PUBLIC ACCOUNTS COMMITTEE

OTHER PROCEEDINGS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 18 MARCH 2015

Members

Mr S.K. L'Estrange (Chair)
Mr B.S. Wyatt (Deputy Chair)
Mr W.J. Johnston
Mr M.H. Taylor
Mrs G. Godfrey

Hearing commenced at 10.35 am

Professor BRYANT STOKES
Director General, Department of Health, examined:

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

Ms ANGELA KELLY
Acting Executive Director, Resourcing and Performance Division, Department of Health, examined:

Ms LISA BRENNAN
Acting Executive Director, Child and Adolescent Community Health, examined:

Mr JEFFREY MOFFET
Chief Executive, WA Country Health Service, examined:

Ms MELISSA VERNON
Chief Operating Officer, WA Country Health Service, examined:

The CHAIR: Good morning, everybody. Thank you so much for taking the time out of your day to come and join us this morning. On behalf of the Public Accounts Committee, I would like to thank you for your appearance today. At this stage I would like to introduce myself and the other members of the committee. I am Sean L'Estrange, the member for Churchlands and the committee chairman. On my left is Mr Ben Wyatt, deputy chair and member for Victoria Park; and fellow committee members, Mrs Glenys Godfrey, the member for Belmont, and Mr Matt Taylor, the member for Bateman. Today's hearing is a proceeding of Parliament and warrants the same respect that proceedings in the house itself demand. Even though you are not required to give evidence on oath, any deliberate misleading of the committee may be regarded as a contempt of Parliament.

Before we commence, there are a number of procedural questions I need you to answer. Have you each completed the "Details of Witness" form?

The Witnesses: Yes.

The CHAIR: Do you understand the notes at the bottom of the form?

The Witnesses: Yes.

The CHAIR: Did you each receive and read an information for witnesses briefing sheet regarding giving evidence before parliamentary committees?

The Witnesses: Yes.

The CHAIR: Do you have any questions relating to your appearance before the committee today?

The Witnesses: No.

The CHAIR: Would you please state your name and the capacity in which you appear before the committee, starting with you, please, Ms Brennan.

Ms Brennan: Lisa Brennan. My role is acting executive director of Child and Adolescent Community Health.

Ms Kelly: Angela Kelly, acting executive director, resourcing and performance, Department of Health.

Mr Aylward: Philip Aylward, chief executive, Child and Adolescent Health Service.

Prof. Stokes: Bryant Stokes, acting director general of Health.

Mr Moffet: Jeffrey Moffet, chief executive, WA Country Health Service.

Ms Vernon: Melissa Vernon, acting chief operating officer.

The CHAIR: Thank you. The committee has asked you here today to discuss the actions taken by the Department of Health in response to recommendations made by the Auditor General in his tenth report of 2014 that followed up his 2010 audit report into universal child health care checks in WA. The committee wanted to get an update on the department's progress and to explore specifically how the department's responses will address the issues raised in the 2014 Auditor General's report. In addition, the committee is interested in discussing the current status of the recruitment process, both metropolitan and regional, that was tied to the $58.5 million allocation of funding in the 2012–13 state budget. Before we move to our questions, would you like to make a brief opening statement addressing the areas of interest to the committee, Professor Stokes?

Prof. Stokes: Thank you for asking us to come. We have, I think you will find, made major progress since the Auditor General's report. One of the issues has been the difficulty, always, in recruiting nurses to do this type of activity. I am going to leave most of the discussion, with your agreement, to Mr Philip Aylward and Jeff Moffet to discuss some of the details of those issues.

Mr Aylward: I just want to concur with Professor Stokes. We have made significant and substantial improvement across those recommendations from the 2014 report. Specifically, we are delivering 49 000 of the universal checks. Of course, beyond the universal checks, which was the focus of the Auditor General's report, was targeted checks. These checks that we have—there are seven stages that we look at—are really the bedrock, if you like, of early childhood development and the opportunity for parents and qualified nurses to discuss issues with their children. It also identifies physical aspects that might need referral to primary care providers. As I said, we also assess the emotional and mental state of the parents as well. We see these checks as a really important part of the health care delivery system.

[10.40 am]

It also allows us to in-reach into the families and deal with sometimes hard-to-get issues, particularly those families who may not be engaging in mainstream health services. Specifically, in terms of improving access—because as you are aware the checks are voluntary in nature, so there is no compulsion for parents to bring their children to any centre or for us to gain entry, so there has to be agreement—we do find that as a result of that, first-time parents really embrace the checks exceedingly well. We get really good take-up in at least the first couple of checks, and then later on, up to at least the preschool or school entry check, it does taper off, and we find that, particularly if it is the second or third child in a family, the parents make choices around their perceived need to have the checks. But all the checks are important and we endeavour to have them available.

