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

# ANNUAL REPORT 2025–26

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

# WELCOME TO OUR ANNUAL REPORT

**The Child and Adolescent Health Service Annual Report 2025–26 provides an overview of the achievements, challenges, performance results and financial outcomes for the past financial year.**

The report summarises our performance against key performance indicators in line with the *Financial Management Act 2006* and the Public Sector Commission's Annual Reporting Information 2025–26.

With highlights aligned to our strategic priorities, the report reflects the breadth of our services and demonstrates how we are supporting the health and wellbeing of children and young people in Western Australia.



# STATEMENT OF COMPLIANCE

for the year ended 30 June 2026

**Hon. Meredith Hammat MLA**
MINISTER FOR HEALTH; MENTAL HEALTH

In accordance with section 63 of the *Financial Management Act 2006*, we hereby submit for your information and presentation to Parliament, the Annual Report of the Child and Adolescent Health Service for the financial year ended 30 June 2026.

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

**Dr Neale Fong**
Board Chair
Child and Adolescent Health Service
8 September 2026

**Mrs Mary Anne Stephens**
Chair, Finance Committee
Child and Adolescent Health Service
8 September 2026

# ACKNOWLEDGEMENT OF COUNTRY

The Child and Adolescent Health Service (CAHS) acknowledges the Whadjuk and Binjareb people of the Noongar Nation as the Traditional Custodians of the land, sea and waters on which we work and live. We pay our respects to the Elders past and present. Aboriginal people, as the First Peoples, have cared for this land for at least 65,000 years.

We recognise and value their continuing cultural and spiritual connections to this land. CAHS acknowledges the diversity of Aboriginal people from across Western Australia who access the health services provided within CAHS.

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

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

## Using the term Aboriginal

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

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# EXECUTIVE SUMMARY

# MESSAGE FROM THE BOARD CHAIR

**I'm pleased to present the Child and Adolescent Health Service 2025–26 Annual Report.**

It is an honour to serve as Chair of the Child and Adolescent Health Service (CAHS) Board, along with my fellow Board members.

As Western Australia's only dedicated health service provider for infants, children and young people, CAHS plays a critical role in shaping the health and wellbeing of future generations.

Our focus is clear: to deliver high-quality care that enables children and young people to lead healthy, fulfilling lives.

We are committed to providing equitable access to world-class health care, advancing research and innovation, strengthening clinical excellence, and delivering family-centred care. We also remain focused on building a skilled workforce and fostering partnerships that drive better outcomes for WA families.

The Board provides strong governance and strategic oversight to support CAHS operations. Working alongside the CAHS Executive team and across our 3 service areas, we are focused on continuous improvement and ensuring that CAHS is well positioned to respond to emerging challenges and changing community expectations.

We deliver a comprehensive and equitable health service that families can trust, underpinned by compassion, clinical excellence and professionalism. We embrace complexity and are always looking to do better to meet the needs of those we serve.

Building on past achievements, we are progressing the development of a new strategic plan that will set clear priorities and direction for CAHS. At the same time, we are enhancing our approach to risk and governance to ensure we maintain a solid and resilient operating foundation.

The Board is committed to strengthening engagement with frontline staff, patients, clients, families and partners to maintain a clear line of sight to service delivery, operational challenges and the issues that matter.

Over the past year, there have been several changes to the Board. I thank outgoing Board members – Pamela Michael (Chair), Professor Daniel McAullay, Dr Shane Kelly, Dr Alexius Julian and James Jegasothy – for their valuable contribution, leadership and guidance.

I also welcome new members Tracey Brand, Professor Eli Gabbay, Amit Khullar, Dr Peter Steer, Mary Anne Stephens and Kelly Worlock, who join me and continuing members, Meghan Maor, John McLean and Professor Karen Strickland.

The 2025–26 annual report outlines the key achievements, challenges and milestones of the past 12 months and reflects the scale and impact of CAHS' work across WA.

By telling the story of how CAHS is advancing better health for children, young people and their families across WA, our annual report is a powerful reflection of the extraordinary efforts of our workforce.

Thank you to the more than 7,000 staff and volunteers whose commitment, expertise and professionalism underpin everything we do.

I also thank our many partners and stakeholders in academia, research and service delivery for their ongoing collaboration in championing paediatric health care and bringing joy to young Western Australians who engage with our service.

There are also many valued partners at CAHS and I especially acknowledge the generosity of the Stan Perron Charitable Foundation as well as the Channel 7 Telethon Trust and the Perth Children's Hospital Foundation for their ongoing support, brought to us by thousands of Western Australians who support these charities.

Finally, I acknowledge the children, young people and families who put their trust in CAHS. We exist to serve you, and we remain focused on always improving health outcomes now and into the future.

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**Dr Neale Fong**
Board Chair
Child and Adolescent Health Service

# MESSAGE FROM THE CHIEF EXECUTIVE

**I am delighted to present the 2025–26 Annual Report for the Child and Adolescent Health Service.**

Each year, I am reminded that at the heart of everything we do are the children, young people and families who place their trust in us. Supporting their health, wellbeing and future is both a privilege and a responsibility we take seriously every day.

Over the past year, we have continued to make meaningful progress by strengthening our services, responding to growing demand and finding new ways to deliver care that is accessible, compassionate and responsive.

A defining achievement for WA has been the development of Sandcastles (Boodja Mia), the state's first children's hospice, which will soon welcome children and families. This has been made possible through our valued partnership with the Perth Children's Hospital Foundation. The purpose-built service will provide comfort, care and support for children living with life-limiting conditions and their families. It represents something truly special for our community.

We have also continued to expand access to mental health support for young people. Through the growth of our CAMHS Crisis Connect helpline, along with investment in clinician training and lived experience roles, and our Acute Care and Response Teams, we are ensuring young people can access support when they need it most, in a way that is safe and respectful.

At Perth Children's Hospital, increased theatre capacity and an expanded surgical workforce are already making a difference by improving access to care and reducing wait times for families.

We are also focused on the everyday experiences that matter. Initiatives like Meals on Demand are transforming hospital stays by giving patients and families more choice, flexibility and comfort. These are small changes that can make a big difference.

Listening remains central to our approach. We continue to learn from children, young people and families, using their feedback and insights to shape how we grow and improve our services. In child development, this has included expanding access and creating practical online resources to support families navigating concerns such as attention, regulation and ADHD.

Our commitment to research ensures we continue to look ahead, better understand emerging health challenges and identify new ways to prevent, diagnose and treat illness and injury.

We are also working to strengthen how we connect with the diverse communities we serve. Programs like our Consumer Ambassador initiative, along with more accessible and translated information, are helping to break down barriers and build stronger, more inclusive relationships. Engaging with and learning from Aboriginal consumers helps us build understanding and adapt our services to ensure care is culturally appropriate for Aboriginal children, young people and their families.

As an organisation, CAHS is on an exciting journey of discovery, refreshing our strategic direction to ensure we have the right foundation to continue to deliver on our promise to the community.

The progress outlined in our annual report reflects not only the scale and complexity of our services, but also the incredible dedication of our people. I am continually inspired by the skill, compassion and dedication of our staff, the generosity of our volunteers and the strength of our partnerships.

Finally, I would like to thank the children, young people and families who have shared their journeys with us this year. Your voices are at the centre of everything we do, and they continue to guide and inspire our commitment to delivering the best possible care.

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**Valerie Buić**
Chief Executive
Child and Adolescent Health Service



# OVERVIEW

# WHO WE ARE

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

### Child and Adolescent Community Health

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

### Child and Adolescent Mental Health Services

Child and Adolescent Mental Health Services (CAMHS) provides specialist public mental health services for children and adolescents with moderate to severe and complex mental health conditions.

Inpatient and specialised services are based in Perth and accessible to children and young people throughout WA.

Community clinics offer network-based outpatient services in metropolitan Perth.

### Perth Children's Hospital and Neonatology

Perth Children's Hospital (PCH) is WA's only specialist paediatric hospital and trauma centre. PCH provides clinical care to children and adolescents under 16 years of age.

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

CAHS supports the health and wellbeing of children in WA, from birth to young adulthood. We aim to give children the best start in life through early intervention and patient-centred, family-focused health care.

Our services are delivered at PCH, KEMH, at more than 160 community clinics, and in schools and homes across metropolitan Perth.

Our workforce and the children and families we serve come from many backgrounds, reflecting the diversity of our WA community. We embrace this diversity and are committed to making everyone who engages with our service feel welcome, respected and valued.

### Why we exist

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

### Child safe organisation

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

CAHS is committed to being a child safe organisation in line with the National Principles for Child Safe Organisations. This is a commitment to a strong culture, reflected through strategy, policy and day-to-day actions and behaviour, to ensure that children are protected.

# OUR VALUES

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

### Excellence

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

### Accountability

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

### Compassion

We treat others with empathy and kindness.

### Collaboration

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

### Equity

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

### Respect

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

# OUR STRATEGIC DIRECTION

Our mission is to create healthy futures for all children and young people in WA.

To help us achieve this, we are developing a new strategic plan – our CAHS Strategy 2026–2031.

By setting out a clear roadmap for CAHS, this new strategy will define our long-term goals and strategic priorities to ensure we remain focused, effective and sustainable as we continue our work championing paediatric health care in WA.

**We continue to be guided by our 8 strategic priorities:**

- Person-centred care
- Prevention and early intervention
- Workforce capability, capacity and development
- Contemporary models of care
- External partnerships
- Inclusivity, diversity and equity
- Organisational culture
- High performance.

# OUR CHILDREN AND YOUNG PEOPLE AT A GLANCE

| Child and Adolescent Health Service | | |
|---|---|---|
| **CAHS interactions with children and young people in 2025–26** | **1,275,405** | **financial year** |
| **Perth Children's Hospital and Neonatology** | | |
| Neonatal hospital admissions | 3,116 | financial year |
| Neonatal days average length of stay | 11 | financial year |
| Neonatal emergency transports | 1,021 | financial year |
| Number of pre-term babies | 358 | financial year |
| Litres of donor milk | 1,022 | financial year |
| Emergency Department (ED) attendances | 71,148 | financial year |
| Hospital admissions | 34,358 | financial year |
| Surgeries performed | 16,875 | financial year |
| Outpatient appointments | 310,373 | financial year |
| Patients receiving outpatient care | 69,210 | financial year |
| **Child and Adolescent Community Health** | | |
| Child health assessments | 119,825 | financial year |
| School entry health assessments | 27,078 | school year |
| Children who received services from the Child Development Service | 44,067 | financial year |
| Immunisations | 123,498 | calendar year |
| New babies welcomed | 25,389 | financial year |
| Families who accepted offer of universal postnatal visit | 24,531 | financial year |
| **Child and Adolescent Mental Health Services** | | |
| Service contacts | 141,204 | financial year |
| Young people seen | 5,997 | financial year |
| Mental health ED presentations | 2,224 | financial year |
| Inpatient unit separations | 523 | financial year |
| CAMHS Crisis Connect calls received | 11,183 | financial year |

# OUR PEOPLE

With a more than 7,000-strong workforce, our incredible employees work with dedication, commitment and professionalism to support the health needs of children and young people in WA across our 3 service areas:

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

**7,406** Number of employees

**3,739** Full-time employees (50.5%)

**3,667** Part-time employees (49.5%)

**27** Senior leadership roles held by women (77.1%)

**113** Aboriginal people (1.5%)

**66** Employees with disability (0.9%)

**1,064** Culturally and linguistically diverse people (14.4%)

**484** Young people aged 18–24 years (6.5%)

Table 1: Total full-time equivalent roles by category

| Category | Description | 2024–25 | 2025–26 |
|---|---|---|---|
| **Administration and clerical** | All clerical occupations, together with patient-facing (ward) clerical support staff. Board members | 1,149.2 | 1,182.5 |
| **Agency** | Administration and clerical, medical support, hotel services, site services, medical salaried (excludes visiting medical practitioners) and medical sessional | 43.6 | 24 |
| **Agency nursing** | Workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest | 7.8 | 5.4 |
| **Assistants in nursing** | Workers who support registered nurses and enrolled nurses in the delivery of general patient care | 61.8 | 57.4 |
| **Dental nursing** | Dental nurses and dental clinic assistants | 9.4 | 9.7 |
| **Hotel services** | Catering, cleaning, stores/supply, laundry and transport occupations | 248 | 260.8 |
| **Medical salaried** | All salary-based medical occupations, including interns, registrars and specialist medical practitioners | 594.7 | 638.5 |
| **Medical sessional** | Specialist medical practitioners who are engaged on a sessional basis | 98.6 | 101.2 |
| **Allied health and health science** | Allied health, health scientists and technical-related professions | 834.7 | 887 |
| **Nursing** | All nursing occupations. Does not include agency nurses | 2,051.6 | 2,111.1 |
| **Site services** | Engineering, garden and security-based occupations | 26.4 | 32.5 |
| **Other roles** | Aboriginal and culturally and linguistically diverse roles | 26.9 | 27.9 |
| **Total** | | **5,152.6** | **5,337.9** |



# OUR VOLUNTEERS

**With their generous spirits and warm smiles, our volunteers are important members of the CAHS team. Volunteers share their time to create a positive and welcoming experience for all children, young people and families who come to CAHS.**

This year our more than 500 volunteers contributed a collective 750 hours a week across 42 service areas, helping children and families feel supported, reassured and cared for. Whether by greeting families, assisting with activities or simply being there to listen, our volunteers ease stress for children and families, allowing staff to focus on clinical care.

Our team reflects the diversity of the community we serve. CAHS volunteers speak more than 45 languages and represent a wide range of ages and experiences. Many are students who are building skills in teamwork, communication and engagement. Some volunteers progress to careers in health – 6 former volunteers joined this year's CAHS nursing graduate program.

The number of people volunteering with CAHS increased by 20 per cent this year, providing more opportunities for children and families to experience our team's support. Sometimes just being there to sit and listen can make the world of difference to the emotional wellbeing of children, young people and families who come to CAHS.

Our much loved therapy dog program continues to offer comfort and connection through regular furry-friend visits to children, families and staff around PCH.

We've trained more than 60 new volunteers who will provide specialist support to children facing life-limiting conditions and their families at the Sandcastles (Boodja Mia) Children's Hospice.

Our volunteers give back to the broader community by assisting in the distribution of donated goods to families in need, and play an important role at key events at CAHS, including Patient Experience Week and our popular Christmas program.

We're incredibly grateful for the compassion and commitment our volunteers show in supporting children and families and strengthening community connections.


# IN THE MEDIA

**Throughout the year, media coverage helped connect communities with CAHS services, highlighting significant achievements and sharing trusted health information.**

This increased visibility supported greater awareness of our work and strengthened our connection with the children, young people and families who rely on our services.


*QR code: Channel 9News coverage*

### Extraordinary care, exceptional teamwork

Celebrating a fantastic outcome for baby Leo, one of only 20 people worldwide diagnosed with a rare and aggressive tumour.


*QR code: 7News coverage*

### Sun safety warning

Media coverage highlighted the dangers of sunburn in young babies, reinforcing the importance of sun safety.


*The West Australian, 18 November 2025, pages 14-15*
*QR code: 7News coverage*

### World-first technology improving care for pre-term babies

Showcasing a world-first study at the CAHS Neonatal Intensive Care Unit at King Edward Memorial Hospital using advanced imaging technology to better understand the skin health of extremely pre-term babies.


*POST Newspaper, 30 May 2026, page 6*

### The heart of patient care

Local media coverage highlighted the invaluable contribution of volunteers across CAHS, featuring one of PCH's longest-serving volunteers. The story showcased the compassion, dedication and support our volunteers provide to children and families during some of their most challenging moments.


*The West Australian, 20 November 2025, page 19*
*QR code: Channel TEN and The West Australian coverage*

### 25 years of laughter and healing

Celebrating the 25-year partnership between PCH and Clown Doctors Australia, recognising the positive impact of humour and play in health care.


*QR code: Channel 9News coverage*

### Ground-breaking brain cancer trial offers new hope

Media coverage highlighted how PCH is improving access to innovative treatments, featuring 11-year-old Maria, the first child in Australia to join an international clinical trial for a targeted brain cancer therapy.

# BUILDING CONNECTIONS THROUGH SOCIAL MEDIA

**Social media remains an important way for us to engage with our community and showcase our services, initiatives and people that make a difference every day.**

With a combined audience of 52,800 followers, we delivered 476 posts and stories across our social media platforms, including 168 Facebook posts, 153 Instagram posts, 127 LinkedIn posts and 28 cross-platform stories, extending the reach of our key messages and strengthening connections with our audiences.

*Facebook | Reach 114,586 | Likes 967*

### Helping babies thrive

In late June 2026, we shared baby Charlie's story to showcase the incredible difference donor breastmilk can make for premature and medically fragile babies. Born at just 27 weeks' gestation, Charlie depended on donated breastmilk during the earliest and most fragile stage of his life, helping him grow stronger every day.

His journey not only celebrated the generosity of milk donors, but also highlighted the urgent need for more Western Australian mothers to donate and help give vulnerable babies the best possible start.

*Instagram | Reach 8,452 | Likes 436*

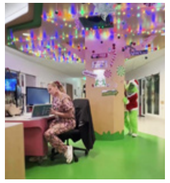
### Making MRI scans less scary

Seven-year-old Vinnique helped showcase PCH's upgraded 3T MRI, becoming one of the first children to use the new technology. The story highlighted how we are investing in innovative equipment to deliver better care, comfort and outcomes.

*LinkedIn | Reach 3,351 | Likes 154*

### Needle-free flu protection for WA children

CAHS played a key role in launching Australia's largest FluMist program, expanding access to a needle-free influenza vaccine for children and helping make immunisation a more positive experience for families.



*Instagram | Views 26,659 | Likes 1,155*

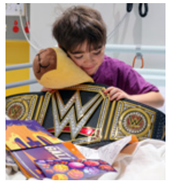
### The Grinch visits Ward 2B

A staff-created reel featuring an unexpected visitor to Ward 2B showcased the spirit of Christmas at CAHS. The reel highlighted how our teams go above and beyond to ensure children and families experience moments of joy, warmth and community during the festive season.


*Facebook | Reach 32,423 | Likes 210*

### Nursing excellence recognised

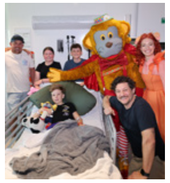
The Rotary-CAHS Nurse of the Year Awards celebrate outstanding nurses who go above and beyond to deliver exceptional child and family-centred care.



*Facebook | Reach 68,541 | Likes 931*

### Special visitors, lasting memories

A visit from WWE superstars brought excitement, laughter and unforgettable moments to young patients at Perth Children's Hospital.



*Facebook | Reach 35,104 | Likes 749*

### Telethon 2025

CAHS was proud to be part of Telethon 2025. Throughout the weekend our staff supported the event through hospital tours, helping in the call centre and sharing inspiring patient stories that highlighted the impact of Telethon for WA children and families.

@perthchildrenshospital

Perth Children's Hospital and Health Service

Child and Adolescent Health Service

# OUR AWARD WINNERS

**We're incredibly proud of the achievements of the many talented people who are part of our CAHS team.**

From advanced research and clinical excellence to tech-led health innovations and best practice corporate management, our amazing staff are making outstanding contributions to the WA community and beyond.

We highlight a selection of our people whose contributions have been honoured via leading formal awards and recognition programs.

## Australia Day Honours List

**Dr Geoff Knight**
Medal of the Order of Australia (OAM) for service to paediatric medicine

**Dr Barry Denison Lewis (retired)**
Member of the Order of Australia (AM) for significant service to biochemical paediatrics and genetics

## Premier's Science Awards

**Professor Asha Bowen OAM**
Mid-Career Scientist of the Year

## WA Excellence in Allied Health Awards

**Weekend Feeding Team at PCH**
Allied Health Team of the Year

**Michelle Gardner, Allied Health Assistant Coordinator at Child Development Service**
Allied Health Assistant of the Year

## Institute of Public Administration Australia WA Achievement Awards

**CAHS Complaints Management Improvement Project**
Commissioner for Children and Young People Award for Best Practice in Child-focused Complaints Handling

## INCITE Awards

**CAHS MERLIN team**
Merit Award

## WA Nursing and Midwifery Excellence Awards

**Sarah Smith, CACH Clinical Nurse Specialist**
Excellence in Primary, Public and Community Nursing

## Patient Australia Awards

**CAHS Hospital in the Home remote monitoring service**
Outstanding Patient Innovation Award

**Cloe Benz, Allied Health Coordinator**
Outstanding Allied Health Clinician Award

*CAHS Hospital in the Home remote monitoring service team*

*PCH Weekend Feeding team*

*Sarah Smith*

*CAHS Complaints Management Improvement team*

# CONSUMER ENGAGEMENT

When families come to CAHS, we want them to be confident they will be listened to, valued and will receive the best care possible for their child and for their family.

To build this culture of trusted care, CAHS is committed to meaningful engagement that's focused on truly listening and understanding consumer needs. We partner with consumers to identify and reduce barriers, support access to care and develop more responsive services.

As part of our commitment to stronger consumer partnership, this year we embedded lived experience more directly into our service design, governance and quality improvement.

An example of how we're creatively engaging with consumers is our 'consumer buddy' model. This approach successfully pairs consumer representatives with clinical services to gather real-time consumer feedback and support co-design.

Our consumer advisory groups also continued to play a central role in representing the voices of children, young people, parents and carers.

As a valuable connection to those we serve, our advisory groups help us better understand the consumer experience, the issues that matter most, and how we can improve our services, policies and supports. Focus topics this year included improving bereavement support for families, enhancing approaches to culturally responsive care through greater representation and participation, and highlighting service access and navigation issues.

Our achievements this year reflect the progress we're making in placing consumers at the core of our work, and our commitment to improving experiences and outcomes for all children, young people and their families.

## Other consumer engagement highlights:

- our Complaints Management Improvement Project won the Commissioner for Children and Young People Award for Best Practice in Child-focused Complaints Handling at the Institute of Public Administration Australia WA Achievement Awards
- co-developed the first CAHS multicultural safety indicator with questions tested by families
- presented the CAHS-led Adolescent Patient-Reported Experience Measure tool nationally through Children's Healthcare Australasia
- joined CAHS Community Ambassadors at multiple community events, including Harmony Week and Youth Week celebrations, strengthening relationships with broader multicultural and youth communities
- implemented the Hidden Disabilities Sunflower Program through staff training and resources
- developed a consumer profile dashboard that improves the visibility of service usage data across CAHS to better inform decision-making
- developed new guidelines to strengthen consumer involvement in policy development and staff training and education
- introduced new consumer advisory groups for clinical services including neonatology, neurology, the Children's Hearing Implant Program, and the Kids Pelvic Health Group Project
- held consumer focus groups about transitioning to adult services to improve neurology and epilepsy services
- consulted with children on the Kids' Voices on Heat project to better understand how children experience extreme heatwaves
- facilitated feedback to mental health service providers from the CAMHS Lived Experience Advisory Group about the transition from youth to adult mental health services.


## Community voices making a difference

Our CAHS Community Ambassadors are passionate community leaders who share their experiences, ideas and cultural knowledge to help improve care for children, young people and families.

This year we launched My Why? – a new series introducing these incredible individuals who share in their own words what drives them to do this important work.

From supporting recent migrants and families of refugee background, to advocating for young people, people with disability, and culturally diverse communities, each Ambassador brings a unique perspective and a strong desire to make a difference.

Learn more about the CAHS Community Ambassador Program on page 39.

Scan the QR code to meet all our Ambassadors and to find out more about the My Why? project

## LISTENING, LEARNING AND IMPROVING TOGETHER

**At CAHS, some of our most important lessons come from families whose experiences with our services did not meet expectations.**

This year, we further strengthened our commitment to partnering with families who have experienced adverse outcomes or felt their voices were not heard during their care journey. Through respectful and sensitive processes, families have been able to share their experiences, provide honest feedback and help us better understand the impact our services can have beyond clinical care.

One family partnered with us to create an educational video about their child's care. They described feeling unsupported and uncertain during an already difficult time. While the outcome could not be changed, their willingness to share their story highlighted opportunities to improve communication, care coordination and family-centred care.

The video is now used in staff education sessions, providing a powerful reminder of the human impact behind clinical decisions and systems. Staff reflected that hearing a parent's real-life experience, rather than a hypothetical scenario, made the learning more meaningful and memorable. Many said the story clearly illustrated how gaps in communication and escalation can combine to contribute to poor outcomes, reinforcing the importance of speaking up, advocating for families and acting on concerns.

The family's insights have informed improvements to staff education, communication practices and processes designed to ensure families feel heard, respected and involved in decisions affecting their care.

By creating safe opportunities for families to share their experiences, we are better equipped to learn, adapt and deliver compassionate, responsive care for children, young people and their families. Importantly, this work helps us move beyond understanding what happened clinically to serving as a powerful reminder that families are at the centre of everything we do.

The courage and generosity of families who share their experiences continues to drive meaningful change across our organisation, helping us improve the quality and safety of care for all Western Australian children and young people.

# CONSUMER FEEDBACK

We are committed to understanding the experiences of children, young people and their families who access CAHS services. We use this feedback to adapt and improve how we care for them.

CAHS proactively seeks consumer feedback to better understand what matters most to our community and to inform improvements across our services.

This year we received an increase in consumer feedback compared with 2024–25, reflecting our ongoing efforts to actively listen to families and ensure their voices help shape the care we provide.

During the 2025–26 period:

- 801 compliments were received through formal feedback processes
- 547 contacts were received through the Child and Family Liaison Service
- 797 complaints were received through formal feedback processes.

From these:

- 100 per cent of complaints were acknowledged within 5 working days
- 95.6 per cent of complaints were resolved within 30 working days.

We value the feedback we get from children, young people, families and carers. It gives us insight into people's experiences of care and the positive impact of our workforce. Feedback demonstrates that CAHS staff consistently deliver care with compassion and kindness, in line with our organisational values.


# MEASURING THE CONSUMER EXPERIENCE

## How we measure the consumer experience

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

What is a good NPS score?

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

### Perth Children's Hospital and Neonatology

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

| | |
|---|---|
| 78 | Inpatient |
| 74 | Outpatient |
| 64 | Emergency Department |

Key themes that emerged:

- **Compassionate, family-centred care:** There was consistent praise for kind, empathetic staff who listened, took concerns seriously, and made families feel safe, respected and supported.
- **Clinical excellence and reassurance:** Families expressed strong confidence in staff expertise and thorough care. Families highlighted timely treatment, clear explanations, and reassurance their child was receiving high-quality, appropriate treatment.
- **Timely, effective emergency response:** Families frequently praised the rapid triage, prompt treatment, and thorough assessment, particularly when children were acutely unwell. Families felt confident their child was prioritised appropriately.
- **Trust in expertise and facilities:** Families consistently expressed confidence in PCH as the right place for children's emergency care. Families valued specialist paediatric knowledge, thorough investigations and the safe, child friendly environment.

### Child and Adolescent Mental Health Services

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

| | |
|---|---|
| 89 | Overall experience score for young people |
| 87 | Overall experience score for parents/carers |

Key themes that emerged:

- **Feeling heard, safe and respected:** Young people and carers consistently valued non-judgemental listening, feeling understood, emotional safety, and being treated with dignity and empathy across services.
- **Strong therapeutic relationships with staff:** There was repeated praise for kind, knowledgeable clinicians who built trust, explained things clearly, respected boundaries, and adapted care to individual needs.
- **Accessible, flexible and supportive care:** Young people and carers expressed high appreciation for timely access, including crisis and after-hours support. Respondents reported consistent follow-up, flexibility in appointments and settings (home, school, community), and practical approaches that supported recovery and confidence.

### Child and Adolescent Community Health

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

| | |
|---|---|
| 84 | Nursing |
| 82 | Child Development Service |

Key themes that emerged:

- **Respectful, family-centred care:** Families consistently experienced care that recognised and respected their values, perspectives and priorities. They felt they were at the centre of decision-making.
- **Collaborative partnerships built on trust:** Families reported strong partnerships with staff, characterised by shared trust, mutual respect and active collaboration towards agreed goals and outcomes.
- **Clear communication and coordinated support:** Families reported consistent, clear communication and effective coordination across staff and teams, which supported continuity of care and a responsive, flexible service experience.

# CONSUMER REPRESENTATIVES

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

**The CAHS Consumer Leadership Council (CLC) has continued to strengthen its role as a key mechanism for elevating consumer voices across the service.**

As Co-Chairs, we are proud to support a council that brings together diverse lived experience perspectives and works collaboratively to influence meaningful change for children, young people and families.

Over the past year, the CLC has focused on strengthening communication between CAHS' consumer advisory groups, the council, and CAHS leadership. The improvements provide clearer guidance on handling consumer insights, which support greater transparency, and ensure consumer priorities are clearly understood and responded to at all levels of the organisation.

The CLC has provided input into priorities such as transition from paediatric to adult health services, LGBTIQA+SB* safety, and sustainability, and advised on key strategic initiatives, ensuring consumer perspectives are embedded in planning, service design and evaluation.

Through these contributions, the CLC is helping to shape a more responsive, inclusive and person-centred health service.

We acknowledge and thank the many consumer representatives who generously contribute their time, experience and insight, as well as the CAHS staff and Executive who continue to engage with and support this work. Together, we are strengthening a culture where consumers are valued partners in shaping the future of care.

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**Amelia Hu and Harley Müller**
Co-Chairs
Consumer Leadership Council

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

# CONSUMER ADVISORY GROUPS

**CAHS has 6 consumer advisory groups which act as a collective voice for consumers. Our advisory group members share their diverse perspectives and lived experiences to inform decision-making and shape CAHS services so that we can adapt to better meet the needs of all those who engage with our health service.**

### Aboriginal Community Advisory Group (ACAG)

The ACAG brings an Aboriginal cultural lens to CAHS, providing advice and guidance to ensure service delivery and care is culturally appropriate for Aboriginal children, young people and families who engage with CAHS.

By sharing learnings and experiences, the advisory group supports a more inclusive health service that improves health outcomes for Aboriginal families. This year the ACAG provided Aboriginal cultural advice on engagement activities, Aboriginal Health research, CAHS innovation projects, and to senior leadership.

### Parent and Carer Advisory Group (PCAG)

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

The PCAG continued to strengthen the role of lived experience in shaping service delivery and improving outcomes for families. The group supported 18 service improvement projects including improving parent information, trauma-informed care approaches, PCH meal options, and support for families of neurodivergent children and young people.

The group continued its successful 'consumer buddy' partnership, which embeds a consumer representative in a clinical service with the aim of strengthening consumer-focus and deepening connections with families.

### Youth Advisory Group (YAG)

The YAG is the key consumer advisory group for young people who use services at PCH and CACH. Its members offer diverse perspectives and lived experience from across our services, providing crucial insights to enhance health services for all children and young people.

This year the YAG launched a youth-led project to improve young people's understanding of their healthcare rights. Group members attended community events, and adopted a bespoke engagement approach to drive meaningful conversations with young people about their healthcare rights. This approach was used by the YAG to represent CAHS at various 2026 Youth Week events.

### Multicultural Access and Inclusion Advisory Group (MAIAG)

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

This year the MAIAG focused on improving culturally responsive resources and engagement. Key initiatives included the 'I wear a veil' poster, translated pamphlets with accessible information about trusted child health resources, and a review of consumer engagement policies to better prioritise and support engagement with culturally and linguistically diverse families.
The group continued to build stronger connections by participating in cultural events and tailored workshops with diverse communities.

These efforts demonstrate CAHS' commitment to reducing barriers, strengthening multicultural safety, and partnering meaningfully with multicultural families across WA.

### Disability Access and Inclusion Advisory Group (DAIAG)

The DAIAG advises on and advocates for improved disability access and inclusion across CAHS services and monitors the implementation of the CAHS Disability Access and Inclusion Plan 2026–2028.

