T R A N S C R I P T

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Mildura — 9 November 2017

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Witnesses

Ms Lois O'Callaghan, CEO, and

Mr Grant Doxey, program leader, social work and community development, Mallee Track Health & Community Service.

The CHAIR — Welcome, everyone, to this public hearing of the Family and Community Development Committee's inquiry into perinatal services in Victoria. This is the seventh hearing to be held by the committee for this inquiry in a series of hearings that are being held in Melbourne and regional Victoria. The committee is delighted to be here in Mildura today and looks forward to hearing from the local community. Please see our website for details of upcoming hearings. Please note that the broadcasting or recording of this hearing by anyone other than accredited media is not permitted. Just a reminder: please turn your cell phones to silent.

Welcome to these public hearings, Ms Lois O'Callaghan, CEO of Mallee Track Health & Community Service. Thank you for attending today. We also have Grant Doxey here.

All evidence taken at this hearing by the committee is protected by parliamentary privilege as provided by the Constitution Act 1975 and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside the hearing will not be afforded such privilege. Just a reminder that it is a contempt of Parliament to provide false evidence. These proceedings will be recorded, and you will be sent a proof copy of the transcript. Other than that we are very, very nice people, and we are here to learn as much as we can today about perinatal services in regional areas, specifically Mildura. If you would like to start with a 10-minute piece telling us about yourself, and we might then ask some questions.

Visual presentation.

Ms O'CALLAGHAN — Thank you for the invitation to come and talk to the committee today. I am Lois O'Callaghan. I am the CEO of Mallee Track Health & Community Service, and my colleague Grant Doxey is a program leader for social work and community development. Our organisation, Mallee Track Health & Community Service, is located across an 18 000-square-kilometre catchment, and we are based primarily at Ouyen, which is 100 kilometres south of Mildura. Our borders stretch across to South Australia, to Murrayville, and we stretch down as far as Sea Lake, which is another 100 kilometres from Ouyen. We service a very rural part of the Mallee, and that is the catchment that we serve. In the 18 000 square kilometres, there is a population of about 4500 people.

I thought I would take the opportunity to talk a bit more broadly. I have a presentation for members of the committee, which I will move through quite quickly. Our organisation is a multipurpose service. The multipurpose service model is only in operation in seven organisations in the state of Victoria. It is quite unique, and it is a model that I think is worthy of consideration in terms of potentially expanding how we improve outcomes in rural areas. A multipurpose service in Victoria is a block funding model in rural aged care in areas where activity-based funding models would not be viable. We have a flexible and pooled funding arrangement with the integration of a whole range of services. We are not a specialist service; we are what would be termed a generalist-type service in a rural context. We provide a state and commonwealth, whole-of-government shared response to improve outcomes in areas of thin population and where there is thin workforce.

Multipurpose services have been around for 20 years in Victoria. A few of the benefits of the MPS model include that it ensures viable aged and community care services are run within a place. It provides for community needs and population planning, which results in service delivery that is efficient and cost-effective and in addition is at the closest point of care to the client. The pooled funding arrangements allow for thinking and service delivery outside of the box, so we can think about what the community needs and how we can use our pooled funding to best meet the needs of that community. There is significant integration of services for a thin population and thin workforce. We can have many staff within our organisation who perform a multitude of roles, so again it is a generalist model within a rural context where specialists cannot necessarily deliver or do not even wish to be located.

What the literature says about improving outcomes for children and families is that where children live can have an impact on their life outcomes and developmental trajectories. The children who live in the catchment where we operate are vulnerable on two or more domains of the Australian Early Development Census. Where children live has a significant impact on developmental outcomes. Families incur costs when services are funded and delivered on a centralisation model, which broadens the health and broader life outcomes divide. What we, as a multipurpose service, see in our community is that a multipurpose service can be utilised as a lever for service viability for a range of state and commonwealth-funded services outside of the tripartite agreement.

