TRANSCRIPT OF PROCEEDINGS

The attached transcript, while an accurate recording of of the day, is not proofread prior to circulation and thus may contain minor errors.

2015/16 HAZELWOOD MINE FIRE INQUIRY

HEALTH IMPROVEMENT FORUMS

TRARALGON

MONDAY, 19 OCTOBER 2015

THE HONOURABLE BERNARD TEAGUE AO - Chairman

MRS ANITA ROPER - Board Member

PROFESSOR JOHN CATFORD - Board Member

MR PETER ROZEN - Counsel Assisting

DTI CORPORATION AUSTRALIA PTY LTD
4/190 Queen Street, Melbourne. Telephone: 8628 5555
Facsimile: 9642 5185

CHAIRMAN: Good morning and welcome to this, the fifth day of our forums in the Latrobe Valley. Could I say that I will be repeating some of the things that I said on previous occasions, but that's because I know there are significant numbers of new people, even though most of you that I can see are very familiar faces.

I will at this stage acknowledge the traditional owners of the land on which we're gathered, the GunaiKurnai, and pay my respects to their elders past and present.

I won't go into the detail of the terms of reference 7, but this is very much focused on that term of reference. What we are doing today is an interesting variation of what has been in other situations where we've had hearings rather than forums of this kind, but so far they've been extremely valuable. This is another Catford variation on the theme, I might say. I give him all the credit, and so far there really is only credit that's come from the process that we've undertaken. It's a bringing together of relevant people in a different kind of format to a hearing which really is, in these circumstances, I think, much more restrictive.

Apart from saying that we will be listening to what emerges from the presentations that will be made today, and taking an interest in the different perspectives that are put together, I will really now pass on to John and then Anita who will explain just how we are intending to proceed this morning.

PROFESSOR CATFORD: Thank you very much, Bernie, and it's a

pleasure to be here again for our 13th Health Improvement Forum. I am conscious that a number of you have been to every forum and some of you are here for the first time, so I'd just like to summarise some of the key features.

Of course, we're very much focused today on looking forwards at how to build and strengthen health in the Latrobe Valley. We're looking at short, medium and long-term proposals which we've been asked to by the Victorian Government when they reopened the Hazelwood Mine Fire Inquiry in May of this year.

We've conducted now 12 forums looking at a range of very important issues. The first nine were what I call deep dives. We looked on 29 December at chronic disease management, health behaviours and mental health - a very dynamic interactive set of forums.

The following day, 30 September, we looked at early detection, high risk screening, health workforce and children and ute.

Then, on the third of those deep dive days, 1 October, we looked at healthy workplaces, healthy environments and social disadvantage. We also have had a special encounter with the Aboriginal community here in the Latrobe Valley on 13 October, and we had our final set of Health Improvement Forums on that day which looked at community engagement and communications and the potential role of a Health Conservation Zone and Health Advocate.

Today's forum is the last in this sequence of forums where we're focusing on governance, leadership and sustainability.

I think, it would be true to say, the Board has been really pleased with the feedback and response we've had through these forums; there's been a real spirit of cooperation, people connecting, agencies talking to each other, and a lot of help coming from outside the Valley from NGOs working across Victoria.

There's been a very strong sense of pride of place in the Latrobe Valley and very positive and constructive orientation to the discussions and proposals. I really think, and shared by Anita and Bernie, a real genuine commitment to make things work better.

We've heard of a wide range of possible opportunities to improve the health of the Valley, from for example 3-year-olds taking blood pressures of their parents, we've heard about the need for a railway station just outside this hotel; we've heard about the needs for seating in walking areas to encourage people to walk more; we've heard about kitchen gardens in schools, community screening days - there's a whole range, a host of interesting ideas; the role of telehealth or telemarketing promoting the Valley more broadly within the community and outside. We've heard about the need for a quit smoking campaign, of community nursing programs, of worker health checks, and so the list goes on - more doctors living in the Valley, advanced medical programs in the Valley, care guidance pathways in primary care and I could go on for a very long time, a myriad of suggestions.

I think, to me, a key theme has been the need to build stronger integration between hospital, community

health, the primary care network and our council and Government. We very much hope we can explore this today and the issue of joined up leadership; agencies engaging, co-designing with the community. That's very much the theme of this last final forum, one of governance, leadership and sustainability.

We're seeing the people of the Valley calling for change, highlighting the need for doing things differently. So what would improved governance look like for collective action in the Valley?

We've also looked at the need for stronger integrated leadership across the health systems in the Valley, or how can this be brought forward.

And a recurring theme about sustainability, of keeping the momentum going through political cycles - how best can we ensure sustainability and commitment and action to improving health in the Latrobe Valley? We're very much hoping we're going to hear further about this.

We've brought together at these forums leaders from within the Valley as well as across Victoria, and we've had the benefit of a very large number of public written submissions, both before the forums and afterwards, and our task now as a Board is to bring these together to produce a report which we hope the Government will look at, and I'm sure will look at seriously and hopefully respond.

I've set the scene perhaps about the purpose of this last final day of bringing together all the various themes, and I'd now like to pass to Anita who will actually talk through the process of the day.

MRS ROPER: Thanks, John. Well today, as John has said, is the final day of our roundtable conversations that we've had down here in the Valley and we've heard a lot from the local folks about their concerns, and today we're going to have a series of presentations from senior health officials from right across the health sector.

We have Kym Peake here today, the acting Secretary of the Department of Health and Human Services; we have Terry Symonds, the Director Sector Performance, Quality and Rural Health of the Department of Health and Human Services; Councillor Dale Harriman, the Mayor of the Latrobe City Council; we have Kellie O'Callaghan, chair of the Board of Latrobe Regional Hospital; John Guy, the chair of the Board of Latrobe Community Health Services; and Nola Maxfield, the chair of the Board of the Gippsland Primary Health Network, and we certainly thank all of you for making yourselves available today to come down here and be with us for our last conversation.

These presentations will run this morning from about 9.45 to 12.30 pm with a 15 minute break in the middle. The presentations will be about 20 to 30 minutes, and then we'll take some questions being led from the Board and Counsel Assisting. We're going to conclude today with a panel discussion with all the presenters and that will be facilitated by Peter Rozen, Counsel Assisting the Inquiry.

As per our previous days, transcripts of today will be available on our website if you want to review them and, as John said, at the conclusion of today we

have the task of reviewing everything we've heard across all the forums, the submissions that we've received both before the forum started and afterwards, and just all the discussions and the immense richness of the discussions that we've had and that will contribute to helping us formulate our responses to Term of Reference 7 and any recommendations we want to make.

As we've said at each of the forums, the Board is very, very conscious that this Inquiry has a limited life and it's really up to those living and working in the Valley to take this work forward in a meaningful way.

I think it's very pleasing for us that, in the past week or so we've already seen examples of this happening, that local people have not waited for the Board to make a report to the Inquiry and not waited for the Government to make a response, but they've taken that leadership that we've really hoped. There's been a number of projects that have formed through our forums that the group has said, "We're going to take them forward now, we don't need anyone to tell us how to do that", and this is what this has been all about.

So we hope that spirit of cooperation will continue, not just with the local people living and working in the Valley, but those from the health sector outside the Valley will assist in carrying that forward.

Some of the issues that we're discussing here are clearly very, very specific to the Valley, but a number of the issues that we've been discussing are not,

they're the same problems that other parts of the Victorian community and even the Australian community are facing. We also have an opportunity to not only solve some issues here and move them forward, but actually to show some leadership across Victoria, and that again is up to the people that live and work in the Valley to take that on as a goal.

As I hand over to Peter, thank you all for attending, in particular our speakers who've travelled today, and we really look forward to hearing what you have to say during the course of today.

MR ROZEN: Thank you, Anita. As Anita indicated, my name's Peter Rozen, I'm Counsel Assisting the Board, and I would like to introduce our first speaker this morning, Ms Kym Peake, acting Secretary of the Department of Health and Human Services. Thank you, Kym.

