Agency performance

Delivering safe, high-quality care

Communicating for safety

CAHS has a commitment to providing care that is safe, high-quality and meets the needs of our children, adolescents and their families. We do this by ensuring that our children and young people are at the centre of everything we do, and we invite our consumers to partner with us in care that meets their individual, spiritual, psychological, and socio-cultural needs.

CAHS has a continual improvement focus on care and treatment, and demonstrates this through internal and external programs to evaluate and improve safe systems and practice. The National Safety and Quality Health Service (NSQHS) Standards (2nd Edition) provide a roadmap for the eight standards that define expected actions for a range of requirements to demonstrate and drive safe practices and quality improvement activities.

Communicating for Safety (Standard 6) is critical to provide the foundation for communicating with each other, our patients and clients, their families and carers, and other healthcare providers. Communicating for Safety aims to ensure timely, focused and effective communication and documentation that support continuous, coordinated and safe care for patients[7]. The need to communicate effectively at every critical point of patient or client care is recognised in this Standard and Partnering with Consumers (Standard 2).

Critical points of care that require comprehensive and accurate communication centred on the needs of the child and family include admission, transfer and discharge from our health service. CAHS has well established systems and processes that align with this Standard. These include discharge summaries that can be sent to the patient's general practitioner, handover between clinical staff at CAHS and other health services, and bedside handovers where we involve the patient and their family.

Another important requirement of this Standard is the need to correctly identify the patient or client to ensure we are providing them with the correct medication or procedure, and giving them the correct test. Communicating critical information is imperative to keep our patients and client safe. Critical information can include alerts and risks like drug and food allergies that staff and families need to know about to prevent harm.

Other practices to enhance timely and effective communication include 'ward safety huddles' where staff can meet to discuss emerging issues, using 'critical language' to enhance the collective understanding of concern and urgency of an issue, and our commitment to the Speaking Up for Safety™ program. This program provides a framework for all staff to understand the importance of speaking up and to and raising concerns that may impact on patient safety in real time. This program enables staff to communicate and escalate clinical concerns in real time.

At PCH, we provide a consumer focused program to allow families and carers to call a senior clinician if they have attempted to share their concerns about the clinical condition of their child but are still concerned. The CARE Call program allows families to escalate their concerns if they are worried about their child. This program has been recently implemented in the emergency department. We monitor and evaluate each CARE Call to apply lessons learned to our practice.

We continue to strive to improve what we communicate to each other, our patients, clients and their families, and how we communicate. We remain committed to Partnering with Consumers, and putting the patient, client and family at the centre of clinical communication.

7 *https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard*

Learning from clinical incidents

It is difficult to talk about learning in the context of the tragic death of a young child or young adolescent knowing the profound impacts on their families, hospital and community. Acknowledging these tragic events in a healthcare setting and more critically learning and instituting change as a consequence is, however, critical to improving the safety and quality of care.

Similarly to other adverse events, critical reflections after the deaths of Aishwarya Aswath and Kate Savage have led to us to re-examine many aspects of our organisation, including staffing numbers, staff training and support, reporting and monitoring processes and equipment, as well as sharing and learning processes.

There are of course solutions that can support improved care that have been easier to implement than others – for example the provision of additional equipment. Others are more complex and can never be considered complete in their implementation – for example the need to support staff to ensure that they are up to date with latest treatments. Acknowledging child and family centred care as the critical guiding element has provided additional focus and impetus to ensure we are able to meet the diverse needs of the children and families we serve. Central to this of course has been the recognition of the critical role parents and guardians play in alerting us to when their child is deteriorating and a more rapid response is required. CARE Call has provided one mechanism through which this is facilitated, and its introduction into our emergency department represents the start of the journey to better enable escalation.

A key focus for CAHS is on working with our staff to ensure children and families from culturally and linguistically diverse (CALD) backgrounds receive care that is safe and appropriate to their cultural needs. We are conducting this work in partnership with our consumers, who have provided valuable insights into the challenges faced by families from diverse cultural backgrounds to ensure they can communicate their child's needs with support from staff and interpreters where required.

CAHS has clear processes in place to investigate clinical incidents in order to understand factors that may have contributed. After a rapid review, adverse events are categorised and investigated accordingly. We ask staff to highlight anything they feel may adversely impact on care of a child. This can range from the use of a wrong name sticker to omission of a medication. For the most significant events (Severity Assessment Code 1 – SAC1), a critical analysis by a panel of experts results in a report with clear recommendations the implementation of which are carefully tracked. This forms part of the 'Clinical Governance' overseeing safety and quality.

"The best way to reduce harm … is to embrace wholeheartedly a culture of learning."

A promise to learn – a commitment to act, The National Advisory Group on the Safety of Patients in England, chaired by Don Berwick, August 2013

Table 1: SAC 1 incidents 2020–21

SAC 1 Incident	
Total notified:	28
Investigated	21
Ongoing investigation	5
Declassified*	2
Total confirmed:	26
Confirmed with patient outcome of death	6
Confirmed with patient outcome of serious harm	9
Confirmed with patient outcome of moderate harm	8
Confirmed with patient outcome of minor harm	3
Confirmed with patient outcome of no harm	0

** Declassified incidents have been investigated and found not to have resulted from health care delivery.*

Sepsis

Sepsis remains a leading cause of childhood morbidity and mortality in Australia. Despite this diagnosis can be challenging as there is no single clinical finding or test that is diagnostic. As part of the work to improve our recognition and management of children we have been working on tools that will enhance recognition and education packages that support staff. We have introduced a paediatric acute recognition and response observation chart that has clear prompts and escalation processes to assist our staff to identify the signs of sepsis early and take action to treat it.

Reducing hospital-acquired complications

In Australia, approximately one in nine patients who are admitted to hospital develops a complication, or one in four patients who are admitted overnight. Complications developed as a result of hospital care can cause patients discomfort, delay recoveries, and extend hospital stays. The most serious complications can cause permanent injury or death.

The Australian Commission on Safety and Quality in Health Care defines a hospital-acquired complication (HAC) as 'a complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring'.

