EDUCATION AND HEALTH STANDING COMMITTEE

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

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 30 NOVEMBER 2011

Members

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

Hearing commenced at 10.25 am

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

SMITH, MR IAN
Chief Executive Officer, WA Country Health Service, examined:

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

GATTI, MRS KATE
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 interest in and appearance before us today. The purpose of the hearing is to assist the committee in gathering evidence for its inquiry into improving educational outcomes for Western Australians of all ages. I am Janet Woollard, next to me is Graham Jacobs, then Peter Abetz, and on my right our secretariat, Dr Brian Gordon, and Darby Evans is the Hansard reporter. The Education and Health Standing Committee is a committee of the Assembly. This hearing is a formal procedure of Parliament and therefore commands the same respect given to proceedings in the house. As this is a public hearing, Hansard is making a transcript for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you would provide the full title for the record. Before we proceed to the questions we have for you today, I need to ask you: have you completed the "Details of Witness" form?

The Witnesses: Yes.

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

The Witnesses: 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?

The Witnesses: No.

The CHAIRMAN: Before we start, I believe that Philip wanted to make some introductory remarks.

Mr Aylward: If I may, Dr Woollard.

The CHAIRMAN: Janet is fine.

Mr Aylward: Thank you. We have taken the opportunity to bring along today our response to the questions the committee has put to us. You wrote to us on 23 November asking a series of questions. We have tabled this response today and will provide that to the committee to Brian separately via email so that it can be formally logged. We note that that information has just been

provided to you and we welcome any comments or queries you have about the data we have provided to you at the committee today. Subsequent to that, if there are any other supplementary questions or queries that we can assist with, we will do so. Health is very pleased to come along today. We do not have a formal presentation, but a particular area that you mentioned the committee is looking at is a longstanding priority for the Department of Health and the public sector; that is, improving outcomes for children—both health and education. The wellbeing outcomes for children across the great state of Western Australia are a high priority for us and we allocate quite a considerable amount of resources for that. Government has also recognised the need to improve the outcomes for children and give them the best opportunity. The investment of $49 million that the government made in child development services has gone a considerable way to improving access to children across the metropolitan and country areas, to such an extent that we have achieved the targets we set out to achieve. We have halved the wait times by 50 per cent. We are experiencing, though, increased demand, as we would expect, as word spreads and news gets around to a range of referrers—in education, GPs and other primary care providers, including school health and child health nurses—that accesses has improved to those services. We are experiencing a demand consistent with population increases, even though the population increase might have tapered a little in the last couple of years. We are very pleased with the implementation and expansion of that program. Again, that is across both metropolitan and country areas. We continue to look at reform, particularly in the information management systems in this space, to provide timely information to our nurses and feedback to parents and obviously other primary care providers. We might be given an opportunity to talk about the development of information systems in this area, which is of particular relevance to certain practitioners in this area, and also more senior people within health management. If we cannot measure it, we are probably not managing it well. Having key performance indicators and reliable data that allows us to plan and deliver services and resource services is crucial to providing an array of options and solutions. They are the opening comments that I wanted to make.

Dr G.G. JACOBS: Phil, thank you and everyone for coming. You mentioned the issue of support for child health and school nurses. You would be aware of the findings in the Auditor General's November 2010 report, "Universal Child Health Checks". One of the findings/recommendations was that many child health nurses do not have access to adequate information technology and that nurses can spend considerable time on clerical tasks instead of checking children. To better support child health and school nurses so that they can reach more children, Health should ensure adequate IT support for child health and school nurses; review its approach to administrative tasks such as booking appointments and collating data, which you touched on, to free up nurses and deliver services; and review its management of child health facilities to coordinate leasing and maintenance. How is this being addressed; and, if it is not being addressed, what are the barriers?

Mr Aylward: We have initiated our own change to processes. We have a very good information system in child development service areas where we get a very transparent and complete view of performance activity and wait times and where we are at across the various centres that provide services. We are, as a measure, implementing a change to that system and modifying it to suit community and child health services. We are hoping to roll out that system, initially in the metropolitan area, in probably the second quarter of the next calendar year.

Mr Morrissey: It is commencing in February and we hope to have it finalised and in place by the end of this coming financial year. We are confident that we can deliver on that.

The CHAIRMAN: What will the changes look like?

Mr Aylward: For the first time, it will allow a comprehensive waitlist, to the extent that we want to have a waitlist. Obviously we want to have a program that allows access to the various checks for child health services to occur at the right times. It will provide transparency and openness around the workload across the various child health nurses and school health and community health

nursing. It will also provide patient-related data, so it will have meaningful information that means that if a child, parent or family were to move locations, the record would go with them. Obviously we have a very good system currently. One of the good things in WA is the booklet that parents and carers keep, but this new system will allow that information to be tracked electronically and to be passed across the health system. There are probably a whole range of other tools that will allow better scheduling and allow us to look at where the workload is and to harmonise and shift resources to where the greatest workload is in a better way than is being done at the moment.

Mr P. ABETZ: Does that mean that each child health nurse will have their own laptop to facilitate that? How is it happening on the ground?

Mr Aylward: We are trialling a few mobile devices at the moment.

Mr P. ABETZ: The iPad is probably the new thing now.

Mr Aylward: Yes, and there are a lot of different tablets such as Android software tablets that we are trialling. That will enable access to even the basic things that the Auditor General and Graham mentioned such as emails and that type of basic communication. A lot of our staff are not fixed in bases; they are highly mobile. They need to be mobile because they are doing home visits and may be covering several clinics. Taking information with them via electronic means will be a crucial part of our solution, and we certainly are gearing up for that. To the extent that it is well covered at the moment, we have devices, probably predominantly—Mark would know—that are fixed desktop machines, but we certainly are looking at using, if not wireless, certainly the 3G network to access information. I think we will see a very rapid uptake on that technology, which we are self-initiating.

Mr P. ABETZ: Hopefully that will create more child contact time for the nurses. Is that the aim?

Mr Aylward: Indeed.

The CHAIRMAN: If we have the nurses there. Now would be a good time to come back to some of the questions that we put to you because we do need the workforce. It is lovely that we will have all this new IT, but the questions that we asked, included the total number of FTE child nurses. You have given us the numbers for 2008, 2009, 2010 and 2011, which show no change in the number of FTEs or in the ratio. The next question we asked you was about referrals. Where are the referrals? I cannot see on here the figures for the referrals for each of those universal visits.