We are undertaking pilots of extended hours services, specifically in the Kwinana, Secret Harbour and the Baldivis area, so it was one of the particular queries the Auditor General pointed out to us, and we are in the process of trialling those to give working parents better opportunities, including starting on a Saturday morning to allow access to those services, if that makes it easier. I think we are also finding that we hope to look at child health checks in childcare centres. We think that is a really good place to provide accessible universal child health checks, so we are looking at in-reaching into childcare services and providing the checks there.

Our implementation of the computer system, which the Auditor General recommended to be rolled out has now been completed, and so certainly across the metropolitan area we have

a comprehensive integrated child health information system. It allows us to also book appointments using a 1300 number that parents can use. We want to make sure that we can achieve that booking approach, and it also allows online registration of parents, so they do not need to come into a centre as such; they can do the registration online. Already we have had, for the first three months of that being operational, over 700 parents taking that opportunity.

The other aspect we have seen is an improvement in our DNA rates. There has been a substantial reduction in our DNA rates, which was highlighted in recommendation 5. We now have text messaging as reminders for parents to bring their child to their scheduled appointment, and we have seen a 25 per cent reduction in did not attends, in the period just gone by.

In our staffing recruitment, we have been quite successful in recruiting our FTE numbers. We are up to about 91 per cent of the FTEs allocated required. There are still about 5.8 to be recruited this year, and the way the funding allocation has been made, there will be a further one FTE in the next financial year. We are happy with that being on target. The computer system that we have put in place also allows us to track productivity as well. For the first time we are able to assess what is occurring on a daily basis in productivity with our staff, and we have seen some really positive improvements—upwards of 20 per cent—since July 2014 to February of this year. We have tackled those key recommendations head-on. I think both the staff that we have got and the community response has been has been very positive with these changes.

The CHAIR: Thanks very much for that opening statement.

Mrs G.J. GODFREY: I have a question on that, Mr Chairman. You mentioned text messaging. I know that a common practice in other services, such as the chiropractor and BreastScreen WA, is they actually phone and check that you have an appointment. Is that done?

Mr Aylward: I do not think so. We just follow up on the text messaging at this stage.

Mr B.S. WYATT: Was it the text messaging alone that has seen the 25 per cent reduction? Has that had that big an impact or has it been other things as well in respect of the DNA rate?

Mr Aylward: I might ask Lisa if there is any other aspect that we have done.

Ms Brennan: We have only just turned the text messaging on in January, so we looked at the month of February only. So it is only a snapshot of data for the month of February, and that showed a 25 per cent reduction, and it really has just been —

Mr B.S. WYATT: Compared to the previous month? Is that a month or is that a trend figure?

Ms Brennan: It is a trend figure, so if you look at on average what our DNA rate would be for the month, and that was the only change that we made in that period.

Mr Aylward: I think if I can just add the other aspect is that with the increase and uplift in staffing it means that there are more choices for parents to make. So instead of being channelled into an appointment that in fact may be difficult or not really conducive, I think the increase in productivity and number of staff has allowed more choice for parents. The progressive use of the 1300 number centralised appointments, so they do not leave messages on answering machines. That was obviously a big improvement in productivity for the individual nurses. You can ring up and get the appointment of your choice and then we follow-up with texting.

Mr M.H. TAYLOR: Can I just follow-up on that question? Is there any seasonal variability to the DNA rate month by month, or is it 25 per cent down on essentially a fairly constant DNA rate no matter what month of the year it is, or does February normally drop compared to January, for example, because people might be away?

Ms Brennan: January, we would probably find that, throughout the school holiday period, that tends to be when the DNA rate can vary. Sometimes it can go up a little bit more because people

have other commitments that they are working towards, but I do not have the data in front of me in terms of being able to give you a more accurate answer than that.

Mrs G.J. GODFREY: How will parents know that we have these other choices, like childcare and after hours? Is someone marketing that?

Mr Aylward: We get notified of the birth of every child through the birth notification system, and there is a contact made. At the moment, the target is within the first 10 or 11 days, I think.

Ms Brennan: The first 10 days.