So our organisation, as a whole-of-government response, has an agreement with the state, commonwealth and the community — it is a three-way arrangement. These services would not necessarily be viable if they were required to stand alone or to operate individually. The approach to flexibility and pooled funding is only able to be applied to those services in scope for the MPS. The community expects more from us as a health service. The community looks to the MPS as the one-stop shop across the life span. Their preference is for services to be delivered in place in their community with a local workforce.

What we also see in our community is that there are a range of drive-in, drive-out services across the early years and the life span. There is potential for better cost efficiency and improved outcomes through applying the MPS model across more service types. The MPS model is a clear demonstration of a collective impact model in action in rural areas. Just to give you a sense of that, in terms of what that meant for us as an MPS 20 years ago, there were nine individual standalone organisations operating across our catchment. In their wisdom they saw the benefits of collectivity and put aside their own needs and agendas and developed the MPS model, which is the one governance arrangement which oversees all of these things. So collective impact is actually a very important platform for the MPS model.

The potential benefit of the MPS model — stability and viability has been demonstrated through the service model, particularly in aged care. Robust governance arrangements provide comfort to the parties in the tripartite arrangement through enacting the organisation, through the Health Act, as a public sector organisation. The Minster for Health has the ultimate control over us as an entity. The MPS has a role to play in addressing life and health outcomes across the life span in the community in which it operates.

Integrated service delivery reduces the need on families and providers for travel and improves service access. Flexibility in the pooled funding arrangements results in wraparound-style services which focuses on outcomes rather than activity results. The responsibility for population-based planning focused on early years services is placed on the state, commonwealth and MPS in a whole-of-government methodology. The MPS model also has local people delivering local services to local people — a one-stop shop in place. It also has the potential for key worker models, which could be applied. Families tell their story once, and service continuity and seamlessness may be able to be achieved.

I guess in conclusion and for the consideration of the committee, expanding the MPS model across the life span has not been explored in the Victorian context, using the lens of improving health and life outcomes for children and families in the rural context. The MPS model should be considered as a potential solution in the rural context where the population and workforce is thin.

For the information of the committee, the MPSs across Victoria are currently undertaking an environmental scan of our model within our system and of where it sits more broadly within our health system, and I would be happy to provide a copy of this to the committee if you would be interested in this at some point,. Thank you for the opportunity to provide a presentation to you today. Are there any other questions you would like me to respond to?

The CHAIR — We will have plenty of questions for you. I might start if that is okay. Thank you for that information. I note that you said in your submission that:

> … the MPS model is a solid solution which we commend for consideration across the age range and life span in the rural context.

And we see from that presentation how effective it is. Do not take this as a negative — this is actually us exploring different options to recommend to the state government — how has the MPS actually been evaluated?

Ms O'CALLAGHAN — That is actually one of our challenges, Paul, and the reason why as MPSs we have commissioned a piece of work around our environmental scan. Very early in the establishment of MPSs — 20 years ago — they evaluated the model in the first five years. No subsequent evaluations of the MPS model have been conducted, but the MPS model has continued to enjoy bipartisan support by health and human service departments. What we do know is, as I presented today, it presents as a financially viable model that delivers to the closest point of care to the client as possible. One of our challenges as MPSs is that we are small — we are only seven in Victoria — so we actually are a very, very small piece of the whole puzzle. As a consequence we fly under the radar a little bit in terms of evaluation of the model. It is less of a priority than other, bigger ticket items within the health system. But very much we would desire as MPSs for that model to

be evaluated to confirm what was found in the first five years around the establishment of the MPS model, and we would welcome that from any side of politics.

The DEPUTY CHAIR — To further understand the way the MPS works, are you able to provide a case study, for example with perinatal services — the requirements there — and what happens and how it works for them?

Ms O'CALLAGHAN — What I can talk about in the context of perinatal services are simple examples around service delivery for services like maternal and child health. As a multipurpose service, we do not currently have that within our service mix and our service type. The way the current model of maternal and child health services work is it is a centralised model. It is delivered by local government, and it is delivered on a hub-and-spoke-type arrangement.