Mr Aylward: I just want to finish. Yes, it will create more patient contact time because our staff do spend an inordinate amount of time running around and returning phone calls. Improvement in communications systems will help improve access. Certainly, as Janet said, the total uplift in FTEs, as you can see, has been fairly static across the state.

The CHAIRMAN: For the past 13 years.

Mr Aylward: Certainly the figures we have provided go back to 2008, so it is a good number of years.

The CHAIRMAN: How many years before that have there been no increases in child health nurses and school health nurses?

Mr Morrissey: The records do not give us a solid response. We have tried to establish a baseline but the systems were quite spread out and different.

The CHAIRMAN: From the all the reports of child health nurses, community health nurses and school health nurses, they have told committee members that it looks like there has been no increase in those the numbers for over a decade.

Mr Aylward: I do not think there has been has been any material uplift in this space for some time.

The CHAIRMAN: There has not been any increase in the numbers but there has been a big increase in population growth. If we go back to this, let us look at the role. If you do not mind, Ian and Kate, we will look at the metropolitan area first, and then you can maybe run through the

answers given to the questions we ask about the metropolitan area from your perspective. We will focus first on the greater metropolitan area. Let us start with the universal health visits. Thank you for supplying us with a copy of the book that you give to young mums. I think it is wonderful. I have looked at what the other states do. It is a very good book. We were told by the community child health nurses that when a mother comes in for an appointment, if a child is referred to someone, they keep something in their book plus the nurse sends something off to the health department. I do not know, Phillip, whether you are at too senior a level to tell me where that goes. I might need to ask Mark. When they fill in those forms, where do they go?

Mr Morrissey: I am not quite sure what they are alluding to. The referral form would go to the relevant non-government or government professional. The other form they might be referring to is that the visit is recorded on an H-Care form, which is an existing database that we are replacing, and that is sent to the Department of Health to collate into the statistics.

The CHAIRMAN: In which case, we have asked you for a copy of those stats for universal health care visits. Have you brought them with you today?

Mr Morrissey: The reason we are moving towards the CDUS expansion for child health is that H-Care is measuring and looking at a model of care that we have moved on from in the last 10 or 20 years. We are delivering a much more up-to-date service. In many ways, what we do now does not reflect what we did when that form was initially established. We are using CDUS as a way of reforming the delivery of service. When people are inputting the data, they are also getting a guide to best practice. The Auditor General made some comments around adequate supervision for nurses. This system will also drive higher-quality practice based on some of the best practice nationally as well as overseas. That is the reason.

The CHAIRMAN: I think that is wonderful. It is great that you are moving to a new system that will incorporate all those additional things. However, at the moment, H-Care is where the data is being collected. Are you willing to provide us with copies of the information that has come to the Department of Health through H-Care? We do not want to create more work for you, but we would like to see from each of those universal visits what is coming out of those visits. If you do not have the staff to collate that, we are quite happy to do that. We are happy to get the raw data from you and, over the next few months, look at analysing that data, because we want a baseline. We would like to baseline in 2008. We think it is great that you are moving in this area, but are you happy to provide that H-Care data to us?

Mr Aylward: Are you are seeking the source referral for every referral? Is that what you are contemplating?

The CHAIRMAN: We want to know for each of those universal visits who is being referred for what. What is going on at those universal visits? We also asked you the other day—I am not sure if this will be recorded in H-Care because, again, it is a practical issue; we are focusing initially on child health nurses—when a nurse sees a mother with a young child, does the two-week, six-week or 12-month visit go into H-Care? We want to know how many mothers—we asked you for that information, and you could tell me that it is in here, in which case I can have a look—but we want to know that if 2 000 babies were born in 2008, how many of those babies in 2009 got their universal visits in the first year; how many in 2010 got their universal visits in the second year; and how many in 2011 got their universal visits in the third year.

[10:43 am]

Mr Aylward: In the document we have tabled today, there is an attachment, refer page 13 and 15, which breaks up between metropolitan and country health services for all referrals that are being initiated and captured in the H-Care system and that breaking down by the categories that are contained. We can see where the referral has gone to. It is quite a comprehensive list.

The CHAIRMAN: Lovely; that is wonderful. That is brilliant. Thank you so much for that. But in addition to that, then—you have given a total of 217 referrals—we also want to know how many children attended the zero to 10-day visit. How many children were seen at that six to eight-week visit? How many children were seen by nurses at the three to four-months, the eight-month and the 18-month and the 3 to 3.5 years? This is great for referrals, but it does not give us the number of children.

Mr Aylward: We can provide the count.

Mr Morrissey: We would have to do a manual count, or we could try. If we put the data in —

Mr Aylward: Is that just for attendees, though, Mark?

The CHAIRMAN: So we are up to 2011 now. If we went back, say, to 2006, so we then would get for 2008, how many children went for their three-year visit? Then 2009 we would be able to get the three year visit. We will just make it for the term of this current government. If you want to take it earlier, back another year, we do not mind, but we need to know how many children are getting each of these token universal visits.

Mr Aylward: To the extent that it is captured in the current information system, which is H-Care, we can provide that to you. If it requires a manual count, then it is probably going to exceed the resources available. I would suggest for all of us —

The CHAIRMAN: If it is not in H-Care, where else would it be?

Mr Aylward: From my point of view, with all the challenges that H-Care is, it is the source of truth for us in terms of data and information. If it is not in H-Care, then it has not been done.

The CHAIRMAN: But within H-Care, do you know that there were last year 1 000 births? Does H-Care record that?

Mr Morrissey: If I may, as I indicated probably earlier, we are moving to a new and a better system because we believe there are some flaws in H-Care. We are really keen to get reliable data. If we put it in, it would be with a clause that there might be some movement in.

Mr Aylward: So the birth notifications as such, we can go to that data source to identify the births, and then we can match it, subject to it being available to the first checks across the spectrum, the 0 to 10 days.

The CHAIRMAN: To each check—each universal check that it matched.

Mr Aylward: That is looking at those intervals. We will need to come back to you and find out whether it is there for each of those intervals. If it is, if it can be aggregated, I am very happy to provide it to the committee.

Mr Morrissey: Kate is probably much more of an expert on this than me. She might have a comment.

