-of-use assets

Year ended 30 June 2022	Buildings $000	Vehicles $000	Total $000
1 July 2021			
Gross carrying amount	10,966	1,714	12,680
Accumulated depreciation	(2,074)	(838)	(2,912)
Carrying amount at start of period	8,892	876	9,768
Additions	1,537	591	2,128
Adjustments	-	28	28
Disposals	-	(14)	(14)
Depreciation	(1,728)	(476)	(2,204)
Carrying amount at 30 June 2022	8,701	1,005	9,706
Gross carrying amount	12,325	2,018	14,343
Accumulated depreciation	(3,624)	(1,013)	(4,637)

Year ended 30 June 2021	Buildings $000	Vehicles $000	Total $000
1 July 2020			
Gross carrying amount	9,996	1,535	11,531
Accumulated depreciation	(829)	(446)	(1,275)
Carrying amount at start of period	9,167	1,089	10,256
Additions	847	246	1,093
Adjustments	412	19	431
Disposals	-	(11)	(11)
Depreciation	(1,534)	(467)	(2,001)
Carrying amount at 30 June 2021	8,892	876	9,768
Gross carrying amount	10,966	1,714	12,680
Accumulated depreciation	(2,074)	(838)	(2,912)

Child and Adolescent Health Service
Notes to the financial statements
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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 a Memorandum of Understanding Agreements (MOU) with the Department of Finance for the leasing of office accommodation. These are not recognised under AASB 16 because of substitution rights held by the Department of Finance and are accounted for as an expense as incurred.

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 recognises 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.

Child and Adolescent Health Service
Notes to the financial statements
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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	2022 $000	2021 $000
Depreciation expense of right-of-use assets	5.2	2,204	2,001
Lease interest expense	7.2	268	255
Short-term leases		13	30
Low-value leases		7	12
Total amount recognised in the Statement of Comprehensive Income		2,492	2,298

The total cash outflow for leases in 2022 was $2.311 million (2021: $2.091 million). As at 30 June 2022 there were no indications of impairment to right-of-use assets.

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5.3 Intangible assets

Computer software	2022 $000	2021 $000
Carrying amount at start of period	29,370	37,889
Amortisation expense (Note 5.3.1)	(8,519)	(8,519)
Carrying amount at 30 June	20,851	29,370
Gross carrying amount	55,638	55,638
Accumulated amortisation	(34,787)	(26,268)
	20,851	29,370

Initial recognition

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

Acquisitions of intangible assets costing $5,000 or more and internally generated intangible assets costing $5,000 or more, that comply with the recognition criteria of AASB 138.57 *Intangible Assets*, are capitalised.

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

Child and Adolescent Health Service
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5.3 Intangible assets (cont.)

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

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

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

(c) The ability to use the intangible asset;

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

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

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

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

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

Subsequent measurement

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

Child and Adolescent Health Service
Notes to the financial statements
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5.3.1 Amortisation and impairment

Charges for the period

Amortisation	2022 $000	2021 $000
Computer software	8,519	8,519
Total amortisation for the period	**8,519**	**8,519**

The Health Service held no goodwill or intangible assets with an indefinite useful life during the reporting period. At the end of the reporting period there were no intangible assets not yet available for use.

Amortisation of finite life intangible assets is calculated on a straight line basis at rates that allocate the asset's value over its estimated useful life. All intangible assets controlled by the Health Service have a finite useful life and zero residual value. Estimated useful lives are reviewed annually.

The estimated useful lives for each class of intangible asset are:

Computer software [(a)]	5 to 10 years

(a) Software that is not integral to the operation of any related hardware.

Impairment

Intangible assets with finite useful lives are tested for impairment annually or when an indication of impairment is identified. The policy in connection with testing for impairment is outlined in Note 5.1.1.

As at 30 June 2022 there were no indications of impairment to intangible assets.

Child and Adolescent Health Service
Notes to the financial statements
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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	2022 $000	2021 $000
Receivables	6.1	11,962	11,490
Amount receivable for services	6.2	470,279	408,937
Inventories	6.3	5,551	3,580
Other current assets	6.4	1,033	909
Payables	6.5	32,213	29,999
Contract liabilities	6.6	119	89
Other liabilities	6.7	125	83

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6.1 Receivables

	2022 $000	2021 $000
Current		
Patient fee debtors	5,827	5,410
GST receivable	653	761
Receivable from North Metropolitan Health Service	1,065	-
Other receivables	3,732	3,996
Allowance for impairment of receivables	(3,450)	(2,581)
Accrued revenue	4,135	3,904
	11,962	**11,490**

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.

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.

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6.1.1 Movement of the allowance for impairment of receivables

	2022	2021
	$000	$000
Reconciliation of changes in the allowance for impairment of receivables:		
Balance at start of period	2,581	3,729
Expected credit losses expense	980	513
Amount written off during the period	(111)	(1,661)
Balance at end of period	3,450	2,581

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)

	2022	2021
	$000	$000
Current	-	-
Non-Current	470,279	408,937
	470,279	**408,937**

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.

Child and Adolescent Health Service
Notes to the financial statements
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6.3 Inventories

	2022 $000	2021 $000
Current		
Pharmaceutical stores - at cost	5,551	3,580

Inventories are measured at the lower of cost and net realisable value. Costs are assigned on a weighted average cost basis.

Inventories not held for resale are measured at cost unless they are no longer required, in which case they are measured at net realisable value.

6.4 Other assets

	2022 $000	2021 $000
Current		
Prepayments	964	850
Unearned patient charges	68	56
Others	1	3
	1,033	909

Other non-financial assets include prepayments which represent payments in advance of receipt of goods or services or that part of expenditure made in one accounting period covering a term extending beyond that period.

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6.5 Payables

	2022 $000	2021 $000
Current		
Trade payables	6,268	6,458
Other payables	43	52
Accrued expenses	8,826	8,464
Accrued salaries	17,076	15,025
	32,213	29,999

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

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

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

The accrued salaries suspense account (See 'Restricted cash and cash equivalents' in Note 7.3.1) consists of amounts paid annually into a Treasury suspense account to meet the additional cash outflow for employee salary payments in the reporting periods with 27 pay days instead of the normal 26. No interest is received on this account.

Child and Adolescent Health Service
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6.6 Contract liabilities

	2022 $000	2021 $000
Current	119	89
Non-current	-	-
	119	89

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

6.6.1 Movement in contract liabilities

	2022 $000	2021 $000
Reconciliation of changes in contract liabilities		
Opening balance	89	53
Additions	119	89
Revenue recognised in the reporting period	(89)	(53)
Balance at end of period	119	89

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

6.7 Other liabilities

	2022 $000	2021 $000
Current		
Paid parental leave scheme	125	83
	125	83

Child and Adolescent Health Service
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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 cash flows used in operating activities	7.3.2
Reconciliation of cash flows from State Government	7.3.3
Capital commitments	7.4

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7.1 Lease liabilities

	2022 $000	2021 $000
Current	1,760	1,858
Non-current	8,403	8,214
Total lease liabilities	10,163	10,072

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.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

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

	2022 $000	2021 $000
Lease interest expense	268	255
	268	**255**

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.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

7.3 Cash and cash equivalents

7.3.1 Reconciliation of cash

	2022 $000	2021 $000
Cash and cash equivalents	50,219	67,836
Restricted cash and cash equivalents		
Current		
Capital work projects	5,678	2,584
Mental Health Commission Funding [(a)]	2,091	2,006
Restricted cash assets held for other specific purposes [(b)]	11,243	12,784
	19,012	17,374
Non-current		
Accrued Salaries Suspense Account [(c)]	12,672	9,972
Total restricted cash and cash equivalents	31,684	27,346
Balance at end of period	**81,903**	**95,182**

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

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

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

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

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

Child and Adolescent Health Service
Notes to the financial statements
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7.3.2 Reconciliation of net cost of services to net cash flows used in operating activities

	Notes	2022 $000	2021 $000
Net cost of services (Statement of Comprehensive Income)		(876,057)	(759,772)
Non-cash items:			
Expected credit losses expense	3.6	980	513
Write off of inventory		16	8
Depreciation and amortisation expense	5	61,543	59,601
Asset revaluation decrement	5.1	-	3,723
Asset revaluation increment	5.1	(6,011)	(605)
Net gain/(loss) from disposal of non-current assets	5.1.2	659	141
Write down of assets	3.6	-	991
Asset write off	3.6	-	407
Interest capitalised		2	2
Donations of assets	4.4	(852)	(1,636)
Services received free of charge	4.1	58,858	42,368
(Increase)/decrease in assets:			
Receivables		(1,452)	(1,600)
Inventories		(1,987)	(626)
Other current assets		(108)	(264)
Increase/(Decrease) in liabilities:			
Payables		2,309	(5,976)
Current provisions		14,829	15,631
Non-current provisions		(1,879)	(4,975)
Grant liabilities		-	(945)
Contract liabilities		30	36
Other current liabilities		42	(6)
Net cash used in operating activities (Statement of Cash Flows)		**(749,078)**	**(652,984)**

Child and Adolescent Health Service
Notes to the financial statements
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7.3.3 Reconciliation of cash flows from State Government

	2022 $000	2021 $000
Service agreement funding - State	516,575	492,775
Service agreement funding - Commonwealth	197,851	159,824
Grants from other state government agencies	73,736	68,828
Services provided to other government agencies	4,036	3,981
Capital appropriation credited directly to Contributed equity (refer Note 9.12)	11,821	11,769
	804,019	737,177
Less notional cash flows:		
Accrual appropriations	(61,342)	(62,580)
Cash Flows from State Government as per Statement of Cash Flows	742,677	674,597

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

	2022 $000	2021 $000
Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows:		
Within 1 year	2,052	211
Later than 1 year, and not later than 5 years	648	-
	2,700	211

Amounts presented for capital expenditure commitments are GST inclusive.

