

WORKSHOP 1

Aged care in rural and remote areas

Chair: Rob Dempsey

Facilitator: Les Stahl

ROB DEMPSEY: This afternoon's session is going to be an interactive one. We're going to hear first of all two presentations, one from Coralanne Walker from the Tandara Lodge, Kentish Health Centre, who's going to outline a health integration services model that's been successfully developed and implemented in Kentish in Tasmania, north-western Tasmania, followed by Nigel Jefford from the Silver Chain organisation who's going to talk about acute care aged care integration in the Margaret River region of Western Australia.

And following that we'll have a facilitated interactive session trying to draw out some information that we can use to make recommendations going forward in relation to the needs and those sorts of things for aged care in rural and remote regions.

I would first like to call upon Coralanne Walker for her presentation. Coralanne is the manager, as I mentioned before, of the Kentish Rural Health Service in north-west Tassie. Coralanne has been involved in aged care and community care since about 1991, and has managed CACP, or community aged care packages, HACC community options, and also day care centres. Coralanne has recently found herself married and is now a farmer's wife, enjoying a new found interest in cows and sheep, which really when you think about it is what rural health is all about. So, welcome, Coralanne.

CORALANNE WALKER: Good afternoon everyone. I can't see you properly when I put my reading glasses on. If I don't put them on I can't tell you what we're all about. Okay. A new way to linking a community together in a rural area for health services is the topic that I'm going to talk about. The state and federal government have for some years attempted to place a range of services into rural communities which would cater for their complete health needs, the emphasis on aged care, community care, primary health care and some acute care facilities often referred to as multi-purpose centres.

While this had limited success there has been another service developed in rural Tasmania which goes beyond the multi-purpose service model and provides primary health care as well as aged and community care. The model developed is a whole of a community response to health, is privately run, not run by either state or federal government. The service was developed by a local community organisation with the assistance of the federal government. This service can be best described as the health integration service model, or HIS model. The development of the HIS model has taken three years and now provides services to a community on a holistic basis. Tandara is a community service run by the community for the community benefit. Okay.

Tandara Lodge Community Care Inc is the organisation which I work for. We're situated on the north-west coast of Tasmania and we call it "the promised land" near Sheffield. The Kentish Municipality, which is in front of you, is an area of 1187 square kilometres. It has a population of five and a half thousand and there are nine major towns. Now, you may think that driving from one end of this municipality to the other wouldn't take long, but believe me, when it snows, when there's ice, when there's rain, it could take anything from an hour and a half to get from where I am up to Cradle Mountain or out to Wilmot, and you must have all

heard about Cradle Mountain. Sheffield is situated 10 kilometres from the base of Mount Roland, and I've put this slide in here because this is my farm and I won't get homesick.

Tandara's mission is providing a high standard of care and quality of life to those who choose to use our health and related services. This building was originally a maternity hospital for the area. When the maternity hospital closed, with a lot of work from the local community it was turned into a nursing home. Four years ago the nursing home branched out and decided to go into community care, so it's now called Tandara Lodge Community Care, not the Tandara Nursing Home.

So, what does Tandara do? We look after our residents and we have 38 beds. We do community programs. The local school is right across the road so the children often come over and spend a lot of time with the residents. The Kentish Health Clinic provides services to the residents in the Kentish Municipality. We actually were lucky enough to purchase a house right next door to the nursing home which we turned into a health clinic.

The school dental service, we used to have one of those old dental caravans, and when they were going to take it out of the area the school came to us and said, "Help us, you know, the kids are going to have to travel a long way to go to the dentist, most people won't take their children to the dentist," so Tandara decided that we would talk to the Oral Health Department and they actually fitted out the dental room. It is the only privately run dental service in Tasmania that has been funded by the state.

Here we have our Director of Nursing, and some of the girls who have just finished their training through the work and training skills. We had a plan for 2000–2003/05 to redevelop our infrastructure, increase numbers of beds for aged care, provide community care, provide a community bus service, to be accredited, to build a hydrotherapy pool, and to provide other health services in the community.

The outcome of the plan, we built an extra 15 rooms onto the aged care facility and renovated the kitchen and laundry, we increased the number of available beds by eight, we commenced community aged care packages – we had four, we now have seven, which isn't large in some – to some people, but in our area, believe me, they're much needed. We commenced a bus service in December 2001, we were accredited in 2000/2003, and we've been accredited again to 2006, provided a regional health service since January 2002, and increased staff numbers by more than 35 per cent over the last two years.

So, where from? Residential care. Where to? So we have residential care, we have community housing, we have community care packages, we have 37 independent living units as well. We do respite care, rural health service, dental clinic, school dentist, and private dentist. We have a chronic disease self-management program. The community response to eliminating suicide program. We had a healthy lifestyle program, education training, aged care management consulting and pre-employment checks.

Services offered since 2002, residential care 38 beds including respite, 37 independent living units, and seven community aged care packages. Under our regional health service we have a 24 hour seven day a week counselling service to all the residents in the municipality. We have a youth health worker, women's clinic, which has two female – both work part-time, physiotherapist, OT, dietitian and podiatrist, chronic disease self-management, diabetic educator, community transport, health promotions, and the list goes on. Services provided because of the regional health service funding.

Now, this is one area where we really worked hard at. It's very easy to just have funding for a particular thing. We could have had the nursing home and the nine or whatever regional

health services, but our community needed more. So what we did was we've done health needs assessments, we looked at what the community want, and we went out and sourced funding from other areas so that we could do other things.

In January this year we were told that we had been given the money to build a hydrotherapy pool and gymnasium – sorry, part of the money to build a hydrotherapy pool and gymnasium, and I always said after we renovated the clinic I wouldn't build anything and now I'm building a swimming pool and a gymnasium. I'm not even sure what it's going to look like, but you know, I'm sure I'll get some points from somebody.

Okay, Kentish Support Group, cancer support groups, skin cancer check clinics have been just marvellous. We had a lady who came in to us and said – she'd come into our skin cancer check clinic, the doctor said to her after he'd checked her out, "I think you should go and see your own GP and have that thing cut off your leg". When she came back to see us she had a massive scar and it was cancerous, and she said if she hadn't have come to our clinic she wouldn't have even known that it was there. And all we do is the local GP under Medicare, we provide the clinic and an RN to help him, and he does 15 minute skin cancer checks, and he just checks over with his little scope, and it's surprising how many people, including myself, have had things burnt off or cut out.

Pap smear clinics, community response to eliminating suicide. We've been able to work with doctors in our area to go and work in Wilmot and Railton. We have pilates, tai chi, strength training. We have the state-wide continence service that visit our area now and school dental service. Prior to the Regional Health Service starting in 2002 none of these services were provided.

So, our private providers who come and use our clinic that we've got back into the area, or got to come to the area, include a private dentist, a dental prosthetist, John King Hearing Centre, massage clinics at Sheffield and Railton, and pre-employment physicals, which helps, actually our OTs go out and do pre-employment physicals, and the income generated from there helps us to go on with other things that we want to do.

We have partnerships. Our youth worker is partnered with a local council. Residential care, CAPS, regional health service, chronic disease self-management under the federal government, dental health through state health, mental health through an organisation called Parakeleo. Parakeleo and Tandara also run the CAUSE program, and the list goes on.

Our growth income, as you can see, has grown considerably over the years. Our assets have increased, and will increase again once the hydrotherapy pool goes into place. Now, for those who work in nursing homes this makes more sense to you than it does to me. Cash per bed per day – do you want me to go back? I have to admit, I didn't put that one in there, my ex-boss did and then left me. I have to apologise for that. If anyone really wants to know I'll find out and get back to you.

Our growth in assets. I'm going the wrong way, aren't I? I knew I'd muck it up. Returns per division, so residential community aged care, Kentish health, the units. This is the number of people using the Tandara services. Since this slide was done it's actually increased again. At the end of November last year when we finished our first three years of our contract there had been over 27 000 single occasions of service to people in the Kentish community, and there's one thing that we do a lot of and that is keep a clear indication of where our stats our running.

Where do we want to go? We want to increase our community housing. The nursing home side is looking into the EACH programs. Further develop our infrastructure, and at least two new community programs every year, provide home and community care services, which is not

easy to get, I can tell you. We're currently setting standards for rural health services within our own organisation. Implement a rural health course through the education department, and we're also trying to get a program called "Listen to Kentish Youth" which would be a youth worker available 24 hours a day. So, we will continue to provide quality care to our residents, and this is John – this one is John – that's John. We will continue to provide the community with health services, education and information to help improve the quality of life for residents of the Kentish municipality.