Mrs Gatti: H-Care is a fairly old system, but basically it is an occasions-of-service accounting system; it counts occasions of service. It has been built on over time. You can register or not register clients, which means that you tie your occasions of service back to a client if the client is registered; that is, you have identified the patient-identifying details. In country, we do do that. We can, hypothetically, tie the occasion of service or the event back to a patient. In metropolitan Perth, as I understand it, they do not. They register the occasion of service. So you might have a universal check—say the 0 to 10 check, for argument's sake—and they might do a three-year-old check and they might see some developmental delay, and they refer to speech and they refer to hearing. This is where H-Care starts letting you down. There are two referrals there, but H-Care in its data source will let you put you in the two but will not pull out that data. It is a primitive system. The reason for the hesitation, I think, by my colleagues is that data is put in. We certainly struggle to get the data out. In country we can more easily bring out occasions of service to a particular event, so we can

more easily identify that. Having said that, running those reports centrally—we asked the Department of Health, with a set of business rules, these are the codes against which we want them to pull the data for these reports for this response—they are pulling the data locally because there is all sorts of little databases all around the country. There were discrepancies that are of concern. We do have some issues in trying to explain that.

The CHAIRMAN: So, Kate, in these documents here now then, do we have for each of the universal visits from H-Care, that 70 per cent of the children born in 2008 had their —

Dr G.G. JACOBS: What about table 1 on page 4?

Mrs Gatti: As Philip mentioned, the denominator we are using is the births from the birth notification register. The numerator that we are using for this is out of the H-Care system, which is an occasions of service module. Against a code, which is the 0 to 10 days or the three-year-old check, we run the occasions of service, and then we marry it up to the denominator to get the percentage, which is presented.

The CHAIRMAN: If we look at table 4 then, all these percentages, for how many —

Mr P. ABETZ: It is table 1 actually.

The CHAIRMAN: Table 1; well done. What was the population that this is done from?

Mr P. ABETZ: It is a percentage. It is Perth metro.

Dr G.G. JACOBS: It is the total cohort of newborn children.

Mr Morrissey: Birth notifications.

The CHAIRMAN: All the birth notices. When was this one? This was —

Mr Aylward: It was 2009–10

The CHAIRMAN: So 2009–10 it was 46. So we actually asked for those figures for 2007–08, 2008–09, 2009–10 and 2010–11. Thank you so much, because this is what we were after from you. Can we have similar statistics given to us for each of those other years as well, so we are able to see which checks have been given? From what we are hearing from community health nurses, the 18-month and the three-year-old check are the ones that have gone down over the last few years. They have been advised. They are telling mothers, because certainly I have heard it personally that mothers are being told that they cannot book in the 18-month check because they have so many younger children they are having to see. Are you happy to provide us then with —

Mr Aylward: If it is available for that period of time, certainly we are happy to provide it.

The CHAIRMAN: If it is available?

Mr Aylward: Yes. We need to go back to make sure the data is preserved from prior years, to make sure that it has been properly archived and what we need to do to pull that information out. My hesitancy is that it is not as robust as our hospital-based information system, but certainly if it is there, I am very happy to provide that. Kate, do you have anything further?

Mrs Gatti: Yes, I have another comment on this one. I am assuming that the reason why just this data set is being produced is because metropolitan Perth went through a project to amalgamate their H-Care databases. This has been pulled from cache To do as you request—and again the integrity of the data I think is questionable—we need to go to the Department of Health with a scope of what codes we would like to pull against. It is against a number of different databases across the state.

The CHAIRMAN: This data is the data was presented in the Auditor General's report. I recognise those figures from the Auditor General's report, so that pullout has been done. How that pullout needs to be done —

Mrs Gatti: This is from the dataset that has been amalgamated in metropolitan Perth.

The CHAIRMAN: Sorry?

Mr Aylward: This is metropolitan Perth data. It was done in specific at that project time. While the Auditor General did ask for trend related information, and as is part of, I guess, their direct and implied critique, is that we were not able to provide all that information that they wanted to see the trend. Look, we will go back and we will see. There is no reluctance for us not to, because it does, I guess, paint a picture. We just need to make sure that it is possible. The other thing, as the committee would know, these are voluntary checks as well. Parents do make choices about whether they attend. There is no compulsion for them to attend. Obviously encouragement is made. Our priority, as you know, we have stated. While all the checks are important, we focus on the first check. We see that as a really important sort of opportunity to establish some rapport with parents and carers. That is achieved in most of the cases. Then, I guess, the school entry check and assessment is another opportunity, nearly a captured place, if you like, when kids need to come to school, so we actually have a high success rate around there.

In relation to the other checks, we do encourage everybody where they want to try to make an appointment. Sometimes it may not fit in directly at the milestone.

The CHAIRMAN: That is not what we are hearing. We are hearing that the community health nurses have been told, because they are in short supply, that they had to prioritise now the universal health checks in the first year. Are you saying that that is not the message that has gone out from the health department?

Mr Aylward: We certainly do not discourage. There is no policy not to accept those checks where a parent or a carer wants to have those checks, but we do say that we are focusing on prioritising on those other two checks at the moment, because of, obviously, demand and resources. The process might be—Mark might have a better idea —

The CHAIRMAN: Are you aware that parents are being told that they cannot do those 18-month checks?

Mr Morrissey: With the nurses, speaking for metro, we encourage them to prioritise on their clinical decision making. I think the evidence and a good clinician is going to focus on the younger child. That is the message. No message has ever been given—and we have clarified this before—not to see older children. There are a number of nurses in the clinics. They are all busy, but the quieter of the busy clinics, they do see. As you can see, there is activity in those other groups. I have been very clear many times that we do what we possibly can and do not avoid or stop seeing other children and just focus on this earlier cohort.

The CHAIRMAN: We actually think that your nurses and your department do a good job, but we know that you can only do a job according to how much funding that you get, which is why we need these statistics so that we can go in and bat for you to get some more money so that we will have more nurses. We have heard that some child health nurses in some areas get 40 or 50 child notifications in a week. If they are getting 40 or 50 child birth notifications, it is going to be very hard for those nurses to do their first visits plus all of these other visits if we do not get more nurses on board. That is why we need these statistics from you so that we can make sure that the government is aware. Because I am being told by the child health nurses that they are being told to do the visits in the first year. Are you aware that South Australia is now focusing on the 18-month check and that the commonwealth is now looking to move the four-year-old check to a three-year-old check? If we come back to you, maybe you could tell us how you see the role of the community child health nurse and value that role and maybe then just discuss those later checks.