So if you were a young mum who lives at Murrayville, out near the South Australian border, 250 kilometres from the regional centre, you would have to book an appointment with your maternal and child health nurse, who might come once a month. Now, if that maternal and child health nurse does not have four clients to see on that day, you might have to wait two months, three months, until enough demand can be queued to be able to have your child assessed, in terms of the requirements that are placed on a maternal and child health service. That is a simple example of how perinatal services can impact on children and families.

What I would perhaps put forward to you for consideration would be models of service. In a community, say, like Murrayville, where there is a school or a long day care service, there is a workforce that already understands early childhood development that could work with and under a delegated scope of practice around maternal and child health to assess children's development and work with the maternal and child health service to report on children's developmental outcomes and how they might work together to be able to improve that. I think there are a number of different models that could be considered in that whole arrangement.

The DEPUTY CHAIR — So how do you go about progressing that?

Ms O'CALLAGHAN — That is one of our challenges. It is actually about how do we develop a generalist workforce in rural areas that is properly funded to respond to the perinatal needs, in this particular context, of the community and of families and children in that community. One of our limiting factors as an organisation is that we are often not the funded organisation to do that. So we see that there are needs, but because we are geographically isolated it becomes very difficult then for us to always facilitate that warm referral across to another service provider who is driving in and driving out of that catchment.

Ms EDWARDS — Thanks for coming in today. My particular interest is around mental health, particularly for women post birth. Does your service provide mental health support, and if not, what are the expectations for women with mental health issues across the region?

Ms O'CALLAGHAN — Thanks, Maree. I might actually refer this one to you, Grant.

Mr DOXEY — I suppose we have a very limited generalist social work service in parts of our catchment, around the Sea Lake area. The mental health services are delivered out of Mildura, so what I see is lots of travelling in. It is delivered from the provincial centre, whereas with a bit of investment in local professionals and support for those professionals, there could be a localised solution, particularly I suppose for the non-acute, the 90 per cent — I am not saying the most important stuff. So I suppose to the first part of your question, it is delivered from outside of the area most of the time. However, there is a capacity to invest in the local people — local professionals — and provide them with the support to deliver a local solution, which would probably be much more readily available in place.

Ms EDWARDS — So your multipurpose service does not actually have a mental health component?

Mr DOXEY — That is correct.

Ms EDWARDS — Could you perhaps outline to me, just to clarify, what professional services you do actually have at the MPS?

Mr DOXEY — For a mental health service we have generalist social work. That could deal with anxiety and depression and, I suppose, non-acute stuff, but it is too thin to cover the need, and it probably needs

investment in to tailor it to have a perinatal focus. Where I would see the advantage is if we could invest in local people who have generalist roles but are skilled up at least to cover nine-tenths of the issues. That would be a significant help and would provide the localised service without having to call on services from 100 kilometres or 200 kilometres away.

Ms O'CALLAGHAN — The other thing that we do have in place as a multipurpose service is that we provide, for example, a district nursing service. So if you are thinking about how we respond in a perinatal context to a mum who might present as preliminary stage postnatal, your first point of call would be your district nursing service, potentially. Whereas you could train a workforce and have a small amount of funding that sits alongside it for a response to that particular issue. I guess it is about how we develop in the rural context wraparound services. That is our key platform in the MPS model.

The other services that we do deliver are in the long day care space and in the kindergarten space. Where you have those services, and where potentially an organisation that is integrated, as we are, and delivering services, they are a key point of entry. Long day care staff will be talking to first-time mums or families who have got multiple children. That is the first point of soft entry. So our best investment is in that kind of workforce, where potentially we could train them in how to respond to those things. At the very frontline level, that would prevent escalation into a secondary or tertiary system. At the moment we do not have the capability to do that, because it would be outside the scope of practice of those particular staff to work in any space other than what they already do.