And we'll finish, "Be glad for work that's difficult, for tasks that challenge you. Workers find a thousand blessings the idle never knew" – and that's my new husband, so now I feel happy. Thank you.

ROB DEMPSEY: Coralanne, thank you so much for that presentation. It's really great to see health services in rural regions around the country actually being proactive and actually growing instead of declining, so congratulations on that.

Our next presenter is Nigel Jefford. Now, Nigel is an RN who has predominantly worked in many areas, including the acute paediatric ICU and accident and emergency areas, though he has a special interest in remote practice, having worked I think in central Australia and in the Kimberleys. He's previously a director, or he might still be a director, of the Council of Remote Area Nurses, or CRANA, and currently is the manager of Silver Chain in the Margaret River region. Nigel states amongst his many interests that he likes riding motor bikes, and also fishing, diving and oddly enough spending time with the family. Would you please welcome Nigel Jefford. Thank you.

NIGEL JEFFORD: Thanks, Rob. "Wurrnte Unte Mora" – I don't think there's any Arrernte people in the audience, thankfully. It basically means, "Hi, how are you going, and are you all right?" So, I spent a lot of time in central Australia, 14 years, and some of that time was spent at the Alice Springs Hospital, and some in accident and emergency and intensive care. Thankfully, I don't see a wound any more, or any violence in accident and emergency, and I now sit in front of a computer most of the day supporting my staff in Margaret River. At the end of the presentation there'll be an auction for my position in Margaret River. A number of friends that I've caught up with are all deeply envious and the bidding will start at \$500 000. Half will go to Silver Chain and the other half to me.

Okay. Silver Chain, it's the second largest provider of health care in Western Australia. It celebrates its hundredth anniversary this year, and I was privileged to be present at the launch of the celebration in the grounds of Government House in Perth by the West Australian Governor a couple of weeks ago, and I think for any organisation to be around for a hundred years has got to say a fair bit for its credibility and its strength, and the passion that West Australians hold for such an organisation.

Aged and acute care in Margaret River, when Pat Sparrow rang me, she said, "I need you to talk about the interface between aged care and acute care," so I'm going to talk about the interface, the interface, the interface, the interface. It's one of those buzz words that we soon get heartily sick of and another one comes along and takes its place. So, I've been there since 2001, three and a half years.

Fortunately for me Silver Chain had taken quite a brave step some four and a half years ago and looked at two of its rural sites, one in Albany and one in Margaret River, and they determined that both those sites were ideal for putting in place integration of services, and that's still ongoing today. My colleague in Albany, Leslie Pearson, and I get on. Don't we, Leslie? She's about somewhere – except when it comes to the matter of wine. I wouldn't buy any wine from Albany, personally. Don't need to really.

Okay. It's a rural community, it's 300 kilometres from Perth south, it takes about three hours driving. It's got a population of 9831. That was the 2001 census figure. It's about 11 and a half thousand now. Augusta Margaret River shire. It's about 75 kilometres long and about 60 kilometres wide. Situated in the south-west of WA. It gets about 200 000 visitors per year, unfortunately. And one of our recent visitors was Sting, who volunteered his services, as did all the workers, as did all the musos, about three weeks ago for the tsunami appeal, and 6000 people raised \$4.9 million. Very good. Mind you, some of those who sat at the front paid \$2000 a ticket. I was about 15 feet to the right of Sting in front of the stage volunteering and didn't pay a cent.

The total shire growth, '91 to 2001, was 5.3 per cent. Margaret River itself went up about 6.4 per cent. And it's one of those sea change communities, so it's receiving a lot of interest, and it's a very popular spot. The bidding is now 750 000. Okay. It's not just wine, surf and sun, it's got a broad population demographic, pastoral, and that was its initial sort of pioneer settlement. People were sent down there to cut out a block from fairly heavily timbered areas and start dairy farming.

It's got reasonably high rainfall of 1400 mm a year. Wine and tourism, the wine industry started in the late sixties, early seventies, with the first wineries going into place. Funnily enough, it was doctors that went down there and saw an opportunity and they made a living out of travelling down on Fridays and tending their wineries Saturdays and Sundays, and going home Sunday evening.

Goods and services, obviously to both the local population and for tourists. As I said before, it's a sea change community. It's got a local government that does its best to self-implode on a regular basis. You'd have thought living in paradise everything could be sweet, but unfortunately the local government has some problems from time to time.

Education-wise, five primary schools, three non-government. There's a Montessori, there's an independent school with no particular affiliation, a Steiner school. It's got a high school. It's got a TAFE. And surprisingly it's got a uni, so if you want to go and study viticulture and oenology, that's basically drinking lots of wine, we've just opened a university in Margaret River.

Health care services, we've only got 11 GPs, geez. There's actually an extra two down in Augusta. It's not an area that suffers a deficiency. I probably shouldn't say that we'd like to auction off some, but we'll keep them. We've got allied health, private and public, private pathology and a pharmacy. Our pharmacy has won the best pharmacy in WA the last two years running, and in fact nationally, so it's a great bunch.

South West Area Health, which is the government health service, runs the Margaret River Hospital, which is 14 beds and including six nursing home type classified beds. Child and women's health, day surgery, A and E, midwifery, x-ray, health promotion, and as of February 2005 – they've waited five years for this, the money was first allocated five years ago – they've started a \$3 million upgrade.

Silver Chain's aged and community services in Margaret River, we've got a low care hostel of 10 beds. That will increase to a 46 bed nursing home in 2006. Fortunately for me \$14 million worth of infrastructure about four weeks ago started to go into place. I run nursing personal care, home help, transport, respite, centre based day care, veterans affairs services.

We have student placements from both South West College of TAFE, Edith Cowan University – that's nursing – return to work people, John Flynn medical students because they're affiliated to one of the GPs in town so they come and play with us for a bit. Thirty independent

living units, that'll increase to 56, that's part of the redevelopment. And we run on site out of the residential facility, just starting, oncology services, supporting St John of God, a private hospital in Bunbury. Assessment, rehabilitation assessment services. Diabetic clinics out of that hostel.

Obviously, similar to Tandara, and I had the privilege of visiting Tandara in September/October last year. Coralanne says it takes about an hour and a half to get from one side to the other side. I was on a motor bike, it didn't take me long. And we involve primary schools. I have a very open door policy with children of staff, so if staff want to go off duty and pick up their child, don't finish – they finish school at quarter past three, staff finish at five, they can – their children can come in to the facility. I've got an eight year old daughter. She's been adopted by several grannies and she enjoys coming there. Other kids come in, not just in a formal sort of school setting, but reasonably free and easy.

Aged and acute links, I've already discussed community based oncology support services, the St John of God. For someone to go from Augusta, which is 50 k's south of us, to Bunbury is an hour's trip, and the way the system works is that they drive up on a Tuesday, they have their pick line dressed, and blood taken, they drive all the way back, their results are processed and they drive all the way back up on Thursday for treatment. Well, what we've done is cut all that travel time in half. They're being dealt with by people they know, local people. We can assist with transport, and that's just about to start.

The photograph on the left is what's happening in Albany. Again, my thanks to Leslie. Rather than a resident in residential care going to an acute care setting, and all the risks that that entails, they have blood transfusions within the residential care setting, and we manage that. GPs, obviously with the right private practice the GPs – we have shared clients. Post acute services, Bunbury especially.

Amanda O'Halloran who's our service co-ordinator there, done a lot of work, a lot of work, in gaining a lot of that post-acute stuff, so instead of them staying in hospital post-surgery they're out in the community quick smart, and we then provide that care in their own homes. And, of course, as we all know, people do better in their own homes. Peel South West Division of General Practice, the restructure of the hospital is expected to take a year. We were holding their diabetic clinics in our residential care facility. The nursing home type classified residents in hospital access our aged and community services.

And you've got to be a bit quiet about this because technically speaking they shouldn't, okay, not allowed to, because if they go down to our day care centre, which is a HACC service, okay, the state is meant to be paying for them receiving everything in the hospital, but when – I don't charge them \$5.00 for their meal down in the HACC centre. These people have lived, grown up – there's a resident in the hospital, he's the one remaining alive person that was one of the first born in the district. Well, you can't turn around to him and say, "We need you to pay \$5.00 for your meal," just because you're moving 50 metres down the road to the day centre. So, those kind of things.

Our dog visits the hospital. Now, we're very fortunate, it's all in the one street, okay, and the street's about 300 metres long. We're a bit fortunate like that. We've got St John's Ambulance, a new service building down the bottom of the street. We've got a Catholic church at the top of the street, an Anglican down the bottom of the street, and all the hospital and independent living units and the hostels all in the one street, so we're a bit fortunate there, it's not scattered.