Mr Aylward: Which is something we are looking at to review because that is not 10 working days and, of course, we are finding that with the increase in the caesarean rate, mums tend to be in hospital a little bit longer. However, that first contact has a very high take-up, and we offer an in-home visit or at a clinic, at the choice of the parent, and then we provide them at that time with—you probably would recall—one of the booklets that are given to every parent, which sets out the ability to record growth factors and key health messages in the booklet. That is given to every parent. So the timing of all the schedules is laid out there and our nurses provide them with information at that first point of contact about where to access. I think the changes in childcare areas is something new that we are approaching, and we agree that we will need to step up our communication to ensure that that occurs. In that space we are actually trying to pick up that area where we do not seem to be as successful and we might otherwise be, so that period over 18 months into the three or four-year category to try to capture that group as well.

The CHAIR: I would like us to now focus a bit on recruitment and funding. In the 2012–13 state budget $58.5 million was allocated over four years to improve access to community child health services statewide and $40.5 million was provided to procure child health services from non-government organisations—NGOs. According to the audit report, only one contract was awarded to an NGO for child health checks. What were the difficulties the department experienced with attempting to procure child health services via the NGO sector?

[10.50 am]

Mr Aylward: If I can cover that question, there were significant challenges for both parties—both the NGO sector and ourselves—in coming to, if you like, develop reasonable partnership specifications that could mean that we deliver the child health checks; they could take the child health checks. As such, because of the specifications and the requirements around clinical governance, it meant that the NGO provider sector and those that did apply at the time—because it was an open and transparent process—did not respond to the level that we anticipated. However, we did get a number of really good providers that are working with us at the moment, in particular the services provided by the Salvation Army at Balgo. They have been really enthusiastic and have adopted the sort of objective of providing access to that community and we are working hard with them. The south coastal women's health care service has also undertaken the enhanced Aboriginal child health checks, because they had a very good embedded and respected presence in that community and were engaged very well with all the other NGOs in the community. So it is correct; there were challenges. We, I guess, ultimately had to assess things on the basis of the universality of standard that we could satisfy ourselves that all the potential bidders could deliver the service to the required level and required standard. It does not preclude us from certainly going out again to look at further opportunities, particularly if there are new models that are proposed. But it is a very heavy nursing directed–type service, and I think that posed particular challenges in the recruitment and their ability to satisfy us that they could provide that level of coverage.

Mr B.S. WYATT: You said there was a problem around the requirements around clinical governance. Can you just elaborate on that a little bit for me, not coming from a health background?

Mr Aylward: Yes. I precluded myself from the assessment process for the tender; however, there were a range of criteria that were part of the assessment of fit-for-purpose or their ability to partner

with us. Some of the issues that came through in terms of the feedback session that we have given to the NGO providers are to ensure that all nurses are registered and require oversight and they require access to ongoing performance appraisal on a nursing profession basis. That was one area that some of the bidders were not able to convince us on. That is one element; there are other aspects that they had that area covered. However, in saying that, there are a couple of providers here that I mentioned previously that were able to satisfy us and therefore were awarded those contracts.

Mr B.S. WYATT: Does that automatically mean that to get that work—to be successful in that tender—it is probably going to have to be an existing reasonably large health provider NGO? You know what I am trying to work out.

Mr Aylward: Yes, I do.

Prof. Stokes: If I might take that, Mr Wyatt, I do not think that is necessarily correct. This really is that the quality and safety of the service should be a uniform one which we believe is the appropriate level of care and assessment that a child should have. So it does not have to be a big organisation, but it has to be an organisation which would have the ability to supervise itself in an appropriate way so that one could be assured that there would be appropriate standards. It is that type of thing.

Mr B.S. WYATT: I guess it is a question I might get to. I have an interest in Aboriginal parents bringing their kids through the whole process, eliminating the DNA rate, if you like, and whether there is the depth of Aboriginal organisations that can effectively tender for that work.

Prof. Stokes: Yes, I think Jeff might answer that clearly.

Mr Moffet: We are obviously talking about the urban context, and that was the focus of last year's audit. Just in relation to the question around the number of NGOs, we have currently around nine NGOs, most of which are Aboriginal community–controlled organisations providing services, in particular targeted services, Mr Wyatt. That is very effective. We have a longstanding working relationship with the community-controlled sector and other NGOs. I agree that clinical governance and safety and quality are central issues but some of those small to medium-sized organisations are well able to deliver clinical governance.

Mr B.S. WYATT: Have those community-controlled organisations been able to win some of that tendered work, in Balga? Sorry, I missed the name.

Mr Aylward: Yes. That was the Salvation Army.

Mr B.S. WYATT: In Balga, are they?

