



Western Australian Auditor General's Report

Universal Child Health Checks

Report 11 – November 2010





THE PRESIDENT
LEGISLATIVE COUNCIL

THE SPEAKER
LEGISLATIVE ASSEMBLY

PERFORMANCE AUDIT – UNIVERSAL CHILD HEALTH CHECKS

This report has been prepared for submission to Parliament under the provisions of section 25 of the *Auditor General Act 2006*.

Performance audits are an integral part of the overall audit program. They seek to provide Parliament with assessments of the effectiveness and efficiency of public sector programs and activities, and identify opportunities for improved performance.

The information provided through this approach will, I am sure, assist Parliament in better evaluating agency performance and enhance parliamentary decision-making to the benefit of all Western Australians.

A handwritten signature in black ink, appearing to read 'C. Murphy'.

COLIN MURPHY
AUDITOR GENERAL
24 November 2010

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Auditor General's Overview

Few things in our community are more important than the health of our children. Child health checks play a critical role in this area through the prevention and early detection of health and development issues. Early detection helps parents to get support, advice and intervention at the right times in a child's early months and years. Prevention and timely intervention not only improve the health, education and life outcomes of individual children and their families, they also benefit overall population health, and help reduce long term health costs.

Child health checks are not a new service, and child and school health nurses have been fulfilling important roles in communities for decades. Over that time little has changed in how services are delivered. But other things have changed. The importance and benefits of addressing issues early in a child's development have become better understood, the level of demand for services has grown and how families want to access child health services has changed.

To get the greatest benefits, child health checks need to reach as many children as possible and, ideally, every child in Western Australia. Health's aim is to offer every child seven checks by the time they enter school. The voluntary nature of the service means Health are unlikely to reach every child, but delivery currently falls far short of this goal. Some of the checks are reaching less than one third of children.

Health considers that this is largely due to resources for child health services not keeping pace with the demand for services. Child health services have not been a focus in the allocation of health resources, and this has been a factor leading to the current situation of some checks being prioritised at the expense of others. But this report also shows that Health could reach more children through more effective and efficient use of its available resources. This would go some way to maximising the benefits to children, their families, the health budget and the community.

Executive Summary

Background

There are around 200 000 children aged 0-6 years living in Western Australia (WA). Research shows that there are critical milestones in children's early development that impact on their physical, mental, social and emotional wellbeing for the rest of their lives. Around 17 per cent of all children are estimated to have some developmental problem that requires intervention.

Checking children's development at the right time during their first five years can prevent or detect problems early on. Undetected developmental delays may worsen and have long term negative effects on a child's health, education and other life outcomes. Untreated developmental problems have been linked to behavioural disorders, poor learning outcomes at school and juvenile delinquency; these carry a social and economic cost to the whole community. It is generally accepted that early detection and intervention saves money in the long term.

WA Health (Health) has a free universal child health check program that promotes the best possible early development for all WA children. It offers seven health and development checks to children aged between birth and school entry (generally around four years old), and is supported by a statewide evidence based policy.

These health checks are the entry point to accessing other child health services. The universal checks are important for identifying potential developmental delay so that children can be referred for further assessment and treatment where necessary. Within the public health system Child Development Services (CDS) are the main provider of these specialist intervention services.

The number of children receiving checks will have a direct impact on the demand for treatment at CDS and their waitlists. If children miss the early detection and intervention opportunities offered by health checks, problems can go undetected and become more severe. This may lead to longer and more intensive treatment which also impacts waitlists for CDS services.

Between 2005 and 2008 the state had a 12 per cent increase in birth rates, mostly in the metropolitan area. There has also been increased migration to WA. These factors have led to more children being eligible to receive the free health checks, but there has not been a corresponding increase in the numbers of child and school health nurses. In its 2010-11 budget, Health allocated around \$60 million for child and adolescent community health services in the metropolitan area, which includes providing health checks and support to families with young children. Health could not tell us how much it spends on child health in the country regions.

Although the schedule of child health checks is the same statewide, how the checks are delivered is not the same. Since 2007 metropolitan child and adolescent health services have been combined and reorganised to improve the consistency of service delivery. This has not been the case in the country, and there are variations between and within the seven country regions. How services are delivered will depend on the size of population centres, the distances between them, and the people who live there. For example, in a region such as the Kimberley that has a high proportion of Aboriginal people (around 50 per cent), living in widely dispersed communities, the service delivery is quite different to that in a country centre like Bunbury.

Our audit focused on three questions:

- Does Health have clear objectives for delivering its universal child health checks and are they being met?
- Does Health understand the universal need/demand for child health checks and the resources required to meet this?
- Is Health using its resources to deliver universal child health checks efficiently and effectively?

Our audit covered the delivery of universal child health checks by both metropolitan and country health services. Seventy-five per cent of WA children aged 0-6 years live in the metropolitan area where birth rates have risen significantly. Since 2007, when metropolitan child health services were combined, there has been a drive to make service delivery consistent within the metropolitan area. In the country, circumstances vary from region to region and so does the delivery of child health checks. Providing even basic information across all regions proved difficult for Health. Consequently, this report draws mainly on evidence from the metropolitan area, highlighting key country issues where appropriate or different. Nonetheless, our findings and recommendations are relevant to service provision across the state.

Audit Conclusion

Many children are missing out on key health checks between birth and school entry. As a result, some developmental problems are not being detected and intervention is being delayed. This can have a significant impact on children's development and school readiness.

Health is giving priority to the first four checks, and is reaching 99 per cent of newborns within the first month in the metropolitan area. But this is at the expense of other checks. Only 30 per cent of 18 month olds and nine per cent of 3 year olds received checks in 2009-10. Health has not demonstrated why it considers this approach to be the best use of available resources.

Take-up of universal child health checks is voluntary. Although Health recognises that it needs to deliver services in flexible ways to make them accessible, in the metropolitan area it has made little progress in improving accessibility. The services available across the metropolitan area are not consistent in spite of attempts to make them so, and depend on where families live rather than their needs.

Health does not have good information on its universal child health checks which hampers its ability to plan and deliver services effectively. Health is not using its current resources as efficiently as it could. More effective facilities management, and better information technology (IT) and administrative support for child health nurses would help them reach more children.

Key Findings

- Universal child health checks are important for detecting developmental problems at the right time.
- Many WA children are missing out on health checks or not getting them at the right time, because Health has prioritised some checks over others.
 - There is a mismatch between actual service delivery and the policy to offer all of the checks to every child.
 - Health is prioritising the first four checks at the expense of other checks and this means that developmental delays are being detected late.
- Health has not demonstrated that what they are delivering with limited resources represents the best value for money.
 - Health does not know if the benefits of prioritising some checks over others outweighs the consequences of missed checks.
 - Health does not have a full suite of appropriate performance targets and measures so it lacks information about how well it is performing.
- Take-up of universal health checks is voluntary and relies on parent engagement, but the services are not easily accessible to all families even though Health has previously recognised that changes are needed to achieve this.
- Services available to families vary depending on where they live and some centres are offering more checks than others.
- Although Health's information system is limited, Health could use it better to manage and report on its services.
- Because Health's service and financial information is not robust, planning for future funding and workforce requirements is based on estimates and assumptions.
- More children could be reached if nurses were better supported to deliver services more efficiently.
 - Many child health nurses do not have access to adequate IT.
 - Nurses are spending considerable time doing clerical tasks instead of checking children.
- Poor facilities management means there is a lack of capacity to house new nurses and many centres are in a state of disrepair.
 - Health lacks effective facilities management so planning and securing new centres is ad hoc.
 - Health relies on local government to provide premises for child health centres, but it is unclear who is responsible for maintenance.
 - Significant underspending on repairs and maintenance means some centres are not safe.