This year the DAIAG focused on developing neuro-affirming resources and strengthening staff training to better support neurodivergent children and young people. This included building staff capability, increasing awareness of barriers, and embedding practical tools, such as video resources for families, accessible handouts and expanded social stories, to improve healthcare experiences.

The DAIAG strengthened its collaboration with Carers WA, Kiind, ADHD WA, the Autism Association and the Youth Disability Advocacy Network. Together, these partnerships improved the recognition of carers and contributed towards the creation of CAHS' first Neurodiversity Celebration Week formal event, alongside ongoing advocacy for more inclusive and accessible services.

### CAMHS Lived Experience Advisory Group (LEAG)

The LEAG is made up of young people, parents and carers with lived experience of CAMHS services. This year the group continued to provide input into service development, reform and quality improvement initiatives across CAMHS.

A key focus this year was improving transitions between youth and adult mental health services. The group developed a formal letter outlining lived experience perspectives, service gaps and recommendations to inform broader discussions with the Mental Health Commission.

The LEAG also co-developed the first CAMHS social story resource in partnership with CAMHS Inpatient Services and continued to provide consultation across a range of initiatives, including CAMHS Multi-Systemic Therapy, Crisis Connect statewide expansion, CAMHS reform initiatives, and other service improvement projects.

# COMPLIMENTS

**We're delighted to hear from children, young people and their families about their positive experiences with our services.**

This year we received compliments highlighting the consistent delivery of compassionate, person-centred care across CAHS services.

Families, children and young people frequently described staff as kind, attentive and professional. They told us they felt valued, listened to, reassured and supported through difficult – and often highly emotional – experiences.

The feedback reflects the impact of our work across nursing, allied health, surgical, medical, emergency, mental health, neonatology, psychology and social work services.

From early intervention and developmental support, to acute care and practical assistance for families, the compliments are testament to a workforce that combines clinical expertise with empathy, respect and genuine commitment to children and families.

These accounts affirm our workforce commitment to service, reflecting the positive difference our staff make every day.

**Builds a sense of belonging**

The School Health Nurse is a high-energy, high-care practitioner who plays a key role in building a strong sense of belonging ... Her nurturing personality and unwavering positivity help create an environment where students and staff feel supported and encouraged.

**Kindness and thoughtful gestures**

Thank you will never be enough for the care and kindness of all the healthcare staff ... The kind gestures, from asking how we were doing to making name signs for our son. Thank you so much.

**Doctor took the time to listen to concerns**

Mum said that this was the first time that a doctor listened to her about her child's weight ... She really appreciated him taking the time to listen to her concerns. She and the whole family are very thankful.

**Confidence improved in a few sessions**

We were so happy with the excellent assessment and service our son received from the Occupational Therapist. We have seen his handwriting, fluency and confidence improve in just a few sessions ... We are so appreciative of this service.

**Kind encouragement helped recovery**

From the bottom of our hearts, we appreciate all of your support and kind encouragement on our son's journey. He is in great recovery again. He is doing really well. We miss you.

**Outstanding care**

I would like to highlight the outstanding quality of care ... All the medical team members we saw were exceptionally nice, gentle and understanding ... I felt warmth and kindness all the time.

**Helped us better understand our child's needs**

Through your sessions, we've gained a much deeper understanding of my child's needs ... The strategies, tools, and guidance you've provided have been invaluable to our entire family ... We are truly grateful for your dedication, compassion, and expertise.

**First-class care, teamwork and trust**

Our sincerest thank you to each and every team member for the first-class care ... We always knew that our son was in the very best hands ... It was great to see the fantastic culture of your team – doctors, nurses and everyone in between working together with respect and trust.

**Trust, growth and meaningful support**

You have helped me grow as a person and helped me get through this rough patch of my life ... I have connected so well with you over these months and have grown so much trust ... Thank you for everything you do. It's truly amazing.

# CARE OPINION

**Care Opinion is an online platform where consumers can anonymously share their healthcare experiences, whether good, great or in need of improvement. It is independent from service providers and supplements existing feedback and complaint management systems.**

Over the past year CAHS received 31 Care Opinion submissions. All Care Opinion stories were shared with staff to highlight areas for improvement and to celebrate achievements.

**Kindness and empathy eased stressful situation**

Our grandson was born requiring surgery post-delivery and transferred from KEMH to PCH via the Newborn Emergency Transport Service. From the neonatal transport service through to all the staff on Level 3B, I say a very big thank you. The care for our grandson and his family was exceptional. There was a lot of kindness and empathy shown and this goes a long way in such a stressful situation.

The consultants were wonderful at explaining what and why certain procedures were being done and although the medical language used when describing someone's precious first baby was sometimes confronting, we as a family were able to process due to our medical backgrounds.

I am a nurse and work within WA Health, and it was amazing to witness firsthand the wonderful nursing care on ward 3B. Again, a big thank you from us all for the incredible job you all do.

**Exceptional care at PCH**

Our 9 year old son was admitted for what we assumed was appendicitis in late August. When he went in for surgery it was discovered it was a slightly more complex issue which was dealt with at the time and he's on his way to a full recovery, resting at home.

We would like to sincerely thank everyone involved in his care, particularly Dr Michael who kept us updated while we were waiting for him to come out of surgery; the fantastic ED team who were patient and caring while he came to terms with various needles, prods and pokes and the ward nurses and support staff in 2B and post-op.

Every interaction, every observation check, every request was dealt with a level of care that made our boy feel informed and important. No one spoke over him or around him.

**Team did an amazing job**

My son got hit by a car and was sent to the Perth Children's Hospital. This was my first time going there and I was nervous as to the care he would get.

Right from the start, all the medical staff, nurses and doctors we saw were great! They were very professional, helpful and friendly. The facilities were great (Fun on Four is awesome!!)

Really want to thank everyone working at the Perth Children's Hospital. I think you guys did an amazing job!! In my opinion, you're doing a hard job, over-worked, and seemingly not recognised nearly enough. Everyone we saw made our time there as painless as possible. Thank you again!!

**Understanding and compassion in the ED**

I attended the PCH ED with my 5 year old recently ... It was very busy and there were lots of sick children and worried parents. Despite the busyness, I believe every single staff I saw was doing their best to ensure that families knew what was happening in their care and checked on them frequently and always with understanding and compassion. Great effort was made to ensure the kids knew what was happening as well.

Our nurse, Tracey working in fast track, was exceptional. Even when she came into the waiting room to see other families, she always checked on us, made sure we knew the plan and had everything we needed in the moment. She was calm and kind which is what everyone needs in that moment. She explained what was happening to my son in a way he could understand and always gave him time to ask questions that he had.

The Resident Medical Officer, Steph, was also wonderful and we appreciated her honesty and compassion around the plan and potential wait. She was thorough and child-centred.



# PERFORMANCE HIGHLIGHTS

**This chapter showcases a selection of our achievements, activities and milestones over the last 12 months.**

**The highlights from across our 3 service areas demonstrate how we are working towards achieving our strategic priorities and improving community outcomes.**

# OVERVIEW OF OUR STRATEGIC PRIORITIES

**CAHS aspires to be a safe, trusted and professional leader in child and adolescent health and wellbeing, and an organisation that truly partners with children, young people and their families to best meet their needs.**

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

Everything we do at CAHS is underpinned by our strategic priorities. Our strategic priorities guide our decisions in planning, investment and operations. They inform the way we work and provide direction for where we want to be in the future.

### Incorporating our priorities into everything we do

The following performance highlight stories demonstrate our progress towards achieving our strategic priorities.

The icons alongside each story reflect the strategic priorities they align to. Many stories feature multiple icons, showing the breadth and inter-connectedness of our operations and how many of our activities at CAHS work towards multiple strategic priorities.

### Person-centred care

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

### Inclusivity, diversity and equity

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

### Organisational culture

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

### High performance

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

### Prevention and early intervention

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

### Contemporary models of care

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

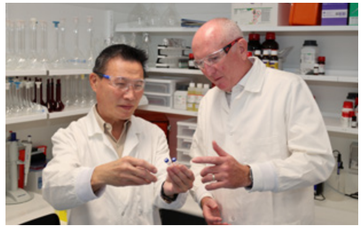
### Workforce capability, capacity and development

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

### External partnerships

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

# PERFORMANCE HIGHLIGHTS



## PCH leads way on medicine supply

Patients around Australia are benefiting from medicines made possible by PCH's specialist pharmaceutical manufacturing facility in Perth.

The purpose-built Auspman facility supplies public hospitals around the country with medicines that are not commercially available or cannot be prepared in hospital pharmacies.

The facility supplies more than 35,000 units each year to over 20 health service sites in WA and will soon expand to supply a further 100 hospitals across Australia.

Built to meet contemporary quality and regulatory standards, Auspman showcases the depth of capability, innovation and commitment to ensuring children and young people at PCH – and patients in other Australian public hospitals – have access to the medicines they need.

The facility also plays an important role in supporting clinical trials and research, and strengthening Australia's pharmaceutical manufacturing capability.

## Hospice to support compassionate, family-centred care

WA's first dedicated children's hospice, Sandcastles (Boodja Mia), is set to open its doors later this year, representing a significant step forward in compassionate, family-centred care for children with life-limiting conditions.

Designed as a place of comfort, care and support for children and families across WA, the purpose-built hospice will provide a warm, welcoming and home-like environment that respects every child's individuality and every family's unique journey.

Delivered through a partnership between CAHS and the Perth Children's Hospital Foundation, Sandcastles expands the existing specialist paediatric palliative care services. It will offer 24/7 medical and nursing care, flexible respite and symptom management stays, and comprehensive family and bereavement support to families across WA.

Every detail of the hospice has been shaped through consultation with families, clinicians and community members. With thoughtfully designed spaces, including family suites, sensory areas, gardens and therapeutic facilities, Sandcastles promotes wellbeing, connection and moments of joy alongside high-quality, safe and compassionate care.

Integrated glass artworks were developed through creative workshops with WA artists and children, families and volunteers. Outdoor areas have been designed with light, orientation and tranquility in mind, and feature rammed earth walls, native gardens and a nature play zone.

More than a building, Sandcastles is a place where families can spend meaningful time together, supported with dignity and compassion. Sandcastles reflects a shared commitment to delivering contemporary, holistic care and ensuring that every child and family receives the support they need, when they need it.

## Celebrating different minds

Listening to and learning from those who engage with CAHS helps us shape a more responsive and inclusive health service that works for everyone.

The youth-led Celebrating Different Minds event at PCH brought young people together with staff, families and community partners to deepen our understanding of neurodiversity and strengthen how we support and embrace neurodivergent children, young people, families and staff across CAHS.

With dynamic speakers, hands-on activities – including an interactive hub for virtual reality experiences – the event provided a special opportunity to connect, learn and celebrate the strengths of neurodivergent children, young people, families and colleagues.

The event covered current approaches, emerging research and personal journeys that increased our understanding of neurodiversity and ways to strengthen inclusion for all who come to CAHS. Members of the CAHS Regulation in a Supportive Environment Consumer Reference Group joined the event and contributed valuable lived experience insights, ensuring discussions were meaningful and centred on neurodivergent perspectives.

Celebrating Different Minds was inspired by CAHS' earlier engagement with young people that explored out-of-the-box thinking on how to support neurodivergent young people.

## SET and GO to enhance child development care

A new home-grown innovation is helping CAHS better understand the impact of our child development services on WA families, ensuring children can get the best start in life.

The SET and GO tool was developed by the CAHS Child Development Service (CDS) and draws on years of research with consumers and staff. The tool asks families and caregivers about their confidence and capacity to support their child's development needs after they've received support from CDS.

SET and GO is designed for families whose children present with developmental challenges such as speech and language delays, emotional regulation difficulties, attention deficit hyperactivity disorder (ADHD) and autism.

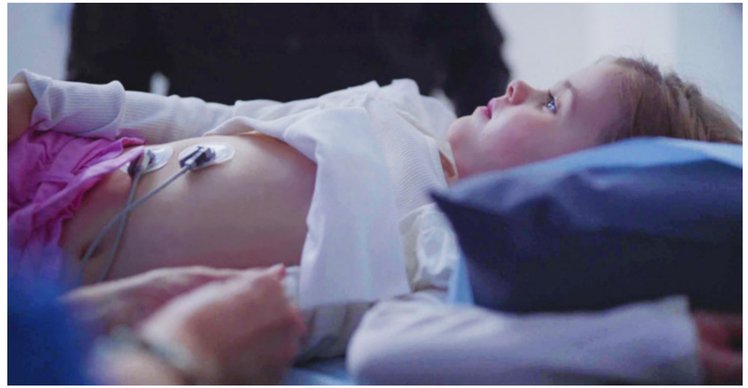
Families complete a short survey after receiving services which helps assess the results of developmental treatment and care. The survey provides practical insight into what is working well for families and where improvements can be made.

More than 200 families have already used SET and GO. Their experiences and feedback are directly shaping child development care by informing more responsive family-centred services.

The learnings are assisting CAHS to better understand family needs, strengthen service provision and ensure children with developmental delays or difficulties receive practical support that meets their needs at home, in the community and in everyday life.

SET and GO is an important step forward in the evolution of child development intervention, and it highlights the essential role of consumer insight in shaping health services.

Scan the QR code to view the SET and GO registration form



## Child's eye video supports calmer hospital visits

An innovative video project aims to reassure and prepare young patients and their families for hospital procedures.

Powered by the CAHS Innovation Fund and led by the CAHS Clinical Psychology and Neuropsychology team, *Through a child's eyes* explores a child's visit to PCH to have an echocardiogram or heart test.

The video was co-designed with children and families, and takes a fresh, preventative approach to reducing childhood medical trauma and strengthening early relational health.

The story is told from a child's perspective, bringing the hospital experience to life through their eyes. By combining clear, practical guidance with a warm, developmentally appropriate and psychologically informed narrative, the video helps children understand what to expect, while supporting families to feel confident in their role.

Hospital visits can be overwhelming, particularly for young children, who are more vulnerable to stress and uncertainty. *Through a child's eyes* empowers caregivers to better support their child, helping reduce anxiety and create calmer, more positive healthcare experiences.

With its focus on prevention rather than intervention, this practical resource promotes a shared understanding between children, families and clinicians, supporting safer, more child-friendly care across PCH.

The project also reflects strong collaboration across CAHS, having drawn on the expertise of staff from psychology, cardiology, communications and innovation teams.

Scan the QR code to watch *My echocardiogram - through a child's eyes*

## New-look ward supports recovery, healing

Young people accessing mental health inpatient services at CAHS are set to benefit from a newly refurbished ward at PCH.

Drawing on the insight of consumers with lived experience of mental health, the recently completed first 'pod' of Ward 5A is designed to provide a safe, comfortable and welcoming therapeutic environment that supports healing and recovery for young people well into the future.

The refurbishment – part of a staged project that will also upgrade the ward's remaining 2 pods – has improved layout, enhanced safety and introduced softer design features to create a comforting space that supports contemporary care.

The new-look ward incorporates fresh artwork designed to evoke positivity, connection and warmth. Featuring calming, muted tones inspired by the WA landscape, the final designs are the result of a unique mentorship project between an established and an emerging artist, and were informed by the perspectives of young people with mental health lived experience.

The refurbishment is a major step towards supporting young people and their families on their journey to better mental health.

# HOSPITAL MEALS REIMAGINED

**An exciting new approach to hospital meal service is giving children and their families more choice, convenience and flexibility.**

Meals on Demand is transforming the PCH mealtime experience by allowing hospital meals to be ordered when patients are hungry, rather than at set times.

The all-day menu was co-designed with more than 1,000 children and families, ensuring meal options reflect what matters most to consumers. Using the new web app, families can order meals in advance from anywhere – at home, at work or by the bedside. QR codes in patient rooms provide quick and easy access.

This patient-first initiative responds to consumer demand for greater menu choice, easy-to-use ordering and a more flexible approach to meal times.

Meals on Demand represents a reimagining of traditional hospital food service, demonstrating how CAHS is adapting to deliver family-centred care that meets contemporary community needs. It's also a national first. PCH is the first Australian paediatric hospital to make on-demand food services available hospital-wide.

Complementing the new changes, Meals on Demand also offers wider menu options that cater to a broad range of nutritional, dietary and cultural needs. From tacos and dhal to tofu dishes and kangaroo stew, the revamped menu was developed following consultation – and taste testing – with children, families, consumer groups and staff. To better support diverse communities, the menu is available in 11 languages.

Coinciding with the Meals on Demand launch, PCH also introduced vibrant artist-designed plates and bowls, adding a pop of colour to hospital-issued dinnerware. Featuring bright designs created by WA artists and chosen by children, the Plateful of Personality project makes mealtimes more fun, and brings moments of colour, creativity and comfort to young patients.

Since its launch in July 2025, Meals on Demand has proved popular – 85 per cent of children and families surveyed prefer the new meal service.

Meals on Demand is also supporting our sustainability goals. With meal preparation now aligned with demand, the new service has reduced food waste by an impressive 25 per cent.

## Focus on access and innovation boosts vaccination

Immunisation plays a vital role in protecting the community – including some of our most vulnerable children – against vaccine-preventable diseases. With a focus on innovative approaches and improved accessibility, CAHS is making it easier for WA families to protect their children through immunisation.

Extended community clinic hours and a new online appointment form are giving families greater choice and convenience, while pop-up clinics take vaccination directly to the community. Our newly established Enhanced Vaccination Access team delivers vaccinations to clients in homes, refuges and schools, boosting access for priority populations.

This year we've maintained a vaccination rate of 90 per cent or more for children aged 5 and under attending CACH Immunisation Clinics, exceeding the general immunisation rates for children in this age group.

More than 20,000 HPV vaccinations were administered through the School Based Immunisation Program, with 67 per cent of eligible students vaccinated.

The introduction of FluMist, a needle-free influenza vaccine, is an exciting game changer for many WA families, especially children with needle anxiety. Available to children and young people in WA aged 2 to 17, FluMist is delivered as a gentle nasal spray and provides the same protection against influenza A and B as traditional injectable vaccines.

Through fresh initiatives and tailored approaches CAHS is reducing barriers and giving families more confidence in keeping kids up to date with childhood vaccinations.

## Crisis support expands to regions

Young people in regional WA now have access to specialist child and adolescent mental health crisis support following the statewide expansion of the CAMHS Crisis Connect 24/7 telephone line.

CAMHS Crisis Connect provides vital support via phone and telehealth to children and young people experiencing mental health distress, ensuring care is available whenever it's needed. The service is also available to anyone who cares for young people in the community, including families, carers, and medical and education professionals.

This year we've taken major steps forward in making help more accessible to those living outside metropolitan areas.

From September 2025, members of the CAMHS Crisis Connect team visited all WA regions to better understand the unique needs of each region, raise awareness of the service and strengthen referral pathways for children and young people living in the regions.

Since December, the 24/7 crisis response line has been available to all young people up to the age of 18 in WA. Since then we've further expanded the service to provide telehealth appointments to regional emergency departments, and will soon go statewide, so that support is available to all young people in WA.

In the last 12 months the service received more than 11,000 calls to our 24/7 crisis telephone line and provided 171 telehealth consultations for children and young people in WA.

The expanded service is already making a difference to those living outside the metropolitan area: nearly 1,000 contacts were from young people in regional WA.

## Theatre boost: Cutting wait times and improving access

This year, meaningful improvements in surgical care have delivered real, everyday benefits for Western Australian families.

By expanding our hospital theatre capacity and strengthening our surgical workforce, we've gone beyond increasing activity – we've improved access in a way that truly matters.

Families are now experiencing shorter waits and greater certainty at critical moments in their care journey. Each reduced wait time tells a human story: a child returning to school sooner, a parent finding relief faster, and households regaining a sense of normalcy.

We've achieved significant improvements in ear, nose and throat surgeries. Over the past year median non-urgent surgical wait times decreased by 43 per cent, from 227 days to 131 days.

Behind the data are the tangible benefits being delivered for WA families as surgical teams provide vital care to more children and young people sooner.

These gains ensure that care is not only safe and high quality, but delivered in a timely manner.


## Expanding care at home

The PCH Hospital in the Home (HiTH) program continues to transform patient care by bringing hospital-level care to families in the comfort of their own homes.

By providing home-based care to children who would otherwise need to stay in hospital, HiTH is not only easing pressure on hospital beds, it's redefining how and where care is delivered.

In the last 12 months, our mobile team of healthcare workers provided care to more than 1,500 children at home, representing around 6,700 days in hospital avoided.

Building on our earlier success, this year we expanded the HiTH program to include allied health, making it easier for more families to access services including occupational therapy, dietetics, physiotherapy, social work and speech pathology services at home. This extends care to more WA families with HiTH already provided in respiratory physiotherapy, remote monitoring and pharmacy.

Others are taking note too. Our HiTH remote monitoring service achieved national recognition, winning the Outstanding Patient Innovation Award at the 2025 Patient Australia Awards. Importantly, HiTH has proved a big hit with families, who value the flexibility, convenience and personalised touch that comes with home-based care.

We're continuing to evolve this highly-valued service to reach more WA families through greater access for neurodivergent children and young people, and families in regional areas.

## Community hubs celebrate first birthday

Our Midland and Murdoch community hubs celebrated a milestone first year of operation. The hubs give WA families one-stop, easy access to child health, development, immunisation and mental health services.

The hubs bring together CACH and CAMHS services under one roof to better meet the needs of children and young people. The hubs are contemporary purpose-built spaces, staffed by teams of health professionals committed to family-centred care that is connected, coordinated and compassionate.

First year hub highlights in numbers:

**Murdoch**

- 5,600 CDS appointments, including for 129 Aboriginal families
- 950 clients attended 220 child development group sessions
- 2,700 nursing appointments
- 450 immunisations
- 9,039 Community CAMHS contacts

**Midland**

- 8,880 CDS appointments, including for 517 Aboriginal families
- 1,353 child health appointments
- 107 drop-in nursing session clients
- 118 parenting support group clients
- 4,434 Community CAMHS contacts.

# PREPARING FOR WINTER: COORDINATED CARE WHEN IT MATTERS MOST

**Preparation, prevention and coordination are at the heart of CAHS' approach to the busy winter season.**

As pressure on health services rises each winter, CAHS is leading a comprehensive program of initiatives to prepare for anticipated demand, promote good health, and provide timely care to children, young people and their families.

The Winter Strategy rolls out a suite of coordinated initiatives designed to keep kids healthy, manage seasonal demand and provide WA families with access to safe, high-quality health care.

Prevention measures have a big impact on improving community health over winter. We've expanded immunisation programs for influenza and respiratory syncytial virus (RSV) for consumers and staff to support healthy living and ease the burden on hospital services.

To improve access to care, we've strengthened key services at PCH including allied health coverage, discharge coordination and Emergency Department supports. These initiatives promote more timely discharge, reduce unnecessary time in hospital and ensure children and families receive the right care, at the right time, in the right place.

Capacity-boosting measures including extended hours in hospital short-stay areas, surge spaces to respond to busy periods, and expanded weekend services are helping to free up beds for those who need them most. Established CAHS initiatives such as our popular Hospital in the Home service are easing hospital demand by connecting families with the care they need, wherever they are.

Together, our staff are playing a vital role in preparing for and responding to winter demand – ensuring children, young people and families have timely access world-class care.


## Multicultural project promotes sense of belonging

CAHS aspires to be a trusted health care provider, where everyone is treated with care, respect and a sense of belonging.

Guided by this goal, CAHS led the Strengthening Multicultural Services election commitment project to learn more about what matters for refugee families in WA and adapt our services to deliver the care that's truly needed.

The 4-year project explored a wide range of approaches to promote health equity, reduce barriers to care and improve our service for recent refugee arrivals who may have varied and complex health needs.

Grounded in community partnership and family-centred care, the project team worked alongside communities to enhance social inclusion, expand access to care and enable staff to better support the unique health needs of refugee families.

The project resulted in a more comprehensive model of care for refugee families, one that expands outreach to families in ways that are culturally responsive and flexible in meeting their needs.

The project is delivering positive results for newly resettled families, making it easier for migrants to navigate the health system and access the care they need.

## Trusted information in your language

Almost one in 5 Western Australians speaks a language other than English at home, so we know how important it is to have ready access to trusted health information in your language.

To better connect with and support families, this year we launched a dedicated translated resources page on the PCH website, making it easier for children and families to find reliable and relevant health information that speaks to them.

The new go-to webpage brings together in one place more than 200 resources in more than 25 languages, including Arabic, Chinese, Dinka, Hindi, Somali and Ukrainian.

The resources cover a range of topics from childhood vaccination and plaster cast care to overseas visitor information and healthcare rights.

Making key health resources available in languages other than English reflects our commitment to community connection and care. The translated resources help to reduce barriers, boost consumer confidence and knowledge about their child's care, and promote positive health outcomes for everyone who engages with our service.

Scan the QR code to visit our online translated resources


## Art celebrates culture and creativity

Fresh artwork adds colour, creativity and culture to CAHS' Child Development Service sites.

A vibrant series of Noongar animal-themed, decorative door stickers was installed across 9 sites. Featuring Australian animals, each beautifully illustrated by an Aboriginal artist, the colourful stickers include a QR code linking to a short video of a Noongar Elder saying the animal's name.

As well as serving as a practical wayfinding tool, the initiative offers a unique opportunity for families and staff to engage with Noongar language and culture, and helps to create a more engaging and inclusive environment for all.

## Creating a welcoming workplace

This year we launched our Inclusion, Diversity and Equity framework designed to foster a safe, open and welcoming workplace, where everyone feels they belong.

Drawing on extensive consultation with staff and volunteers across all areas of CAHS, the framework affirms the culture of inclusion we are building at CAHS. It sets out the steps we will take to create the behaviours, work environments and team dynamics where we can deliver our best services.

It's not just about recruiting a diverse workforce. We're nurturing our workforce and evolving our approaches to create an environment where all team members can thrive personally and professionally and deliver the best care to the children of WA.

Complementing the framework, our newly established Inclusion Council aims to strengthen our inclusion efforts, helping create a workplace that celebrates our differences and values the contributions of all team members.

Importantly, this work helps us better serve the community and improve health outcomes. Fostering workplace inclusion strengthens the sense of belonging for all those who come to CAHS, ensuring all families, children and young people feel respected, valued and cared for.

## Community Ambassadors: Building bridges, strengthening connection

We want all families to have access to the healthcare services and information they need in ways that work for them.

Since launching last year, the CAHS Community Ambassador Program has established itself as a deeply meaningful and much valued bridge between CAHS and the diverse communities we serve.

We have 8 Ambassadors representing cultural connections to various communities including Indian, Vietnamese, Somali, Hazara, Brazilian, Anywaa/Anuak and Chinese, as well as Youth Ambassadors.

By contributing their lived experience, insight and leadership, Ambassadors facilitate deeper conversations and learnings to help us better understand the strengths, needs and everyday realities of multicultural families. Their guidance has shaped research activities, staff training, immunisation initiatives, and the development of culturally informed resources that reflect real community priorities.

The program has strengthened CAHS' presence in the community. Supported by our Ambassadors, CAHS has attended multicultural festivals, shared information about child health services to diverse communities, and co-facilitated workshops for families on topics such as navigating the health system and accessing reliable health information.

These partnerships show that we are listening, learning and working alongside multicultural communities to ensure services are accessible, culturally responsive and grounded in lived experience.

Our Youth Ambassadors continued to share their lived experience to inform youth-friendly resources, mental health information, neuro-affirming care and staff education. Their partnership is strengthening our engagement opportunities and connection with young people, with CAHS planning an even greater focus on youth leadership in the coming year.

Scan the QR code to learn more about the CAHS Community Ambassador Program

# EMPOWERING FAMILIES THROUGH ACCESSIBLE INFORMATION

**This year marked a significant step forward in how we connect with and support families navigating child development concerns. With the launch of refreshed Child Development Service (CDS) webpages on the CAHS website, we have reimagined how information is delivered by placing clarity, accessibility and inclusion at the centre of every interaction.**

At the heart of this transformation is a simple but powerful goal: making it easier for families and carers to find trusted, evidence-based guidance when they need it most. The new webpages bring together a carefully curated mix of written resources, videos and graphics, designed to meet people where they are – whether they prefer to read, watch, or explore visually.

Developed in close collaboration with clinicians and consumers, including Aboriginal families and those from culturally and linguistically diverse backgrounds, the content reflects real experiences and diverse needs.

The resources include guidance on supporting children at home, working with schools, and information about other developmental concerns such as anxiety and sensory processing. These resources are freely available for all families in WA whether or not they are accessing CDS services.

A standout achievement is the introduction of a dedicated section addressing common concerns about attention, regulation and concentration, including attention deficit hyperactivity disorder (ADHD).

For many families, understanding the challenges associated with ADHD can be overwhelming. By breaking down complex information into practical, easy-to-understand resources, this new section offers clarity, reassurance and actionable guidance.

Importantly, the ADHD-focused resources have been translated into 10 languages, removing barriers and opening doors for more families to access vital information. This multilingual approach ensures that more parents and carers can engage confidently with content that supports their child's development, regardless of their background or preferred language.

Beyond the content itself, these updates represent a broader commitment to improving how we communicate and partner with families, and demonstrate our dedication to continuous improvement and responsive service design.

Scan the QR code to visit our new CDS webpages

Scan the QR code to visit our ADHD translated resources

## Skilling up in mental health nursing care

CAHS continues our specialist graduate program designed to give registered nurses the skills, experience and confidence to serve in the paediatric mental health space.

The 12-month Transition to Practice Program mental health stream includes two 6-month placements in mental health settings, including acute care. Participants work towards completing a post-graduate certificate in mental health through Edith Cowan University.

By deepening understanding of adolescent mental health, the program demonstrates how CAHS is strengthening capacity to better serve young people experiencing mental health challenges and make a meaningful difference to WA families.

## Shared insights strengthen CAHS culture

We want CAHS to be a workplace where people feel supported, respected and can grow to reach their full potential.

This year we engaged with hundreds of staff, volunteers and consumer representatives to strengthen CAHS' organisational culture, grounded in the voices and experiences of our people.

Through a structured program of activities, participants explored what matters to them, the importance of shared purpose and collaboration, and how we can shape a positive workplace culture.

The consultation helped CAHS develop a clearer understanding of cultural strengths and has shaped meaningful improvements to the everyday experiences of staff and volunteers, enabling CAHS to foster the kind of workplace we aspire to be.

The work goes beyond our staff and volunteers. A strong organisational culture is essential to delivering safe, high-quality care for the children, young people and families we serve.

The insights gained through the consultation informed the development of 2 key culture-building tools at CAHS:

- Our Culture Framework highlights the connection to everyday experiences at work, including a sense of belonging, the value of contributions, a culture of working together and being supported at work.
- Our Culture Promise provides a shared vision for how we work together every day, built around being purposeful, people-centred and pursuing excellence.

Guided by the insight and experiences of our people, we're taking these learnings to inform workforce planning, leadership practices and organisational strategy to build a workforce fit for the future.

## Embedded workers help young people reach better place

Specialist workers are helping young people on their mental health care journey by working alongside children and families who come to CAMHS.

CAMHS has a robust carer peer worker and Aboriginal mental health worker workforce. This year additional members of this workforce joined CAMHS' multidisciplinary Acute Care and Response Teams and phone-video support line, CAMHS Crisis Connect.

Working alongside clinicians, these embedded roles provide active support to the care and treatment of children, young people and their families. Carer peer workers offer the perspective of their lived experience by providing encouragement and a vision for recovery.

Aboriginal mental health workers provide a culturally safe point of contact to help young people and families navigate their mental health journey. These valued professionals also provide cultural liaison and community integration, a vital element of the service for Aboriginal families.

Grounded in real world perspective and guided by compassion and cultural insight, carer peer workers and Aboriginal mental health workers enhance support for young people facing mental health distress, helping them reach their recovery goals.