In terms of the population and how an MPS works in the aged-care space, which is how it was established many, many years ago, state and commonwealth looked at the population size and determined on a per capita basis the amount of funds that would be set aside that would meet the aged-care requirements of that community. They set aside that bucket of money, for want of a better term, to say, 'Determine with the community the best wraparound style of service that you can within this scope of what fits within aged care'.

A similar parallel we could do potentially in these kinds of service areas would be to say that on a per-population basis we would anticipate potentially this many mental health presentations or this many interventions at a primary level. You could potentially bind all that together in the mental health space, the maternal and child health space or any other broadband community service style, for want of a better word. You could wrap them together and have an integrated workforce that delivers that at the closest point of care for the client. So what it means is that workforce-like district nurses might be more than just district nurses. They would be mental health workers. They could potentially work with a higher scope of practice around maternal and child health. I recognise that in maternal and child health obviously you need quite an extensive amount of qualification to be able to perform that. But more and more what we see in rural communities is what we call delegated scopes of practice. So for areas where we have difficulty recruiting doctors, we use practice nurses and we use RNs as first-level triage. Why wouldn't we be turning our thinking to other service models, say for mental health, where you cannot get a mental health clinician? We might train mental health assistants or other forms of workforce that allow us to respond to the first and presenting need of those families and communities.

Dr CARLING-JENKINS — Thank you for coming in today. I really appreciate it. Your submission was fantastic. Thank you for supplying that to us. I am really interested in a point that you made in your submission, and you also mentioned it in your presentation, around children being identified as developmentally vulnerable. I wonder if you could unpack some of the reasons here for that and perhaps explore, parallel to that, the flexibility of your model in dealing with that group of children.

Ms O'CALLAGHAN — Would members of the committee be familiar with the Australian Early Development Census?

Ms COUZENS — Yes.

Ms O'CALLAGHAN — In the cohort that we have looked at — and I can provide it post hearing today if you are interested in particular service profiles specific to our community — there are four or five different domains. I did not bring the material with me, so I will just have to speak offhand about that. There are five different domains that the census measures. It is around social maturity, physical development, mental health and a couple of others. The point they use to measure that is through kindergartens. I think it is in the first or second year of school maybe that they do some longitudinal work around that, because that is the earliest point where they can measure cohorts in a big number around those things.

Dr CARLING-JENKINS — Okay, so it is not in earlier childhood?

Ms O'CALLAGHAN — No, because unless you intervene and go and assess children's development in long day care, which is where your next biggest cohort would be, the earliest point of measurement for the early developmental index is at kindergarten, where you can get a captured group of children in one space and are able to measure those domains.

When I talk about children being developmentally vulnerable, the domains that children in this part of the catchment are developmentally vulnerable on are around their social skills, their physical development and their mental health.

Dr CARLING-JENKINS — Mental health?

Ms O'CALLAGHAN — Yes. It is difficult for us to draw conclusions about that. We can only assume why that would be. I guess what we do know as an MPS is that we are an early years manager; we manage kindergartens. What we do see is that with children another area is speech. Children are developmentally delayed with speech. What that often means is that they have not had perhaps parents being taught to talk to their child from a very early age and to sit and read so that they learn the early language and literacy skills that are required. By the time they present at kindergarten they are already delayed.

The other thing that is important about the MPS model is that where MPSs are present there is a distinct lack of private providers. In our particular context there is no private speech pathologist. There is plenty of market in the provincial areas. Why would private providers want to move to a rural area where there are more costs involved with delivering the service?

These are the issues. That is actually probably to the core of the problem — the lack of private providers. Where there would normally be one or some services to respond to that need in your community, it is just not present, because they can get enough demand somewhere else. That is why the MPSs were established around using a public sector model of service delivery.

Dr CARLING-JENKINS — So I guess early intervention is a gap as well, then?

Ms O'CALLAGHAN — Yes.