Recommendations

To demonstrate that it is delivering best value for money, Health should:

- set performance targets for each child health check and report its performance against these in its annual report
- improve its patient management system and financial reporting to provide better business information for service management and planning, and performance monitoring
- use its existing information system (HCARe) more effectively as a stop gap until an improved system is in place
- undertake analysis to demonstrate that its current practice gives the best value for money.

To increase the number of children receiving checks, Health should:

- better promote to parents the importance of all the child health checks and particularly the 18 month and 3 year old checks, which rely to a greater extent on parent engagement
- implement different models of service delivery to improve accessibility of services in response to changing community needs.

To improve consistency of services and support offered to families wherever they live, Health should:

- put in place monitoring mechanisms to support nurses in delivering services in keeping with the core business framework
- consider partnering with other agencies to make better use of other government and non-government services that are funded and set up to deliver relevant complementary services, such as parenting information and toddler groups.

To better support child health and school nurses so they can reach more children, Health should:

- ensure adequate IT support for all child health and school nurses
- review its approach to administrative tasks such as booking appointments and collating data to free-up nurses to deliver services
- review its management of child health facilities to coordinate leasing and maintenance to ensure that buildings are safe, 'fit for purpose' and located in the right place.

Response from WA Health

WA Health welcomes the report and the recommendations of the performance audit and is committed to addressing them. WA Health acknowledges that there are gaps in community based child health services in Western Australia, and has started to address this issue through an additional investment of \$49.6 million statewide over four years to improve access to Child Development Services.

Western Australia's approach like other States and Territories in Australia, is to provide a foundation universal child health service which includes child health checks supplemented by more targeted and specialist services.

The first year of life is critical to ensuring the healthy growth and development of children. WA Health's child health nurses provide a wide range of services and support to ensure that health issues are identified and addressed. This includes issues such as 'failure to thrive', infections, hearing loss and congenital abnormalities, as well as supporting a strong emotional attachment between parents and babies. Child health nurses also play an important role in reducing infant mortality through addressing risk factors for sudden infant death syndrome. If these issues are not addressed a child is much more likely to experience poor health, emotional and educational outcomes throughout their life.

WA Health's aims to provide accessible services to all children and families, however it is evident that services have not kept pace with increased demand resulting from the unprecedented population growth in recent years. WA Health is making the best use of available resources by focussing on the first year of life and ensuring the ability to provide support to families and children with higher needs.

WA Health is committed to improving the effectiveness, efficiency and accountability of child and school health services and will consider the Auditor General's recommendations. The importance of an adequate electronic client service information management system to support service delivery and provide performance data is acknowledged.

WA Health acknowledges the need for improvements in community health and will use the Auditor General's report to inform its facilities planning as part of our State Health Infrastructure Plan.

Universal child health checks are important for detecting developmental problems at the right time

Research shows there are critical developmental milestones in a child's early years that impact on lifelong physical, social, emotional and mental wellbeing. Around 17 per cent of all children will have a developmental delay. Timely detection and intervention for health and developmental problems gives children a better chance for positive life outcomes.

Government recognises the importance of these early years in improving the health and wellbeing of infants, young children and their families. In its November 2009 response to the Community and Justice Standing Committee inquiry, government confirmed its commitment to achieving a vision that 'children will have the best start in life to achieve optimal wellbeing, development and learning'.

Health offers a universal health check program to promote the best possible early development for all WA children. Checking children at the right time during their development can prevent or detect problems early on. If problems are not detected at the right time they may worsen and have a longer term negative impact on a child's health, schooling and other life outcomes. These negative outcomes also carry a social and economic cost to the community as a whole. It is generally accepted that early intervention saves money in the long term.

Western Australia's free Universal Child and School Health Schedule is delivered by child health and school nurses

Health's free universal program of child health checks offers seven checks to all WA children. These checks are based on the *Universal Child and School Health Schedule*, which lists optimum times for health and developmental assessments (Appendix 1). There are six checks between birth and three years, plus a school entry assessment in the first year of school attendance, which can be at kindergarten, pre-primary or year one. The universal child health schedule is based on clinical evidence and reviewed every three years.

Since the 1920s WA has delivered some form of universal child health service to the community. Health employs child and school health nurses who are registered nurses with post graduate qualifications in child and family health to deliver the service. There are around 350 full time equivalent (FTE) positions doing this work. The checks are generally delivered in child health centres owned by local governments and located throughout the state, and in the case of school entry assessments at private and public schools.

Today, the child health nurse does more than just weigh and measure babies. Their role has grown to match society's increasing understanding of the complexity of problems faced by parents. As well as checking a baby's growth and physical development (such as sight and hearing and 'clicky hips'), nurses also assess maternal and family health and wellbeing. They do this to detect early signs of issues, such as post natal depression, concerns with breastfeeding, hereditary health risks, domestic violence, child abuse, and drug or alcohol issues in the home. These can impact on whether mother and baby form an attachment and bond in the first years of life. Attachment is considered critical for forming positive relationships and social functioning throughout life.

Nurses use clinical and professional judgement as well as a variety of tools and techniques to make these assessments including:

- observation of family dynamics and the home environment
- discussions with parents (usually the mother) and toddlers
- questionnaires for parents about the child's development
- questionnaire for mothers to detect signs of postnatal depression.

Nurses also promote child health and development by giving timely and relevant advice on issues such as avoiding Sudden Infant Death Syndrome, the best time for introducing solid food, good nutrition and sleep strategies, promoting 'tummy time' to strengthen baby's neck muscles, 'reading and rhyming' to assist speech development, and 'lift the lip' to encourage early dental care.

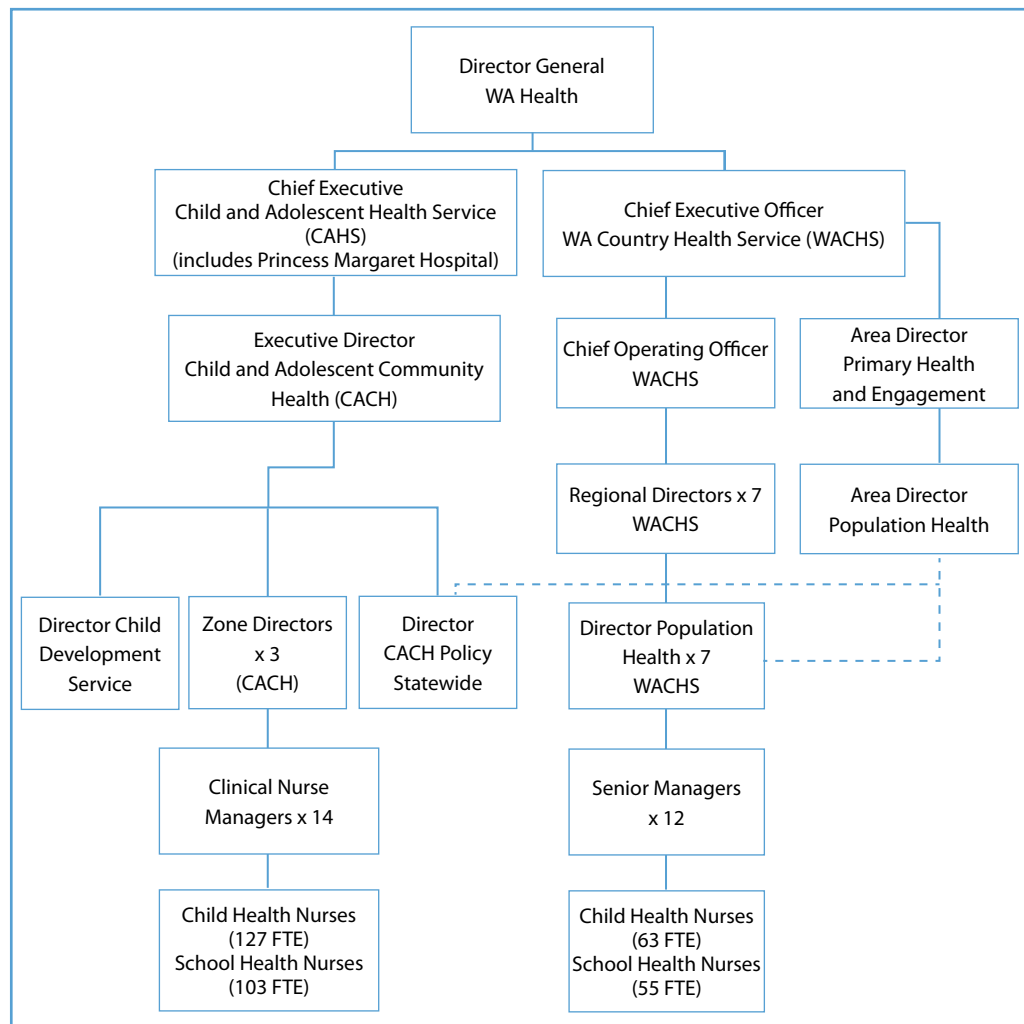
Nurses are an important referral point linking families and children to other services within the health system and the community. The universal checks are complemented by targeted services, and nurses refer families to these when more intensive support is warranted, or when a culturally specific approach is more appropriate (such as services for Aboriginal or refugee families). When developmental issues are identified (such as vision, hearing or speech problems) nurses refer families to a GP or to the state's Child Development Service for further assessment and treatment.