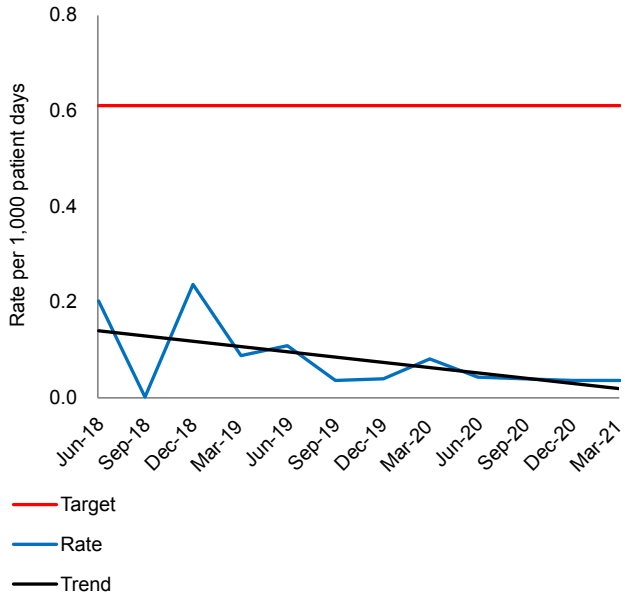
CAHS monitors HACs to identify and explore issues relating to the quality of care, and to implement strategies to minimise them.

Pressure injuries

A pressure injury, also known as a pressure ulcer or sore, occurs when an area of skin is damaged due to unrelieved pressure, dragging or pulling on the skin. Pressure injuries can develop quickly and take a long time to heal, which has consequences for patients' quality of life. Such injuries are susceptible to infection, can cause severe pain, and lead to sleep and mood disturbance. They can also lead to increased length of stay in hospital, and adversely affect rehabilitation, mobility and long-term quality of life. Preventing pressure injuries is therefore an important challenge for hospitals.

Figure 3 shows the success CAHS has had keeping the rate of the most serious Stage III and IV pressure injuries below the target set by the WA Department of Health and reducing the rate over time. This is attributed to frequent review of data and incidents by the Comprehensive Care Committee, and completing rounds, whereby various medical disciplines come together to discuss the patient's condition and coordinate care.

Figure 3: Rate of Stage III & IV pressure injury

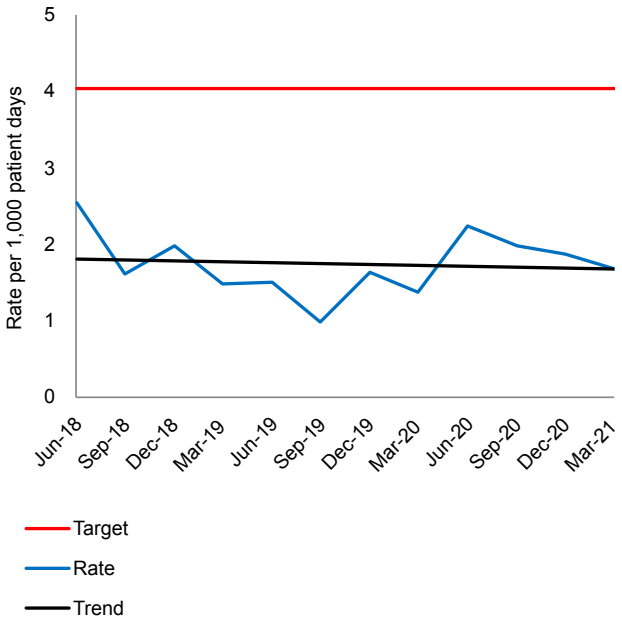


Healthcare-associated infections

Healthcare-associated infections (HAIs) are those infections that are acquired as a direct or indirect result of healthcare. HAIs are one of the most common hospital-acquired complications, can cause unnecessary pain and suffering for patients and families, prolong a patient's stay in hospital and increase the cost of their care. As such, healthcare-associated infections are identified as the highest reported category of SAC 1 incidents.

To reduce HAIs, CAHS implemented an action plan focused on key areas of clinical guidelines and policies, hand hygiene auditing, aseptic technique competencies for central venous access devices for clinical staff, antibiotics prophylaxis, and education regarding documentation of peripheral intravenous devices. The work is monitored and reported regularly via the Preventing and Controlling Healthcare Acquired Infections Committee. Figure 4 indicates the plan has proven successful, with the average rate of HAIs over the past three years remaining steady at below half the target set by the WA Department of Health.

Figure 4: Rate of healthcare associated infection



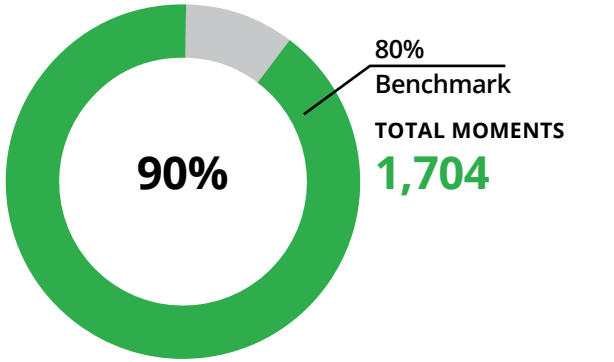
Hand hygiene

Effective health care worker hand hygiene is a core strategy in the prevention of healthcare-associated infections and the transmission of antimicrobial resistance. Strategies include provision of alcohol-based hand rub at the point-of-care, health care worker education, and regular auditing, with performance feedback of hand hygiene compliance according to the '*5 Moments for Hand Hygiene*' approach. The five moments are:

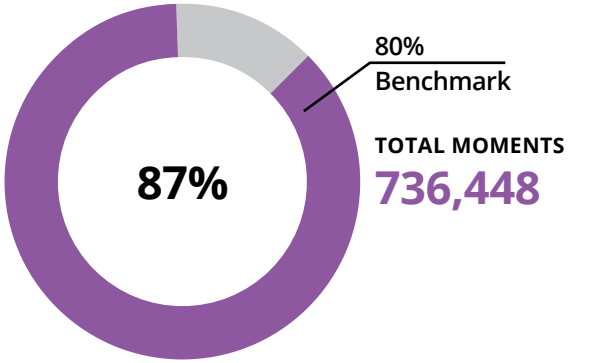
1. before touching a patient
2. before a procedure
3. after a procedure or body fluid exposure risk
4. after touching a patient
5. after touching a patient's surroundings.

Audits are conducted three times each year, and the most recent audit of 2020–21 shows PCH continues to exceed the benchmark of 80 per cent and perform better than the national average.

Perth Children's Hospital



National



Emergency Department access

Emergency Departments (EDs) are specialist multidisciplinary units with expertise in managing acutely unwell patients for their first few hours in hospital.

The Perth Children's Hospital (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 ED typically sees over 66,000 patients per year, with a hospital admission rate of 20 per cent. It has three resuscitation bays, a 23 bed acute pod area, an eight cubicle low acuity area, a fast track (minor injuries) area, a psychiatric assessment pod and an 11 bed short stay unit.