Child and Adolescent Health Service
Notes to the financial statements
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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

Child and Adolescent Health Service
Notes to the financial statements
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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 long-term debt obligations.

Child and Adolescent Health Service
Notes to the financial statements
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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:

	2022 $000	2021 $000
Financial Assets		
Cash and cash equivalents	50,219	67,836
Restricted cash and cash equivalents	31,684	27,346
Financial assets at amortised cost [(a)]	481,588	419,666
	563,491	**514,848**
Financial Liabilities		
Financial liabilities measured at amortised cost	42,376	40,071
	42,376	**40,071**

(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 2022							
Expected credit loss rate		9%	16%	27%	25%	65%	83%
Estimated total gross carrying amount at default	9,127	3,122	903	635	1,279	679	2,509
Expected credit losses	(3,450)	(293)	(144)	(174)	(315)	(443)	(2,081)
30 June 2021							
Expected credit loss rate		3%	7%	17%	23%	55%	69%
Estimated total gross carrying amount at default	9,874	4,571	626	360	1,127	1,015	2,175
Expected credit losses	(2,582)	(149)	(46)	(60)	(263)	(554)	(1,510)

Child and Adolescent Health Service
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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
2022										
Financial Assets										
Cash and cash equivalents		50,219	-	-	50,219	50,219	50,219	-	-	-
Restricted cash and cash equivalents		31,684	-	-	31,684	31,684	19,012	-	-	12,672
Receivables [(a)]		11,309	-	-	11,309	11,309	11,309	-	-	-
Amounts receivable for services		470,279	-	-	470,279	470,279	-	-	-	470,279
		563,491	-	-	563,491	563,491	80,540	-	-	482,951
Financial Liabilities										
Payables		32,213	-	-	32,213	32,213	32,213	-	-	-
Lease liabilities	2.65%	10,163	10,163	-	-	11,449	522	1,420	5,413	4,094
		42,376	10,163	-	32,213	43,662	32,735	1,420	5,413	4,094

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

Child and Adolescent Health Service
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8.1 Financial risk management (cont.)

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

	Weighted average effective interest rate %	Carrying amount $000	Interest rate exposure: Fixed interest rate $000	Interest rate exposure: Variable interest rate $000	Interest rate exposure: Non-interest bearing $000	Nominal Amount $000	Maturity dates: Up to 3 months $000	Maturity dates: 3 months to 1 year $000	Maturity dates: 1-5 years $000	Maturity dates: More than 5 years $000
2021										
Financial Assets										
Cash and cash equivalents		67,836	-	-	67,836	67,836	67,836	-	-	-
Restricted cash and cash equivalents		27,346	-	-	27,346	27,346	17,374	-	-	9,972
Receivables [(a)]		10,729	-	-	10,729	10,729	10,729	-	-	-
Amounts receivable for services		408,937	-	-	408,937	408,937	-	-	-	408,937
		514,848	-	-	514,848	514,848	95,939	-	-	418,909
Financial Liabilities										
Payables		29,999	-	-	29,999	29,999	29,999	-	-	-
Lease liabilities	2.49%	10,072	10,072	-	-	11,424	542	1,521	4,744	4,617
		40,071	10,072	-	29,999	41,423	30,541	1,521	4,744	4,617

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

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

8.2 Contingent assets and liabilities

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

8.2.1 Contingent assets

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

8.2.2 Contingent liabilities

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

Litigation in progress

The Health Service does not have any pending litigation that are not recoverable from RiskCover insurance at the reporting date.

Contaminated sites

Under the *Contaminated Sites Act 2003*, the Health Service is required to report known and suspected contaminated sites to the Department of Water and Environmental Regulation (DWER). In accordance with the Act, DWER classifies these sites on the basis of the risk to human health, the environment and environmental values.

Where sites are classified as contaminated – remediation required or possibly contaminated – investigation required, the Health Service may have a liability in respect of investigation or remediation expenses.

At the reporting date, the Health Service does not have any suspected contaminated sites reported under the Act.

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Notes to the financial statements
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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:

2022	Notes	Level 1 $000	Level 2 $000	Level 3 $000	Fair value at end of period $000
Land	5.1				
Residential		-	675	-	675
Specialised		-	-	23,995	23,995
Buildings	5.1				
Residential		-	80	-	80
Specialised		-	-	968,199	968,199
		-	755	992,194	992,949
2021					
Land	5.1				
Residential		-	625	-	625
Specialised		-	-	22,975	22,975
Buildings	5.1				
Residential		-	80	-	80
Specialised		-	-	902,054	902,054
		-	705	925,029	925,734

There were no transfers between Levels 1, 2 or 3 during the current and previous periods.

Child and Adolescent Health Service
Notes to the financial statements
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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.

Child and Adolescent Health Service
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8.3 Fair value measurements (cont.)

Fair value measurements using significant unobservable inputs (Level 3)

2022	Land $000	Buildings $000
Fair value at start of period	22,975	902,054
Reclassification between asset classes	-	283
Additions	-	478
Revaluation increments/(decrements) recognised in Profit or Loss	1,020	4,941
Revaluation increments/(decrements) recognised in Other Comprehensive Income	-	80,360
Depreciation expense	-	(19,917)
Fair Value at end of period	**23,995**	**968,199**
2021		
Fair value at start of period	23,720	920,587
Transfer from other agencies	3,000	-
Additions	-	711
Revaluation increments/(decrements) recognised in Profit or Loss	(3,745)	625
Depreciation expense	-	(19,869)
Fair Value at end of period	**22,975**	**902,054**

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.

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8.3 Fair value measurements (cont.)

Fair value of the land is then determined on the assumption that the site is rehabilitated to a vacant marketable condition. This requires costs associated with rehabilitation to be deducted from the hypothetical alternate land use value of the land. Costs may include building demolition, clearing, planning approvals and time allowances associated with realising that potential.

In some instances the legal, physical, economic and socio political restrictions on a land results in a minimal or negative current use land value. In this situation the land value adopted is the higher of the calculated rehabilitation amount or the amount determined on the basis of comparison to market corroborated evidence of land with low level utility. Land of low level utility is considered to be grazing land on the urban fringe of the metropolitan area with no economic farming potential or foreseeable development or redevelopment potential at the measurement date.

Buildings (Level 3 fair values)

The Health Service's hospital and medical centres are specialised buildings valued under the cost approach. This approach uses the depreciated replacement cost method which estimates the current cost of reproduction or replacement of the buildings, on its current site, less deduction for physical deterioration and relevant forms of obsolescence. Depreciated replacement cost is the current replacement cost of an asset less, where applicable, accumulated depreciation calculated on the basis of such cost to reflect the already consumed or expired future economic benefits of the asset.

The techniques involved in the determination of the current replacement costs include:

a) Review and updating of the 'as-constructed' drawing documentation;

b) Categorisation of the drawings using the Building Utilisation Categories (BUC's) which designate the functional areas within the clinical facilities. Each BUC has different cost rates which are calculated from the historical construction costs of similar clinical facilities and are adjusted for the year-to-year change in building costs using building cost index;

c) Measurement of the general floor areas;

d) Application of the BUC cost rates per square meter of general floor areas.

The maximum effective age used in the valuation of specialised buildings is 50 years. The effective age of buildings is initially calculated from the commissioning date, and is reviewed after the buildings have undergone substantial renewal, upgrade or expansion.

The straight line method of depreciation is applied to derive the depreciated replacement cost, assuming a uniform pattern of consumption over the initial 37 years of asset life (up to 75% of current replacement costs). All specialised buildings are assumed to have a residual value of 25% of their current replacement costs.

The valuations are prepared on a going concern basis until the year in which the current use is discontinued.

Buildings with definite demolition plan are not subject to annual revaluation. The depreciated replacement costs at the last valuation dates for these buildings are written down to the Statement of Comprehensive Income as depreciation expenses over their remaining useful life.

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9. Other disclosures

This section includes additional material disclosures required by accounting standards or other pronouncements, for the understanding of this financial report.

