EDUCATION AND HEALTH STANDING COMMITTEE

AN INQUIRY INTO IMPROVING EDUCATIONAL OUTCOMES FOR WESTERN AUSTRALIANS OF ALL AGES

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 15 AUGUST 2012

SESSION ONE

Members

Dr J.M. Woollard (Chairman)
Mr P.B. Watson (Deputy Chairman)
Dr G.G. Jacobs
Ms L.L. Baker
Mr P. Abetz

Hearing commenced at 9.28 am

AYLWARD, MR PHILIP
Chief Executive Officer, Child and Adolescent Health Service, examined:

MORRISSEY, MR MARK
Executive Director, Child and Adolescent Community Health, Department of Health, examined:

GATTI, MRS KATHRYN JANE
Area Director, Population Health, WA Country Health Service, examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee I would like to thank you for your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into improving educational outcomes for Western Australians of all ages. At this stage I would like to introduce myself, Janet Woollard. Next to me is Peter Watson, Graham Jacobs and Peter Abetz. Lisa Baker sends her apologies to you. And on my right is Brian Gordon and Lucy Roberts, our secretariat. From Hansard this morning we have Geraldine O'Loughlin.

This committee is a committee of the Assembly. This hearing is a formal procedure. Hansard will be making a transcript of the proceedings. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title. Before we proceed to questions and discussion, I need to check that you have completed the "Details of Witness" forms.

The Witnesses: We have.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

Mr Aylward: Indeed; yes.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form today?

The Witnesses: Yes.

The CHAIRMAN: Do you have any questions in relation to being a witness at today's hearing?

Mr Aylward: No.

The CHAIRMAN: Then would you please state your full name and the capacity in which you appear before the committee today?

Mr Morrissey: Mark Morrissey, Executive Director, Child and Adolescent Community Health.

Mr Aylward: Philip Aylward, Chief Executive, Child and Adolescent Health Service.

Mrs Gatti: Kate Gatti, Area Director, Population Health WA Country Health Service.

The CHAIRMAN: Before we move on to questions, I might ask you, first, in view of the fact that this inquiry has been going on for several months—we are hoping to table in a few months—what areas do you think, according to our terms of reference, we should have been looking at in order to see where there are strengths and weaknesses? Should we start with Mark and then move along?

[9.30 am]

Mr Morrissey: I think the committee has looked appropriately at most of the key areas in which we have been working. I think there are quite a few strengths across child development services and we have seen some really big improvements there in the last couple of years. Child health is, obviously, a really critical part of growing healthy families in WA. You cannot miss that, so that was very appropriately looked that. School health, obviously, is the next phase to it.

The CHAIRMAN: And weaknesses within your department, or you do not see any weaknesses?

Mr Morrissey: Look, all of us could do better.

Mr P.B. WATSON: Challenges, aren't they?

The CHAIRMAN: Challenges.

Mr Morrissey: Personally, I think we often go through this—and I genuinely mean this—and by looking at things we do find opportunities to do things better. So one direct consequence of this committee's work is that we have looked earnestly at everything we do, and that is part of how we work now; it has created a whole lot of opportunities.

The CHAIRMAN: But that does not tell us of any challenges you see ahead.

Mr Morrissey: I think the challenges we face, like all people in government in Western Australia, are a growing population, increasingly complex families, the hard-to-reach—Aboriginal child health, in particular, is a challenge for us.

Mr P.B. WATSON: Drugs and alcohol?

Mr Morrissey: Drugs and alcohol is a big one; yes, significant. As research becomes more sophisticated we are able to understand issues we did not understand more clearly. So the more we know, the more there is this challenge around responding to the range of—yes. So there are challenges.

Mr Aylward: I think more than ever the profile that this committee has given, as well as other people, particularly the Commissioner of Children and Young People in terms of the special needs of children, has focussed the agenda like at no other time in relation to provision, recognition. There are really challenging issues, some driven by population.

The CHAIRMAN: What are the other challenging issues though? That is what we want to hear from you.

Mr Aylward: I think it is the first time that we have seen across government that there is not only willingness and commitment to deal with early years' issues, whether it be education, whether it be other government departments, child protection, community services and the like, and certainly health, but there are resources, effort and commitment, and a lot of evidence has come to the party. It is a very contemporary discussion and debate that is occurring.

The CHAIRMAN: And future challenges?

Mr Aylward: The future challenges are two-fold. Mark has alluded to those. We have had a rapid increase in population both in the metropolitan area—Kate can allude to some unique challenges across the rural sector as well, not only in the often referred to booming towns in the north-west, but also in the communities as they struggle with change in terms of the economic status of the communities. The impact we know on children from employment and the like for a family is quite profound in certain outcomes. We aspire to deliver, and we have seen that with the recent investment in child health, both opportunities have been looking at non-government organisations that want to come to assist us in delivering those services. It has been refreshing to see that so many have both inquired about the provision of services and also extended that further and said, "Actually, we really do want to be part of this." That has come a bit left-field from where we

thought things might have developed in this space. So that is building the capital, if you like, within the community.

The CHAIRMAN: That is not telling us, though, what you see are the challenges for the future.

Mr Aylward: I think the challenge is the population growth; it is the remote and rural nature of delivery of services so we have a consistent approach. We must ensure that we can reach those hard-to-get population groups, whether it be Aboriginal groups or non–English speaking groups, and the like. So they are really significant challenges.

We know we are not achieving all our KPIs in terms of universal access, and we need to improve that so every child and family gets a chance to be seen by a child health nurse, and then, obviously, to be referred to appropriate services if it cannot be dealt with by the child health nurse.

With school health, which we will talk about in terms of educational outcomes, we know a lot more about the causal links between what happens at birth, even the time of pre-birth in terms of conditions, whether it be FASD or other developmental challenges within the family. So we are becoming more focussed and putting more effort on those early years. When I say early years, I mean nought to five, nought to four. Others would argue some other dates. It does not mean we leave out the middle years or the youth aspect at all. It all needs to be addressed.

My role is to ensure coordination across the sectors I am responsible for—child health, school health and child and adolescent mental health—so that it becomes more seamless. I am sure the committee has heard many times that a standard set of basic services provided to every child and family across the board should be paramount no matter where you are. It is not a postcode lottery issue, as you have probably heard; it is really crucial—the notion of a one-door entry point.

I think that as we have reported previously to the committee and publicly, there is a need for further investment and resources in these areas, and there is a commitment by both agencies and government, and certainly the government is being responsive to this need. So I think we are in a far better place than where we have been in the past, because the focus and effort by Parliament and by government around the early years is a lot stronger, even in the short time that I have been in my role in the last three years.

The CHAIRMAN: We are giving you the ball first, but both Peter and Graham would like to ask you a question before we move on to Kate.