Dr CARLING-JENKINS — That is what you are indicating. You are catching these issues in kindergarten, but obviously early intervention would —

Ms O'CALLAGHAN — Yes, and there are platforms I think for us to engage earlier with families. In our particular service model, which is unique to other MPSs, we are the governing body for five different long day care services. So we are a very early point of entry potentially where you could do integrated and wraparound services for families.

Dr CARLING-JENKINS — But again it is that funding.

Ms O'CALLAGHAN — Wouldn't it be great? The earliest a child can present for long day care is at six weeks. It is a great opportunity to be able to intervene earlier in a child's development and to work a lot more closely with the family at the very earliest point of contact with that family — if we could build a workforce and a model that allowed us to do some wraparound services.

I guess probably a good example of that — we are a funded family services provider — is that when a family that is vulnerable presents to our long day care service, our long day care service will provide what they can in the long day care space, but what that means is that they have to refer the family then to a service provider 100 kilometres away to get further support around the other issues that are presenting as vulnerable for that family, where they might be at risk of child protection involvement.

I guess probably our desire as an MPS would be that we would not want to necessarily have to refer that family out when we already have a warm point of contact, that we could potentially provide wraparound services where the family only tells their story once and they can get what they need in a rural context.

Dr CARLING-JENKINS — That is that key worker model.

Ms O'CALLAGHAN — Yes, the key worker model works very, very well. I guess probably what is important about the MPS model is that it was built for rural, and rural communities in our experience have a very strong desire around self-determination. I guess probably the parallel that I would draw would be around what we see in Aboriginal community-controlled organisations where they have a strong desire for self-determination. In the rural context, rural communities have that similar desire. They would like a local workforce and they would like to be able to determine for themselves what that looks like in the service mix. MPSs were established only for rural areas. Both models were never considered because the workforce is thin and the populations are thin.

Dr CARLING-JENKINS — And you have that fly-in fly-out.

Ms O'CALLAGHAN — The best we can do is to move away from the fly-in fly-out. We might try to fly out a specialist service as and when we need it, but where we have the capability, we will build a workforce —

Dr CARLING-JENKINS — But you prefer to build the capacity here, of course.

Ms O'CALLAGHAN — Yes.

Ms COUZENS — Thank you for your presentation today. Just focusing on the multiskilling of health workers that has been talked about this morning, you are saying that that is perhaps the best way to go with that wraparound service and skilling up workers to take on other roles. How would you actually do that? Are you doing it now?

Ms O'CALLAGHAN — We are not doing it in the perinatal space, which is what you are looking at here, because we are not a funded provider for that. We are certainly doing it in areas like allied health and medical services.

The best example I can give you is with our podiatry service. It is a very simple example, and draws a parallel, I guess, to perinatal services. In our podiatry service we employ one podiatrist who services our whole catchment. What we have with our podiatrist is what I have referred to a couple of times now around a delegated scope of practice. We have an allied health assistant who is trained to a level where she can do some of the less complex work of podiatry. She can cut toenails, she can give preliminary assistance and she can do a care plan. So quite a complex client might come in. They might get seen by the podiatrist who sets out a care plan and sets out specific instructions for that allied health assistant, and then the next time the client comes in they will see the allied health assistant, who will be implementing the care plan as set out by the podiatrist or the head professional in that kind of circumstance. So I see that there could be parallels with that when you look at something like a maternal and child health service, where we know the workforce is quite thin in maternal and child health across the state. We have difficulty recruiting them. There is the potential for us to develop maternal and child health assistants, where you might have the maternal and child health nurse who comes in and sets a care plan that is then monitored by somebody who is a maternal and child health assistant, to be able to deliver the care plan to that particular child or family.

Ms COUZENS — So how would you skill up that assistant? I mean, how do you see that working?

Ms O'CALLAGHAN — It works in allied health through the allied health professional training that particular assistant in a particular skill or competency. The only way that allied health assistant can take that skill and competency on is if the allied health professional is confident that that person is competent at what they are going to ask them to do, and that allied health assistant is given a very strong structure around working only within what they are competent in and trained to do by that allied health professional.