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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 Future impact of Australian Accounting Standards not yet operative

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

		Operative for reporting periods beginning on/after
AASB 2020-1	*Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-current* This Standard amends AASB 101 to clarify requirements for the presentation of liabilities in the statement of financial position as current or non-current. There is no financial impact.	1 Jan 2023
AASB 2020-3	*Amendments to Australian Accounting Standards – Annual Improvements 2018–2020 and Other Amendments* This Standard amends: (a) AASB 1 to simplify the application of AASB 1; (b) AASB 3 to update a reference to the Conceptual Framework for Financial Reporting; (c) AASB 9 to clarify the fees an entity includes when assessing whether the terms of a new or modified financial liability are substantially different from the terms of the original financial liability; (d) AASB 116 to require an entity to recognise the sales proceeds from selling items produced while preparing property, plant and equipment for its intended use and the related cost in profit or loss, instead of deducting the amounts received from the cost of the asset; (e) AASB 137 to specify the costs that an entity includes when assessing whether a contract will be loss-making; and (f) AASB 141 to remove the requirement to exclude cash flows from taxation when measuring fair value. There is no financial impact.	1 Jan 2022
AASB 2020-6	*Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-current – Deferral of Effective Date* This Standard amends AASB 101 to defer requirements for the presentation of liabilities in the statement of financial position as current or non-current that were added to AASB 101 in AASB 2020-1. There is no financial impact.	1 Jan 2022

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

		Operative for reporting periods beginning on/after
AASB 2021-2	*Amendments to Australian Accounting Standards – Disclosure of Accounting Policies and Definition of Accounting Estimates* This Standard amends: (a) AASB 7, to clarify that information about measurement bases for financial instruments is expected to be material to an entity's financial statements; (b) AASB 101, to require entities to disclose their material accounting policy information rather than their significant accounting policies; (c) AASB 108, to clarify how entities should distinguish changes in accounting policies and changes in accounting estimates; (d) AASB 134, to identify material accounting policy information as a component of a complete set of financial statements; and (e) AASB Practice Statement 2, to provide guidance on how to apply the concept of materiality to accounting policy disclosures. There is no financial impact.	1 Jan 2023
AASB 2021-6	*Amendments to Australian Accounting Standards – Disclosure of Accounting Policies: Tier 2 and Other Australian Accounting Standards* This standard amends AASB 1054 to reflect the updated accounting policy terminology used in AASB 101 Presentation of Financial Statements. There is no financial impact.	1 Jan 2023

9.3 Remuneration of auditors

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

	2022 $000	2021 $000
Auditing the accounts, financial statements, controls, and key performance indicators	226	220

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9.4 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 ($)	**2022**	**2021**
$0	1	1
$1 - $10,000	1	1
$20,001 - $30,000	1	-
$40,001 - $50,000	7	8
$70,001 - $80,000	-	1
$80,001 - $90,000	1	-
Total number of members of the Accountable Authority	11	11

	2022 $000	**2021 $000**
Short-term employee benefits	399	404
Post-employment benefits	40	38
Total compensation of members of the Accountable Authority	**439**	**442**

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9.4 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 ($)	2022	2021
$170,001 - $180,000	2	-
$200,001 - $210,000	-	1
$210,001 - $220,000	1	1
$220,001 - $230,000	3	1
$230,001 - $240,000	-	1
$240,001 - $250,000	-	1
$490,001 - $500,000	1	-
$500,001 - $510,000	-	1
$540,001 - $550,000	-	1
$570,001 - $580,000	1	-
$580,001 - $590,000	-	1
Total number of senior officers	8	8

	2022 $000	2021 $000
Short-term employee benefits	1,888	1,841
Post-employment benefits	221	216
Other long-term benefits	208	198
Termination benefits	-	470
Ex-gratia payment	-	55
Total compensation of senior officers	**2,317**	**2,780**

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

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9.5 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).

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9.5 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	2022 $000	2021 $000
Income			
Service agreement funding - State	4.1	516,575	492,775
Service agreement funding - Commonwealth	4.1	197,851	159,824
Mental Health Commission - Service delivery agreement	4.1	73,192	68,097
Department of Health - Research development grant	4.1	446	598
Department of Health grant - COVID-19 vaccination	4.1	62	94
Department of Health grant - Aboriginal Cadetship Program	4.1	36	39
North Metropolitan Health Service - various clinical services	4.1	3,279	3,187
WA Country Health Service - various clinical services	4.1	478	752
South Metropolitan Health Service - training for radiology registrars	4.1	-	18
Assets assumed/(transferred)	4.1	-	863
Services received free of charge	4.1	58,858	42,368
Expenses			
Contracts for services - North Metropolitan Health Service [(a)]		6,592	6,512
Facility management services - North Metropolitan Health Service [(a)]		5,925	6,065
Contracts for services - Department of Communities [(a)]		529	522
Insurance payments - Insurance Commission (RiskCover)		9,448	6,291
Rental and other accommodation expenses - Department of Finance [(a)]		1,242	1,125
Lease interest expense - State Fleet	7.2	33	31
Remuneration for audit services - Office of the Auditor General	9.3	226	220

(a) These transactions are included at Note 3.2 ‘Contracts for services’, Note 3.5 ‘Other supplies and services’ and Note 3.6 ‘Other expenses’.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

9.5 Related party transactions (cont.)

Significant transactions with Government-related entities (cont.)

	Notes	2022 $000	2021 $000
Assets			
Receivables at 30 June - North Metropolitan Health Service	6.1	1,065	-
Liabilities			
Payables at 30 June - North Metropolitan Health Service	6.5	-	180
Lease liabilities at 30 June - State Fleet	7.1	1,031	935
Repayments of lease liabilities - State Fleet		542	461
Contributed Equity			
Capital appropriations administered by Department of Health	9.12	11,821	11,769
Transfer of assets from/(to) state government agencies	9.12	-	3,000

Material transactions with other related parties

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

	2022 $000	2021 $000
Superannuation payments to GESB	42,596	37,532
Payable to GESB	1,410	1,169

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.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

9.6 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.

9.7 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.

9.8 Services provided free of charge

During the reporting period, the following services were provided to other agencies free of charge:

	2022 $000	2021 $000
Department for Communities - health assessments for children in care	245	275
Disability Services Commission - paediatric services for children with disability [(a)]	-	3,243
Department of Education - school health services	13,266	15,118
	13,511	18,636

(a) As a result of the transition of disability services to the National Disability Insurance Scheme, the service delivery arrangement between the Health Service and the Disability Service Commission has ceased.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

9.9 Other statement of receipts and payments

	2022 $000	2021 $000
Commonwealth Grant - Christmas and Cocos Island		
Balance at the start of period	(52)	(30)
Receipts		
Commonwealth grant - provision of paediatric services	139	69
Refund of Commonwealth grant [(a)]	8	-
Payments		
Costs of visiting specialists	(95)	(91)
Balance at the end of period	**-**	**(52)**

(a) The refund is for reduction of $8,175 in costs for 2020-21.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

9.10 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*.

	2022 $000	2021 $000
Balance at the start of period	2,006	2,175
Receipts		
Service delivery agreement - Commonwealth contributions	15,520	11,222
Service delivery agreement - State contributions	57,672	56,456
Other	-	419
	73,192	68,097
Payments	(73,108)	(68,266)
	84	(169)
Balance at the end of period	**2,090**	**2,006**

9.11 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.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

9.12 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.

	2022 $000	2021 $000
Contributed equity		
Balance at start of period	1,454,126	1,439,357
Contributions by owners		
Capital appropriations administered by Department of Health [(a)]	11,821	11,769
Transfer of net assets from other agencies [(b)]		
Crown land from the Department of Planning, Lands and Heritage [(c)]	-	3,000
Total contributions by owners	**11,821**	**14,769**
Distributions to owners	**-**	**-**
Balance at end of period	**1,465,947**	**1,454,126**

(a) Treasurer's Instruction (TI) 955 '*Contributions by Owners Made to Wholly Owned Public Sector Entities*' designates capital appropriations as contributions by owners in accordance with AASB Interpretation 1038 *'Contributions by Owners Made to Wholly-Owned Public Sector Entities*'.

(b) AASB 1004 '*Contributions*' requires transfers of net assets as a result of a restructure of administrative arrangements to be accounted for as contributions by owners and distributions to owners. TI 955 designates non-discretionary and non-reciprocal transfers of net assets between state government agencies as contributions by owners in accordance with AASB Interpretation 1038. Where the transferee agency accounts for a non-discretionary and non-reciprocal transfer of net assets as a contribution by owners, the transferor agency accounts for the transfer as a distribution to owners.

(c) In the 2020-21 financial year, a crown land was transferred from the Department of Planning, Lands and Heritage for the Perth Children's Hospice. During the transfer of crown land for the Perth Children's Hospice site, there was incorrect information provided by Landgate on the land value resulting in overstatements of Property, plant and equipment and Contributed Equity by $12.700 million. See Note 9.15 for correction of prior period error on land value transferred.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

9.12 Equity (cont.)

	2022 $000	2021 $000
Assets revaluation reserve		
Balance at start of period	-	-
Net revaluation increments/(decrements) [(a) (b)]		
Buildings	80,360	-
Balance at end of period	80,360	-

(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.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

9.13 Supplementary financial information

(a) Revenue, public and other property written off

	2022 $000	2021 $000
Revenue and debts written off under the authority of the Accountable Authority	130	1,745
Revenue and debts written off under the authority of the Minister	184	-
Public and other property written off under the authority of the Accountable Authority	407	-
	721	1,745

(b) Losses through theft, defaults and other causes

	2022 $000	2021 $000
Losses of public money and pubic and other property through theft or default	7	-
Amounts recovered	(7)	-
	-	-

(c) Gifts of public property

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

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

9.14 Explanatory statement

All variances between annual estimates (original budget) and actual results for 2022 and between the actual results for 2022 and 2021 are shown below. Narratives are provided for key major variances, which are greater than 10% from the Estimate and 2021 Actuals and greater than 1% ($8.338 million) of Total Cost of Services for the previous year for the Statement of Comprehensive Income and Statement of Cash Flows, and are greater than 10% from the Estimate and 2021 Actuals and greater than 1% ($16.441 million) of Total Assets for the previous year for the Statement of Financial Position.