## Building a strong Aboriginal workforce

The Aboriginal Workforce Action Plan 2026–2028 strengthens our commitment to culturally safe care by focusing on recruitment, retention and career development. It sets out clear, practical steps to build a strong, skilled and sustainable Aboriginal workforce across our services.

By increasing Aboriginal representation at all levels, including leadership roles, we are embedding cultural knowledge, lived experience and community connection into how care is designed and delivered. This helps create environments that are more respectful, responsive and free from bias and discrimination.

Aboriginal employment is 1.5 per cent of the total CAHS workforce. We continue to work towards the Public Sector Commission's Aboriginal employment target of 3.7 per cent.

A visible and supported Aboriginal workforce strengthens trust and engagement with families, helping them feel understood, respected and culturally secure when accessing care. Through this work, we are improving both the experience and outcomes of care, supporting equitable access to safe, high-quality services for Aboriginal children and young people across Western Australia.

Scan the QR code to read the CAHS Aboriginal Workforce Action Plan 2026-2028

## Global study to shape rare disease family support

Families of children living with rare disease in WA are set to benefit from the world's best practice family care and support, thanks to a CAHS clinician's global investigations.

Anna Thetford, clinical program lead of the CAHS Rare Care Centre, received a Churchill Fellowship to explore internationally leading family support programs.

Her study – which took her to Romania, Sweden, Norway, the UK and Ireland – explored how the most effective programs empower families, build resilience and improve quality of life for those navigating the challenges of rare and undiagnosed disease.

Anna's findings highlighted the importance of placing families at the centre of program development, to ensure that services meet real family needs. Her work emphasised the need for sustainable, culturally responsive programs that are informed by lived experience, embedded with research and grounded in empathy.

Back in WA, the Rare Care Centre is applying these learnings to develop family-centred support programs that will improve long-term outcomes for children living with rare disease.

Opportunities like Anna's show how global learnings can be adapted locally to strengthen understanding and improve care for WA families.

## Major funding to transform rare disease care

A major funding donation is set to revolutionise care for children and families affected by rare and undiagnosed disease across WA.

The Stan Perron Charitable Foundation pledged an extraordinary $221.1 million over 10 years to establish the Rare Care Comprehensive Centre. With additional support from the Perth Children's Hospital Foundation ($25 million) and the University of Western Australia ($3 million), the centre will support earlier diagnosis, treatment access, and research and innovation.

By providing coordinated care, the centre will give fresh hope to the estimated 63,000 children and their families in WA affected by rare and undiagnosed disease.

The centre will translate research into tangible outcomes for families, and provide family support, education and advocacy, to bring about brighter futures for children living with rare disease.

Co-designed by families, clinicians, researchers and community partners to ensure lived experience is embedded in every aspect of its work, the centre's collaborative model places child and family needs at the heart of service design and delivery.

The centre brings together a powerful alliance of partners including the PCH Foundation, University of Western Australia, Harry Perkins Institute of Medical Research, Perron Institute of Neurological and Translational Science, Curtin University, Murdoch University and The Kids Research Institute Australia.

The Rare Care Comprehensive Centre will set a new global benchmark in rare and undiagnosed disease care.

## Purple Book collaboration creates opportunities and inclusion

This year CAHS celebrated our decade-plus partnership with disability employment provider Westcare, producer and distributor of the Purple Book, the trusted companion for parents of young children across WA.

Westcare provides meaningful employment opportunities for people with disability, ensuring that every book is not only a resource for families but also a symbol of dignity and purpose. This year CACH and Westcare achieved a publishing milestone when Westcare delivered copy number 350,000 of the Purple Book. That's 350,000 moments of reassurance, guidance and support – made possible by a partnership built on shared values.

From printing to packing and distribution statewide, it's a significant operation. But our collaboration with Westcare is more than logistics; it's about creating opportunities, fostering inclusion and celebrating the contributions of people with disability in our community.

The Purple Book is a valued resource and testament to what we can achieve when we work together. Our partnership with Westcare will remain important as we continue to explore other ways for families to access the essential information in our Purple Book online.

Scan the QR code to learn more about CAHS' Community Child Health and the Purple Book

## Bringing world-class cancer care closer to home

For children and families facing a cancer diagnosis, accessing the best possible care close to home can make all the difference.

Launched this year, the WA Comprehensive Kids Cancer Centre brings together world-leading clinicians and researchers to deliver innovative treatments, clinical trials and personalised therapies for WA children and young people.

United by a shared passion to transform outcomes for childhood cancer, the centre is a collaboration between PCH, The Kids Research Institute Australia and the University of Western Australia, as well as funding partners, the Stan Perron Charitable Foundation and the Perth Children's Hospital Foundation.

By combining exceptional care with ground-breaking research, the centre is helping create a brighter future for families and improving outcomes for children with cancer across WA.


Photo courtesy of Perth Children's Hospital Foundation

## Revolutionising rehabilitation

This year PCH became the first public children's hospital in Australia to introduce the ZeroG 3D rehabilitation robot, a world-leading system that helps children safely practise walking, balance and everyday movements.

Supporting children with conditions including cerebral palsy, cancer, brain and spinal injuries, and stroke, the technology is building confidence, independence and mobility.

Since its introduction, more than 25 children have benefited from the innovative system, made possible by the generous funding from the Perth Children's Hospital Foundation and supported by specialist clinicians from Kids Rehab WA.

Scan the QR code to learn more about the ZeroG 3D robotic body weight support system

# STRENGTHENING MENTAL HEALTH SUPPORT THROUGH PARTNERSHIPS

**Partnerships play a critical role in improving the mental health and wellbeing of children and young people across WA. By working alongside trusted organisations, CAMHS is expanding access to support, strengthening care pathways and creating more opportunities for young people to receive help in ways that work for them.**

This year CAMHS partnered with leading youth mental health organisation Orygen to introduce MOST (Moderated Online Social Therapy), a free digital mental health platform for young people aged 12–25.

MOST combines evidence-based information and therapeutic activities with peer connection and professional support, providing a safe and accessible space where young people can build skills, access guidance and connect with others who understand their experiences.

Through this partnership, young people now have another flexible support option, helping them access the right care at the right time, wherever they are.

Our collaborations are also delivering better health outcomes for one of our most vulnerable groups of young people – children in care.

Through our partnership with the Department of Communities, a dedicated child protection and family support worker is embedded within CAMHS hospital services. This innovative model strengthens support for children, families and carers, while helping staff navigate complex care needs through shared expertise, stronger communication and coordinated decision-making.

Built on a commitment to collaboration, knowledge-sharing and continuous improvement, the partnership is already enhancing the way services work together to support children and young people.

Looking ahead, there are plans to further expand this successful model by embedding specialist staff across CAMHS community services to provide more intensive services to our most vulnerable children.

By strengthening connections between agencies and broadening access to expertise, these partnerships are ensuring children, young people and families receive more connected, responsive and effective care.

# SUSTAINABILITY

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

Sustainability is a guiding principle at CAHS. It informs our planning, decision-making and activities.

CAHS strives to reduce our environmental footprint, be resilient in the face of climate change and champion an environmentally sustainable health service that supports all children and young people and allows future generations to thrive.

We engage with staff and consumers to genuinely listen and partner on how we can improve sustainability across the organisation.

And the message is clear: our people support strong sustainability action. Sustainability is not an optional extra.

Buoyed by this feedback and motivated by our target of achieving net zero emissions by 2040, we are progressing a range of sustainability actions and initiatives across CAHS.

We have chosen to adopt the Australian Commission on Safety and Quality in Healthcare's Sustainability and Resilience Module, designed to put sustainability at the heart of service delivery.

Our Environmental Sustainability Strategy and Action Plan 2023–2027 is helping us integrate sustainability thinking into all CAHS policies, planning and operations, and grow our sustainability culture at CAHS. It also details how we will meet requirements set out by the National Health and Climate Strategy, the Western Australian Climate Policy and the WA Emissions Reduction Framework.

## Sustainability in action

Young people told us they want meaningful action on sustainability, and we listened.

This year we've advanced innovative thinking and evidence-backed approaches to support more sustainable behaviours, foster a climate-smart workforce, divert waste from landfill, enhance cross-agency collaboration and improve our overall sustainability performance.

By working together, truly listening and embracing sustainability values, CAHS is taking meaningful action towards a healthier, more sustainable tomorrow that will support the health and wellbeing of future generations.

Some of this year's highlights:

### Growing a climate-informed workforce

- Collaborated with the Department of Health on system-wide learning to enhance staff understanding of climate change
- Supported scholarships for 4 staff to undertake carbon literacy training through Edith Cowan University
- Delivered tailored sustainability education to CAHS staff as part of leadership and medical training programs.

### Charging ahead with electric cars

- Replaced petrol-powered fleet cars with electric vehicles, exceeding the WA Government target for low emission fleet vehicles
- Developed education materials to familiarise staff with electric vehicles.

### Sharing sustainability knowledge

- Collaborated on climate risk assessments with the Department of Water and Environmental Regulation
- Joined a water symposium to share knowledge on water efficiency across WA Health.

### Finding homes for unwanted items

- Introduced an online asset reuse portal for staff to enable greater reuse of equipment and assets. Dubbed a Buy Nothing group for the workplace, the initiative is an example of the circular economy in action, finding new homes for unwanted items
- Partnered with not-for-profit and educational groups to reuse expired stock as educational resources.

### Driving down waste

- Rolled out recycling for syringe plastic components in operating theatres, keeping hundreds of kilograms of plastic out of landfill
- Continued to scale up our waste-reduction efforts to make recycling initiatives part of everyday CAHS-wide operations
- Led a system-wide workshop to identify and rethink the use of single use plastic items in the workplace
- Expanded our Pharmacycle recycling program to include inhalers, syringes, measuring cups, measuring spoons and other plastics
- Recycled more than 10,000 containers through the Containers for Change program and reinvested the funds to support staff sustainability initiatives.

# PHARMACY RECYCLING STRENGTHENS SUSTAINABILITY CULTURE

**A new inhaler recycling service at PCH is cutting waste, boosting recycling rates and growing the culture of sustainability at CAHS.**

Before the recycling service was launched, all used and expired inhalers at PCH were incinerated. This meant hundreds of kilograms of waste every year. It also heightened the risk from the disposal of residual pharmaceuticals and made a weighty contribution to CAHS' carbon footprint.

PCH pharmacist Debbie Lalich knew it didn't have to be like this.

Inspired by her CAHS-backed carbon literacy training, Debbie spotted an opportunity for improvement and led the charge for a dedicated inhaler recycling service in the PCH Pharmacy Department.

Pharmacy team members worked with recycling company Pharmacycle to expand the collection service to include used and expired inhalers – the first service of its kind in a WA hospital.

The inhaler recycling service – which can be used by staff and members of the public – is part of a larger suite of waste-busting initiatives in the Pharmacy Department. The team was already set up for recycling syringes, measuring cups and spoons, blister packs and tablet bottles.

Staff awareness and education was a big part of the Pharmacy team's green push. The experience turned team members into active waste warriors who better understand recycling logistics, the importance of recycling correctly, and how it can help to address broader environmental goals.

The inhaler initiative even owes its genesis to the proceeds of recycling – the service was financed by funds raised by PCH's Containers for Change program.

## Shaping a sustainability culture

Small, tangible projects like this are about more than simply reducing waste. They show how practical, staff-led innovations can make a positive difference to everyday behaviours, shift thinking towards the bigger issues, and help grow the culture of sustainability we're creating at CAHS.

# OUR RESEARCH

**At CAHS, we're committed to research excellence. We know it's vital to improving the health and wellbeing of the children and families who access our care.**

Research helps us understand and respond to emerging health challenges, and find new and better ways of preventing, diagnosing and treating illness and injury. Our robust and dynamic research program involves researchers from across the health disciplines who are passionate about ensuring children across WA have access to the best possible health care.

While our focus is local, the impact of CAHS' research extends well beyond WA's borders.

From pioneering clinical trials to nurturing research careers and harnessing emerging technologies, we are proud of the positive difference our research and innovation makes to the lives of children here and around the world.

We are grateful for the ongoing partnership and support of The Kids Research Institute Australia, the Perth Children's Hospital Foundation, Channel 7 Telethon Trust, the Future Health Research and Innovation Fund and the Stan Perron Charitable Foundation.

Key achievements in 2025–26:

- Launched the Perth Children's Trials Centre, WA's flagship centre for paediatric clinical trials, giving local families access to new and novel treatments right here in WA
- Welcomed a 34 per cent rise in research grant funding generated by our investigators – a $1.7 million increase on the previous year
- Identified strong support among CAHS staff for our research work – two-thirds of non-research staff expressed an interest in research participation. The inaugural CAHS Research Capacity and Culture Survey will help us refine our work to support investigators and strengthen our research capacity
- Celebrated 40 years of child health research investment in WA through the Telethon Trust Research Fellowships program. The program will expand to include fellowships for aspiring researchers in nursing and allied health, thanks to a major funding boost from Telethon Trust
- Investigated the effect of disordered eating on bone development and long-term health and wellbeing. The research – which found high levels of low bone density in young people admitted to the PCH-based Eating Disorders Service – is expected to increase the focus on bone health in this vulnerable patient cohort.

## Diabetes research makes life better

Our research is making life easier for children and families managing type 1 diabetes with the development of an innovative app and access to ground-breaking preventative therapies.

The DiabHQ digital app was developed by CAHS researchers, in collaboration with investigators from The Kids Research Institute Australia.

The app gives families easy access to their child's medical information including clinical reports, pathology results and appointment details, helping families feel more informed, supported and confident in managing their child's care.

Our research is also giving families access to preventative therapies that have the potential to slow the progress of type 1 diabetes, helping ease the burden on children and families.

The recent discovery of blood markers that can identify type 1 diabetes before symptoms develop is enabling WA families to access novel preventative therapies such as Teplizumab and Baricitnib, which have shown promise in delaying diabetes progression.

With type 1 diabetes affecting around 1,200 children in WA, access to these therapies has the potential to be truly life changing for many families.

## WA children benefit from home-grown trials centre

WA families now have greater access to novel – and potentially life-saving – treatments and therapies without having to travel interstate or overseas, following the launch of the Perth Children's Trials Centre (PCTC).

Building on WA's existing trials capability the PCH-based centre strengthens WA's competitiveness in the paediatric clinical trials space with added specialist expertise and new and improved clinical infrastructure.

By bringing cutting-edge treatments closer to home, the centre promotes greater access and equity, offering new hope and better health outcomes to WA children and families.

The PCTC will also boost WA's appeal to prospective research collaborators, attract more novel therapies to WA and support locally led clinical trials and investigations.

## Forty years of Telethon Trust Research Fellowships

This year CAHS joined with Channel 7 Telethon Trust to celebrate 40 years of investment in WA child health through the Telethon Trust Research Fellowships program.

Since the first fellowship was awarded in 1986, the program has gone from strength to strength. It has nurtured around 100 clinician researchers in the early stages of their careers, including many of WA's leading child health investigators.

The program has been pivotal in fostering CAHS' culture of research excellence – through the advances and insights generated by research fellows' projects, and the legacy of their mentoring, skills sharing and passion for discovery.

In this milestone year, a major Telethon Trust funding boost has expanded the Research Fellowship program to include non-medical clinicians. The expansion creates 2 new fellowships – one each for aspiring researchers in nursing and allied health – providing a total of 5 annually awarded fellowships.

## RSV research supports informed vaccine choices

CAHS research into vaccines is protecting newborn babies and empowering families to make informed choices that support the health of mothers, children and the community.

In a national study involving more than 3,700 babies, CAHS led investigations into Australia's hybrid respiratory syncytial virus (RSV) immunisation program, which uses both maternal and infant vaccines.

The research found the program was associated with a 44 per cent reduction in RSV-related hospitalisations for babies under 3 months of age – the group most at risk of severe RSV.

Babies whose mothers were vaccinated against RSV during pregnancy were around 82 per cent less likely to be admitted to hospital with RSV than unvaccinated babies.

Where expectant mothers were not vaccinated – but the babies received the nirsevimab vaccine – infants were around 90 per cent less likely to require hospital admission.

Evidence of strong RSV protection was also shown for babies who received nirsevimab later on as part of a vaccination catch-up program.

By providing real world insight into the RSV program, CAHS research is keeping babies out of hospital, reducing community risks and supporting families to protect child health.



# GOVERNANCE

# OUR MINISTER, ENABLING LEGISLATION AND OPERATIONS

## Responsible Minister

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

## Enabling legislation

CAHS was established as a Board-governed health service provider in the Health Services (Health Service Provider) Order 2016 made by the Minister for Health under section 32 of the *Health Services Act 2016* (the Act).

## Accountable authority

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

The Minister appoints the CAHS Board Chair and Board members.

The Director General of the Department of Health, as System Manager, is responsible for strategic leadership, 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 and high-quality health services.

# CAHS BOARD

The CAHS Board is the governing body of CAHS. Appointed by the Minister for Health, Board members bring wide ranging expertise across areas including health, finance, strategy and community engagement.

The Board meets monthly. During 2025–26, the Board met on 11 occasions. In this period, there were 4 standing committees of the Board:

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

The CAHS Board is a diverse team of clinical and corporate professionals united by a shared passion for helping children reach their full potential.

With a commitment to robust governance and family-centred care, the Board provides strategic oversight and leadership across all CAHS service areas. The Board's work ensures that CAHS is well placed to address challenges, explore opportunities and respond to evolving community needs to help young Western Australians live their happiest, healthiest lives.

Scan the QR code to learn more about the CAHS Board

# CAHS EXECUTIVE

As at 30 June 2026

### Valerie Buić

**Chief Executive**

Child and Adolescent Health Service

### Anna Barrington

**Executive Director**

Strategy, Planning and Performance

### Sam Campanella

**Executive Director**

Safety, Quality and Innovation

### Clare Dobb

**Executive Director**

People, Capability and Culture

### Tony Dolan

**Executive Director**

Perth Children's Hospital and Neonatology

### Michael Hutchings

**Executive Director**

Contracting, Infrastructure, Digital Health and Patient Support Services

### Dr Clare Matthews

**Executive Director**

Medical Services

### Jill Pascoe

**Executive Director**

Child and Adolescent Mental Health Services

### Michael Roberts

**Acting Chief Finance Officer**

Finance and Corporate Services

### Marie Slater

**Executive Director**

Nursing Services

### Judith Stewart

**Executive Director**

Child and Adolescent Community Health

# PERFORMANCE MANAGEMENT FRAMEWORK

As at 30 June 2026

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

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

There were no changes to the Outcome Based Management Framework affecting CAHS for 2025–26.

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

- **Outcome 1**: Public hospital-based services that enable effective treatment and restorative health care for Western Australians
- **Outcome 2**: Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives.

### Government goal

Ensuring every Western Australian can access the health care we need, when we need it

### WA Health goal

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

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

#### Effectiveness KPIs

- Unplanned hospital readmissions for patients within 28 days for selected surgical procedures
- Percentage of elective wait list patients waiting over boundary for reportable procedures
- Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days
- Percentage of admitted patients who discharged against medical advice: **a)** Aboriginal patients; and **b)** Non-Aboriginal patients
- Readmissions to acute specialised mental health inpatient services within 28 days of discharge
- Percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient service

#### Efficiency KPIs

**Service 1: Public hospital admitted services**

- Average admitted cost per weighted activity unit

**Service 2: Public hospital emergency services**

- Average ED cost per weighted activity unit

**Service 3: Public hospital non-admitted services**

- Average non-admitted cost per weighted activity unit

**Service 4: Mental health services**

- Average cost per bed-day in specialised mental health inpatient services
- Average cost per treatment day of non-admitted care provided by mental health services

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

#### Efficiency KPIs

**Service 6: Public and community health services**

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

# SHARED RESPONSIBILITIES WITH OTHER AGENCIES

## External partnerships

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

In 2025–26 CAHS partnered with 49 non-government agencies and community and not-for-profit organisations to deliver support and health-related services to children, young people and their families.

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

Services were provided through 125 arrangements:

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



# 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.

# SIGNIFICANT CHALLENGES


# DEMAND FOR CHILD DEVELOPMENT SERVICES

We want every child to have access to early intervention, assessment and care that supports their development and helps them reach their full potential.

CAHS continues to experience significant demand for child development services from families seeking support for a range of developmental delays and difficulties, including language delays; attention, regulation and concentration concerns; and autism.

To respond to this challenge, the CAHS Child Development Service (CDS) is making changes designed to strengthen our workforce, improve engagement with families and boost access to services, ensuring more kids get a healthy start in life.

Many of the initiatives were enabled by a previously announced $30.4 million WA Government funding investment to boost staffing.

This year almost 100 additional allied health, nursing and paediatric professionals joined the CDS, which reduced wait times and helped more families access the care they need.

The staffing boost and other improvements have resulted in a significant 42 per cent increase in assessments and a 30 per cent increase in treatments per month. Wait times have dropped for most allied health services.

We continued to support choice and convenience with Saturday appointments at our Joondalup and Rockingham clinics, and expanded services at our new Kwinana clinic, bringing care closer to where families live. These options have assisted local communities, including Aboriginal families, who are benefiting from more accessible, culturally safe and community-based care.

To assist families referred to CDS, we've developed practical online resources to educate and empower families to support their child's development. Available on the CAHS website, these evidence-based resources include videos, graphics and translated resources to better support diverse communities.

CDS continues to progress system-wide reforms set out by the Select Committee into Child Development Services in Western Australia to deliver more integrated, locally driven and culturally responsive services, to ensure that more families can access the support they need to help their child flourish.

We will continue to focus on increasing access to care so children and families can receive the right support as early as possible, demonstrated by our ongoing partnership around broader national reforms including the Federal Government's Thriving Kids initiative.

# DIGITAL HEALTH

Maximising opportunities to advance our digital services while modernising legacy systems and supporting growing clinical demand remains a significant challenge.

There is also a need to adapt to the emergence of new sophisticated technology such as artificial intelligence and to continue to position the organisation to address the challenges of cyber risk.

To address these challenges, CAHS is enhancing our digital capability so we can deliver safe, accessible and connected care for children and families across WA.

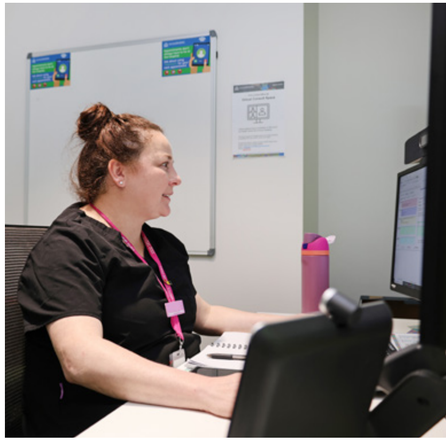
This year we delivered key clinical technology investments including the commissioning of the 3T magnetic resonance imaging (MRI) platform at PCH and the deployment of essential medical equipment.

We continue to mature our digital governance and planning with strengthened processes that improve investment prioritisation, lifecycle management, cybersecurity and risk oversight across digital assets. These initiatives support more sustainable and informed decision-making to ensure our technology investments deliver value to patients, families and clinicians.

Our progress towards statewide electronic medical record (EMR) readiness continues. Preparing for EMR implementation remains a complex undertaking, requiring significant clinical engagement, workflow redesign and system integration across care services.

This year CAHS led delivery of the intensive care unit EMR at PCH, strengthened clinical engagement, improved integration across care settings, and advanced our preparedness for broader digital transformation.

Virtual care is offering improved access to outpatient services, reducing travel and promoting timely follow-up, particularly for regional families.



Our Hospital in the Home remote monitoring service uses digital technology to safely monitor children at home and support timely clinical intervention in real time. This enables children to return home sooner, supported by hospital-level care in the comfort of their own home.

CAHS will continue to prioritise EMR implementation, expand virtual care models, strengthen digital foundations and invest in technology that supports safe, high-quality care. We will increase our focus on robust governance frameworks, data-driven decision-making, cybersecurity resilience and innovation to improve clinical outcomes for children and young people.

# FACILITIES AND INFRASTRUCTURE

CAHS delivers trusted healthcare services to children, young people and families at more than 160 facilities across the Perth metropolitan area.

Increasing demand for services, greater clinical complexities, and a shift towards community-based models of care continue to place pressure on our diverse and expanding infrastructure portfolio. CAHS continues to respond to the ongoing challenge of providing fit-for-purpose infrastructure to meet growing service needs.

This year we've progressed work to strengthen our approach to infrastructure management and better align our community facilities with service needs.

CAHS will continue to mature our data driven asset management framework to strengthen the accuracy of forecasting, prioritisation and investment planning. We continue our work to identify and mitigate key risks related to asset condition, lifecycle, fire safety, workplace safety and accessibility across our facilities.

Addressing these risks across the wider metropolitan area and an ageing asset base requires a sustained and strategic approach to infrastructure investment and renewal to ensure CAHS is positioned to deliver care that meets the needs of WA families.

# DEMAND FOR MENTAL HEALTH SERVICES

CAHS continues to experience growing demand for mental health services and is responding to this challenge to meet the needs of children, young people and their families.

Our new Community CAMHS area networks, based across the Perth metropolitan area, are supporting multidisciplinary teams to deliver more coordinated assessment, care and treatment for children and young people experiencing mental health challenges.

Our Acute Care and Response Teams continue to operate metro-wide, providing mobile, urgent and specialised mental health care, bringing crisis support closer to home.

We're also continuing to progress work in response to the recommendations of the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents.

To strengthen equity and access to care, this year we have expanded the CAMHS Crisis Connect 24/7 telephone service to serve young people in regional WA. Previously a metropolitan-only service, CAMHS Crisis Connect is now available to young Western Australians wherever they are. The statewide service can also be used by those who care for young people, including family members, and medical and education professionals.

To further support the mental health of young people in the regions, we've expanded services to provide telehealth appointments to regional emergency departments, working closely with the WA Country Health Service, and plan to go statewide soon.

Recruitment of specialists is an ongoing challenge in a global professional job market. The introduction of dedicated mental health recruitment specialists at CAHS is helping attract and recruit mental health professionals from across Australia and around the world, ensuring young people in WA receive the best care possible.



# KEY PERFORMANCE INDICATORS

# CERTIFICATION OF KEY PERFORMANCE INDICATORS

## Child and Adolescent Health Service

**Certification of key performance indicators for the year ended 30 June 2026**

We hereby certify that the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the Child and Adolescent Health Service's performance, and fairly represent the performance of the Child and Adolescent Health Service for the financial year ended 30 June 2026.

**Dr Neale Fong**
Board Chair
Child and Adolescent Health Service
28 August 2026

**Mrs Mary Anne Stephens**
Chair, Finance Committee
Child and Adolescent Health Service
28 August 2026

# KEY PERFORMANCE INDICATORS

Effectiveness KPI – Outcome 1

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

### Rationale

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

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

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

The surgeries selected for this indicator are based on those in the current National Healthcare Agreement Unplanned Readmission performance indicator (NHA PI 23)[3].

### Target

The 2025 targets are based on the total child and adult population, and for each procedure is:

| Surgical procedure | Target (per 1,000) |
|---|---|
| Tonsillectomy and adenoidectomy | ≤79.2 |
| Appendicectomy | ≤27.8 |

### Result

#### Tonsillectomy and adenoidectomy

**Figure 1: Rate of unplanned hospital readmissions for patients within 28 days for tonsillectomy and adenoidectomy, 2023 to 2025**

| 2023 | 2024 | 2025 | Target |
|---|---|---|---|
| 56.6 | 40.4 | 49.3 | ≤79.2 |

While the rate for tonsillectomy and adenoidectomy procedures increased compared to 2024, it remained below the 2023 result of 56.6 per 1,000 and well below the target of ≤79.2 per 1,000.

CAHS continues to take a proactive approach to patient care before, during and after surgery. Pre-operative telehealth and virtual care continue to support patient and family readiness for surgery and recovery.

Following surgery, CAHS provides comprehensive education to parents and carers at discharge, including accessible post-operative information and post-discharge telehealth consults.

#### Appendicectomy

**Figure 2: Rate of unplanned hospital readmissions for patients within 28 days for appendicectomy, 2023 to 2025**

| 2023 | 2024 | 2025 | Target |
|---|---|---|---|
| 14.8 | 17.5 | 29.5 | ≤27.8 |

The rate of unplanned readmissions for appendicectomy procedures increased to 29.5 per 1,000 in 2025, compared to 17.5 per 1,000 in 2024, and is above the target of ≤27.8 per 1,000.

Results reflect a low volume of cases, clinical complexity and a low threshold for readmission. CAHS reviews all unplanned readmissions for appendicectomy procedures to identify if there were any modifiable factors contributing to readmission. Where opportunities for improvement are identified, targeted improvements are progressed through established governance processes to strengthen care pathways and reduce avoidable readmissions.

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

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

[1] Australian Institute of Health and Welfare (2009). Towards national indicators of safety and quality in health care. Cat. no. HSE 75. Canberra: AIHW. Available at: www.aihw.gov.au/reports/health-care-quality-performance/towards-national-indicators-of-safety-and-quality/summary

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

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

Effectiveness KPI – Outcome 1

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

### Rationale

Elective surgery refers to planned surgery that can be booked in advance following specialist assessment, resulting in placement of the patient on an elective surgery waiting list.

Elective surgical services delivered in the WA health system are those deemed to be clinically necessary. Excessive waiting times for these services can lead to deterioration of the patient's condition and/or quality of life, or even death[4]. Waiting lists must be actively managed by hospitals to ensure fair and equitable access to limited services, and that all patients are treated within clinically appropriate timeframes.

Patients are prioritised based on their assigned clinical urgency category:

- Category 1 – procedures that are clinically indicated within 30 days
- Category 2 – procedures that are clinically indicated within 90 days
- Category 3 – procedures that are clinically indicated within 365 days.

### Target

The 2025–26 target is 0% for each urgency category. Performance is demonstrated by a result that is equal to the target.

### Result

**Figure 3: Percentage of elective wait list patients waiting over boundary for reportable procedures, by urgency category, 2023–24 to 2025–26**

| | 2023–24 | 2024–25 | 2025–26 | Target |
|---|---|---|---|---|
| Category 1 | 8.7% | 4.6% | 3.5% | 0% |
| Category 2 | 26.3% | 18.8% | 15.5% | 0% |
| Category 3 | 34.7% | 26.1% | 7.2% | 0% |

In 2025–26, CAHS continued to reduce in the percentage of patients waiting over clinically recommended timeframes across all urgency categories. While performance has improved significantly compared to prior years, results remain above the target of 0 per cent, reflecting ongoing demand for elective surgical services.

As of 30 June 2026, 3.5 per cent of Category 1 patients were not treated within 30 days, 15.5 per cent of Category 2 patients were not treated within 90 days, and 7.2 per cent of Category 3 patients were not treated within 365 days.

CAHS continues to actively manage elective surgery demand and capacity through a coordinated service-wide approach. CAHS results reflect improvements from targeted initiatives to improve theatre utilisation and scheduling efficiency, increased surgical capacity, and strengthened partnerships with the Western Australian Country Health Service to support access to care across the state.

Note: The result is based on an average of weekly census data for the financial year.
Reporting period: Financial year.
Data source: Elective Services Wait List Data Collection.

[4] Derrett, S., Paul, C., Morris, J.M. (1999). Waiting for Elective Surgery: Effects on Health-Related Quality of Life, International Journal of Quality in Health Care, Vol 11 No. 1, 47-57.

Effectiveness KPI – Outcome 1

## Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days

### Rationale

*Staphylococcus aureus (S. aureus)* bloodstream infection is a serious infection that may be associated with the provision of health care. *S. 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[5]).

HA-SABSI is generally considered to be a preventable adverse event associated with the provision of health care. Therefore, this KPI is a robust measure of the safety and quality of care provided by WA public hospitals.

A low or decreasing HA-SABSI rate is desirable and the WA target reflects the nationally agreed benchmark.