MS PEAKE: Thank you very much for the opportunity to present today. I did want to also start by paying my respects to the traditional custodians of the land on which we are meeting, and in particular pay my respects to elders past and present.

I believe this forum is a really important opportunity for us to reflect on the lessons that have come from the Hazelwood Fire and this Inquiry to really make sure that we understand those learnings and that those learnings enable us to shape a healthcare system that is better able to respond to such events and provide the high standard of care that is expected of Victorians wherever they live around the State.

Today I just want to cover off on a few matters, in particular what the department has heard from the

community, early actions that we have taken, and then some reflections on where we might go from here.

Following my presentation, Terry Symonds, the Deputy Secretary responsible for strategy and reform in our department, will then discuss in a bit more detail some of the work underway to support health service improvement in Victoria, as well as outlining some of the opportunities presented by national reform to help us get the best results from an improved and more sustainable health system.

So, what have we heard? We have been actively listening to what the community has been saying to us, and there are a number of themes that I believe have been very consistently put to us through the Health Improvement Forums.

Firstly, this community has underlined the importance of having a more coordinated person-centered approach to healthcare.

Secondly, it has been emphasised that we need to take a "with us", not "to us" approach to designing new services as the community wants to be involved and empowered to co-design new initiatives collaboratively with Government.

Third, the community wants long-term sustainable solutions and actions that improve health outcomes for the whole community.

Next, it's obvious we need to tackle the social determinants of health in the Latrobe Valley if we are to improve health outcomes in the long-term.

Finally, there's a need to build on the great strengths of this community. There are

well-established trusted networks in the Latrobe Valley and a strong sense of community that I think we've just heard all members of the Inquiry reflect on.

The region has high rates of membership in organised groups and high participation in community events and these are strengths that we need to build on for a healthier community.

But, as you can see from these charts, Gippsland also has relatively high levels of chronic disease which make the need to tackle this problem extremely important to the general health and growth of the region.

In addition, Gippsland also reports high barriers to care. The barriers to equality and access to services in producing the quality of health outcomes will continue to be priorities for me and for this Government.

That endeavour though will be assisted by the region's great strengths in very healthy levels of citizen engagement, strong social networks and an even stronger sense of community that can be of great service in helping to drive productive changes that will lead to better services and healthier communities.

Over the past year the Government has been also taking early steps, as this Inquiry has unfolded. If I focus on one of these steps: during the Hazelwood Mine Fire a small number of recognised community leaders were brought together curing the response and relief stage with support from DHHS. Many of those community members have chosen to stay on this committee, now known as the Community Recovery Committee.

The committee is currently chaired by Carolyne Boothman and a local Councillor, Graham Middleton, as deputy chair.

DHHS has provided funding to the Latrobe City Council to support the community and to deliver on the recovery activities for the community. The committee comprises the Department, community members and local community agencies. It has overseen a range of recovery activities, including a number of community events aimed at celebrating and advocating the strengths of Morwell and highlighting key achievements, for example a "thank you to emergency services" event.

From my perspective this committee has been a really powerful voice for the community, advocating on behalf of the needs of the community with Government agencies.

Most recently, Latrobe City Council, in partnership with the committee, has undertaken a local door knock of 80 households in southern Morwell. They've also run a number of planning meetings with local residents, and I know that more are planned across Morwell and across the region. These activities have been designed to community building and inform future planning and development of a resilience plan for Morwell that will be linked into the municipal public health and wellbeing plan. I think this is just one example of the community leadership that you were referring to earlier.

Of course, there are many aspects of life that contribute to health and wellbeing, including access to education, employment, secure housing, freedom from

violence, supportive social networks and services and opportunities to participate in community life. Health and wellbeing is everyone's responsibility.

As I mentioned, we've heard really strong feedback that a long-term whole-of-community approach is required to improve health and wellbeing, based on governments and communities working together to improve economic opportunities, social supports and to address the drivers of both good and ill-health.

Looking ahead to 2025, across the State as a whole and particularly in regional communities, the Government is committing to a comprehensive jobs and investment plan. Regional Development Australia and Regional Management Forums will continue to work with local businesses and community leaders to maximise opportunities for this region.

In particular, State and regional approaches will focus on creating an environment for jobs and investment through boosting regional growth through tourism and population patterns, enabling high growth sectors to grow, export and employ; supporting innovators and start ups to succeed and scale up; seeking to attract more international students and enticing them to live and work here; leveraging our liveability and to complete globally for talent; investing in planning and transport infrastructure to enhance our productivity; and helping businesses and communities right across the State to benefit from the Asian century by Government leveraging its inter-governmental partnerships and working with industry to better integrate into global supply chains

so that we grow the ability of Victorian businesses to design, package, market and brand products for Asian preferences.

I actually sit on the Gippsland Regional Management Forum and this has been one of the continuing conversations that we've been having about increasing opportunities here in Gippsland.

The most recent strategic plan for Gippsland which has just been recently released identifies three major opportunities for jobs and economic growth. The first is about really leveraging the tourism potential of both coastal and bushland locations. The second is around expanding intensive and organic food production, and the third is really about leading dairy innovation.

If we then turn to how we build strong and resilient communities: looking out to 2025 it's likely that all parts of Victoria will face challenges from changes in where people choose to work and live and an ageing population.

Maintaining opportunities and equitable access to services, both where populations grow, but also where they contract will be a particular challenge.

We also know that we face challenges with people living longer, which is a good thing, with projections suggesting that there will be around 40,000 centurions in 2054-2055, almost nine times the number in 2014/15, and that an ageing population, as we always hear, will impact on spending, with 70 per cent of the total burden of disease and injury likely to be attributed to chronic disease by 2022.

Breaking the cycle of disadvantage, particularly

in areas where it is particularly entrenched, is therefore an absolutely key pillar of building an inclusive and prosperous society.

For example, we know that there are lack of clear pathways into work for young people, with 51 per cent of 15-24-year-olds churning between periods of work and unemployment. We know that our social services are experiencing increasing client complexity. I spent Friday talking with the Family Violence Royal Commission about the growth in family violence and the impact that has on families and communities, and social service systems are not well equipped in their current state to respond effectively.

Early intervention, integrated services and services that are co-designed with communities can empower communities and deliver tailored solutions to local problems.

I would say that the early intervention argument has been won, but the question of how to fund and how to implement are central to making inroads. People have families, people live in communities and people are in very different circumstances and our services need to account for this individuality. People have existing strengths and motivations; we need to listen and respond to these.

Of course, integrating service is a key part of addressing complex multi-faceted issues such as family violence, but integrating services requires whole-of-Government social service system reform. We have to find ways to empower workers to innovate and deliver more personalised services, and place-based

localised responses are key to how we address the particular needs of communities, and to do that we need to entrust and empower those communities.

In particular, we will need to find new ways of delivering services to vulnerable Victorians if we're going to keep up with demand. That requires us to have a much stronger focus on the achievement of outcomes. Continuous improvement is possible if we measure and track progress with rigor.

The system that sits behind all of our systems needs to talk to each other and empower workers to make a difference, and our interactions with clients need to be both supportive and motivating, building confidence, developing skills and capabilities and providing opportunities for people to participate.

At our last regional management forum we agreed to establish an education and community wellbeing sub-committee here in Gippsland to progress this very agenda.

If we move then through to how we best enhance our health system. In many ways and in many areas Victoria's health system performs well. We do have some of the most efficient hospitals in Australia and we are often referred to as having one of the better health systems internationally.

However, there is no room for complacency. Evidence from Gippsland and from across the State and across the country shows there are areas where we can do better.

Our current approaches do not work well for people with chronic disease or complex needs. Care is often

not well coordinated to meet people's needs; we don't have a strong enough focus on prevention, early intervention and self-management; patients in communities are not always treated as partners in care, and there are variations in health outcomes across different parts of our community.