When patients first enter ED, 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 treatment acuity. Treatment should commence within the recommended time of the triage category allocated (see Table 2). The purpose of this process is to ensure treatment is given in the appropriate time, with the aim of preventing deterioration in the patient's condition.

Table 2: Triage category, description and WA performance targets

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%

With increasing demand on emergency departments, it is important to monitor performance to help develop strategies to manage this demand and assess the effectiveness of service provision.

Percentage of Emergency Department patients seen within recommended times

This indicator measures how effective emergency departments are at the starting point of patient care. It captures the percentage of patients treated within the timeframes recommended by the Australasian College for Emergency Medicine. A higher percentage indicates better performance.

CAHS strives to treat all Emergency Department patients within the recommended period, but places most emphasis on the sickest and most time critical patients assigned to Categories 1 and 2. In 2020–21, CAHS continued to exceed performance expectations for Categories 1 and 2, although performance in Categories 3 and 4 declined slightly compared with last year (Table 3). Category 5 access sits 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.

In 2020–21, the 12-month Graduate Nurse Program run by the CAHS Department of Paediatric Nursing Education was expanded to include specialist paediatric Emergency Department training, with Dejana Jovanovic (L) and Megan Winter (R) being the first graduates. The Professional Development Progression Pathway assists and supports new graduates transition to the acute care area of an Emergency Department. Over 12 months they learn and develop the specialist skills required by an Emergency nurse including nursing assessments, procedural sedation, and resuscitation room responsibilities.

Annual results are affected by factors such as high winter demand, the total number of cases and the timing of presentations. For instance, patients mostly arrive at the Emergency Department at intervals between zero and five minutes for several hours in a row, particularly in the evening, which can make it difficult to achieve the targets consistently. Wait times for Categories 3 and 4 have been negatively impacted in 2020–21; first by an unseasonal increase in presentations October 2020 to February 2021 due to respiratory syncitial virus, and subsequent impact of hospital capacity and access block. Access block affects waiting times by reducing the number of treatment spaces available to assess and manage patients within ED. COVID-19 precautions continue to be a factor impacting waiting times. In order to protect staff, patients and families, significant changes were made to workflows and personal protective equipment (PPE) recommendations at PCH ED in light of COVID-19. The delays attributable to the sharp rise in the use of PPE, in conjunction with increased cleaning requirements, are reflected in the slight deterioration in performance in the Category 3 and 4 figures for 2020–21. The Emergency Department is looking at various strategies to improve the Category 3 and 4 performance and has implemented some changes, such as the Triage Rapid Assessment Model team.

Table 3: Percentage of Child and Adolescent Health Service Emergency Department patients seen within recommended times, by triage category, 2018–19 to 2020–21

Triage category	2018–19	2019–20	2020–21	Target
1	100%	100%	**100%**	**100%**
2	88.5%	87.6%	**81.0%**	**≥80%**
3	66.3%	61.5%	**46.6%**	**≥75%**
4	65.8%	64.7%	**53.6%**	**≥70%**
5	97.5%	95.0%	**81.0%**	**≥70%**

Favourable performance **Unfavourable performance**

Early into the COVID-19 pandemic, CAHS recognised that personal protective equipment intended to prevent its spread could increase anxiety in young patients to the Emergency Department. Life-sized posters were placed in waiting areas to assure patients that despite these precautions, it was the same caring doctors and nurses beneath.


Way Out

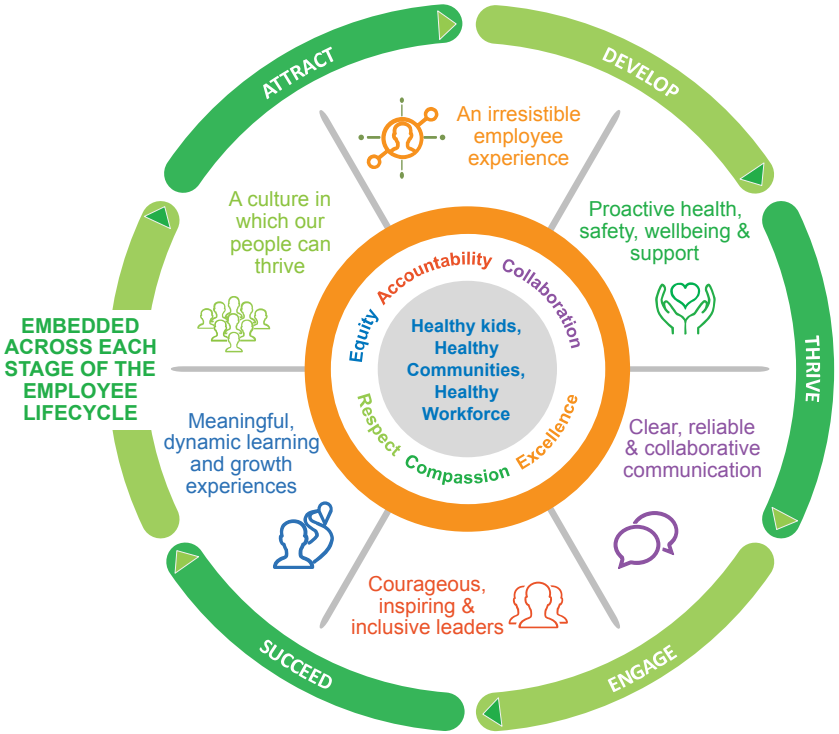
People, capability and culture

Year in Review

Valuing and respecting our employees continues to be a strategic priority for CAHS, with a strong focus on supporting the culture and wellbeing of the workforce. During the reporting period, the People, Capability and Culture (PCC) directorate continued with progressing the maturity of the directorate to effectively support the organisation to achieve its strategic priorities and to meet its future needs. Key to this was the development of PCC's vision, strategy and framework to guide the directorate's purpose, objectives and initiatives for the next 5 years. This work was undertaken in partnership with key stakeholders through evaluation surveys, workshops and consultative processes to ensure the vision of the directorate aligned to the needs of the organisation. It was carried out over several months, with workshops initially held in July 2020, and the final PCC vision and strategy being presented to and endorsed by the CAHS Board in February 2021.

The PCC vision is to lead and partner in a values-based environment that invests in our people and enables an agile, healthy workforce that aspires to excellence in performance. To identify the priorities of this vision, all work was aligned to six key themes:

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



Core activities have been identified to achieve these priorities, with a key focus on using evidence-based people management theory and practice to enable a solutions focused approach to current and future workforce challenges. PCC aims to lead and drive initiatives through partnership with CAHS service areas to elevate our position as an 'employer of choice' by working with business units to create a positive workplace environment that values, respects, engages and supports individual contributions and collective strength.