### Target

The 2025 target is ≤1.0 infections per 10,000 occupied bed-days.

### Result

**Figure 4: Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days, 2023 to 2025**

| 2023 | 2024 | 2025 | Target |
|---|---|---|---|
| 0.70 | 0.55 | 1.08 | ≤1.0 |

The *S. aureus* bloodstream infection rate increased to 1.08 per 10,000 occupied bed-days in 2025, compared to 0.55 in 2024, and is above the WA health system target of ≤1.0 per 10,000 occupied bed-days.

CAHS participates in a statewide surveillance program and reviews all *S. aureus* bloodstream infections to identify if there were any modifiable factors that may have contributed to the infection. During 2025 CAHS identified a number of opportunities for improvement including enhanced central line care practices, introduction of new antimicrobial technologies and strengthened compliance with antimicrobial screening and decolonisation protocols. Collectively, these interventions are expected to strengthen infection prevention controls and support a return to target performance achievement.

Reporting period: Calendar year, to account for lag in reporting in clinical coding completion.
Data source: Healthcare Infection Surveillance Western Australia Data Collection.

[5] van Hal, S. J., Jensen, S. O., Vaska, V. L., Espedido, B. A., Paterson, D. L., & Gosbell, I. B. (2012). Predictors of mortality in Staphylococcus aureus Bacteremia. Clinical microbiology reviews, 25(2), 362–386. doi:10.1128/CMR.05022-11

Effectiveness KPI – Outcome 1

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

### Rationale

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

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

This indicator provides a measure of the safety and quality of inpatient care. Reporting the results by Aboriginal status measures the effectiveness of initiatives within the WA health system to deliver culturally responsive 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.

The DAMA 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 National Agreement on Closing the Gap, which was agreed to by the Coalition of Aboriginal and Torres Strait Islander Peak Organisations, and all Australian Governments in July 2020[10].

### Target

The 2025 targets are based on the total child and adult population:

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

### Result

**Figure 5: Percentage of admitted patients who discharged against medical advice, 2023 to 2025**

| | 2023 | 2024 | 2025 | Target |
|---|---|---|---|---|
| Aboriginal patients | 0.24% | 0.11% | 0.51% | ≤2.78% |
| Non-Aboriginal patients | 0.10% | 0.06% | 0.06% | ≤0.99% |

In 2025, CAHS recorded a DAMA rate of 0.51 per cent for Aboriginal patients, which remains below the target of 2.78 per cent. For non-Aboriginal patients, the rate was 0.06 per cent, which is also below the target of 0.99 per cent.

CAHS continues to maintain low DAMA rates. A range of support services, including those provided by Aboriginal Liaison Officers, social workers and clinical teams, continue to support patients and families and contribute to these outcomes.

Targeted initiatives to improve culturally responsive care remain a key focus, including implementation of the CAHS Aboriginal Workforce Action Plan 2026–28, delivery of face-to-face cultural training, and the continued development of welcoming and culturally safe care environments. CAHS is committed to strengthening engagement with Aboriginal patients and families to support continued improvement in DAMA rates and broader Aboriginal health outcomes.

Reporting period: Calendar year, to account for lag in reporting due to clinical coding completion.
Data source: Hospital Morbidity Data Collection

[6] Yong et al. Characteristics and outcomes of discharges against medical advice among hospitalised patients. Internal medicine journal 2013:43(7):798–802.
[7] Aliyu ZY. Discharge against medical advice: sociodemographic, clinical and financial perspectives. International journal of clinical practice 2002;56(5):325–27.
[8] See Table D3.09.3 www.indigenoushpf.gov.au/measures/3-09-self-discharge-from-hospital/data#DataTablesAndResources
[9] For more information see www.pc.gov.au/ongoing/report-on-government-services/
[10] www.closingthegap.gov.au/national-agreement

Effectiveness KPI – Outcome 1

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

### Rationale

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

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

These readmissions mean that patients spend additional time in hospital and utilise additional resources. A low readmission rate suggests that good clinical practice is in operation. Readmissions are attributed to the facility at which the initial separation (discharge) occurred rather than the facility to which the patient was readmitted.

By monitoring this indicator, key areas for improvement can be identified. This can facilitate the development and delivery of targeted care pathways and interventions aimed at improving the mental health and quality of life of Western Australians.

### Target

The 2025 target is ≤12%.

### Result

**Figure 6: Readmissions to acute specialised mental health inpatient services within 28 days of discharge, 2023 to 2025**

| 2023 | 2024 | 2025 | Target |
|---|---|---|---|
| 24.3% | 18.5% | 20.1% | ≤12% |

The rate of total hospital readmissions increased to 20.1 per cent in 2025, compared to 18.5 per cent in 2024, and remains above the target of 12 per cent. It should be noted that this indicator does not distinguish between planned and unplanned readmissions. CAHS continues to provide clinically appropriate planned admissions for young people who would benefit from an additional inpatient stay.

During 2025, CAMHS continued to strengthen discharge planning, multidisciplinary case review processes and coordination with community mental health services to support continuity of care following discharge.

Additional initiatives, including enhanced community-based alternatives to admission and expansion of intensive outreach responses, are expected to further support young people during periods of transition and reduce avoidable readmissions. CAHS will always prioritise the safety of young people and their families through admission to an inpatient mental health service when required.

Reporting period: Calendar year, to account for lag in reporting due to time difference between index episode discharge date and clinical coding completion of readmission episode.
Data source: Hospital Morbidity Data Collection (Inpatient Separations).

[11] Australian Health Ministers Advisory Council Mental Health Standing Committee (2011). Fourth National Mental Health Plan Measurement Strategy. Available at: www.aihw.gov.au/getmedia/d8be52c84-a53f-4eef-a7e6-f81a5af94764/Fourth-national-mental-health-plan-measurement-strategy-2011.pdf.aspx

Effectiveness KPI – Outcome 1

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

### Rationale

In 2022, one in four (6.6 million) Australians reported having a mental or behavioural condition[12]. Therefore, it is crucial to ensure effective and appropriate care is provided not only in a hospital setting but also in the community.

Discharge from hospital is a critical transition point in the delivery of mental health care. People leaving hospital after an admission for an episode of mental illness have increased vulnerability and, without adequate follow up, may relapse or be readmitted.

The standard underlying the 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 2025 target is ≥75%.

### Result

**Figure 7: Percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services, 2023 to 2025**

| 2023 | 2024 | 2025 | Target |
|---|---|---|---|
| 78.5% | 83.6% | 86.8% | ≥75% |

In 2025, 86.8 per cent of young people admitted to CAHS acute specialised mental health inpatient services were contacted by a CAHS mental health service team member within 7 days of discharge. This is above the target of 75 per cent and an improvement from 83.6 per cent in 2024.

This improvement reflects ongoing efforts to strengthen discharge planning, improve coordination between inpatient and community services, and prioritise timely post-discharge review for young people with complex mental health needs. Key initiatives have included enhanced monitoring of follow-up timeframes and continued development of community-based support options to facilitate safe transitions from inpatient care. CAHS is committed to supporting safe transitions of care from hospital to the community for our young people.

Reporting period: Calendar year, to account for reporting delays caused by time difference between episode discharge date and clinical coding completion of non-admitted post-discharge episode.
Data source: Mental Health Information Data Collection, Hospital Morbidity Data Collection (Inpatient separations).

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

Efficiency KPI – Outcome 1 | Service 1: Public hospital admitted services

## Average admitted cost per weighted activity unit

### Rationale

This indicator is a measure of the cost per weighted activity unit compared with the State target, as approved by the Department of Treasury and Finance, and published in the 2025–26 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 2025–26 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

### Target

The 2025–26 target is ≤ $8,183 per weighted activity unit.

### Result

The average admitted cost per weighted activity unit was $9,925 in 2025–26, which is 21.3 per cent unfavourable against 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 2025–26 CAHS delivered considerably more admitted activity than the prior year, which was achieved at a higher cost profile in comparison to 2024–25. The higher cost profile contributing to the higher than target outcome in 2025–26 was a result of higher than expected Enterprise Bargaining Award increases from the Government's Wages Policy, and escalating costs for goods and services.

**Figure 8: Average admitted cost per weighted activity unit, 2023–24 to 2025–26**

| 2023–24 Actual | 2024–25 Actual | 2025–26 Actual | 2025–26 Target |
|---|---|---|---|
| $9,199 | $9,174 | $9,925 | $8,183 |

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, 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 and Finance, which is published in the 2025–26 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 2025–26 target is $8,094 per weighted activity unit.

### Result

The average Emergency Department cost per weighted activity unit was $11,024 in 2025–26 which is 36.2 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.

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

**Figure 9: Average Emergency Department cost per weighted activity unit, 2023–24 to 2025–26**

| 2023–24 Actual | 2024–25 Actual | 2025–26 Actual | 2025–26 Target |
|---|---|---|---|
| $11,388 | $11,259 | $11,024 | $8,094 |

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 (aggregated) target, as approved by the Department of Treasury and Finance, which is published in the 2025–26 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 2025–26 target is $8,328 per weighted activity unit.

### Result

The average non-admitted cost per weighted activity unit was $10,032 in 2025-26, which is 20.5 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 2025–26, the higher cost profile for non-admitted services is due to the higher than expected Enterprise Bargaining Award increases from the Government's Wages Policy and inflationary cost pressures. Compared to the prior year, CAHS has delivered significantly more non-admitted services.

**Figure 10: Average non-admitted cost per weighted activity unit, 2023–24 to 2025–26**

| 2023–24 Actual | 2024–25 Actual | 2025–26 Actual | 2025–26 Target |
|---|---|---|---|
| $9,430 | $9,334 | $10,032 | $8,328 |

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 Waitlist 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 2025–26 target is ≤$3,445.

### Result

In 2025–26 , the average cost per bed-day in specialised mental health inpatient services was $7,461, representing a 116.6 per cent increase above the target. This variance was driven by a combination of factors, including the continuation of additional staffing to support reforms arising from the Ministerial Taskforce into Public Mental Health Services. The higher than target cost profile includes the increase in workforce to support the commissioning, operations and licensing costs of the Nickoll Ward at the Hollywood Hospital. The Nickoll Ward continues to be used as a decant facility whilst the refurbishment of the inpatient mental health ward at the Perth Children's Hospital is completed.

**Figure 11: Average cost per bed-day in specialised mental health inpatient units, 2023–24 to 2025–26**

| 2023–24 Actual | 2024–25 Actual | 2025–26 Actual | 2025–26 Target |
|---|---|---|---|
| $5,533 | $8,021 | $7,461 | $3,445 |

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.

Public community-based mental health services are generally targeted towards people in the acute phase of a mental illness who are receiving post-acute care.

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

### Target

The 2025-26 target is $1,117 per treatment day.

### Result

In 2025–26, the average cost per treatment day for non-admitted care provided by public clinical mental health services was $1,025, which was 9 per cent higher than the prior year but 8.2 per cent below the target. The increase from 2024–25 was influenced by a range of cost pressures, including increased employment costs arising from higher than expected Enterprise Bargaining Award wage increases from the Government's Wages Policy and inflationary cost impacts. Despite these cost increases, the average cost per treatment day remained below target.

**Figure 12: Average cost per treatment day of non-admitted care provided by mental health services, 2023–24 to 2025–26**

| 2023–24 Actual | 2024–25 Actual | 2025–26 Actual | 2025–26 Target |
|---|---|---|---|
| $876 | $932 | $1,025 | $1,117 |

Note: PCH, Specialised and Community Child and Adolescent Mental Health Services have been restructured into a single integrated service for reporting. This restructure is intended to support continuity throughout the patient journey, improve coordination between services, and minimise duplication when patients transition from one service to another.
The 2025–26 KPI denominator has been calculated using a revised methodology, including the updated approach to the calculation of treatment days and the rationale for this change. This revised methodology will be applied consistently in future reporting periods.
The target and comparative figures for 2024–25 and 2023–24 have been calculated using the previous methodology and therefore remain unchanged. The impact of applying the revised methodology to the comparative figures is considered immaterial and, accordingly, no restatement of the comparative figure is required.
Reporting period: Financial year.
Data sources: Health Service financial system, Mental Health Information Data Collection.

Efficiency KPI – Outcome 2 | Service 6: Public and community health services

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

### Rationale

Population health units support individuals, families, and communities to increase control over and improve their health.

Population health aims to improve health by integrating all activities of the health sector and linking them with broader social and economic services and resources as described in the WA Health Promotion Strategic Framework 2022–2026[13]. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

### Target

The 2025-26 target is $318 per person.

### Result

In 2025-26, the average cost per person for delivering population health programs through Population Health Units was $345, which is 8.5 per cent unfavourable against the target. The higher cost profile which contributed to the indicator being above target was largely attributed to increased employment costs related to higher than expected Enterprise Bargaining Award increases from the Government's Wages Policy, and inflationary pressures experienced throughout the financial year.

**Figure 13: Average cost per person of delivering population health programs by population health units, 2023–24 to 2025–26**

| 2023–24 Actual | 2024–25 Actual | 2025–26 Actual | 2025–26 Target |
|---|---|---|---|
| $281 | $322 | $345 | $318 |

Reporting period: Financial year.

Data sources: Health Service financial system, Estimated Resident Populations for 2020–2024 as provided by Epidemiology Directorate, Public and Aboriginal Health Division, WA Department of Health

[13] WA Health Promotion Strategic Framework 2022-2026: www.health.wa.gov.au/Reports-and-publications/WA-Health-Promotion-Strategic-Framework



# FINANCIAL STATEMENTS

Auditor General

**INDEPENDENT AUDITOR'S REPORT**

**2026**

**Child and Adolescent Health Service**

To the Parliament of Western Australia

## Report on the audit of the financial statements

### Opinion

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

- the statement of financial position as at 30 June 2026, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended
- notes comprising a summary of material accounting policies and other explanatory information.

In my opinion, the financial statements are:

- based on proper accounts and present fairly, in all material respects, the operating results and cash flows of the Health Service for the year ended 30 June 2026 and the financial position as at the end of that period
- in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions.

### Basis for opinion

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

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

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

### Responsibilities of the Board for the financial statements

The Board is responsible for:

- keeping proper accounts
- preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions
- such internal control as it determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Board is responsible for:

- assessing the entity's ability to continue as a going concern
- disclosing, as applicable, matters related to going concern
- using the going concern basis of accounting unless the Western Australian Government has made policy or funding decisions affecting the continued existence of the Health Service.

### Auditor's responsibilities for the audit of the financial statements

As required by the *Auditor General Act 2006*, my responsibility is to express an opinion on the financial statements. The objectives of my audit are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Australian Auditing Standards will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal control.

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

## Report on the audit of controls

### Opinion

I have undertaken a reasonable assurance engagement on the design and implementation of controls exercised by the Health Service. The controls exercised by the Health Service are those policies and procedures established to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with the State's financial reporting framework (the overall control objectives).

In my opinion, in all material respects, the controls exercised by the Health Service are sufficiently adequate to provide reasonable assurance that the controls within the system were suitably designed to achieve the overall control objectives identified as at 30 June 2026, and the controls were implemented as designed as at 30 June 2026.

### The Board's responsibilities

The Board is responsible for designing, implementing and maintaining controls to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property and the incurring of liabilities are in accordance with the *Financial Management Act 2006*, the Treasurer's Instructions and other relevant written law.

### Auditor General's responsibilities

As required by the *Auditor General Act 2006,* my responsibility as an assurance practitioner is to express an opinion on the suitability of the design of the controls to achieve the overall control objectives and the implementation of the controls as designed. I conducted my engagement in accordance with Standard on Assurance Engagements *ASAE 3150 Assurance Engagements on Controls* issued by the Australian Auditing and Assurance Standards Board. That standard requires that I comply with relevant ethical requirements and plan and perform my procedures to obtain reasonable assurance about whether, in all material respects, the controls are suitably designed to achieve the overall control objectives and were implemented as designed.

An assurance engagement involves performing procedures to obtain evidence about the suitability of the controls design to achieve the overall control objectives and the implementation of those controls. The procedures selected depend on my judgement, including an assessment of the risks that controls are not suitably designed or implemented as designed. My procedures included testing the implementation of those controls that I consider necessary to achieve the overall control objectives.

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

### Limitations of controls

Because of the inherent limitations of any internal control structure, it is possible that, even if the controls are suitably designed and implemented as designed, once in operation, the overall control objectives may not be achieved so that fraud, error or non-compliance with laws and regulations may occur and not be detected. Any projection of the outcome of the evaluation of the suitability of the design of controls to future periods is subject to the risk that the controls may become unsuitable because of changes in conditions.

## Report on the audit of the key performance indicators

### Opinion

I have undertaken a reasonable assurance engagement on the key performance indicators of the Health Service for the year ended 30 June 2026 reported in accordance with the *Financial Management Act 2006* and the Treasurer's Instructions (legislative requirements). The key performance indicators are the Under Treasurer-approved key effectiveness indicators and key efficiency indicators that provide performance information about achieving outcomes and delivering services.

In my opinion, in all material respects, the key performance indicators report of the Health Service for the year ended 30 June 2026 is in accordance with the legislative requirements, and the key performance indicators are relevant and appropriate to assist users to assess the Health Service's performance and fairly represent indicated performance for the year ended 30 June 2026.

### The Board's responsibilities for the key performance indicators

The Board is responsible for the preparation and fair presentation of the key performance indicators in accordance with the *Financial Management Act 2006* and the Treasurer's Instructions and for such internal controls as the Board determines necessary to enable the preparation of key performance indicators that are free from material misstatement, whether due to fraud or error.

In preparing the key performance indicators, the Board is responsible for identifying key performance indicators that are relevant and appropriate, having regard to their purpose in accordance with Treasurer's Instruction 3 Financial Sustainability – Requirement 5 Key Performance Indicators.

### Auditor General's responsibilities

As required by the *Auditor General Act 2006,* my responsibility as an assurance practitioner is to express an opinion on the key performance indicators. The objectives of my engagement are to obtain reasonable assurance about whether the key performance indicators are relevant and appropriate to assist users to assess the Health Service's performance and whether the key performance indicators are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. I conducted my engagement in accordance with Standard on Assurance Engagements *ASAE 3000 Assurance Engagements Other than Audits or Reviews of Historical Financial Information* issued by the Australian Auditing and Assurance Standards Board. That standard requires that I comply with relevant ethical requirements relating to assurance engagements.

An assurance engagement involves performing procedures to obtain evidence about the amounts and disclosures in the key performance indicators. It also involves evaluating the relevance and appropriateness of the key performance indicators against the criteria and guidance in Treasurer's Instruction 3 - Requirement 5 for measuring the extent of outcome achievement and the efficiency of service delivery. The procedures selected depend on my judgement, including the assessment of the risks of material misstatement of the key performance indicators. In making these risk assessments, I obtain an understanding of internal control relevant to the engagement in order to design procedures that are appropriate in the circumstances.

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

## My independence and quality management relating to the report on financial statements, controls and key performance indicators

I have complied with the independence requirements of the *Auditor General Act 2006* and the relevant ethical requirements relating to assurance engagements. In accordance with ASQM 1 *Quality Management for Firms that Perform Audits or Reviews of Financial Reports and Other Financial Information, or Other Assurance or Related Services Engagements,* the Office of the Auditor General maintains a comprehensive system of quality management including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

## Other information

Those charged with governance are responsible for the other information. The other information is the information in the entity's annual report for the year ended 30 June 2026, but not the financial statements, key performance indicators and my auditor's report.

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

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

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

## Matters relating to the electronic publication of the audited financial statements and key performance indicators

This auditor's report relates to the financial statements and key performance indicators of the Child and Adolescent Health Service for the year ended 30 June 2026 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 Health Service to confirm the information contained in the website version.

Aloha Morrissey
A/Deputy Auditor General
Delegate of the Auditor General for Western Australia
Perth, Western Australia
1 September 2026

# CERTIFICATION OF FINANCIAL STATEMENTS

## Child and Adolescent Health Service

**Certification of financial statements for the year ended 30 June 2026**

The accompanying financial statements of the Child and Adolescent Health Service have been prepared in compliance with the provisions of the *Financial Management Act 2006* from proper accounts and records to present fairly the financial transactions for the financial year ended 30 June 2026 and the financial position as at 30 June 2026.

At the date of signing, we are not aware of any circumstances which would render the particulars included in the financial statements misleading or inaccurate.

**Ms Janet Yap**
Acting Chief Finance Officer
Child and Adolescent Health Service
28 August 2026

**Dr Neale Fong**
Board Chair
Child and Adolescent Health Service
28 August 2026

**Mrs Mary Anne Stephens**
Chair, Finance Committee
Child and Adolescent Health Service
28 August 2026

# FINANCIAL STATEMENTS

Child and Adolescent Health Service

## Statement of comprehensive income for the year ended 30 June 2026

| | Notes | 2026 $000 | 2025 $000 |
|---|---|---|---|
| **COST OF SERVICES** | | | |
| **Expenses** | | | |
| Employee benefits expense | 3.1(a) | 905,159 | 845,124 |
| Fees for visiting medical practitioners | | 4,761 | 4,582 |
| Contracts for services | 3.2 | 8,707 | 8,778 |
| Patient support costs | 3.3 | 144,671 | 139,483 |
| Finance costs | 7.2 | 1,724 | 1,708 |
| Depreciation and amortisation expenses | 5 | 54,061 | 52,544 |
| Loss on disposal of non-current assets | 5.1.2 | 210 | - |
| Repairs, maintenance and consumable equipment | 3.4 | 28,256 | 30,014 |
| Other supplies and services | 3.5 | 69,007 | 65,695 |
| Other expenses | 3.6 | 60,126 | 49,466 |
| **Total cost of services** | | **1,276,682** | **1,197,394** |
| **INCOME** | | | |
| Patient charges | 4.2 | 34,466 | 32,573 |
| Other fees for services | 4.2 | 48,936 | 46,174 |
| Grants and contributions | 4.3 | 24,021 | 19,115 |
| Donation revenue | 4.4 | 3,012 | 1,539 |
| Gain on disposal of non-current assets | 5.1.2 | - | 103 |
| Asset revaluation increments | 5.1 | 965 | 920 |
| Other income | 4.5 | 6,700 | 6,835 |
| **Total income** | | **118,100** | **107,259** |
| **NET COST OF SERVICES** | | **1,158,582** | **1,090,135** |

| | Notes | 2026 $000 | 2025 $000 |
|---|---|---|---|
| **INCOME FROM STATE GOVERNMENT** | | | |
| Service agreement funding - State | 4.1 | 775,211 | 697,500 |
| Service agreement funding - Commonwealth | 4.1 | 212,823 | 197,838 |
| Grants from other state government agencies | 4.1 | 117,861 | 105,525 |
| Services provided to other government agencies | 4.1 | 3,957 | 3,945 |
| Assets (transferred)/assumed | 4.1 | - | 268 |
| Resources received free of charge | 4.1 | 66,466 | 63,338 |
| **Total income from State Government** | | **1,176,318** | **1,068,414** |
| **SURPLUS/(DEFICIT) FOR THE PERIOD** | | **17,736** | **(21,721)** |
| **OTHER COMPREHENSIVE INCOME** | | | |
| **Items not reclassified subsequently to profit or loss** | | | |
| Changes in asset revaluation reserve | 9.13 | 49,751 | 196,914 |
| **Total other comprehensive income** | | 49,751 | 196,914 |
| **TOTAL COMPREHENSIVE INCOME FOR THE PERIOD** | | **67,487** | **175,193** |

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

Child and Adolescent Health Service

## Statement of financial position as at 30 June 2026

| | Notes | 2026 $000 | 2025 $000 |
|---|---|---|---|
| **ASSETS** | | | |
| **Current Assets** | | | |
| Cash and cash equivalents | 7.3 | 18,803 | 17,730 |
| Restricted cash and cash equivalents | 7.3 | 38,738 | 28,102 |
| Receivables | 6.1 | 24,369 | 16,419 |
| Inventories | 6.3 | 6,810 | 4,980 |
| Other current assets | 6.4 | 2,296 | 1,119 |
| **Total Current Assets** | | 91,016 | 68,350 |
| **Non-Current Assets** | | | |
| Receivables | 6.1 | 26,872 | 18,872 |
| Amounts receivable for services | 6.2 | 677,683 | 628,351 |
| Property, plant and equipment | 5.1 | 1,415,501 | 1,368,464 |
| Right-of-use assets | 5.2 | 24,742 | 26,486 |
| Intangible assets | 5.3 | 4,376 | 6,888 |
| **Total Non-Current Assets** | | 2,149,174 | 2,049,061 |
| **TOTAL ASSETS** | | **2,240,190** | **2,117,411** |

| | Notes | 2026 $000 | 2025 $000 |
|---|---|---|---|
| **LIABILITIES** | | | |
| **Current Liabilities** | | | |
| Payables | 6.5 | 53,704 | 51,801 |
| Contract liabilities | 6.6 | 1,106 | 796 |
| Capital grant liabilities | 6.7 | 3,457 | 1,245 |
| Lease liabilities | 7.1 | 3,008 | 2,914 |
| Employee benefits provisions | 3.1 (b) | 184,470 | 174,883 |
| Other current liabilities | 6.8 | 6,359 | 100 |
| **Total Current Liabilities** | | 252,104 | 231,739 |
| **Non-Current Liabilities** | | | |
| Lease liabilities | 7.1 | 27,893 | 29,444 |
| Employee benefits provisions | 3.1 (b) | 37,332 | 36,541 |
| Other non-current liabilities | 6.8 | 13,960 | - |
| **Total Non-Current Liabilities** | | 79,185 | 65,985 |
| **TOTAL LIABILITIES** | | **331,289** | **297,724** |
| **NET ASSETS** | | **1,908,901** | **1,819,687** |
| **EQUITY** | | | |
| Contributed equity | 9.13 | 1,526,965 | 1,505,238 |
| Reserves | 9.13 | 474,469 | 424,718 |
| Accumulated deficit | | (92,533) | (110,269) |
| **TOTAL EQUITY** | | **1,908,901** | **1,819,687** |

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 2026

| | Notes | 2026 $000 | 2025 $000 |
|---|---|---|---|
| **CASH FLOWS FROM STATE GOVERNMENT** | | | |
| Service agreement funding - State | | 725,879 | 650,284 |
| Service agreement funding - Commonwealth | | 212,823 | 197,838 |
| Grants from other state government agencies | | 117,861 | 105,525 |
| Services provided to other government agencies | | 3,957 | 3,945 |
| Capital appropriations administered by Department of Health | | 20,040 | 15,701 |
| **Net cash provided by State Government** | 7.3.3 | **1,080,560** | **973,293** |
| **CASH FLOWS FROM OPERATING ACTIVITIES** | | | |
| **Payments** | | | |
| Employee benefits | | (890,646) | (813,131) |
| Supplies and services | | (253,868) | (232,114) |
| Finance costs | | (1,700) | (1,688) |
| **Receipts** | | | |
| Receipts from customers | | 27,816 | 32,309 |
| Grants and contributions | | 26,543 | 20,583 |
| Donations received | | 373 | 723 |
| Other receipts | | 54,247 | 50,271 |
| **Net cash used in operating activities** | 7.3.2 | **(1,037,235)** | **(943,047)** |

| | Notes | 2026 $000 | 2025 $000 |
|---|---|---|---|
| **CASH FLOWS FROM INVESTING ACTIVITIES** | | | |
| **Payments** | | | |
| Purchase of non-current assets | | (20,682) | (25,634) |
| **Receipts** | | | |
| Proceeds from sale of non-current assets | 5.1.2 | 9 | 210 |
| **Net cash used in investing activities** | | **(20,673)** | **(25,424)** |
| **CASH FLOWS FROM FINANCING ACTIVITIES** | | | |
| **Payments** | | | |
| Principal elements of lease payments | | (2,943) | (2,861) |
| Payment to accrued salaries account | | (8,000) | (3,500) |
| **Receipts** | | | |
| Lease incentive received | | - | 4,398 |
| **Net cash used in financing activities** | | **(10,943)** | **(1,963)** |
| **Net increase in cash and cash equivalents** | | 11,709 | 2,859 |
| Cash and cash equivalents at the beginning of the period | | 45,832 | 42,973 |
| **CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD** | 7.3 | **57,541** | **45,832** |

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

## Statement of changes in equity for the year ended 30 June 2026

| | Notes | Contributed equity $000 | Reserves $000 | Accumulated deficit $000 | Total equity $000 |
|---|---|---|---|---|---|
| **Balance at 1 July 2024** | | 1,489,537 | 227,804 | (88,548) | 1,628,793 |
| Deficit | | - | - | (21,721) | (21,721) |
| Other comprehensive income | 9.13 | - | 196,914 | - | 196,914 |
| Total comprehensive income for the period | | - | 196,914 | (21,721) | 175,193 |
| Transactions with owners in their capacity as owners: | | | | | |
| Capital appropriations administered by Department of Health | 9.13 | 15,701 | - | - | 15,701 |
| Total | | 15,701 | - | - | 15,701 |
| **Balance at 30 June 2025** | | **1,505,238** | **424,718** | **(110,269)** | **1,819,687** |
| **Balance at 1 July 2025** | | 1,505,238 | 424,718 | (110,269) | 1,819,687 |
| Surplus | | - | - | 17,736 | 17,736 |
| Other comprehensive income | 9.13 | - | 49,751 | - | 49,751 |
| Total comprehensive income for the period | | - | 49,751 | 17,736 | 67,487 |
| Transactions with owners in their capacity as owners: | | | | | |
| Capital appropriations administered by Department of Health | 9.13 | 20,040 | - | - | 20,040 |
| Transfer of Crown land from DPLH | 9.13 | 1,687 | - | - | 1,687 |
| Total | | 21,727 | - | - | 21,727 |
| **Balance at 30 June 2026** | | **1,526,965** | **474,469** | **(92,533)** | **1,908,901** |

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





## Notes to the financial statements for the year ended 30 June 2026

### 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 28 August 2026.

#### Statement of compliance

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

The Act and Treasurer's instructions are legislative provisions governing the preparation of financial statements and take precedence over Australian Accounting Standards, the Framework, Statement of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board. Where modification is required and has had a material or significant financial effect upon the reported results, details of that modification and the resulting financial effect are disclosed in the notes to the financial statements.

#### Basis of preparation

These financial statements are presented in Australian dollars applying the accrual basis of accounting and using the historical cost convention. Certain balances will apply a different measurement basis (such as the fair value basis). Where this is the case, the different measurement basis is disclosed in the associated note. All values are rounded to the nearest thousand dollars ($000).

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

Notwithstanding the Health Service's deficiency of working capital (total current assets being less than total current liabilities), the financial statements have been prepared on the going concern basis. This basis has been adopted because, with continuing funding from the State Government, the Health Service is able to pay its liabilities as and when they fall due.

### Judgements and estimates

Judgements, estimates and assumptions are required to be made about financial information being presented. The significant judgements and estimates made in the preparation of these financial statements are disclosed in the notes where amounts affected by those judgements and/or estimates are disclosed. Estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances.

### Contributed equity

AASB Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities* requires transfers in the nature of equity contributions, other than as a result of a restructure of administrative arrangements, to be designated as contributions by owners (at the time of, or prior, to transfer) before such transfers can be recognised as equity contributions. Capital appropriations have been designated as contributions by owners by TI 8 – Requirement 8.1(i) and will be credited directly to Contributed Equity.

The transfers of net assets to/from other agencies, other than as a result of a restructure of administrative arrangements, are designated as contributions by owners where the transfers are non-discretionary and non-reciprocal.

Child and Adolescent Health Service
Notes to the financial statements for the year ended 30 June 2026

## 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.

| | Notes |
|---|---|
| Health Service objectives | 2.1 |
| Schedule of Income and Expenses by Service | 2.2 |

### 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.

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.