Mr Aylward: I guess the great strength with the system we have in Western Australia is that we have a system and a great network of nurses that provide evidence-based and certainly well-articulated policy-led checks, because we believe they make a difference. The evidence and the professional advice is that they make a difference on the trajectory of the kids who are seen. We do

know that not every parent comes to us. They have other choices and they choose to exercise those choices. Sometimes it is purely because of their experience with previous children that they feel more confident in their parenting skills or the particular issues that present or they use other places to get access to services, whether it be GPs or other non-government organisations to get that reassurance and checks. We see these checks as the cornerstone, because it allows us to identify children, families who might need the services. Sometimes it can be a simple bit of information, a bit of support, to a full referral. You can see the comprehensiveness of what community and child health nurses refer children to. It is quite comprehensive, when you look and you think, "Wow, there's a lot of activity that goes into that space." A lot of knowledge that our nurses put into this in getting the referrals for children as early as they can." In relation to other states, there is variability in some of the other states. I know my colleagues Mark and Kate are probably best qualified because they mix amongst that on a fairly regular basis. There are similarities across the states. Whether there are 10 checks or seven checks or some other number, there are similarities. The commonwealth government, you quite rightly said, is putting a special emphasis around this and encouraging the checks to be done and linking that, I think. Are they linking to child benefits at all?

[11.00 am]

Mr Morrissey: For some parents, as you know, they link in this check to receiving the benefit on an ongoing basis. But it is quite a narrow band of parents.

The CHAIRMAN: We heard over east that the federal government is now looking to move the four-year-old check to a three-year-old check because they believe that the four-year-old check is too late. That is why, when we look at this table, which shows that only nine per cent of children receive that three-year-old health check, we are way behind the eight ball. Mark, thank you for that. Would you like to expand on why they are called universal checks?

Mr Morrissey: That is a good question. There is some really strong evidence—you have probably come across it already—that it is important to screen or check a whole population. If you move away from that universal, there is good evidence that the population, over a generation or two, will get sicker. So our premise is that we endeavour to see as many children as possible, or all children, in those first years of life to identify any issues that need addressing in those milestones. Those checks, I guess, are targeted at particular issues that might emerge. The first home check is looking at specific things—risk and a whole range of things that we have already provided information on and so forth. We believe they are critical. But the check in itself is not a therapy; it is just a screen. You can often focus on the checks but not realise the vast amount of work that then goes into the referral, the treatments, the interventions, screening for postnatal depression, developmental delay, speech pathology problems, autism and a whole range of things. As Philip said, there is so much that actually passes through and is picked up in this space. You could have several pages of issues that would be picked up. I think that is a critical reason that we do the checks.

The CHAIRMAN: Could I ask you to expand on that? We are hearing from both child health nurses and general practitioners that it is not just the check and the identification to speech therapy or physiotherapy; it is building the relationship and linking those families with MOPS or family day care. Could you expand on that, not just that they are behind on this and need a referral to speech or whomever, but the role that that community child health nurse plays in both the family and parents integrating within the community?

Mr Morrissey: Just one example of many is the new mother groups. They are often the first contact that mothers actually connect into their local community. Often they establish those networks, as some people around the table might be aware, which they maintain sometimes for life. But they also establish that therapeutic community of friends. They also connect it into a whole range of other things. It is not just focusing on dealing with problems; it helps build upon the strengths already. A healthy family can benefit greatly from going to a child health nurse and getting their existing strengths built on. There is a whole range of, as you alluded to, positive spin-offs from that. I guess

it is a therapeutic relationship with the child health nurse. They are highly valued in the community, as those of us sitting on this side of the table know. We get lots of feedback from community members around how they value their local child health nurse. They like them kept where they have always been. The range of services they provide are extensive. They provide programs to help children deal with obesity. There is PPP, which is positive parenting, which you have all heard of. There is the postnatal referral and treatment. There are playgroups and there are support groups. Mothers and fathers sometimes identify issues in a local community, and the nurse will be the conduit facilitator to make that happen positively.

The CHAIRMAN: So what would you say to a comment from someone who says, "It doesn't really matter if a parent doesn't see a child health nurse. If they're concerned about their child, they'll go and see a GP"?

Mr Aylward: I think that, again, the benefit we have in WA and Australia is that there is that choice that parents can exercise. From our perspective, the universal net needs to capture everybody. People might choose to go to another provider, which might be very adequate and quite appropriate in the circumstance, because we know that GP practices and services of that type, and even NGO providers, across the state do provide and are providing more and more comprehensive services and look at the family holistically.

The CHAIRMAN: Do you think they provide an equivalent service to your community child health nurses?

Mr Aylward: There might be similarities, but there are issues with GP practices around access as well. There are sometimes co-payments and the like that need to be made. That can be a factor and an inhibitor. Also, we have to look at the shortage of GPs that we have in Australia and their accessibility. Certainly, I know my colleagues in the country can speak about that at length. But we know that there are pockets in the metropolitan area where access is quite problematical. An experienced, well-trained community child health nurse, I think, can address, and we need to create the time for them to address, and help new and existing parents or carers to navigate through the system and obviously undertake some of that checking work that needs to be done, as Mark has alluded to. It is case finding and they refer on, but they also often can provide another link to follow up with that family if they are not progressing their referral. So it is complementary; it is not replacement. And there is a role for both.

The CHAIRMAN: Do members have any more questions about the metropolitan child health nurses? Then we will look at metropolitan school health nurses. We might finish off child health nurses and then go to country.

Mrs Gatti: Can I just add a comment? As a child health nurse, child health nurses are trained in primary health care. They tend to provide a paradigm of a wellness model. They are complementary, particularly to the medical model and GPs in that they seek to maintain wellness. They work on a strengths model. They identify and refer potentially deficit and weakness to the non-government and GP sectors. It is not an either/or. I think it is a complementary service. Child health nurses generally are community-based and have the capacity to work more holistically with the family in that support-type model other than GPs. Again I think it is a support model.

The CHAIRMAN: I think it is a support model to GPs, the same as it is for referrals to speech therapists or physiotherapists. I think the child health nurse would refer to a general practitioner when she sees that there is a problem with the child or within the family.

Dr G.G. JACOBS: Can I just ask three questions in and around table 1 about the service indicator? Obviously, we cannot get to all newborns in 10 days; we sort of can after 21 days. I would like your comment about that. Is that because we have got issues of resource? Generally, in Esperance, the child health nurse actually does a visit within the first 10 days. So obviously this is not happening here. The other thing is that what obviously sticks out in these statistics is the three-year-old health

check, and I would like you to comment about that. What do you think is the reason for that? If a girl takes her baby to the GP, what are the follow-up issues within the child health system? The child health nurse in Esperance needs to know that a woman did not take her baby for the six-week check because she took her to the GP. How does she actually know that and what systems do we have for follow-up to make sure that that has been done at least by someone?