Mr Aylward: In Balga and then there was the South Coastal Women's Health Services in Rockingham that won the tender for us in the metropolitan area to provide services.

Prof. Stokes: I went and opened that service, actually.

Mr Aylward: The one in Rockingham is focused upon the Aboriginal families and children in that area. From my point of view, I think the success of those two models—and they are relatively small groups—is they have been able to demonstrate they can provide the oversight and the safety needed.

Mr B.S. WYATT: The governance issues.

Mr Aylward: We hope that will build success and not preclude other entrants who want to consider this into the future.

Mrs G.J. GODFREY: Can I have some background on the Salvation Army, because I did not think that was an area that they had moved into?

Mr Aylward: When we sought expressions of interest, we had a very diverse and wide group of people involved in the provision of both health care and also social service–type functions.

The Salvation Army in the particular area of Balga has a very strong community-engaged model that provides a raft of support services. They saw it and because they had really good access to young families that were attending their centres and their programs, they thought this was something that they could add significant value to. As their proposal turned out, for that location, we actually agree with them. From subsequent discussions, they themselves are watching how that develops and works for them, as it will for us. I do not think it precludes them from expanding that service model to other locations where there is a good match between what they are doing in that community to access, if you like, families and young people. In our mind, governance was important and they do have the right structure that they put into place there. It is a very solid structure, but equally they have access to the community. It was clearly for us something that we probably did not have to the extent they have.

Mrs G.J. GODFREY: What about local government? Are there any local governments that have the funding?

Mr Aylward: No; no local governments. I am not aware that any local governments applied to provide these services. It might be a little bit different in the country. Local government is a really important part of the provision of infrastructure to the child health services in the metropolitan area and, I assume, the country as well. They have a long history of providing child health clinics and services. That is very much appreciated. They see themselves, I think, in the main as facilitatory, providing infrastructure, but none has approached us to be service providers or service deliverers—in the metropolitan area that is.

Mrs G.J. GODFREY: It is just that I thought they provided a nurse for immunisations.

Mr Aylward: There are a few that subcontract that work. I do not know off the top of my head, but it is less and less. It is mainly general practitioners who provide that service and we, ourselves, have a service that operates in West Perth that also provides school-based immunisations and sometimes opportunistic immunisations as well.

Prof. Stokes: We are having a bit of a discussion with local government, because as, Mr Aylward has said, they provide the infrastructure—a clinic building and so forth. We provide the staff and services. Some local governments are now wanting to charge us rent and I think this is a bit unfair because it is not in our budget process, as you can understand. We are having a bit of a battle with that and I think that we are providing a service to their community, they are providing the building and I do not really feel we should provide rent on top of it.

[11.00 am]

Mrs G.J. GODFREY: I guess they feel it is a state initiative, so it should be provided in a state facility —

Prof. Stokes: I suppose that is what they think. It is not the same view that I share, I must say.

Mr B.S. WYATT: You are a former mayor!

Prof. Stokes: I know that!

Mr B.S. WYATT: Once a mayor!

The CHAIR: Continuing the funding and recruitment line of questioning, it was estimated that $58.5 million in funding would enable the recruitment of 128.2 full-time equivalent child health nurses statewide. Mr Aylward, I know you mentioned in your opening statement some of the targets you are achieving. Can you just confirm for me how the department is tracking against the recruitment target of 128.2 FTE?

Mr Aylward: Can I say, in terms of nurses, the number is 100 FTE across the state, and that is between country and metropolitan areas, so I just wanted to just bring that clarification. We are on track, though, as I mentioned in my opening statement, there are some competing demands.

The competing demands are that the state government has invested heavily in school health nurses as well, so there is a draw upon that resource. We are working with the chief nursing officer to look at how we might create opportunities, particularly for new graduates, because in the past we have got very experienced nurses; they have stayed with us, which has been fabulous, for a long period of time and they have got to know their community. But we do have a real significant challenge to keep the nursing levels up that we have now been asked to provide. As I said, we have most of our quota for nurses in the metropolitan area. We have got about one more to go in 2015–16 of our quota and just—Lisa, what is, if I can ask, the total quota that we are seeking —

The CHAIR: Just on the quota you are referring to, are you referring to the Child and Adolescent Health Service quota?

Mr Aylward: That is correct, for the metropolitan area.

The CHAIR: So you have got only one person to find off that quota?

Mr Aylward: So we have 5.8 still to be recruited this financial year and we have got one further full-time equivalent—bearing in mind that might need a number of part-time staff—in 2015–16.