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

9.14.1 Statement of Comprehensive Income Variances

	Variance note	Estimate 2022 $000	Actual 2022 $000	Actual 2021 $000	Variance between estimate and actual $000	Variance between actual results for 2022 and 2021 $000
Expenses						
Employee benefits expense	(g)	593,035	645,719	558,987	52,684	86,732
Fees for visiting medical practitioners		2,706	2,859	2,693	153	166
Contracts for services		13,728	9,408	9,453	(4,320)	(45)
Patient support costs	(a) (h)	93,300	114,768	101,975	21,468	12,793
Finance costs		253	268	255	15	13
Depreciation and amortisation expense		60,676	61,543	59,601	867	1,942
Asset revaluation decrements		-	-	3,723	-	(3,723)
Loss on disposal of non-current assets		-	659	141	659	518
Repairs, maintenance and consumable equipment	(b)	17,941	29,006	23,214	11,065	5,792
Other supplies and services	(c) (i)	46,595	59,023	49,390	12,428	9,633
Other expenses	(d)	11,623	29,226	24,337	17,603	4,889
Total cost of services		**839,857**	**952,479**	**833,769**	**112,622**	**118,710**

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

9.14.1 Statement of Comprehensive Income Variances (cont.)

	Variance note	Estimate 2022 $000	Actual 2022 $000	Actual 2021 $000	Variance between estimate and actual $000	Variance between actual results for 2022 and 2021 $000
Revenue						
Patient charges		22,213	21,672	21,787	(541)	(115)
Other fees for services		32,613	32,046	30,470	(567)	1,576
Grants and contributions		6,640	9,849	13,828	3,209	(3,979)
Donation revenue		986	1,161	2,096	175	(935)
Asset revaluation increments		-	6,011	605	6,011	5,406
Other revenue		4,666	5,683	5,211	1,017	472
Total income other than income from State Government		**67,118**	**76,422**	**73,997**	**9,304**	**2,425**
NET COST OF SERVICES		**772,739**	**876,057**	**759,772**	**103,318**	**116,285**
INCOME FROM STATE GOVERNMENT						
Service agreement funding - State		515,249	516,575	492,775	1,326	23,800
Service agreement funding - Commonwealth	(e) (j)	148,581	197,851	159,824	49,270	38,027
Grants from other state government agencies		73,439	73,736	68,828	297	4,908
Services provided to other government agencies		1,858	4,036	3,981	2,178	55
Assets (transferred)/assumed		-	-	863	-	(863)
Resources received free of charge	(f) (k)	33,612	58,858	42,368	25,246	16,490
Total income from State Government		**772,739**	**851,056**	**768,639**	**78,317**	**82,417**
SURPLUS / (DEFICIT) FOR THE PERIOD		**-**	**(25,001)**	**8,867**	**(25,001)**	**(33,868)**
OTHER COMPREHENSIVE INCOME						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve		-	80,360	-	80,360	80,360
Total other comprehensive income		-	80,360	-	80,360	80,360
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**-**	**55,359**	**8,867**	**55,359**	**46,492**

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

9.14.1 Statement of Comprehensive Income Variances (cont.)

Major Variance Narratives

Variances between estimates and actuals

(a) The variance in patient support costs against budget is largely due to increase in medical, surgical and diagnostic costs associated with Covid-19 RATS test kits supplied as resources received free of charge from Health Support Services. The additional spending on medical and surgical instruments to maintain existing and additional beds was also supported by the increased funding provided following the Government's Mid-Year Review.

(b) The amount expended above budget is mainly due to increase in repairs and maintenance for Information, Communication and Technology (ICT) and medical equipment, the costs on defect rectification for the G Block link bridge, and equipment that do not meet the asset capitalisation threshold.

(c) Other supplies and services are above the estimate largely due to increased expenses associated with information technology, supply, accounting and human resource services received free of charge from Health Support Services. Budget adjustments were received during the financial year for these services.

(d) Other expenses are above the estimate largely due to Covid-19 expenses which were not funded at time of preparation of the estimates and increase in insurance premium paid to the Insurance Commission of Western Australia. Budget adjustments were received during the financial year for the Covid-19 expenses.

(e) Increase in actual Service Agreement funding from Commonwealth primarily relates to increases in National Health Reform Agreement funding under the National Partnership Agreement for the Covid-19 response and additional funding for activity increases during the financial year.

(f) Increase in resources received free of charge relates mainly to services provided by Health Support Services for information technology, supply, accounting and human resources, as well as support for Covid-19 management and response.

Child and Adolescent Health Service
Notes to the financial statements
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9.14.1 Statement of Comprehensive Income Variances (cont.)

Major Variance Narratives (cont.)

Variances between actuals for 2021-22 and 2020-21

(g) The increase in employee benefits expense is mainly due to increased staffing costs to address continuing cost pressures in clinical areas, largely associated with the Government's announcement for additional beds within Wards and Emergency Department, and staff uplift to increase hospital workforce capacity to ensure preparedness for Covid-19 management and responses.

(h) The increase in patient support costs is primarily associated with Covid-19 RATS test kits received as free of charge from Health Support Services, and increased medical, surgical and diagnostic costs for activity associated with the Government's announcement for additional beds within Wards and Emergency Department.

(i) The increase in other supplies and services is largely due to increases in resources received free of charge from Health Support Services for information technology, supply, accounting and human resource services. Additional costs were also incurred for Covid-19 response and management.

(j) Increase in actual Service Agreement funding from Commonwealth primarily relates to increases in National Health Reform Agreement allocation under the National Partnership Agreement for the Covid-19 response and additional activity funding received during the financial year.

(k) Increase in resources received free of charge relates mainly to services provided by Health Support Services for information technology, supply, accounting and human resources, as well as support for Covid-19 management and response.

Child and Adolescent Health Service
Notes to the financial statements
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9.14.2 Statement of Financial Position Variances

	Variance note	Estimate 2022 $000	Actual 2022 $000	Actual 2021 $000	Variance between estimate and actual $000	Variance between actual results for 2022 and 2021 $000
ASSETS						
Current Assets						
Cash and cash equivalents		64,983	50,219	67,836	(14,764)	(17,617)
Restricted cash and cash equivalents		17,374	19,012	17,374	1,638	1,638
Receivables		11,490	11,962	11,490	472	472
Inventories		3,580	5,551	3,580	1,971	1,971
Other assets		1,262	1,033	909	(229)	124
Total Current Assets		98,689	87,777	101,189	(10,912)	(13,412)
Non-Current Assets						
Restricted cash and cash equivalents		12,472	12,672	9,972	200	2,700
Amounts receivable for services		408,937	470,279	408,937	61,342	61,342
Property, plant and equipment		1,106,587	1,125,366	1,084,908	18,779	40,458
Right-of-use assets		10,390	9,706	9,768	(684)	(62)
Intangible assets		29,370	20,851	29,370	(8,519)	(8,519)
Total Non-Current Assets		1,567,756	1,638,874	1,542,955	71,118	95,919
TOTAL ASSETS		**1,666,445**	**1,726,651**	**1,644,144**	**60,206**	**82,507**

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

9.14.2 Statement of Financial Position Variances (cont.)

	Variance note	Estimate 2022 $000	Actual 2022 $000	Actual 2021 $000	Variance between estimate and actual $000	Variance between actual results for 2022 and 2021 $000
LIABILITIES						
Current Liabilities						
Payables		30,171	32,213	29,999	2,042	2,214
Contract liabilities		-	119	89	119	30
Lease liabilities		1,501	1,760	1,858	259	(98)
Employee benefits provisions		123,317	138,146	123,317	14,829	14,829
Other liabilities		-	125	83	125	42
Total Current Liabilities		154,989	172,363	155,346	17,374	17,017
Non-Current Liabilities						
Lease liabilities		7,303	8,403	8,214	1,100	189
Employee benefits provisions		26,365	24,486	26,365	(1,879)	(1,879)
Total Non-Current Liabilities		33,668	32,889	34,579	(779)	(1,690)
TOTAL LIABILITIES		**188,657**	**205,252**	**189,925**	**16,595**	**15,327**
NET ASSETS		**1,477,788**	**1,521,399**	**1,454,219**	**43,611**	**67,180**
EQUITY						
Contributed equity		1,477,695	1,465,947	1,454,126	(11,748)	11,821
Reserves		-	80,360	-	80,360	80,360
Accumulated surplus		93	(24,908)	93	(25,001)	(25,001)
TOTAL EQUITY		**1,477,788**	**1,521,399**	**1,454,219**	**43,611**	**67,180**