Mr Aylward: They are all good questions and we will try to share them around, because I will speak only in generalities. It is a combination of system delays in getting notifications out. They are sent as quickly as possible, but it might be the next day. Remember, this target is from day zero—that is, from date of birth. In a large dispersed community, they need to be sent out and eventually get to a child health nurse. Then there would be attempts to get hold of that parent, and we have to find a time when they are available and we are available. We would like to see it happen quicker. There are probably some resource issues. I think Janet has alluded to that. There are periods in the year when you do get bombarded with a number of notifications in that zone or at that particular child health clinic, but it is under constant monitoring. Certainly, when we have our whole-of-metro system in place, it will become very much a key performance indicator for us to try to bring that down close to 10 days. The further it is away—even though we have a good capture rate at 21 days, as you can see—the more it creates the opportunity for slight separation to occur when we do not want that to happen; we want at least that initial contact and the ability of somebody to provide that support immediately or at least be a resource. I think we have canvassed some of that in terms of where we sit with our priorities. The feedback I have had from community health nurses and other people says that at that stage some parents are more confident and unless there is a specific issue that is ongoing—a child might be at risk or dealing with a chronic illness—as you can see clearly here, it tapers off after four months and eight months and it falls away very quickly from there and it is not picked up until we —

Dr G.G. JACOBS: Get it before school.

Mr Aylward: Yes, before school. I do not know whether Mark or Kate want to comment about the three-year-old check if there are other factors.

Mrs Gatti: Yes, I am happy to. On the nought to 10 day, the definition and policy around that is a home visit, so the data pulls up home visit only. What it is not necessarily showing, because of the definition, in care around this is the nought to 10 day contact—that is, was it a phone call because they live on the other side of the rabbit proof fence and you have gone through a series of questions? What the data may not be picking up is whether the mother said, "Look, I'll be in town to do my shopping anyway. I'll catch up with you at the clinic or the hospital." That will explain some of the nought to 10 day. Also, from a country perspective—this is an issue for us and it is an inward referral, so it is our discharging hospital referral system that we are trying to tidy up—as you in country well know, people may stay with parents or others in Perth. A third of country babies are delivered in Perth, and they are not turning up back home within the 10 days. That explains some of it, and only some of it. With the three-year-olds, as you know, many children are enrolling in kindergarten. They are three and a half to four-year-olds, so many parents are anecdotally saying to me that they know they are going to get a three and a half or four-year-old check—you can see that our rate is quite good—so they are skipping the three-year-old check, and it is in part due to the earlier kindy enrolment. Having said that, there is a risk around that in that the kids who tend to enrol in kindy are not the at-risk kids we necessarily would like to see. I again caution that, but it is what is happening in part.

[11.15 am]

Mr Aylward: Finally, the information system bid—that connectivity—is a very vexed one. I guess it can be better solved in smaller local communities. I would hope that the universal medical record—the patient-controlled clinical record—will assist and maybe overcome that to allow information to be transferred more readily and more automatedly, but in terms of referral of

information back, I am not aware of any comprehensive connectivity back from GPs to our child health nurses, other than maybe a child at risk.

Dr G.G. JACOBS: Other than filling out the book.

Mr Aylward: Yes.

Mrs Gatti: GPs do fill out the book, and there are two —

Dr G.G. JACOBS: Yes, but how does the nurse know that the GP has done that check and actually filled out the book until they turn up again?

Mr Aylward: I suspect, unless it is a child or a family that might be seen with a complex care need or a complex issue that it is at risk, it would only happen, I think, if the GP or the practice manager or somebody in the practice rang up the child health nurse or sent a message through that way. So you are right; it is very much reliant upon personal initiation, not a system routine sort of feedback loop.

Mrs Gatti: And the checks are slightly different, so if they double that, that is a bonus. As you have indicated, the risk is that neither happens.

Mr Morrissey: With the new database that we are setting up, we plan to have a trigger. If we refer out to a GP and we have not heard back, we are looking at systems to follow that up and actually see whether it actually has been followed through. And, as Philip said, we do have a fairly, I guess, tight process. If any children are identified at risk, we do follow them through. We will ring up; we will drive around to their house; we will make sure that they do not slip through the gaps. And I think that is the risk assessment you make with the family on that first visit.

Mr P. ABETZ: One of the things that strikes me is that there have been a number of inquiries over time that have all indicated that there should be more child health nurses in the system. You seem to be getting reasonable rates, but what sort of numbers would you need to really optimise the capacity to follow up? Obviously, if you had thousands of them, you could pursue one person, but you have got to have a cost–benefit type of thing. What sorts of numbers do you think you would need to really get it up to the optimum?

Mr Aylward: I guess we have been having dialogue with government around this for a little while, and the government has indicated that in this term of government they are prepared to start a process of rectifying maybe some of the resource constraints that we are looking at. We are looking at being very much outcome focused, so focusing on the rates, and it could be that we will look at different ways of delivering that, whether it is straight FTE numbers, extra nurses, or there may be some other providers. I know, particularly in remote areas, or even in our own metropolitan area, there is an array of other providers that we would look at to actually deliver those services and be accessible. Our mind is very open on not coming up with a strict, "Well, we need 20 FTEs." What we need is these rates to change. We need to actually hit the targets on those rates, and if we say this is important, then we should actually be working towards hitting them, and the feedback we have had from within the health department likes that: "Yes, we support that", and we need to put a proposition to get that nailed.

Mr P. ABETZ: And what is the capacity to actually fill vacancies? Is there a problem with actually being able to recruit the staff you need?

Mr Aylward: Look, I speak for the metropolitan area. I know country has some —

Mr Smith: It is variable. Some towns are obviously far more attractive work environments than others, so we will have our peaks and troughs, and I think that is what Philip is alluding to. In the country, we have to take very much a partnership approach, and we have got to be really sensible about working with the other providers in those areas to support them, whether they are able to do elements of the service or all of the service. It would be crazy for us in some of the remote Aboriginal communities that are being serviced by the community-controlled health providers not

to be using them to the absolute maximum we can in this area. But the state is too big to give you a simple answer about whether we can get staff.

Mr P. ABETZ: Yes. But overall there is not a desperate shortage so that you cannot fill vacancies?