The last of the seven checks is the school entry assessment. This is delivered by a school health nurse and can take place at school in either kindergarten, pre-primary or in year one, depending on when the child is first enrolled, and the policy of the school.

School entry assessments focus on detecting hearing and vision problems. At this assessment, nurses do not generally check for other developmental issues such as speech or language, unless a concern has been raised by a parent or teacher. Parents are asked to complete a Parent Evaluation of Developmental Status (PEDS) questionnaire. The nurse uses this to determine whether the parent has any concerns, and whether the child is already undergoing treatment for issues. If issues are identified or confirmed, the child may be referred for further assessment to the Child Development Service or a private practitioner. Parental consent is required before a child can undergo the school entry assessment and it is provided in most cases.

Delivering universal health checks presents different challenges in the country and metropolitan areas

Child health checks are a universal service available to all children in WA, and the schedule of child health checks applies across the state. There is a statewide policy that supports the delivery of child health services, however the structures, the models of delivery and the ways of working are different in the country and metropolitan areas (Figure 1).



*FTE is operational FTE at 2009-10

Source: CACH, WACHS and Office of the Auditor General

Figure 1: Organisational structure of Health's child health services in Western Australia

WA Health provides universal child health checks across the whole state. In the metropolitan area the service is provided through the Child and Adolescent Health Service, which incorporates Princess Margaret Hospital and the Child Development Service. In country areas child health checks are provided by seven different regions as part of community health services.

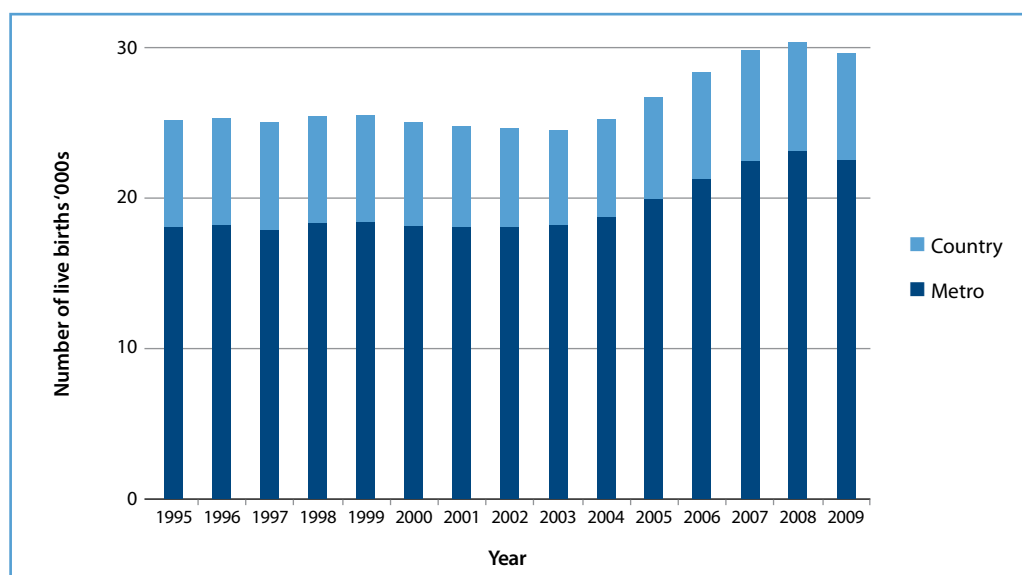
Historically, child health services have been aligned to individual area health services, with child health nurses employed by the area health service. This is still the case in the country. Child health services are provided by seven regional health services that are coordinated by WA Country Health Service (WACHS). In most instances, community health is still linked to and located with the local country hospital, and often child health services are delivered by community health nurses. These nurses are responsible for more than child health and have several roles, including hospital based work and community work with adults.

Between and within the seven country regions the delivery model varies depending on the size of population centres, the distances between them, and the people who live there. For example, in a region such as the Kimberley that has a high proportion of Aboriginal people (around 50 per cent), living in widely dispersed communities, the service delivery is quite different to that in a country centre like Bunbury. Because of these differences WACHS encourages nurses to adopt a localised approach and greater flexibility in the way services are delivered.

However, a different approach has been taken in the metropolitan area where the aim is to provide a consistent service. Following the release of the Health Reform Implementation Taskforce recommendations in 2007, all metropolitan child health services have been combined and aligned with Princess Margaret Hospital, to form the Child and Adolescent Health Service. Child and Adolescent Community Health (CACH) is part of the Child and Adolescent Health Service and is responsible for delivering child health checks. Unlike country regions, where nurses have multiple roles, CACH has dedicated child health nurses that carry out the first six checks, and school nurses that deliver the school entry assessment.

Since 2002 there has been a significant increase in the number of children eligible for child health checks, but Health advises resources have not kept pace

An estimated 200 000 children aged 0-6 years live in WA of which 75 per cent live in the metropolitan area¹. Between 2005 and 2008, there was a 12 per cent increase in birth rates (Figure 2). Most of the increase has been in the metropolitan area.



Source: Health and ABS

Figure 2: Country and metropolitan birth rates (live births) between 1995 and 2009

Between 1995 and 2003 the birth rate was fairly stable. However, there was a significant increase in the number of births between 2005 and 2008.

¹ ABS population projections for 2010 provided by Health.

Given child health checks are available to children between birth and school entry, birth rates are only one indicator of demand for the service. International and interstate migration is another key factor. With the current resources boom, there has also been an increase in migration to WA, and some of these will be people with young families. However, Health advises there has not been a corresponding increase in child health and school health nurses to service the growing population.

Health allocates \$66 million to deliver child and adolescent community health services in the metropolitan area

For 2010-11, Health has committed \$285 million to deliver child and adolescent health services in the metropolitan area, which includes Princess Margaret Hospital. Twenty-three per cent (\$66 million) was allocated to child and adolescent community health services, including child and school health checks.

WA Country Health Services (WACHS) was unable to provide an estimate of the total cost of these services in country regions because its accounting does not separate the child health services, including child health checks, and other community health services.

Child health checks are the 'front door' to other child health services

Universal child health checks are the entry point to other child health services. Child health nurses are the main referral point to CDS. The Child Development Service employs doctors and therapists to provide specialist intervention for issues such as vision, hearing, behaviour and speech and language problems. Overall, because the delivery of child health checks and the demand for child development services are directly linked, efforts to address waiting lists in CDS are unlikely to be effective without an understanding of the 'front end' of the service. To manage CDS services effectively in the long term, Health needs a clear understanding of which child health checks will be delivered, how many children will be reached and the likely number of referrals to CDS.