Mr P. ABETZ: You look after child health nurses and —

Mr Aylward: For the metropolitan area.

Mr P. ABETZ: Is there continuity in the school health nurses' access to the records that the child health nurses have, in the sense that if there are kids at risk, they go to school, the child health nurse relinquishes responsibility, and it may take 18 months before the school health nurse or the school actually becomes aware of what the issues are unless there is actual communication or access to—is there some computerised database that the nurses can tap into to see that this is what has been done with this child in the past or not?

Mr Aylward: I think there are two parts to that. First of all, any child, any family identified at risk, we do not drop the ball on. We put a great deal of effort to ensure we stay joined up, both within our services, between child and school health and, importantly, with other agencies, whether they be government agencies or other not-for-profit agencies. That is one of the core things that we strive to do well.

The CHAIRMAN: How are school health nurses notified of problems by the child health nurses, seeing as how the school health nurses cover 10 schools in some instances, or several schools?

Mr Aylward: I will talk about the information systems, because since we last spoke we did talk about the roll-out of an information system, and we can talk about that, how successful that has

been. At the moment, and not in every case, it is electronic, that notification, in terms of a record. But there is now a record in the metropolitan area, a computerised record, there is certainly information—Kate will talk about the country in a minute—for every child that enters into the system. So we are able to track in a clinical sense from the time of that first assessment done at birth, or within the first two weeks, first ten days, right the way through. It provides information around all their health status, both physical and emotional health status, where they have been referred to and the follow-up that takes place, and also makes sure that they are flagged if they are particularly at risk.

The CHAIRMAN: How many children do you have on that database? What percentage of children from the total population of zero to five would you have on your database?

Mr Morrissey: We pretty much did a catch-up. It is difficult to do a retrospective when you set up a new database, but we probably have the last two years of children. So every kid that is born is put onto the database and it goes right through to school, primary school.

The CHAIRMAN: So the last two years are all coming in?

[9.40 am]

Mr Aylward: When they come back in, say, for example, a child who has their preschool or school entry check, they would be entered in at that point in time, but we do not go back and try to capture that right at the moment. I suspect in five years' time we will have every current, active child, except those who are probably a bit older than five years. So that is happening as routine.

The CHAIRMAN: Perhaps you could let us know as supplementary information how many children have gone into that database because then we can look at how many children have gone into your database as statistics from birth over the last two years to see what your capture has been, to see whether it has been as high as you would like.

Mr Morrissey: We can try to put that together.

Dr G.G. JACOBS: What is the job description of a school health nurse? What does she do?

Mr Aylward: The specific role?

Dr G.G. JACOBS: Education versus screening; what do they do?

Mr Aylward: I may refer to both my colleagues about the specifics, because it is fair to say there are often some misconceptions about the role of a school health nurse. It is not a first-aider, as such, back from my recollection of days of school health nurses, as somebody you go to at the sick bay and be seen, to be treated due to an injury at sport. They will certainly assist in those things if they are there, but it is far more developed and advanced and more evidence-based now. So maybe Mark or Kate would like to say how those tasks or functions are split up.

Mr Morrissey: I am happy to answer but, Kate, did you want to say something?

Mrs Gatti: You go ahead and I will add bits as a child health nurse.

Mr Morrissey: We have two classes of nurses in schools. We have the nurses who go into the primary schools and do the screening; then we have the nurses who work in the high schools. Both are equally important. The nurses in the high schools deal with things such as mental health. This is critically important, particularly in those early adolescent years. They do health promotion. They do sex education. They work as part of the pastoral team in the school. So they are very much embedded in the school, that social, health, mental health support.

Mr P.B. WATSON: Albany Senior High School has a psych who does that and have teachers who teach sex education, so where does the health nurse come in?

Mrs Gatti: A lot of it is as an anonymous drop-in centre for youth. With my other hat on as clinical leader for the child and youth clinical network, we found at a clinical senate that kids were

informing us through various forums that they wanted this anonymous ability to come in and speak to someone who they perceived as confidential and who had knowledge in the health area. So in the high school arena there is a lot of one-to-one, particularly psycho-social, mental health, counselling in high schools.

Mr Aylward: So it is still joined up as part of the total team, but it is important that it is not part of the authority or educational framework, even though they do and still have great rapport with kids.

Mrs Gatti: Additionally, they provide the school with health expertise as required, so that includes kids with special needs.

The CHAIRMAN: How many school health nurses do you have at the moment?

Mr Aylward: Statewide—I just happen to have that number—there are 158, nearly 159.

Mr P.B. WATSON: Nearly 159, that sounds good.

Mr Aylward: Yes. I could give you percentages because we do points.

The CHAIRMAN: From the review you did in 2007, and you presented a report to the government in 2008, there were 135 school health nurses short. You have just told us there has been a population increase: how many school nurses are you short now? That number would have increased, so what is the number now?

Mr Aylward: We are still holding that there is still—look, you are right. The population has increased, but there has been a change in practice so we still sit at the moment at 135.

The CHAIRMAN: You are saying you are still 135 short?

Mr Aylward: Yes.

The CHAIRMAN: Even though there has been an increase in population?

Mr Aylward: We are comfortable with that number at the moment.

The CHAIRMAN: Could you tell us the ratio that you used? If you do not have it now, you can give it to us by way of supplementary.

Mr Aylward: Yes.

The CHAIRMAN: That is, the ratio that was used in 2007 to come up with the statistic of 135 school nurses short. Then if we could have, using that same ratio used, what that number would be now, because whilst you are happy that you could cope with a 135, there are obviously some people who believe that school health nurses could play a more valuable role and others who would just like to see a school health nurse.

Mr Aylward: Indeed. I hear what you are saying.

The CHAIRMAN: Could we have that ratio by way of supplementary information?

Kate, you did not have an opportunity—do you have the ratio now?

Mr Aylward: I think we provided that separately to you, did we?

The CHAIRMAN: Yes.

Mr Aylward: So we will do that as a supplementary.

The CHAIRMAN: You do not want to provide it now?

Mr Aylward: I do not have it with me at the moment.

Dr G.G. JACOBS: With the job description stuff, you talked about high schools, and you talked about primary schools and screening; can you tell us about the screening?

Mr Morrissey: When children start school they go through their four-and-a-half, five-year check.

Mrs Gatti: Three-and-a-half to four-and-a-half.

Mr Morrissey: Basically it is just an assessment in all of the major domains. We can provide that—I think we already have in the past, but it is a basic health psycho-social screen that picks up anything that is outside of the accepted —

The CHAIRMAN: It is a questionnaire, is it not?

Mr Morrissey: There are a range of activities that occur. It is a very important screening and it is quite a high ratio as well. So if somehow the parents have slipped through the gap, it is often the first big pick-up around the issue. But we then refer them to our child development service and get the kids seen. So it is a really important start to school and it is actually important to their future success in school, getting it right.