Ms COUZENS — Is that on-the-job training rather than studying?

Ms O'CALLAGHAN — It is a new and emerging field in allied health. In allied health, they are quite a number of years ahead of, I guess, probably a number of other disciplines. There are accredited qualifications you can do as allied health assistants as baseline qualifications. With allied health assistants, you do a baseline qualification, but it depends on the discipline that you might work with. I have given the example of podiatry, but allied health assistants also work in physiotherapy, occupational therapy and there is an emerging field in social work. They will do a baseline mandated qualification, but then it is only when they decide the discipline that they are going to work in that the allied health professional will train them to be competent and confident in

what they do. An allied health professional would never delegate to an allied health assistant unless they thought that person was competent and confident in what they do.

Ms COUZENS — So you do not see there are any risks, particularly around mental health and those sorts of areas?

Ms O'CALLAGHAN — There is always risk involved with that. I think our best area, again, to look at is allied health and how they have managed those risks. In fact we already see those models happening in medicine. When we look at how GPs work in rural areas, there are emerging models around RIPERN nurses. That is a Queensland model, where RIPERN nurses actually work as GPs at urgent care centres where GPs cannot do after-hours or on call. A patient might present at an urgent care centre, which provides a first point of response. They might even write a script, because they have the capability and the training to do that as an interim measure until the client can see the doctor or the GP the next day. I think there are a number of other disciplines where that is already happening where we could learn lessons about how we would manage risk around all of those things. There are new and emerging fields around all of that.

The other area that I think is worthy of exploration is advanced scopes of practice. We have a specific example in our catchment where we cannot recruit a doctor, but what we have is a nurse practitioner, a GP nurse practitioner, who has prescribing rights. She can refer for X-rays, she can do chronic disease management plans — all of the functionality that GPs have, with the exception of things that are more complex and outside of her scope of practice that she would not be trained to do.

I see there would be opportunities for us to equally develop that in the mental health field and in the kinds of areas you are looking at today as a committee around perinatal services around advanced scopes of practice, where there would be very little chance you might recruit a specialist, but you could certainly invest in a local workforce by training a nurse to a higher level of practice who could work under the delegation of a specialist.

Ms COUZENS — Do you have a view around maintaining and attracting professional staff?

Ms O'CALLAGHAN — Yes, we do — local, local and local.

Ms COUZENS — Right. But how do you get the local people to do that?

Ms O'CALLAGHAN — We have always invested very heavily at the very first entry point around traineeships. We start actually right back at the very start with the schools. We talk to local children, local young people about career pathways in our health service. Every year we host a careers day where we talk about what it is we do as a health service and where potentially might be your career options. We expose the young people to a whole range of thinking — things they may not have even thought about. We link up with other professions in our local community. We partner with our schools in our catchment —

Ms COUZENS — Has that been successful, do you think? Have you seen young people transitioning into studies?

Ms O'CALLAGHAN — We started that initiative probably about eight years ago, and we are starting to see now young people go away — and this is quite a trend; I am an example of it myself — for a few years. They study, they might work away for a bit and then they come back in their late 30s. It is not an unusual model for that to happen. But certainly we are very proud as an organisation of developing the allied health models. They have been good around sustaining a local workforce. In our early childhood space where we deliver long day-care services we have a young workforce — young women particularly, which is often not uncommon in long day care — who are staying locally and want to live locally. That is their desire.

Ms COUZENS — And are you actively working with Aboriginal and Torres Strait Islanders or through organisations? How is that connection?

Ms O'CALLAGHAN — Within our catchment we are quite homogenous. We do not have a big population of Indigenous and Aboriginal people. It is certainly something that we do have a desire to do, but a genuine lack of presence of an Indigenous and culturally and linguistically diverse population makes that very difficult for us to do. But we certainly have a desire.

Ms EDWARDS — I just have one question about your MPS. Are there other examples in Victoria or Australia of this model?

Ms O'CALLAGHAN — Of the MPS model?