So, those residents access that social and emotional support that keeps them in contact with their peers, friends, activities, because those of you that know both systems, the accreditation system for hospitals is totally different to that for residential aged care. We believe we go

through the mill a lot more than what they do, but of course, the parameters within those two accreditation systems as applies to people who are aged, living in nursing home type classified beds within hospitals, I don't believe receive as much as what we're able to give because we have to provide a number of services under our accreditation but hospitals don't.

Rationale and reality, so all services in the same street. It's a rural community, rural values. Well, we all know about that. Some of it's negative. I know your business, you know my business. Okay. But sometimes that's a positive. Mrs Jones, we knocked on the door today and she wasn't there. My staff had the mobile phone, they ring up, we contact the relative, "Well, she was there earlier, I spoke to her on the phone". We call the police, or find the key, you generally know where the key is kept, and then you go call St John's, into the hospital etcetera etcetera.

Common bonds between individuals, families and communities. Photograph on the left, Carol Baird, South West Development Commission, is handing Ross Bradshaw who's our CEO a cheque for \$30 000 for some specialist beds for our new nursing home facility. And of course we do things like – I think most of this comes down to relationships, and I'm very careful that they're not person to person relationships, they're system to system relationships, because if a person leaves then that, you know, relationship can break down, but if it's a system to system relationship.

So, the South West Area Health manager at the hospital, just by coincidence this year she's chairing our advisory committee, and they're an advisory committee, and they know they can give advice. We know we can thank them for that advice but not necessarily use it, and vice-versa. So, there's a nice symbiotic relationship where you often have boards of – in rural communities, they can often come into conflict with the provider who's providing the care. But they're an advisory committee, and that's made up of five representatives from five different service clubs, and they have a mandate to take the information back to each of those service clubs.

I'm a member of the Healthy Communities Committee, I'll go into that a little bit later. Service club involvement obviously through that advisory committee. I've got 60-plus volunteers. I got 30 at once. A year and a half ago we took on meals on wheels. Meals on wheels had been operating out of the hospital, we built a new day centre, the hospital said, "Look, they're mainly your clients, you've got a grade A kitchen now, are you happy to take over meals on wheels?" which we did.

We paid for all the police clearances for those volunteers and that system hasn't changed in terms of there's been no hiccups, it was a smooth transition, they still manage the service, we manage the cooking and the dollars and so on and so forth. And some of those volunteers had been there since it started 30 years. Some of them are now receiving meals on wheels.

Local shire, CSIRO, we're one of three communities in the country following the shire's lead for which it's received some flak, looking at sustainability of rural communities. So, we're not necessarily where we – where you'd want to be in five years' time, but where are we going to be in 25 years' time? What do we want? What footpaths do we want? You know, how are we going to manage this sea change process? Social gatherings we share with hospital staff, things like Melbourne Cup, Christmas in July. We celebrate each other's accreditation processes etcetera etcetera.

Healthy Communities Committee, broad community representation, Sergeant of Police, high school Principal, south west development, health promotion officer at the hospital, myself with aged care, maternal and child health nurse, social worker who comes down from Busselton, acute health, the manager at the hospital, youth services. The shire took a brave step, they offer

a bursary every year to a year 12 student who's taking a gap year prior to going to university, and so we're now on to our third student. Disability Services Commission and the shire have a rep. Main emphasis, good governance. How many of us have seen organisations go down the toilet because of bad governance?

Education research which is evidence based, advocacy forums. We're about to do a four-day – sorry, two day-forum that involves mental health, drugs, alcohol, youth issues, information. You often go to a winery and it says, "Who's the skipper?" Okay. Well, this committee has come up with, "Skip it tonight". So, there are incentives for people who drive around their mates who don't drink. They get a fuel card that allows them to get 20 buck's worth of fuel. There's obviously the things like the hats and the caps and so on and so forth.

All the bottle shops are involved and are happy to support such a process, as well as the police. Police will stop a car, "Anybody been drinking?" "Yeah, all my mates in the back, but I'm not, I'm the skipper tonight." "Okay, here's a free cap/hat." And the last one that was stopped, Chris Marsh, our local police senior constable, had them all out of the car etcetera etcetera and there was a Freo police sergeant in mufti sort of watching it all going on, he was one of the passengers in the back of the car. And his wife was the skip.

And that's basically what we have. It's all about relationships, structures, getting on with each other. I think there are some small acorns there which are growing. The oncology service etcetera etcetera with St John of God. But as we all know, acorns or gum nuts in our area grow into quite stunning kauri and jarrah trees. And that's basically us. So, further information, we've got a good website, and I've got some cards if anybody would like to talk to me afterwards. Thanks.

ROB DEMPSEY: Nigel, thanks very much for that presentation on Silver Chain. If you would like any more information besides checking out the websites etcetera, and I believe that there's also a website for Kentish Health too which – but if you want to speak to either Coralanne or Nigel, please feel free to visit them at the aged care stand in the exhibition area. We're mostly there at one point in time or another.

What I need to do now is to move on to the next stage, which is our interactive stage, and I'd like to introduce Les Stahl as our facilitator for this afternoon. Now, I've personally worked with Les on numerous occasions, and I've just found him to be an absolutely excellent facilitator who really has a great ability to draw out much needed information from the audience. He has done an enormous amount of work in aged care, at both national, state and regional meetings and forums, and these are for a range of aged care agencies and alliances, and certainly has done wonders at all of those things. Les was formerly a health professional himself, and an adult educator, so I'll hand over to Les, thank you, Les.

LES STAHL: Thanks very much, Rob. Thanks very much for setting me up, all those good words. Good afternoon, ladies and gentlemen. We're running about five minutes or so late. We've got less than an hour left. We were planning to have a small question and answer session, which we'll still have for about five minutes or maybe 10 minutes at the most.

This is about interfacing with primary health, interfacing with acute care, so if there are any general questions that you want to ask Coralanne or Nigel to do with interface issues from their presentation I'm going to ask you to maybe stand up in a minute, just identify yourself briefly, and pose the question. Hopefully that mike over on that table might be working, Rob. There's a switch underneath, I think.

If it's a specific question not related to interfacing issues, the preference would be to try and catch Coralanne or Nigel afterwards if you can. But there are lots of things that they talked

about, rural health services being provided, partnerships, increasing dollars, increasing staff, transport, being involved in respite care, blood transfusions, clinics, and having kids of staff very welcome in their facilities.

After a five or ten minute question time we're then meant to answer two questions. The two questions are, what are the positive aspects from our two presentations that we can take away and either do something ourselves at the local level, things that are within our sphere of control that we in our services might be able to replicate or build upon. And the second question is, what are the things that need some policy work by some other agency first, and whether it's a state agency or a regional agency or a Commonwealth agency.

So, let's have a small question time, then let's try and draw out some of the positive aspects that we can take away ourselves, some of the things that might need some policy work, and then we'll see if we might draw one or two recommendations for the rest of the Alliance. First of all, questions. Does someone have a particular interface or integration question to either Coralanne or Nigel? Just say who the question is directed to. If you could stand up and share your name and where you're from. Thanks very much. Thank you.

JULIE: ...(inaudible)...

LES STAHL: To any particular person, Julie?

JULIE: Either.

LES STAHL: Thank you. Where were the carers in your presentations?

NIGEL JEFFORD: Okay, thanks for that. That is ...(inaudible)... Yes, I do have a respite program for our carers in the community. We put a lot of effort based on a small amount of money that was allocated to us to run that program. We run a three monthly, if you like, massager for our complementary therapy program for our carers. They come in, we've got about 15. They come in and we provide that for them in our small hall, so we have complementary therapists come in. Some do it for free, some charge a fee. We have monthly teas for our carers, which Sharon, my co-ordinator, facilitates. They don't pay for it, we pay for that, and they meet and greet.

There's a lot of shyness about carers coming forward and meeting if they're actually caring for somebody. They're primarily caring for people with Alzheimers and it's not yet I don't think out in the public forum. It's a charge that ...(inaudible)... now that our infrastructure work has started up ...(inaudible)... what are you going to do about people in outlying communities and their families? So, we are doing something, and yes ...(inaudible)...

LES STAHL: Thanks, Nigel. Coralanne, any quick response?

CORALANNE WALKER: ...(inaudible)...

LES STAHL: You'll have to really speak up loud.

CORALANNE WALKER: We actually don't do a lot of work with carers as such through my mental health service program. The nursing home does offer respite. We work very closely with the Carer Respite Centre in Burnie and have close associations with the Carers Association in Hobart. We have meetings with service providers right across ...(inaudible)... every two months in which the Carers Association, the Reach Carer Support and all those people attend at the ...(inaudible)... with referrals, but we actually don't advise one on one.