Our people – employee profile

CAHS employs over 5,000 staff who perform a wide variety of roles in service of WA children and their families and carers. Many are part-time employees, but when measured as full-time equivalents, our Service grew in 2020–21 (Table 4). The majority of growth relates to Neonatology staff transferred from the North Metropolitan Health Service in February 2020 and the impact of staff resources regarding COVID-19 and the COVID-19 vaccination program. CAHS also delivered more activity this year, which required more staff.

MEDIAN AGE
41

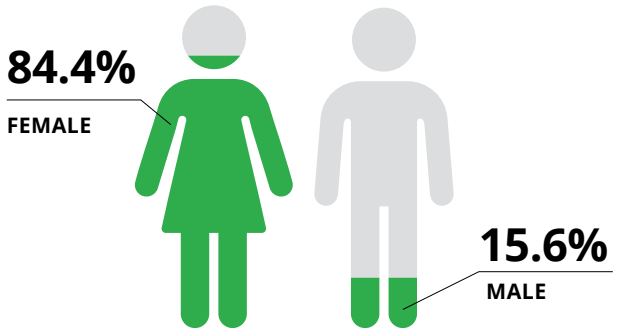
ABORIGINAL EMPLOYEES
1.6%

CALD EMPLOYEES
13.7%

EMPLOYEES WITH A DISABILITY
1.2%

AVERAGE LENGTH OF SERVICE
9.1 YEARS

CAHS EMPLOYEES BY GENDER



AVERAGE HOURS WORKED PER FORTNIGHT
59.5 HOURS

Leasa Ashton is a teacher with the School of Special Educational Needs: Medical and Mental Health. She works at PCH within inter-disciplinary teams to support the educational needs of long-term patients within the Complex Pain Service and Rheumatology department. Leasa was awarded a Churchill Fellowship and is undertaking research into increasing the quality of life and educational outcomes for young people with chronic pain and fatigue. Her research will also take her overseas once international borders reopen.

Table 4: Total full-time employees of CAHS, by category

Category	Definition	2019–20	2020–21
Administration & clerical	All clerical-based occupations together with patient-facing (ward) clerical support staff	686.3	742.4
Agency	Administration and clerical, medical support, hotel services, site services, medical salaried (excludes visiting medical practitioners) and medical sessional	29.0	41.7
Agency nursing	Workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest	3.6	1.6
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care	16.0	29.5
Dental nursing	Dental nurses and dental clinic assistants	6.6	7.5
Hotel services	Catering, cleaning, stores/supply laundry and transport occupations	175.3	187.4
Medical salaried	All salary-based medical occupations including interns, registrars and specialist medical practitioners	384.0	459.5
Medical sessional	Specialist medical practitioners that are engaged on a sessional basis	69.3	90.1
Medical support	All Allied Health and scientific/technical related occupations	631.6	649.0
Nursing	All nursing occupations. Does not include agency nurses	1,415.4	1,673.0
Site services	Engineering, garden and security-based occupations	2.2	1.3
Other occupations	Aboriginal and ethnic health employees	25.6	28.0
	Total	**3,444.8**	**3,911.0**

Workforce planning

During 2020–21, CAHS undertook a baseline assessment of the workforce as part of developing a strategy to ensure the composition and supply of the future workforce meets expected requirements.

The purpose of the workforce assessment was to provide granular detail of the current workforce composition, including the identification of factors and influences potentially impacting on future planning while identifying strategic workforce risks.

This baseline assessment will be used to inform People Capability and Culture strategies and actions.

Volunteers

The 'team in tangerine' consists of over 400 volunteers who support CAHS to provide a warm and welcoming environment for children, their families and carers. They are a diverse group of people from 18 to 86 years old, speaking over 60 different languages. Our longest serving volunteer has completed 41 years of service.

Our volunteers operate in the following areas of Perth Children's Hospital:

- All entrances – welcoming visitors, screening, assisting outpatients check in, directing and escorting where necessary
- Emergency Department
- Wards

- Outpatient clinics
- Admissions, pre-op and recovery in the theatre area
- Refugee clinic
- Stitches shuttle
- Refugee bus
- School of Special Educational Needs
- Supporting delivery of PCH play and wait strategy
- Archives
- Aboriginal health

Ad hoc support is provided to projects across the hospital including:

- Research
- Pastoral care service
- Diabetes clinic
- Play, leisure and engagement
- Paediatric exams

CAHS also provides volunteers to work collaboratively with our NGO partners including:

- Telethon Kids Institute Discovery Centre
- Animal Companions
- Starlight Foundation
- Perth Children's Hospital Foundation
- Scholastic Book Bunker

Since the COVID-19 pandemic, CAHS has seen a huge demand for volunteers providing support for visitor screening and in the vaccination clinic.

Our culture

Led by Professor David Forbes and Dr Asha Bowen, the Shape our Future Steering Team continued to provide multi-disciplinary input into making CAHS a great place to work. The team continued to meet monthly throughout the year to guide the cultural transformation of CAHS, either via MS Teams or in person depending on COVID-19 restrictions. The enthusiasm and commitment of the Shape our Future Steering Team has continued, with activities that focus our attention on Living our Values of collaboration, compassion, accountability, respect, equity and excellence at CAHS.

In November 2020, CAHS celebrated World Kindness Day, a Shape our Future initiative aimed at highlighting good deeds and providing an opportunity for staff to let each other know how much they are appreciated and valued. CAHS Kindness Cards were available in print and digital versions for staff to share messages of kindness to others. The cards featured the colouring in from Living our Values week by Melissa Miro in Community Health.

The tradition of *Living our Values* Week continued across CAHS from 22 to 26 February 2021. A working group of Shape our Future members organised and promoted activities, including an official Welcome to Country and opening from the CAHS Board and Executive, meditation and mindfulness sessions, long table lunches and a values colour dress up day.

The bi-annual Barrett's Cultural Values Assessment will be completed again in November 2021, with Neonatology included for the first time since joining CAHS. The 2019 cultural values assessment highlighted that CAMHS required a specific focus and action to address employee engagement. CAMHS undertook a Shape our Future process in 2020 to enable staff to contribute to a CAMHS Culture Action Plan. A total of 229 participants (over 50 per cent of CAMHS staff) provided feedback in a series of 29 focus groups, eight individual interviews and online feedback, with representation from all teams and disciplines. Feedback was analysed using an iterative process by working group members, ambassadors and staff, including "Your Said, We Heard" sessions in December 2020. Recommendations for action to improve workplace culture and the experience of staff have been developed for consideration by CAHS and CAMHS leadership. In 2021–22, we will focus on CAMHS nursing staff as a key activity of our cultural transformation.