There are no significant variances for the Statement of Financial Position.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

9.14.3 Statement of Cash Flows Variances

	Variance note	Estimate 2022 $000	Actual 2022 $000	Actual 2021 $000	Variance between estimate and actual $000	Variance between actual results for 2022 and 2021 $000
CASH FLOWS FROM STATE GOVERNMENT						
Service agreement funding - State		454,855	455,233	430,195	378	25,038
Service agreement funding - Commonwealth	(a) (c)	148,581	197,851	159,824	49,270	38,027
Grants from other state government agencies		73,439	73,736	68,828	297	4,908
Services provided to other government agencies		1,858	4,036	3,981	2,178	55
Capital appropriations administered by Department of Health		10,869	11,821	11,769	952	52
Net cash provided by State Government		**689,602**	**742,677**	**674,597**	**53,075**	**68,080**
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits	(d)	(593,036)	(630,710)	(544,132)	(37,674)	(86,578)
Supplies and services	(b)	(152,563)	(186,032)	(178,529)	(33,469)	(7,503)
Finance costs		(253)	(266)	(253)	(13)	(13)
Receipts						
Receipts from customers		22,213	19,946	21,451	(2,267)	(1,505)
Grants and contributions		6,640	9,887	12,919	3,247	(3,032)
Donations received		633	106	123	(527)	(17)
Other receipts		37,280	37,991	35,437	711	2,554
Net cash used in operating activities		**(679,086)**	**(749,078)**	**(652,984)**	**(69,992)**	**(96,094)**

Child and Adolescent Health Service
Notes to the financial statements
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9.14.3 Statement of Cash Flows Variances (cont.)

	Variance note	Estimate 2022 $000	Actual 2022 $000	Actual 2021 $000	Variance between estimate and actual $000	Variance between actual results for 2022 and 2021 $000
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Purchase of non-current assets		(8,979)	(4,771)	(8,239)	4,208	3,468
Receipts						
Proceeds from sale of non-current assets		-	-	11	-	(11)
Net cash used in investing activities		**(8,979)**	**(4,771)**	**(8,228)**	**4,208**	**3,457**
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Principal elements of lease		(1,890)	(2,107)	(1,853)	(217)	(254)
Net cash used in financing activities		**(1,890)**	**(2,107)**	**(1,853)**	**(217)**	**(254)**
Net increase / (decrease) in cash and cash equivalents		(353)	(13,279)	11,532	(12,926)	(24,811)
Cash and cash equivalents at the beginning of period		95,182	95,182	83,650	-	11,532
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**94,829**	**81,903**	**95,182**	**(12,926)**	**(13,279)**

Child and Adolescent Health Service
Notes to the financial statements
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9.14.3 Statement of Cash Flows Variances (cont.)

Major Variance Narratives

Variances between estimates and actuals

(a) Service Agreement funding - Commonwealth - see explanation in variance note (e) for the Statement of Comprehensive Income.

(b) Supplies and services – Payments are above estimate due to the additional spending on medical and surgical instruments to maintain existing and additional beds, increase in repairs and maintenance, Covid-19 expenses which were not funded at time of preparation of the estimates, and increase in insurance premiums.

Variances between actuals for 2021-22 and 2020-21

(c) Service Agreement funding - Commonwealth - see explanation in variance note (j) for the Statement of Comprehensive Income.

(d) Employee benefits - see explanation in variance note (g) for the Statement of Comprehensive Income.

Child and Adolescent Health Service
Notes to the financial statements
For the year ended 30 June 2022

9.15 Correction of prior period error

During the transfer of crown land for the Perth Children's Hospice site, there was incorrect information provided by Landgate on the land value resulting in overstatements of Property, plant and equipment and Contributed Equity by $12.700 million.

Statement of Financial Position	As reported previously $000	Adjustment $000	Restated $000
As at 30 June 2021			
Non-current assets			
Property, plant and equipment	1,097,608	(12,700)	1,084,908
Equity			
Contributed equity	1,466,826	(12,700)	1,454,126

Key performance indicators

Certification of key performance indicators

CHILD AND ADOLESCENT HEALTH SERVICE

CERTIFICATION OF KEY PERFORMANCE INDICATORS FOR THE YEAR ENDED 30 JUNE 2022

We hereby certify that the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the Child and Adolescent Health Service's performance, and fairly represent the performance of the Child and Adolescent Health Service for the reporting period ended 30 June 2022.

Dr Rosanna Capolingua
Board Chair
Child and Adolescent Health Service
1 September 2022

Dr Alexius Julian
Board Member
Child and Adolescent Health Service
1 September 2022

The relationship between the following key performance indicators and the Government goal, outcomes and services is described in the Performance Management Framework section commencing on page 83.

The latest available data has been used to report performance, which in some instances means results are for the 2021 calendar year.

KPIs measuring Outcome 1:

KPIs measuring Outcome 2:

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

Unplanned hospital readmissions for patients within 28 days for selected surgical procedures

Rationale

Unplanned hospital readmissions may reflect less than optimal patient management and ineffective care pre-discharge, post-discharge and/or during the transition between acute and community-based care.[1] These readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

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

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

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/contents/table-of-contents

Target

The 2021 targets are based on the total child and adult population, and for each procedure is:

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

Results

Tonsillectomy & Adenoidectomy

The rate of unplanned readmission for tonsillectomy and adenoidectomy was 49.1 per 1,000, which is lower than previous years and below the target of 81.8 per 1,000 (Figure 1).

Appendicectomy

The rate of unplanned readmissions for appendicectomy was 11.0 per 1,000, which is lower than previous years and below the target of 25.7 per 1,000 (Figure 2).

Figure 1: Rate of unplanned hospital readmissions for patients within 28 days for tonsillectomy and adenoidectomy, 2019 to 2021

Actual 2019	Actual 2020	Actual 2021	Target
77.9	65.5	49.1	81.8

Figure 2: Rate of unplanned hospital readmissions for patients within 28 days for appendicectomy, 2019 to 2021

Actual 2019	Actual 2020	Actual 2021	Target
19.3	16.5	11.0	25.7

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

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

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

Rationale

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

Elective surgical services delivered in the WA health system are those deemed to be clinically necessary. Excessive waiting times for these services can lead to deterioration of the patient's condition and/or quality of life, or even death[2]. 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.

2 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.

On 1 April 2016, the WA health system introduced a new state-wide performance target for the provision of elective services. For reportable procedures, the target requires that no patients (0 per cent) on the elective waiting lists wait longer than the clinically recommended time for their procedure, according to their urgency category.

Target

The 2021–22 target is zero per cent for each urgency category. Performance is demonstrated by a result that is equal to the target.

Results

Figure 3 shows an average of 4.7 per cent of Category 1 patients were not treated within 30 days, 28.1 per cent of Category 2 patients were not treated within 90 days, and 26.8 per cent of Category 3 patients were not treated within 365 days.

CAHS is dedicated to ongoing improvement in service delivery and clinical management to ensure patients with the most critical clinical need are prioritised and treated as soon as possible. CAHS considers the performance reported unacceptable and continues to work toward improved access to elective surgery for patients.

Declines in performance were impacted due to the COVID-19 pandemic with patients not being fit for surgery, reduced booking of cases and increased cancellations. Continued impact of furloughed staff due to COVID-19 has also reduced the capacity of surgical cases and reduction in elective surgery to manage WA health service demand.

This included the scaling back of elective surgeries in September 2021 due to hospital capacity issues state-wide, and again from March 2022 when the COVID-19 Framework for System Alert and Response (SAR) moved to a phase 'red' alert, which reduced the amount of Category 2 and 3 surgical activity to support a coordinated risk management approach to the pandemic.

Figure 3: Percentage of elective wait list patients waiting over boundary for reportable procedures, by urgency category, 2019–20 to 2021–22

	Actual 2019-20	Actual 2020-21	Actual 2021-22	Target
Category 1	4.7%	1.7%	4.7%	0%
Category 2	15.1%	29.2%	28.1%	0%
Category 3	13.1%	21.5%	26.8%	0%

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.

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

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

Rationale

Staphylococcus aureus bloodstream infection is a serious infection that may be associated with the provision of healthcare. *Staphylococcus aureus* is a highly pathogenic organism and even with advanced medical care, infection is associated with prolonged hospital stays, increased healthcare costs and a marked increase in morbidity and mortality (SABSI mortality rates are estimated at 20–25 per cent[3] in adults and five per cent in children).

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

Target

The 2021 target is ≤1.0 infections per 10,000 occupied bed-days.

Result

CAHS provides a range of specialised services, including neonatal and paediatric intensive care, cardiothoracic surgery and oncology. Many patients are therefore at higher risk of Staphylococcus aureus (S. aureus) infection than those at hospitals providing less specialised services. Despite this, CAHS maintained its S. aureus bloodstream infection rate in 2021 to 0.88 per 10,000 occupied bed-days, which is below the WA health system target of 1.0 per 10,000 bed-days (Figure 4). The favourable result is due to a number of initiatives that CAHS has in place to prevent S. aureus infection, particularly S. aureus decolonisation of all children where a new central venous access device (CVAD) is inserted, a strong focus on hand hygiene and aseptic technique compliance, and the dedicated CVAD insertion and management service.