But we do have a 24 hour seven days a week counselling service, which is available not only for people who have mental health problems, but for those people who are in need of anything, as in a carer who is struggling, someone who has a grief or loss problem. And our training counsel group have got the referral process in place if that's ...(inaudible)...

LES STAHL: Thanks very much, Coralanne. Thanks for the question. Does someone else have a question about interface issues or integration issues? Aged care with primary health. Thanks very much. Loud voice.

GABRIELLE O'KANE: Gabrielle O'Kane from Charles Sturt University. I'm really interested in the way, Coralanne, you've sort of adopted all those services and it seems to have happened very quickly. I'm wondering whether when you're attracting funding, maybe in those earlier stages it must have been very difficult to attract the funding, but do people now see that things are working and so therefore funding extra things becomes easier. And probably the other part of my comment is, is it very difficult to attract all these people, like dentists and doctors to do the ...(inaudible)...

CORALANNE WALKER: A lot of hard work. What actually happened was there was a health needs assessment funded by the Commonwealth in 2002, and that surveys ...(inaudible)... said, "Well, we need this, we need that". And the other thing that come out of that was the community said, "We're sick of being surveyed because every time we're surveyed nothing ever happens," and I'm sure most of you have been in that boat.

But from that survey they were able to apply for the Regional Health Service funding, and so we looked at what the recommendations were from the regional health assessment and put in place ...(inaudible)... that we needed the most within our community. And that was my job. I walked in and they said, "You've got an office, you've got a desk, you've got the phone, this is what we want, go out and do it".

Now, because we are an hour from Burnie, 30 minutes from Devonport, and an hour from Launceston, we actually had a lot of health professionals that live in our – in this region, so we were able to talk one on one, and that was my job to go out and talk to people and find out whether ...(inaudible)... Now, most of our services are run part-time, so for them to give up a day a fortnight or whatever to come and work in their local community, they were more than happy to do.

The other providers such as our physiotherapist, he comes from Burnie. Our podiatrist is from Devonport. ...(inaudible)... travels from Launceston. It was just a matter of going out and talking to them, and convincing them that it was a community need, that we'd use their service. The same with the dentist. We had our official opening of our clinic, had a photo of the CEO, myself and a few other people sitting in the dentist – the mayor was sitting in the dentist's chair, and a dentist rang up and asked me whether we had a dentist, and I said, "No, when do you want to start work?" A fortnight later he came and worked for me. Now, he has a practice in Smithton, which is an hour the other side of Devonport, but he lives in Burnie, so he travels to Smithton ...(inaudible)...

So I just feel that we're very lucky in that we had the resources out there and it was really a matter of going out and looking for them. And the other thing that I work very hard at is supporting the staff that come and work in our clinic, and so once – sorry, three times a year I put all the service providers, I have the dentist, the bus driver, the podiatrist, the physiotherapist, the dietitian, the diabetic educator, everybody that works, and there is about 29 programs at the moment all happening, we all get together and we have a meal and we network.

Now, they have told me on many occasions that they have never known that to happen before. They'll walk into a health centre, they'll do their job, they'll walk out, and they wouldn't even know who the person in the room next to them was. But I can't help thinking that by working together and getting them to network together and talk in as we are a team – and that's exactly how they work, and I've still got 95 per cent of the people I started with still working with me, and the ones that finished up have ...(inaudible)...

LES STAHL: Thanks, Coralanne. We've got time for one other interface or integration question. Loud voice, sir.

MALE SPEAKER: ...(inaudible)... I'm just interested that I think this is an incredible program ...(inaudible)... a lot of enthusiasm and utilisation of ...(inaudible)... But if I could be unduly critical just for the sake of discussion, wouldn't it be better to actually go for a real comprehensive aged care service and actually try to put all the gaps into aged care ...(inaudible)... I wondered if you would feel if I was being really unduly critical, but there's a lot of areas that aged care people need that haven't been filled in because you've utilised other things in the community that are actually filling up the space and the resources ...(inaudible)... lots of things specifically for aged care. I think you should see this as a mode for stimulating discussion, and I'm not criticising what you've done.

LES STAHL: Critical analysis is always good. Our responses need to be relatively short, I think.

CORALANNE WALKER: We actually have ...(inaudible)... project in place which covers the osteo and the arthritis and other conditions ...(inaudible)... All our programs are targeted ...(inaudible)... so we're not targeting youth or aged or people in the clinic. The Regional Health Service covers everyone, and then the aged care facility ...(inaudible)...

NIGEL JEFFORD: Okay. Thanks for your question. Look, I don't believe in working in isolation. I don't think you can improve just the aged care system so it's perfect and then start looking around at everybody else and ...(inaudible)... I think you have to work, and that's one of the reasons a healthy community model, and from four people, including myself, around a breakfast table at one of the local restaurants, so now we have to go to a boardroom because we've involved that many more people.

I think I have very good aged care services, and all that – nursing, personal care, EBA, residential care – is within the budget constraints. But we step outside of that and we look at it from a healthy community perspective, and I think that's the way to go in a rural area. You can't work in isolation. You can't ...(inaudible)... the hospital or the residential care or the day centre or St John's. We all work together for the betterment of the whole community, and that's how we operate.

LES STAHL: Thanks, and thanks for that thought provoking question. Time though, we've got to move along with the next part of this session otherwise we'll all have significant time issues. I'm going to pose you a question, and the question is, of all the things you've heard about the models presented, how they were interfacing, how they were integrating, how they were looking at community needs, what do you think was the most positive aspect of them?

Just have a pause for a minute while I get a whiteboard set up. What's the most positive aspect of what you've heard? I just want to ask people to share in that. The most positive aspect of the models presented. Who wants to share what they think are the most positive aspects? We've had a few thinking ...(inaudible)... What's most applicable from what you've heard? What's the most positive aspect? Who wants to go first? Thanks very much. Loud voice in this room.

FEMALE SPEAKER: I think from what I heard the overall community involvement would have to be a significant aspect, from my point of view.

LES STAHL: Thank you very much. Why is it the most important from your point of view? Just briefly. Why is it the most important?

FEMALE SPEAKER: Because I work in small rural communities in northern New South Wales and you can't treat one thing in isolation when working in those communities. Everything is interconnected and ...(inaudible)... and that's what those services have done, they've taken them as a whole, so for me, yes, it's simply ...

LES STAHL: Thank you very much for that. Thank you. Someone else's most positive aspect of what you've heard this afternoon. Thank you. Big voice.

FEMALE SPEAKER: The involvement with all the different parts of the health service and the allied, the whole box and dice, normally work in isolation and won't join in. You've got ...(inaudible)...

LES STAHL: Thank you very much for that. If someone else has another more positive aspect that they see from what they've heard? Thank you.

FEMALE SPEAKER: I think one of the things it showed people about this is it's capturing much of the grant money that's out there as you can: regional services money, care money, any of the other things that you can pull together to make them work for one another. And just as an aside, we have 68 volunteers in a population of 1500, not 9000.

LES STAHL: ...(inaudible)... is good for our souls.

NIGEL JEFFORD: And I think that's a very important point. For the first 18 months I was in Margaret River I was able to source \$200 000, and please don't get me wrong, Margaret River is not an affluent community. It might seem that – one of the ministers calls it the chardonnay post – but it has got some very poor socio-economic groups within it, so it's not a rich region.

But, for instance, Rotary gave \$100 000 towards the nursing home, and that was as a result of going out and talking with them, and you've got to get out there, you've got to go to Probus, you've got to go to Rotary, you've got to go to ...(inaudible)... Historical Society, you've got to sell yourself. Don't work in isolation ...(inaudible)... Whilst I do that, I still go out and talk and listen too. Nothing to do with changes done in Margaret River have been done without the community wanting it. They decided on the nursing home, etcetera, etcetera.

MARIA HOGAN: Can I just ...

LES STAHL: If you could stand up with a loud voice, it would be great.

MARIA HOGAN: I'm sorry. I'm Maria Hogan from ...(inaudible)... and I just think that this can also be a negative. I think our governments need to start to look at funding health services without having to access separate funding. I think the state and Commonwealth need to look at what they should be putting into the – because it's time consuming and we should be looking at the ...(inaudible)...

LES STAHL: Thank you.

CORALANNE WALKER: But sometimes it's small grants. Like, we managed to get a grant for \$1500, but we had a group of people who ...(inaudible)... who wanted to continue doing exercises so we bought the mats and weights and those leg things – you can see I don't do it

...(inaudible)... but those little things make communities healthier, but they wouldn't have had access otherwise because there's — I mean, you've got to have an incorporated body
...(inaudible)...