Mrs Gatti: The aim is to detect early developmental delay. Ideally we have picked it up in child health, but if it is missed, children through the comprehensive screening —

Dr G.G. JACOBS: Including hearing?

Mrs Gatti: Including hearing.

The CHAIRMAN: And if we follow on from that, maybe you can discuss now what you see as the challenges, particularly in the rural area. We are particularly interested in hearing because when we recently went to the north-west—you would have seen our report where we discovered that 94 per cent or higher of children in grades one to three had hearing problems, and there were sound systems in the classrooms, teachers were using Auslan—it was suggested to the committee by paediatricians that the school health nurses could do an ear inspection on Monday mornings. If someone had glue ear they could syringe the ears, they could put the children who needed it on antibiotics, and when they had been treated a couple of times for infections, they could then be put on the urgent list for the ENT specialist next time they were up there. If you would like to discuss with us what you see as the challenges ahead, and then, particularly because of your background, tell us about the challenges for child health nurses and school health nurses. I went on to the government jobs, jobs WA, website yesterday to see what positions were being advertised.

Mr P. ABETZ: Looking for a job, Janet?

The CHAIRMAN: No, I wanted to know how many child health nurses, positions, have been advertised and how many positions have been taken up since our last report was tabled, and I believe that only one—there has only been one additional child health nurse appointed since the government announced the $57 or $58.5 million.

Mr Morrissey: Could I clarify?

The CHAIRMAN: Yes, because I would like to know where those advertisements are going for those child health nurse positions, because that is what I was looking for, to make sure—because the government has given a commitment and was sincere with that commitment, so I want to know why only one nurse has been appointed.

[9.50 am]

Mr Morrissey: I think it is a very good news story here. We are about to bring on 16 new nurses into metro—brand new positions. And they should all be in place in the next month or so. There is a process that takes a little while.

The CHAIRMAN: So they are 16 of the 100 new, or 16 replacing some people who have left?

Mr Morrissey: No, they are brand new positions out of the new 58.5. There are some in the country as well. But the important thing to add is there is going to be a significant boost through the non–government sector, as Philip alluded to before. So once we finalise the contracts, they will also be bringing on staff.

The CHAIRMAN: Well done on those 16. Philip, my question then to you —

Mr P.B. WATSON: Eighteen regional areas.

The CHAIRMAN: And eight child health nurses?

Mrs Gatti: Are being advertised as well.

The CHAIRMAN: From additional or replacements?

Mrs Gatti: Additional.

The CHAIRMAN: Well done. I was looking for those positions.

Mr P.B. WATSON: But I would prefer the ratio to be a bit higher in country areas because you have a lot bigger areas to cover.

Mr Aylward: It is a good question. We have in the metrics and the split of that money put a greater weighting for the country, because there are a whole range of the things—distance, cost, impediment and things like that. It costs more --

Mr P.B. WATSON: And more health issues.

Mr Aylward: And more health issues proportionately.

The CHAIRMAN: Could we receive then a copy of the job descriptions for those new nurses that have been appointed, particularly those who are now working in the non–government sector, because I believe it is very important. What we found in our previous report we tabled was that children were missing out on universal screening, and what we need to be sure of is that the nurses who are being appointed, be it from a non–government sector, are being appointed to do immunisations here and something else over there. Are they being appointed as true child health nurses or are they being appointed to do a particular skill?

Mr Aylward: The approach for the non-government sector, and it is a similar approach in the rural sector in terms of being consistent, is that there will be different solutions depending on location, because there will be different providers that might be available in the country in some localities but not in others. So it is going to be a fairly detailed mapping process to get that into place. We are at the point now where we have had our first round of significant consultations with the NGO sector. We have attended a couple of briefings and we invited stakeholders, so people interested in this space, and also NGO providers, potential providers. We put a massive number of invitations out to people. We have followed that up with a series of other workshops with the groups. So as NGO providers have expressed interest, and if they have stayed in, then we have continued to get down into an engagement process. We have not been prescriptive in how that service will be delivered because we want innovation to come through and we want a genuine partnership. The old ways of purchasing would have been to replicate what we are doing at the moment and it may have stifled something innovative, whether it be from a small NGO that might operate in a particular geographical area or it might be one of the bigger NGOs.

The CHAIRMAN: The baseline is, what are they being appointed for?

Mr Aylward: So at the moment—sorry, I'm not trying to be long-winded about it. So we have had this engagement. We have had a lot of feedback from them about how they perceive solving the problem. We have said there are a couple of things that are core for us. One is the clinical standards and the quality aspect. So the service delivered has to be the same level of capability and competence no matter who is providing that service. We will not compromise and do not want to compromise on that aspect. We have also set some key benchmarks that will be mandatory as well, because our compact or our agreement with government will be that we achieve a whole lot of those KPIs, particularly those around children who are in care, the more than 3,000 children who are in care at the moment.

The CHAIRMAN: Is universal screening part of those benchmarks?

Mr Aylward: It is, absolutely.

The CHAIRMAN: Will all of those nurses be doing all of those universal check-ups?

Mr Aylward: Absolutely, and we have a progression over the four years of what we believe the start and the end points will be.

We have now developed a draft set of specifications that are going through some internal assessment, and then we will go to the so-called community sector, probably in late September, early October, and ask for proposals. We have to be respectful that there will be an arm's length approach to this as well, because a lot of government money is involved, and we will get their proposals. I suspect their solutions will start to come in towards the end of October, early November, on how they will deliver the services to the population.

The CHAIRMAN: But the base standard you are asking them is the traditional role of the child health nurse as per the job description of the Health Department or not?

Mr Aylward: No, we are saying this is what we do at the moment, but we describe it in clinical standards and outcomes. For example, some have suggested to me, "What if we are able to deliver the standard and we have a different worker involved in that delivery of service?"

The CHAIRMAN: So you have someone else doing something that may have traditionally been done—are you appointing other people under this funding for child health nurses?

Mr Aylward: No. We are asking for it for ourselves, state-funded. We are appointing child health nurses, but there are always opportunities we need to look at to see whether other clinical staff could undertake some of the jobs.

Dr G.G. JACOBS: So what you are saying is that you would like someone else to do the paperwork or the computer work?

Mr Aylward: It could be all of that.

The CHAIRMAN: Is that additional funding you have or is that funding coming from the child health nurse funding?

Mr Aylward: It will be funding to deliver the child health services for the population both in the metro and the country.

The CHAIRMAN: But the government's commitment was for that funding to go to child health nurses, so you are now saying that you are using that money not to employ child health nurses but you are taking it to non-government organisations and saying, "These are traditionally the roles done by child health nurses, if you can meet some of these roles, we will give you some of the money?"