Figure 4: Healthcare associated Staphylococcus aureus bloodstream infections (HA-SABSI) per 10,000 occupied bed-days, 2019 to 2021

Actual 2019	Actual 2020	Actual 2021	Target
0.89	0.48	0.88	1.0

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

Data source: Healthcare Infection Surveillance Western Australia Data Collection.

3 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


ULTRASOUND

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

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

Rationale

Discharge against medical advice (DAMA) refers to patients leaving hospital against the advice of their treating medical team or without advising hospital staff (e.g. absconding or missing and not found). Patients who do so have a higher risk of readmission and mortality[4] and have been found to cost the health system 50 per cent more than patients who are discharged by their physician.[5]

Between July 2015 and June 2017 Aboriginal patients (3.4 per cent) in WA were over 11 times more likely than non-Aboriginal patients (0.3 per cent) to discharge against medical advice, compared with 6.2 times nationally (3.1 per cent and 0.5 per cent respectively) 6. This statistic indicates a need for improved responses by the health system to the needs of Aboriginal patients.

This indicator provides a measure of the safety and quality of inpatient care. Reporting the results by 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.

Target

The 2021 targets are based on the total child and adult population:

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

Results

In 2021, CAHS recorded a rate of discharge against medical advice of 0.33 per cent for Aboriginal patients, which is well below the target of 2.78 per cent. For non-Aboriginal patients, the rate was 0.04 per cent, which is also well below the target of 0.99 per cent (Figure 5). Contributing to the continued favourable result, comparative to target, for Aboriginal patients is the Koorliny Moort (Walking with Families) program, which engages with Aboriginal people through the patient's journey.

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

Figure 5: Percentage of admitted patients who discharged against medical advice, 2019 to 2021

	Actual 2019	Actual 2020	Actual 2021	Target
Aboriginal Patients	0.13%	0.14%	0.33%	2.78%
Non-Aboriginal Patients	0.10%	0.06%	0.04%	0.99%

Reporting period: Calendar year, to account for lag in reporting due to clinical coding completion.
Data source: Hospital Morbidity Data Collection.

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

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

Rationale

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

While multiple hospital admissions over a lifetime may be necessary for someone with ongoing illness, a high proportion of readmissions shortly after discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was not adequate to maintain the patient's recovery out of hospital[6].

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 2021 target is ≤12 per cent.

Result

Although above the target of 12 per cent, the rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit in 2021 has improved over the years to 13.6 per cent (Figure 6). The reduction is in part due to the continuation of the Emergency Telehealth Service to provide mental health assessments within the home. It should be noted that this indicator does not distinguish between planned and unplanned readmissions. Child and Adolescent Mental Health Services provide planned admissions for those who require frequent inpatient admissions and non-acute interventions as part of their care.

Figure 6: Readmissions to acute specialised mental health inpatient services within 28 days of discharge, 2019 to 2021

Actual 2019	Actual 2020	Actual 2021	Target
26.6%	23.3%	13.6%	12.0%

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)

6 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-a53f4eef-a7e6-f81a5af94764/Fourth-national-mental-health-plan-measurement-strategy-2011.pdf.aspx

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

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

Rationale

In 2017–18, one in five (4.8 million) Australians reported having a mental or behavioural condition.[7] 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 2021 target is ≥75 per cent.

Result

In 2021, 87.2 per cent of young people who were admitted to CAHS acute specialised mental health inpatient services were contacted by a community-based public mental health non-admitted health service within seven days of discharge, which is well above the target of 75 per cent (Figure 7). This included contacts with their carers. The continuation of the Emergency Telehealth Service in 2021 contributed to this performance by establishing a formal process of follow up for those young people discharged to private and not-for-profit care providers.

Figure 7: Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services, 2019 to 2021

Actual 2019	Actual 2020	Actual 2021	Target
89.1%	94.1%	87.2%	75.0%

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).

7 National Health Survey 2017-18

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

Average admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per WAU compared with the State target, as approved by the Department of Treasury and published in the 2021-22 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 2021-22 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

Target

The 2021–22 target is ≤$6,907 per weighted activity unit.

Result

The average admitted cost per weighted activity unit was $7,816 in 2021–22, which is 13.2 per cent above the target. The target was developed at a whole of WA health system level and the same target applies to all Health Service Providers. In 2021-22 admitted activity slowed as a result of the COVID-19 pandemic, and the combination of the higher cost profile and lower activity contributed to the indicator being above target. Increases were noted in employment costs to address continuing pressures in clinical areas, largely associated with Government's announcement of opening additional beds on the wards and Emergency Department. In addition, staffing levels were uplifted to enhance safety and quality measures and increase hospital workforce capacity to ensure preparedness for COVID-19 management and response.

Figure 8: Average admitted cost per weighted activity unit, 2019–20 to 2021–22

2019-20 Actual[(a)]	2020-21 Actual[(a)]	2021-22 Actual	2021-22 Target
$ 7,327	$ 6,866	$7,816	$6,907

[(a)] The Under Treasurer has approved the changes to the calculation methodology of the 2021-22 efficiency indicators by removing financial products, such as depreciation and amortisation expense, to allow for better comparison of performance across the Health Service Providers. CAHS has restated the 2019-20 and 2020-21 results for comparability.

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 a ssign cost weights to each diagnostic group.

Reporting period: Financial Year

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 2021-22 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 2021–22 target is ≤$6,847 per weighted activity unit.

Result

The average Emergency Department cost per weighted activity unit rose significantly to $9,200 in 2021–22, which is 34.4 per cent above the target. The target was developed at a whole of WA health system level and the same target applies to all Health Service Providers. Activity in Emergency Department continues to increase and remains above the recorded level in the prior year. The higher cost profile which contributed to the indicator being above target is mainly as a result of staff uplift to increase Emergency Department workforce capacity and to ensure preparedness for COVID-19 management and response.

Figure 9: Average Emergency Department cost per weighted activity unit, 2019–20 to 2021–22

2019-20 Actual[(a)]	2020-21 Actual[(a)]	2021-22 Actual	Target 2021-22
$ 7,565	$7,056	$9,200	$6,847

(a) The Under Treasurer has approved the changes to the calculation methodology of the 2021-22 efficiency indicators by removing financial products, such as depreciation and amortisation expense, to allow for better comparison of performance across the Health Service Providers. CAHS has restated the 2019-20 and 2020-21 results for comparability.

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

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 target, as approved by the Department of Treasury, which is published in the 2021-22 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 2021–22 target is ≤$6,864 per weighted activity unit.

Result

The average non-admitted cost per weighted activity unit rose significantly to $7,207 in 2021–22, which is 5.0 per cent above 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 contributed to the indicator being above target is mainly as a result of staff uplift to increase hospital workforce capacity and to ensure preparedness for COVID-19 management and response.

Figure 10: Average non-admitted cost per weighted activity unit, 2019–20 to 2021–22

2019-20 Actual[(a)]	2020-21 Actual[(a)]	2021-22 Actual	2021-22 Target
$7,271	$6,318	$7,207	$6,864

(a) The Under Treasurer has approved the changes to the calculation methodology of the 2021-22 efficiency indicators by removing financial products, such as depreciation and amortisation expense, to allow for better comparison of performance across the Health Service Providers. CAHS has restated the 2019-20 and 2020-21 results for comparability.

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

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 2021–22 target is ≤ $3,209 per bed-day.

Result

The average cost per bed-day in specialised mental health inpatient services rose to $3,374 in 2021-22, which is 5.1 per cent above the target. The decline in financial performance in 2021-22 is attributable to fewer bed days due to staffing shortages and the impact of furloughed staff as a result of COVID-19.

Figure 11: Average cost per bed-day in specialised mental health inpatient units, 2019–20 to 2021–22

2019-20 Actual[(a)]	2020-21 Actual[(a)]	2021-22 Actual	2021-22 Target
$3,425	$2,750	$3,374	$3,209

(a) The Under Treasurer has approved the changes to the calculation methodology of the 2021-22 efficiency indicators by removing financial products, such as depreciation and amortisation expense, to allow for better comparison of performance across the Health Service Providers. CAHS has restated the 2019-20 and 2020-21 results for comparability.

Reporting period: Financial Year

Data sources: Health Service financial system, BedState

Efficiency KPI – Outcome 1
Service 4: Mental health services

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

Rationale

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

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

Target

The 2021–22 target is ≤ $609 per treatment day.

Result

The average cost per treatment day of non-admitted care provided by public clinical mental health services rose to $653 in 2021-22, which is 7.2 per cent above the target. The decline in financial performance in 2021-22 is attributable to a combination of higher operating costs and lower treatment days due to the impact of COVID-19 on staffing and patient attendance.