CAHS is continuing its 5–10 year process towards becoming a values based organisation. Now in our fourth year, we have renewed our commitment with the launch of the Culture Action Strategy 2.0 (2021–2023) and recently welcomed new members to the Shape our Future Steering Team.


Certificate of Appreciation


World Kindness Day
CAHS Kindness Card
In honour of
World Kindness Day,
I want to say....

2021 WA Sonographer of the Year

Over the past year, WA Sonographer of the Year Leanne Lamborn, her team and her radiologist colleagues implemented several new examinations that eliminated the need for paediatric patients to undergo a general anaesthetic. Leanne and her professor also provide a new option for assessing liver lesions using ultrasound contrast instead of a liver biopsy. In response to COVID-19, Leanne produced short videos for doctors to help them with machine covers and cleaning procedures to ensure staff and patients were safe.

Recognising our people

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 2020–21, there were 13 winners from 131 nominations. CAHS is grateful for the ongoing support of award sponsors HESTA and Perth Children's Hospital Foundation.

WA Nursing and Midwifery Excellence Awards

CAHS is very proud of the following staff who were finalists for the 2020 WA Nursing and Midwifery Excellence Awards:

Graduate of the Year
Alexandra Brindley – Community Health

Excellence in Primary, Public and Community Care
Lisa Palchak – Community Health

Excellence in Registered Nursing
Jeremy Johnson – Neonatology

(L-R) Pania Falconer, Elaine Taaffe, Dr Robina Redknap (Chief Nursing and Midwifery Officer), Jane Lake, Kate Addiscott, Terri Barrett (Acting Executive Director, Nursing Services). Absent Kate McLaughlan and Dianna Tanian

CAHS International Nurses Day Nursing Awards

Six nurses were recognised by CAHS on International Nurses Day 2021 for exemplifying CAHS values of compassion, excellence or being an inspiration to others.

Australasian College of Health Service Management (WA) – Stars of COVID-19

The Stars of COVID-19 campaign was launched by ACHSM to acknowledge and celebrate staff from all over WA's health care, aged care and community care sectors who demonstrated compassion and exceptional leadership during the pandemic. CAHS nominees were:

- Elizabeth Harding (Clinical Nurse Manager, Community Health)
- Gillian Charlwood (Clinical Nurse Specialist, Infection Prevention and Control)
- Kate McKenzie (Occupational Therapist, Community Health)
- Julie Branley (Nurse Educator, Community Health)
- Victoria Stone and Talitha Halliday (Emergency Management Unit)
- Child and Adolescent Mental Health Service Extended Leadership Group
- Samara Gardiner and Samantha Barba (Procurement, Infrastructure and Contract Management)
- Nicola Palmer (Clinical Nurse Specialist, Community Health)
- Carrie Dunbar (Nurse Co-Director, Surgical, Perth Children's Hospital)
- Newborn Hearing Screening Team

Highlights in workplace relations 2020–21

Planning and preparations to react in a timely manner to the ongoing COVID-19 threat presented challenges throughout the year. Structures were reconfigured both to improve services and respond promptly to any contingencies that could have arisen. Rapid recruitment processes ensured staffing levels could be maintained or increased in the event of community spread. Additionally, CAHS played a pivotal role in staffing vaccination centres throughout the metropolitan area.

Another area of key focus was addressing insecure employment contracts (with a continued drive to fill all vacancies on a permanent basis). This occurred through both standard recruitment and conversion processes to enable permanent contracts to be issued to fixed term and casual employees.

The requirement to provide accurate and timely advice to line managers on new and emerging workplace issues in this changed environment placed significant demand on workplace relations advisory services. Activity levels for individual employee issues requiring ongoing management and workplace relations advice rose again during the year. There was also an increase in the number of disputes or appeals in 2020–21, mostly related to individual employee matters. All the disputes or appeals were successfully resolved without the need for arbitration, but increased use of formal conciliation or meditation and use of formal internal dispute resolution procedures was evident.

Throughout the year, the unions have run a number of campaigns for their membership, such as the *S.A.F.E.*[8] *Mental Health Campaign*. In terms of employees raising issues at the workplace level, this campaign activity had some impact, with CAHS management, in a number of instances, taking immediate positive steps to engage with the employees and consider potential resolutions.

Compliance with public sector standards and ethical codes

As part of CAHS' ongoing commitment to engaging and developing an ethical, transparent and accountable health service we:

- focus on building an ethical culture by continuing to strengthen communication and promotion of employee responsibilities across the organisation. This included the implementation of an Integrity Policy Framework.
- actively participate as a member of the WA Health Integrity Working Group in support of a consistent approach to integrity and ethics across the WA health system.
- publish expected standards of conduct on the CAHS website and inform the public about how to give compliments or complaints, and notify us about misconduct and Public Interest Disclosures.
- partner with the Corruption Crime Commission to

8 Sustainable, Accessible, Funded, Excellent.

support misconduct resistance and prevention, along with the Public Sector Commission to entrench the integrity-focused partnership.

To ensure our employees are aware of their rights and responsibilities in accordance with the Public Sector Standards and ethical codes, CAHS ensures:

- resources, expectations, and accountabilities are communicated to employees through online and face-to-face forums, inductions, orientations, and learning programs.
- policies, procedures and associated guidelines are regularly reviewed and made accessible electronically via external-facing websites and local intranet sites.
- information about the Standards and their application is communicated via the CAHS intranet.
- matters raised by employees are tracked via regular reporting to support equitable and timely resolution.
- Human Resources and Integrity and Ethics Officers are available to advise managers and staff.

Compliance monitoring

During 2020–21, there were five claims lodged against the employment standard. No claims were resolved internally, with all five referred to the Public Sector Commission (PSC) for review. Two were subsequently declined by the PSC, two were withdrawn by the claimant following referral, and one outcome is still pending. There was one claim lodged against the grievance standard in 2020–21.

A total of 55 reports or complaints alleging non-compliance with the Code of Conduct (breaches of discipline) were lodged (Table 5). 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 (4) or the Corruption Crime Commission (8) 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 5: Complaints alleging non-compliance with the Code of Conduct, by area of compliance

Type	
Communication and official information	7
Conflict of interest	0
Fraud and corrupt behaviour	17
Personal behaviour	29
Record keeping and use of information	1
Use of public resources	1
Total	**55**

Fraud and corruption prevention

CAHS has zero tolerance of fraud and corruption. Reporting suspected fraud or corruption is strongly encouraged, and will be investigated and resolved in accordance with the *Corruption, Crime and Misconduct Act 2003* and internal policies and procedures.