When a potential problem is detected by child health nurses, information and strategies may be provided to assist parents to address the problem. However, if the problem persists or if a serious developmental delay is detected then the child is referred to CDS. This means that the number of children receiving universal checks has a direct impact on the demand for specialist services provided by CDS, and on their waitlists.

Children missing their universal health checks can also impact CDS and the waiting list for specialist services. If children miss their checks, developmental issues may not be detected, intervention may be delayed and this can lead to a need for more intensive and prolonged treatment later. This in turn takes up more capacity within CDS which can increase waiting times.

There have been three parliamentary inquiries into child health and development services

Child health and development has been the subject of recent inquiries by parliamentary committees. Their reports have highlighted a number of concerns with current child health services, including that:

- services in WA have not kept pace with the state's population growth and are under-resourced
- waitlists for therapy and treatment of identified developmental delays are too long
- health, education and care services lack integration creating potential gaps in and duplication of services.

In response, government is considering how best to integrate services for young children and their families. It has also increased funding for therapists to address the long wait lists at CDS. However, there has been no specific response in relation to child health checks.

While delays in treatment is a significant issue, of equal concern is the number of children missing out on child health checks at the appropriate times or altogether, resulting in problems not being identified in the first place.

Audit focus and scope

The focus of this audit is the universal child health check program carried out by WA Health through the Child and Adolescent Health Services (CAHS) and the WA Country Health Service (WACHS).

Our audit focused on three lines of inquiry:

- Does Health have clear objectives for delivering its universal child health checks and are they being met?
- Does Health understand the need/demand for universal child health checks and the resources required to meet this?
- Is Health using its resources to deliver universal health checks efficiently and effectively?

Our scope includes the seven universal child health checks offered to children from birth to school starting age (0-6 years) living in WA.

Our audit covered the delivery of child health checks by both metropolitan and country health services. Seventy-five per cent of WA children aged 0-6 years live in the metropolitan area where birth rates are increasing most rapidly, and where the demand for child health checks will grow most in coming years. Since 2007 metropolitan child health services have been combined and reorganised to improve the consistency of service delivery.

In the country, circumstances vary from region to region and so does the delivery of child health checks. Management information about country services was limited and the situation in the country areas we visited may not be representative in every respect of all the other regions. Consequently, this report draws mainly on evidence from the metropolitan area, highlighting key country issues where appropriate or different. Nonetheless, our findings and recommendations are relevant to service provision across the state.

The audit does not include targeted services (such as those for Aboriginal or refugee families, or families considered at risk by Department of Child Protection), or health checks provided by general practitioners, or services provided by other organisations (such as commonwealth funded Aboriginal Medical Services, or non-profit organisations).

The audit was conducted in accordance with the Australian Auditing Standards.

Many Western Australian children are missing out on health checks or not getting them at the right time, because Health has prioritised some checks over others

Findings

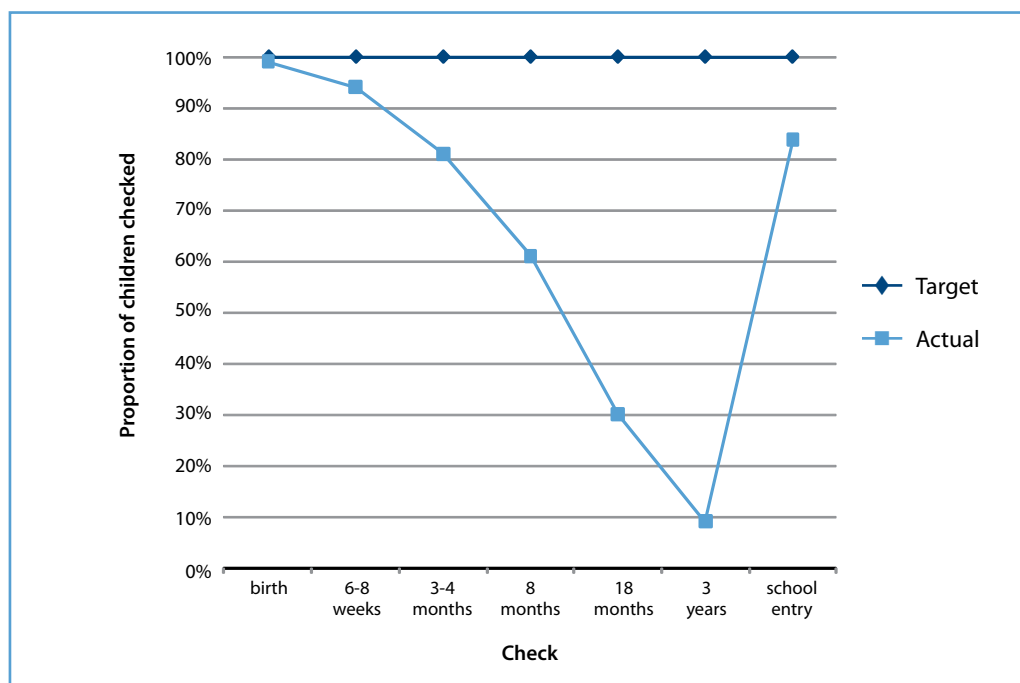
- Many WA children are missing out on health checks or not getting them at the right time, because Health has prioritised some checks over others.
 - There is a mismatch between actual service delivery and the policy to offer all of the checks to every child.
 - Health is prioritising the first four checks at the expense of other checks and this means that developmental delays are being detected late.
- Health has not demonstrated that what they are delivering with limited resources represents the best value for money.
 - Health does not know if the benefits of prioritising some checks over others outweighs the consequences of missed checks.
 - Health does not have a full suite of appropriate performance targets and measures so it lacks information about how well it is performing.

There is a mismatch between actual service delivery and the policy to offer all of the checks to every child

The universal schedule aims to offer six checks between birth and 3 years of age, plus a school entry assessment. Research based evidence says that each of these checks is equally important. However, Health's data for 2009 in the metropolitan area shows that many children missed out on checks (Figure 3).

In 2009, 99 per cent of newborns had the initial home visit check, but only 30 per cent of 18 month old children and nine per cent of 3 year old children were checked. This situation improved at school entry with 84 per cent checked.

Many Western Australian children are missing out on health checks or not getting them at the right time, because Health has prioritised some checks over others



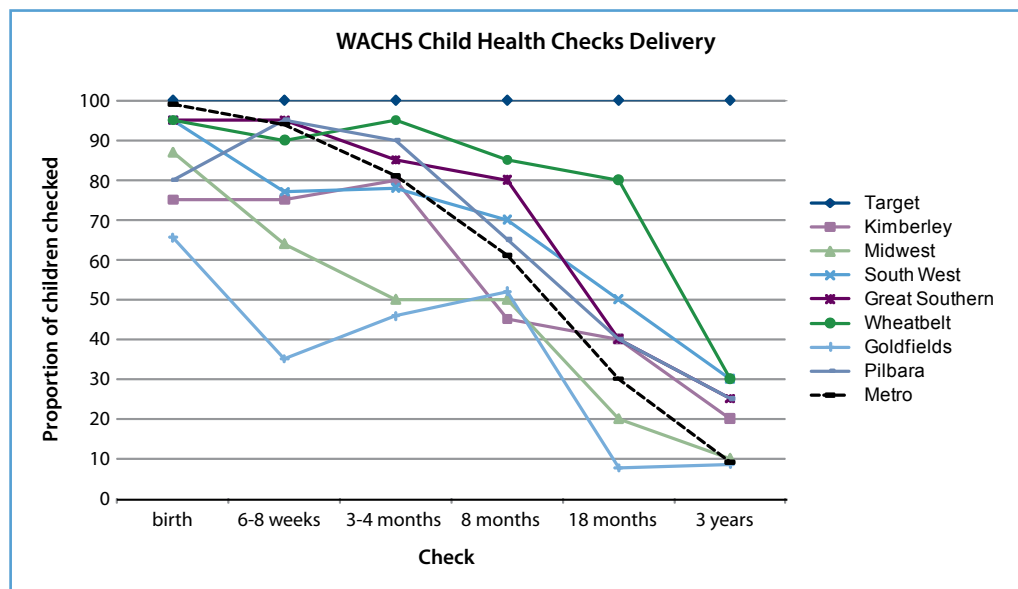
Source: CACH and Office of the Auditor General

Figure 3: Health's policy aim and actual occasions of service for child health checks in the metropolitan area

Health's aim is to offer all checks to 100 per cent of WA's children at the appropriate time. However, in practice, Health is falling well short of this goal. Metropolitan data for the first six checks is current at 2009-10. The school entry assessment percentage is based on 2008 data, as this is the most recent data available.