Mr Aylward: I think there is overall some significant workforce challenges facing us in our nursing and other clinical workforce issues, just purely looking at the average age and the like, though I suspect that people's mindsets about when they can retire are changing dynamically as the weeks go on, and particularly with the economic situations. They are very real things. So I think we will see, which is great, a workforce that is prolonged a little bit more into the future than what we thought of before. Can I say that in terms of the partnering with other groups, we found in the child development space that there were going to be challenges for us to get staff—speech pathologists, occupational physios, occupational therapists—a real, significant challenge for it to be public sector, or we would be robbing from one part of the business to service another part, and then all you get is a waiting list or denial of services elsewhere because of lack of workforce. Our paradigm has changed quite a bit. We have been very impressed that there are providers out there—NGOs and the like—that are able to gear up and move quickly into this space to provide the level of service that is appropriate from a quality and safety point of view that allows access. So in this space we are very open to talking to a range of providers that work in child health, or even work in a different model, and certainly Ian has spoken of the already existing community control groups, but there are a group of others that we are going to be very interested to talk to.

Mr P. ABETZ: One other question I have is: the percentage figures are great. Obviously, we need to track that. But our inquiry is focusing on educational outcomes for all Australians. My wife and I had five kids. If the child nurse was not available, we would have gone to the doctor because that is the kind of people that we are. In terms of improving educational outcomes, it would seem to me that, for want of a better term, the lower socioeconomic, less educated people who do not pick up on health things as well would really need to be a top priority if we are to lift educational outcomes.

Mr Aylward: Indeed.

Mr P. ABETZ: To what extent is that reflected in the work that child care nurses do? Often they are the harder ones to track down. One of my concerns with KPIs is that it is easier for a child care nurse to boost her figures by going to the nice people who are easy to track down because they have got a phone and they live in a house and all that sort of stuff, whereas if she actually pursues the ones who desperately need it, where there would be the maximum benefit for educational outcomes, her KPIs would be way down: "Why have you done only 30 visits instead of 100 this month?"—that type of thing. How do we work around that?

Mr Aylward: Peter, that is a very, very good question. The complexity of cases will vary across all our sectors, all our places, depending on the intensity of the work and the efforts needed. We have got really good examples, though, and models that work well in WA, where we have focused our efforts on providing solutions, first, for a population group. So there is some partnership work that we do at the moment with schools, and I do not know whether it is published yet, but there are some really impressive results where school outcomes—and I think education is probably the best place to talk about those—have been greatly changed over a short period of time with intervention that has been both educational and health and wellbeing–type interventions. I believe you have to follow that lead—early intervention, change of trajectory will maximise your potential to change outcomes for children, and I think there are some really good examples, and examples that we will continue to work on with the Department of Education on an ongoing basis. So that is some of the really exciting stuff.

Mr P. ABETZ: So how can we help? What suggestions do you have? Auditor Generals do KPIs and all this; and KPIs, while they are necessary, often can have an opposite effect to what we are actually trying to achieve. How can we prevent that from happening in the child health work?

Mr Aylward: I guess we have got to try to have some of those other measures. It is not just the grossed-up measure of a rate; we need to have some other measures. We also look after—really, Health has got a really good relationship, and a formal relationship, with the Department for Child Protection now for children in care. I know that the Ombudsman has made some comments in a recent report released, I think it was, yesterday or the day before. So we will have a focus upon children who are high risk—definitely high risk—and I know that is the focus in remote communities as well about closing the gap; you hear that terminology around closing the gap. So we have got to not chase the headline indicators. It is important. We have to be able to interpret this for government and the community to accept that they are getting value for money by something that might take four times the time to sort through and resolve, rather than one time. I know that we do not want to deal with too many anecdotes, but it is a bit like when you speak to community health nurses. You get a message on the phone and somebody wants to change an appointment. As this nurse explained to me, it is never about changing an appointment; it is about a whole range of things that are happening in their lives, whether it be domestic violence or other aspects that they are seeking support and encouragement and advice on. So I agree with you. We do have to guard against just the sole pursuit of, say, some headline measures. Equally, the flipside is that we have to come up with those measures that—would you agree, Ian—need to be balanced, not just straight workload measures.

Mr Smith: I would be devastated—I am looking at this figure—the 94 per cent at six to eight weeks—if that same six per cent goes the whole way down, so that at the end of the A4 for school entry, if that person has had no contact whatsoever, that is the problem we have got. I am reassured from the discussions with Kate and others that our staff are getting the at-risk people, so it is not a constant run through, because we do the same thing, and that is what scares us as well.

Mr Morrissey: In regard to educational outcomes, there is some very good emerging evidence, and Philip alluded to whether it is published or not. There is stuff out there, but there will be some new stuff coming out of WA that shows that if you get a child in their first year at school—before that, if you have got the health experts working with the child health nurse, the speech pathologist, and whoever else, their educational outcomes at 12 months in the school will be so much greater than kids without that pre-loading with what Health does. I think that is a dawning reality.

Mr Aylward: So it is definitely worth investing in this space and maintaining our effort as well. We also need to look at issues around mental health and intervention around child and adolescent mental health. To make a difference in that space is really crucial in the early years as well.

Ms L.L. BAKER: Very quickly—and you might not be able to help me with this—I have been speaking to people involved in dental health, particularly with the little ones when they are growing their teeth and arriving at kindy and preschool and all that kind of stuff. In the new and emerging communities, I am hearing some dreadful reports about babies who have had a very poor upbringing in Somalia or wherever, and arrive here with dreadful teeth problems. Do you have any involvement in the dental care?

Mr Aylward: We do. We have involvement in a couple of areas. At child health level there is a program—I think it is called the Lift the Lip program—so that is part of the universal checks as well.

Ms L.L. BAKER: Do you have interpreters to help? The dentists I have spoken to have been really stressed because they get these kids, and their parents do not —

Mr Aylward: It is not only children from CALD backgrounds; it is a significant issue for all of us. But the answer for interpreters, I can speak from our place. We have moved into quite a comprehensive service model now, which requires professional interpreters, but I cannot speak for dental health services. Both Ian and I do not run dental health. We do see at Princess Margaret Hospital the consequences of poor oral health, and it is a matter of attention that we are placed on it, because we do see children in circumstances that they should not be.

Ms L.L. BAKER: Is there a gap there then—sorry to interrupt—and something that the committee might think about?

Mr Aylward: I think there is a lot more that should and needs to be done in this space. The health department is aware of what needs to be done, and that is again part of a conversation that Health will have with government over the next couple of months to deal with it, because, again, for us it is a truism; it is early intervention in both a preventative sense and a public health sense.

[11.30 am]

Good, healthy messages, whether it be on obesity or good oral hygiene, are constant and do not change and should not change. However, intervention, whether it be through dentists and dental therapists, is necessary. Ian and I were having a chat beforehand and saying that particularly for the country, the mantra is about looking at the whole child and the whole family to provide solutions for all their healthcare needs where we can.