With all of the forces of change continually assailing the healthcare system, particularly the rising levels of chronic disease and the needs of an ageing population, there can be no time to rest if we are going to continue to remain one of the best and meet the demands of the future; in which case, substantial and ongoing reform is of absolute importance for the people of this region and Victoria.

So, what does this change agenda look like? The health system is complex and can interconnected at national, State and local levels. The Government and its reform agenda is committed to creating a health system that works well for all Victorians, no matter where they live and work. This means Statewide principles and approaches linked to national directions but with the flexibility to meet and address local needs. It means working with local communities in close collaboration to co-design effective access and provision of services. It means organising around people, not providers, with a focus on individual and population wellbeing, and it means developing new models of access, service provision and flexible funding that targets local priorities and needs.

The Government released Health 2040, a discussion paper, in September to stimulate discussion about

directions for health reform. Alongside a call for public views and submissions, the Minister for Health recently held a health summit of leading clinicians, administrators, academics and experts to discuss opportunities to build an outcomes approach for the health system, enable a more person-centered view of healthcare, strengthen early intervention and prevention, improve the way that health and social service systems work together, and to promote a stronger community voice and participation in the design of the health system.

The summit's outcomes and submissions to the Health 2040 discussion paper will inform the develop of a detailed Government response later this year which we'll be very happy to share with the Inquiry.

In parallel, the Travis Review reported to Government in August. This review conducted a Statewide census of hospital capacity and provided recommendations about how to increase the capacity of Victorian public hospitals.

The Government again is committed to implementing all of the recommendations of that review which will deliver benefits to regional areas of Victoria, including ensuring that capacity and services are in the right places to meet the needs of regional areas and, importantly, ensuring that innovation is scaled up and spread across the system so that the best ideas have impact across the whole state.

A new framework for health planning will be developed by 2017 to reform major infrastructure and service planning and to ensure that in the future more

patients are treated more effectively in a timely way as close to home as possible and in the most cost-effective manner.

The Travis review also recommended the establishment of a new body, Better Care Victoria, which will be supported by Better Care Victoria Innovation Fund and will have a key role in driving innovation to increase the capacity of the public health system, assess new health initiatives, scale up proven initiatives, and improve the interface between primary and acute care, as well as facilitating an evidence-based approach to ensure long-term sustainability. Again, we can provide more information about the directions for Better Care Victoria.

If we move then through to how health is nested in a broader approach to regional, economic and social development. Earlier this year, John Brumby conducted a review of regional planning and services, and one of the key pieces of feedback he heard was that current approaches for supporting regional strategic planning would benefit from deeper engagement with local communities and clearer feedback loops to inform and influence State Government policy and investment decisions.

The Government has committed to working with local and Commonwealth governments to enhance partnership models and ensure regional strategic planning covers both Statewide and local priorities. This will build on existing strategic plans - and I mentioned earlier that there has just been a strategic plan finalised for this region, but will, as I say, look to have much

deeper approaches to community engagement and clearer feedback loops into Government.

I'm really confident that there will be opportunities to develop stronger links between Statewide, social and economic strategies, these regional strategic plans, and then deeper dives into local strategies to improve health and social service systems.

As I said, the Government's response to that review is due in the coming weeks and we'll make that available to the Inquiry.

Cascading from whole-of-region planning to how the health system develops in this region, I'm conscious there's been lots of discussion through these Health Improvement Forums on options to strengthen local health planning and collaboration. There has been a strong theme of adopting population health approaches to focus prevention and early intervention on the health issues that are the most relevant and important to this community, and to adopt a community development approach to health to strengthen health and broader social outcomes. I would strongly endorse these directions.

There is an opportunity to leverage national and state reform efforts to maximise the impact of local initiatives. Of particular note, in September the Victorian Minister for Health released a new Public Health and Wellbeing Plan. The vision of the plan is for a Victoria free of the avoidable burden of disease and injury, so that all Victorians can enjoy the highest attainable standards of health and wellbeing at

every age.

The plan's priorities for 2015-2019: a healthier eating and active living; tobacco-free living; reducing harmful alcohol and drug use; improving mental health; and preventing violence and injury. This is the second of these Statewide health and wellbeing plans and is stronger in its focus on health inequities.

The Government has also committed to deliver a new 10 year Victorian mental health strategy. The strategy will focus on outcomes we want to see for people with a mental illness, their families and carers, and the broader community. It will have a strong recovery focus and a strong focus on community-based support and care.

Minister Foley has committed to a focus in the plan on improving access to mental health services in Regional Victoria.

These two plans, alongside the work of Better Care Victoria and broader Commonwealth and State reform discussions that Terry will discuss in a bit more detail in a moment, provide a really valuable framework for how regional services are planned and organised going forward.

I also think that there is an opportunity to leverage existing and emerging networks in this region to drive planning and collaboration on prevention, early intervention and more person-centered health and social care.

I think it's critically important that the approach to local improvement initiatives is co-designed and co-produced through local leaders.

I know that the Commonwealth is interested in kick-starting primary health networks, and I understand that the Gippsland PHN is currently designing its local subregional and regional level Government structures and is kicking off work on strengthening care pathways.

Terry will talk more about the opportunities presented by PHNs and other Commonwealth and State processes.

But I in particular wanted to note local leadership initiatives at the moment such as Carepoint, which I think you've heard a bit about, and web-based care pathways as really great examples of projects to establish patient-centered care that is informed by evidence and really helps to bring together different professionals in a coordinated way.

In parallel, the Family Violence Royal Commission, and reviews being led by Minister Mikakos and Minister Foley, are very focused on strengthening social service partnerships and networks to create simpler front doors into social services, to integrate case management services so that people don't have to re-tell their story and navigate multiple services on their own, and to keep building the evidence of effective interventions to help people before problems escalate and provide them with greater continuity of support.

I think there's a fabulous opportunity for the Latrobe Valley to position itself to move first and be the location to trial how these consolidating networks can work together to achieve collective impact.

In further developing local services I'll just finish with two reflections - I know this is a very

busy slide. The first is that I think there's great merit in closely combining primary and community health approaches to influence healthy behaviours and strengthen screening, early prevention, early diagnosis and treatment and management of chronic diseases.

For example, public health approaches can provide knowledge about the prevalence of disease and public health tools can enhance the planning of primary care activities. Cooperation between these two sectors could help to document unmet needs and the identification of evidence-based health promotion activities.

A health system based on a strong primary care infrastructure and strong public health sector has the greatest potential to optimise health of the population as well as individual patients, and improving the interaction between public health and primary care will depend both on access to timely information about regional and community health concerns and needs, but also a deep commitment to cultural change and new ways of working.

My second observation is that community health services could provide a powerful platform for a community development approach to health through strong relationships with primary and social care services. Community health services are, in my view, an excellent vehicle for promoting healthy lifestyles and engaging patients who may not otherwise be reached by other services.

Through co-location and referral pathways, community health services can play a valuable role in

coordinating care particularly for people with more complex needs.

So, to conclude, delivering a Statewide approach with local flexibility that produces real improvement to health outcomes and wellbeing means being guided by a clear set of principles. The Government's approach to health reform is still evolving and will of course be informed both by this Inquiry and the various reviews that I have referred to today, but there are common themes that come through clearly and consistently from the people of the Latrobe Valley, the Statewide consultations on health reform, and the experience and evidence coming from other health systems.

Future approaches should be guided by principles of patient-centered care, a long-term whole-of-system perspective, community development approaches to health, collaborative local leadership which leverages the networks that exist here today, and community engagement and consumer empowerment.

For mine, I look forward to continue to working with people, institutions and community groups of Latrobe and Gippsland on the big tasks that lie ahead.

I wanted to finish by acknowledging that I appreciate the traumatic and difficult time that this region has been through and make my own personal commitment that we will continue to listen and learn as reforms and changes are developed and rolled out.