Levels of service delivery in the country vary from region to region, and in some country regions levels of delivery are consistently higher than in the metropolitan area (Figure 4). For example, 80 per cent of children in the Wheatbelt received the 18 month check in 2009-10. This compares with 30 per cent of children in the metropolitan area and 7.6 per cent in the Goldfields for the same check.

Many Western Australian children are missing out on health checks or not getting them at the right time, because Health has prioritised some checks over others



Source: WACHS, CACH and Office of the Auditor General

Figure 4: Health's policy aim and actual occasions of service for child health checks in the seven country regions and the metropolitan area

The seven country regions are performing differently but none are achieving Health's target for all checks. The Wheatbelt region appears to be reaching the highest proportion of country children. Several regions are performing better than the metropolitan area, but the Goldfields and the Midwest are consistently below other regions and the metropolitan service.

Health is prioritising the first four checks at the expense of other checks in the metropolitan area, and this means that delays in child development are being detected late

Health promotes the first checks up to 8 months of age, but places particular emphasis on the initial home visit in the metropolitan area. The effect of prioritising these is that fewer children receive later checks. This is especially the case for the 18 month and 3 year old checks, which in 2009 reached only 30 per cent and nine per cent of children respectively. Up to the first 8 months of age, parents are encouraged to have children checked, and nurses proactively schedule appointments for these checks so that they happen at the right time. For later checks, parents are advised to make appointments only if they have concerns, and then may have to wait up to six weeks for an appointment.

This means that developmental delays that would potentially be picked up at these later checks may not be detected until the school entry assessment when the child is 4-5 years old. If the child's school entry check is missed, detection of developmental issues will rely on parents and teachers noticing a problem.

Many Western Australian children are missing out on health checks or not getting them at the right time, because Health has prioritised some checks over others

Key developmental milestones occur between 8 months and 3 years of age, particularly those related to speech and language. The best time to detect speech and language problems and provide intervention is at the 18 month check. Children who miss checks at this stage are at risk of not being 'school ready' and this can adversely affect long term educational outcomes.

Health has recognised this service gap and its potential impact on child development and school readiness. A 2010 draft internal Health memorandum highlighted that 'the lack of access to community child health nurses potentially presents the risk of long term consequences for children and WA – developmentally, socially and economically'.

There are flow-on effects for CDS in the metropolitan area which are responsible for delivering specialist intervention. Children with speech and language development delays that are not identified until school entry age (around 4 years old) may require longer and more intensive treatment. They may also wait longer for therapy than children with delays detected at 18 months, because CDS gives priority to younger children. The prioritisation framework used to waitlist children for treatment services gives service priority to children aged 0-3 years over children aged 4-6 years. At July 2010, 47 per cent of children on the CDS waitlist were waiting for a speech therapy assessment. This is the highest of all the assessment waitlists.

We note that in spite of the emphasis on the first home visit being done within 10 days of birth, only 46 per cent were done within that target time. In 2009-10, the majority of first home visits occurred between 10 and 22 days. While it is a good result that Health is reaching the majority of newborns with a first home visit, some of the potential benefits may be lost for those outside the 10 day target.

Health has not demonstrated that what they are delivering with limited resources represents the best value for money

The universal schedule shows that all checks are equally important. However, Health considers its child health resources are insufficient to deliver all the scheduled checks to all children. It therefore made a decision that in the metropolitan area it will focus its resources on the first four checks so as to best ensure that it can reach as many children as possible early on.

Health has not demonstrated that the benefits of prioritising some checks over others outweighs the consequences of missed checks

We expected Health to have a clear documented reason for its decision to focus its efforts on the first four checks. This was not the case. Health has evidence of the importance of the first checks, but it has not demonstrated that the benefits of these early checks outweigh the consequences of later checks being missed by the majority of children.

Health has chosen to give priority to the first home visit and the other three checks in a child's first 8 months of age, rather than deliver all the checks to fewer children. However, it cannot demonstrate that their approach delivers better outcomes for WA children.

Many Western Australian children are missing out on health checks or not getting them at the right time, because Health has prioritised some checks over others

The schedule of seven checks between birth and school entry are based on evidence that each check is as important as the next and all coincide with key developmental milestones. The earlier checks focus on infant and maternal health, detection of developmental delay, early intervention and access to timely service and supports. Later checks, particularly those occurring at 18 months and 3 years of age, focus on detection of development delays which are best detected at these later ages, including speech and language. It is therefore important that all seven checks are completed at the right time so that developmental delays can be detected for timely intervention.

Health does not have a full suite of appropriate performance targets and measures so it lacks knowledge about how well it is performing

On the way to achieving its long term target of universal delivery, Health has not set realistic short term targets to measure its performance. Health has not articulated what it considers an acceptable proportion of children that should receive each of the scheduled checks. As a result, we cannot give assurance that the proportion of children currently receiving checks represents acceptable performance and a good use of resources.

In September 2010, Health endorsed two internal key performance indicators for child health nurses delivering the universal child health checks, but neither of these set targets to increase the number of children checked. The internal KPIs for child health nurses are:

- 90 per cent of the parents of newborns are offered a universal postnatal first contact within 10 days after birth
- 100 per cent of mothers attending the 6-8 week and 3-4 month schedule contacts are offered the Edinburgh Postnatal Depression Scale questionnaire.

On the other hand, school nurses do have a target that aims to increase the number of children checked:

- 90 per cent of enrolled (government and non-government) kindergarten students receive a school entry assessment.

While development of these indicators is a step in the right direction, they fall short of setting an interim performance target to drive progress in increasing the number of children checked towards the goal of universal coverage. Further, we note that the first indicator only requires nurses to 'offer' a home visit within the first 10 days, rather than requiring actual checks to be completed within the first 10 days. This indicator seems to require a lesser performance level than current practice, which is that the home visit should be 'completed' within the first 10 days.

Services would reach more children if they were more accessible, consistent and better managed

Findings

- Take-up of universal health checks is voluntary and relies on parent engagement, but the services are not easily accessible to all families even though Health has previously recognised that changes are needed to achieve this.
- Services available to families vary depending on where they live and some centres are offering more checks than others.
- Although Health's information system is limited, Health could use it better to manage and report on its services.
- Because Health's service and financial information is not robust, planning for future funding and workforce requirements is based on estimates and assumptions.

Take-up of universal health checks is voluntary and relies on parent engagement, but the services are not accessible to all families

Health's objective is to offer a universal service to each child from birth to school entry. Given the voluntary nature of the service, it relies on parent uptake and participation. It is unlikely that Health will ever reach all children, but if its services were more accessible to parents it could increase the number of children checked.

Currently, Health's two key points of capture are at the first home visit and again at school entry. This is because the model of service delivery for these checks does not rely on parents bringing children to the centre.