## 2.1 Health Service objectives (cont.)

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.

(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 2026

## 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 | |
|---|---|---|---|---|---|---|---|---|
| | 2026 | 2025 | 2026 | 2025 | 2026 | 2025 | 2026 | 2025 |
| **COST OF SERVICES** | **$000** | **$000** | **$000** | **$000** | **$000** | **$000** | **$000** | **$000** |
| **Expenses** | | | | | | | | |
| Employee benefits expense | 425,430 | 399,905 | 82,163 | 78,022 | 136,360 | 123,641 | 95,607 | 91,028 |
| Fees for visiting medical practitioners | 1,190 | 1,142 | 2,619 | 2,525 | 952 | 915 | - | - |
| Contracts for services | 7,149 | 7,086 | 4 | 4 | 55 | 10 | 29 | 25 |
| Patient support costs | 87,662 | 80,844 | 8,519 | 9,500 | 38,646 | 34,930 | 3,179 | 3,248 |
| Finance costs | 44 | 53 | 8 | 8 | 24 | 17 | 123 | 128 |
| Depreciation and amortisation expenses | 31,091 | 29,216 | 6,349 | 6,024 | 8,548 | 9,053 | 3,531 | 3,327 |
| Loss on disposal of non-current assets | 161 | - | 39 | - | 10 | - | - | - |
| Repairs, maintenance and consumable equipment | 14,311 | 15,172 | 2,910 | 3,185 | 4,539 | 5,094 | 1,463 | 2,002 |
| Other supplies and services | 32,195 | 31,058 | 4,735 | 4,514 | 10,520 | 9,574 | 7,567 | 7,374 |
| Other expenses | 20,631 | 15,947 | 3,222 | 2,369 | 6,473 | 4,756 | 11,528 | 8,260 |
| **Total cost of services** | 619,864 | 580,423 | 110,568 | 106,151 | 206,127 | 187,990 | 123,027 | 115,392 |
| **Income** | | | | | | | | |
| Patient charges | 30,318 | 28,236 | 1,243 | 1,247 | 2,436 | 2,570 | 469 | 520 |
| Other fees for services | 31,900 | 29,962 | 5,783 | 5,683 | 10,771 | 10,071 | 109 | 128 |
| Grants and contributions | 9,514 | 7,970 | 1,066 | 1,101 | 9,832 | 6,909 | 484 | 614 |
| Donation revenue | 1,970 | 1,010 | 357 | 188 | 665 | 332 | - | - |
| Gain on disposal of non-current assets | - | 130 | - | 4 | - | (3) | - | - |
| Asset revaluation increments | 57 | 118 | 11 | 22 | 20 | 39 | 72 | (80) |
| Other income | 4,244 | 4,353 | 768 | 802 | 1,430 | 1,424 | 22 | 20 |
| **Total income** | 78,003 | 71,779 | 9,228 | 9,047 | 25,154 | 21,342 | 1,156 | 1,202 |
| **NET COST OF SERVICES** | **541,861** | **508,644** | **101,340** | **97,104** | **180,973** | **166,648** | **121,871** | **114,190** |
| **INCOME FROM STATE GOVERNMENT** | | | | | | | | |
| Service agreement funding - State | 378,743 | 334,433 | 72,629 | 68,011 | 118,823 | 102,880 | 4,731 | 6,099 |
| Service agreement funding - Commonwealth | 133,698 | 125,407 | 24,438 | 21,757 | 53,628 | 49,097 | - | - |
| Grants from other state government agencies | 1,014 | 3,109 | 638 | 645 | 940 | 1,654 | 115,131 | 99,845 |
| Services provided to other government agencies | 3,293 | 3,353 | 261 | 263 | 390 | 322 | - | 5 |
| Assets (transferred)/assumed | - | 190 | - | 28 | - | 49 | - | - |
| Resources received free of charge | 31,262 | 29,871 | 4,541 | 4,339 | 9,401 | 8,981 | 7,773 | 7,431 |
| **Total income from State Government** | 548,010 | 496,363 | 102,507 | 95,043 | 183,182 | 162,983 | 127,635 | 113,380 |
| **SURPLUS / (DEFICIT) FOR THE PERIOD** | **6,149** | **(12,281)** | **1,167** | **(2,061)** | **2,209** | **(3,665)** | **5,764** | **(810)** |

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

| | Aged and Continuing Care Services [a] | | Public and Community Health Services | | Total | |
|---|---|---|---|---|---|---|
| | 2026 | 2025 | 2026 | 2025 | 2026 | 2025 |
| **COST OF SERVICES** | **$000** | **$000** | **$000** | **$000** | **$000** | **$000** |
| **Expenses** | | | | | | |
| Employee benefits expense | 4,703 | 3,884 | 160,896 | 148,644 | 905,159 | 845,124 |
| Fees for visiting medical practitioners | - | - | - | - | 4,761 | 4,582 |
| Contracts for services | 1 | 1 | 1,469 | 1,652 | 8,707 | 8,778 |
| Patient support costs | 1,216 | 688 | 5,449 | 10,273 | 144,671 | 139,483 |
| Finance costs | - | - | 1,525 | 1,502 | 1,724 | 1,708 |
| Depreciation and amortisation expenses | 10 | 9 | 4,532 | 4,915 | 54,061 | 52,544 |
| Loss on disposal of non-current assets | - | - | - | - | 210 | - |
| Repairs, maintenance and consumable equipment | 62 | 84 | 4,971 | 4,477 | 28,256 | 30,014 |
| Other supplies and services | 166 | 158 | 13,824 | 13,017 | 69,007 | 65,695 |
| Other expenses | 148 | 210 | 18,124 | 17,924 | 60,126 | 49,466 |
| **Total cost of services** | 6,306 | 5,034 | 210,790 | 202,404 | 1,276,682 | 1,197,394 |
| **Income** | | | | | | |
| Patient charges | - | - | - | - | 34,466 | 32,573 |
| Other fees for services | 330 | 270 | 43 | 60 | 48,936 | 46,174 |
| Grants and contributions | 224 | 246 | 2,901 | 2,275 | 24,021 | 19,115 |
| Donation revenue | 20 | 9 | - | - | 3,012 | 1,539 |
| Gain on disposal of non-current assets | - | - | - | (28) | - | 103 |
| Asset revaluation increments | 1 | 1 | 804 | 820 | 965 | 920 |
| Other income | 44 | 37 | 192 | 199 | 6,700 | 6,835 |
| **Total income** | 619 | 563 | 3,940 | 3,326 | 118,100 | 107,259 |
| **NET COST OF SERVICES** | **5,687** | **4,471** | **206,850** | **199,078** | **1,158,582** | **1,090,135** |
| **INCOME FROM STATE GOVERNMENT** | | | | | | |
| Service agreement funding - State | 4,814 | 2,760 | 195,471 | 183,317 | 775,211 | 697,500 |
| Service agreement funding - Commonwealth | 741 | 1,267 | 318 | 310 | 212,823 | 197,838 |
| Grants from other state government agencies | 1 | 2 | 137 | 270 | 117,861 | 105,525 |
| Services provided to other government agencies | - | - | 13 | 2 | 3,957 | 3,945 |
| Assets (transferred)/assumed | - | 1 | - | - | - | 268 |
| Resources received free of charge | 180 | 172 | 13,309 | 12,544 | 66,466 | 63,338 |
| **Total income from State Government** | 5,736 | 4,202 | 209,248 | 196,443 | 1,176,318 | 1,068,414 |
| **SURPLUS / (DEFICIT) FOR THE PERIOD** | **49** | **(269)** | **2,398** | **(2,635)** | **17,736** | **(21,721)** |





## 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 | 2026 | 2025 |
|---|---|---|---|
| | | $000 | $000 |
| Employee benefits expense | 3.1(a) | 905,159 | 845,124 |
| Contracts for services | 3.2 | 8,707 | 8,778 |
| Patient support costs | 3.3 | 144,671 | 139,483 |
| Repairs, maintenance and consumable equipment | 3.4 | 28,256 | 30,014 |
| Other supplies and services | 3.5 | 69,007 | 65,695 |
| Other expenses | 3.6 | 60,126 | 49,466 |

### Liabilities incurred in the delivery of services

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

| | Notes | 2026 | 2025 |
|---|---|---|---|
| | | $000 | $000 |
| Employee benefits provisions | 3.1(b) | 221,802 | 211,424 |

### 3.1(a) Employee benefits expense

| | 2026 $000 | 2025 $000 |
|---|---|---|
| Employee benefits | 811,114 | 762,823 |
| Termination benefits | 132 | 290 |
| Superannuation - defined contribution plans | 93,913 | 82,011 |
| | 905,159 | 845,124 |

**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 for the year ended 30 June 2026

### 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.

| | 2026 $000 | 2025 $000 |
|---|---|---|
| **Current** | | |
| Employee benefits provisions | | |
| Annual leave [(a)] | 91,830 | 83,779 |
| Time off in lieu leave [(a)] | 21,950 | 20,375 |
| Long service leave [(b)] | 69,177 | 69,551 |
| Deferred salary scheme [(c)] | 1,513 | 1,178 |
| | 184,470 | 174,883 |
| **Non-Current** | | |
| Employee benefits provisions | | |
| Long service leave [(b)] | 37,332 | 36,541 |
| | 37,332 | 36,541 |
| **Total employee benefits provisions** | 221,802 | 211,424 |

(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:

| | 2026 $000 | 2025 $000 |
|---|---|---|
| Within 12 months of the end of the reporting period | 68,883 | 58,598 |
| More than 12 months after the end of the reporting period | 44,897 | 45,556 |
| | 113,780 | 104,154 |

The provision for annual leave and time off in lieu leave is calculated at the present value of expected payments to be made in relation to services provided by employees up to the reporting date.

### 3.1(b) Employee benefits provisions (cont.)

(b) **Long service leave liabilities:** Unconditional long service leave provisions are classified as current liabilities as the Health Service does not have an unconditional right to defer settlement of the liability for at least 12 months after the end of the reporting period.

Pre-conditional and conditional long service leave provisions are classified as non-current liabilities because the Health Service has an unconditional right to defer the settlement of the liability until the employee has completed the requisite years of service.

Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

| | 2026 | 2025 |
|---|---|---|
| | $000 | $000 |
| Within 12 months of the end of the reporting period | 24,191 | 22,746 |
| More than 12 months after the end of the reporting period | 82,318 | 83,346 |
| | 106,509 | 106,092 |

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:

| | 2026 | 2025 |
|---|---|---|
| | $000 | $000 |
| Within 12 months of the end of the reporting period | 290 | 231 |
| More than 12 months after the end of the reporting period | 1,223 | 947 |
| | 1,513 | 1,178 |

Child and Adolescent Health Service
Notes to the financial statements for the year ended 30 June 2026

### 3.1(b) Employee benefits provisions (cont.)

#### Key sources of estimation uncertainty – long service leave

Key estimates and assumptions concerning the future are based on historical experience and various other factors that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year.

Several estimates and assumptions are used in calculating the Health Service's long service leave provision. These include:

- Expected future salary rates;
- Discount rates;
- Employee retention rates; and
- Expected future payments.

Changes in these estimations and assumptions may impact on the carrying amount of the long service leave provision.

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

Any gain or loss following revaluation of the present value of long service leave liabilities is recognised as employee benefits expense.

### 3.2 Contracts for services

| | 2026 $000 | 2025 $000 |
|---|---|---|
| Neonatal services [a] | 7,065 | 7,065 |
| Community and primary health | 1,468 | 1,658 |
| Other contracts | 174 | 55 |
| | 8,707 | 8,778 |

**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

| | 2026 $000 | 2025 $000 |
|---|---|---|
| Medical supplies and services [a] | 122,984 | 118,262 |
| Domestic charges | 9,995 | 9,996 |
| Food supplies | 2,018 | 1,992 |
| Power and water charges | 7,389 | 7,395 |
| Patient transport costs | 2,070 | 1,431 |
| Research, development and other grants | 215 | 407 |
| | 144,671 | 139,483 |

**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 $8.079 million from PathWest Laboratory Medicine WA (2025: $7.530 million). See Note 4.1 ‘Income from State Government’.

Child and Adolescent Health Service
Notes to the financial statements for the year ended 30 June 2026

### 3.4 Repairs, maintenance and consumable equipment

| | 2026 $000 | 2025 $000 |
|---|---|---|
| Repairs and maintenance | 21,893 | 23,963 |
| Consumable equipment | 6,363 | 6,051 |
| | 28,256 | 30,014 |

**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

| | 2026 $000 | 2025 $000 |
|---|---|---|
| Facility management services | 2,963 | 2,795 |
| Administrative services | 5,248 | 3,944 |
| Interpreter services | 1,600 | 1,632 |
| Shared services for accounting [a] | 977 | 935 |
| Shared services for human resources [a] | 6,352 | 6,284 |
| Shared services for information technology [a] | 46,064 | 43,942 |
| Shared services for supply [a] | 4,162 | 4,055 |
| Other | 1,641 | 2,108 |
| | 69,007 | 65,695 |

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

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

### 3.6 Other expenses

| | 2026 | 2025 |
|---|---|---|
| | $000 | $000 |
| Workers compensation insurance | 8,730 | 8,546 |
| Other insurances | 17,764 | 11,473 |
| Computer services | 5,553 | 3,799 |
| Printing and stationery | 3,072 | 3,011 |
| Consultancy fees | 1,836 | 1,960 |
| Rental expenses [(a)] | 3,424 | 3,672 |
| Expected credit losses expense [(b)] | 635 | 630 |
| Other employee related expenses | 2,174 | 3,110 |
| Communications | 2,353 | 1,985 |
| Other accommodation expenses [(c)] | 3,293 | 2,818 |
| Audit expenses | 685 | 490 |
| Legal expenses | 447 | 399 |
| Freight and cartage | 549 | 555 |
| Motor vehicle expenses | 662 | 553 |
| Periodical subscription | 626 | 761 |
| Write-off of plant and equipment (Note 5.1) | - | 31 |
| Other | 8,323 | 5,673 |
| | 60,126 | 49,466 |

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

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

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

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





## 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 | 2026 | 2025 |
|---|---|---|---|
| | | $000 | $000 |
| Income from State Government | 4.1 | 1,176,318 | 1,068,414 |
| Patient charges and other fees for services | 4.2 | 83,402 | 78,747 |
| Grants and contributions | 4.3 | 24,021 | 19,115 |
| Donation revenue | 4.4 | 3,012 | 1,539 |
| Other revenue | 4.5 | 6,700 | 6,835 |

## 4.1 Income from State Government

| | 2026 $000 | 2025 $000 |
|---|---|---|
| Service agreement funding received during the period: | | |
| Department of Health - Service agreement - State component | 775,211 | 697,500 |
| Department of Health - Service agreement - Commonwealth component (i) | 212,823 | 197,838 |
| **Total service agreement funding** | **988,034** | **895,338** |
| Grants from other state government agencies during the period: | | |
| Mental Health Commission - Service delivery agreement | 115,131 | 99,845 |
| Department of Health - Research development grant | 1,268 | 675 |
| Department of Health - ICWA motor vehicle accident scheme funding | 1,037 | 4,522 |
| Department of Health - Institute of Health Leadership program | 100 | 100 |
| Department of Health - Aboriginal cadetship program | - | 12 |
| Department of Health - Auspman fitout capital project | 39 | - |
| Department of Health - Graduate Transition to Practice Support Program | 234 | 327 |
| Department of Health - Other grants | 52 | 44 |
| **Total grants from other state government agencies** | **117,861** | **105,525** |
| Services provided to other state government agencies during the period: | | |
| North Metropolitan Health Service - various clinical services | 3,304 | 3,275 |
| WA Country Health Service - various clinical services | 600 | 545 |
| Pathwest - infectious diseases program | - | 68 |
| Other | 53 | 57 |
| **Total services provided to other state government agencies** | **3,957** | **3,945** |
| Assets transferred from other State government agencies during the period: | | |
| Transfer of medical equipment from/(to) other Health Services - | - | 268 |
| **Net assets transferred** | **-** | **268** |





## 4.1 Income from State Government (cont.)

| | 2026 $000 | 2025 $000 |
|---|---|---|
| Resources received free of charge from other State government agencies during the period: | | |
| Health Support Services - accounting, human resources, information technology and supply services | 57,555 | 55,216 |
| State Solicitor's Office - legal services | 367 | 328 |
| Department of Education - uses of Child Parent Centres on school sites and other facilities | 172 | 167 |
| Department of Housing and Works - leasing of accommodation | 293 | 97 |
| PathWest Laboratory Medicine WA - pathology services | 8,079 | 7,530 |
| **Total resources received free of charge** | **66,466** | **63,338** |
| **Total income from State Government** | **1,176,318** | **1,068,414** |

(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 and Finance.

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

(i) Included in the Commonwealth component of the service agreement funding are activity based funding and block grant funding received from the Commonwealth Government under the National Health Reform Agreement for services, health teaching, training and research provided by local hospital networks (Health Services). The funding arrangement established under the Agreement requires the Commonwealth Government to make funding payments to the State Pool Account from which distributions to the local hospital networks (Health Services) are made by the Department of Health and Mental Health Commission.

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

(c) **Transfer of assets:** Discretionary transfers of assets and liabilities between State government agencies are reported under Income from State Government. Transfers of assets and liabilities in relation to a restructure of administrative arrangements are recognised as distribution to owners by the transferor and contribution by owners by the transferee under AASB 1004. Other non-discretionary non-reciprocal transfers of assets and liabilities designated as contributions by owners under Treasurer's Instruction 8 are also recognised directly to equity.

(d) **Resources received free of charge** or for nominal cost, are recognised as revenue at the fair value of those services that can be reliably measured and which would have been purchased if not received as free services. A corresponding expense is recognised for services received (Note 3.3 'Patient support costs' and Note 3.5 'Other supplies and services').

## 4.2 Patient charges and other fees for services

| | 2026 $000 | 2025 $000 |
|---|---|---|
| **Patient charges** [a] | | |
| Inpatient charges | 30,307 | 28,754 |
| Outpatient charges | 4,159 | 3,819 |
| | 34,466 | 32,573 |
| **Other fees for services** | | |
| Recoveries from the Pharmaceutical Benefits Scheme [b] | 44,748 | 42,090 |
| Clinical services to other health organisations [c] | 3,472 | 3,401 |
| Non clinical services to other health organisations [c] | 716 | 683 |
| | 48,936 | 46,174 |
| | 83,402 | 78,747 |

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

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

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

Child and Adolescent Health Service
Notes to the financial statements for the year ended 30 June 2026

## 4.3 Grants and contributions

| | 2026 $000 | 2025 $000 |
|---|---|---|
| Perth Children's Hospital Foundation Ltd | 7,417 | 4,196 |
| Channel 7 Telethon Trust | 3,359 | 3,782 |
| The Kids Research Institute Australia | 2,893 | 1,427 |
| Stan Perron Charitable Foundation | 2,597 | 2,764 |
| Angela Wright Bennett Foundation | 1,000 | 167 |
| Icon Clinical Research Pty Ltd | 461 | - |
| Murdoch Children's Research Institute | 444 | 365 |
| Parexel International Pty Ltd | 416 | 524 |
| Raine Medical Research Foundation | 375 | 594 |
| Syneos Health Australia Pty Ltd | 309 | 579 |
| Diabetes Australia | 296 | 327 |
| The Royal Australasian College of Physicians | 289 | 196 |
| Monash University | 262 | 199 |
| Toby FCC Ltd | 248 | - |
| Edith Cowan University | 240 | 154 |
| Children's Health Queensland Hospital & Health Service | 236 | 300 |
| University Of WA | 235 | 223 |
| Camp Quality | 197 | 161 |
| Premier Research Pty Ltd | 195 | 48 |
| Roche Products Pty Ltd | 190 | 13 |
| University Of Queensland | 179 | 65 |
| Rare Voices Australia Ltd | 160 | 160 |
| Pharmaceutical Research Associates Pty Ltd | 134 | - |
| Novo Nordisk Pharmaceuticals Pty Ltd | 125 | 47 |
| Insulet Corporation | 125 | - |
| Other [a] | 1,639 | 2,824 |
| | 24,021 | 19,115 |

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.

(a) Other - The total of $1.639 million for 2025-26 consists of the amounts below $125,000 from individual fund providers.

### 4.4 Donation revenue

| | 2026 | 2025 |
|---|---|---|
| | $000 | $000 |
| Perth Children's Hospital Foundation - donations of equipment | 2,639 | 816 |
| Other | 373 | 723 |
| | 3,012 | 1,539 |

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

### 4.5 Other revenue

| | 2026 | 2025 |
|---|---|---|
| | $000 | $000 |
| Pharmaceutical manufacturing activities | 2,454 | 2,283 |
| Rent from commercial tenants | 618 | 588 |
| Expense recoupment from tenants | 2,933 | 3,099 |
| Immunisation services | 158 | 175 |
| Use of hospital facilities by medical practitioners | 13 | 14 |
| Other | 524 | 676 |
| | 6,700 | 6,835 |

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.

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 | 2026 | 2025 |
|---|---|---|---|
| | | $000 | $000 |
| Property, plant and equipment | 5.1 | 1,415,501 | 1,368,464 |
| Right-of-use assets | 5.2 | 24,742 | 26,486 |
| Intangible assets | 5.3 | 4,376 | 6,888 |
| **Total key assets** | | 1,444,619 | 1,401,838 |

| | Notes | 2026 | 2025 |
|---|---|---|---|
| **Depreciation and amortisation expense** | | $000 | $000 |
| Property, plant and equipment | 5.1.1 | 48,207 | 46,349 |
| Right-of-use assets | 5.2 | 3,342 | 3,261 |
| Intangible assets | 5.3.1 | 2,512 | 2,934 |
| | | 54,061 | 52,544 |

## 5.1 Property, plant and equipment

| Year ended 30 June 2026 | Land | Buildings | Site infra-struc-ture | Lease -hold improve -ments | Com -puter equip -ment | Furni -ture & fittings | Medical equip -ment | Motor vehicles, other plant & equip -ment | Work in progress | Art-works | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 |
| **1 July 2025** | | | | | | | | | | | |
| Gross carrying amount | 30,215 | 1,246,282 | 20,380 | 19,387 | 80,133 | 11,358 | 121,088 | 24,641 | 5,477 | 3,257 | 1,562,218 |
| Accumulated depreciation | - | - | (3,599) | (3,491) | (76,942) | (5,162) | (87,379) | (17,181) | - | - | (193,754) |
| Accumulated impairment losses | - | - | - | - | - | - | - | - | - | - | - |
| **Carrying amount at start of period** | **30,215** | **1,246,282** | **16,781** | **15,896** | **3,191** | **6,196** | **33,709** | **7,460** | **5,477** | **3,257** | **1,368,464** |
| Additions | - | - | - | - | 20 | - | 7,279 | 345 | 15,194 | 1 | 22,839 |
| Transfer from DPLH [b] | 1,687 | - | - | - | - | - | - | - | - | - | 1,687 |
| Disposals (Note 5.1.2) | - | - | - | - | - | - | (172) | (47) | - | - | (219) |
| Transfer between asset classes | - | 880 | - | 781 | - | - | 108 | - | (1,769) | - | - |
| Transfer to work in progress [c] | - | - | - | - | - | - | (182) | (40) | 222 | - | - |
| Revaluation increments [a] | 5,517 | 65,420 | - | - | - | - | - | - | - | - | 70,937 |
| Depreciation (Note 5.1.1) | - | (30,167) | (479) | (1,551) | (589) | (718) | (12,614) | (2,089) | - | - | (48,207) |
| **Carrying amount at 30 June 2026** | **37,419** | **1,282,415** | **16,302** | **15,126** | **2,622** | **5,478** | **28,128** | **5,629** | **19,124** | **3,258** | **1,415,501** |
| Gross carrying amount | 37,419 | 1,282,415 | 20,380 | 20,168 | 80,152 | 11,357 | 126,032 | 24,781 | 19,124 | 3,258 | 1,625,086 |
| Accumulated depreciation | - | - | (4,078) | (5,042) | (77,530) | (5,879) | (97,904) | (19,152) | - | - | (209,585) |
| Accumulated impairment losses | - | - | - | - | - | - | - | - | - | - | - |

(a) Revaluation increment is recorded in the asset revaluation reserve, except to the extent that any increment reverses a revaluation decrement of the same class of assets previously recognised as an expense. Revaluation decrement is recognised as an expense, except to the extent of any balance existing in the asset revaluation reserve in respect of that class of assets. In 2025-26, revaluation increment of $0.965 million for land is recognised as an income and revaluation increment of $4.552 million for land is recognised in the asset revaluation reserve. A revaluation increment of $65.420 million for buildings is recognised. During the year, the aluminium composite panel (ACP) cladding at the Perth Children's Hospital has been identified as requiring remediation, resulting in the recognition of a provision of $20.221 million that is capitalised to buildings (see Note 6.8 'Other liabilities'). Accordingly, the net increase recognised for buildings in the asset revaluation reserve is $45.199 million (see Note 9.13 'Equity').

(b) With the approval of the Minister for Health, the Department of Planning, Lands and Heritage (DPLH) transferred the additional adjacent land ($1.687 million) to the Health Service for amalgamation with the Hospice Reserve site in May 2026. The Health Service has accounted for the transfer as a contribution by owner.

(c) Transfers made from clearing accounts to work in progress accounts with respect to balances as at 30 June 2025.





## 5.1 Property, plant and equipment (cont.)

| Year ended 30 June 2025 | Land | Buildings [b] | Site infra-struc-ture | Lease -hold improve -ments | Com -puter equip -ment | Furni -ture & fittings | Medical equip -ment | Motor vehicles, other plant & equip -ment | Work in progress | Art-works | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 |
| **1 July 2024** | | | | | | | | | | | |
| Gross carrying amount | 29,295 | 1,070,389 | 20,380 | 6,403 | 76,777 | 11,358 | 116,470 | 24,249 | 7,176 | 5,072 | 1,367,569 |
| Accumulated depreciation | - | - | (3,120) | (2,237) | (75,233) | (4,446) | (73,012) | (15,064) | - | - | (173,112) |
| Accumulated impairment losses | - | - | - | - | - | - | - | - | - | (1,820) | (1,820) |
| **Carrying amount at start of period** | **29,295** | **1,070,389** | **17,260** | **4,166** | **1,544** | **6,912** | **43,458** | **9,185** | **7,176** | **3,252** | **1,192,637** |
| Additions | - | - | - | - | 2,459 | - | 5,105 | 338 | 16,502 | 5 | 24,409 |
| Transfer from other Health Services | - | - | - | - | - | - | 71 | - | - | - | 71 |
| Disposals (Note 5.1.2) | - | - | - | - | - | - | (107) | - | - | - | (107) |
| Transfer between asset classes | - | 4,298 | - | 12,984 | 897 | - | (39) | 61 | (18,201) | - | - |
| Revaluation increments [a] [b] | 920 | 196,914 | - | - | - | - | - | - | - | - | 197,834 |
| Depreciation (Note 5.1.1) | - | (25,319) | (479) | (1,254) | (1,709) | (716) | (14,748) | (2,124) | - | - | (46,349) |
| Write-offs (Note 3.6) | - | - | - | - | - | - | (31) | - | - | - | (31) |
| **Carrying amount at 30 June 2025** | **30,215** | **1,246,282** | **16,781** | **15,896** | **3,191** | **6,196** | **33,709** | **7,460** | **5,477** | **3,257** | **1,368,464** |
| Gross carrying amount | 30,215 | 1,246,282 | 20,380 | 19,387 | 80,133 | 11,358 | 121,088 | 24,641 | 5,477 | 3,257 | 1,562,218 |
| Accumulated depreciation | - | - | (3,599) | (3,491) | (76,942) | (5,162) | (87,379) | (17,181) | - | - | (193,754) |
| Accumulated impairment losses | - | - | - | - | - | - | - | - | - | - | - |

(a) Revaluation increment is recorded in the asset revaluation reserve, except to the extent that any increment reverses a revaluation decrement of the same class of assets previously recognised as an expense. Revaluation decrement is recognised as an expense, except to the extent of any balance existing in the asset revaluation reserve in respect of that class of assets. In 2024-25, revaluation increment of $0.920 million for land is recognised as an income and revaluation increment of $196.914 million for buildings is recognised in the asset revaluation reserve.

(b) Of this amount, $133.643 million relates to professional and project management fees, which are now included in the value of current use building assets under the current replacement cost basis as required by the prospective application of AASB 2022-10 *Amendments to Australian Accounting Standards – Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities*.

### 5.1 Property, plant and equipment (cont.)

#### Initial recognition

Items of property, plant and equipment, costing $5,000 or more are measured initially at cost. Where an asset is acquired for no cost or significantly less than fair value, the cost is valued at its fair value at the date of acquisition. Items of property, plant and equipment costing less than $5,000 are immediately expensed direct to the Statement of Comprehensive Income (other than where they form part of a group of similar items which are significant in total).

The cost of a leasehold improvement is capitalised and depreciated over the shorter of the remaining term of the lease or the estimated useful life of the leasehold improvement.

#### Subsequent measurement

Subsequent to initial recognition of an asset, the revaluation model is used for the measurement of land and buildings.

Land is carried at fair value. Buildings are carried at fair value less accumulated depreciation and accumulated impairment losses.

All other property, plant and equipment are stated at historical cost less accumulated depreciation and accumulated impairment losses.

When buildings are revalued, the accumulated depreciation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount.

Land and buildings are independently valued annually by the Western Australian Land Information Authority (Landgate). The effective date is at 1 July 2025, with the valuations performed during the year ended 30 June 2026 and recognised at 30 June 2026.

In addition, for buildings under the current replacement cost basis, estimated professional and project management fees are included in the valuation of current use assets as required by AASB 2022-10 *Amendments to Australian Accounting Standards – Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities*.

In undertaking the revaluation, fair value was determined by reference to market values for land: $1.062 million (2025: $0.870 million) and buildings: $0.308 million (2025: $0.250 million). For the remaining balance, fair value of buildings was determined on the basis of current replacement cost and fair value of land was determined on the basis of comparison with market evidence for land with low level utility (high restricted use land). These valuations are undertaken annually to ensure that the carrying amount of the assets does not differ materially from their fair value at the end of the reporting period.

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

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

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Notes to the financial statements for the year ended 30 June 2026

### 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

| Depreciation | Notes | 2026 $000 | 2025 $000 |
|---|---|---|---|
| Buildings | 5.1 | 30,167 | 25,319 |
| Site infrastructure | 5.1 | 479 | 479 |
| Leasehold improvement | 5.1 | 1,551 | 1,254 |
| Medical equipment | 5.1 | 12,614 | 14,748 |
| Computer equipment | 5.1 | 589 | 1,709 |
| Furniture and fittings | 5.1 | 718 | 716 |
| Motor vehicles, other plant and equipment | 5.1 | 2,089 | 2,124 |
| **Total depreciation for the period** | | **48,207** | **46,349** |

An impairment of $20.221 million has been recognised in the asset revaluation reserves in respect of the aluminium composite panel (ACP) cladding at the Perth Children's Hospital. The ACP cladding is identified as requiring remediation, resulting in an impairment of the affected building component. Refer Note 6.8 'Other liabilities' for details of the related remediation provision.

As at 30 June 2026, there were no other indications of impairments.

### 5.1.1 Depreciation and impairment charges for the period (cont.)

#### Finite useful lives

All property, plant and equipment having a limited useful life are systematically depreciated over their estimated useful lives in a manner that reflects the consumption of their future economic benefits. The exceptions to this rule include assets held for sale and land.

Depreciation is generally calculated on a straight line basis, at rates that allocate the asset's value, less any estimated residual value, over its estimated useful life.