We are united in our determination to deliver real and sustainable improvements in wellbeing in this region, and build on our capacity to tackle and reduce

inequality, disadvantage and illness in the Latrobe Valley. Thank you.

MR ROZEN: Thank you very much, Kym, for that very informative presentation.

Our second speaker is also from the Department of Health and Human Services. Terry Symonds is the Deputy Secretary of Portfolio, Strategy and Reform. Thanks, Terry.

MR SYMONDS: Thanks very much, Peter. I'd like to also acknowledge that we're meeting on Aboriginal land today and pay my respects to their elders past and present and elders from other communities that are here today.

I think where Kym's finished off by talking about principles is a good place for me to pick up. I would say, my overall assessment would be that we're in an exciting time in health reform where the key principles and the pieces, if you like, of the jigsaw are now fairly well understood and agreed across jurisdictions, both in Australia and internationally, and the challenge we have, I think, is to put those together into a working model that is sustained beyond individual projects or pilots or programs or the life of this or that Government and I think we are very close to that point.

I guess it's important to begin by acknowledging that Victoria has great experience on the ground to build on as we approach that key next stage. If we look across that continuum of key principles or pillars, if you like, of health reform that Kym outlined, if we think about outcomes, our new Public Health and Wellbeing Plan will require us to develop

regional outcome frameworks and measures that will include, not only rates of chronic disease, but also risk and protective factors at a regional level, and also broader enablers, measures of social capital, public participation, et cetera, things that we now know are fundamental to improving the health and resilience of local communities.

So, the requirement and commitment by Government to develop regional measures of those things, I think, is a really good position for us to measure the outcomes of our work, not just the outputs or the activity that we're doing.

A population-based perspective has a long history in Victoria of work in particular areas around cancer, diabetes, et cetera, a range of chronic diseases. The example I've pulled up here, Pathways to Good Health, is a program that's actually based in community health targeting prioritised healthcare for children in out-of-home care, our most vulnerable cohort of children in the community.

I raise it there because I think we sometimes think about population approaches to health as being about primary prevention or tackling very upstream risk factors, but population health also involves understanding particular segments of the community who may be at greater risk, and this is an example of us using a strong Victorian platform in our community health services to target priority access, particularly at primary healthcare, for a population that we know to be at greater risk.

Integration has been picked up by John in your

opening comments and touched on by Kym as well; this is a very exciting time for us in integrated care, and I'll come back to opportunities that I think exist at a national level. There's a couple of examples there in the slide. Carepoint is an experiment going on, a collaboration between private health insurers and the State to see whether coordinated access in the community to GPs and private healthcare might help reduce avoidable admissions to hospital.

Healthlinks is an example of the State relaxing our long-standing activity-based funding model for hospitals to give hospitals flexibility to take that investment and put it into the community to help keep people out of hospital and give them care where they need it, and primary care partnerships - again, we have something like 600 different organisations that participate in 28 PCPs around the State, and so a strong tradition there of collaboration between sectors. I'll come back to what I think are some of the opportunities ahead of us in terms of integration.

Participation: I've picked up mental health as an example here. We have two years now of experience of dialogues for consumers and consumer advocates and representatives of consumer organisations to come together, agree on their advice to Government, ensure that they're influencing Government policy around mental health services. We have an equivalent dialogue that exists for carers and carer organisations. Victoria has a recognised strong and long history of participation by clients, consumers, carers and families in healthcare.

I think we have a challenge ahead of us in terms of public participation and thinking about how we engage broadly with communities as well, not just those that directly access our services. The Auditor-General released a guide earlier this year to public participation and a call on agencies to do more around how to directly engage with communities, not just the individuals that access our services.

To help meet that challenge we've established in my own division within the Department an engagement branch that will start to pull together good evidence from around the world of public participation in policy making to ensure that our policies and programs are well directed to the needs of communities.

And place and the importance of location and a local approach to services, the example I've pulled up there of Koolin Balit is our Aboriginal strategy for the Department. More than half of the budget for Koolin Balit is actually determined locally by local committees, including in Gippsland all of the Aboriginal controlled community health organisations who come together, they decide on local priorities and how to spend that money, and the fact that a majority of that money is committed to local investments reflects, I think, the Department's commitment to local prioritisation of needs and local control of our work.

That's a good base, I think, for us to move forward. I want to touch on a couple of examples in particular. Kym's referred to them in passing.

Primary health networks are the latest iteration of the Commonwealth ongoing deliberations about how

best to fund and commission and manage GPs and primary healthcare; they replaced the former Medicare Locals. There are six primary health networks in Victoria that are slightly larger and the intention is for them to align with hospital networks.

There's an explicit intention for the primary health networks to be in a position to aggregate local need, understand local need and then commission services in primary care to respond to that need.

The Commonwealth has appointed Steve Hamilton, former president of the AMA, to chair a primary healthcare advisory group, who are currently conducting consultations and will report back to Government, I think in December of this year, on options for primary healthcare reform.

They are suggesting that the primary health networks might go - they haven't delivered their report yet, but one of the options canvassed publically by them in their discussion papers is that the primary health networks might oversee population-based funding models for GPs. So in addition to them being paid on a fee-for-service basis for individual episodes, they might be paid to actually improve the health of communities in which they work, and that might be a key role for PHNs to ensure that that actually occurs. I think it's a really promising direction, it reflects what I mentioned at the beginning which is the emerging consensus I think internationally, that we have to bring together the curative individual oriented platforms of healthcare, both in primary care and hospitals, and move towards population-based approaches

to healthcare. The Commonwealth's explicit, at least endorsement of that option being considered, reflects I think that appetite and it's a huge opportunity ahead of us.

Victoria and Australia are reasonably well placed in that, sometimes better placed than we assume. Something like two-thirds of all Australians when surveyed say they have had the same primary care practitioner for at least five years, and almost all Australians over the age of 65 years old can name a nominated primary care provider. That's a very good platform, very good basis on which to think about, if that is the case, why we still only fund GPs based on the individual episodes of activity for which they present to a GP.

We have essentially a good platform for enrolled populations and a good conversation with GPs or primary health networks more importantly about how those needs can be better understood, planned for in advance and services commissioned. That's an option the Commonwealth is considering and it's premature to comment directly on it, but we think it reflects a kind of emerging opportunity.

If we go to the next slide, Victoria has an opportunity to directly influence some of the work going on. The Council of Australian Governments, COAG, met in Sydney in July and commissioned the latest round of national health reform work under the banner of Reform of the Federation.

Sometimes national health reform feels like a chronic condition in itself, particularly for

bureaucrats. But there's reason I think to have particular hope and optimism about the process we've got now.

They have commissioned two essential planks of work: one around hospital funding and, because of the sheer scale of dollars invested in hospitals, that will always be a focus for national health reform work; but they've importantly commissioned another piece of work around coordination of care for chronic disease.

What the COAG agreement reflects is that consensus between State and Territory Governments responsibile primarily for hospitals and the Commonwealth responsible primarily for funding GPs and primary care, that they need to move from their respective platforms beyond paying for activity in whatever form they do, to starting to pay for better health and how to better coordinate their services and align their services to ensure that that is delivered.

Victoria has been asked by COAG to put the proposal together and bring it back into COAG in December for how that might occur. We are very busy in conversations with other States and Territories about that. There's a couple of important features about whatever will come out of that that are worth pointing out and I'll finish here.

The first is that, there isn't clear evidence yet for any one particular model that's going to be implemented. We're not going to pull something off the shelf here and say, this is the model for Gippsland, this the model for Geelong, this is the model for Sydney. Evidence is still emerging - internationally

evidence is still emerging, and everyone's interested but no-one's kind of got the holy grail yet. And so, whatever model, whatever proposal we come up with here, there's going to be flexibility for different options to get tested and trialled, and I think that is an opportunity that is worth considering in the context of the Valley and this process.