Health's data shows that after the first contact there is a steady decline in the use of the service. The reasons may include:

- the centres are only open during weekday business hours which can make accessibility difficult for working parents
- parents become more confident and require less support as the child grows older
- parents may choose to use other services instead, for example GPs
- parents with second and third children may be less likely to use the service as they may have less time to schedule appointments
- Health does not actively promote the importance of all checks, particularly the 18 month and 3 year old checks.

Health's services are not easily accessible to all families though it has recognised this need

Health's model of service delivery is not well suited to the lifestyles of many modern families. The limited opening hours and the historical location of some centres impacts on many working parents and reduces the potential number of children that could be checked.

In the main, the service delivery model has not changed in the metropolitan area since the 1960s. Historically, child health facilities were single buildings located in or near the local park and in 'pram-walking distance' from home. Most of these facilities were open 9am to 5pm Monday to Friday, allowing mothers to take their children while their husbands were at work.

However, times have changed and what was an appropriate and relevant model then may not be now. For example, today most families have access to a car or public transport; there are many more working mothers and more children are in childcare. (According to the Department for Communities 2009 Annual Report, around 70 000 children were enrolled in licensed child care centres. This was around 35 per cent of children aged 0-6 in the state).

While Health's 2007 policy and draft 2010 policy encourage a flexible approach to service delivery, the policy initiatives have not been implemented. For example, centres could:

- open evenings or weekends for working parents
- arrange regular mobile services to childcare centres, shopping centres and at community events
- make the service more 'father' friendly through the introduction of fathers' groups, using father centric language and emphasising the importance of the father's role.

Health has piloted some options since 2007, including locating child health centres at shopping centres across the metropolitan area. Even though these pilots were successful, Health has not continued to provide this model of service.

One successful initiative that has continued is the introduction of home visits within 10 days after birth. This has replaced the 1-2 week scheduled centre visit since 2007.

In the country areas there are more flexible models of service delivery. Some regions use an 'outreach model' particularly for Indigenous people or people living in remote areas of the state. This allows nurses to go to the community and the people, rather than wait for the people to come to the service.

Services available to families vary depending on where they live

Historically, Child Health nurses have worked autonomously with limited oversight. The role of child health nurses is unique and multifaceted and aims to respond to problems that families face. These problems are complex and include domestic violence, drug and alcohol abuse, social isolation, and postnatal depression. Consequently, over time centres have offered different services depending on individual nurse's qualifications, experience, special interests and local need. This means that different

services are available in different locations. For example, one centre may offer expert breastfeeding and sleep consultations and another may not. In some cases, one centre may provide this type of service for the whole region.

Health has begun to use population and socio-economic data to help determine where expert services are most needed. However, currently the service a family receives is still mostly reliant on the interest and capacity of the individual nurse at the centre. Therefore, some families may miss out on valuable services because they are not offered at their local centre.

As part of a drive for more consistent and equitable service delivery across the metropolitan area, the Service Objectives and Governance Activity (SOGA) review was commenced in 2008 and is ongoing. The aim of SOGA is to determine 'core business' for nurses. Prior to SOGA implementation, some nurses were providing services not typically aligned to child health. For example, grandparent walking groups and providing health care to teachers.

An outcome of SOGA was the development of core business frameworks for child and school health nurses in 2010. These frameworks guide nurses on which services to deliver. While the framework is currently in place, there is no mechanism to ensure nurses are adhering to it or interpreting the framework in the same way across the metropolitan area.

Some centres are offering more checks than others

Some WA children are being offered 18 month and 3 year old checks and others are not. This is because Health's universal schedule, policy and verbal advice from management are inconsistent. This inconsistency was evident at child health centres we visited in the metropolitan and country regions and from discussions with senior management.

Health's October 2009 universal schedule lists the health and development assessments and interventions that child and school health nurses are meant to deliver to all families at the seven contact schedule stages from birth to school entry assessment. This emphasis on all seven checks is inconsistent with Health's 2007 Policy Rationale which advises nurses to promote opportunities for families to have contact with their child health service at the critical points in the first 12 months of a child's development. Health advised us that metropolitan nurses were verbally instructed in 2009 to no longer contact parents to proactively schedule appointments for the 18 month and 3 year old checks.

This inconsistency has led to some centres:

- not offering the 18 month and 3 year old checks at all
- offering the checks in a different format, for example via telephone
- continuing to promote and offer the 18 month check.

This inconsistency was starkly evident in comparisons of completed checks between the Wheatbelt and the metropolitan area. Health's data shows that 80 per cent of 18 month checks are completed in the Wheatbelt compared with only 30 per cent in the metropolitan area. This is because in the Wheatbelt nurses are actively promoting the 18 month check and linking this to the 18 month immunisation.

Health's information system is limited but it could be used better to manage and report on its services

Health currently uses HCARE, first implemented in 1992, to maintain child health check information. HCARE, a hospital based system, was not designed to hold community health information. Currently, there are five different versions of the HCARE database in the metropolitan area, and around 50 in country regions. These are not integrated, which makes compiling regional or statewide data difficult and time consuming. Because of these limitations, Health does not have the data it needs to effectively manage its service.

While we understand these limitations, Health could nevertheless get greater benefit from the system by using all available data fields and ensuring consistent data entry. For example, nurses currently only record an 'occasion of service' for a completed check but are not required to enter the unique medical record number (UMRN). Entering this information would allow Health to track individual children over time and know how many children are receiving each of the checks.

Further, Health is not using the HCARE field for recording the length of time spent on different types of occasions of service. This means that Health cannot distinguish between the time taken for a telephone call to schedule an appointment, an extended telephone call to a distressed parent (both considered a consultation), and the delivery of a child health check. Entering the time taken for each type of occasion of service would assist resource planning and allow Health to compare the time taken to deliver services across centres.

Since 2008, there has been planning for the design and implementation of a new web-based patient management system. This was to replace HCARE and would be specifically designed for non-hospital health services, including child and school health. In its July 2010 response to the Education and Health Committee parliamentary inquiry, government said that the new system was a 'high priority', and that funding had been identified and planning was well advanced. However, at November 2010, Health had still not progressed the new system.

Health has advised that the advantages of the proposed system would be:

- integrating data and replacing the multiple HCARE databases with a single purpose built system
- greater capacity to record and track child health information for individual children
- greater accessibility – nurses could access the system via the internet rather than requiring computers to be networked and the system could be shared with school health nurses (who currently use education networks)
- providing improved clinical governance and greater capacity to monitor and evaluate service delivery
- providing necessary service activity data for planning and management.

In August 2010, Health introduced statewide HCARE Coding Guidelines to improve the consistency of data that nurses enter in HCARE. Implementation of the new guidelines is not yet complete. The need for quick implementation was evident to us in September 2010 when some nurses advised that they recorded a single check as one occasion of service, while others advised that they recorded a single check as two or three occasions of service, depending on how many family members participated in the discussion. Group screening and information sessions are also being recorded differently across centres.

In the South West region, Bunbury in particular, has started using children's UMRN in HCARE. This information should allow nurses to track individual children through the system.

Planning for future funding and workforce requirements is not based on robust data and analysis

In order to plan for future services effectively, robust financial and service information is required. Health uses a range of information including numbers of live births, FTE numbers and HCARE data. However, because Health's HCARE data is limited and incomplete, Health relies on estimates and assumptions about its service delivery when planning and analysing its resource requirements.

For instance, Health uses the number of occasions of service to estimate the proportion of time that nurses spend on delivering various child health services (checks, consultations, and group sessions) which in turn feeds into planning for the number of nurses needed. In its resource planning Health has assumed that occasions of service equate to time spent.

Health's assumption is incorrect because the time spent on different types of occasions of service varies. For example, each scheduled check is one occasion of service, and takes an average of 45 minutes but a phone call may take only five minutes but still be recorded as one occasion of service. A group session with 10 children may be recorded as 10 occasions of service but only take an hour. Occasions of service data also does not capture the time nurses spend on clerical and administrative tasks.