Mr Aylward: No, we are not. We are saying that we want a comprehensive service provided by child health nurses. It is standards driven, it is documented standards driven at the same level of quality so it will not matter whether the service is provided by a public sector employee or one of the NGO services; it will be the same standard. What we have asked for—and, as you know, in the delivery of service, where you have front-facing staff all the time—is that are there other ways of delivering. For example, they may decide to deliver it not on a location basis; they may decide to deliver it on a functional basis. So in some hard to get to communities they have talked about, "Well, what if we get a bus and delivered those services in Aboriginal communities"—even in the metropolitan area—"and we go to the staff as well?" If we think that sounds like a pretty good suggestion, they will have costs associated with the provision of those services. So the money given to us is to ensure that we have the frontline staff and the services provided by child health nurses. But we are saying, "Let's see if there is some innovation." We do not have to accept that at all, but we are not being closed. Our mind is not closed for innovation.

The CHAIRMAN: But you do realise the government will be held to account, or taken to account in terms of they promised 100 where we needed 151 child health nurses, and it seems to me that you are saying to this committee that that money is not just going into child health nurses.

Dr G.G. JACOBS: Can I say something?

Mr Aylward: I am not sure that I have explained it well enough. We are not diverting money away from the purpose.

Dr G.G. JACOBS: I may be able to help you, as most humbly as I can. If you talk to the child health nurses in the community health centre in my town, they will say, "Graham, we spend a lot of time doing a lot of things that are not core to being a child health nurse. We are answering phones. We are making appointments. We are putting data into the computer" or whatever. Someone else can do that and you can still deliver a very good service and maintain all those standards that Philip was talking about. But a lot of child health nurses—Kate might want to say something about this—say to me they spend a lot of time on non-nursing stuff and there may be an ability for someone else to do that, still delivering more bang for your buck because you are doing more core work.

[10.00 am]

The CHAIRMAN: But there should be additional funding for that, Graham. That funding should not come from that budget that was set aside for the child health nurses.

Dr G.G. JACOBS: It is delivering a service though.

Mr P. ABETZ: We can say we have done the right thing as government, kept our promise, we have all these nurses, but they are doing all this admin work. They are doing this admin work but it is not delivering the service to the kids, which is the important part. So if an NGO says, "We can employ somebody at $25,000, a junior, to do the data entry," that will free up that nurse to do more interaction nursing work.

The CHAIRMAN: That sounds fine, but, remember, from the auditor general's report we know that 90 per cent of children were getting that first visit between five to 10 days; 30 per cent of children were getting that visit at 18 months; and only 10 per cent were getting that visit at three years. I have no problem with people coming on board to do admin work, but that funding was for child health nurses so that we can have a report back in 12 months' time and we can see that that 90, 30, 10 has gone to 90, 50, 30.

Dr G.G. JACOBS: And that will improve if you get a nurse to do more of the nursing work and less of the paperwork.

Mr Aylward: We know that nurses today are frontline; they do everything. I have spoken to your community nurses, as I know you have, Janet. They do the whole lot. They do the reception work, make the appointments, take the phone calls, et cetera. We are trying to say that outside of this, and included—because there is always a component in our budget bill for things like office expenses, vehicles, accommodation—is to put a nurse on the ground, to front-face the community, and it costs a lot of money. That is in the budget build. That is in the $58.5 million in our request. What we know is that some of the providers have said we actually manage, for example, fleets. We run a huge number of fleets in the community at the moment, but there is actually a health provider that actually manages incredibly efficiently the allocation of a fleet. Now that might seem to be a trivial item, but if that releases our nurses not to hassle and challenge and get a car, it gives them another five hours a fortnight to provide more clinic front-facing time with people, then that is what I was referring to as opportunity.

Mr P.B. WATSON: What proportion of the $58.5 million would go to administration?

Mr Aylward: We have, deliberately at this stage, not disclosed that to the providers, the reason being is that we want to keep them sharp. We do have a figure, absolutely, in our build. I am happy for the committee to ask for it. I do not have it with me.

The CHAIRMAN: We would ask for that by way of supplementary information. Could we have the breakdown from what Peter said of $58.5 million, over four years. If 100 nurses were to be employed over the four years, because it is meant to be over four years, is it?

Mr Aylward: That is correct.

The CHAIRMAN: If we could have as part of that breakdown how much of that $58.5 million would be required to employ 100 nurses, and then how much additional there is in that $58.5 million that could be used for those other areas, or if not, then where else you are seeking funds for these additional things so that the two-thirds of the child health nurses that we need are actually going to be appointed.

Mr Aylward: I would seek a bit of flexibility from the committee if I could: we want to conclude the negotiations with the NGOs, because if we give a number they will target it.

Mr P.B. WATSON: I can understand that.

Mr Aylward: I understand your need as well, but can I —

Mr P.B. WATSON: I am concerned, like Janet, that $58.5 million was for nurses. Okay, we will get all these extra nurses, but now we find that the administration costs—I can understand the concept of doing it. But when $58.5 million is to say we are going to provide new nurses, I think what Janet is saying is that we would prefer that $58.5 million to go to providing nurses and for the department to go for the administration side, to come out and say, "We need this for administration." It is a little bit misleading to the public that all that money is going to go to provide community nurses.

Mr Aylward: What is clear is that the funds will provide up to 100 nurses over four years. That is what the government —

The CHAIRMAN: But the government did not say "up to"; the government said "100". "Up to" could be 20, 30, 40.

Mr Aylward: Sorry—at least the funding is there. Let me clarify so there is no ambiguity. The government will provide with the money allocated 100 nurses over the four years. What is included in that is that it is incumbent upon us to, say, put a nurse at Kununurra, the cost of accommodation, and you know —

Mr P.B. WATSON: Wouldn't that be taken into account before the government made that decision?

Mr Aylward: They have, and that is part of the $58 million. It would be not responsible of us to say to the government it only costs $100 000 to put a nurse in Kununurra. We know it will not cost that. There are overheads and there is administrative support for each individual person. There is also housing as well. And to the credit of the government, they recognised those costs and have funded it accordingly. Otherwise you would be cannibalising other parts of the system. The good thing is these positions are fully funded, and it will not matter if they work from Armadale or Kununurra or Bunbury or Albany or any other place. We are able to fully fund them to put a person on the ground.

Can I also say that in, for example, the partnerships with NGOs, the commitment we have with them, if we are not able to get a response, a success in all circumstances, then we will look at how to provide that service ourselves. But we have generally gone --

Mr P.B. WATSON: Above the $58 million?

Mr Aylward: No, it would be within the $58 million because there is adequacy within that number.

Mr P.B. WATSON: How can you do that now when you do not know the figure the NGOs are going to provide?