So we had to be prepared to work on that because if we make our communities healthier earlier we're not going to have these huge problems down the track, and that's where we're
...(inaudible)...

LES STAHL: Thanks, Coralanne. Neither of our presenters are saying this is the only way to go
...(inaudible)... but these are real life services ...(inaudible)... but we're just trying to find out for the purpose of this session what it is that they've done that has a real positive aspect. We're going to move on in a few minutes. We've only got a few minutes left of this question. We need to move on. Thanks very much.

FEMALE SPEAKER: I just wanted to comment and say that another positive is actually this business of acting on the community needs assessment that's been done, so instead of being ignored again it's actually being acted upon.

LES STAHL: Okay. So, once the assessment has been done it's actually acting on it?

FEMALE SPEAKER: Yes.

LES STAHL: Thanks very much. There was somebody else who wanted to ...

FEMALE SPEAKER: I'm not sure ...(inaudible)...

LES STAHL: Okay. Could you just repeat that last bit, they can't hear you down the back.

FEMALE SPEAKER: Saying about the ...(inaudible)...

NIGEL JEFFORD: Look, I think we're all in agreement with that. I mean, do I want to go into a retirement village? Do I want to go into residential care? Whether we like it or not there are going to be some people who will require it. They will require 24 hour care. I do as much as I can to keep people out of residential care. I actively dissuade them, because I can provide quite high care in their own home. If they need their bathroom renovated, they need rails, they might need a wall knocking down. But those are the main precursors, if they don't do that
...(inaudible)... into residential care. I do agree with you. I do look at this as having a 25 year life, and I think anybody realistically has to look along those kind of time parameters.

LES STAHL: Okay. ...(inaudible)...

CORALANNE WALKER: I was actually going to ...(inaudible)... situation. One of the things I think is so important about this that's not happening in other places, but you are seeking out
...(inaudible)... aged care parameters, and in small rural communities, and there are a lot of concerns about them taking the opportunity because I'm ...(inaudible)...

MALE SPEAKER: Why wouldn't you ...

CORALANNE WALKER: ...(inaudible)... packages available in the community, but there's not enough out there.

LES STAHL: Okay, you see this as way of maybe ...(inaudible)...

CORALANNE WALKER: Yes.

LES STAHL: All the way over here?

FEMALE SPEAKER: I just want to add another comment to that. Having worked largely in large institutions, aged care institutions, and I look at those community based models where community is involved and they're situated within the community when so many aged care, the big ones, are outside at suburbs where people can't travel, where they're inaccessible. Give me that any day, if I have to live in aged care.

NIGEL JEFFORD: There's a new service outside of Bunbury at ...(inaudible)... is 160 beds.

FEMALE SPEAKER: Oh yuck.

NIGEL JEFFORD: Now, they've done what they think is appropriate for their needs in that area, but it wouldn't suit where we are.

LES STAHL: Being in the community is ...(inaudible)... Maybe last comment. This gentleman up here has been waiting.

MALE SPEAKER: Just Nigel's comment about, you know, really the whole thing is dependent on establishing relationships and maintaining those relationships ...(inaudible)...

LES STAHL: Okay, importance of relationships and maintaining those. All right, look, we need to move on. Some of the comments you've said about being the most positive aspects of the two models that have been shared with us today. Some see this as a basis of shifting outside the traditional institutional paradigm. Some see it as being really in the community, part of the community.

Some see it as being based on the importance of relationships and the models that have been talked about, the degree of community involvement, the involvement of a range of different parts of health services. That is actually capturing grant monies that you might otherwise not be able to capture. If it's based on community want, and in fact, acting on community needs assessments, it's not just conducting community needs assessments and not following it through.

The two questions I've been asked to pose to you in this next part of this session is have they given that and given some of the critical possibly negative comments that have been suggested, which is a good analysis of any modelling framework, the two questions I've been asked to pose to you, and I'll move these two ...(inaudible)... out the front in a minute – the first is, based on what we've heard today what can we take back to our local communities ourselves? What out of what we've heard today is within our sphere of influence, our sphere of ability to influence? We might get some thoughts on that.

And the second question I've been asked to pose to you is, okay, out of these models that have been shared with you today what is it that is outside our sphere of influence? What is it that needs some other policy work or some other decision making by some other body? For example, the governor bodies or president bodies, something like that. So there's two questions. If anybody has a thought on those two I'm going to ask you to share those in a tick.

And what from what we've heard today can we follow up in our own local areas? Who would like to go first on that question? Does somebody see something that you can take away from here today that you might be able to make use of in your own local community? What is practical enough for the other ...(inaudible)... Thank you again. We need to sort of look and address to the crowd because our voices are – you're really good at the front but not that good at the back. Thank you, Julie.

JULIE: ...(inaudible)...

LES STAHL: Thanks, Julie. More support for carers. Yes, sir, down the front. If you turn and address the big room, that would be great.

MALE SPEAKER: My idea would be to get a copy of the presentation because, you know, the fine detail in some of the things that they introduced in their communities, and I think that I will go back to my staff and my community and say, "This would be useful to us, what are the gaps in our community?" and look at amendments to our Regional Health Service program and try and initiate some of those things in our community.

LES STAHL: Thanks for that. Rob as the chair you might like to respond to that at the end of the session, about copies. Thank you, someone else has a comment or a thought about what you can do in your local community? Thank you, sir, if you address the group.

ALAN MORRIS: I'm Alan Morris, I'm the CEO of ...(inaudible)... Hospital and we've got a Regional Health Service program. What I take back from this is the — and from within this room — I have to say the dynamic energy that sort of comes from a session like that for a start, but also to reflect previous comments in relation to the fact that we're at the present time looking to talk to communities about reaccreditation for the next three years. And I'm getting ideas from this to say, well, okay, is a youth worker and a community support worker in three sites the appropriate way to go or should we expand and change the whole damned thing.

I don't know, but one thing's for sure, certainly I've listened to the speakers and thought to myself, well, you know, there is another way, there are different options. And I reflect what Brendan says, I'd love to have it, I'll give you my email address afterwards, you can send the whole damned thing, Brendan.

LES STAHL: Thank you, sir. Any other comments? Serious comments. This is not just meant to be a motivational session. This is meant to be an information sharing session and ...(inaudible)... always the right one. Are there any other thoughts about what we could take back to our local community based services based on things we've heard today? Thank you.

BERNADETTE McLAREN: Bernadette McLaren ...(inaudible)... With the things of what you guys are doing, fantastic, but in our smaller community we've ...(inaudible)... and it would be really difficult to integrate that without ...(inaudible)...

NIGEL JEFFORD: Can I disagree with that? Sorry. I appreciate each area is different and the dynamics are different, and individuals are different, but ...(inaudible)... and they will see how ridiculous it is to have all these different silos and different buckets of money. Go to your community, explain the situation, they will come back to you with a solution, which is what we ...

BERNADETTE McLAREN: ...(inaudible)... we actually tried to get an ...(inaudible)...

MALE SPEAKER: ...(inaudible)... don't give up.

LES STAHL: And you've got to start somewhere.

MALE SPEAKER: That's right.

LES STAHL: But there are forces for and forces against. Let's try and keep the balance. Who else — sorry, Coralanne.

CORALANNE WALKER: I actually like Nigel's comment, and I think it really is important ...(inaudible)... aged care, that there is a time when people have to go into residential, but they lose all their contact, and because they're in residential care, they can't access ...(inaudible)... or

whatever, and I'm a little bit out of touch there, and I think that that needs to be addressed. I mean, I'm no longer – I mean, I'm actually not a nurse, I'm an administrator, and I'm not in the HACC field now, so I'm not sure exactly where it is, but it needs to be addressed. People shouldn't lose something just because they move from area to another.

LES STAHL: How do you want me to put that up there, Colleen?

FEMALE SPEAKER: HACC and aged care, and two arrows.

FEMALE SPEAKER: It comes down to communication with the agencies because our ...*(inaudible)*...

NIGEL JEFFORD: It's not that you can't do it; it's how can you do it. And you're local, you work with your local community. Do it. If someone up in Perth or Bunbury says you can't ...*(inaudible)*...

LES STAHL: Okay, the less you hear about community mobilisation despite some of the forces for and against that we experience in our own community. Thanks, sir, to the room.