Similar to its service data, Health's financial information is inadequate to support effective planning and delivery. In 2009-10, the Child and Adolescent Community Health Service spent approximately \$60 million on child health services. The 2010-11 budget is similar. Health's use of block funding for all community health services means that it is unable to provide a detailed breakdown of funds spent on specific services such as child health checks. As a result, Health is unable to determine the cost of delivering a health check and therefore relies on estimates for future planning purposes.

The WA Country Health Service was similarly unable to advise the total cost of providing child health checks in country regions. Child health services are delivered by community nurses who are responsible for more than child health. It is therefore difficult for WACHS to determine the proportion of time and cost involved in delivering child health services.

One of the impacts of limited data and financial information is that Health has been unable to develop a successful business case that demonstrates the need for more child and school health nurses. Health has advised it is currently in the process of drafting a new business case.

More children could be reached if nurses were better supported to deliver services more efficiently

Findings

- More children could be reached if nurses were better supported to deliver services more efficiently.
 - Many child health nurses do not have access to adequate IT.
 - Nurses are spending considerable time doing clerical tasks instead of checking children.
- Poor facilities management means there is a lack of capacity to house new nurses and many centres are in a state of disrepair.
 - Health lacks effective facilities management so planning and securing new centres is ad hoc.
 - Health relies on local government to provide premises for child health centres, but it is unclear who is responsible for maintenance.
 - Significant underspending on repairs and maintenance means some centres are not safe.

Many child health nurses do not have access to adequate information technology

While the 2007 restructure has centralised service delivery in the metropolitan area, communication and information technology (IT) support services are still fragmented. This has resulted in nurses continuing to use inefficient manual systems for recording and reporting.

A 2008 internal Health memorandum acknowledged that IT support services are fragmented, untimely and limited. Prior to amalgamating metropolitan child health services, centres were aligned to area health services. However the central coordination of child health services has not been extended to IT support. Child health centres are still dependent on technical support from the local hospital. Hospitals have their own priorities and this means there are varying levels of support provided to nurses in child health centres.

In 2008, Health implemented the network connectivity project. Nearly all centres now have computers. But in four out of the eleven centres we visited in the metropolitan area, the computers were still not networked. This means that some centres cannot receive electronic birth notifications. At these centres, birth notices are received by fax or post.

A lack of network connectivity also means nurses are also unable to input their HCARE data electronically. As a result, nurses manually compile information and submit this weekly to administration centres where the information is entered electronically in HCARE. This double-handling is inefficient and increases the potential for data entry errors.

Historically, nurses have kept handwritten records for each child. Given the limited information able to be captured in HCARE, nurses update a separate health record book for each child at each visit. The storing of these records at each centre constrains information sharing in and between child health and school health nurses. Therefore, possible indicators of developmental delay or concerns raised by parents or nurses during early screening may not be followed up at later health checks or at the school entry assessment.

Regional services that are co-located with hospitals have better IT support. However, some centres in the north west are so remote that their computers cannot access the Health network or internet.

The IT situation for school health nurses is also not ideal as the computers they use at schools are networked to the Department of Education's IT system rather than Health's systems. The only way they can get access to Health's electronic information is by returning to their administration base.

Nurses can spend considerable time on clerical tasks instead of checking children

In addition to providing their core services child health nurses are also responsible for administrative tasks such as:

- scheduling appointments and returning telephone calls
- entering weekly HCARE data (manually or electronically)
- photocopying information sheets (either in the centre or at regional administration base)
- ordering and arranging pickup or delivery of stores (baby wipes, paper towels, hand sanitiser).

Nurses can spend considerable time doing clerical and administrative tasks. For the centres we visited, nurses advised they could spend up to two hours each day on administrative tasks including returning calls from clients. Some of these calls might be quick ones to schedule appointments but others take longer, and may result in phone consultations, depending on the needs of the client. This additional workload often resulted in nurses working through lunch breaks or after closing hours.

In the Greater Bunbury area, a centralised booking service, run by administration staff, has been successfully piloted and implemented. Although Health has not yet determined whether this has led to more children being checked, some benefits have been identified:

- fewer phone calls for nurses to return each day
- fewer grievances and improved work/life balance for nurses (who are now able to take a lunch break)
- improved customer service – parents making appointments can speak to a person rather than leaving a message on an answering machine
- booking changes can be made by administration staff and are reflected immediately in nurses' diaries.

Health is yet to decide whether to implement a similar booking service across other regions or in the metropolitan area.

In South Australia, the Children, Youth and Women's Health Service (CYWHS) is responsible for providing child health services. It involves volunteers in the provision of its community-based services to assist child health nurses run their centres.

More children could be reached if nurses were better supported to deliver services more efficiently

Trained volunteers work alongside nurses to provide non-clinical support, such as:

- welcoming parents and children into the centre and facilitating interaction between parents in open sessions
- playing with toddlers and supervising young children while parents are with professional staff
- assisting parents who wish to weigh their babies and children
- assisting staff with parenting groups and promotional displays
- providing information to parents about children, youth and women's health services and community resources.

While we recognise that volunteer coordination will also take time, this is one approach that Health could consider to free-up nurses' time.

Poor facilities management means there is a lack of capacity to house new nurses and many centres are in a state of disrepair

Health is not effectively planning and managing its child health facilities to support service delivery. It needs more centres, but is not pro-actively planning or securing new sites. The majority of its existing centres are in local government owned premises, many of which are old and in a run down condition. Responsibility for the condition of the centres is blurred and Health has no budget for their maintenance and repairs. Health is therefore not well placed to expand its services or to ensure that the existing centres are safe or fit for purpose.



Figure 5: Front entrance of the Carlisle Child Health Centre

The Carlisle Child Health Centre has a permanent sign erected on the centre's fence advising the community it is 'not a public toilet'. This centre is a similar style to other centres housed in older local government owned premises.

Source: Office of the Auditor General

Health lacks effective facilities management so planning and securing new centres is ad hoc

Currently there are 106 child health centres in the metropolitan area. The majority of these are located in local government owned premises. Health has asked for 105 more child health nurses over the next four years. However, the existing centres in the metropolitan area cannot house all of the requested staff and so more centres would be needed. But, facilities management is currently not coordinated and planning is ad hoc.

We would expect Health to have effective facilities management and planning to support service delivery. This should include:

- coordinating existing leases
- liaising with local governments
- finding and negotiating potential new sites
- organising the re-location of some existing centres
- managing repairs and maintenance.

Between 2008 and 2009, Health had a facilities manager responsible for all child health service facilities, including child health centres in the metropolitan area. However, this position was abolished in 2010. Currently facilities management is shared between senior staff that may not all have the specialist skills, the right networks or the time to pro-actively seek opportunities for new sites. Consequently, Health often finds out about a potential site after the planning stage has commenced or been completed. This results in Health missing out completely or being allocated rooms that are not fit for purpose. For example, there may be no sink for washing, which creates hygiene risks, or having to share a room with another service provider, which would compromise confidentiality.

A review of all metropolitan child health facilities undertaken in January 2007 made recommendations about Health pro-actively seeking to partner with local government and other stakeholders to establish new facilities. Health has advised that as part of the its 10 year State Health Infrastructure Plan it is developing an overarching facilities plan. This will aim to identify the facilities required to deliver an integrated health service, and will include community health. In 2010, Health employed a special projects manager to oversee negotiations for securing space for centres at proposed GP super clinic sites in Cockburn, Wanneroo and Midland. A similar coordinated approach has not been adopted for securing other sites. The review also recommended co-location and integration of child health services in single purpose-built facilities.