In 2020–21, CAHS commenced the development of an assurance map relating to fraud and corruption prevention controls, gaps and red flags across key areas of CAHS.

Our commitment to integrity is supported through:

- increased resourcing in the Integrity and Ethics Unit
- ongoing review and monitoring of integrity and ethics internal and external reporting
- internal audits focused on hot spots, including additional hours and overtime
- reviewing and updating the communication plan to target and align key messages with global awareness dates.

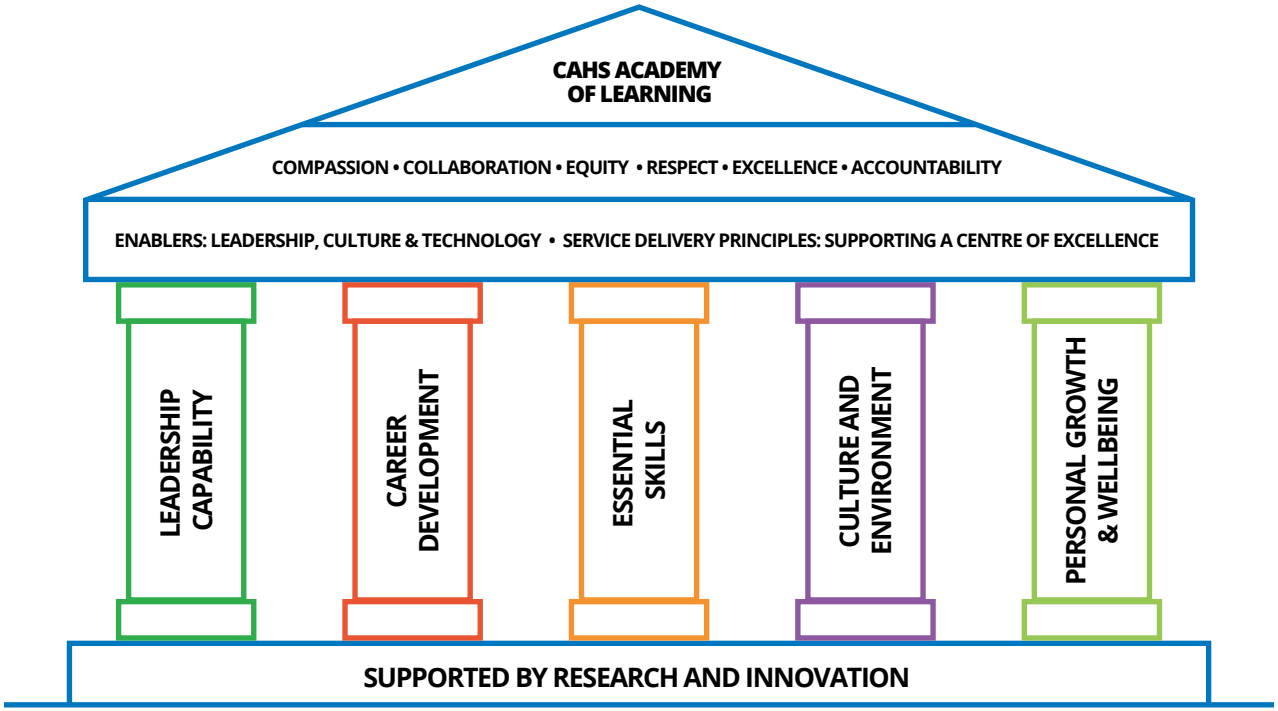
Our capability

In March 2021, People, Capability and Culture (PCC) launched the CAHS Learning and Development Strategy and Model 2020–2025 to support its strategic objective of achieving high-impact learning and development in the workplace. The notion of high-impact learning acknowledges the need to ensure the knowledge, capability and performance of the workforce supports the delivery of excellence in health care.

The strategy also aligns with the broader PCC framework which aspires to offer 'meaningful, dynamic learning and growth experiences'.

The strategy aims to support our employees through a sustainable and future-focused learning and development vision that centers on collaboration, communication and improved alignment across CAHS. It will shape and enhance development of every individual to inspire learning and excellence in health care delivery.

Going forward, the delivery of learning and development activities at CAHS will be supported by the establishment of an Action In Learning hub. The hub will support CAHS Learning and Development teams and subject matter experts by embracing fresh thinking, consider the learner's experience and be solution focused. The hub function includes leadership and governance, learner experience, organisational development and service support.



Workforce development

CAHS encourages a culture of life-long learning and professional development across the organisation through provision of ongoing education, training and development of employees. In-house training programs are facilitated by a number of areas within CAHS, and employees are supported to access external opportunities through a number of corporate partnerships.

During 2020–21, the People, Capability and Culture team worked with a number of internal stakeholders to develop the overarching learning and development

vision for CAHS that will guide the organisation over the next five years. This vision aims to develop an outcome focused, high impact and dynamic learning culture that supports its people to drive excellence in the delivery of health care and is supported by a roadmap to build capability within the workforce by developing leadership and management programs, introducing capability frameworks, capitalising on technology and supporting communities of practice. This model will be supported by an Action In Learning hub that will be established during the next financial year.

Some highlights for the year included:

- Development of a new hub page to bring together a collection of training and resources for staff
- Development of a new escalation system based on research – Paediatric Acute Recognition and Response Observation Tool (PARROT).

This entailed significant collaboration across the health service and CAHS has a number of initiatives in the pipeline for the next financial year.

Leadership Capability

Leadership capability has been identified as a key focus area within the strategic Learning and Development vision of establishing a CAHS Academy of Learning.

In 2020–21, a third cohort of participants completed the Leading CCAREE[9] program, a tailored program focusing on leading with the CAHS values to contribute to a unified and collaborative culture across CAHS.

At the start of 2021, the PCC team launched some important initiatives to support leadership development at CAHS in line with the Learning and Development Strategy:

9 The Leading CCAREE program is named after the CAHS values of Compassion, Collaboration, Accountability, Respect, Excellence and Equity.

- The Medical Head Development Program is an in-house program delivered by those CAHS staff with subject matter expertise in areas considered to be fundamentals of management.
- The CAHS Mentoring Program, facilitated by Leadership Development Consultant Dee Roche, is underway with paired mentors and mentees from various occupational groups across CAHS, completing their orientation in April 2021.
- Work has commenced in determining the preferred structure for a new tailored CAHS Leadership Development Program that will be offered in 2022.
- CAHS is also strengthening partnerships with the WA Health Institute of Health Leadership in supporting employees to participate in programs such as Coach as Leaders Programs, Aboriginal LEAD Program and the First Step Aboriginal Emerging Leaders Program.