The other is that, needs are different in different areas, and so, whatever model is developed has to involve local commissioning based on local needs and a shared understanding between acute hospital-based providers and primary care providers about what those needs are.

The form that takes is not yet clear. Primary health networks are an exciting opportunity, but they have yet to deliver on commissioning primary care, let alone commissioning broader spectrums of care, but I think that's an interesting question for us to ask, is what form that will take. But, regardless of the form, alignment of the existing investment is an implicit commitment, I think, now from State and Territory and Commonwealth Governments, which is an historic opportunity and goes beyond just making hospitals more efficient.

We are now talking about putting together combined resources of the Australian healthcare system to improve population health on the basis of local needs, determined by local bodies, and that I think is an historic opportunity and we're at key stage in terms of timing for this Inquiry, because I think the interest and recommendations that you make will land at a time

when Governments, in particular the State Government, are considering models and how best to actually prosecute this discussion.

It's a good time for fresh ideas and a good time to think about how best to apply locally some of the emerging concerns that we've got. I'll leave it there, thank you.

MR ROZEN: Thank you very much, Terry.

In the next little while we have some time set aside for questions from myself and also from Members of the Board of the two speakers that we've just heard from. If we could invite both of you up to the stage, if you don't mind.

Perhaps if I could kick off, and maybe just a question for Kym. I'm just looking at your first slide and you I think identified something which we've heard a lot about during the forums, and that is the need for long-term sustainable solutions to improving health outcomes.

One of the particular themes that's come through - one of the questions we've had from the community and a lot of the submissions the Inquiry has received has been the design of solutions and systems that can outlive the short-term political cycle and the challenge that that presents to Government; I was wondering if that's something you are able to address.

MS PEAKE: Yeah, and I think the opportunity that presents itself, both through the public health and wellbeing plan that goes beyond the cycle of any one term of Government, and that regional planning process that I described, is what assists with durability.

The strategic plans that have been in place regionally have cut across political cycles, have been continued and built on. Of course, every Government of the day is going to have particular priorities, and that is why they're elected, but that sort of planning process which is more deeply embedded in community, thinks about the relationship between things like town planning and land use planning and our health outcomes I think is a fantastic vehicle for durability of planning and solutions.

The third point I would make is that, as Terry's just described, if we can get the relationships right between primary health networks, the community health platform and our hospital networks, then that local leadership to maintain relationships and initiatives is incredibly powerful.

MR ROZEN: If I could ask a follow-up question. Are there things that local communities, and in particular the community of the Latrobe Valley, can do as a community to ensure that reforms are longer lasting beyond political cycles?

MS PEAKE: Again, I would come back to that point about the participation and collaboration of local leaders through those service networks and those strategic planning processes is important. Good ideas endure. Good programs, they might be tweaked, slightly repositioned, but at their heart, if they're having outcomes, they have got a much more powerful case for re-investment.

One of the things that we haven't done very well right across the public sector is have really good

outcomes measures, and that, combined with an evidence base on the efficacy of interventions, are the two most powerful ways of convincing incoming governments to stay the course on a health direction. Measuring of outcomes relies at its heart on the data that is collected through our services, measuring the efficacy of our services again is importantly influenced and supported by all of the clinicians in our system as well as our public health professionals.

I think our local leaders are incredibly important in setting their own destiny.

PROFESSOR CATFORD: I wonder if I could follow with a supplementary, Kym. I absolutely agree that the public health and wellbeing plan is a very useful sort of platform. Of course, there's also an Act, and I just wondered if you felt the Act was also a vehicle for maintaining this continuity?

We heard at a previous forum the possibility of a consultative council which is enshrined in the Act. Is that another mechanism, do you think, that might be suitable for advancing things in the Latrobe Valley?

MS PEAKE: Certainly, there are already consultative arrangements that are both facilitated and required through various legislation. I think that you also want to make sure that you leave enough dynamism so that, as contexts change over time, the focus of consultative arrangements, and even the composition of consultative arrangements can change as well; so, there's always a balance between durability and flexibility I think. I don't know if you want to add anything to that, Terry?

MR SYMONDS: I would say the Act requires local governments to develop public health and wellbeing plans. They are variable across the State. As with all planning exercises as to how well and how collaboratively they're done; I'd commend the process that has been followed here locally, I think there's been a lot of consultation going on locally to ensure the plan is reflective of advice that the council and the stakeholders have received.

But I'm optimistic, I suppose, that if we put council and acute health services and primary health network and other groups together, and they all have a requirement to understand local needs, they wouldn't be doing it separately, the public health and wellbeing plans locally in the Act, without any change in legislation, would be informed by a consensus amongst those groups about what those needs and priorities are.

PROFESSOR CATFORD: Could I just follow up also the comment about outcomes, and I'm sure you're absolutely right, we need to be much better at monitoring and tracking outcomes. Of course, another development is actually paying by outcomes, and I just wondered if you wanted to comment on your thinking there.

Particularly, Terry, you were talking about the pooling arrangements for the Commonwealth, which I absolutely agree is a fantastic opportunity to consider. I'm aware in other countries and in other States, we've been looking at social impact bonds; is this another vehicle or machinery that one could think about in terms of putting more sort of rigor into the system?

MS PEAKE: A couple of comments that I would make: certainly, I think there is a great prospect in thinking about how outcomes are used to drive everything we do, not just sort of passively reported against. It is obviously really important in designing any sort of outcomes-based payment models that we don't create perverse incentives, whether that's perverse incentives to only service people with needs that are easily accommodated, or whether it's about the benefits of one set of activities by one part of the system really being reaped by another part of the system. It is important, and I've seen lots of examples of where the way an outcome payments model has been designed hasn't been sufficiently well thought through and has actually led to unintended consequences.

So, the principle I really support; the design is incredibly important, and it's important that we do this in an evolutionary way as we get the data systems better to enable us to have better outcome measures as well.

A separate question then is whether a social investment approach is required on top of paying by outcomes. I think that there's kind of mixed evidence about the cost-benefit analysis, and I think it is a very case-by-case scenario. Incredibly even more important when you get to a social investment model that you've got the measures right, that you can measure effectively the change that you're trying to effect.

I would be tempted to step it out by thinking about, where are the areas of health delivery where the

outcomes data is most readily available, where we then think through carefully what the design of the funding models are to give effect to those outcomes, and think through whether social investment is going to give added value, or whether in practice simply having a really driven outcomes approach would achieve the same end.

MR SYMONDS: The only thing I would add, John, this is a problem I think of attribution. Healthcare is not the major determinant of health, and for certain individuals at particular stages healthcare is critical to their survival, but in general for populations there's a range of factors, including their income, the physical environments they're in, their access to means to maintain health, et cetera, that we think are more important, so attributing outcomes to individual organisations, particularly healthcare organisations, is difficult in that regard, but I think it's a direction that we welcome, it's certainly something that we and other Governments are spending a lot of time thinking about.

From my own point of view, I think the key thing is to balance incentives and I think that's the right direction to go because, if there is some remuneration that is tied outcomes, the same as there should be some tied to quality, then it balances the other incentives that are in place for providers to be efficient for instance or to minimise costs, and I think we need a balance of incentives for providers, not everything in one basket.

I think, from our point of view, we're working

towards hospitals having at least some part of their funding tied to their work to reduce admissions, rather than just paying for admissions - that's a balance of incentives. I think likewise for primary health networks and for GPs, and the Primary Healthcare Advisory Group of the Commonwealth flagged this, they're headed towards a mix of incentives for GPs, not just a payment of a schedule for the episode for the patient that's walked through the door, but perhaps we need a mix of incentives for GPs as well, and if we get alignment across those platforms, then I think we're moving towards outcomes for which we share responsibility while looking after things that are in our own patch.

MRS ROPER: I have a question. A lot of what we've talked about this morning - they were very interesting presentations - was long-term, there's a lot of reviews and a lot of work to be done in integration and all very important to institutionalise. But part of our terms of reference is also looking at long-term actions. Do you have any thoughts about where we could be focusing our minds at the moment, or the local community could be focusing their attention on short-term actions that will help build a base as a foundation towards some long-term objectives?