The CHAIR: With regards to the WA Country Health Service's figures, how are they?

Mr Moffet: We have around 30 FTEs. That is our target or quota, if you like. We have currently recruited 90 per cent, or 27 of those. There is a split of around 11 of those in the NGO sector in equivalent FTE terms and the balance of 16 in Country Health. We are currently negotiating an additional three as we speak being procured through the non-government sector.

The CHAIR: Are there any locations in Western Australia where you are having a lot of difficulty in allocating some of those FTEs to?

Mr Moffet: It varies from time to time for us but the more remote one gets, the more difficult, typically, is the case. I do not know specifically, Melissa, whether there is any particular region that has popped out more than another in this initiative?

Ms Vernon: Not in particular. The Pilbara, at times, and remote Kimberley, where you are trying to get people out. But the use of the NGO sector has assisted us, so the AMS sector, where we have been able to use people that are in that sector with child health qualifications to be able to do the job that might not have come into the public sector.

Mr B.S. WYATT: In respect to the 100 FTE, how many of those are Aboriginal nurses, do you know? The 100 is across regional and metropolitan, is it not?

Mr Aylward: That is correct. Look, I do not know the numbers. The challenge, I think, for the health and education sector is to look at how successful we are in getting Aboriginal students through the various training programs. We are looking at—this is part of breaking down, which we hope to do next year—the components and checks so we can possibly get enrolled nurses involved into the delivery of these services. That opens up greater choices and options, particularly for Aboriginal workers. There is great use of health workers in other settings, maybe in particular in the country, but it is one of our particular challenges and I guess a gap that we might have at the moment.

Mr B.S. WYATT: Mr Moffett, in respect of the 20-odd that you employ—the 27 —

Mr Moffet: Sixteen we have employed, and there are 11 in the NGO sector, and there are another three to come in the NGO sector. I do not know the answer to your question at this stage. Obviously, for our 16 employees we could derive that data fairly quickly, so long as there was self-identification at employment. I suspect there will be some Indigenous employees in the NGO sector. We will need to —

Mr B.S. WYATT: It sounds like if you are using the AMS there is.

Mr Moffet: Yes. The intent is really that we have got an established workforce, high Aboriginal employment rates and much more effective penetration. We could certainly provide that information, but I do not have it here today.

The CHAIR: Thank you. Moving onto the funding aspect again, $26.7 million of the $38.4 million of your Child and Adolescent Health Service funding was provided for the contracting of NGOs. We know that $10 million was transferred to the funding of direct recruitment. The committee wishes to seek clarification regarding the allocation of the remaining $16.7 million. Specifically, according to the report, the cost of the package of contracts with the NGOs was expected to increase from $7.5 million to $10.7 million. Can you explain the reason for the $3.2 million increase?

Mr Moffet: I am not sure that we have that level of detail to explain. I know that the total contract for five years with our providers was $13.8 million. That is what we expect. That is the total service agreement value for the five-year term. We have got that broken down for us with the various providers, which we are very happy to provide to the committee, and we are very happy to obviously provide a reconciliation to yourselves as a committee.

The CHAIR: Thank you. Approximately $1.2 million of the funds have been absorbed by an increase in staff wages. Is this exclusively for child health nurses or for other staff within WA Health?

Ms Kelly: I do not have the information available, Mr Chair, but I would think, based on how we allocate the funding, that it will be for child health nurses. But I am happy for us to have a look at that and provide you with that detail.

The CHAIR: Thank you very much. An amount of $4.8 million has been redirected to other areas within child and adolescent health services. Where has this funding been redirected to?

Mr Aylward: We can again provide a breakdown of that $4.8 million. The introduction of the CDIS process—the introduction of the online registration service—has contributed to that amount. So we will provide the breakdown of that $4.8 million to the committee.

The CHAIR: Thank you. I now refer to recommendation 1. In your response to the Auditor General, the department states that the expansion of the community child health nursing workforce will enable the introduction of new service models which have been designed to be flexible and ready to meet the needs of families. Could you please provide some detail regarding these new service models and how you see them improving the flexibility of service and meeting the needs of families?

Mr Aylward: I think the example of that is the extended hours that we are using as a flexible model. We are piloting those, as I mentioned earlier, in Kwinana, Secret Harbour and Baldivis.

Prof. Stokes: They have not started yet. They start in May this year.

Mr B.S. WYATT: Are they the ones that will open on Saturdays as well?