Mr Aylward: We do have an internal benchmark figure that we have used to create $58.5 million, to create the 100 nurses. We know what that will cost us. So we are asking the NGO sector—that is why it is the NGO sector rather than a for-profit sector—and this is where they can get the innovation. We know that in certain communities, and particularly in the country, there will be smaller groups, Aboriginal control groups for example, that would be potentially—I think they are interested to provide that. They will come to the party. I was in Roebourne recently as part of a look up there, and they will come to the party and say, "Look, we actually have the infrastructure covered." We are not trying to get anything on the cheap here. But if an NGO says, "We have the infrastructure covered and, by the way, we will accelerate the value the government has for that position", then I think that will be a win-win for the community.

Equally, if they need to provide a house or lease a house, et cetera—we know the cost, $2 500 a week in some communities, maybe more—we will not expect the NGO to say, "By the way, we will give you only $100 000 to employ the nurse and then it's up to you", because that will be a failure. That is setting up people to fail.

Mark or Kate, do you want to say anything else?

Mr Morrissey: Something we may have missed is that some non-government organisations will bring some stuff to the child health nurse role that will be added value into that, and we are starting to hear conversations around that in our conversations with them now. So in six months we will be a better place to assess real value of what a number of these people are talking about that we cannot bring to it, cost effectiveness as well as a really good breakdown.

[10.10 am]

Mr Aylward: We are encouraged by the responsiveness so far from the non-government sector. It is hard work for them. The feedback I have had is that there is a lot of work for them, but they are bona fide in their commitment to see whether they can be part of this. Some of them are more than that; some are absolutely committed and say, "Look, we definitely want to see this as part of the solution." But we will have 100 front-facing child health nurses, well-supported, integrated across both. In the NGO sector we will information flow, so that comment you made before, there will be no Chinese walls about information, so that is a crucial bit.

Mr P.B. WATSON: If you have a system to say it is 100 over four years, is it 25 a year or will you have 15 the first year and 25 the next?

Mr Aylward: I cannot recall the ramp-up. Do you know?

Mrs Gatti: I can tell you in the country. The country is putting on all these internal build, internal FTE, in the first year and carrying them through, so they are all being put on in the first year. For the not-for-profit contracting, because it takes time to test the market and then put it on, there is a ramping up in the process.

Mr Morrissey: With the NGO sector, we will probably not have any clear idea until around Christmas time. That is just the process. But we cannot forget that we will have 16 staff on, doing the work in metro, in the next month.

Mr P.B. WATSON: Do you look at the worst areas first or the remotest areas first? What is your—especially in regional areas?

Mrs Gatti: In country regions there are two primary needs that must be addressed. One is the area of high population growth, and that is obviously the south-west region, which has had the most significant growth in country. The Pilbara has had some growth but not like the south-west. And then you look at health need. So it is weighing up where that is. It is also looking at where are the opportunities for other access. So in the Kimberley, where there is significant health need, there is actually good access. I cannot tell you the exact number but there are a number of Aboriginal

medical services. So part of the strategy is to improve access to existing services as well. But it is more complicated than just looking at population growth.

The CHAIRMAN: You mentioned the Aboriginal services, and you will remember when we went up there—I cannot remember the Aboriginal health service we visited, but one of the Aboriginal health services said WACHS prohibited them from doing immunisations in Roebourne.

Mrs Gatti: Mawarnkarra is the Aboriginal medical service. It is the Poisons Act that actually prohibits them. WACHS does not prohibit anybody from doing anything.

The CHAIRMAN: It was because of the Poisons Act, was it?

Mrs Gatti: The Poisons Act is quite —

The CHAIRMAN: So that is a recent change?

Mrs Gatti: No.

The CHAIRMAN: Because they were doing it previously?

Mrs Gatti: It was overlooked before.

Mr P. ABETZ: Can it be overlooked again?

Mrs Gatti: If they choose to do it. It is up to them.

Dr G.G. JACOBS: Can I get to school health nurses. In the screening area, do you think we would be able to get to, what Janet was alluding to, screening kids for ear disease?

Mrs Gatti: By the time you pick up ear disease at school, you have missed the boat. Where there is a gap and where we need to significantly change practice is identifying these kids in the nought to four-year-olds, and the earlier the better, because by the time they get to school, they have solid glue middle ears.

The CHAIRMAN: So it is scarred, most of their ears are scarred, are they?

Mrs Gatti: It is just blocked thick gunk, so many of these children who are going home to the lands are having their first cold in the first few months of life. That is when it is starting. So we need access to screening and treatment earlier. By the time they get to school it is too late; there is a lot of damage done. And, yes, you can do the surgical intervention and the antibiotic intervention, but, ideally, if we are to try to fix this problem, a number of interventions need —

Dr G.G. JACOBS: We are talking about child health nurses, then, are we?

Mrs Gatti: We are talking about primary care.

Dr G.G. JACOBS: If we are talking about nurses and screening, and if it is not school health nurses then we have to talk about child health nurses because you are saying it is happening earlier.

Mrs Gatti: And we are talking about GPs.

Mr Aylward: And families themselves, developing the families.

Mrs Gatti: We are talking about a far broader knowledge base in the families. Many of us would recognise a kid with an earache and do something about it, so a multi-interventional action needs to be taken. It is about health promotion to families: identifying the young baby that is crying because of a sore ear and getting it looked at for the bulging eardrum and the red eardrum and getting the appropriate treatment. Screening at school at a point in time, if you screened most school kids at the moment, all would have hearing deficit because they have colds and they have blocked sinuses and all have hearing deficit. Screening once at a point in time does not necessarily solve your glue ear problem. It certainly does not diagnose --

The CHAIRMAN: Screening on a weekly basis, which is what the specialist said to us?

Dr G.G. JACOBS: With follow-up, and making sure they are followed up?

Mrs Gatti: Yes, and at school, having them followed up with primary care. So you need, because our Poison Act's regulations —

Dr G.G. JACOBS: And to make sure they do go to their GP.

Mrs Gatti: Yes, and that service is happening in part. My point is that at school there is already hearing and speech loss. We need to prioritise our efforts in this back in the nought to four-year-olds.

The CHAIRMAN: Shouldn't we be doing everything? Should we not be doing the zeros to four as a priority, plus having the school nurses check and work with those children at school?

Mrs Gatti: And in the Kimberley schools there is annual screening of all the communities. Annual screening does not do a lot.

The CHAIRMAN: We were told weekly. What the paediatrician said to us was that it should be done weekly, particularly in the wet season, by the school health nurses.

Mrs Gatti: And in some Kimberley schools that is happening where there is a nurse going to those schools weekly. The access to primary care is an issue. Access to GPs in much of rural Western Australia is an issue.

