AGENCY PERFORMANCE

SUMMARY OF KEY PERFORMANCE INDICATORS

Key performance indicators (KPIs) help us monitor and assess how we are progressing toward achieving State Government outcomes. KPIs help inform the community about how CAHS is performing.

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

A summary of the CAHS KPIs and variation from the 2025-26 targets is given in Table 2.

See page 67 for full details of CAHS KPIs.

Table 2: Actual results versus KPI targets

Key performance indicator		2025–26 Target	2025–26 Actual
Unplanned hospital readmissions for patients within 28 days for selected surgical procedures*	Tonsillectomy and adenoidectomy	≤79.2	49.3
	Appendicectomy	≤27.8	29.5
Percentage of elective wait list patients waiting over boundary for reportable procedures	**Category 1** (≤30 days)	0%	3.5%
	Category 2 (≤90 days)	0%	15.5%
	Category 3 (≤365 days)	0%	7.2%
Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days*		≤1.0	1.08
Percentage of admitted patients who discharged against medical advice (DAMA): a) Aboriginal patients; and b) non-Aboriginal patients*	Aboriginal	≤2.78%	0.51%
	non-Aboriginal	≤0.99%	0.06%
Readmissions to acute specialised mental health inpatient services within 28 days of discharge*		≤12.0%	20.1%
Percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services*		≥75%	86.8%
Average **admitted** cost per weighted activity unit		$8,183	$9,925
Average **Emergency Department** cost per weighted activity unit		$8,094	$11,024
Average **non-admitted** cost per weighted activity unit		$8,328	$10,032
Average cost per bed-day in **specialised mental health inpatient services**		$3,445	$7,461
Average cost per treatment day of **non-admitted care provided by mental health services**		$1,117	$1,025
Average cost per person of **delivering population health programs by population health units**		$318	$345

* Data is for the 2025 calendar year.

FINANCIAL SUMMARY

See page 81 for full financial statements.

Table 3: Financial summary

	2025–26 target[1] ($000)	2025–26 actual ($000)	Variation[7] ($000)
Total cost of services (expense limit) (sourced from Statement of Comprehensive Income)	1,194,177	1,276,682	82,505[2]
Net cost of services (sourced from Statement of Comprehensive Income)	1,083,325	1,158,582	75,257[3]
Total equity (sourced from Statement of Financial Position)	1,717,603	1,908,901	191,298[4]
Net increase in cash held (sourced from Statement of Cash Flows)	(2,356)	11,709	14,065[5]
Approved salary expense level	835,900	905,159	69,259[6]

Notes:

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

[2] The major causes for the variation of $82.503 million in total cost of services are the cost escalations for existing, expanded and new services in 2025–26 and award salary increases for employees.

[3] As a result of the higher than budgeted grants and contributions from charitable organisations ($5.785 million) and donation revenue ($2.803 million), the variation in net cost of services is $7.248 million less than the variance in total cost of services.

[4] The estimate, determined at the beginning of the 2026-27 financial year, does not include the year end asset revaluation increments of $133,643 million for 2024-25 and $49.751 million for 2025-26. Additionally, the equity increase has been improved by the operating surplus of $17.736 million. The details are set out in Note 9.13 'Equity' to the financial statements for the year ended 30 June 2026.

[5] The higher than budgeted cash held (+$14.065 million) is mainly caused by the increase of $5.212 million in unspent restricted cash assets and the increase of $5.708 million in unspent funds from the Mental Health Commission.

[6] Salaries and superannuation costs are above budget partly because of the pay increases awarded to employees under the industrial agreements and additional staffing resourcing engaged to address increased service needs throughout the Health Service, expanded and new services and to maintain safety and quality measures within the Perth Children's Hospital.

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

EMERGENCY DEPARTMENT

The 2025–26 financial year saw 73,143 patients attend PCH Emergency Department (ED) for assessment and treatment. Consistent with previous years, 20.8 per cent required inpatient admission following initial treatment in the ED.

Percentage of Emergency Department patients seen within recommended times

The Australasian Triage Scale (ATS) category review time targets are supportive indicators. They measure the time to first review by an ED doctor or nurse practitioner, or the start of treatment.

The triage system aims to provide a balance between the need to provide immediate care to those at highest risk with clinical resources in the ED.

Table 4: Triage categories

Triage category	Description	Response	Target	Achieved
1	Immediate life-threatening	Immediate (≤ 2 minutes)	100%	100%
2	Imminently life-threatening OR time-critical treatment OR very severe pain	≤ 10 minutes	≥ 80%	84.1%
3	Potentially life-threatening OR situational urgency	≤ 30 minutes	≥ 75%	33.6%
4	Potentially serious OR situational urgency OR significant complexity or severity	≤ 60 minutes	≥ 70%	56.7%
5	Less urgent	≤ 120 minutes	≥ 70%	91.3%

The primary commitment of PCH ED remains the immediate clinical assessment and resuscitation of ATS Category 1 and 2 patients. CAHS continues to meet or exceed performance targets for our most critical patients, as shown in Category 1 and 2 data – even with a 5.2 per cent increase in Category 1 and a 2.6 per cent increase in Category 2 presentations this year.