Mr Aylward: Correct, yes. We are also providing some child health services from the new child and parent centres that are being been established on school sites. The roll-out of that across the metropolitan and country areas will accelerate as the building works are completed on those school sites. That is about, if you like, providing access to parents so that when they bring their other siblings to school, the younger ones can get access to child health services that are accessible rather than having to go to multiple sites to receive those services. I guess the other major area for us—we have not started this yet—is in the childcare centres themselves. We are looking at one provider and starting off in the Baldivis area as a particular location. Again, we hope that service will get underway by the middle of this year for improving access. They will deliver certainly improved access to those families. The provision of some of the parenting groups in a variety of locations by NGOs, particularly Ngala, I think is now proving to be quite successful. They have a significant

community profile within certainly the metropolitan area, and that is something new for us that is now established and in place.

[11.10 am]

Prof. Stokes: The other issue there is that there may be an industrial issue for the Australian Nursing Federation because in their clause they talk about the fact that nurses in a community setting work 38 to 40 hours a week between 0800 and 1800 hours Monday to Friday. There may be an issue there but I am hoping there is not going to be. I mean, we would not be asking them to work longer hours, but what it might mean is that we might have to have some more staff cover. It is just an issue to think about.

The CHAIR: I refer to recommendation 3. WA Health advises that the centralised booking system introduced in 2013 is already receiving more calls than it can manage. What is the department doing to address this issue?

Ms Brennan: We have had to look at how we can manage the workload internally within the team and how we can look at their workload and redistribute the workload for non-core activities to other staff members so we have more targeted FTE on the online booking system. At the moment that has proven to be a successful strategy. I guess what we do not know just yet in terms of future demand is where we might see some peaks, but we will aim to address those as we reach those peaks in demand.

Mr Aylward: An obvious extension to this, subject to available funding, is a bit like—I think Mrs Godfrey mentioned BreastScreen before—they have the capability for online booking of appointments and we have online registration, which has been an attempt to reduce that pressure on the call centre. That take-up is in early days, but it really has been positive. The ability to have online booking will allow parents to schedule a time that suits them without the need to interact with a telephone operator. I think that is the direction we are going to head in—still providing the call centre, of course, but giving choice through that other system is going to be far more preferable to improve access.

The CHAIR: What is your start date for the online booking system?

Mr Aylward: We are in the process of scoping that at the moment. We have a couple of other ideas around the use of smart applications as well, particularly for child health books, but at this stage it might be something that we would have probably scoped an idea about how to implement this in the next 12 months. The fact that we have a working model in health through BreastScreen shows that we do not need a proof of concept, as such. That also deals with multiple locations. Hopefully, we will be able to leverage off that and allow that system to easily roll in, but I think we are probably still 12 months away, realistically.

The CHAIR: Have you looked to see whether there is any correlation between receiving more calls than it can manage and the did not attends?

Mr Aylward: No, we have not undertaken that analysis as yet. Again, it is early days, but we have had very strong feedback that a 25 per cent reduction in DNA rates has been positive. Clearly, we want to get that down to a level that is three or four per cent. There will always be good reasons for people not to be able to attend, particularly with young families, and we will probably always have a level of DNA rates.

The CHAIR: I refer to recommendation 5. In 2012–13 the rate of "did not attend" to health checks was estimated to be 12 per cent, equating to approximately 30 000 missed appointments. You have mentioned that now with the SMS-ing or texting of appointments that that has dropped by 25 per cent. Are there any other strategies you have in mind or that you intend on rolling out to further reduce the did not attends?

Mr Aylward: I think we can establish an online booking system or scheduling system that should improve the flexibility where parents may not be able to get through to a call centre. If they are able to go online and quickly cancel that appointment, then it eliminates the do not attends, and it gives us an opportunity to reallocate that appointment to someone else. I think that is probably the next big improvement that we will see in that DNA rate. But we will certainly examine the follow-up phone calls or pre-emptive phone calls. There are systems available that could undertake that automatically to people's designated phones. That is a further option that we will certainly look at. It is in both our mutual interest to reduce the DNA rates. They are a scourge upon this particular area because it means it is a missed opportunity for someone else to get into that slot, so we are really acutely aware to make it easier for people to make appointments if we do that; then I think our DNA rates will diminish even further.

Prof. Stokes: One of the things I think we need to do, Mr Chairman, is to try to do some more public awareness, because a lot of the DNAs, I would think, and I am not an expert in this area, is probably because they forget to do it and there has to be a degree of parental responsibility in all areas to take advantage of these things. And I think your publicity that we give to these and the requirements at various stages should be done. I think it is important for the committee to appreciate that we are having a review done of the effectiveness of the work that has been done. An expert in the field of public health and community health, Professor Karen Edmond, is being appointed in April to look at doing a survey of are we and the patients getting the best value for money out of what we are spending? And I think it is important to know.