Figure 12: Average cost per treatment day of non-admitted care provided by mental health services, 2019–20 to 2021–22

2019-20 Actual[(a)]	2020-21 Actual[(a)]	2021-22 Actual	2021-22 Target
$575	$581	$653	$609

(a) The Under Treasurer has approved the changes to the calculation methodology of the 2021-22 efficiency indicators by removing financial products, such as depreciation and amortisation expense, to allow for better comparison of performance across the Health Service Providers. CAHS has restated the 2019-20 and 2020-21 results for comparability.

Reporting period: Financial Year

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

KPIs measuring Outcome 2
Service 6: Public and community health services

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

Rationale

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

Population health aims to improve health by integrating all activities of the health sector and linking them with broader social and economic services and resources as described in the WA Health Promotion Strategic Framework 2017–2021. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

The 2021–22 target is ≤ $235 per person.

Result

The average cost per person of delivering population health programs by population health units is fairly constant at $242 in 2021-22, which is 3.0 per cent above the target.

Figure 13: Average cost per person of delivering population health programs by population health units, 2019–20 to 2021–22

2019-20 Actual[(a)]	2020-21 Actual[(a)]	2021-22 Actual	2021-22 Target
$236	$239	$242	$235

(a) The Under Treasurer has approved the changes to the calculation methodology of the 2021-22 efficiency indicators by removing financial products, such as depreciation and amortisation expense, to allow for better comparison of performance across the Health Service Providers. CAHS has restated the 2019-20 and 2020-21 results for comparability.

Reporting period: Financial Year

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

Other financial disclosures

Board and committee remuneration

Annual remuneration for each board or committee is listed in Table 10.

Table 10: Child and Adolescent Health Service Board, 2021-22

Position	Name	Type of remuneration	2021–22 period of membership	2021–22 total remuneration[1]
Chair	Dr Rosanna Capolingua	Annual	12 months	$80,370.56
Acting Chair	Professor Geoffrey Dobb	Ineligible	12 months	0
Acting Deputy Chair	Professor Di Twigg	Annual	12 months	$45,971.13
Member	Ms Miriam Bowen	Annual	12 months	$45,971.20
Member	Ms Kathleen Bozanic	Annual	3 months	$9,724.66
Member	Ms Anne Donaldson (Linley Donaldson)	Annual	12 months	$45,971.20
Member	Dr Alexius Julian	Annual	12 months	$45,971.20
Member	Dr Daniel McAullay	Annual	12 months	$45,971.20
Member	Mr Peter Mott	Annual	12 months	$45,971.13
Member	Ms Maria Osman	Annual	12 months	$45,971.38
Member	John McLean	Annual	7 months	$27,405.93
Total				**439,299.59**

Notes:
1. The above list of board is as per the State Government Boards and Committees Register.
2. 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.
3. Remuneration amounts can vary depending on the type of remuneration, the number of meetings attended, and whether a member submitted a remuneration claim.
4. 'Period of membership' is defined as the period (in months) that an individual was a member of a board/committee during the 2021–22 financial year.

Pricing policy

The National Health Reform Agreement sets the policy framework for the charging of public hospital fees and charges. Under the Agreement, an eligible person who receives public hospital services as a public patient in a public hospital or a publicly contracted bed in a private hospital is treated free of charge.

This arrangement is consistent with the Medicare principles which are embedded in the Health Services Act 2016 (WA).

The majority of hospital fees and charges for public hospitals are set under Schedule 1 of the Health Services (Fees and Charges) Order 2016 and are reviewed annually. The following informs WA public hospital patients' fees and charges for:

Compensable or ineligible patients

Patients who are either private or compensable and Medicare ineligible (overseas residents) may be charged an amount for public hospital services as determined by the State. The setting of compensable and ineligible hospital accommodation fees is set close to, or at, full cost recovery.

Private patients (Medicare eligible Australian residents)

The Commonwealth Department of Health regulates the Minimum Benefit payable by health funds to privately insured patients for private shared ward and same day accommodation. The Commonwealth also regulates the Nursing Home Type Patient contribution based on March and September pension increases. To achieve consistency with the Commonwealth Private Health Insurance Act 2007, the State sets these fees at a level equivalent to the Commonwealth Minimum Benefit.

Veterans

Hospital charges of eligible war service veterans are determined under a separate CommonwealthState agreement with the Department of Veterans' Affairs (DVA). Under this agreement, the Department of Health does not charge medical treatment to eligible war service veteran patients; instead, medical charges are fully recouped from DVA.

Other fees and charges

The Pharmaceutical Benefits Scheme regulates and sets the price of pharmaceuticals supplied to outpatients, patients on discharge and for day admitted chemotherapy patients. Inpatient medications are supplied free of charge.

There are other categories of fees specified under the terms of Health Services (Fees and Charges) Order 2016, which include the supply of surgically implanted prostheses, orthoses, magnetic resonance imaging services and pathology services. The pricing for these hospital services is determined according to their cost of service.

Capital works

The Auspman pharmaceutical manufacturing facility became operational in August 2021. The facility was capitalised at a total cost of $4.9m. Remaining works to be funded and completed during 2022-23 include equipment fit out, TGA licensing and provision for potential defects rectification.

Funding of $1.6m was provided in the 2022-23 State Budget Process for the purchase of 278 Tympanometers for use at 293 community based child health centres and primary school sites for the early detection and screening of chronic middle ear infection in children in response to recommendations included in the OAG Improving Aboriginal Children's Ear Health (2019) Report. Some equipment was expensed during 2021-22 and the remaining funding will be utilised in 2022-23 for continued commissioning of tympanometers and for the equipment maintenance contract.

The Medical Equipment Replacement Program also completed capital works in 2021–22.

Table 11 shows the financial details of the capital works program.

Table 11. Major asset investment program works completed in 2021-22

Capital Works Programs Completed (1)	2021-22 $'000
Auspman Paediatric Pharmaceutical Manufacturing Facility	4,785
Tympanometers - Community Health Centres	879
Medical Equipment Replacement	1,391
Minor Building Works and Other Plant & Equipment	379
Total	**7,434**

Note
(1) Excludes equipment funded outside of the State Government's Asset Investment Program and equipment expensed

Governance disclosures

Indemnity insurance

In 2021–22, 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 $79,350.

Government policy requirements

Pecuniary interests

Senior officers of government are required to declare any interest in an existing or proposed contract that has, or could result in, the member receiving financial or other benefits. In 2021–22, none of the CAHS senior officers declared a pecuniary interest.

Other legal requirements

Ministerial directives

Treasurer's Instructions 903 (12) requires disclosing information on any written Ministerial directives relevant to the setting of desired outcomes or operational objectives, the achievement of desired outcomes or operational objectives, investment activities, and financing activities.

The Minister for Health has directed the Health Service Providers to disclose all gifts and payments over $100,000 made under section 36(5) of the Health Services Act 2016 within their annual reports. In 2021-22, CAHS did not provide any ex-gratia gift or make any ex-gratia payment over $100,000.

Advertising expenses

In accordance with section 175ZE of the Electoral Act 1907, CAHS incurred the following advertising expenditure in 2021–22 (Table 12).

Table 12: Summary of advertising for 2021-22

Summary of advertising	Amount
Advertising agencies	$0
Market research organisations	$0
Polling organisations	$0
Direct mail organisations	$0
Media advertising organisations	
Meta	$1,674
The Australian Orthotic Prosthetic Association	$375
Australian Diabetes Educators Association Limited	$150
Total advertising expenditure	**$2,199**

Unauthorised use of credit cards

In accordance with State Government policy, CAHS has issued corporate credit cards to certain employees where their functions warrant usage of this facility for purchasing goods and services. These credit cards are not to be used for personal (unauthorised) purposes. Despite each cardholder being reminded annually of their obligations under the credit card policy, it was found that two employees inadvertently utilised the corporate credit card for personal expenditure on five occasions. Review of these transactions confirmed that they were the result of honest mistakes. Notification and full repayments were made by the employees concerned (Table 13).

Table 13 Credit card personal use expenditure in 2021–22

Credit card personal use expenditure	Amount
Aggregate amount of personal use expenditure for the reporting period	$201
Aggregate amount of personal use expenditure settled by the due date (within five working days)	$0
Aggregate amount of personal use expenditure settled after the period (after five working days)	$201
Aggregate amount of personal use expenditure outstanding at the end of the reporting period	$0

Disability Access and Inclusion

The Child and Adolescent Health Service (CAHS) values diversity within its consumers, carers, families and workforce; recognising and promoting the importance of creating a welcoming and inclusive organisational culture based on equity and respect.

CAHS is committed to ensuring that people with a disability, their families and carers are able to access services, information and facilities.

Throughout the year, CAHS has undertaken an extensive consultation process with consumers, families and staff to inform the development of the next three-year Disability Access and Inclusion Plan (DIAP) 2022 – 2025, endorsed by the CAHS Board in June 2022.

Consultation has identified the need for:

- Consumer and staff consultation at all levels.
- Regular reports on actions and achievements.
- Ensuring appropriate information is widely available.
- Better use of patient records for capturing disability and complex needs.

CAHS is committed to continue working alongside people with disability, families and staff to ensure we are responsive to their diverse needs and deliver real change in practice, process and our environment.