Health relies on local government to provide premises for child health centres but it is unclear who is responsible for maintenance

Most centres in the metropolitan area are located in local government owned premises. Up to 2008, the responsibility for service delivery and maintenance of child health centres had been based on a non-legally binding 1953 Cabinet Minute between Health and local government authorities. Historically, Health employed the child health nurse, and local governments provided the premises, including ongoing maintenance. Increasingly, local governments are asking Health to pay rent at commercial rates or pay for maintenance of buildings, and in some cases to give up the premises.

In January 2008, Health, WA Local Government Association and Department of Local Government and Regional Development (now Department of Local Government) signed a memorandum of understanding (MOU) to 'underpin the planning and support for the provision of child health facilities in Western Australia'. It included an in-principle agreement to formalise terms and conditions of Local Partnership Agreements between area health services and local governments, and for the negotiations to be based on the needs of the local community. However, the MOU does not specify which of the parties is responsible for maintenance, so this continues to be an unresolved issue.

It remains unclear what impact these agreements will have on mitigating any responsibility that Health has for maintenance costs. Health's 2010-11 budget does not include an allocation for maintenance and repairs of child health centres.

Significant underspending on repairs and maintenance means some centres are not safe

The majority of the centres in the metropolitan area are local government owned and were constructed 30 to 40 or more years ago. Many are now in need of significant maintenance and upgrade. In 2009, Health identified that many of these facilities needed urgent maintenance to address breaches of standards for:

- fire and safety
- occupational health and safety
- hazardous substances management
- disability access.

Health's estimate of the total cost for repairs to its child health and child development centres was \$5.2 million, based on an average cost of \$40 000 per site. The minor works included in the estimate were: painting, roof repairs, plumbing repairs, security systems, asbestos removal where present, air conditioning and floor coverings.

However, the 2009 estimate of \$5.2 million may be understated. Assessments obtained by Health of the cost of repairs to three sites averaged around \$69 000. If the cost of repairs to these three sites is representative of the condition of the other centres, then we estimate the total cost would be \$8.7 million.

More children could be reached if nurses were better supported to deliver services more efficiently



Figure 6: Front entrance of the Karrinyup Child Health Centre

Similar to some other child health centres, Karrinyup's Child Health Centre is isolated in the corner of a local park. This local government owned building is old and in a run down condition, however Health has no budget for its maintenance or upgrade.

Source: Office of the Auditor General

Appendix 1



Delivering a Healthy WA

Government of Western Australia
Department of Health

Community Health Services

Universal Child and School Health Schedule

Contact Schedule	Health & Development Assessments	Intervention *	Promotion of Health & Development
Birth < 10 days Home visit	1. Family health and wellbeing 2. Hearing risk factors 3. Vision risk factors	Respond to assessments **Safe-sleeping intervention	Infant feeding /Breastfeeding Immunisation Parent support and child development Injury prevention Maternal and family health
6-8 weeks	1. Family health and wellbeing 2. Full physical Assessment 3. Vision Assessment 4. Hearing/language and vision questions 5. Maternal health and wellbeing - EPDS	Respond to assessments Talking Together/Yarning Together	Infant feeding /Breastfeeding Immunisation Parent support and child development Injury prevention/safety Communication, language and play Maternal health/ anxiety & depression Family health
3-4 months	1. Family health and wellbeing 2. Developmental Assessment (PEDS) 3. Vision Assessment 4. Weight Assessment 5. Vision/hearing/language questions 3. Maternal health and wellbeing - EPDS	Respond to assessments Better Beginnings family literacy program	Infant feeding /Introduction to solids around 6mths Immunisation Parent support and child development Injury prevention Maternal health/ anxiety & depression Family health Playgroups information
8 months	1. Family health and wellbeing 2. Developmental Assessment (PEDS) 2. Full physical Assessment 3. Vision Assessment 4. Vision/hearing/language questions 5. Maternal health and wellbeing – EPDS 6. Oral Health	Respond to assessments **Lift the Lip	Nutrition/Transition to lumpy foods Injury prevention Communication, language and play Sleep Immunisation Parent support and child development Maternal health/ anxiety & depression
18 months	1. Family health and wellbeing 2. Developmental Assessment (PEDS) 3. Vision/hearing/language questions 4. Oral Health	Respond to assessments **Lift the Lip	Healthy eating for toddlers Injury prevention Immunisation Parent support and child development Playgroup and child care information
3 years	1. Family health and wellbeing 2. Developmental Assessment (PEDS) 3. Vision/hearing/language questions 4. Oral Health	Respond to assessments **Lift the Lip	Family healthy eating and physical activity Injury prevention Immunisation Preparing for school Parent support and child development
School Entry Assessment	1. Family health and wellbeing 2. Developmental Assessment (PEDS) 3. Vision Assessment 4. Hearing Assessment	Respond to assessments	Family healthy eating and physical activity Immunisation Injury Prevention Parent support and child development Hints for starting school

* The Interventions described are those that are universally offered to all families - At all contacts community health nurses will respond to parental or nurse concerns (e.g. parenting, safety or child and family health issues) and act on professional observation and judgement within their scope of nursing practice.

**The Safe Sleeping and Lift the Lip Interventions will be introduced universally in 2010.

(Version 1 Oct 2009)



Auditor General's Reports

REPORT NUMBER	2010 REPORTS	DATE TABLED
12	Second Public Sector Performance Report 2010 – The Price is Right? Setting fees and charges for government services – Royalties for Regions – Local government spending	24 November 2010
11	Universal Child Health Checks	24 November 2010
10	Audit Results Report – Annual 2009-10 Assurance Audits	10 November 2010
9	ICT Procurement in Health and Training	13 October 2010
8	Environmental Management of Cockburn Sound	22 September 2010
7	Fitting and Maintaining Safety Devices in Public Housing	11 August 2010
6	Energy Smart Government	30 June 2010
5	Fiona Stanley Hospital Project	23 June 2010
4	Audit Results Report: Annual Assurance Audits completed since 2 November 2009, including universities and public colleges; and Compliance Audits: Managing attractive assets; Managing salary payment errors	5 May 2010
3	Public Sector Performance Report 2010 – Opinions on three 'Ministerial Notifications' – ministerial decisions to not provide information to Parliament – Registration of Medical Practitioners	5 May 2010
2	Information Systems Audit Report	24 March 2010
1	The Planning and Management of Perth Arena	10 March 2010

REPORT NUMBER	2009 REPORTS	DATE TABLED
13	Audit Results Report: 2008-09 Assurance Audits	11 November 2009
12	Fourth Public Sector Performance Report 2009 – Preliminary Examination of the Royalties for Regions Program – Accountability for Government Grants – Management of Government Purchasing Cards	11 November 2009
11	Third Public Sector Performance Report 2009 – Regulation of Firearms – Follow-up – Managing Staff Attendance in the Public Sector – Evaluation in Government	21 October 2009
10	Adult Community Mental Health Teams: Availability, Accessibility and Effectiveness of Services	14 October 2009
9	Every Day Counts: Managing Student Attendance in Western Australian Public Schools	19 August 2009
8	Opinion on Ministerial Notification: Ministerial Decision to not Provide Information to Parliament – Country Age Pension Fuel Card	19 August 2009
7	Second Public Sector Performance Report – Dangerous Goods Safety – Compliance in Western Australia's Commercial and Recreational Fisheries	25 June 2009
6	Maintaining the State Road Network	17 June 2009
5	Rich and Rare: Conservation of Threatened Species	10 June 2009
4	Coming, Ready or Not: Preparing for Large-scale Emergencies	20 May 2009
3	Audit Results Report – 31 December 2008 Assurance Audits and other audits completed since 3 November 2008	6 May 2009
2	Information Systems Audit Report	8 April 2009
1	Public Sector Performance Report 2009 – Management of Water Resources in Western Australia – Follow-up – Administration of the Metropolitan Region Scheme by the Department for Planning and Infrastructure – Management of Fringe Benefits Tax	1 April 2009

The above reports can be accessed on the Office of the Auditor General's website at www.audit.wa.gov.au

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