Strategies to increase our workforce of nurse practitioners – highly skilled clinicians who provide an additional level of expertise and continuity in the ED – are helping us better respond to the challenges of rising ED demand.

Following a successful winter 2025 pilot, which increased the number of nurse practitioners in the ED, the bolstered workforce was extended through the 2025–26 summer months.

The expansion of the nurse practitioner role, as well as other strategies to improve workflow efficiency, is reflected in improved outcomes for ATS Category 3 and 4 patients. Targets for Category 3 rose by 23.5 per cent on 2024–25 data, while Category 4 was up by 23.2 per cent on the previous year.

CAHS exceeded the target for Category 5 patients, a 5.1 per cent improvement on the previous year's results.

Quality improvements

More kids get the care they need

Over the past 12 months, PCH ED has nearly halved the rate of families leaving hospital before receiving treatment, meaning more children and young people are getting the care they need.

In 2025–26, the rate of families who leave the ED before being medically assessed or treated – known as 'Did Not Wait' – fell by 41 per cent to 2.7 percent, down from 4.6 per cent in 2024–25.

This improvement reflects ongoing efforts to streamline care and improve patient flow, helping more children and young people received timely treatment in the ED.

Get-a-Fix: Empowering staff for rapid improvements

A new solutions-focused innovation is helping frontline clinical staff identify, mitigate and resolve operational issues in ED before they affect patient care.

Since its launch, the Get-a-Fix platform has been credited with driving rapid, targeted improvements in the ED.

Key improvements include:

- Strengthened collaboration: Brought teams together monthly to identify and address barriers to care, helping children and young people access the right support at the right time
- Better tech: Resolved technical issues to improve how our internal communications system works with hands-free communication devices to ensure seamless clinical coordination
- Improved equipment allocation: Increased the immediate availability of essential diagnostic tools, such as thermometers, in ED.

By turning frontline feedback into actionable data, Get-a-Fix continues to foster a culture of continuous improvement, ensuring our staff are equipped with the tools and systems needed to provide world-class emergency care.

Workforce capability

First paediatric emergency nursing graduates

A specialised training program is strengthening professional competencies among ED nurses and enhancing emergency care for WA families.

Thirteen PCH nurses completed the Postgraduate Certificate in Paediatric Emergency Nursing, delivered through a partnership with Curtin University – the first cohort of PCH nurses to complete this specialised curriculum.

Hospital exchange program supports trauma care

With a focus on inter-hospital collaboration and supporting system-wide trauma readiness, PCH ED has fostered a reciprocal exchange program with Sir Charles Gairdner Hospital (SCGH) and Royal Perth Hospital (RPH).

The program exposes postgraduate ED nurses to trauma care in adult hospital settings, while ED nurses at SCGH and RPH have valuable opportunities to develop paediatric clinical competencies at PCH. The program has received very positive feedback from staff and further strengthened important connections between teams.

Advancing ED research

From coordinating peer-reviewed publications to supporting clinical studies, the ED Research Team continued to advance high quality paediatric emergency medicine research through strong national and international collaborations.

The team contributed to diverse projects including those focused on complex behavioural presentations, febrile convulsions and concussion management. The team is also progressing several clinical prediction tools to support earlier and more accurate diagnosis of appendicitis and cervical spine injuries, and has a strong focus on research-led training and mentoring for staff.

The PCH ED research program is supported by competitive funding from the WA Child Research Fund, the Perth Children's Hospital Foundation, and national schemes including National Health and Medical Research Council and Medical Research Future Fund grants.

PATIENT SAFETY AT CAHS

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

Learning from clinical incidents

CAHS clinicians and support staff bring a high level of expertise and commitment to every patient, at every moment of care. For the vast majority of people who interact with our services, their experience is positive.

However, there are occasions where care does not occur as intended and an interaction may contribute to a clinical incident or unintended harm.

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

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

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

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

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

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

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

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

In 2025–26 CAHS reported and reviewed 17 clinical incidents with a SAC 1 rating.

At the time of this report, 15 reviews from the 2025–26 year have been completed.

Of these, 5 incidents were approved for declassification by the Department of Health Patient Safety Surveillance Unit, based on findings that there were no healthcare factors that contributed to the adverse patient outcome. Two (2) SAC 1 clinical incident reviews are still in progress.

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

Table 5: Patient outcomes for SAC 1 investigations completed or in progress for 2025–26.

No harm	0
Minor harm	3
Moderate harm	5
Serious harm	3
Death	1

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