Work health, safety and wellbeing

CAHS is committed to providing employees, contractors, volunteers, patients/consumers/clients, families, carers, elders and visitors with a healthy and safe working environment. This is done in accordance with the *Occupational Safety and Health Act 1984* by taking a proactive approach to prevention and risk management for all.

Harmonisation of new legislation expected in early 2022 prompted a review of current functions and capacity of the Occupational Safety and Health department within CAHS. The review highlighted a need for a work health, safety and wellbeing model that recognises both physical and psychosocial safety and their interdependence, and shows the relationship culture has on both.

Consultation on Work Health and Safety (WHS) issues is a management responsibility, but is supported through elected employee safety representatives across all departments and service areas. Dedicated WHS Committees coordinated by the CAHS WHS team meet bi-monthly to:

- Monitor workplace hazards
- Review WHS policies and procedures
- Make recommendations to CAHS about workplace activities affecting safety and health.

Wellbeing

A Health and Wellness Coordinator joined CAHS in June 2020 to support the development of health and wellness initiatives across the organisation. Initially, time was spent developing CAHS' approach to wellbeing, including an overarching wellbeing strategy, wellbeing communication strategy, intranet page and wellness advocates across the multiple sites. The strategy outlines two aims:

1. creating a work environment where CAHS provides the same kindness, compassion and care for the wellbeing of ourselves and colleagues as we do for our patients
2. creating an engaged and empowered workforce where staff look after their wellbeing and are physically and psychologically safe in our workplaces, and are supported to maximise their health and wellbeing.

Initiatives implemented since June 2020 include:

- establishing a wellbeing intranet hub providing information and initiatives across the pillars of health (physical, mental, social, spiritual and financial)
- psychological support for staff, including internal psychological support for staff after critical incidents, mental health education, development of wellbeing and staff support resources, review of EAP services
- implementation of a fitness passport
- financial education workshops, and
- collaborating and listening to the wellbeing needs of staff through the wellbeing survey and other surveys.

We are committed to building on and further embedding initiatives identified during this time to ensure readiness for the future.

Pastoral care services

Dedicated pastoral care services form part of the new WHSW department. It is integral to the development of the Wellbeing Centre, providing support for the emotional, psychosocial and spiritual health and wellbeing of families and staff.

Having a child in hospital is a confronting, difficult and dislocating time that may cause feelings of uncertainty or apprehension. Pastoral care services are therefore available to all, offering a no-cost, confidential, supportive service to patients and their families, as well as staff at PCH.

Injury management

The CAHS Board and Executive have formal consultation mechanisms in place to fulfil their legislative role. 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 PCC Executive Committee, which is accountable for the safety of all CAHS staff, visitors, patients/clients, carers and contractors. Through values based leadership, CAHS supports injured workers through a comprehensive injury management service provided by professional injury management staff.

Workers' compensation

When employees sustain a work-related injury, CAHS aims to support their return to work in a safe and timely manner. This is done in consultation and agreement with the injured worker, management and treating medical practitioner.

A total of 74 workers' compensation claims were made in 2020–21 (Table 6).

Work health, safety and wellbeing performance

Recent work health and safety and injury performance for CAHS is summarised in Table 7.

Table 6: Number of workers' compensation claims in 2020-21

Category	Claims
Nursing Services / Dental Care Assistants	31
Administration and Clerical	14
Medical Support	6
Hotel Services	22
Maintenance	0
Medical (salaried)	1
Total	**74**

Table 7: Occupational safety, health and injury performance, 2018–19 to 2020–21

Measure	2018–19	2019–20	2020–21	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%	**1.6%**	0 or 10% improvement on the previous 3 years	Target met
Lost time injury severity rate (per 100, i.e. percentage of all LTI/D)	36.4%	47.8%	**59.7%**	0 or 10% improvement on the previous 3 years	Target not met
Percentage of injured workers returned to work within 13 weeks	77%	75%	**80%**	No target	
Percentage of injured workers returned to work within 26 weeks	77%	88%	**90%**	≥80%	Target met
Percentage of managers trained in occupational safety, health and injury management responsibilities	48%	80%	**54%**	≥80%	+37% in progress

PCH Food Services ensure patients and eligible parents receive nutritious, appetising and satisfying meals and snacks that help meet their clinical, nutritional, social and cultural needs. This service is supported by Dietetics and the Food and Nutrition Working Group.

Financial targets

	2020-21 TARGET [1] $000	2020-21 ACTUAL $000	VARIATION [7] $000
Total cost of services (expense limit) (sourced from Statement of Comprehensive Income)	797,935	834,777	36,842[2]
Net cost of services (sourced from Statement of Comprehensive Income)	732,728	759,772	27,044[3]
Total equity (sourced from Statement of Financial Position)	1,453,283	1,466,919	13,636[4]
Net increase / (decrease) in cash held (sourced from Statement of Cash Flows)	(6,360)	11,532	17,892[5]
Approved salary expense level	549,124	558,987	9,863[6]

Note

(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 $36.842 million in total cost of services are the unexpectedly higher drug costs ($10.473 million), increased employee benefits expenses ($9.863 million) for delivering additional activities at the Perth Children's Hospital (PCH) and Neonatology, and the costs incurred for the COVID-19 pandemic.

(3) As a result of additional funding ($4.413 million) for the higher drug costs from the Pharmaceutical Benefits Scheme, and increases in patient charges ($2.713 million) and donation revenue ($1.586 million), the variation in net cost of services is less than the variance in total cost of services.

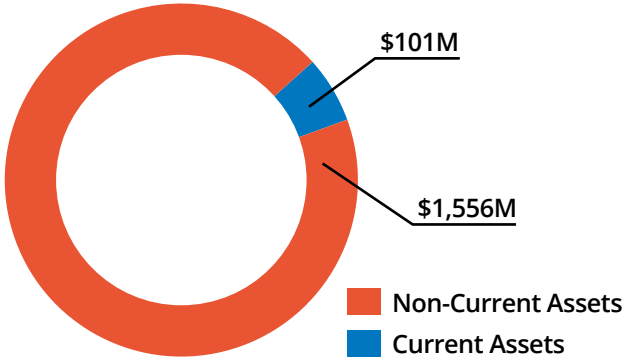
(4) The operating surplus of $8.867 million and the transfer of Crown land amounting to $15.700 million for the Perth Children's Hospice have contributed to the increase in total equity. Conversely, the equity increase has been lessened by the reduction of $10.931 million in State Government's appropriations for capital works program. The details are set out in Note 9.13 'Equity' to the financial statements.