Mr Smith: Country has an advantage, because often everyone knows everyone in the town as well, so some of the formality that may be required in the metro is not required so much in the country, because there is more than one person watching out for families and there is much better connectivity around the families. So there are some benefits to living in the country.

The CHAIRMAN: I think, members, that we might keep our questions to community child health nurses and have another hearing for the school health nurses, because we are almost out of time, and we have not managed to get to many of the questions.

I want to come back to a statistic. Thank you very much for the information that you have given us on page 1 in terms of the number of child health nurses in 2008, 2009, 2010 and 2011. I believe that in the eastern states, they have a ratio—I believe they call them maternal child health nurses rather than community child health nurses—of one FTE maternal child health nurse to 70 to 100 new birth notifications. I believe the UK has a ratio—they call them health visitor—of one FTE health visitor to 87 birth notifications. We have here—thank you very much—the number for 2008, of 211 child health nurses. We know that in 2008, from the plan that was given to the government, that we need 105 child health nurses. I have been given some statistics in WA of one full-time equivalent child health nurse to 230 new birth notifications. I am not sure if that was based on the 2008 statistics or the current statistics. Could you provide us with the figures for 2009, 2010 and 2011? In 2008, it was 196 community child health nurses. If we were putting this in a table, the next column would be number required, and in 2008, it was 105. Could you fill out then, in that table, how many were required in 2009, 2010 and 2011? Could you then, in the next column of that table, give us the population for 2008, 2009, 2010 and 2011?

Mr Aylward: The birth population?

The CHAIRMAN: Yes, the birth population. It is the birth population that then gives us the one FTE to 230, which is the figure for WA, versus the one FTE to 17 in the eastern states, and the one FTE to 87 in the UK. We need to be able to see the population and the ratio. So, if we have 196 for 2008, and we have the population, we would have a figure for what that ratio would have been in 2008. We know that 105 are required, so we would be able to say that in 2008, the goal for the ratio would have been to have one FTE to whatever. So we would have the ratio for 2008 and what the goal ratio would have been with the additional 105 nurses.

Mr Aylward: Yes, using the eastern states reference.

The CHAIRMAN: We do not need to compare it with the eastern states, because we can look ourselves. We need to know for WA, that for 2008, the number of children born was maybe 2 000, and there were 196 nurses, so the ratio of child health nurses to babies was this. We know from the plan that was given to the government that there was a request for 105 additional child health nurses. That would have brought that ratio down in the next column. Then we can look at that ratio

in 2008, with the growth in births over the last few years, and see what has happened with that ratio for the child health nurses and also for the school health nurses. Ian, you wanted to add something?

Mr Smith: Can we separate that between country and metro? If we do not, the numbers will be skewed, because so many of our nurses have to do far more travelling. That would be a more pure model. Also, if you are going to compare WA with the eastern states, I do not know what the roles and responsibilities are of the maternal child nurses, to make sure they are similar, because they could be vastly different, and they might be doing only a portion of the job, which is why their ratio is higher. For country, I would rather see that shown completely separately.

The CHAIRMAN: Yes, it would be lovely if you could present it in the table. It may well be that your community child health nurses are more multi-skilled.

Mr Smith: It is certainly different.

The CHAIRMAN: We would appreciate any additional information that you can give us.

Mr Smith: I would be expecting the Aboriginal health workers in some of the communities to be participating in that process and being part of that multidisciplinary team across providers. So just using numbers will not work for the country, but I think you want a pure model for the metro.

Mr Aylward: That is a part of what I mentioned before to the committee; namely, that the models going forward may not all be related to those that have been used in the past in relation to it is all going to be child health nurses. I know definitely that it will not be. Ian certainly is going to use a different mix of staff as well. So we will have to look at that as well.

The CHAIRMAN: I accept that you are looking at other models, but I hope that you are not going to deskill this area, because I think that with those child health nurses and those visits, each visit gives an opportunity for the child health nurse to further develop their relationship with that family. So just tendering for one-year visits or 18-month appointments or three-year appointments is not looking at the whole family.

Mr Aylward: I think nothing could be further from the truth. I think it is about streaming and looking at the model of care. When we look at admin work, admin work can be resolved by better information systems or additional admin support. There may be tasks within the workforce that can be appropriately done, under good supervision, by another level of worker, whether it be a beginning practitioner or an enrolled nurse. We need to be open to the idea. But the principle that the committee is espousing is that we need to make sure that it remains comprehensive, that it is a highly skilled workforce and that it is done in a safe and appropriate manner. We would definitely agree with that. We would not contemplate a health check “light” or a health check “inadequate”. It still remains comprehensive.

The CHAIRMAN: We want to move on and give Ian and Kate an opportunity to talk about outside of the metropolitan area, and we will come back to school health nurses, maybe also by way of supplementary. We also have not had an opportunity today to talk about transport. We have been told that one of the problems that the child health nurses have is that they have to use their own cars. So maybe you could address that issue by way of supplementary information.

Mr Aylward: We are very happy to provide that by way of supplementary question.

The CHAIRMAN: I will hand over then to Ian and Kate. I am so sorry. We need a whole day for this, because it is such an interesting area. Could you discuss some of these issues from your perspective?

Mr Smith: What a sweeping introduction! I suppose one of the philosophies that I would like to do—we start here right where we started the discussion—I want to have a common state system, so that with the IT system that is being rolled out in the metro, we have to make sure as we are going forward that we do not have a system for the country and a system for the metro, because we have struggled in the past with not being able to maintain connectivity to the metro. One of the things we

are looking at doing is getting a state-wide patient administration system. That underpins so much of the ability for us to track the patient across the whole of the state, in and out of services. There will be lots of additional benefits as we go forward, of course, for subsystems like CBUS to be part of that process, which will have benefit to the country. I think we have got the right trajectory of reforms in that ICT area. It will take a while to get that. But the great platform of moving forward with the web is the best news that we in the country have had for probably 10 years. We do not have it now. So with all the data that you have asked for now, we will go out of our way to use our best endeavours, provided what caveats we have, to give you the information. What was the second point? I think we have sort of covered it, because we jumped in halfway through each of those discussions, but was there anything particular in the country that you thought, well, we have got the metro response; I would like to know the country component?