MS PEAKE: I'll start and Terry will have some other observations. I think a couple that we mentioned this morning are early actions that could be progressed: the first, the Carepoint project, that Carepoint trial really looking at integrated care in the sphere of chronic disease is a really important foundation for

thinking about longer term approaches.

Similarly, the thinking about the work that the PHNs are doing around web-based healthcare pathways again is a really critical first step in how professionals work together differently and more effectively.

The final one for me was that example I used around the community health platform and how we might make more use of it to better support people who have multiple needs, and to start joining up the social services response and healthcare response to meet those needs. It's an existing platform, it's servicing clients already who often have those multiple needs, it's a really good platform to start work on.

MR SYMONDS: I think I'd follow the same theme, Anita. My observation is, the State and Commonwealth Governments, they're open now to proposals to relax some of their existing arrangements if it means that they will get better outcomes for their investment. I think both State and Commonwealth governments are open to suggestions and ideas around that.

Every State in Australia has at least two or three trials going on at the moment of integrated care between primary and acute health, and each of them are different, each of them represent the State Government's relaxing to varying degrees on existing arrangements and being prepared to invest in things to see if they work; all of them rely on local players coming to the table with shared agreed proposals around how that might happen.

I've heard about discussions here around care

pathways, using map of medicine - a UK developed tool - to come up with pathways to help us work out what's the most appropriate point at which individuals in the community might access the healthcare system. If we can come up with proposals to share what we already have on the table and move it around to ensure that we get the best outcome based on evidence about what we know about what people need, then I think everyone's in a mood to talk.

I think now's a good time to think about proposals for how to use the investment we've got for better effect.

MR ROZEN: If I could change the topic a little. One of the practical problems that we've heard about that people face here is having to travel to Melbourne to take their children to see specialists or themselves to see specialists. At the same time, we've also heard about the opportunities presented by telehealth in that regard, the ability to reduce the inconvenience and costs of travel by making greater use of technology. I was wondering if that's something you're able to address.

MR SYMONDS: So telehealth, like other developments we've talked about, is at a relatively early stage in its development. There is no question that telehealth improves the experience for patients living in rural and regional communities and avoids the inconvenience of travel.

I think the balance that is not yet sorted internationally in evidence is around safety, quality and most efficient kind of model: is it more efficient

to do that than it is to have specialists travel or to subsidise travel to large centres? Do you risk disbursing the volumes that are necessary to ensure that you've got quality that comes from concentrating services and making sure that the people that do a certain job do it in sufficient numbers, that they do it really, really well - do you risk that? There's some of those questions, I think, that are still being sorted, but the Government, like all governments, are committed to doing that and there are a number of projects underway now, including in areas of paediatrics, orthopaedics, et cetera, where we're looking at models of doing that, and investing in experiments to try and develop that evidence.

Again, if there are particular proposals from the Valley for that kind of work, then I think the Department's in a good position to discuss them.

PROFESSOR CATFORD: Just picking up that theme, and trying to focus down on the Valley, do you think there's a case for articulating a special designation for the Valley?

In our first report we talked about the notion of a health conservation zone, but leaving aside the name, is there merit in thinking of the Valley as a special focus for health innovation for example, where this would be the place of choice to trial and investigate new opportunities? Because clearly, in terms of trying to bounce up, as one of our consultants recommended in a previous forum, we need not just to return the Valley to its former health status, but to actually advance it very significantly. Therefore, is there a case to

actually suggest and indicate that the Valley is a special focus for investment into the future?

MS PEAKE: I think, building on what we've both talked about, I wonder whether just a slight re-framing - rather than a sort of a top-down kind of anointed designation, the support and encouragement to leverage the local ideas and networks - and I really hand on heart say that there are incredibly strong networks and planning that's happening in this region making use of the opportunity of these hearings that have, I agree, catalysed and galvanised a lot of that collaboration across the region to put forward those ideas has the same practical effect of then having early action, prioritised investment, exemplars and trials of new ways of working, but it's really been co-produced, co-created through community leadership rather than it being sort of imposed on the community that, here are the things that you will innovate in relation to.

MR SYMONDS: I'd comment that, I think there's a number of reasons why I think Gippsland and the Valley has a strong case for trialling new initiatives: one is to do with need, and Kym's presented some of the rates of chronic disease; access to services is another question where I think we can do better; but social capital, rates of public participation I think are promising.

The other thing is, the intersections between providers. I think the collaboration that occurs between providers is a key factor in the success of any initiative that we're going to do going forward. There may be more needy communities from time to time, but if the relationships don't exist as a platform on which to

trial different initiatives, then we're asking a lot as a kind of a step up; whereas, I think that platform that exists here in the form of the relationships between primary care and acute providers, that is a very good platform in which to do something.

I guess my comment, and reflecting on your questions about funding models and so on, I think to me that's encouraging, because the national context, the national reform context means, anything we trial now has to be with an eye towards how this could be replicated and spread for the benefit of other communities, and there might be reasons to say this or that community is well placed to trial something, but we're in a position now where we have to develop because of larger pressures around demographics, health costs, et cetera. Demand for health services is a much greater issue now for governments than price and cost. We have to deal with those things across all communities, so anything that we do in any local area has to have an eye to its replicability across the community.

MS PEAKE: I think what you're hearing from both of us is that there's a natural convergence in terms of need, leadership and focus, and it is the right time to leverage all of that in an environment where reform ideas are both being looked for and supported by all levels of Government, and so, packaging up what those proposals are, I would be very confident would be really well received by all levels.

CHAIRMAN: Can I follow up that to ensure whether there's any region in the last two to five years, if you like,

which has been particularly outstanding in overcoming sibling rivalry and other problems that do apply in certain areas, in just getting their act together so that they really are at the forefront of pressing, the State Government in particular, to be involved to lead the way in some of these areas?

MR SYMONDS: The last part of your question is more difficult for me to get a read on. If I can make a couple of observations, I think Geelong is worth having a look at. I think Geelong has some advantages in terms of both pressing imperatives, particularly around significant shocks to employment in the area, job losses, but also very thick strong networks between GPs and other healthcare providers, and so, I think they've come up with interesting ideas and been very proactive with them to the Department and the State Government. That's one example that comes to mind. I can't comment on how that's positioned them in terms of additional Government investment, but I think it's been noted, both in Victoria and nationally, how strongly that group of providers has been able to say, let's think about how to get shared care of patients and populations across the community and put some new initiatives in place. That's just one that comes to mind.

PROFESSOR CATFORD: I wonder if we could switch tack a little bit to talk about local issues. Kym, you mentioned community engagement, that the Department was moving on that. Maybe you could just outline what actually is happening, because obviously we have been very interested in that area.

Perhaps also as a supplementary, just comment on Aboriginal health, which I think Terry also commented on as well - you know, what's happening down here?

MS PEAKE: Sure. In terms of community engagement, again there's both a Statewide approach and local activity that is underway. Terry mentioned that in the last month we've created a new community engagement unit in his division that is absolutely intended to be a centre of excellence for the sorts of techniques that you adopt for different purposes and the different channels that you use.

My substantive position in the Government is the Deputy Secretary responsible for a whole range of governance policy and coordination functions in The Department of Premier and Cabinet, including communication and sector engagement, so we're partnering closely with my team back in DPC about what is happening around the world, what are the different techniques you use if you're talking about feedback on particular services versus input to different health policy questions.

That's at the sort of whole-of-department level. More locally we're currently recruiting through the regional office for a community engagement officer for Morwell; they will work closely with a similar position that's being created in the EPA to make sure that, before, during and after any future events that we've got much more expertise locally, but also obviously would have an ongoing role in terms of engaging with the community about what matters to them.