The CHAIRMAN: How many school health nurses do you have in the Kimberley? How many school health nurses do you have in the Pilbara? How often do they visit? How many schools do those school health nurses service in the Kimberley? How many schools do those school health nurses service in the Pilbara? How often, then, can they visit the schools, because a paediatrician said to check everyone on a Monday morning and then the school health nurse could give the antibiotics—I think from what he said they could be provided twice a day so they got them first thing in the morning, so they got all their antibiotics during school hours; not having to take any home to be given that might not be given. So they got given the antibiotics first thing in the morning and before they go home so that hopefully by the end of the week things had improved, and if they had not they could then tap into a community health centre if the child needed further treatment to make sure someone was going around to give those antibiotics.

Mrs Gatti: I would have to take that on notice. I can tell you that in the Kimberley we have 6.5 employed school health nurses and in the Pilbara we have 5.5 school health nurses. I can also say that in the Kimberley and Kutjungka region, the camps provide the school health service. In the Kutjungka region the schools provide the school health service and it is a contracted-out service and that has been the arrangement for many years.

The CHAIRMAN: So if you could tell us how many schools your school health nurses service and how many schools CAMS services, and then we can ask CAMS the same question about the funding for their school health nurses and whether their school health nurses can go in and do these hearing tests. I might let you finish off, Graham, but I would like to come back to—you are saying that it is both—more assessments need to be done in the early years as well as in school. Have you considered that the committee could make a recommendation from a memorandum of understanding that the school health nurses could do a check on a Monday morning and they could administer —

Mr P. ABETZ: And prescribe.

The CHAIRMAN: They do not have to prescribe, it could be a protocol that is set for them. That is what you have in hospitals where nurses can give drugs in an emergency.

Mrs Gatti: Nurses cannot prescribe.

The CHAIRMAN: No, but if the protocol is written that if a child has an ear infection —

Mrs Gatti: That is in breach of the Poisons Act. But that is not saying you cannot get access to an order for a doctor as appropriate.

Dr G.G. JACOBS: Or a nurse practitioner.

Mrs Gatti: Nurse practitioner legislation will allow it.

[10.20 am]

Dr G.G. JACOBS: I take your point that a lot of this process starts really early, but it is all about access and it is all about availability, and those are big, big challenges. We saw that in the Kimberley and Pilbara. But if we are presented with a child and we have some ability in that environment because they are accessible because they come to school—actually a lot do not come to school—it is an area where we can access children potentially. If it presents to you that a child does present at six years' old with glue ear, understood that perhaps they might have had multiple infections, they might have scarred drums, but it also might be their third episode of glue ear, or whatever, there is a potential to do something about that, to reverse that and have them hear. All we are trying to do—I know there are issues about nurses prescribing, but we find that these kids are dropping down in the early years and also in the later years. We have to start somewhere. We will talk to Harvey Coates soon after this session with you —

Mrs Gatti: Graham, I support that —

Dr G.G. JACOBS: We are just trying to basically get our way through. We are not asking school health nurses to do everything, but we are trying to engage and make a difference in that screening and ensure it is followed up, and that is difficult.

Mrs Gatti: That is very possible. My issue with that is if we are to make sustained change in ear health disease we need to change the culture and the attitude within the whole family and within the whole community. A multifaceted approach needs to be taken. If a nurse identified my child as not hearing at school and they managed through whatever means to get antibiotics and treatment without my consent as a parent, I would be upset. So I believe we need to maintain an appropriate informed consent process. However, in that process we must empower, educate and enable the family unit and the broader community to change behaviour. Why is it that this is more prevalent in Aboriginal communities than other communities? It is far broader than the medical disease process. It is the socially determinative stuff we need to talk about. There is a prime opportunity through engaging the broader family in the treatment process of a child to start changing attitude within the broader family and community.

Dr G.G. JACOBS: Having said that, though, I am practical enough to know that some things are dysfunctional and have not moved for years.

The CHAIRMAN: Decades.

Dr G.G. JACOBS: We can talk about changing the education culture but that has not had results and what we have is an enormous number of kids who are deaf. Yes, it is all about ear health, ear hygiene, Eustachian tube patency. I understand all of that—a child who is living in a low socio-economic area, prone to infection, prone to blockage of Eustachian tubes, all of that. We will not move that quickly but what we do have is an enormous number of children with serious otitis media who are basically not hearing.

Mrs Gatti: Yes.

Dr G.G. JACOBS: I understand that those interventions are not necessarily once-off—they have to be sustained and followed up—but there are practical ways of making this happen. I understand all those other issues you have spoken about, but we will not move this quickly.

Mrs Gatti: I am not saying do not do those; I am saying, do those in consultation with the family. As difficult as it is, we in the child health, school health field struggle with consent, but that is absolutely fundamental to getting more sustained service to that individual at a point in time and over time.

Coming back to your original questions and your terms of reference, the thing I am most excited about was a reference to alcohol. That is the biggest issue in country areas. It is in foetal alcohol spectrum, and I have already been before the committee speaking about that. We did comment that antenatal would have been good in that. Some communities have a much higher prevalence of ear health disease than others. You have to ask the question why. The communities that are more empowered are the communities that have fewer health problems, including ear health diseases. So doing what you suggest is one strategy of many. What I am suggesting is that strategy needs to link the family in and take that as an opportunity to link the family.

Mr P. ABETZ: One of the real issues I have seen in remote communities is the, you know, little Johnny is part of that community but mum and dad are up in the next community and he is staying with uncle or aunt or grandma. Who has authority?

Mrs Gatti: If you understand family politics, the grandparents are often the caregivers. That is normal. They are the ones we are talking about here.

Mr P. ABETZ: But the grandparents—from my interaction with Aboriginal communities over the years, if you do something for their kids, in terms of medical treatment that helps their kids, they are more than happy for you to do it. In the communities that I have been involved with over the years it would be a total non-issue for them to get antibiotics in school, or for the nurse to chase them up if they have not been to school and give them their medication because they have glue ear. You would not need written permission. That is just not where they are at. So in terms of that dynamic, we need to move forward, because if we do not treat those kids, we condemn those kids to a life-long hearing loss because we are waiting for these other things to happen. I think we need to get in there and make it happen for those kids and do those other things as well, and hopefully that will move things forward. But we really need to act. If we know a child has an ear infection and it is not being treated and it will contribute to that child becoming deaf, it borders on child abuse.

Mrs Gatti: I am not suggesting do not treat them in any shape or form. I am suggesting taking that opportunity to engage the broader family.