Typical estimated useful lives for the different asset classes for current and prior years are included in the table below:

| | |
|---|---|
| Buildings | 50 years |
| Site infrastructure | 50 years |
| Leasehold improvements | Term of the lease |
| Computer equipment | 5 to 8 years |
| Furniture and fittings | 5 to 20 years |
| Motor vehicles | 8 to 10 years |
| Medical equipment | 3 to 18 years |
| Other plant and equipment | 4 to 20 years |

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

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

#### Impairment

Non-financial assets, including items of plant and equipment, are tested for impairment whenever there is an indication that the asset may be impaired. Where there is an indication of impairment, the recoverable amount is estimated. Where the recoverable amount is less than the carrying amount, the asset is considered impaired and is written down to the recoverable amount and an impairment loss is recognised.

Where an asset measured at cost is written down to its recoverable amount, an impairment loss is recognised through profit or loss.

Where a previously revalued asset is written down to its recoverable amount, the loss is recognised as a revaluation decrement through other comprehensive income.

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Notes to the financial statements for the year ended 30 June 2026

### 5.1.1 Depreciation and impairment charges for the period (cont.)

#### Impairment (cont.)

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

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

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

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

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

| | 2026 | 2025 |
|---|---|---|
| | $000 | $000 |
| Carrying amount of non-current assets disposed: | | |
| Property, plant and equipment | (219) | (107) |
| Proceeds from disposal of non-current assets: | | |
| Property, plant and equipment | 9 | 210 |
| **Net gain/(loss) on disposal of non-current assets** | **(210)** | **103** |

**Realised and unrealised gains** are usually recognised on a net basis.

Gains and losses on the disposal of non-current assets are presented by deducting from the proceeds on disposal the carrying amount of the asset and related selling expenses.

## 5.2 Right-of-use assets

| Year ended 30 June 2026 | Buildings $000 | Vehicles $000 | Total $000 |
|---|---|---|---|
| **1 July 2025** | | | |
| Gross carrying amount | 33,334 | 2,772 | 36,106 |
| Accumulated depreciation | (8,247) | (1,373) | (9,620) |
| **Carrying amount at start of period** | **25,087** | **1,399** | **26,486** |
| Additions | 820 | 744 | 1,564 |
| Adjustments | - | 34 | 34 |
| Depreciation | (2,797) | (545) | (3,342) |
| **Carrying amount at 30 June 2026** | **23,110** | **1,632** | **24,742** |
| Gross carrying amount | 33,837 | 3,013 | 36,850 |
| Accumulated depreciation | (10,727) | (1,381) | (12,108) |

| Year ended 30 June 2025 | Buildings $000 | Vehicles $000 | Total $000 |
|---|---|---|---|
| **1 July 2024** | | | |
| Gross carrying amount | 15,322 | 2,518 | 17,840 |
| Accumulated depreciation | (6,494) | (1,306) | (7,800) |
| **Carrying amount at start of period** | **8,828** | **1,212** | **10,040** |
| Additions | 19,008 | 603 | 19,611 |
| Adjustments | - | 96 | 96 |
| Depreciation | (2,749) | (512) | (3,261) |
| **Carrying amount at 30 June 2025** | **25,087** | **1,399** | **26,486** |
| Gross carrying amount | 33,334 | 2,772 | 36,106 |
| Accumulated depreciation | (8,247) | (1,373) | (9,620) |

Child and Adolescent Health Service
Notes to the financial statements for the year ended 30 June 2026

## 5.2 Right-of-use assets (cont.)

The Health Service has leases for vehicles, office and clinical accommodations.

The Health Service has also entered into Memorandum of Understanding Agreements (MOU) with the Department of Housing and Works for the leasing of office accommodation. These are not recognised under AASB 16 because of substitution rights held by the Department of Housing and Works and are accounted for as an expense as incurred.

The Health Service recognises leases as right-of-use assets and associated lease liabilities in the Statement of Financial Position.

The corresponding lease liabilities in relation to these right-of-use assets have been disclosed in Note 7.1.

### Initial recognition

At the commencement date of the lease, the Health Service right-of-use assets are measured at cost including the following:

- the amount of the initial measurement of lease liability;
- any lease payments made at or before the commencement date less any lease incentives received;
- any initial direct costs; and
- restoration costs, including dismantling and removing the underlying asset.

The Health Service has elected not to recognise right-of-use assets and lease liabilities for short-term leases (with a lease term of 12 months or less) and low value leases (with an underlying value of $5,000 or less). Lease payments associated with these leases are expensed over a straight-line basis over the lease term.

### Subsequent Measurement

The cost model is applied for subsequent measurement of right-of-use assets, requiring the asset to be carried at cost less any accumulated depreciation and accumulated impairment losses and adjusted for any re-measurement of lease liability.

### 5.2 Right-of-use assets (cont.)

#### Depreciation and impairment of right-of-use assets

Right-of-use assets are depreciated on a straight-line basis over the shorter of the lease term and the estimated useful lives of the underlying assets. If ownership of the leased asset transfers to the Health Service at the end of the lease term or the cost reflects the exercise of a purchase option, depreciation is calculated using the estimated useful life of the asset.

Right-of-use assets are tested for impairment when an indication of impairment is identified. The policy in connection with testing for impairment is outlined in Note 5.1.1.

The following amounts relating to leases have been recognised in the Statement of Comprehensive Income:

| | Notes | 2026 $000 | 2025 $000 |
|---|---|---|---|
| Depreciation expense of right-of-use assets | 5.2 | 3,342 | 3,261 |
| Lease interest expense | 7.2 | 1,724 | 1,708 |
| Low-value leases | | 2 | 1 |
| **Total amount recognised in the Statement of Comprehensive Income** | | **5,068** | **4,970** |

The total cash outflow for leases in 2026 was $4.738 million (2025: $4.402 million). As at 30 June 2026, there were no indications of impairment to right-of-use assets.

Child and Adolescent Health Service
Notes to the financial statements for the year ended 30 June 2026

### 5.3 Intangible assets

| **Computer software** | 2026 $000 | 2025 $000 |
|---|---|---|
| Carrying amount at start of period | 6,888 | 9,822 |
| Amortisation expense (Note 5.3.1) | (2,512) | (2,934) |
| **Carrying amount at 30 June** | **4,376** | **6,888** |
| Gross carrying amount | 55,638 | 55,638 |
| Accumulated amortisation | (51,262) | (48,750) |
| | **4,376** | **6,888** |

#### Initial recognition

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

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

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

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

(a) The technical feasibility of completing the intangible asset so that it will be available for use;
(b) An intention to complete the intangible asset and use it;
(c) The ability to use the intangible asset;
(d) The intangible asset will generate probable future economic benefit;
(e) The availability of adequate technical, financial and other resources to complete the development and to use the intangible asset;
(f) The ability to measure reliably the expenditure attributable to the intangible asset during its development.

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

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

#### Subsequent measurement

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

### 5.3.1 Amortisation and impairment

#### Charges for the period

| Amortisation | 2026 $000 | 2025 $000 |
|---|---|---|
| Computer software | 2,512 | 2,934 |
| **Total amortisation for the period** | **2,512** | **2,934** |

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

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

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

| | |
|---|---|
| Computer software [(a)] | 8 to 10 years |

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

#### Impairment

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

As at 30 June 2026, there were no indications of impairment to intangible assets.





## 6. Other assets and liabilities

This section sets out those assets and liabilities that arose from the Health Service's controlled operations and includes other assets utilised for economic benefits and liabilities incurred during normal operations:

| | Notes | 2026 $000 | 2025 $000 |
|---|---|---|---|
| Receivables | 6.1 | 51,241 | 35,291 |
| Amount receivable for services | 6.2 | 677,683 | 628,351 |
| Inventories | 6.3 | 6,810 | 4,980 |
| Other current assets | 6.4 | 2,296 | 1,119 |
| Payables | 6.5 | 53,704 | 51,801 |
| Contract liabilities | 6.6 | 1,106 | 796 |
| Capital grant liabilities | 6.7 | 3,457 | 1,245 |
| Other liabilities | 6.8 | 20,319 | 100 |

## 6.1 Receivables

| | 2026 $000 | 2025 $000 |
|---|---|---|
| **Current** | | |
| Patient fee debtors | 9,622 | 6,958 |
| GST receivable | 603 | 668 |
| Receivable from North Metropolitan Health Service | 436 | 1,426 |
| Other receivables | 9,454 | 6,560 |
| Allowance for impairment of receivables | (4,007) | (3,463) |
| Accrued revenue | 8,261 | 4,270 |
| | **24,369** | **16,419** |
| **Non-current** | | |
| Accrued salaries account [(a)] | 26,872 | 18,872 |
| | **26,872** | **18,872** |
| **Total Receivables** | **51,241** | **35,291** |

(a) Funds transferred to Department of Treasury and Finance for the purpose of meeting the 27th pay in a reporting period that generally occurs every 11 years. This account is classified as non-current except for the year before the 27th pay year.

Patient fee debtors and other receivables are recognised at original invoice amount less any allowances for uncollectible amounts (i.e. impairment). The carrying amounts of net patient fee debtors and other receivables are equivalent to fair value as it is due for settlement within 30 days.

The Health Service recognises an allowance for expected credit losses (ECLs) on patient fee debtors, measured at the lifetime expected credit losses at each reporting date. The Health Service has established a provision matrix that is based on its historical credit loss experience, adjusted for forward-looking factors specific to the debtors and the economic environment. Please refer to Note 3.6 for the amount of ECLs expensed in this financial year.

The Health Service does not hold any collateral or other credit enhancements as security for receivables.

Accrued salaries account contains amounts paid annually into the Treasurer's special purpose account. It is restricted for meeting the additional cash outflow for employee salary payments in reporting periods with 27 pay days instead of the normal 26. No interest is received on this account.

Child and Adolescent Health Service
Notes to the financial statements for the year ended 30 June 2026

## 6.1 Receivables (cont.)

### Accounting procedure for Goods and Services Tax

Rights to collect amounts receivable from the Australian Taxation Office (ATO) and responsibilities to make payments for GST have been assigned to the Department of Health. This accounting procedure was a result of application of the grouping provisions of "*A New Tax System (Goods and Services Tax) Act 1999*" whereby the Department of Health became the Nominated Group Representative (NGR) for the GST Group as from 1 July 2012. The entities in the GST group include the Department of Health, Child and Adolescent Health Service, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service, WA Country Health Service, Health Support Services, PathWest Laboratory Medicine WA, Queen Elizabeth II Medical Centre Trust, Mental Health Commission, and Health and Disability Services Complaints Office.

GST receivables on accrued expenses are recognised by the Health Service. Upon the receipt of tax invoices, GST receivables for the GST group are recorded in the accounts of the Department of Health.

### 6.1.1 Movement of the allowance for impairment of receivables

| | 2026 $000 | 2025 $000 |
|---|---|---|
| **Reconciliation of changes in the allowance for impairment of receivables:** | | |
| Balance at start of period | 3,463 | 3,891 |
| Expected credit losses expense | 635 | 630 |
| Amount written off during the period | (91) | (1,058) |
| Balance at end of period | 4,007 | 3,463 |

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)

| | 2026 $000 | 2025 $000 |
|---|---|---|
| Current | - | - |
| Non-Current | 677,683 | 628,351 |
| | 677,683 | 628,351 |

The Health Service receives service appropriations from the State Government via the Department of Health, partly in cash and partly as a non-cash asset. Amounts receivable for services represent the non-cash component and it is restricted in that it can only be used for asset replacement or payment of leave liability.

Amounts receivable for services are considered not impaired (i.e. there is no expected credit loss for the holding account).

Subject to the State Government's approval, the receivable is accessible on the emergence of the cash funding requirement to cover the payments for leave entitlements and asset replacement.

### 6.3 Inventories

| | 2026 $000 | 2025 $000 |
|---|---|---|
| **Current** | | |
| Pharmaceutical stores - at cost | 6,810 | 4,980 |

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

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

### 6.4 Other current assets

| | 2026 $000 | 2025 $000 |
|---|---|---|
| **Current** | | |
| Prepayments | 2,282 | 1,100 |
| Unearned patient charges | 14 | 19 |
| | 2,296 | 1,119 |

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.

Child and Adolescent Health Service
Notes to the financial statements for the year ended 30 June 2026

### 6.5 Payables

| | 2026 $000 | 2025 $000 |
|---|---|---|
| **Current** | | |
| Trade payables | 5,965 | 8,841 |
| Other payables | 44 | 42 |
| Accrued expenses | 12,380 | 11,835 |
| Accrued salaries | 35,315 | 31,083 |
| | 53,704 | 51,801 |

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

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

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

### 6.6 Contract liabilities

| | 2026 $000 | 2025 $000 |
|---|---|---|
| **Reconciliation of changes in contract liabilities** | | |
| Opening balance | 796 | 472 |
| Additions | 1,213 | 1,359 |
| Revenue recognised in the reporting period | (903) | (1,035) |
| **Total contract liabilities at end of period** | 1,106 | 796 |
| | | |
| Current | 1,106 | 796 |
| Non-current | - | - |

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

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

### 6.7 Capital grant liabilities

| | 2026 $000 | 2025 $000 |
|---|---|---|
| **Reconciliation of changes in capital grant liabilities** | | |
| Opening balance | 1,245 | 101 |
| Additions | 3,397 | 1,235 |
| Revenue recognised in the reporting period | (1,185) | (91) |
| **Total capital grant liabilities at end of period** | 3,457 | 1,245 |
| | | |
| Current | 3,457 | 1,245 |
| Non-current | - | - |

The Health Service recognises a capital grant liability for the excess of the initial carrying amount of a financial asset received in a transfer to enable the acquisition or construction of a recognisable non-financial asset under its control.

The Health Service recognises income in profit or loss as the obligations of the capital grant liability are satisfied under the transfer. Refer to Note 4.3 for the details of revenue recognition policy.

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

### 6.8 Other liabilities

| | 2026 $000 | 2025 $000 |
|---|---|---|
| **Current** | | |
| Paid parental leave scheme | 98 | 100 |
| Make good provision [(a)] | 6,261 | - |
| Total current | 6,359 | 100 |
| **Non-current** | | |
| Make good provision [(a)] | 13,960 | - |
| Total non-current | 13,960 | - |
| **Total other liabilities at end of period** | 20,319 | 100 |

(a) A provision of $20.221 million has been recognised for the estimated cost of remediating the aluminium composite panel (ACP) cladding at the Perth Children's Hospital. The provision represents management's estimate of the expenditure required to complete the remediation works.

Child and Adolescent Health Service
Notes to the financial statements for the year ended 30 June 2026

## 7. Financing

This section sets out the material balances and disclosures associated with the financing and cashflows of the Health Service.

| | Notes |
|---|---|
| Lease liabilities | 7.1 |
| Finance costs | 7.2 |
| Cash and cash equivalents | 7.3 |
| Reconciliation of cash | 7.3.1 |
| Reconciliation of net cost of services to net cash flows used in operating activities | 7.3.2 |
| Reconciliation of cash flows from State Government | 7.3.3 |
| Capital commitments | 7.4 |

## 7.1 Lease liabilities

| | 2026 $000 | 2025 $000 |
|---|---|---|
| Current | 3,008 | 2,914 |
| Non-current | 27,893 | 29,444 |
| **Total lease liabilities** [(a)] | 30,901 | 32,358 |

(a) The 2026 total lease liabilities include $29.176 million (2025: $30.835 million) for leased buildings and $1.723 million (2025: $1.521 million) for leased vehicles.

### Initial measurement

The Health Service measures a lease liability, at the commencement date, at the present value of the lease payments that are not paid at that date. The lease payments are discounted using the interest rate implicit in the lease. If that rate cannot be readily determined, the Health Service uses the incremental borrowing rate provided by Western Australia Treasury Corporation.

Lease payments included by the Health Service as part of the present value calculation of lease liability include:

- Fixed payments (including in-substance fixed payments), less any lease incentives receivable;
- Variable lease payments that depend on an index or a rate initially measured using the index or rate as at the commencement date;
- Amounts expected to be payable by the lessee under residual value guarantees;
- The exercise price of purchase options (where these are reasonably certain to be exercised);
- Payments for penalties for terminating a lease, where the lease term reflects the lessee exercising an option to terminate the lease.

The interest on the lease liability is recognised in profit or loss over the lease term so as to produce a constant periodic rate of interest on the remaining balance of the liability for each period. Lease liabilities do not include any future changes in variable lease payments (that depend on an index or rate) until they take effect, in which case the lease liability is reassessed and adjusted against the right-of-use asset.

Periods covered by extension or termination options are only included in the lease term by the Health Service if the lease is reasonably certain to be extended (or not terminated).

Variable lease payments, not included in the measurement of lease liability, are recognised by the Health Service in profit or loss in the period in which the condition that triggers the payment occurs.

This section should be read in conjunction with Note 5.2.

Child and Adolescent Health Service
Notes to the financial statements for the year ended 30 June 2026

## 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

| | 2026 $000 | 2025 $000 |
|---|---|---|
| Lease interest expense | 1,724 | 1,708 |
| | **1,724** | **1,708** |

Finance costs are recognised as expenses in the period in which they are incurred.

Lease interest expense is the interest component of lease liability repayments.

## 7.3 Cash and cash equivalents

### 7.3.1 Reconciliation of cash

| | 2026 $000 | 2025 $000 |
|---|---|---|
| **Cash and cash equivalents** | 18,803 | 17,730 |
| **Restricted cash and cash equivalents** | | |
| Current | | |
| Capital work projects | 4,806 | 5,091 |
| Mental Health Commission Funding [a] | 8,011 | 2,302 |
| Restricted cash assets held for other specific purposes [b] | 25,921 | 20,709 |
| Total restricted cash and cash equivalents | 38,738 | 28,102 |
| **Balance at end of period** | **57,541** | **45,832** |

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

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

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

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

Child and Adolescent Health Service
Notes to the financial statements for the year ended 30 June 2026

### 7.3.2 Reconciliation of net cost of services to net cash flows used in operating activities

| | Notes | 2026 $000 | 2025 $000 |
|---|---|---|---|
| Net cost of services (Statement of Comprehensive Income) | | (1,158,582) | (1,090,135) |
| Non-cash items: | | | |
| Expected credit losses expense | 3.6 | 635 | 630 |
| Write-off of inventory | | (8) | 11 |
| Depreciation and amortisation expenses | 5 | 54,061 | 52,544 |
| Assets received from other Health Services expensed | | - | 197 |
| Asset revaluation increments | 5.1 | (965) | (920) |
| Loss on disposal of non-current assets | 5.1.2 | 210 | (103) |
| Write-off of plant and equipment | 3.6 | - | 31 |
| Interest capitalised | | 24 | 20 |
| Donations of assets | | (2,110) | (336) |
| Resources received free of charge | 4.1 | 66,466 | 63,338 |
| (Increase)/decrease in assets: | | | |
| Receivables | | (8,585) | (3,401) |
| Inventories | | (1,822) | 368 |
| Other current assets | | (1,313) | 222 |
| Increase/(Decrease) in liabilities: | | | |
| Payables | | 1,856 | 5,800 |
| Current provisions | | 9,587 | 17,459 |
| Non-current provisions | | 791 | 9,764 |
| Grant liabilities | | 2,212 | 1,144 |
| Contract liabilities | | 310 | 324 |
| Other current liabilities | | (2) | (4) |
| **Net cash used in operating activities (Statement of Cash Flows)** | | **(1,037,235)** | **(943,047)** |

### 7.3.3 Reconciliation of cash flows from State Government

| | 2026 $000 | 2025 $000 |
|---|---|---|
| Service agreement funding - State | 775,211 | 697,500 |
| Service agreement funding - Commonwealth | 212,823 | 197,838 |
| Grants from other state government agencies | 117,861 | 105,525 |
| Services provided to other government agencies | 3,957 | 3,945 |
| Capital appropriation credited directly to Contributed equity (refer Note 9.13) | 20,040 | 15,701 |
| | 1,129,892 | 1,020,509 |
| Less notional cash flows: | | |
| Accrual appropriations | (49,332) | (47,216) |
| **Cash Flows from State Government as per Statement of Cash Flows** | 1,080,560 | 973,293 |

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

| | 2026 $000 | 2025 $000 |
|---|---|---|
| Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows: | | |
| Within 1 year | 8,095 | 5,389 |
| Later than 1 year, and not later than 5 years | 1,862 | 5,773 |
| Later than 5 years | - | - |
| | 9,957 | 11,162 |

Amounts presented for capital expenditure commitments are GST inclusive.

Child and Adolescent Health Service
Notes to the financial statements for the year ended 30 June 2026

## 8. Risks and Contingencies

This note sets out the key risk management policies and measurement techniques of the Health Service.

| | Notes |
|---|---|
| Financial risk management | 8.1 |
| Contingent assets | 8.2.1 |
| Contingent liabilities | 8.2.2 |
| Fair value measurements | 8.3 |

## 8.1 Financial risk management

Financial instruments held by the Health Service are cash and cash equivalents, restricted cash and cash equivalents, lease liabilities, receivables and payables. The Health Service has limited exposure to financial risks. The Health Service's overall risk management program focuses on managing the risks identified below.

### (a) Summary of risks and risk management

Credit risk

Credit risk arises when there is the possibility of the Health Service's receivables defaulting on their contractual obligations resulting in financial loss to the Health Service.

The maximum exposure to credit risk at the end of the reporting period in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any allowance for impairment as shown in the tables at Note 8.1(c) 'Credit risk exposure' and Note 6.1 'Receivables'.

Credit risk associated with the Health Service's financial assets is generally confined to patient fee debtors and other receivables (see Note 6.1). The main receivable of the Health Service is the amounts receivable for services (holding account). For receivables other than government agencies and patient fee debtors, the Health Service trades only with recognised, creditworthy third parties. The Health Service has policies in place to ensure that sales of products and services are made to customers with an appropriate credit history. In addition, receivable balances are monitored on an ongoing basis with the result that the Health Service's exposure to bad debts is minimised. At the end of the reporting period, there were no significant concentrations of credit risk.

All debts are individually reviewed, on a timely basis at 30, 60, 90 and 120 days. In a circumstance where a third party is responsible for payment, or there are legal considerations, payment of accounts can be delayed considerably. Unpaid debts are referred to an external debt collection service within six months of the accounts being raised.

Allowance for impairment of financial assets is calculated based on objective evidence such as observable data indicating changes in client credit ratings.

Liquidity risk

Liquidity risk arises when the Health Service is unable to meet its financial obligations as they fall due. The Health Service is exposed to liquidity risk through its normal course of operations.

The Health Service has appropriate procedures to manage cash flows including drawdowns of appropriations by monitoring forecast cash flows to ensure that sufficient funds are available to meet its commitments.

Market risk

Market risk is the risk that changes in market prices such as foreign exchange rates and interest rates will affect the Health Service's income or the value of its holdings of financial instruments. The Health Service does not trade in foreign currency and is not materially exposed to other price risks. The Health Service's exposure to market risk for changes in interest rates relates primarily to the lease liabilities.





## 8.1 Financial risk management (cont.)

### (b) Categories of financial instruments

The carrying amounts of each of the following categories of financial assets and financial liabilities at the end of the reporting period are:

| | 2026 $000 | 2025 $000 |
|---|---|---|
| Financial Assets | | |
| Cash and cash equivalents | 18,803 | 17,730 |
| Restricted cash and cash equivalents | 38,738 | 28,102 |
| Financial assets at amortised cost [a] | 728,321 | 662,974 |
| | **785,862** | **708,806** |
| Financial Liabilities | | |
| Financial liabilities measured at amortised cost | 84,605 | 84,159 |
| | **84,605** | **84,159** |

(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 2026** | | | | | | | |
| Expected credit loss rate | 20% | 2% | 9% | 7% | 19% | 33% | 65% |
| Estimated total gross carrying amount | 19,684 | 8,760 | 1,688 | 1,401 | 2,097 | 1,631 | 4,107 |
| Expected credit losses | (4,008) | (177) | (145) | (104) | (399) | (533) | (2,650) |
| **30 June 2025** | | | | | | | |
| Expected credit loss rate | 24% | 2% | 8% | 12% | 31% | 59% | 75% |
| Estimated total gross carrying amount | 14,406 | 6,601 | 1,673 | 949 | 1,505 | 721 | 2,957 |
| Expected credit losses | (3,465) | (125) | (132) | (117) | (464) | (422) | (2,205) |

## 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 $000 | Fixed interest rate $000 | Variable interest rate $000 | Non-interest bearing $000 | Nominal Amount $000 | Up to 3 months $000 | 3 months to 1 year $000 | 1-5 years $000 | More than 5 years $000 |
| **2026** | | | | | | | | | | |
| Financial Assets | | | | | | | | | | |
| Cash and cash equivalents | | 18,803 | - | - | 18,803 | 18,803 | 18,803 | - | - | - |
| Restricted cash and cash equivalents | | 38,738 | - | - | 38,738 | 38,738 | 38,738 | - | - | - |
| Receivables [a] | | 50,638 | - | - | 50,638 | 50,638 | 23,766 | - | 26,872 | - |
| Amounts receivable for services | | 677,683 | - | - | 677,683 | 677,683 | - | - | - | 677,683 |
| | | 785,862 | - | - | 785,862 | 785,862 | 81,307 | - | 26,872 | 677,683 |
| Financial Liabilities | | | | | | | | | | |
| Payables | | 53,704 | - | - | 53,704 | 53,704 | 53,704 | - | - | - |
| Lease liabilities | 5.45% | 30,901 | 30,901 | - | - | 48,788 | 1,173 | 3,444 | 13,970 | 30,201 |
| | | 84,605 | 30,901 | - | 53,704 | 102,492 | 54,877 | 3,444 | 13,970 | 30,201 |

(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 2026

## 8.1 Financial risk management (cont.)

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

| | Weighted average effective interest rate % | Interest rate exposure | | | | | Maturity dates | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Carrying amount $000 | Fixed interest rate $000 | Variable interest rate $000 | Non-interest bearing $000 | Nominal Amount $000 | Up to 3 months $000 | 3 months to 1 year $000 | 1-5 years $000 | More than 5 years $000 |
| **2025** | | | | | | | | | | |
| Financial Assets | | | | | | | | | | |
| Cash and cash equivalents | | 17,730 | - | - | 17,730 | 17,730 | 17,730 | - | - | - |
| Restricted cash and cash equivalents | | 28,102 | - | - | 28,102 | 28,102 | 28,102 | - | - | - |
| Receivables [a] | | 34,623 | - | - | 34,623 | 34,623 | 15,751 | - | 18,872 | - |
| Amounts receivable for services | | 628,351 | - | - | 628,351 | 628,351 | - | - | - | 628,351 |
| | | 708,806 | - | - | 708,806 | 708,806 | 61,583 | - | 18,872 | 628,351 |
| Financial Liabilities | | | | | | | | | | |
| Payables | | 51,801 | - | - | 51,801 | 51,801 | 51,801 | - | - | - |
| Lease liabilities | 7.88% | 32,358 | 32,358 | - | - | 51,525 | 1,112 | 3,327 | 14,687 | 32,399 |
| | | 84,159 | 32,358 | - | 51,801 | 103,326 | 52,913 | 3,327 | 14,687 | 32,399 |

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

### 8.2 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

**Casual long service leave**

Under the *Long Service Leave Act 1958* casual employees who have been employed for more than ten years and meet continuous service requirements are entitled to long service leave. The Department of Health, in conjunction with Health Support Services, is assessing the impact of continuity of service on the Health Service's casual long service leave liability. As at June 2026, the Health Service has elected not to record a liability in respect of casual long service leave until this assessment is complete as the financial effect cannot presently be reliably estimated.

**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.

Child and Adolescent Health Service
Notes to the financial statements for the year ended 30 June 2026

### 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:

| 2026 | Notes | Level 1 $000 | Level 2 $000 | Level 3 $000 | Fair value at end of period $000 |
|---|---|---|---|---|---|
| Land | 5.1 | | | | |
| Residential | | - | 1,062 | - | 1,062 |
| Specialised | | - | - | 36,357 | 36,357 |
| Buildings | 5.1 | | | | |
| Residential | | - | 308 | - | 308 |
| Specialised | | - | - | 1,282,107 | 1,282,107 |
| | | - | 1,370 | 1,318,464 | 1,319,834 |
| **2025** | | | | | |
| Land | 5.1 | | | | |
| Residential | | - | 870 | - | 870 |
| Specialised | | - | - | 29,345 | 29,345 |
| Buildings | 5.1 | | | | |
| Residential | | - | 250 | - | 250 |
| Specialised | | - | - | 1,246,032 | 1,246,032 |
| | | - | 1,120 | 1,275,377 | 1,276,497 |

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

### 8.3 Fair value measurements (cont.)

#### Valuation processes

The Health Service obtains independent valuations of land and buildings from the Western Australian Land Information Authority (Landgate) annually.

There were no changes in valuation techniques during the period.

Transfers in and out of a fair value level are recognised on the date of the event or change in circumstances that caused the transfer. Transfers are generally limited to assets newly classified as non-current assets held for sale as Treasurer's instructions require valuations of land and buildings to be categorised within Level 3 where the valuations will utilise significant Level 3 inputs on a recurring basis.

#### Valuation techniques to derive Level 2 fair values

Level 2 fair values of land and buildings (converted residential properties) are derived using the market approach. This approach provides an indication of value by comparing the asset with identical or similar properties for which price information is available. Analysis of comparable sales information and market data provides the basis for fair value measurement.

The best evidence of fair value is current prices in an active market for similar properties. Where such information is not available, Landgate consider current prices in an active market for properties of different nature or recent prices of similar properties in less active markets, and adjust the valuation for differences in property characteristics and market conditions.

For properties with buildings and other improvements, the land value is measured by comparison and analysis of open market transactions on the assumption that the land is in a vacant and marketable condition. The amount determined is deducted from the total property value and the residual amount represents the building value.

The Health Service's residential properties consist of residential buildings that have been re-configured to be used as health centres or clinics.

Child and Adolescent Health Service
Notes to the financial statements for the year ended 30 June 2026

### 8.3 Fair value measurements (cont.)

#### Fair value measurements using significant unobservable inputs (Level 3)

| | Land | Buildings |
|---|---|---|
| **2026** | **$000** | **$000** |
| Fair value at start of period | 29,345 | 1,246,032 |
| Additions | 1,687 | 880 |
| Revaluation increments recognised in Profit or Loss | 965 | - |
| Revaluation increments recognised in Other Comprehensive Income | 4,360 | 65,362 |
| Depreciation expense | - | (30,167) |
| **Fair Value at end of period** | **36,357** | **1,282,107** |
| | | |
| **2025** | | |
| Fair value at start of period | 28,555 | 1,070,299 |
| Additions | - | 4,298 |
| Revaluation increments recognised in Profit or Loss | 790 | - |
| Revaluation increments recognised in Other Comprehensive Income | - | 196,752 |
| Depreciation expense | - | (25,317) |
| **Fair Value at end of period** | **29,345** | **1,246,032** |

#### 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)

Low Utility land values are applied to land highly encumbered by community service obligations or infrastructure, where the economic highest and best alternative land use is not permitted. Land Values determined under this methodology take into consideration the legal, physical, economic and socio-political factors that inhibit economic highest and best use alternatives.

Fair value measurement of public sector land draws on the values from the primary real estate market, based on comparable utility with an underlying going concern assumption.

### 8.3 Fair value measurements (cont.)

Buildings (Level 3 fair values)

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

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

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

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

c) Measurement of the general floor areas;
d) Application of the BUC cost rates per square metre of general floor areas.

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

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

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

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

In addition, professional and project management fees estimated and added to the current replacement costs provided by Landgate for current use buildings represent significant Level 3 inputs used in the valuation process. The higher level of estimated professional and project management fees would result in higher fair value of these assets.

Child and Adolescent Health Service
Notes to the financial statements for the year ended 30 June 2026

## 9. Other disclosures

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

### 9.1 Events occurring after the end of the reporting period

There were no events occurring after the reporting period which had significant financial effects on these financial statements.