Engagement is important, that it's both ways; it's

not only about pushing out information, although that is important, it's also about genuinely having feedback back. That's probably the space on community engagement.

The third level of this I mentioned was the new regional governance arrangements. Again, I can't talk too much about those, they are in front of Government to be considered currently, but absolutely the principle is, how do we design collaborative, whole-of-region strategic planning mechanisms that involve all levels of Government and community and business leaders where that regional governance is not the only voice that feeds back to Government but actually is the vehicle through which there is deeper engagement with the community. So, there will be more to inform you about on the practicalities of how that engagement will work and the tools that will be adopted in the next couple of months.

In terms of Aboriginal health: certainly one of the really key initiatives that was started by Gill Callister in this location was a partnership network arrangement where she was the champion and heavily invested and involved in working with the Aboriginal organisations about strategies, particularly focused on children and families to improve social outcomes. That work has been going on for the last five years.

I have just agreed that I will take over the sort of championing role for that work. I think we're at a point where there is really significant relationships that have been built and a clear agenda. The next step is to look at, how does that then translate into

specific projects and proposals which may include looking at a cooperative arrangement which has not been in this part of the region for a while. So, there's a few promising - it's not health-specific, but a few promising opportunities for how the Aboriginal communities down here are working together and with Government to achieve better outcomes for children and families.

MR ROZEN: Thank you very much for the moment, Kym and Terry, we'll be inviting you back to participate in the panel discussion later on after we've had a break for lunch. It is my happy responsibility now to inform everyone that we're going to have a 15 minute break for a cup of tea or coffee. I'm sure the catering standard here is as good as it has been on previous days. I make it just after 10 to 11, so perhaps if we could reconvene at 10 past 11 please.

(Short adjournment.)

MR ROZEN: Welcome back, everybody. We have as our next speak, Councillor Dale Harriman, who's the Mayor of the Latrobe City Council, probably known to many people in the room. Dale, if I could call you up to the lectern, please.

CR HARRIMAN: Thank you. I too would like to acknowledge that we're meeting on a traditional land of the GunaiKurnai people and pay my respects to their past and present elders and any elders who may be here from other tribes.

Thank you for inviting me here today. It's a pleasure to be involved, from our community point of view, with such an important discussion; a discussion

that has the potential to transform our community and its fundamental sense of self.

I'd like to firstly thank you for allowing council and its officers to be involved in a range of meetings and discussions. Staff have valued the opportunities to meet, discuss and explore a range of health-related topics with experts in their field.

As an organisation, we are passionate about the long-term health and prosperity of our community, and we implore the Inquiry to make a number of recommendations which enable transformational change to occur in this space.

We have broadly stated our overwhelming support for the establishment of a health conservation area and a Health Advocate, and today we will seek to provide some reflection on how this may operate in the future.

My presentation today will consider the establishment of the Health Conservation Zone, the appointment of a Health Advocate, as well as council's view on embedding sustainability into any approach moving forward and a range of recommendations.

While council is a strong partner of the health sector, we provide only a small reflection on these matters relating to clinical care and practice, believing that those more closely connected to the system are best suited to identify opportunities for its enhancement.

If we consider the establishment of a Health Conservation Zone as a health response, then it's council's view that the system requires the enhancement across the whole of the health community.

However, we believe that the largest investment should be made in the areas of prevention. Every effort should be made to empower residents to improve and enhance their own health and wellbeing to keep them out of the health system for as long as possible.

Council's consistent position has been that any structures, agencies or initiatives established to support the long-term health of the Latrobe Valley should be aligned to the Public Health and Wellbeing Act 2008. Utilising existing legislative structures leverages established Government practice, existing reporting arrangements, partnerships and collaborations across the sector while preventing unnecessary duplication.

It is important to note that the Act currently requires the council to develop an MPHWP, examine data about health status and health detriments, identify goals and strategies based on available evidence, provide for the involvement of people in the local community and specify how council will work in partnership with agencies undertaking public health initiatives.

Council meets these requirements through the provision of appropriate resources and staffing. However, the scale and impacts sought to be achieved through a structure such as a health conservation zone is well beyond the financial capacity of council, particularly with so many current constrained rates environments.

In an innovative approach, council is demonstrating the ability of the public health and

wellbeing lens, currently utilising the Municipal Public Health and Wellbeing Plan, to guide its most recent emergency recovery activities.

In partnership with the Community Recovery Committee, council is facilitating the development of a mine fire community resilience plan for the community at Morwell South and as an addendum to the Municipal Public Health and Wellbeing Plan at appendix A.

This strategy will require the same level of accountability and public transparency as is provided to the Municipal Public Health and Wellbeing Plan. The structure further provides a framework within which the community can be focused on enhancing their health and wellbeing outcomes as opposed to focusing on the trauma of the event.

The data of the trial has been completed in the community of Morwell South, or the Rose Garden community as they now refer to themselves as. Through a community development strength-based approach, the council has supported the neighbourhood to build their own localised health and wellbeing plan owned, created and now being delivered by the neighbourhood.

Likewise, it may be possible to shape the establishment of the Health Conservation Zone and a Health Advocate within the current frameworks of the Public Health and Wellbeing Act 2008. The Act currently makes provision for the establishment of consultative councils. We believe that this may be the appropriate access for the creation of a Health Conservation Zone.

Utilising an existing structure further has the

benefit of timeliness in that, as the existing provisions, it can be enabled by the Minister immediately. Such a model would utilise existing structures and settings while maintaining public accountability, transparency, as well as a lens to support confluence within the existing health system.

Council recommends that the Health Conservation Zone should be established for a period of at least 10 years to coincide with the work being undertaken through the Monash Health study. The Health Conservation Zone should provide an annual report to the community; use a strengths-based approach; focus on the social determinants of health; ensure that the work of the Health Conservation Zone is placed through the lens of an asset-based approach; facilitate the establishment of neighbourhood health and wellbeing plans following on from the work already commenced by council.

To ensure that the Inquiry's recommendations are able to make a meaningful difference, adequate funding will need to be provided to facilitate opportunities for innovation, transformation and dynamic co-creation.

During the Inquiry hearings, the forums, and indeed the Inquiry's report, there's been considerable discussion around the conditions of our community. Part of this has been an examination of the Latrobe community in a range of health statistics, most of which painted a fairly bleak picture about the continued health and wellbeing of our community.

However, if we look to our community through the lens of a strengths-based approach, there are many

things we can remain proud of. In my mind, the most critical of these is local community leadership.

Local leadership during the mine fire, after the mine fire and in more recent weeks and months has been one of the greatest strengths of this community, which is remarkable if we consider the range of challenges that our community has faced: bushfires, flood, structural adjustments to its economic base, pockets of chronic disadvantage, long-term industrial exposure to asbestos, just to name a few. In spite of all this, ours is a community that, even in the most difficult and challenging of times, will nurture leaders, leaders who will speak to the community, connect with the community and give tireless service in support of the community.

Local leadership continues to be our strength and council's position is that any structure of methodology moving forward should seek to harness and utilise this strength.

We would like to acknowledge with gratitude and thanks three key local groups who have played an important role in the local leadership space: the Community Recovery Committee has, for over the last 12 months, worked with council, the State and the community to develop and implement a recovery methodology which seeks to empower community to build stronger resilience, social cohesion and wellbeing.

The Morwell Neighbourhood House: during and after the event the Morwell Neighbourhood House has provided a vital information conduit to the community, establishing itself as a trusted source of information.

Voices of the Valley have emerged through adversary to become a strong voice of the community, challenging the status quo, holding others to account and seeking to draw attention to uncomfortable issues.

A Health Advocate will need to ensure that the community, in speaking to Government, does not replace the voice of the community. A Health Advocate will need to have a strong and positive working relationship with the health and Allied Health sector, council and the State and Federal Government.

The role of the advocate may be difficult for one individual to fill, therefore again we look to the Public Health and Wellbeing Act for guidance. Within the provisions of the consultative council it states that the Minister may appoint a number of members specified by order.