Mr Aylward: I absolutely agree with it. Those grandparents are the ones that are engaging now. It is the hard to get areas, and I think it is—it is not being glib, it is multifactorial. We absolutely will treat on presentation, but the antecedence of this go far back earlier than this, and we do have models of success and there are communities are that successful in turning it around. That is the model behaviour. I know the stuff we are doing across the board in closing the gap is very much about fundamentally empowering the family unit to make decisions. We will not not screen or not intervene or not refer on—absolutely not. I am going back to an earlier query: we are open to ideas and strategies, and I am sure government will listen to the committee's report on ideas, whether they come from clinicians or other organisations about how we might approach this. But one thing I would be reticent about is a one-hit, one-screening program. It might tidy things up for a short period of time, but it is not a long term solution.

The CHAIRMAN: Back to Kate, it was not a one-hit screening, it was what the paediatricians were saying; it was a weekly screening, particularly in the wet season. You said that at the moment the Poisons Act prohibits nurses, or would prohibit school health nurses, from giving antibiotics, but if the school health nurse did an assessment and found that the child had otitis media, is the school health nurse not able to phone a paediatrician or the health department?

Mrs Gatti: If they phoned a doctor and got an order over the phone, so long as there is a doctor's order based on a set of criteria within a set criteria or time—and there is the process —

The CHAIRMAN: And it has to be a phone call or can there not be a protocol if the nurses have a competence?

Dr G.G. JACOBS: Could there be a standing order?

Mrs Gatti: No. Standing orders are prohibited.

The CHAIRMAN: So it could not be if nurses had done —

Mr P.B. WATSON: They make it difficult.

Dr G.G. JACOBS: It is not really. I have practised out there. Nurses say it is, but the reality is that you get a presentation, you describe the symptom—I have worked in remote hospitals for much of my career—you ring RFDS in Perth, you ring Royal Perth reg, you get your order and you get faxed an appropriate script.

The CHAIRMAN: So it could be done that way then. We all agree that the families have to be educated, but could it not be the same as the current practice in our schools where the parents at the beginning of the year sign a slip saying that if there are any media functions at the school they are happy for their children to be involved? Could the parents not, at the beginning of the school year, sign something saying —

[10.30 am]

Mrs Gatti: It is not about the signature but about informed consent and what that means. It is about the opportunity to educate and have —

The CHAIRMAN: But can it be done?

Mrs Gatti: Absolutely.

The CHAIRMAN: So it could be done, because nothing is happening for some of those children at the moment now. We would like to see something. When I say nothing, in some areas you are doing a good job, and you have school nurses doing those checks and things are working well. But in other areas nothing is happening and it is in those areas where nothing is happening that this type of approach may help with some children.

Mrs Gatti: Yes.

The CHAIRMAN: And for those children who are missing the boat, this could make a big difference for them.

Mrs Gatti: Yes, without a doubt.

The CHAIRMAN: So in terms of, then, the school health nurse calling the GP and getting it signed off on, would there need to be a change to the Poisons Act for that?

Mrs Gatti: No.

The CHAIRMAN: There would only need to be a change to the Poisons Act then if we were asking to —

Mrs Gatti: The nurse to prescribe.

The CHAIRMAN: The nurses must pass a competence-based course to be able to prescribe antibiotics at school. Would that be the only time there would be a need to change the legislation?

Mrs Gatti: You would need to get an exemption of that particular drug and protocol from the Poisons Act. And there is some precedence—immunisation is the precedence.

The CHAIRMAN: So it has already been done for immunisation?

Mrs Gatti: Yes.

Mr P.B. WATSON: In education support schools, school health nurses are empowered to provide direct clinical care for students with high needs. What does this mean in practice? Are the nurses in those schools differently qualified from those in mainstream schools? If the role is more circumscribed in mainstream schools, why is this so?

Mr Morrissey: The nurses in these schools are obviously qualified registered nurses. They choose to go into that area. They are given training or they often come with training to manage kids, so it is often management of epilepsy. Whatever the presenting problem is, the nurses are skilled to work in

regard to support and training. These kids often have aids so they are to support that as well. So that is their qualification and skill. What is the second part?

Mr P.B. WATSON: Are the nurses in these schools differently qualified? You have already said that. If the role is more circumscribed in mainstream schools, why is this so?

Mr Morrissey: I am not sure of the question; Kate?

Mrs Gatti: No, I have to say when Brian presented this to me —

Mr Aylward: I think there are more kids with special needs who are being mainstreamed into schools, if that is what the approach is.

Mr Morrissey: That is probably the angle.

Mr Aylward: So more kids with higher needs are being mainstreamed into general schools rather than specialising them. I know there are paediatricians at our place that are strong advocates of ensuring that where possible the kids go to their local school, for a sensible lot of reasons, rather than a special school. It involves both the training and upskilling of carers, educational aids, and also in the few occasions where there needs to be a nurse assistant. There are a few very high-end needs where the kids are supported by a contract that we have with some kids who have severe disability needs. We are finding there are more kids, whether it be diabetes or something like nutritional feeds and other things. With the expanding population, there are more needs. We seem to be able to measure and match that quite adequately.

Not all of them need specialised nursing schools. Some aids and assistants can be educated and trained and are comfortable with managing those kids with more complexity.

Mr P.B. WATSON: I know in Albany the special needs schools are attached to the main schools. So would those special needs nurses be able to be used for children with special needs who are in the general population?

Mrs Gatti: There are only two special needs schools as gazetted in the country—one in Geraldton, one in Bunbury.

Mr P.B. WATSON: There are some in Albany.

Mrs Gatti: Not in a special needs school. There are special needs children in mainstream schools throughout the country, throughout the state. In terms of gazetted special needs school, there are only two in country WA.

Mr P.B. WATSON: We have one at North Albany Senior High School and one at Spencer Park Primary School.

Mrs Gatti: But it is not gazetted as a special needs school.

Mr P.B. WATSON: So they are just attached to the school, are they?

Mrs Gatti: They are.

Mr Aylward: They just go there? Do they gravitate there from that community?

Mrs Gatti: Yes.

Dr G.G. JACOBS: We have that in Esperance too.

Mrs Gatti: And Northam.

Dr G.G. JACOBS: This question is like the how long is a piece of string question; in practical terms, not the Rolls Royce standard but the Holden variety that do the job. You talked about school health nurses in the Kimberley and Pilbara: can you give us a feel for what you think the shortfall is in the numbers? You talked about six nurses or something, school health nurses in the Kimberley.

Mrs Gatti: It is, “How long is a piece of string?”

Dr G.G. JACOBS: I mean, six for me, my gut feeling, my gut reaction, having visited there—I know the disparity of the schools and enormous area, but my gut feeling is that six is seriously underdone.

Mrs Gatti: Can I make a comment, going back to the role of child and school health nurses?

Dr G.G. JACOBS: That is where I started, you see.