### 9.2 Initial application of Australian Accounting Standards

**AASB 2026-1 – *Amendments to Australian Accounting Standards – Disclosures about Uncertainties in the Financial Statements***

The Standard amends AASB 136 *Impairment of Assets* and AASB 137 *Provisions, Contingent Liabilities and Contingent Assets* to illustrate how an entity applies the requirements of the Standards to report the effects of uncertainties in its financial statements. in particular:

a) AASB 136 – how an entity discloses information about key assumptions it uses to determine recoverable amounts of assets under ASB 136; and
b) AASB 137 - How an entity might disclose information about plant decommissioning and site restoration obligations even if its plant decommissioning and site-restoration provision is immaterial.

The Health Service does not have any site restoration obligations for its most significant leases.





### 9.3 Future impact of Australian Accounting Standards not yet operative

The Health Service cannot early adopt an Australian Accounting Standard unless specifically permitted by Treasurer's Instruction (TI) 9 – Requirement 4 *Application of Australian Accounting Standards and Other Pronouncements* or by an exemption from TI 9. Where applicable, the Health Service plans to apply the following Australian Accounting Standards from their application date.

| | | Operative for reporting periods beginning on/after |
|---|---|---|
| *AASB 2024-2* | *Amendments to Australian Accounting Standards – Classification and Measurement of Financial Instruments*<br>This Standard amends AASB 7 and AASB 9 as a consequence of the issuance of *Amendments to the Classification and Measurement of Financial Instruments* (Amendments to IFRS 9 and IFRS 7) by the International Accounting Standards Board in May 2024.<br>The Health Service has not assessed the impact of the Standard. | 1 January 2026 |
| *AASB 2024-3* | *Amendments to Australian Accounting Standards – Annual Improvements Volume 11*<br>This Standard amends AASB 1, AASB 7, AASB 9, AASB 10 and AASB 107 as a consequence of the issuance of *Annual Improvements to IFRS Standards - Volume 11* by the International Accounting Standards Board in July 2024.<br>The Health Service has not assessed the impact of the Standard. | 1 January 2026 |
| *AASB 18* | *Presentation and Disclosure in Financial Statements [for not-for-profit entities]*<br>This Standard replaces AASB 101 with respect to the presentation and disclosure requirements in financial statements applicable to not-for-profit entities This Standard is a consequence of the issuance of IFRS 18 *Presentation and Disclosure in financial Statements* by the International Accounting Standards Board in April 2024.<br>This Standard also makes amendments to other Australian Accounting Standards set out in Appendix D of this Standard.<br>The Health Service has not assessed the impact of the Standard. | 1 January 2028 |

### 9.4 Remuneration of auditors

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

| | 2026<br>$000 | 2025<br>$000 |
|---|---|---|
| Auditing the accounts, financial statements, controls, and key performance indicators | 380 | 368 |

### 9.5 Key management personnel

The key management personnel include Ministers, board members, and senior officers of the Health Service. The Health Service does not incur expenditures to compensate Ministers and those disclosures may be found in the *Annual Report on State Finances*.

The total fees, salaries, superannuation, non-monetary benefits and other benefits for members of the Accountable Authority for the reporting period are presented within the following bands:

| **Compensation band ($)** | **2026** | **2025** |
|---|---|---|
| $0 - $10,000 | 2 | - |
| $10,001 - $20,000 | 2 | - |
| $20,001 - $30,000 | 4 | 2 |
| $30,001 - $40,000 | 2 | - |
| $40,001 - $50,000 | 4 | 7 |
| $50,001 - $60,000 | 1 | - |
| $60,001 - $70,000 | - | 1 |
| **Total number of members of the Accountable Authority** | 15 | 10 |

| | 2026<br>$000 | 2025<br>$000 |
|---|---|---|
| Short-term employee benefits | 404 | 394 |
| Post-employment benefits | 49 | 45 |
| **Total compensation of members of the Accountable Authority** | **453** | **439** |

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Notes to the financial statements for the year ended 30 June 2026

### 9.5 Key management personnel (cont.)

The total fees, salaries, superannuation, non-monetary benefits and other benefits for senior officers for the reporting period are presented within the following bands:

| **Compensation band ($)** | **2026** | **2025** |
|---|---|---|
| $0 - $50,000 | - | 1 |
| $50,001 - $100,000 | 1 | 1 |
| $100,001 - $150,000 | - | 1 |
| $200,001 - $250,000 | 4 | 4 |
| $250,001 - $300,000 | 4 | 4 |
| $300,001 - $350,000 | - | 1 |
| $450,001 - $500,000 | - | 1 |
| $500,001 - $550,000 | 2 | - |
| **Total number of senior officers** | 11 | 13 |

| | 2026<br>$000 | 2025<br>$000 |
|---|---|---|
| Short-term employee benefits | 2,535 | 2,439 |
| Post-employment benefits | 345 | 322 |
| Other long-term benefits | 296 | 292 |
| **Total compensation of senior officers** | **3,176** | **3,053** |

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

### 9.6 Related party transactions

The Health Service is a wholly-owned public sector entity that is controlled by the State of Western Australia.

Related parties of the Health Service include:

- all Ministers and their close family members, and their controlled or jointly controlled entities;
- all board members, senior officers and their close family members, and their controlled or jointly controlled entities;
- Wholly owned public sector entities (departments and statutory authorities), including their related bodies, that are included in the whole of government consolidated financial statements;
- Associates and joint ventures of a wholly-owned public sector entity; and
- Government Employees Superannuation Board (GESB).

Child and Adolescent Health Service
Notes to the financial statements for the year ended 30 June 2026

### 9.6 Related party transactions (cont.)

#### Significant transactions with Government-related entities

In conducting its activities, the Health Service is required to transact with the State and entities related to the State. These transactions are generally based on the standard terms and conditions that apply to all agencies. Such transactions include:

| | Notes | 2026 | 2025 |
|---|---|---|---|
| | | $000 | $000 |
| Income | | | |
| Service agreement funding - State | 4.1 | 775,211 | 697,500 |
| Service agreement funding - Commonwealth | 4.1 | 212,823 | 197,838 |
| Mental Health Commission - Service delivery agreement | 4.1 | 115,131 | 99,845 |
| Department of Health - Research development grant | 4.1 | 1,268 | 675 |
| Department of Health grant - COVID-19 vaccination | 4.1 | 100 | 100 |
| Department of Health grant - Aboriginal Cadetship Program | 4.1 | - | 12 |
| North Metropolitan Health Service - various clinical services | 4.1 | 3,304 | 3,275 |
| WA Country Health Service - various clinical services | 4.1 | 600 | 545 |
| Department of Health - Auspman fitout capital project | 4.1 | 39 | - |
| Department of Health - Graduate Transition to Practice Support Program | 4.1 | 234 | 327 |
| Assets assumed/(transferred) | 4.1 | - | 268 |
| Services received free of charge | 4.1 | 66,466 | 63,338 |
| Expenses | | | |
| Contracts for services - North Metropolitan Health Service | 3.2 | 7,065 | 7,065 |
| Facility management services - North Metropolitan Health Service | 3.5 | 2,963 | 2,795 |
| Contracts for services - Department of Communities [(a)] | | 682 | 661 |
| Insurance payments - Insurance Commission (RiskCover) [(a)] | | 26,548 | 20,015 |
| Rental and other accommodation expenses - Department of Housing and Works [(a)] | | 2,904 | 3,256 |
| Lease interest expense - State Fleet [(a)] | | 115 | 87 |
| Remuneration for audit services - Office of the Auditor General | 9.4 | 380 | 318 |

(a) These transactions are included at Note 3.6 ‘Other expenses’ and Note 7.2 ‘Finance costs’.

### 9.6 Related party transactions (cont.)

#### Significant transactions with Government-related entities (cont.)

| | Notes | 2026 $000 | 2025 $000 |
|---|---|---|---|
| Assets | | | |
| Receivables at 30 June - North Metropolitan Health Service | 6.1 | 436 | 1,426 |
| Liabilities | | | |
| Lease liabilities at 30 June - State Fleet | 7.1 | 1,723 | 1,521 |
| Repayments of lease liabilities - State Fleet | | 521 | 494 |
| Contributed Equity | | | |
| Capital appropriations administered by Department of Health | 9.13 | 20,040 | 15,701 |

#### Material transactions with other related parties

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

| | 2026 $000 | 2025 $000 |
|---|---|---|
| Superannuation payments to GESB | 64,003 | 57,792 |
| Payable to GESB | 4,366 | 3,620 |

All other transactions (including normal citizen type transactions) between the Health Service and Ministers, or board members, or senior officers, or their close family members, or their controlled (or jointly controlled) entities are not material for disclosure.



### 9.7 Related bodies

A related body is a body which receives more than half its funding and resources from the Health Service and is subject to operational control by the Health Service.

The Health Service had no related bodies during the financial year.

### 9.8 Affiliated bodies

An affiliated body is a body which receives more than half its funding and resources from the Health Service but is not subject to operational control by the Health Service.

The Health Service had no affiliated bodies during the financial year.

### 9.9 Services provided free of charge

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

| | 2026 $000 | 2025 $000 |
|---|---|---|
| Department for Communities - health assessments for children in care | 229 | 244 |
| Department of Education - school health services | 14,785 | 14,054 |
| | 15,014 | 14,298 |

## 9.10 Other statement of receipts and payments

| | 2026 $000 | 2025 $000 |
|---|---|---|
| **Commonwealth Grant - Christmas and Cocos Island** | | |
| Balance at the start of period | (80) | (82) |
| Receipts | | |
| Commonwealth grant - provision of paediatric services [(a)] | 80 | 82 |
| Payments | | |
| Costs of visiting specialists [(b)] | (91) | (80) |
| **Balance at the end of period** | **(91)** | **(80)** |

(a) The grant to cover the costs of visiting specialists in 2024-25 has been received from Commonwealth in 2025-26.

(b) The grant to cover the costs of visiting specialists in 2025-26 will be received from Commonwealth in 2026-27.



## 9.11 Special purpose accounts

### Mental Health Commission Fund (Child and Adolescent Health Service) Account

The purpose of the special purpose account is to receive funds from the Mental Health Commission, to fund the provision of mental health services as jointly endorsed by the Department of Health and the Mental Health Commission, in the Child and Adolescent Health Service, in accordance with the annual Service Agreement and subsequent agreements.

The special purpose account has been established under section 16(1)(d) of *the Financial Management Act 2006*.

| | 2026 $000 | 2025 $000 |
|---|---|---|
| Balance at the start of period | 2,302 | 737 |
| Receipts | | |
| Service delivery agreement - Commonwealth contributions | 34,050 | 31,119 |
| Service delivery agreement - State contributions | 81,081 | 68,726 |
| Specific project - Ward 5A relocation costs | - | - |
| | 115,131 | 99,845 |
| Payments | (109,423) | (98,280) |
| | 5,708 | 1,565 |
| **Balance at the end of period** [(a)] | **8,010** | **2,302** |

(a) The closing cash balance of $8,010,818 is classified as restricted cash (2025: $2,302,384).

## 9.12 Administered trust accounts

Trust Accounts are used by the Health Service to account for funds that they may be holding on behalf of another party. The Health Service does not have control of the use of these funds, and cannot deploy them to meet its objectives. Trust Accounts do not form part of the resources available to the Health Service, and are not reported as assets in the financial statements.

The Health Service administers a trust account for the purpose of holding patients' private moneys.

The trust account did not have any receipts or payments during the financial year.

### 9.13 Equity

The Western Australian Government holds the equity interest in the Health Service on behalf of the community. Equity represents the residual interest in the net assets of the Health Service. The asset revaluation reserve represents that portion of equity resulting from the revaluation of non-current assets.

| | 2026 $000 | 2025 $000 |
|---|---|---|
| **Contributed equity** | | |
| Balance at start of period | 1,505,238 | 1,489,537 |
| *Contributions by owners* | | |
| Capital appropriations administered by Department of Health [(a)] | 20,040 | 15,701 |
| Transfer of Crown land from the DPLH [(b)] | 1,687 | - |
| **Total contributions by owners** | **21,727** | **15,701** |
| **Balance at end of period** | **1,526,965** | **1,505,238** |

(a) Treasurer's Instruction (TI) 8 – Requirement 8.1(i) note designates capital appropriations as contributions by owners in accordance with AASB Interpretation 1038 'Contributions by Owners Made to Wholly-Owned Public Sector Entities'.

(b) The Department of Planning, Lands and Heritage (DPLH) transferred the additional adjacent land to the Health Service for amalgamation with the Hospital Reserve site. See Note 5.1 'Property, Plant and Equipment'.

| | 2026 $000 | 2025 $000 |
|---|---|---|
| **Assets revaluation reserve** | | |
| Balance at start of period | 424,718 | 227,804 |
| Net revaluation increments/(decrements) [(a) (b)] | | |
| Land | 4,552 | - |
| Buildings [(c)] | 45,199 | 196,914 |
| **Balance at end of period** | 474,469 | 424,718 |

(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. See Note 5.1 'Property, plant and equipment'.

(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.

(c) The 2026 building revaluation increments includes $20.221 million for the impairment of ACP cladding. Refer to Note 5.1 'Property, plant and equipment' for further information.

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Notes to the financial statements for the year ended 30 June 2026

### 9.14 Supplementary financial information

#### (a) Revenue, public and other property written off

| | 2026 $000 | 2025 $000 |
|---|---|---|
| Revenue and debts written off under the authority of the Accountable Authority | 101 | 682 |
| Revenue and debts written off under the authority of the Minister | - | 587 |
| Public and other property written off under the authority of the Accountable Authority | - | 33 |
| Public and other property written off under the authority of the Treasurer | - | 1,820 |
| | 101 | 3,122 |

#### (b) Losses through theft, defaults and other causes

| | 2026 $000 | 2025 $000 |
|---|---|---|
| Losses of public money and public and other property through theft or default | 10 | - |
| Amounts recovered | (10) | - |
| Net Losses | - | - |

#### (c) Gifts of public property

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

### 9.15 Explanatory statement

All variances between annual estimates (original budget) and actual results for 2026, and between the actual results for 2026 and 2025 are shown below. Narratives are provided for key major variances which vary more than 10% from their comparative and that the variation is more than 1% of the following:

1. Estimate and actual results for the current year
   - Total Cost of Services of the annual estimate for the Statement of comprehensive income and Statement of cash flows ($11.941 million), and
   - Total Assets of the annual estimate for the Statement of financial position ($20.134 million).
2. Actual results for the current year and the prior year actual
   - Total Cost of Services for the previous year for the Statements of comprehensive income and Statement of cash flows ($11.974 million), and
   - Total Assets for the previous year for the Statement of financial position ($21.174million).

*Treasurer's Instruction 3 – Requirement 7.2* excludes changes in asset revaluation surplus, cash assets, receivables, payables, contributed equity and accumulated surplus from the definition of major variances for disclosure purpose.

Child and Adolescent Health Service
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#### 9.15.1 Statement of Comprehensive Income Variances

| | Variance note | Estimate 2026 $000 | Actual 2026 $000 | Actual 2025 $000 | Variance between actual and estimate $000 | Variance between actual results for 2026 and 2025 $000 |
|---|---|---|---|---|---|---|
| **Expenses** | | | | | | |
| Employee benefits expense | | 835,900 | 905,159 | 845,124 | 69,259 | 60,035 |
| Fees for visiting medical practitioners | | 4,539 | 4,761 | 4,582 | 222 | 179 |
| Contracts for services | | 8,695 | 8,707 | 8,778 | 12 | (71) |
| Patient support costs | | 140,653 | 144,671 | 139,483 | 4,018 | 5,188 |
| Finance costs | | 888 | 1,724 | 1,708 | 836 | 16 |
| Depreciation and amortisation expenses | | 49,332 | 54,061 | 52,544 | 4,729 | 1,517 |
| Loss on disposal of non-current assets | | - | 210 | - | 210 | 210 |
| Repairs, maintenance and consumable equipment | | 29,732 | 28,256 | 30,014 | (1,476) | (1,758) |
| Other supplies and services | | 65,922 | 69,007 | 65,695 | 3,085 | 3,312 |
| Other expenses | | 58,516 | 60,126 | 49,466 | 1,610 | 10,660 |
| **Total cost of services** | | **1,194,177** | **1,276,682** | **1,197,394** | **82,505** | **79,288** |

### 9.15.1 Statement of Comprehensive Income Variances (cont.)

| | Variance note | Estimate 2026 $000 | Actual 2026 $000 | Actual 2025 $000 | Variance between actual and estimate $000 | Variance between actual results for 2026 and 2025 $000 |
|---|---|---|---|---|---|---|
| **Income** | | | | | | |
| Patient charges | | 36,936 | 34,466 | 32,573 | (2,470) | 1,893 |
| Other fees for services | | 52,783 | 48,936 | 46,174 | (3,847) | 2,762 |
| Grants and contributions | | 18,236 | 24,021 | 19,115 | 5,785 | 4,906 |
| Donation revenue | | 209 | 3,012 | 1,539 | 2,803 | 1,473 |
| Gain on disposal of non-current assets | | - | - | 103 | - | (103) |
| Asset revaluation increments | | - | 965 | 920 | 965 | 45 |
| Other income | | 2,688 | 6,700 | 6,835 | 4,012 | (135) |
| **Total income** | | **110,852** | **118,100** | **107,259** | **7,248** | **10,841** |
| **NET COST OF SERVICES** | | **1,083,325** | **1,158,582** | **1,090,135** | **75,257** | **68,447** |
| **INCOME FROM STATE GOVERNMENT** | | | | | | |
| Service agreement funding - State | (a) (b) | 688,839 | 775,211 | 697,500 | 86,372 | 77,711 |
| Service agreement funding - Commonwealth | | 210,357 | 212,823 | 197,838 | 2,466 | 14,985 |
| Grants from other state government agencies | (c) | 112,697 | 117,861 | 105,525 | 5,164 | 12,336 |
| Services provided to other government agencies | | 4,702 | 3,957 | 3,945 | (745) | 12 |
| Assets (transferred)/assumed | | - | - | 268 | - | (268) |
| Resources received free of charge | | 66,431 | 66,466 | 63,338 | 35 | 3,128 |
| **Total income from State Government** | | **1,083,026** | **1,176,318** | **1,068,414** | **93,292** | **107,904** |
| **SURPLUS / (DEFICIT) FOR THE PERIOD** | | **(299)** | **17,736** | **(21,721)** | **18,035** | **39,457** |
| **OTHER COMPREHENSIVE INCOME** | | | | | | |
| **Items not reclassified subsequently to profit or loss** | | | | | | |
| Changes in asset revaluation reserve | | - | 49,751 | 196,914 | 49,751 | (147,163) |
| **Total other comprehensive income** | | - | 49,751 | 196,914 | 49,751 | (147,163) |
| **TOTAL COMPREHENSIVE INCOME FOR THE PERIOD** | | **(299)** | **67,487** | **175,193** | **67,786** | **(107,706)** |





### 9.15.1 Statement of Comprehensive Income Variances (cont.)

#### Major Variance Narratives

Variances between estimates and actuals

(a) Service agreement funding – State - The increases reflect additional budgets and funding provided by Government to support increased cost of existing, expanded and new services in 2025-26. These included increases for hospital activity and pricing, mental health services, and other non-hospital services. Funding supplementation was also received to support adjustments to the Government Wages Policy and increasing cost for consumables to maintain service safety.

Variances between actuals for 2025-26 and 2024-25

(b) Service agreement funding – State - The increases reflect additional budgets and funding provided by Government to support increased cost of existing, expanded and new services in 2025-26. These included increases for hospital activity and pricing increase, and other non hospital initiatives including the Child Development Services. Increase in funding was also received to support adjustments to Government Wages Policy and the associated increase in superannuation costs.

(c) Grants from other government agencies - The increase in funding is mainly from the Mental Health Commission of $15.1M. This increase in funding was to support the full year operations and licencing costs of the Nickoll Ward at the Hollywood Hospital, which was used as a decant facility whilst the inpatient mental health ward at the Perth Children's Hospital undergoes refurbishment. Additional funding was also provided by the Mental Health Commission for changes from the Government's Wage Policy.

### 9.15.2 Statement of Financial Position Variances

| | Variance note | Estimate 2026 $000 | Actual 2026 $000 | Actual 2025 $000 | Variance between actual and estimate $000 | Variance between actual results for 2026 and 2025 $000 |
|---|---|---|---|---|---|---|
| **ASSETS** | | | | | | |
| **Current Assets** | | | | | | |
| Cash and cash equivalents | | 15,674 | 18,803 | 17,730 | 3,129 | 1,073 |
| Restricted cash and cash equivalents | | 27,802 | 38,738 | 28,102 | 10,936 | 10,636 |
| Receivables | | 16,418 | 24,369 | 16,419 | 7,951 | 7,950 |
| Inventories | | 4,980 | 6,810 | 4,980 | 1,830 | 1,830 |
| Other current assets | | 1,119 | 2,296 | 1,119 | 1,177 | 1,177 |
| **Total Current Assets** | | 65,993 | 91,016 | 68,350 | 25,023 | 22,666 |
| **Non-Current Assets** | | | | | | |
| Receivables | | 24,672 | 26,872 | 18,872 | 2,200 | 8,000 |
| Amounts receivable for services | | 677,683 | 677,683 | 628,351 | - | 49,332 |
| Property, plant and equipment | (a) | 1,217,626 | 1,415,501 | 1,368,464 | 197,875 | 47,037 |
| Right-of-use assets | | 23,075 | 24,742 | 26,486 | 1,667 | (1,744) |
| Intangible assets | | 4,375 | 4,376 | 6,888 | 1 | (2,512) |
| **Total Non-Current Assets** | | 1,947,431 | 2,149,174 | 2,049,061 | 201,743 | 100,113 |
| **TOTAL ASSETS** | | **2,013,424** | **2,240,190** | **2,117,411** | **226,766** | **122,779** |



### 9.15.2 Statement of Financial Position Variances (cont.)

| | Variance note | Estimate 2026 $000 | Actual 2026 $000 | Actual 2025 $000 | Variance between actual and estimate $000 | Variance between actual results for 2026 and 2025 $000 |
|---|---|---|---|---|---|---|
| **LIABILITIES** | | | | | | |
| **Current Liabilities** | | | | | | |
| Payables | | 54,183 | 53,704 | 51,801 | (479) | 1,903 |
| Contract liabilities | | 796 | 1,106 | 796 | 310 | 310 |
| Capital grant liabilities | | 627 | 3,457 | 1,245 | 2,830 | 2,212 |
| Lease liabilities | | 2,662 | 3,008 | 2,914 | 346 | 94 |
| Employee benefits provisions | | 174,033 | 184,470 | 174,883 | 10,437 | 9,587 |
| Other current liabilities | | 100 | 6,359 | 100 | 6,259 | 6,259 |
| **Total Current Liabilities** | | 232,401 | 252,104 | 231,739 | 19,703 | 20,365 |
| **Non-Current Liabilities** | | | | | | |
| Lease liabilities | | 26,904 | 27,893 | 29,444 | 989 | (1,551) |
| Employee benefits provisions | | 36,516 | 37,332 | 36,541 | 816 | 791 |
| Other non-current liabilities | | - | 13,960 | - | 13,960 | 13,960 |
| **Total Non-Current Liabilities** | | 63,420 | 79,185 | 65,985 | 15,765 | 13,200 |
| **TOTAL LIABILITIES** | | **295,821** | **331,289** | **297,724** | **35,468** | **33,565** |
| **NET ASSETS** | | **1,717,603** | **1,908,901** | **1,819,687** | **191,298** | **89,214** |
| **EQUITY** | | | | | | |
| Contributed equity | | 1,535,234 | 1,526,965 | 1,505,238 | (8,269) | 21,727 |
| Reserves | | 291,075 | 474,469 | 424,718 | 183,394 | 49,751 |
| Accumulated surplus | | (108,706) | (92,533) | (110,269) | 16,173 | 17,736 |
| **TOTAL EQUITY** | | **1,717,603** | **1,908,901** | **1,819,687** | **191,298** | **89,214** |

### 9.15.2 Statement of Financial Position Variances (cont.)

#### Major Variance Narratives

Variances between estimates and actuals

(a) Property, Plant and Equipment - The $197.9 million variance is mainly caused by the $183.4 million asset revaluation increments of which $138.3 million relating to the estimated professional and project management fees added to the carrying amounts of buildings as at 30 June 2026.

### 9.15.3 Statement of Cash Flows Variances

| | Variance note | Estimate 2026 $000 | Actual 2026 $000 | Actual 2025 $000 | Variance between actual and estimate $000 | Variance between actual results for 2026 and 2025 $000 |
|---|---|---|---|---|---|---|
| **CASH FLOWS FROM STATE GOVERNMENT** | | | | | | |
| Service agreement funding - State | (a) (b) | 639,507 | 725,879 | 650,284 | 86,372 | 75,595 |
| Service agreement funding - Commonwealth | | 210,357 | 212,823 | 197,838 | 2,466 | 14,985 |
| Grants from other state government agencies | (c) | 112,697 | 117,861 | 105,525 | 5,164 | 12,336 |
| Services provided to other government agencies | | 4,702 | 3,957 | 3,945 | (745) | 12 |
| Capital appropriations administered by Department of Health | | 29,997 | 20,040 | 15,701 | (9,957) | 4,339 |
| **Net cash provided by State Government** | | **997,260** | **1,080,560** | **973,293** | **83,300** | **107,267** |
| **CASH FLOWS FROM OPERATING ACTIVITIES** | | | | | | |
| **Payments** | | | | | | |
| Employee benefits | | (832,157) | (890,646) | (813,131) | (58,489) | (77,515) |
| Supplies and services | | (241,627) | (253,868) | (232,114) | (12,241) | (21,754) |
| Finance costs | | (888) | (1,700) | (1,688) | (812) | (12) |
| **Receipts** | | | | | | |
| Receipts from customers | | 36,936 | 27,816 | 32,309 | (9,120) | (4,493) |
| Grants and contributions | | 18,236 | 26,543 | 20,583 | 8,307 | 5,960 |
| Donations received | | 209 | 373 | 723 | 164 | (350) |
| Other receipts | | 55,472 | 54,247 | 50,271 | (1,225) | 3,976 |
| **Net cash used in operating activities** | | **(963,819)** | **(1,037,235)** | **(943,047)** | **(73,416)** | **(94,188)** |

Child and Adolescent Health Service
Notes to the financial statements for the year ended 30 June 2026

### 9.15.3 Statement of Cash Flows Variances (cont.)

| | Variance note | Estimate 2026 $000 | Actual 2026 $000 | Actual 2025 $000 | Variance between actual and estimate $000 | Variance between actual results for 2026 and 2025 $000 |
|---|---|---|---|---|---|---|
| **CASH FLOWS FROM INVESTING ACTIVITIES** | | | | | | |
| **Payments** | | | | | | |
| Purchase of non-current assets | | (27,206) | (20,682) | (25,634) | 6,524 | 4,952 |
| **Receipts** | | | | | | |
| Proceeds from sale of non-current assets | | - | 9 | 210 | 9 | (201) |
| **Net cash used in investing activities** | | **(27,206)** | **(20,673)** | **(25,424)** | **6,533** | **4,751** |
| **CASH FLOWS FROM FINANCING ACTIVITIES** | | | | | | |
| **Payments** | | | | | | |
| Principal elements of lease | | (2,791) | (2,943) | (2,861) | (152) | (82) |
| Payment to accrued salaries account | | (5,800) | (8,000) | (3,500) | (2,200) | (4,500) |
| **Receipts** | | | | | | |
| Lease incentive received | | - | - | 4,398 | - | (4,398) |
| **Net cash used in financing activities** | | **(8,591)** | **(10,943)** | **(1,963)** | **(2,352)** | **(8,980)** |
| **Net increase / (decrease) in cash and cash equivalents** | | (2,356) | 11,709 | 2,859 | 14,065 | 8,850 |
| Cash and cash equivalents at the beginning of period | | 45,832 | 45,832 | 42,973 | - | 2,859 |
| **CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD** | | **43,476** | **57,541** | **45,832** | **14,065** | **11,709** |

### 9.15.3 Statement of Cash Flows Variances

#### Major Variance Narratives

Variances between estimates and actuals

(a) Service agreement funding – State – see explanation in variance note (a) for the Statement of Comprehensive Income.

Variances between actuals for 2025-26 and 2024-25

(b) Service agreement funding – State - see explanation in variance note (b) for the Statement of Comprehensive Income.

(c) Grants from other state government agencies - see explanation in variance note (c) for the Statement of Comprehensive Income.



# DISCLOSURES AND LEGAL COMPLIANCE

# MINISTERIAL DIRECTIVES

Treasurer's Instructions 903 (12) requires disclosing information on any written Ministerial directives relevant to the setting of desired outcomes or operational objectives, the achievement of desired outcomes or operational objectives, investment activities and financing activities.

There were no Ministerial directives received for 2025–26.

# OTHER FINANCIAL DISCLOSURES

## Pricing policy

The National Health Reform Agreement sets the policy framework for the charging of public hospital fees and charges. Under the agreement, an eligible person who receives public hospital services as a public patient in a public hospital or a publicly contracted bed in a private hospital is treated 'free of charge'. This arrangement is consistent with the Medicare principles which are embedded in the *Health Services Act 2016 (WA)*.

Most hospital fees and charges for public hospitals are set under Schedule 1 of the Health Services (Fees and Charges) Order 2016 and are reviewed annually. The following informs WA public hospital patients' fees and charges.

### Compensable or Medicare ineligible patients

Patients who are either 'private' or 'compensable' and Medicare ineligible (overseas residents) may be charged an amount for public hospital services as determined by the State Government. The setting of compensable and Medicare ineligible hospital accommodation fees is set close to, or at, full cost recovery.

### Private patients (Medicare eligible Australian residents)

The Australian Department of Health, Disability and Ageing regulates the Minimum Benefit payable by health funds to privately insured patients for private shared ward and same day accommodation.

The Australian Government also regulates the Nursing Home Type Patient contribution based on March and September pension increases. To achieve consistency with the *Commonwealth Private Health Insurance Act 2007*, the State Government sets these fees at a level equivalent to the Commonwealth Minimum Benefit.

### Other fees and charges

The Pharmaceutical Benefits Scheme regulates and sets the price of pharmaceuticals supplied to outpatients, patients on discharge and for day admitted chemotherapy patients. Inpatient medications are supplied free of charge.

There are other categories of fees specified under health regulations through determinations, which include the supply of surgically implanted prostheses, magnetic resonance imaging services and pathology services.

The pricing for these hospital services is determined according to their cost of service.

## Capital works

**Table 6: Capital works in progress in the 2025–26 financial year**

| Project name | Expected financial year of completion* | Estimated cost to complete ($'000) | Estimated total cost of project ($'000) | Variance from previous financial year** ($'000) | Explanation of variance (>=10%) |
|---|---|---|---|---|---|
| Western Australian Hospitals Central Pharmaceutical Manufacturing Facility (Auspman) | 2025–26 | 5,140 | 5,140 | 0 | |
| Perth Children's Hospital Theatre Shell Fit-out | 2025–26 | 3,716 | 3,716 | -334 | Funds redirected to Minor Building Works Statewide Program*** |
| Gait Laboratory Fit-out | 2026–27 | 560 | 560 | 560 | |
| Children's Hospice Western Australia | 2027–28 | 2,964 | 2,964 | 600 | Funding for ICT enablement |
| MRI and Fit-out | 2027–28 | 4,832 | 4,832 | 4,832 | New project |
| PET CT Scanner and Fit-out | 2027–28 | 6,874 | 6,874 | 6,874 | New project |
| Statewide Cladding | Ongoing | 25,924 | 25,924 | 25,924 | New project |
| Bentley Community Clinic | 2028–29 | 2,784 | 2,784 | 2,784 | New project |
| Perth Children's Hospital – Reconfiguration of Ward 5A | 2028–29 | 21,881 | 21,881 | 0 | |

Notes:

* Expected financial year of completion considers the defects liability period and project funding timeframe after practical completion.
** Variance represents the difference between the estimated total cost of the project in comparison to the estimated total cost in the previous reporting. The previous reporting can be found in the CAHS Annual Report 2024–25.
*** The Minor Building Works Statewide Program is an ongoing program which consists of multiple projects with varying completion dates.
• The information represents the CAHS major capital works program, including expensed capital but excludes statewide programs.