Mr B.S. WYATT: Is that just across the health system?

Prof. Stokes: No, in child care; childcare assessments.

Mr M.H. TAYLOR: Is that as a result of the increased costs?

Prof. Stokes: I do not think so. No, it is not, because I am a believer in having some evidence that what we are doing is actually doing something, and I think it is important that we do all these checks but are we making a difference to child health? That is the real, fundamental issue, and that is why we want this done.

Mr Aylward: Could I add to that? Professor Karen Edmond is the professor of Aboriginal paediatric health for the University of Western Australia and has an appointment with us. I think we can also ask her about the issue of the universal checks versus targeted checks for those that are at greater risk as well. So, I think we will get a very good play on getting the value, as Professor Stokes says, because we are putting our resources in where they are going to be most effective.

Mrs G.J. GODFREY: It is interesting that you raise that, because of the seventh check of children aged five to six, and I understand at a school that I have in my area, Tranby, there are children that come to school who have not learnt to clean their teeth and other issues that then have speech issues for learners. So, for this five to six, you are assessing all of these seven checks. Is it possible you could take one of the checks out to extend it further into primary schools so you would not get any did not attends because they are all at school?

Prof. Stokes: With respect, Mrs Godfrey, I think we need some paediatric advice in that regard.

Mrs G.J. GODFREY: Yes, of course.

Prof. Stokes: Because it is fairly important, and I am not competent, and no-one around here is competent, to make that decision. And that is partly why I think that the review will help us in that regard.

Mrs G.J. GODFREY: So, you are saying that the fourth check at eight months, I do not know what you are looking for, but you are saying that is why you are going to assess the whole seven checks, for what you are actually getting at each one?

Prof. Stokes: Correct, yes.

Mrs G.J. GODFREY: One that has come to me is that the dental checks are stopping at 16, and yet students have to stay until 17 and sometimes 18 when they are in year 12. Does that come under your area?

[11.20 am]

Mr Aylward: If I can answer that—no, it does not. But we do have a program—it is called various things—called Lift the Lip, to actually start that dental hygiene and give advice to parents at a very early age. I think you have picked up that we want the best opportunities for our children to be ready for school and to pick up, if you like, developmental delay far earlier in their age group. There is another part of our service which provides child development service in speech pathology, physio, OT and the like; actually look at those things to make children school-ready or at least to get the best possible outcome for those teachers with the skills and the attributes that they have. Professor Edmond will look at all these elements for us and look at the evidence; it will be very evidence based. She is a paediatrician as well and she will be well placed to provide advice to the health department and ourselves on these matters.

Mrs G.J. GODFREY: But paediatrician is to what age?

Prof. Stokes: Early-to-late teens.

The issue you raised about teeth is terribly, terribly important. I think that our dental program, funded by both the commonwealth and by the state, is not achieving what is really required. It is going to require much more investment. The commonwealth is assisting in some way, but we need a lot more assistance.

Mrs G.J. GODFREY: At least to cover children while they are at secondary college.

Prof. Stokes: Yes.

Mr M.H. TAYLOR: I have a broader question. Based on your statements today, you have made some really good progress in terms of some of the concerns that were raised by the Auditor General. There are two things I am curious about: the service delivery was more expensive than first thought based on some of these allocations. I am just wondering why was it more expensive and are you comfortable with the factors that have contributed to that? Is that accountable? Secondly, you seem to have ticked a lot of boxes in what the Auditor General raised. Is there anything that is within this context that is still of concern to you beyond what we have already discussed today?

Mr Aylward: If I could answer the last point first. I think the professor, in his opening comments, said the challenge for us is that you have two elements—voluntary screening; therefore we need to encourage and adopt very much a public health model to be persuasive for parents to come and have their children screened and assessed. Then from that we can direct families and young people into getting the right services, hopefully at the right time. That is a perennial challenge for us. We are adopting this from an access point of view. We are trying to improve the access. I think communicating to the community about what we are doing in terms of improving access and also the services, I think we could definitely enhance in terms of how we approach things. That is very much a strong focus of ours, and will be over the next couple of years. We think there is, for targeted areas, really strong opportunities to further engage the NGO sector. I think there is value there. Whether it is population based or whether it is those from overseas backgrounds, there is some really strong value based in relation to providing holistic care to families and young people. I think there are opportunities for us there.