Mrs Gatti: I think this discussion has highlighted the difference in roles depending on health needs across the state. We are talking in the Kimberley and Pilbara about primary schools and we are talking primary health. We are talking primary and public health. We are not talking, often as has been described by Mark in the high schools, in the mental health stuff because we are talking pretty basic health stuff. So the roles are different. If you are wanting primary health access in each of these schools, it is probably a nurse practitioner type of thing and it is a slightly different role to what has been described, which I think comes back to what Phil was talking about before, around leaving it more open in the initial stages and the contracting out, because the needs of the community are different, and that is what we need to respond to. A school—a child health nurse and a school health nurse does have a generic scope and role, but their specialties changes whether they are working in a special needs school versus a high school versus a primary school in the Kimberley.

Dr G.G. JACOBS: Can I ask you about primary schools in the Kimberley, and, as Mark said, the major screening role that they have? That is the bit I am interested in and the shortfall in FTEs of the school health nurses. What is your feeling? It is difficult, I know.

Mrs Gatti: It is difficult. For the universal screening, which is at three-and-a-half to four-and-a-half-year-olds, the Kimberley coverage rate is pretty good. It is up around 90 per cent. If you are talking about screening every week on a Monday for ear health, that would require significantly more, probably double, resources.

Dr G.G. JACOBS: I am talking about the status quo at the moment. Let us not talk about the weekly screening of kids' ears. Let us talk about what is happening at the moment.

Mr Aylward: Would you like to reframe that out of the gap we have identified: what portion of that effort is needed in the Kimberley compared with what you have at the moment?

Dr G.G. JACOBS: Yes.

Mr Aylward: Perhaps we might need to take that on notice, because we would have done the metrics on that, and then give you the feedback to, say, based on our 135, what numbers do we think need to be invested in that area. Kate is also correct. There may be basic nutritional needs and really basic public or primary health needs as opposed to other communities in the metro, although there are those issues where we are probably talking about a different set of needs, and it may be more about sexual health discussions or healthy lifestyle, exercise, obesity, things like that. Whereas a community in the Kimberley may in fact be right back and need a lot of support around basic things that we discussed around identifying an ear health problem, how do you help with good nutrition? But we could find the gap, without trying to change anything that we have put forward before. I think we could—if Kate is happy to do that—come back to the committee.

Dr G.G. JACOBS: For instance, are all the schools covered? What sort of coverage would you get?

Mrs Gatti: All the schools are visited, yes.

Dr G.G. JACOBS: How often?

Mrs Gatti: I will take that on notice because I do not know specifically now.

[10.40 am]

The CHAIRMAN: How often over a one-year period would each school receive a visit and for how long would that visit be? So for the schools, the number of students and how long the visit would be and how many visits over the year.

I have one final question. Apart from looking on your website to see where the child health nurses were going, I also phoned around this week some of the child development centres and I asked about waiting times. I thought it was a golden opportunity given all that work we did and that funding we got for child development services. I phoned—and they did not ask me my name so I did not have to say I was Janet Woollard, so I was not dishonest. But they did tell me the waiting times for some areas, and I was a bit shocked, because the government had given a commitment to get the waiting times down to 50 per cent. I believe some of the waiting times, from what I heard yesterday, have crept up again. So could I ask, by way of supplementary information, if you could provide us again with the waiting times for the health professionals that we asked about in that lovely table we gave you two years ago?

Mr Aylward: Very happy to do that. The good news is that we are seeing nearly eight per cent more children than we have done before so we are doing the work we said we would do, so more kids are being seen in a more timely basis. That has meant that at the back it has created in some of the disciplines some pressure in terms of time frames. But on the basis of that, is it higher than seven per cent?

Mr Morrissey: It is creeping up.

The CHAIRMAN: What we did not ask last time, for that average that you gave across the board for those figures, what I was made aware of when I called—and I do not know whether it was yesterday or the day before—was that if you were phoning for an appointment for a speech therapist, if you are a level one it might be 11 months, and if you are a level two it might be 13 months. So with those things, can we have the average for the level one, because I was not aware before that we had different waiting times for level one and for level twos.

Mr Aylward: We triage the severity of the cases as they present, so, yes, we have recorded the average of everybody, and with that there is a cohort that we look at and say, "Of the particular conditions presenting, how quickly did we respond to that?" It is no different, if you like, in terms of elective surgery, though it is a different categorisation process.

The CHAIRMAN: Obviously some children who have multiple problems need to be seen urgently, but equally —

Mr Morrissey: Kids who are triaged or categorised as category one, we see quickly, often within a few days or a week or less than a month.

The CHAIRMAN: I was told for speech therapy —

Mr Morrissey: Okay, we will get back to you with that.

The CHAIRMAN: At Rockingham I was told it might have been nine months for level one and 10 months for level two. At Mandurah I was told 11 months and 12 months. I did only a couple of them; I did not phone all around but I just wanted to put it to you.

Mr Morrissey: We will get some stuff through.

Mr P. ABETZ: Bletchley Park Primary School is an independent public school—I am on the school board so I happen to know about this—and they have employed a speech therapist for the school because there is a need and they have got scope for that and they said they were going to do this.

Mr Morrissey: They are an independent school?

Mr P. ABETZ: Yes, an independent public school. That flexibility schools are going to get—increasingly more schools will want to be independent public schools, so that gives schools the

opportunity to respond to their local needs. How will that impact on the role of a school nurse? I think it is positive.

Mr Aylward: It is complementary in the whole initiative for not only independent public schools, but also in the early years centres, the child and parenting centres being created—the 10 they have already initiated—will give the local schools the opportunity to work with us in partnership and other providers, to say, "Can we have a higher focus, higher effort?" There is resourcing to do that. I think it is very complementary and an exciting development.

The CHAIRMAN: This is obviously an area that is dear to our hearts and there are a more questions we would like to put to you. We have not touched on child and adolescent mental health. I just had a briefing this week and heard that you have taken funding away from the children on the streets, the 12 to 25-year-olds—there was a program helping them. So what we might do is put some of these questions we have not had an opportunity to ask you in writing and some additional questions. Writing answers to questions takes a long time. If you prefer to say to us, "We think it would be easier to come back and meet with you for an hour", even if it is not through a formal hearing, we can make it an informal meeting to answer those questions because we do not want to take up your time. We think you are doing a great job. I know it sounds like we are go, go, go, but we were trying to fit as much as we could into that hour.

Mr Aylward: We are happy to do either. Having a chance to have a discussion around this is helpful for us and hopefully it has been helpful for you. We are happy to come and talk about CAMS services and anything specific.

The CHAIRMAN: That would be wonderful. In that case, unless there is anything you would like to say —

Mr Morrissey: Can I comment? Over the past few years there has been unprecedented support and investment in kids. It is a privilege to work in the area, but it is a credit to all the people who have contributed to that. So that is just an acknowledgement of that work.

The CHAIRMAN: Thank you for your evidence before the committee today. A transcript for this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to it. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added by these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence. Thank you.

Hearing concluded at 10.47 am