Ms EDWARDS — Yes.

Ms O'CALLAGHAN — The Victorian model is very unique. There are seven MPSs in Victoria. The Mallee Track is one. Robinvale District Health Services, who we are neighbouring, are also in this region. Otway Health, Timboon, Upper Murray — I could get you a list. The Victorian model is different to nationwide. There are actually 250 MPSs nationwide, but our governance model in Victoria is different. I am not sure how that came to be, but we are established as entities in our own right. The difference is that across Australia MPSs have been linked to local health networks as governing bodies, whereas in Victoria we are standalone and we are answerable to the Minister for Health. So we operate our own governance body, our own independent board of management —

The DEPUTY CHAIR — The Victorian Minister for Health?

Ms O'CALLAGHAN — Yes. Jill Hennessy, I believe, is the Minister for Health at the moment. We are tiny in the context of the broader health and human services sector, which in lots of ways makes the MPS model invisible, because we get swamped by lots of other service models and needs. But we are a very important model in the rural context.

The DEPUTY CHAIR — Just following up from that. We have got MPSs all around Australia —

Ms O'CALLAGHAN — Yes, correct.

The DEPUTY CHAIR — So in each state they are responsible to their own state health ministers?

Ms O'CALLAGHAN — No. That is something that is unique to Victoria.

The DEPUTY CHAIR — So we are the only ones responsible to a state health minister?

Ms O'CALLAGHAN — Yes, correct.

The DEPUTY CHAIR — And the others are responsible to —

Ms O'CALLAGHAN — The New South Wales model is local health networks. They effectively operate as a —

The DEPUTY CHAIR — That is the New South Wales model, though — just the New South Wales model?

Ms O'CALLAGHAN — Yes, in New South Wales. I am not familiar with the other states, but my understanding is Victoria is a unique model in terms of how it was enacted 20 years ago when they started building MPSs.

The DEPUTY CHAIR — So when you talk about funding, and you mentioned several levels of government — the federal, the state — and that you have got funding for different programs, that you like to work with the community to determine how best to spend that money, and you mentioned, for example, that you provided for family day care, does that not mean you just have to spend that money there?

Ms O'CALLAGHAN — Correct.

Dr CARLING-JENKINS — So how do you determine what pool of funds is available to be carved up how you think fit?

Ms O'CALLAGHAN — The pool of funds available to our community at this point in time is only limited to aged care, because that is where our MPS agreement currently sits.

The DEPUTY CHAIR — Yes, I get that.

Ms O'CALLAGHAN — So you will remember I talked in my presentation about the leverage that is being used by the state and the commonwealth. So our MPS agreement has formed the basis of other departments, like parts of government, coming to us as an organisation to say, 'We see there is a need for this in your community. We want to enter into a funding and service agreement with you to deliver this service but only for that aspect of it'.

So you are absolutely right; with our long day care service we can only use those funds for long day care because at this point in time they do not actually fit into our MPS pooled, flexible funding arrangement. But our MPS agreement has been used to deliver — it has formed the financial basis of how financial scale has been achieved to ensure a viable service so that other funding and service agreements and services can then be used to deliver off that.

The DEPUTY CHAIR — You mentioned also the engagement with community to find out what is needed, but then you have just said too that somebody came in and said, 'You need this', and, 'We want to provide it' So is it a bit of both?

Ms O'CALLAGHAN — Yes, absolutely, it is both ways. I guess probably the fact that we have a sense of what our community needs also means we can go and talk to other departments about what we see as needs in our community; and certainly where there is another funding opportunity we would use that to be able to draw on that rather than using our MPS or block funds to be able to do that. It makes us spread a lot further in terms of service delivery.

The DEPUTY CHAIR — Yes, you have lots of generalists and things like that. Is there ever any friction within the MPS model?

Ms O'CALLAGHAN — You might be best to talk to that. He is the practitioner, I am the CEO.

The CHAIR — Productive friction.