## Governance disclosures

### Indemnity insurance

In 2025–26, the amount of insurance premium paid to indemnify any 'director' (as defined in Part 3 of the *Statutory Corporations (Liability of Directors) Act 1996*) against a liability incurred under sections 13 or 14 of that Act was $97,005 (excluding GST).

### Pecuniary interests

Senior officers of government are required to declare any interest in an existing or proposed contract that has, or could result in, the member receiving financial or other benefits. In 2025–26, none of the CAHS senior officers declared a pecuniary interest.

## Employee profile

This information is included in Our people. See page 13.

## Unauthorised use of credit cards

In accordance with State Government policy, CAHS has issued corporate credit cards to certain employees where their functions warrant use of this facility for purchasing goods and services. These credit cards are not to be used for personal (unauthorised) purposes.

Cardholders are reminded annually of their obligations under the credit card policy. In the reporting period, 4 employees used their corporate credit card for personal expenditure on 5 occasions. Review of these transactions confirmed that they were the result of honest mistakes. Notification and full repayments were made by 3 employees within the reporting period. An amount of $9.30 was outstanding from one employee as at 30 June 2026 (Table 7).

**Table 7: Credit card personal use expenditure in 2025–26**

| Credit card personal use expenditure | Amount |
|---|---|
| Aggregate amount of personal use expenditure for the reporting period | $88.71 |
| Aggregate amount of personal use expenditure settled by the due date (within 5 working days) | $79.41 |
| Aggregate amount of personal use expenditure settled after the due date (after 5 working days) | $0 |
| Aggregate amount of personal use expenditure outstanding at the end of the reporting period | $9.30 |

## Industrial relations

The CAHS Workplace Relations team supports compliance with applicable industrial instruments and promotes constructive, productive relationships with key stakeholders, including the Department of Health, unions and professional associations.

We continued to provide accurate and timely workplace relations advice and services in an increasingly complex and dynamic industrial environment.

There were 12 industrial disputes or appeals in the 2025–26 period.

While most matters related to individual employee issues, some involved multiple employees. Ten matters were resolved through conciliation, mediation and dispute resolution processes. Two matters remain subject to arbitration.

Since the last reporting period, all WA Health Industrial Agreements have been implemented, with Workplace Relations playing an instrumental role in facilitating new initiatives under the Agreements.

A review of 489 senior medical practitioners employed on fixed-term contracts to determine eligibility for permanency was completed within the designated timeframes. We also reviewed 749 fixed-term and casual employees including salaried officers, nurses (including assistants in nursing and enrolled nurses) and miscellaneous workers, to determine eligibility for permanency in accordance with the relevant Industrial Agreements.

# OTHER LEGAL REQUIREMENTS

## Act of grace payments

The Minister for Health has directed the health service providers to disclose all gifts and act of grace payments over $100,000 made under section 36(5) of the *Health Services Act 2016* within their annual reports. In 2025–26, CAHS did not provide any gift or make any act of grace payment over $100,000.

## Advertising expenses

In accordance with section 175ZE of the *Electoral Act 1907*, CAHS incurred the following advertising expenditure in 2025–26.

**Table 8: Summary of advertising for 2025–26**

| Summary of advertising | Amount |
|---|---|
| Advertising agencies | $0 |
| Market research organisations | $0 |
| Polling organisations | $0 |
| Direct mail organisations | $0 |
| Media advertising organisations | $18,646 |
| **Total advertising expenditure** | **$18,646** |

## Compliance with public sector standards and ethical codes

CAHS is committed to being an ethical, transparent and accountable public sector organisation with systems and processes in place to support compliance with Public Sector Standards and relevant codes.

Employees are informed of their rights and obligations through a comprehensive suite of policies, procedures and supporting guidelines, which are communicated through multiple channels. Managers and employees can access advice and guidance from the Human Resources and Integrity and Ethics teams as needed.

Information for patients, families and the broader community is publicly available on the CAHS website, including guidance on providing compliments, lodging complaints about employee conduct, and raising concerns about potential non-compliance with ethical standards.

Allegations of non-compliance with the Public Sector Standards and ethical codes are recorded, de-identified and reported to the CAHS Board and Executive. Reporting includes a range of metrics that support governance oversight and monitor emerging trends.

### Compliance monitoring

14 claims were lodged against the Employment Standards.

Of these:

- 5 claims were resolved internally
- 9 claims were referred to the Public Sector Commission for review
  - 6 were declined by the Public Sector Commission
  - 2 were withdrawn while being reviewed by the Public Sector Commission
  - 1 is pending with the Public Sector Commission.

Two claims were lodged against the Grievance Standards. Neither was resolved internally with the claimants referring the matter to the Western Australian Industrial Relations Commission.

No claims were lodged against the Termination Standards.

In 2025–26, 107 reports alleging non-compliance with the Code of Conduct (breaches of discipline) were lodged (see Table 9).

Suspected breaches of discipline, including matters of reportable misconduct, were dealt with through the WA Health disciplinary processes and, where appropriate, reported to the Public Sector Commission (7), the Corruption and Crime Commission (29), WA Police (20) or the Australian Health Practitioner Regulation Agency (2), as required under the *Corruption, Crime and Misconduct Act 2003, Health Services Act 2016* and Reportable Conduct to the WA Ombudsman (1) under the *Parliamentary Commissioner Act 1971*.

Where breaches were substantiated, the decision-maker determined the appropriate action in accordance with the *Health Services Act 2016*.

**Table 9: Complaints alleging non-compliance with the Code of Conduct, by area of compliance**

| Type | Amount |
|---|---|
| Communication and official information | 7 |
| Conflict of interest | 2 |
| Fraud and corrupt behaviour | 25 |
| Personal behaviour | 61 |
| Recordkeeping and use of information | 11 |
| Use of public resources | 1 |
| **Total** | **107** |

## Disability access and inclusion

CAHS is dedicated to fostering an inclusive culture that celebrates diversity and champions equity across our organisation, for consumers, carers, families, and our workforce.

In 2025 the Disability Access and Inclusion Advisory Group (DAIAG) concluded the Disability Access and Inclusion Plan (DAIP) 2022–2025, having successfully completed all actions. Extensive public and workforce consultation informed the development of a new, revised CAHS Disability Access and Inclusion Plan 2026–2028.

The new plan adopts a phased approach to ensure strong foundations, sustained growth, and embedded inclusive and accessible practices, which are aligned with the 7 desired outcomes of the Disability Services Regulations 2004.

In the first year, our focus is on strengthening existing foundations, raising awareness and deepening our understanding of the diverse needs of consumers and the workforce. In the second and third years, our focus will shift to deepening engagement, refining inclusive processes and embedding inclusive practices across all areas of CAHS.

CAHS acknowledges all those who contributed their time, insights and lived experience to the development of the DAIP 2026–2028.

Key initiatives delivered this reporting year include:

- full implementation of CAHS' first workforce reasonable adjustment portal, enabling all staff to register their requirements and engage in open, productive and inclusive conversations with leaders
- strengthened commitment to equitable employment opportunities for people with disability through a partnership agreement with Disability Employment Services. The partnership supports inclusive recruitment practices and reduces barriers to meaningful employment
- enhanced accessibility information and care through initiatives such as the Neurodiversity Care Program which provides tailored resources for children and young people who attend the Emergency Department
- partnerships with key community organisations to promote awareness and education, including celebration of Purple Day (epilepsy awareness), Rare Diseases Day, Neurodiversity Celebration Week, and Mental Health Week
- membership of the Sunflower Hidden Disability Program which increases staff awareness and capability to provide inclusive support to colleagues, consumers and families living with hidden disabilities
- strengthened inclusive service delivery and workforce capability through consultation-informed reform activities, development of disability and neurodiversity resources, and inclusive wellbeing initiatives. Such initiatives include neurodiversity workforce webpages, resources for managers, a wellbeing calendar, sound healing sessions and therapy dog visits.

Scan the QR code to read the Disability Access and Inclusion Plan 2026–2028

## Integrity and ethics

Integrity and ethical behaviour are integral to CAHS' core business and in maintaining the trust of the community we serve. It means putting the public interest first in fulfilling our public duty, and making the right decisions that can be explained and justified in accordance with agreed policies and procedures.

A key CAHS value for embedding integrity is accountability – taking responsibility for our actions and doing what we say we will. All CAHS employees share this responsibility to act with the highest level of integrity and ethical conduct.

CAHS embeds integrity and promotes an ethical culture throughout the organisation via a range of educational and communication opportunities, ensuring staff are aware of their responsibilities and obligations.

These opportunities include:

- CAHS Corporate Induction
- Accountable and Ethical Decision-Making (and refresher) training
- Recordkeeping Awareness training
- Bullying and Sexual Harassment in the Workplace training
- Code of Conduct, Conflicts of Interest, Gifts, Benefits and Confidentiality training
- Safe and Positive Behaviour training
- Reportable Conduct Scheme and Child Safeguarding training
- Discipline Process Decision-Maker training
- Preliminary Inquiry and Investigative Assessment training.

The CAHS Integrity Framework sets out the systems and processes that promote integrity and support an ethical culture across CAHS. It outlines the principles, reporting mechanisms, structures and policies that ensure transparent, accountable and effective organisational performance in line with legislative and corporate requirements.

In 2026, the framework was reviewed to align with the Public Sector Commission Embedding Integrity Strategy objectives and the CAHS culture program.

CAHS is committed to the highest possible standards of openness, probity and accountability in all aspects of services, and has zero tolerance of fraud and corruption. Suspected fraud or corruption reporting is strongly encouraged. Any reported instances are investigated and resolved in accordance with internal policies and procedures, and the *Corruption, Crime and Misconduct Act 2003*.

CAHS has incorporated improvements to integrity, fraud and corruption prevention into the revised CAHS Fraud and Corruption Control System, in alignment with Australian Standard AS8001-2021 Fraud and Corruption Control.

The CAHS Promoting Integrity Sub-Committee met 5 times during the reporting period. The committee provides high-level governance and oversight of misconduct risks, corrective actions, related systemic improvements, compliance and strategic direction for the Integrity and Ethics program. This work aims to promote an integrity culture, and improve safety and quality outcomes, and safe systems and practice.

Key achievements include:

- improvements to the discipline decision-making framework
- participation in an integrity framework maturity self-assessment
- completion of the Public Sector Commission's integrity snapshot tool
- support for an anonymous reporting channel
- implementation of external discipline management review recommendations.

## Work health, safety and wellbeing

CAHS is committed to promoting and enabling better staff health, safety and wellbeing in the workplace. This year we have focused on strengthening prevention initiatives and capability building to support a safe and sustainable workforce that delivers consistent, compassionate care to children, young people and their families.

With a clear focus on continuous improvement that goes beyond meeting minimum compliance requirements, CAHS has promoted timely incident and hazard reporting, enhanced consultation, and improved local governance and assurance.

We've also strengthened our work health, safety and wellbeing capacity through dedicated staff roles that provide specialist support to our workforce; expanded staff education opportunities, including coaching for managers; and advised on work health and safety matters across CAHS and the broader WA health system.

Other highlights include:

- improvements to safety reporting that incorporate trend identification and targeted prevention activities
- implementation of an e-hazard inspection tool to strengthen data quality and improve prevention and risk controls for workplace violence and aggression
- improved psychosocial hazard management and psychological injury prevention via a newly created role
- post-incident support to better assist staff who encounter aggression, challenging admissions and patient deaths
- expanded reflective supervision to better support staff managing the emotional demands of clinical work.

CAHS continues to monitor performance, review controls, and pursue opportunities for shared learning to support continuous improvement in work health, safety and wellbeing systems and outcomes.

## Injury management and return to work

CAHS is committed to providing a safe, healthy and supportive workplace that enables our workforce to deliver high-quality care for children, young people and their families. Injury management and return-to-work activities focus on prevention and early intervention, timely access to support, and meeting our obligations for rehabilitation and return to work under the *Workers Compensation and Injury Management Act 2023*.

The CAHS Injury Management team continues to strengthen manager and supervisor capability to support workers to remain at work or return following injury or illness. This includes early engagement, identifying safe and suitable duties, and coordinating return-to-work programs. Work has also progressed to clarify role requirements to support appropriate matching of duties and recovery needs.

This year we've expanded our Early Intervention Program to include additional service providers and service types, which has improved access to early assessment and treatment. The program supports prevention, reduces barriers to timely care and contributes to positive recovery outcomes. Positive staff feedback has led to further investment in the program.

Early access to appropriate treatment improves recovery outcomes, reduces time away from work and minimises secondary impacts associated with prolonged absence from work. Effective return to work, supported by suitable duties and workplace adjustments where needed, helps maintain connection, routine and skills. This benefits worker wellbeing and broader organisational performance through sustained workforce participation and reduced disruption to services.

Claim severity continues to be influenced by injury and illness complexities, including those requiring longer recovery periods and ongoing workplace adjustments. See Table 10 for the impact on the performance measures.

Table 10: Work Health Safety and Injury Management performance 2023–24 to 2025–26

| Measure | 2023–24 | 2024–25 | 2025–26 | Target | Comment |
|---|---|---|---|---|---|
| Fatalities (number of deaths) | 0 | 0 | 0 | 0 | Target met |
| Lost time injury/diseases (LTI/D) incidence rate (per 100) | 1.9% | 1.5% | 1.5% | Reduce by 2% per year and 15% by 2033 compared with 2023 | Target not met |
| Lost time injury severity rate (per 100, i.e. percentage of all LTI/D, 1 week or more) | 47.9% | 74.7% | 71.4% | Reduce by 2.5% per year and 20% by 2033 compared with 2023 | Target met |
| Incidence of claims resulting in permanent impairment | 1.85% | 1.75% | 2.7% | Reduce by 2% per year and 15% by 2033 compared with 2023 | Target not met |
| Incident rate of work-related respiratory disease | 0.21% | 0.19% | 0.19% | Reduce by 2.5% per year and 20% by 2033 compared with 2023 | Target not met |
| Percentage of managers and supervisors trained in injury management and work health and safety responsibilities | 87.6% | 85.5% | 68% | Greater than or equal to 80% within the last 2 years | Target not met* |
| Percentage of injured workers returned to work within 13 weeks | 49% | 43.8% | 41.6% | No target | No target |
| Percentage of injured workers returned to work within 26 weeks | 61.2% | 56.2% | 53.3% | Greater than or equal to 70% | Target not met |
| Work Health, Safety Management System has been independently assessed in the last 5 years | n/a | n/a | Yes | Yes | n/a |

*Change in reporting frequency affected 2025–26 performance.

- LTIs and severe claims lodged during the financial year as provided by RiskCover; data are adjusted each year to reflect modifications to pended claims.
- Calculated from RiskCover All Claims. Report includes lost time claims with an accident date within the previous year. Calculations are based on days lost divided by days normally worked, where the worker is fit for pre-injury duties and pre-injury hours.

### Health and safety representatives

In 2025–26 there were 114 health and safety representatives across CAHS, representing 2.1 per cent of the workforce or a 1:2.4 ratio to the number of workplaces occupied by CAHS. During the reporting year 56 representatives attended health and safety representative training.

Our 3 health and safety committees are: PCHN Health and Safety Committee, CACH Health and Safety Committee and CAMHS Health and Safety Committee.

## Workers compensation

A total of 116 workers compensation claims were made in 2025–26. Of these, 46 per cent of claims came from Nursing staff. Medical Support accounted for 18 per cent of claims and Hotel Services 17 per cent.

**Table 11: Workers compensation claims for 2025–26 (based on date of lodgement)**

| Category | Claims |
|---|---|
| Nursing Services/Dental Care Assistants | 53 |
| Administration and Clerical | 16 |
| Medical Support | 21 |
| Hotel Services | 20 |
| Maintenance | 4 |
| Medical (salaried) | 2 |
| **Total** | **116** |

## WA Multicultural Policy Framework

CAHS continued to implement our Multicultural Action Plan (MAP) 2022–27, strengthening our commitment to equitable, culturally responsive care.

Key to our MAP progress is our work building genuine partnerships with multicultural communities and the momentum we are creating across CAHS. We were honoured to be a nominee in the WA Multicultural Awards 2026, which recognised the strength and impact of our MAP implementation.

### Policy priority 1: Harmonious and inclusive communities

- The CAHS Community Ambassador Program continues to be greatly valued by multicultural communities. Ambassadors share rich insights that help us understand the realities, strengths and needs of their cultural groups. Ambassadors partnered with CAHS on key projects including research, immunisation and translation initiatives, to ensure our work is shaped by lived experience and grounded in what truly matters to multicultural families.
- CAHS hosted our annual Ramadan Iftaar at PCH, attended by Muslim and non-Muslim CAHS staff, Community Ambassadors, consumer representatives and their families. After breaking fast at sunset, the shared meal was a special opportunity for community, connection and meaningful conversations.
- CAHS celebrated Harmony Week with a vibrant stall at PCH in partnership with our Multicultural Access and Inclusion Advisory Group (MAIAG) and a ‘taste of diversity’ staff morning tea. We attended community events in the City of Belmont and Bannister Creek. Activities were designed to go beyond internal celebrations of diversity as CAHS took steps to meaningfully connect with multicultural families and stood alongside the communities we serve.
- CAHS strengthened connections with multicultural communities by attending a wide range of cultural events throughout the year. We engaged directly with families at the Indian Society of WA’s Naari event, Culture Care WA Youth Day and the Festa Junina de Perth by sharing information about CAHS services and listening to community priorities. We also hosted tailored workshops with the Vietnamese Women’s Association WA, the Chinese Language School parent community, and Somali families, to ensure that our health resources, messages and supports are shaped by real community insight.

### Policy priority 2: Culturally responsive policies, programs and services

- To support a more culturally respectful experience for young people and families during hospital stays, CAHS introduced the ‘I wear a veil’ poster. The optional poster prompts staff to knock and wait before entering, giving families the privacy and preparation time they may need. Developed with the MAIAG, the resource empowers families to choose what feels right for them and has strong support from PCH clinical leaders and teams.
- Development progressed on our Strategic Workforce Inclusion and Diversity Framework, which embeds cultural competency, cultural sensitivity and equity across all CAHS roles. By establishing clear baseline standards for staff knowledge, skills and behaviours, the framework will strengthen CAHS’ ability to deliver culturally responsive policies, programs and services.
- CAHS contributed to Recommendation 3 of the WA Health Sustainable Health Review by supporting system-wide initiatives to improve care for people from refugee backgrounds and those with limited English proficiency. This included helping develop resources to strengthen engagement with culturally and linguistically diverse (CaLD) communities; promoting health equity and literacy; contributing to the Working with Consumers and Carers Toolkit; and supporting the rollout of the Health Equity Impact Statement Declaration Policy, which showcased a CAHS project as the exemplar.
- CAHS developed a short translated pamphlet with links to a range of trusted health resources including information for overseas visitors and translated health information. The pamphlet has been widely shared by Community Ambassadors with their communities, making it easier for families to access trusted content in their preferred language.

### Policy priority 3: Economic, social, cultural, civic and political participation

- The MAIAG consumer Co-Chair continued to serve as Co-Chair of the CAHS Consumer Leadership Council and as a member of the CAHS Executive Committee. Through representation on these groups they provided advocacy at the highest level and ensured that the voices of multicultural families are meaningfully represented in organisational decision-making.
- CAHS progressed work on our Talent Acquisition Strategy, ensuring that recruitment processes align with the Public Sector Commission’s diversity requirements, remove barriers for CaLD applicants and build a workforce that reflects the diversity of the communities we serve.
- CAHS reviewed our engagement policies to ensure that CaLD families are actively prioritised and supported to participate in all engagement initiatives, and that we embed practices that remove barriers, strengthen multicultural safety and elevate diverse community voices in decision-making.

## Freedom of Information

The *Freedom of Information Act 1992* (the Act) provides the rights to access various documents and to ensure that personal information contained in documents is accurate, complete, up to date and not misleading.

Freedom of Information applications are managed by the CAHS Release of Information department.

CAHS reports statistics annually to the Office of the Information Commissioner (OIC), as required by section 111(3)(a) of the Act, which are published in the OIC's annual report and can be viewed on the OIC's website.

For the 2025–26 reporting period CAHS received 454 valid applications under the Act, compared to 249 in 2024–25.

## Recordkeeping

The *State Records Act 2000* (the Act) establishes a standardised framework for recordkeeping across all WA Government agencies. In accordance with section 19 of the Act, CAHS maintains a Recordkeeping Plan approved by the State Records Commission, which oversees compliance and monitors recordkeeping practices.

During the reporting period CAHS monitored and reviewed our recordkeeping systems, including the Recordkeeping Plan, supporting policies and procedures, and our Electronic Document and Records Management System (EDRMS). The review focused on system use, metadata quality, and compliance with recordkeeping requirements.

In October, CAHS upgraded our EDRMS from Records Manager to Content Manager. The upgrade enhanced system functionality, improved usability, and strengthened compliance capabilities by supporting more efficient capture and management of records.

Following the review we updated our Recordkeeping Plan this year, incorporating learnings from stakeholder consultation and ensuring alignment with operational and legislative requirements.

No significant compliance issues were identified during the reporting period. Minor improvements relating to metadata consistency and user guidance were implemented through updated procedures and targeted support. CAHS will continue to strengthen controls to ensure ongoing compliance with State Records Commission Standards.

### Recordkeeping training

Mandatory training includes Department of Health Recordkeeping Awareness training and Content Manager training, delivered through a mix of face-to-face training, virtual sessions and one-on-one support. Staff also have access to online recordkeeping resources and information on the CAHS intranet.

Evaluation of recordkeeping training has found solid engagement and positive staff feedback across CAHS.

All new staff are required to complete a recordkeeping induction within 3 months of starting at CAHS, covering topics such as procurement, confidentiality, cyber security and recordkeeping responsibilities.



# APPENDIX

# BOARD AND COMMITTEE MEETING ATTENDANCE

| Name | Number of meetings | Meetings attended |
|---|---|---|
| Ms Pamela Michael*<br>Chair July-September 2025 | 3 | 3 |
| Dr Neale Fong<br>Chair from 1 October 2025 | 8 | 7 |
| Prof. Eli Gabbay<br>From 28 July 2025 | 10 | 9 |
| Mr John McLean | 11 | 10 |
| Mrs Meghan Maor* | 7 | 5 |
| Prof. Karen Strickland | 11 | 9 |
| Dr Peter Steer<br>From 1 October 2025 | 8 | 8 |
| Ms Kelly Worlock<br>From 1 October 2025 | 8 | 5 |
| Ms Tracey Brand<br>From 15 December 2025 | 5 | 4 |
| Mr Amit Khullar<br>From 15 December 2025 | 5 | 5 |
| Mrs Mary Anne Stephens<br>From 15 December 2025 | 5 | 5 |
| Dr Alexius Julian* | 3 | 3 |
| Dr Shane Kelly* | 3 | 3 |
| Prof. Dan McAullay* | 3 | 2 |
| Mr James Jegasothy* | 1 | 0 |
| Dr Richelle Douglas* | 1 | 0 |

| Finance Committee | Number of meetings | Meetings attended |
|---|---|---|
| Dr Alexius Julian<br>Chair July-September 2025 | 3 | 3 |
| Mr John McLean<br>Chair October-March 2026 | 8 | 7 |
| Mrs Mary Anne Stephens<br>Chair from April 2026 | 3 | 3 |
| Dr Shane Kelly | 3 | 3 |
| Mr Amit Khullar | 3 | 3 |
| Mrs Meghan Maor | 5 | 3 |
| Dr Peter Steer* | 2 | 1 |

| Safety and Quality Committee | Number of meetings | Meetings attended |
|---|---|---|
| Prof. Karen Strickland<br>Chair July-October 2025 | 10 | 9 |
| Prof. Eli Gabbay<br>Chair from November 2025 | 9 | 8 |
| Ms Tracey Brand* | 1 | 1 |
| Mr James Jegasothy | 1 | 1 |
| Dr Shane Kelly | 2 | 2 |
| Prof. Dan McAullay | 3 | 0 |
| Dr Peter Steer | 5 | 2 |

| Audit, Risk and Compliance Committee | Number of meetings | Meetings attended |
|---|---|---|
| Mr John McLean<br>Chair | 6 | 6 |
| Dr Alexius Julian | 1 | 1 |
| Mr Amit Khullar | 3 | 3 |
| Mrs Meghan Maor | 4 | 4 |
| Ms Kelly Worlock | 4 | 2 |

| People, Capability and Culture Committee | Number of meetings | Meetings attended |
|---|---|---|
| Prof. Karen Strickland<br>Chair | 5 | 5 |
| Ms Tracey Brand | 2 | 1 |
| Prof. Eli Gabbay* | 2 | 2 |
| Mr James Jegasothy | 1 | 1 |
| Prof. Dan McAullay | 2 | 1 |
| Ms Kelly Worlock | 3 | 2 |

Notes:

* Board terms of Ms Pamela Michael, Prof. Dan McAullay and Dr Alexius Julian ended in September 2025.
* Mrs Meghan Maor was on leave from July to September 2025.
* Dr Shane Kelly resigned from the Board in September 2025.
* Mr James Jegasothy resigned from the Board on 16 July 2025.
* Dr Richelle Douglas was appointed in July 2025, was on unpaid leave and resigned from the Board in September 2025.
* Dr Peter Steer stepped down from the Finance Committee in March 2026.
* Ms Tracey Brand stepped down from the Safety and Quality Committee in March 2026.
* Prof. Eli Gabbay stepped down from the People, Capability and Culture Committee in January 2026.

# BOARD AND COMMITTEE REMUNERATION

| Position | Name | Type of remuneration | 2025–26 period of membership | 2025–26 total remuneration |
|---|---|---|---|---|
| Chair | Ms Pamela Michael | Annual | 3 months | $25,204 |
| Chair | Dr Neale Fong | Annual | 9 months | $59,900 |
| Deputy Chair | Prof. Eli Gabbay | Annual | 11 months | $41,406 |
| Member | Mr John McLean | Annual | 12 months | $46,807 |
| Member | Mrs Meghan Maor | Annual | 12 months | $46,807 |
| Member | Prof. Karen Strickland | Annual | 12 months | $46,807 |
| Member | Dr Peter Steer | Annual | 9 months | $38,503 |
| Member | Ms Kelly Worlock | Annual | 9 months | $32,945 |
| Member | Ms Tracey Brand | Annual | 6 months | $24,303 |
| Member | Mr Amit Khullar | Annual | 6 months | $24,303 |
| Member | Mrs Mary Anne Stephens | Annual | 6 months | $24,303 |
| Member | Dr Alexius Julian | Annual | 3 months | $13,862 |
| Member | Dr Shane Kelly | Annual | 3 months | $13,862 |
| Member | Prof. Dan McAullay | Annual | 3 months | $9,901 |
| Member | Mr James Jegasothy | Annual | 1 month | $4,140 |
| Member | Dr Richelle Douglas* | Annual | 1 month | $0 |
| Total | | | | $453,066 |

Notes:

* Dr Richelle Douglas was appointed in July 2025, was on unpaid leave and resigned from the Board in September 2025.
- Information is as per the WA Government Boards and Committees Register.
- Remuneration is provided to private sector and consumer representative members of a board/committee. Individuals are ineligible for remuneration if their membership on the board/committee is considered to be an integral part of their organisational role.
- Remuneration amounts can vary depending on the type of remuneration, the number of meetings attended, and whether a member submitted a remuneration claim.
- 'Period of membership' is defined as the period (in months) that an individual was a member of a board/committee during the 2025–26 financial year.

# ABBREVIATIONS

| | |
|---|---|
| ACAG | Aboriginal Community Advisory Group |
| ADHD | Attention deficit hyperactivity disorder |
| AM | Member of the Order of Australia |
| ATS | Australasian Triage Scale |
| CACH | Child and Adolescent Community Health |
| CAHS | Child and Adolescent Health Service |
| CAMHS | Child and Adolescent Mental Health Services |
| CaLD | Culturally and linguistically diverse |
| CDS | Child Development Service |
| CES | Carer Experience of Service |
| CLC | Consumer Leadership Council |
| DAIAG | Disability Access and Inclusion Advisory Group |
| DAIP | Disability Access and Inclusion Plan |
| DAMA | Discharged against medical advice |
| ED | Emergency Department |
| EDRMS | Electronic Document and Records Management System |
| EMR | Electronic Medical Records |
| HA-SABSI | Healthcare-associated *Staphylococcus aureus* bloodstream infection |
| HiTH | Hospital in the Home |
| KEMH | King Edward Memorial Hospital |
| KPI | Key performance indicators |
| LEAG | Lived Experience Advisory Group |

| | |
|---|---|
| LGBTIQA+SB | Lesbian, gay, bisexual, transgender, intersex, queer, asexual, Sistergirl and Brotherboy |
| LTI/D | Lost time injury/diseases |
| MAIAG | Multicultural Access and Inclusion Advisory Group |
| MAP | Multicultural Action Plan |
| MOST | Moderated Online Social Therapy |
| NPS | Net Promoter Score |
| OAM | Medal of the Order of Australia |
| OIC | Office of the Information Commissioner |
| PCAG | Parent and Carer Advisory Group |
| PCH | Perth Children's Hospital |
| PCTC | Perth Children's Trial Centre |
| RPH | Royal Perth Hospital |
| RSV | Respiratory syncytial virus |
| SAC 1 | Severity assessment code 1 |
| *S. aureus* | *Staphylococcus aureus* |
| SCGH | Sir Charles Gairdner Hospital |
| Telethon | Channel 7 Telethon Trust |
| WA | Western Australia |
| YAG | Youth Advisory Group |
| YES | Your Experience of Service |

# LOCATIONS AND CONTACT INFORMATION

## Child and Adolescent Health Service

**Street address**
Level 5, Perth Children's Hospital
15 Hospital Avenue, Nedlands WA 6009

**Postal address**
Locked Bag 2010 Nedlands WA 6909

**Phone**
(08) 6456 2222

**Email**
cahs.cecorrespondence@health.wa.gov.au

**Web**
cahs.health.wa.gov.au

## Child and Adolescent Community Health

**Street address**
Level 2, 2 Mill Street, Perth WA 6000

**Postal address**
Locked Bag 2010 Nedlands WA 6909

**Phone**
(08) 6372 4500

**Email**
CACHExecutiveCorrespondence@health.wa.gov.au

**Web**
cahs.health.wa.gov.au/Our-services/Community-Health

## Perth Children's Hospital

**Street address**
15 Hospital Avenue, Nedlands WA 6009

**Phone**
(08) 6456 2222

**Email**
perthchildrenshospital.enquiries@health.wa.gov.au

**Web**
pch.health.wa.gov.au

**Postal address**
Locked Bag 2010 Nedlands WA 6909

## Neonatology

**Street address**
374 Bagot Road, Subiaco WA 6008

**Phone**
(08) 6458 1260

**Postal address**
PO Box 134 Subiaco WA 6904

**Web**
cahs.health.wa.gov.au/Our-services/Neonatology

## Child and Adolescent Mental Health Services

**Street and postal address**
Level 2, 52–54 Monash Avenue
Nedlands WA 6009

**Phone**
(08) 6389 5800

**Email**
camhs.correspondence@health.wa.gov.au

**Web**
cahs.health.wa.gov.au/Our-services/Mental-Health

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

**This document can be made available in alternative formats on request.**