(5) The unexpected increase ($17.892 million) in cash held was mainly caused by the $18.041 million of service agreement funding being received from the Department of Health on the last day of the financial year.

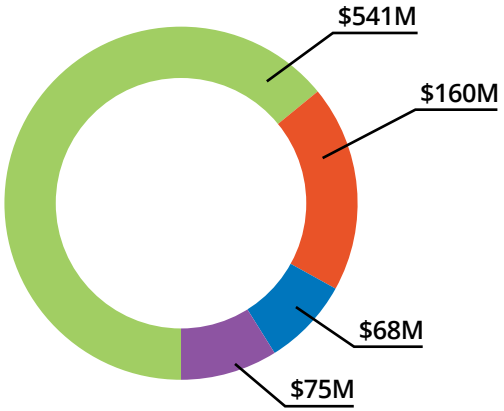
(6) The amounts for salary expense level include superannuation.

(7) Further explanations are contained in Note 9.15 'Explanatory Statement' to the financial statements.

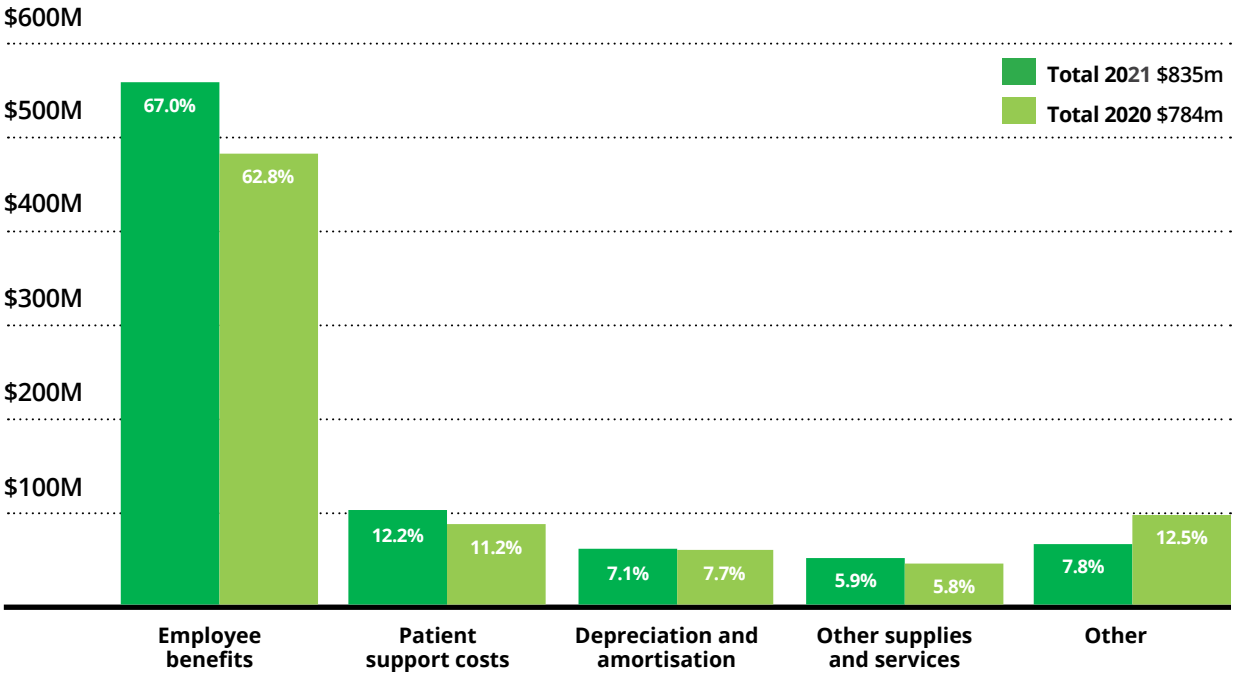
Total assets



Income



Expenditure by type



Total assets

The Child and Adolescent Health Service finished the 2021 year with a total asset value of $1,657 million, which represents an increase of $40 million over the previous year. The major components of assets are Property plant and equipment totalling $1,098 million and Cash and cash equivalents totalling $95 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 2021.

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 $653 million comprising the State component of $493 million and the Commonwealth component of $160 million for the 2021 year. A further $42 million in income was received via services received free of charge from State Government entities and $68 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 2021.

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 2021 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 2021.

Summary of key performance indicators

Key performance indicators assist the Child and Adolescent Health Service (CAHS) assess and monitor the extent to which State Government outcomes are being achieved.

Effectiveness indicators provide information that assess the extent to which outcomes have been achieved through resourcing and delivery of services to the community. Efficiency indicators monitor the relationship between the services delivered and the resources used to provide the service. Key performance indicators also provide a means to communicate to the community how CAHS is performing.

A summary of the CAHS key performance indicators and variation from the 2020–21 targets is given in Table 8.

Note: It is essential that Table 8 be read in conjunction with detailed information on each key performance indicator found in the Disclosures and Legal Compliance section of this report.

Table 8: Actual results versus KPI targets

Key performance indicator		2020–21 Target[1]	2020–21 Actual	Variation	Further info
Unplanned hospital readmissions for patients within 28 days for selected surgical procedures	Appendicectomy	25.7	**16.5**	9.2	p.218
	Tonsillectomy & Adenoidectomy	81.8	**65.5**	16.3	
Percentage of elective wait list patients waiting over boundary for reportable procedures	Cat 1 (≤30 days)	0	**1.6**	1.6	p.220
	Cat 2 (≤90 days)	0	**29.1**	29.1	
	Cat 3 (≤365 days)	0	**21.2**	21.2	
Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days		1.0	**0.48**	0.52	p.221
Percentage of admitted patients who discharged against medical advice	Aboriginal	2.78	**0.14**	2.64	p.222
	Non-Aboriginal	0.99	**0.06**	0.93	
Readmissions to acute specialised mental health inpatient services within 28 days of discharge		12%	**23.3%**	11.3%	p.223
Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services		75	**94.1**	19.1	p.224
Average admitted cost per weighted activity unit		$7,073	**$7,547**	$473	p.225
Average Emergency Department cost per weighted activity unit		$6,853	**$8,013**	$1,160	p.226
Average non-admitted cost per weighted activity unit		$7,025	**$6,877**	-$147	p.227
Average cost per bed-day in specialised mental health inpatient services		$3,815	**$3,408**	-$407	p.228
Average cost per treatment day of non-admitted care provided by mental health services		$617	**$598**	-$18	p.229
Average cost per person of delivering population health programs by population health units		$255	**$250**	-$4	p.230

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**