Mr DOXEY — I think there is always friction in any organisation to a certain level, but I think being local and committed to a community we try very hard to work together. One of the areas I am particularly familiar with is family services. We try hard to work together with the long day care, the kindergartens and everything like that, but as you are pointing out there are strictures on the funding. Say, to family services, 'We do it this way' — a siloed approach. I suppose our organisation would like to chop down the barriers a bit and meld it together a bit along the model of aged care.

Ms O'CALLAGHAN — Our biggest friction seems to be with funders who do not quite get our model, because they have difficulty understanding how someone can be so generalist or how such a workforce can be so diverse, with so many people doing so many different things. I guess what we have been very careful to do is to build a workforce that understands very much about what their scope of practice is and how they make sure they work within what it is we are funded to deliver, because once we start to work outside of that, that is not something that is safe for anybody.

The CHAIR — I have got just one last question, Lois. I notice you have a masters in human services management and also you are a graduate of the Australian Institute of Company Directors.

Ms O'CALLAGHAN — Yes.

The CHAIR — I just want to know your secret. When you have a specialist leave, what do you do to attract an appropriate specialist to your community when you have not got someone you have propagated from high school up through the ranks?

Ms O'CALLAGHAN — That is a great question.

The CHAIR — If you can answer it, we can go.

Dr CARLING-JENKINS — We have done our job.

Ms O'CALLAGHAN — I guess probably one of the other things is thinking about our succession planning internally within our organisation and probably more broadly. Probably a really good example of that is, say, at

our board level. One of our philosophies is about having a self-replacing flock. So when you know it is going to be your time to leave the board or leave the governing responsibilities, it is your job to work with the board to find your own replacement. So we have that, I guess, philosophy; we are always on the lookout. One of the things about rural communities is that farmers often marry women from outside, and sometimes those women bring great skills into our community. So sometimes we get lucky.

The CHAIR — *The Farmer Wants a Wife*?

Ms O'CALLAGHAN — Yes, *The Farmer Wants a Wife*. Sometimes we get lucky. But more often than not it is because we have thought about, 'Okay, we know the tenure for this position is that long. We need to think about who is coming next. What are we doing to build that? Do we need to bring in a specialist?' — because sometimes specialists are the answers and sometimes they are not. One of the things we are most challenged with in rural communities is the recruitment of doctors. The recruitment of doctors is a great answer, but it is not the only answer. What we have found is being able to train nurses to do more is a better answer than always relying on the fact that a doctor will always be in our community. I see it in a similar fashion in other service types. Rural communities do not have the luxury of always knowing that a specialist is always going to be there.

The other part that I have not talked about at length at all today is around developing models of telehealth or telesupport. They are certainly new and emerging models. We are starting to see that a lot in particularly medical services, where you might have nurse-led models — nurses with the patient in the room and the specialist on the other end of the telehealth-type arrangements. Both arrangements can work well. They are limited, depending on what the clinical need is of the client. It really does depend on what the presenting issue is in terms of what the client is seeking assistance for.

The CHAIR — Thanks so much. I am going to chalk that up to good planning then.

Ms O'CALLAGHAN — Thank you.

The CHAIR — Thank you so much for coming in today and making a contribution. It has been very, very useful for us. We might say goodbye to you and call on the next witness.

Ms O'CALLAGHAN — Thank you for the opportunity. Sorry, can I just check: I was to provide a copy of the environmental scheme; was there anything else the committee was seeking from us? The early development census profiles?

The CHAIR — Was there anything else you requested, Rachel?

Dr CARLING-JENKINS — Yes, the environmental scheme, as well, that you mentioned in your closing.

The CHAIR — If we could get the profiles that would be good.

Ms O'CALLAGHAN — Yes, I can provide environmental scheme and the AEDC data.

Dr CARLING-JENKINS — That would be great. Thank you very much.

The CHAIR — Thank you so much.

Ms O'CALLAGHAN — Thank you very much for your time.

Witnesses withdrew.