MALE SPEAKER: I just wanted to pick up on a point about the ...*(inaudible)*... and we have the blessing of our regional HACC co-ordinator, but on the proviso I think one of the ...*(inaudible)*... was saying that we don't charge ...*(inaudible)*... and certainly the staffing ratio ...*(inaudible)*... work extremely well. You just can't ...*(inaudible)*... the numbers. So, I think as far as a change in policy, you can have it, you just can't have it as part of a group. But you can put it in place of sort of diversional therapy or a planned activity group. For residential aged care ...*(inaudible)*...

LES STAHL: How is our time going, Mr Chairman? How much longer do we have.

ROB DEMPSEY: About 20 minutes.

LES STAHL: 20 minutes. Okay. We've got about two or three minutes left of this session, we need to move on to recommendations but before we do, does anyone else want to make comments about things we could follow ourselves, things we can take back out of this session or things that you think need some policy work done. Nice loud voice for the group, thanks.

FEMALE SPEAKER: Am I allowed to ask, given that I did sort of get here ...*(inaudible)*... about the Hogan report, maybe there something in that in terms of ...*(inaudible)*...

MALE SPEAKER: There is much work going on, like with the community care – the Hogan implementation things surrounding initial adjustment payment, with the various supplements and early supplements and so forth. I'd like to be able to say that we're all going in the right direction because I actually don't think that we are. Simply, what started off I think as a good and generous buffer or bumper to aged care, has somehow got inextricably linked with bureaucratic red tape, and now all of a sudden accountability principles coming into effect, which seem to be creating, or probably end up creating, far more paperwork than what we've got at the moment.

Despite that, in our organisation the national ...*(inaudible)*... is try and feverishly to have some influence in all of that, but I have to say that a lot of it's actually been railroaded at a rapid rate of knots, so hopefully if we are successful in getting at least some of our changes and amendments into it, well, that would be great but, for the main part, I think what we are seeing coming out in various in media releases, it's going to be ...*(inaudible)*...

FEMALE SPEAKER: But that means we have to be a bit more creative.

MALE SPEAKER: Yes, exactly.

MALE SPEAKER: And I think one of the other things too, and it came out in one of these other things, every once in a while you get so busy with the day to day humdrum and the accountability, the red tape and all that sort of stuff, compliance, accreditation, all that stuff, that you actually sit back and you forget about what it is that you're doing. And one of the questions you have to ask yourself, "Is this all we can do?" or "What else could we be doing?" It's the diversification issue. You've always going to have that in the back of your mind as an alternate, you know, service or revenue scheme.

LES STAHL: Thanks, Rob. Last opportunity for comment, on either things to take back, to follow up, or things that are outside our control that need some policy work.

NIGEL JEFFORD: Just very briefly, can I just ask, who here writes a column for their local paper about what they do?

FEMALE SPEAKER: ...(inaudible)...

MALE SPEAKER: Three, four, five.

NIGEL JEFFORD: That is has probably been the best vehicle I have used on a regular basis for getting information out to the local community about HACC services, about residential care, about accreditation, about the day centre funding, about the stages of what we're doing with our infrastructure. If you don't go out to the community, they don't know what you're about and what you do. They're not interested in buckets of funding, they just want someone to hold their hand ...(inaudible)... pick them up on the bus, take them to the day centre, provide them with options. You've got to get out there and sell your product and in selling your product, you educate them, and by educating Rotary turn around and give you dollars, or whatever. So, it's an important factor and I'm pleased that a number of people do, but not enough.

MALE SPEAKER: ...(inaudible)...

MALE SPEAKER: That's it, yes.

LES STAHL: That's Nigel, our grey haired community advocate — activist over there.

MALE SPEAKER: Silver.

LES STAHL: Silver hair. Last call for anybody who wants to make a comment about local work we can take back or policy work needed.

FEMALE SPEAKER: I have a quick, I guess it's a question about something on ...(inaudible)... tonight I am just wondering, do you have a workforce that actually works across all of your department, or do you actually keep them in silos?

MALE SPEAKER: No, when I first started, I had one staff member setting the contracts.

FEMALE SPEAKER: ...(inaudible)...

MALE SPEAKER: Bloody nightmare, I can tell you.

FEMALE SPEAKER: And does it include ...(inaudible)...

MALE SPEAKER: No, it doesn't include ...(inaudible)... he's been my maintenance supervisor. When their supervisors went on leave, my maintenance supervisor went across the road and did their work. And when he goes on leave now, I do his work.

MALE SPEAKER: Because you can't ...(inaudible)...

MALE SPEAKER: But yes, we've got seven contracts ...(inaudible)... past AWAs which suit this particular type of environment. It doesn't necessarily suit all employees, but I only offer an AWA when someone has got two contracts and ...(inaudible)... so I've got, for instance, that same person worked today ...(inaudible)... residential care, that's three days a week in the day centre, so the Commonwealth, state/Commonwealth funding and does some Commonwealth funding respite care. So you've got to have a flexible workforce, and because you can't give them full time in one area, but they can build up their hours in a number of areas, and that's the beauty of rural. I think you can't do that in a city; you can do it in rural.

LES STAHL: Thanks very much. Some of the ideas you've suggested about within our ...(inaudible)... I'll take back is more support for carers, getting a copy of the presentation today, somehow capturing that dynamic energy that was shared today, talking to the communities, being the local community's columnist, selling and educating what you're doing and having a flexible integrated workforce. Some of the areas for the policy change we might need a bit of work on is in terms of those silo funding groups, the relationship, the interface between the different funding buckets and regimes like HACC and residential services, and some of the stuff that's happening ...(inaudible)...

We have about ten minutes left of this session and our chair would really like it, if it was possible – it may not be possible; we'll soon find out – if there are some recommendations this group might want to add to this conference's overall recommendations. So, I'm going to pose the question, the last question to you today, and that question is, in terms of the rural and remote health, what we're focusing on, are there any recommendations you think you would like to make in relation to interface and integration issues: aged care, acute care, primary health.

So for rural and remote health, integration/interface recommendations. I'm going to put them up. Just think about what's the most important recommendation. And then I hope we'll see how the group goes and what people suggest. Okay, a loud voice, if you can address it, that would be great.

FEMALE SPEAKER: I don't know all the words around it, but I think it's the issue around – of the methods of interface and integration of the Commonwealth and state ...(inaudible)... And so really it's about the recommendations focusing around a fundholder that's separate to or not run by one particular agency. I'm not sure what the answer is, but it's something about, how do we get over and around this ...

MALE SPEAKER: Integration of funding.

FEMALE SPEAKER: I think ...(inaudible)... the Commonwealth, when it funds, it funds a flexible pool of money that can be used across the aged care and primary health care sector.

FEMALE SPEAKER: ...(inaudible)...

FEMALE SPEAKER: Yes. Well, it's flexible. Yes. ...(inaudible)...

LES STAHL: We've got plenty of time ...(inaudible)... we'll make sure if you've got a really important recommendation, you'll hear it. Here, then over here, thank you.

FEMALE SPEAKER: Well, what runs ...

LES STAHL: To the group, say it to the group.

FEMALE SPEAKER: So, in addition with the sort of integration of funding and having ...(inaudible)... the dollars, I think everyone would agree that we need minimisation of reporting requirement and standardisation of reporting requirements across the ...(inaudible)...

LES STAHL: Okay, less reporting requirements and more standardisations. Thank you for that. Thank you for your patience. To the group in a loud voice.

FEMALE SPEAKER: Something a little bit radical but it's actually taking responsibility for funding or ...(inaudible)... mistakes, or leaving it with the Commonwealth.

LES STAHL: ...(inaudible)... thoughts of that.

FEMALE SPEAKER: ...(inaudible)... to report it.

LES STAHL: All dollars – all aged care dollars to the Commonwealth. Thank you. We've got five possible recommendations. Any other serious critically important recommendations more important than those? If you've got a recommendation about interface issues, integration in aged care with the other areas of health in rural and remote communities, now is the time to share it, if it's more important than those five. Here and then here, thanks very much. Loud voice to the group.

FEMALE SPEAKER: It's not more important than the other five, but probably a pre-condition for the sorts of models that have been talked about ...(inaudible)... Regional Health Services program, so perhaps the Commonwealth government needs to be approached to reopen that funding source.

LES STAHL: What would be a succinct way I could put that up there?

MALE SPEAKER: More money.

MALE SPEAKER: There should be some formula-based funding, but again, going back to that, it's just ridiculous that every community has to start from ...(inaudible)... and it's great for the innovative one getting there, but I mean the point is they're wasting half their day accessing funds, when really, there should be a base pool and then the innovation can happen on top of that.

LES STAHL: Okay, thank you. I've got four people waiting. This gentleman, then here, then over here and then that's it. There are four people that think there are more important recommendations than what we've got up here. Thank you, sir.