Dr G.G. JACOBS: Can I just highlight that one of the issues that we might not be aware of, but that I would like you to be aware of, is that, as Mark says, the clinical work takes precedence, and rightly so, in a child health nurse dealing with the workload that she has. But I think what is happening in my area is that if the actual waiting list blows out on the clinical work of the checks, some of the other programs do suffer. So, the nutrition classes go, because they tend to put that on hold to do the clinical work; and I think they are still running the community program. Then, of course, there is the issue of the drop-in clinic, where they assign one morning a week for people to just drop in because the baby has a rash, or whatever. So they tend to have that, and rightly so; I think it is a good idea. But I think we need to be very careful—which we might not see when we look at statistics—to make sure that we do not drop off the educational program or the nutrition class because the nurses have had to devote their work to overcoming the problems with their waiting list and the clinical work.

Mrs Gatti: Can I make a comment here? The reality in a child health nurse's day is that the checks—the universal screening—is only about a third, or even less, of their work. The majority of their work is that other stuff. Most mothers will tend to want to visit you more outside of those checks in the first year, for reassurance and for parenting issues. The child is doing well from a medical perspective and a developmental perspective. But it is important that support is given to that mother. An example is an emerging population in Newman, which is unsupported young mothers —

Dr G.G. JACOBS: With all the breastfeeding issues and what have you?

Mrs Gatti: Yes, the breastfeeding issues, and they do not have the social supports, and so we tend as child health nurses to get that reliance. The actual majority of our work is that; and I think that is the point that you are making. That is in many respects more important than the checks, and that is the true value of the service, and it is linking them into the broader societal supports that are there, and identifying the psychosocial risks that are there early. One of the risks in the Auditor General's report and the questioning is that we tend to focus on the developmental checks, which is only part of the work. I think Ian touched on this. The work is far more general, and in the country even more so; and that is purely a critical mass, population dispersion efficiency–effectiveness issue. So in the country, a child health nurse will also have a sexual health certificate and an immunisation certificate, and they will also do the school one day a week, and they might do a night duty as well. So the context of that one FTE is different, and that is purely a numbers game; it is not anything else. But what we need to do, to be able to meet the population need at the time, is be flexible in our approach. So we have to guard against being stuck into a ridged line, because in Newman we really do need a lot more psychosocial support than what we are providing at the moment, because of the demographic that is growing up there quite fast.

The CHAIRMAN: I appreciate what you are saying, Kate, but I think Ian hit the nail on the head when he said that the value of those universal health checks is that someone could miss all those checks, so you do not get an opportunity to build that relationship and to give that additional

support that that family require; and that is why we are simply asking for the statistics, because it is very hard to validate and put to the government this role that the child health nurse is playing within the community. But we can say to the government that we do not have enough nurses, these visits are not being conducted, and these visits are a way of getting people in the door so that the child health nurses can work with the child.

Mrs Gatti: It is a wonderful excuse to engage.

The CHAIRMAN: Yes, it is, and as you said, Ian, you can make sure that the few per cent who miss the first visit do not also miss the second visit and the third visit, so that somewhere the red light goes on that there is a family here that is being missed. We have just the seven universal visits. In South Australia, when they identify a family in need, they have 32 visits within two years. So we are just trying to get from the government funding for 110 child health nurses for those seven universal visits. How much more funding would we be asking for, for the families at high risk and the children at high risk, if we were to offer a service similar to the service that is offered in other states, to really make sure that those children get the support that they need within the community? Maybe you would like to come in at that point, Mark, or Philip—I am not sure— in terms of what plans there are in the future to provide that additional support. We know that other states are providing that additional support. Do you see that additional support for those children and families in need coming through the traditional child health nurse role? Who will provide that support? Are you developing a tool to identify those children at high risk; and what are the plans, when they are identified, for giving them additional support?

Mr Morrissey: I think we largely identify the children at high risk through the screening. But there are other ways that the kids are picked up, through the various steps as they grow up. I think one of the primary roles, as we have alluded to, is the work that the nurses do beyond the screening. They are working with the high-risk families. They are doing that stuff that you described before, be it health promotion and all that other work. I would see it still being a central part of what they currently do. But, as Philip has alluded to, we are looking at, I guess, expanding and broadening our model and at bringing in other experts and other non-government organisations to supplement and work in close partnership with what the child health nurses are doing now. Child health nurses in many ways are already doing the work that you are alluding to.

Mrs Gatti: Additionally, we are developing a metro and then a statewide policy, and developing an augmented Aboriginal schedule, and piloting an acuity tool to more objectively identify the at-risk families. We are piloting that both in country and metropolitan services at the moment.

Mr Morrissey: It is a first for Australia, and we should have that up and running early next year.

Mr Smith: But it is fair to say that is the culture to which health has moved forward with this activity-based funding and activity-based management component. We are having to be far more definitive in the service that we are delivering, and the quality of the service. So the whole national reform agenda is really providing us with the emphasis to be far more astute in what are the outcomes that we are actually getting. So I am quite a devotee.

The CHAIRMAN: Normally I would ask each of you, in one or two minutes, to summarise, but I see that it is already 12 minutes to noon, so would you mind if I asked Philip on your behalf to give a summary to the committee on what we have discussed? We also need to thank you very much, because Philip and Mark met with us before we started this inquiry and gave us very useful advice in terms of who to meet with in the eastern states. We would like to thank you very much. The visit that we had really did give us a good foundation for this current inquiry. Would you like to sum up in a few minutes, Philip?

Mr Aylward: I guess we are very pleased to come to the committee today to outline what we are currently doing and what our thoughts are around the future. I think hopefully we have been able to at least articulate the valued role that child health, community and school health nurses play as their

part in service provision to our youngest and potentially our most vulnerable children and citizens in Western Australia. We have got lots of good ideas, lots of opportunities where we are going to be trialling different models of care, and different tools, as Kate has mentioned, that we are going to use to identify with high risk patients and clients. A lot more work needs to be done, and we are encouraged by the feedback that we get both from this committee in terms of support of our work, but through the government as well, which is very keen to support, I guess, the notion that early intervention is crucial to changing the trajectory of outcomes for children from both an educational and health and wellness perspective.

The CHAIRMAN: Thank you, and we will try to organise another hearing for school health nurses, because we did not really touch on that.

Thank you very much, each of you, for your evidence before the committee today. A transcript of 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 via 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. In particular, Kate, the program that you were talking about in terms of identifying high risk, if we could have some more information on that, that would be great. Is that through you, Kate?

Mrs Gatti: It is more in Mark's area, because he is coordinating it.

The CHAIRMAN: So could we have some more information on that, because it is wonderful. We are a bit behind the eight ball in some areas, so it would be nice to be able to say that we are leading in other areas. So please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence. Thank you all once again for coming along today.

Hearing concluded at 11.50 am