In terms of the overall cost aspects, we want to eliminate any waste. That is why there is a strong focus on DNA rates, to get better productivity, which we have been able to do with the CDIS area. We do have increases in productivity with our nurses in the metropolitan area. Some areas up to 20 per cent more patients or more children are seen than what we had previously done. That is a particular focus of ours to get that. The contract management regime is very fair but robust in type, with both the providers and ourselves, to look at really strong KPIs and outcomes. This is

a really important area for us to ensure that we direct our money where it will have the biggest impact. We will hopefully get lots of learnings from Professor Edmond's report to make changes. I think we are up for making those changes over the next 12 months and next couple of years.

Prof. Stokes: We have not really answered your question, Mr Taylor, with regard to why there was an increased cost. There was increased activity, and that may have played a part, but I do not think it was the only reason, so we would need to look into that for you.

Mr B.S. WYATT: I guess I have a bit of a comment, and I say this having five minutes ago SMS-ed my wife saying are we up to date on our child health checks? Yes, we are. I am in Victoria Park, which is a broadly middle-class electorate, and the purple books are absolutely fantastic. It is often those things that actually sit on my bookshelf and I see them and know I have to get it done.

Mrs G.J. GODFREY: Are they purple now?

Mr B.S. WYATT: Yes.

Mrs G.J. GODFREY: They used to be pink and blue.

Mr B.S. WYATT: Both purple, two girls! It is more a question about country health. In the Kimberley in particular, foetal alcohol syndrome is becoming more aware in the public's mind. The use of NGOs, I think, is perhaps going to be the best way forward. I think of June Oscar's mob out there in Fitzroy; I do not know how the resource centre there is doing. It is often those organisations, in Fitzroy in particular the Marninwarntikura organisation, people from outlying communities will come through there. I am telling you something that you already know. In terms of grabbing those kids, it strikes me as so much more difficult because they are harder to get. Often these are not people with bookshelves and purple books sitting there prominently in their minds. I have a comment and then two questions. I do not want you to put out a survey or anything but if you have got the stats of those 100 nurses who are Aboriginal, I would like to get those, if you could. I do not want an email going out, but if you have got them, that would be great.

The CHAIR: That is metropolitan and country?

Mr B.S. WYATT: The 100 FTE, yes. I think it captures both. And just a personal interest question, I think you mentioned at the beginning of your statement, what is the difference between firstborns and subsequent kids on the DNA? Do you know that? Is it simply because parents get more comfortable and confident with their children or is it like that I have lots of photos of my firstborn and none of my second born?

Mr Aylward: It is just anecdotal feedback that we get from our clinicians that parents seem to be more confident and therefore skip those middle checks a little bit. There is probably a number of societal factors associated with that such as business and the like. There is no evidence; no study has been done on that but we do see, though, their attendance fall away very strongly in the metropolitan area. First check, fine, but for the rest there is not such a take-up.

Prof. Stokes: It would be interesting to know whether developmental abnormalities, for example, which have not been detected early, are appearing later in life because they have not been to them. That might be something you could talk to Karen Edmond about see whether there is some evidence of that.

Mr Moffet: I will just respond more generally to your initial question around more vulnerable kids, particularly in the Kimberley. In those sorts of communities, obviously the child health checks is just one element of good health care for those kids. We are developing an early years' strategy that is evidence-based and we would be very interested to work with Philip and with Professor Karen Edmond to make sure that we get strong evidence around the way in which we approach some of the chronic diseases in kids such as scabies and ear disease. There are some good strategies invested currently by government in those spaces. It does rely, as you say, very heavily on partnering with NGOs, and it is very much a partnering approach. We need to deliver the programs together

because of the referral pathways through the system for kids that have a disease detected. The Fitzroy Valley is a good example of where partnering with Nindilingarri for example, through Maureen Carter, has been very successful. We are constantly trying to have a more family-centric view of the way in which services are accessed and delivered. We do not have all the answers yet, but we are trying to develop a strategy around those vulnerable kids in particular, right across the state. This is one element of it, but you are right to identify that the state on its own cannot deliver that. We need to have strong partnerships through our regional health planning forums in particular, but not exclusively, to deliver that. We do have that strategy in our sites with our development. We have a particular project in place at the moment to bring the best evidence to there, and we will be working very closely with CAHS around Professor Edmund's review as well.

The CHAIR: Thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for the correction of minor errors. Please make these corrections and return the transcript within 10 working days of the date of the covering letter. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be introduced 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 once again.

Hearing concluded at 11.32 am