MALE SPEAKER: As important, I guess, in the recommendation but pretty well pertinent but ...(inaudible)... integrated services, looking at the accreditation process, so that we're not having one ...(inaudible)...

LES STAHL: Okay. Integrated accreditation process. Thank you, sir. Yes, thank you.

FEMALE SPEAKER: The current funding formula as I understand it is 100 for everybody over 70, is it?

MALE SPEAKER: 180 for every thousand people over 70.

FEMALE SPEAKER: Well, is there a differential for Aboriginal people ...(inaudible)...

LES STAHL: Thank you. If you could stand and address the group, that'd be great.

FEMALE SPEAKER: My name is Kelly, I work in a number of small communities Aboriginal health program in northern New South Wales. A lot of those communities have nothing, zilch, and they are a number of miles away from where there are any other services. There has to be some way that a service, even HACC, can be provided to the people living in their home communities, rather than them missing out or having to relocate. I don't know how to word that, but I guess it's more equity and access to services for the people in these small rural communities.

FEMALE SPEAKER: Our regional services, we actually take them and drive them to ...(inaudible)...

FEMALE SPEAKER: And therefore funding them to provide adequacy of that, so that they don't just provide that small ...(inaudible)... that there's actually a capacity for that.

LES STAHL: Okay. I might focus on providing services to where people live, particularly in small remote communities.

FEMALE SPEAKER: Yes.

LES STAHL: Someone over here was waiting, and then over here I think we'll have to ask you to make a vote by a show of hands, to ask you, of these things, which three do you think are the most important. So we don't ...(inaudible)... Over here, thank you.

FEMALE SPEAKER: I think I have more of a comment.

LES STAHL: Loud voice to the group. You all have such a quiet voice.

FEMALE SPEAKER: Well, I had more of a comment I think than a recommendation. And that is that the bucket of money that the government has is not endless and that we need to compete with education and transport and a whole range of, I guess, issues, and that this is just one of them. And I think it's about choosing what is more important than others and it's getting that money to us.

LES STAHL: Thank you very much for that. I'm actually going to ask the group to choose in a minute. Did I hear somebody? Thank you.

FEMALE SPEAKER: Sorry, it's more of a comment. I manage the community health service in a small rural town in northern New South Wales ...(inaudible)... but we have vacant positions for podiatry basically. Five years we've had a vacancy for ...(inaudible)... not unusual to have vacancies for over two years. We're good at ...(inaudible)... grants applications to get the money, but we can't get the people to work in the area.

MALE SPEAKER: Okay. Greater focus on workforce. Okay, I'm going to go through these possible recommendations and ask you to choose, in terms of interfacing and integrating aged care with acute care and primary health – which is the three most important things for yourself. The first is that there be more dollars. I'll put the numbers up as well, so that's number one. Number two, is that the various funding sources, all the different buckets of money, need to be more integrated, at government level, that the funding sources themselves need to be better integrated.

The third is that the pool of money be more flexible so that there's opportunities to be more flexible in what you use it for. The fourth is that there be a focus, so there is less reporting requirements on services. The fifth is that there be more standardisation available, so that we've not got all these different forms to fill in for all these different requirements, they're more standardised across the different sorts of services we provide. Six is that we actually ask

the Commonwealth to take responsibility for the funding, all this sort of aged care interface/integration issues, get rid of the state/Commonwealth issue by choosing the Commonwealth.

The seventh possible recommendation is that in whatever funding source, whether it's integrated, whether it's flexible, that there be a base pool and then an innovative pool on top of that. The eighth possible key recommendation is that the accreditation process for these various services be integrated, so that you don't have to jump through multiple different accreditation requirements, depending on the services you decide to provide. The ninth is that there be a higher focus, much higher focus on providing services to where people live, particularly in small remote communities. And the tenth and last one, is the critical issue of workforce, particularly in a range of remote areas.

Okay. I'm going to ask you, of those ten, pick three that you feel are most important. I have two people who want to make some sort of comment. Hopefully, this is important.

FEMALE SPEAKER: I just want to add to that last point, with the workforce, whether the government can ...(inaudible)...

MALE SPEAKER: Well, let's keep that in the workforce issue. Workforce is a critical issue that ...(inaudible)... possible some inclusion in that. You, sir, you wanted to say something?

MALE SPEAKER: I was really just going to comment that there's several of those that have been ...(inaudible)...

MALE SPEAKER: I'm giving it three.

MALE SPEAKER: Yes, I know. I mean, that's ...

FEMALE SPEAKER: Yes, but the money ...(inaudible)...

MALE SPEAKER: We could, but I can tell you we don't have the time, the chairperson is going to call this to a close very shortly. We don't want to miss out on the opportunity of seeing where the strength is. This process, we have to trust the process for this. If we had another 15 or 20 minutes, I would do that, I would go out and put them together. We don't have the time. Have we got three? Of those things, the three things you think are the most important in terms of progressing the issue of the integration and interface.

FEMALE SPEAKER: If we could have a flexible pool of funds funding ...(inaudible)...

MALE SPEAKER: Could we just have a show of hands to see just on that point, whether people think that it's important enough to actually do that, and maybe spend another 10 or 15 minutes?

FEMALE SPEAKER: Yes.

MALE SPEAKER: Or if you've got a burning desire to go.

MALE SPEAKER: We've come all this way, I think it's ridiculous to put recommendations up that are substandard.

MALE SPEAKER: Okay. Well, let's do it but I think you might need more time than that ...(inaudible)... group, but we'll see how we go. Okay. The majority of people did not put their hands up. Show of hands to stay longer.

MALE SPEAKER: We want to count the people that want to stay so ...(inaudible)...

MALE SPEAKER: All those that say we need to close in five minutes. Okay. I just think we need to get this checked first. We will do what you are suggesting, but I want to get a check of the larger group, while everyone is here. ...(inaudible)... for those that have to leave. I'm going to call for these quickly, one to three, the most important, just put your hands up, okay? Number one, just having more dollars, some more dollars, if that was one of your three, just put your hand up very quickly. Okay. I can call that one, primarily because one person put their hand up.

If you think that the need is to put pressure and to work about integrating the different buckets of money, if that was one of three, I need to call, Mr Chairman, I'd say that's about two-thirds, that's a lot of people. If you think that the funding pool of money needs to be more flexible, however it's arranged, more flexible? Yes, hands are up, maybe about half.

Less reporting requirements, was less reporting requirements one of your three most important? There are six hands up. If you think there needs to be more standardisation in reporting across the range, is that your most important, one of your three most important recommendations?

FEMALE SPEAKER: ...(inaudible)... outcomes from the other two.

MALE SPEAKER: It's okay. ...(inaudible)... this process does work. What about all dollars go to the Commonwealth? One, two, three, four. Okay, that we have a base pool of funding, an innovative pool on top of that? Was that one of your three most important? Three people, one, two three, thank you. You can see where there's a whole lot of support, more important than others. Here, that accreditation process across the ...(inaudible)... be more integrated, is that one of your three?

MALE SPEAKER: That can already be done ...(inaudible)...

MALE SPEAKER: I believe your colleagues ...(inaudible)...

MALE SPEAKER: We just did accreditation on our entire district which has nursing homes, hospitals, community health services, and it was all done at once. So I mean, it can be ...

MALE SPEAKER: Okay, thanks for that. That there be a higher focus over the next months and few years about providing services where people live, particularly important for small remote communities. Was that one of your three? That's more than half again. And that we have a more important focus, more energetic focus, on workforce issues. That's two-thirds again.

Okay, just for those people who have got to go – those who are going to stay, we'll work through this – but clearly more innovation of funding sources, including a flexible pool of money, was really important for the group. Over here, about integrated accreditation process, is very important to the majority of people. About focusing on services where people live and about workforce. There were four areas with a lot of support.

Those who can stay, we'll thresh it out a bit more. Thank you for those who came. Do you want to close? Keep going? Those who can stay, come down the front a little bit. Okay, if everybody wants to move to the front, that would be great, so we can continue. There are four areas with a lot of support. There they are. Is somebody unhappy. Sorry, workforce. There are five areas with a lot of support in the group. Is somebody either able to merge those five into less, or are we happy to have them as four or five? This about integration of funding sources, it's about making them flexible, integrating accreditation, focusing services where people live, and workforce. Someone down here was going to suggest something earlier.

MALE SPEAKER: Number two and three can easily be ...(inaudible)...

LES STAHL: Okay, so put those together, on the same ...(inaudible)...

MALE SPEAKER: Two, three and four ...(inaudible)...