The Disability Access and Inclusion Committee is an advisory group which has responsibility for developing, implementing, monitoring and evaluating the Disability Access and Inclusion Plan. The Committee plays a key role in establishing initiatives to increase organisational knowledge and skills in working with and providing care to those with disability, increasing awareness of barriers that people with disability face, and providing practical advice to improve disability access and inclusion across all CAHS services.

This year the Committee appointed its first Consumer Co-chair who will assist in supporting the consumer voice to be well represented and enable better connections with other CAHS consumer committees to promote inclusivity.

This DAIP also recognises the intersection between disability and other diverse groups and strengthens our commitment to proactively address any form of discrimination in CAHS. This aims to ensure all consumers and staff can access tailored resources and supports, have opportunities for meaningful engagement and are confident in providing feedback to services.

The Disability Access and Inclusion Committee Chair, and Co-Chair.

Recordkeeping

The *State Records Act 2000 (the Act)* was established to mandate the standardisation of statutory recordkeeping practices for every State Government agency. Government agencies are also subject to scrutiny by the State Records Commission (Commission).

Section 19 of the Act, states that every government organisation must have a Recordkeeping Plan that has been approved by the Commission.

CAHS has an approved Recordkeeping Plan which provides overarching guidance regarding our recordkeeping systems, policies, practices, processes and disposal arrangements. The Recordkeeping Plan identifies one area for improvement which relates to establishing a comprehensive and centralised approach to the lifecycle management of inactive hardcopy records sent off-site. Work is underway to identify and appraise corporate records held off-site, to apply appropriate retention and disposal codes to the records, and importantly to create a central register of holdings. The work is scheduled to be completed in 2023.

CAHS has a number of mechanisms to orientate and provide guidance to staff on good recordkeeping practices.

The CAHS induction and orientation program provides new, casual and agency employees with information relevant to their employment within six weeks of commencement. The program has been updated and includes a session relating to CAHS workplace specific work practices and procedures, as well as a general introduction to understanding key accountabilities in terms of public sector recordkeeping, procurement, confidentiality and cybersecurity.

CAHS staff are required to complete mandatory Department of Health Records Awareness Training and CAHS Electronic Document and Records Management System (EDRMS) training upon allocation of a licence. A total of 1,924 staff completed the course during the year.

CAHS has maintained a commitment to the continuing deployment of the EDRMS for management of all corporate records. Significant progress has been made within PCH's operational and administrative areas, allied health, Community Health and CAMHS. The project has delivered improved monitoring and reporting of corporate recordkeeping compliance within CAHS. During this reporting period 414,724 records were captured into the EDRMS.

Health Information and Administrative Services along with the Corporate Records and Compliance team provide ongoing advisory services for the retention and disposal of records and contribute to the development of policies and procedures that result in creation and management of corporate and clinical records.

Total content in RM as of 30 June 2022	**22,20,327**
Documents (including emails)	2,016,379
Total emails	819, 743
Total folders	64,949
Archive boxes	265
HR folders	2,677
Ministerial documents	28,564

Substantive equality

CAHS aims to achieve equitable outcomes for all patients and clients by recognising and promoting awareness of the different needs of our client group. As part of this, CAHS is committed to addressing all forms of systemic discrimination in our health service, in accordance with the WA Health Policy Framework for Substantive Equality.

Refugee Health

The CAHS Refugee Health Service continue to raise the need for awareness of equity, diversity and inclusion principles in all aspects of organisational activity and broader health care delivery. Refer to page 50.

Reconciliation Action Plan

In May 20221, CAHS launched a Reflect Reconciliation Action Plan which provides a structured approach to build relationships, respect and opportunities for reconciliation between staff, consumers and the wider community. Refer to page 16.

Cultural awareness at CAHS

CAHS aims to drive an open and inclusive workplace culture where diversity is valued and the cultural backgrounds and uniqueness of all employees, volunteers, consumers, families and visitors are respected.

WA is the most multicultural of all Australian states, and the diversity we have within CAHS is one of our greatest strengths. To support our continual learning and commitment to cultural awareness, two new self-directed training packages were launched in March 2022.

CAHS also hosted a 'Cultural Conversation' with staff and consumers to discuss how we can work more effectively with families from culturally and linguistically diverse backgrounds.

Disability Access and Inclusion Plan

Our updated Disability Access and Inclusion Plan will be released in late 2022, reaffirming our commitment to delivering health services that are welcoming, inclusive and equitable for the children and families of our state's diverse communities. The Plan was developed in partnership with our consumers, staff and key supporting agencies and non-government organisations to ensure we are focused on the areas of improvement that are important to our stakeholders. Refer to page 30.

Multicultural Action Plan

CAHS delivers health services to patients and clients from a wide variety of cultural and linguistic backgrounds, typically identified by birthplace outside of Australia or a language other than English spoken at home.

In the first half of 2022, CAHS conducted a consultation process with staff and consumers from multicultural backgrounds in addition to non-government organisations in the settlement and multicultural services sector to inform the development of our second Multicultural Action Plan. The new plan will span over the next five years and contains 37 key actions that will continue to build our capacity in utilising best-practice equity, diversity and inclusion approaches to deliver services through a welcoming and inclusive environment.

The CAHS Multicultural Plan outlines the strategies and actions we will take to strengthen the diversity and cultural competence of our workforce, contribute to the elimination of systemic discrimination, and deliver health services

that are welcoming, inclusive and equitable for the children, adolescents and families of WA's diverse communities.

- A number of key achievements from the Multicultural Plan have been made including:
- Increased diversity of consumer representatives on the CAHS Consumer Advisory Council and Youth Advisory Council.
- New welcome signage in different languages implemented across Perth Children's Hospital.
- CAHS hosted our first 'CAHS Conversations on Culture' seminar during Harmony Week in March 2022, bringing staff and consumers together to discuss working effectively with families from diverse backgrounds.

The second edition of our Multicultural Plan will be released in late-2022, thanks to the input from two development groups established in early 2022, which included staff, volunteers and consumers from multicultural backgrounds that guided the development of this Plan. The groups provided crucial direction and guidance which led to the identification of key pieces of work needed at CAHS to achieve impactful and meaningful improvement for cultural and linguistically diverse families who use our services and reduce barriers for those who do not.

Equality, Diversity and Inclusion at CAHS

CAHS is committed to ensuring its workforce is representative of the Western Australian community and is responsive to the diverse needs of consumers, families, carers and visitors. For all employees, it means supporting the endeavors of CAHS in promoting equity and diversity as both a responsibility and an opportunity to show respect and support for our colleagues and the community.

CAHS is a proud member of the Diversity Council of Australia.

Language services

Interpreting services are available to all CAHS staff and consumers who require it and are delivered in a variety of ways. Accredited professional interpreters are engaged directly and through interpreting and translating agencies. CAHS Language Service activity is reported annually to the Department of Health in accordance with the requirements of the WA Health System Language Services Policy 2017 and the WA Language Services Policy 2020.

The CAHS Language Services Policy is in place to ensure CAHS demonstrates the universal right to equitable access and participation in health care for patients, clients and parents, carers who have limited or no English language proficiency, and to ensure that critical health information and advice to those receiving services is fully understood. The Policy is congruent with the WA Language Services Policy 2020 and defines the processes required for appropriate access to interpreter services.

Diversity group	30 June 2021 actual	30 June 2022 actual	2022 target
Women in management	68%	68%	68.0%
People from culturally diverse backgrounds	13.7%	13.1%	17.8%
Aboriginal people	1.8%	1.4%	2.0%
People with disability	1.2%	1.2%	2.5%
Youth	6.8%	8.8%	3.9%

Abbreviations

CAC	Consumer Advisory Council
CAHS	Child and Adolescent Health Service
CAMHS	Child and Adolescent Mental Health Services
CDS	Child Development Service
DAIP	Disability Access and Inclusion Plan
DAMA	Discharge Against Medical Advice
EDRMS	Electronic Document and Records Management System
HA-SABSI	Healthcare-associated Staphylococcus aureus bloodstream infection
ICT	Information and Communications Technology
KEMH	King Edward Memorial Hospital
KPI	Key Performance Indicator
NETS WA	Neonatal Emergency Transport Service WA
NICU	Neonatal Intensive Care Unit
NSQHS	National Safety and Quality Health Service
OBM	Outcome Based Management
PARROT	Paediatric Acute Recognition and Response Observation Tool
PCH	Perth Children's Hospital
PPE	Personal Protective Equipment
PSC	Public Sector Commission
RACP	Royal Australasian College of Physicians
RAP	Reconciliation Action Plan
RAT	Rapid Antigen Testing
RHS	Refugee Health Service
SAC	Severity Assessment Code
SHICC	State Health incident Command Centre
UWA	University of Western Australia
WAU	Weighted Activity Unit
WHSW	Work Health Safety and Wellbeing
YAC	Youth Advisory Council

> Looking ahead, we will continue to work together to deliver a legacy of lasting change which will inform and improve our health service for decades to come.

Dr Rosanna Capolingua, Board Chair,
Child and Adolescent Health Service

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Child and Adolescent Health Service

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