LES STAHL: People are saying, those two can come together. Anybody opposing that? I think we might have got those two together then. Some other comments, other ideas?

MALE SPEAKER: ...(inaudible)...

LES STAHL: Let's try and keep that recommendation though as simple as we can.

MALE SPEAKER: I think reporting standardisation and accreditation could probably could probably ...(inaudible)... too, because there's again similarities between all of that.

LES STAHL: So we might use that as an example. But again, to be honest with the group here, I think we should try and – the main step of our recommendations where these things were, but however you ...(inaudible)... word the accreditation, that might be an example.

MALE SPEAKER: I think nine and ten could be tweaked. If you're going to have focus on where you're going to deliver the services, you actually need a workforce that's capable of providing that service.

FEMALE SPEAKER: And ...(inaudible)...

LES STAHL: Some people support it, it's all right, I will make sure everybody ...(inaudible)... That sounds a good idea to me because I've got a colleague here who ...(inaudible)... wisdom.

FEMALE SPEAKER: ...(inaudible)... major difference is when it's about isolation, how people can't come to us because they don't have a transport infrastructure ...(inaudible)... to not being able to get the staff because there's so many other things ...(inaudible)... so many different ways you can address those issues ...(inaudible)... and I voted for both those issues being the top ones because they are really important to me though.

LES STAHL: And there's nothing wrong with having four recommendations. You've got it down to four, and four is quite acceptable, and that way you don't run the risk of somebody outside this forum, particularly if the government were to misinterpret what we've found ...(inaudible)... for that. Someone here to say something.

FEMALE SPEAKER: You know with the two and three and the eight, if you got those, then sort of four and five will kind of both fit in those.

LES STAHL: Except this is about funding, this is about accreditation processes.

FEMALE SPEAKER: Yes, but then four and five kind of actually fit under both of those, as a sort of a result of.

LES STAHL: We hope so anyway.

FEMALE SPEAKER: Yes.

LES STAHL: Okay. So we'll take that on board. Is the chairman saying ...(inaudible)...

FEMALE SPEAKER: I just want to make a comment about the flexible pool of funding and just to note that it needs to be flexible from a community's point of view, not from the Commonwealth's point of view. So, like, the Commonwealth often say it's flexible but put a

whole heap of rules around it, so it needs to be quite flexible from our community's point of view.

FEMALE SPEAKER: Can I just say, I experienced the opposite. You know, like I've had no trouble with the flexible funding ...(inaudible)...

FEMALE SPEAKER: I don't agree.

MALE SPEAKER: I think if you can substantiate an innovation that works, no matter how you got there, they'll support it, as long as you can demonstrate ...

FEMALE SPEAKER: ...(inaudible)...

LES STAHL: Given that it's working in some places, you wouldn't mind ...(inaudible)...

FEMALE SPEAKER: I have no — I support it, after hearing what these guys have done, we do a similar thing with the state/Commonwealth funding with an acute — you know, we've got a whole ...(inaudible)... package together, and yes, I'm the one that was putting that, that the flexibility is there, they could do with ...(inaudible)...

LES STAHL: The last call for a couple of other comments, otherwise you've got four strong recommendations. Going once.

FEMALE SPEAKER: It's already — I mean, there's a lot of money being spent on workforce issues at the moment and ...(inaudible)... restructured.

MALE SPEAKER: All on administration.

FEMALE SPEAKER: Well, it's not ...(inaudible)...

LES STAHL: Well, let's hear that first.

FEMALE SPEAKER: No, no, look, I mean — and I'm very passionate about it too, I mean I've had a physio position empty for a year, we've had a — we've spent a lot of money with a recruiting company bringing someone from New Zealand. So yes, I mean, I know what the workforce issues are, but I also know there's a lot of state and federal initiatives around workforce now, that still haven't — and the universities as well are looking at sort of a system to try to look after our trained therapists and minimise what they have to do, so that we maximise the use of their skills and bring in the lesser trained people doing sort of ...

FEMALE SPEAKER: ...(inaudible)...

FEMALE SPEAKER: Yes, that's right. ...(inaudible)... a lot of the issues are happening right now around workers. I mean, I'm on a couple of steering committees that I've even ...(inaudible)... and it is really important and I think it's going to remain on the agenda, so I just want to let people know that there is a lot of money being spent right now on ...(inaudible)... It's not like the government doesn't know about it.

LES STAHL: Thank you for that. We've got four strong recommendations. Do you want to ...(inaudible)...

MALE SPEAKER: ...(inaudible)... I think we probably need to clarify ...(inaudible)...

LES STAHL: Well, how do you want that clarified, what will you want to add to that?

MALE SPEAKER: ...(inaudible)... recommending focus on work ...(inaudible)...

LES STAHL: You tell us what you think needs to be up there.

FEMALE SPEAKER: I think that the point was made that what was ...(inaudible)... about actually making that thing work in remote areas. You're talking primarily about ...(inaudible)... issues.

FEMALE SPEAKER: ...(inaudible)... different people on an international market, we're not even talking about a national market, it's an international market. Physios are staying for 12 months and going overseas.

LES STAHL: Okay. So we've got two issues; it's about recruitment and it's about retention. Let's put them both in.

MALE SPEAKER: And especially in remote areas.

LES STAHL: I'll put especially in remote, rural and remote.

FEMALE SPEAKER: Can I just add to that though that in remote areas it's not only about allied health professionals; it's about carers, it is about support groups, it is about that basic level.

FEMALE SPEAKER: Where there's buckets of training money went, nobody to train.

FEMALE SPEAKER: ...(inaudible)... that puts.

FEMALE SPEAKER: Yes, and I don't want it to get lost in a ...

LES STAHL: That's a good point. I'll have both those up there.

FEMALE SPEAKER: It also about ...(inaudible)... education. I mean, for a lot of us that are in remote services, you know, if you want a well trained professional, you can't access university, so people have to leave town to get that education. Once they've left, they never come back.

MALE SPEAKER: Can I stick an iron in the fire, in terms of ...(inaudible)... physician's assistant. I think if we continue to go down the path of registered nurse, doctor, physio, OT, in rural and remote Australia, we should be looking more at generalist positions, and you've got ideal mechanisms within the Centre for Remote Health here where they've got a postgraduate program, a masters level, where a doctor can join, a physio can do it, remote area nurse do it, an Aboriginal health worker can do it, and they're streamed off into their own particular areas of expertise.

But I think if you bring it back to – why can't you have someone who does a year of physio, year of OT and a year of podiatry and becomes a generalist allied health practitioner? There aren't going to be enough people in 10, 20, 30 years to have single solo positions. So it's a multi-disciplinary workforce.

LES STAHL: So there are now about five or six specific things we can put under workforce. And this lady has been very patient.

FEMALE SPEAKER: I just wanted to ...(inaudible)... aged care embedded somewhere in that ...(inaudible)...

LES STAHL: Okay. You have got now a very fleshed-out workforce issue and stuff. You've basically done the impossible. The advice I gave was that you cannot do this in an hour and thirty minutes with a large group like this, but you've actually managed somehow to give some questions and answers to the two speakers. There were some positive comments, there

were a few critical analysis-type comment and questions. We then looked at what you can take back to your own communities, and this stuff will be recorded, as well as ...(inaudible)... You also suggested some positive work issues that needed to be come with up, and you've up with four key areas of some recommendations and we've got a panel here that will put that together. So, well done, you did pull off what I thought was impossible.

Mr Chair, just before you close, there were two comments you need to make, at least. One is about the possible circulation of the presented material, how could people access that. And the second is, how are people who attended today's session able to see the draft recommendations that you might come up with, before it goes to the final conference? All right. Thanks very much.

ROB DEMPSEY: Thanks very much, Les. A couple of questions, we've got a sheet running around at the moment, so people that want the two presentations, we'll make sure that we get it to you. The other thing is that there should be available from this conference, there was I think, website or web – yes, there is a website, yes, as it comes round.

But the other thing that we can do is we can actually put it up on our national organisation's website so you can access it there and that, just off the top of my head is www.agedcare.org.au. So yes, we'll get it up there as soon as we can, straight after the conference. With regard to these, what you do is, we'll work these through and we'll also put these up on that website as well in a general area, so again if you go, it's Aged and Community Services Australia, which is www.agedcare.org.au, we'll have them up there within a couple of days. So, thank you very much.

Les, I would like to seriously thank you for the work that you've done this afternoon, it's seriously hard work. You just don't realise how hard it is to go through and do this stuff. I do thank you, you've done a wonderful job. You've beaten your own record, so I congratulate you on that and for everyone who attended here.