Of the members appointed by order under subsection (3), one must be appointed as Chairperson, one may be appointed as the deputy chairperson, with the majority being appointed with special knowledge in the relevant matters. This structure allows specialist skills and knowledge and can be shared amongst the members.

Council sees the key specialist skills requirement being, knowledge and experience in empowering communities in health prevention, community development and clinical health. Our position is that these three advocates are possibly one Chief and two deputies. The Office of the Health Advocate will require a team of skilled professionals to support the advocates, much like the highly skilled team supporting the Inquiry.

The Office of the Health Advocate will require appropriate funding to empower a community-centred methodology, which is perhaps bolder and more experimental in its approach to health prevention and health services.

The Office of the Health Advocate must - and I emphasise, "must" - be located in the Latrobe Valley; more specifically, it must be located in Latrobe City. The work of the Office of the Health Advocate must leverage, complement and enhance work already being undertaken; have experience in deploying a community-led strengths-based approach which is deeply grounded in engagement and community capacity building.

There must be a resolute belief in the wisdom of the community to empower the community and to create solutions to community issues. A strengths-based community approach will be critical to creating momentum, sustainability and growing community resilience. The Health Advocate must recognise that the real leaders and creators of any sustainable solution will be the community itself.

Healthy Together Latrobe has a unique partnership between Latrobe City Council and the Latrobe Community Health Service. This approach occurred in the health prevention space through a settings approach. As with any unfunded programs, there is a risk this work will be forgotten in the rush to embrace the new health prevention paradigm. We would simple request that we not lose the good work already undertaken but use it as a platform for what's next.

Council's mine fire recovery work is a trial of

neighbourhood settings and we believe this has worked well in connecting with the community. The investment through Healthy Together Latrobe is a demonstration of possibility, that agencies are able to work productively in creativity in partnership to improve the health and wellbeing of our community.

Finally, having read, listened and participated in a range of forums on health and wellbeing in our community, council respectfully presents to the Inquiry a range of replications for consideration.

In the short term it is difficult to disassociate the health challenges of our community from its broader social, empowerment and economic challenges.

Indeed, the social determinants of the health requirements are a significantly broader consideration than just the health system or the health prevention system.

The recommendation: the Community Engagement Communication Panel recommended that the State lead the development of a bipartisan, economic development and transformation plan for the Latrobe Valley, and that this plan involve significant community engagement, consultation and investment. Council supports this recommendation with a request that the work commence in 2016.

The Health Conservation Zone must be holistic in its consideration of the Latrobe Valley community. A purely clinical health system response will not fix the underlying determinants of ill-health.

Council's view is that a community which is healthy, connected and engaged, is more inclined to

take action to ensure its own health and wellbeing outcomes and will be sustainable beyond any initial investment.

The recommendation: a neighbourhood setting approach to community health and wellbeing such as that currently being undertaken by Latrobe City Council be immediately funded to continue to work with the community to identify opportunities to enhance health and wellbeing. It should be noted that council's work in this space will conclude in December 2015.

A Health Conservation Zone provides an opportunity to deploy a range of initiatives and trials to a community in desperate need of intervention. While such a recommendation may be challenging for the State to consider from a funding perspective, there are many pioneering community-led engagement approaches which could be trialled in the Latrobe Valley and then replicated more broadly across Victoria.

The recommendation: that the Latrobe Valley be established as an innovative health preventative hub of excellence and share its learnings with other communities. The establishment of a Health Conservation Zone and Office of the Health Advocate, and engage with the community to co-create the objectives, functions and public reporting requirements of the Health Conservation Zone and the essential characteristics of the Health Advocates.

Expand the terms of the Hazelwood Mine Fire health study to include persons who worked in Morwell but reside outside of Morwell. This is an area of major concern to the community, and I know it's not in my

notes but I want to reiterate this.

We have a large number of people that worked within Morwell and worked within Latrobe City that reside outside of Morwell or reside outside of Latrobe City. They were in that mine fire doing their eight, 10, 12 hour days and bearing the brunt of it. We know the residents took 24 hours a day, but those working there took their eight to 12 hours a day as well and it had a huge impact on them as well, and we think they need to be undertaken into the health study as well.

Recommendation: particular focus and commitment be given to screening and managing health within vulnerable communities through engagement with the community to create and craft a unique screening and engagement response that is both safe and in place.

The Health Advocates immediately investigate the issue of roof cavity cleaning and make recommendations to the State.

Immediately consider the role of the Health Advocates within the State emergency arrangements, including liaison with the State and community communication and engagement principles as well as the Municipal Emergency Response Plan.

At the moment, if there is another fire, if there is another issue relating to the health of the Latrobe City community, the Health Advocate cannot get involved until after that emergency. We need the Health Advocate to be involved as soon as the emergency starts, to be part of the State emergency arrangements, so that, when it happens we have somebody who's advocating for the community, in the interests of the

community, there on the ground speaking for the community. We don't need, as has happened in the past, bureaucrats coming from Melbourne telling our community what they need to do. Our community knows, our community understands, and having an advocate that is locally based, that is aware of the issues in this region, will be able to step in and will be able to provide a trusted local voice.

Recommendation: adequate funding be allocated to implement the Morwell urban design revitalisation plan currently in development as a response to the mine fire to enhance the liveability and economic resilience of the Morwell community.

Recommendation: that the Health Conservation Zone have a strong focus on prevention, recognising that the focus must be on keeping the community healthy as opposed to focusing on treating them once they become ill.

Recommendation: that the state regulators commit to undertake a process with Health Advocates to create within the community a vision for the remediated Hazelwood Mine.

Recommendation: that the state use all available mechanisms to ensure that there is not a repeat of the Hazelwood Mine Fire and that the risk of such an event is eliminated for the community.

Recommendation: that the State utilise its considerable employment capacity to grow jobs in the Valley through regionalisation of Melbourne-based agencies. It is recommended that at a minimum the Department of Energy and Earth Resources and the

Environmental Protection Authority be relocated to the Latrobe Valley.

Recommendation: investigations be given to enhancing the customer experience within the health system with a particular focus given to client centricity, connectedness of service and the establishment of a client concierge which supports those experiencing ill-health to make decisions, appointments, connections and arrangements during a time of impaired or compromised capacity.

In closing, I'd like again to thank the Inquiry for the commitment to the community of the Latrobe Valley. Your collective investigation, consideration and commitment to a wide number of issues pertinent to the long-term health and wellbeing of this community has been remarkable.

Our thanks to you and your staff for your generosity with your time and expertise. We wish you well in your deliberations and we look forward with a degree of excited anticipation to your final report. Thank you very much.

MR ROZEN: Dale, I might just ask if you could stay. Thank you very much for that very focused and practical presentation. We have a short amount of time now in which questions could be asked of you, if that's all right.

CR HARRIMAN: That's fine with me.

MR ROZEN: They won't be too challenging, I hope. The first thing I'll ask, if I can kick it off, one of the themes that has come through some of the consultations by the Board has been general support for the idea of an

Office of the Health Advocate, general support for the idea of designation as a health conservation or improvement zone, or whatever title one gives it. But a concern that, in an already complicated health system, one wants to avoid adding another layer of bureaucracy. I just wonder if that's something you could make some observations about.

CR HARRIMAN: What we're looking at is, we have some highly qualified professionals already here, we have some organisations already set up to work in that area. It's not a matter of setting up a new organisation to run it. Use the organisations that are already there; just fund them to do it.

We've got Latrobe Regional Hospital, we've got Latrobe Community Health, just to name two, that can do the work, that have the expertise, that have the people, that understand the local community and have people, more importantly, that understand the local community. They need funding to be able to do that, and that's where we'd be looking at, to those organisations, and I won't talk to all of them because they are here to talk for themselves, but we would see organisations such as those that already exist being the bodies that are used to provide the people to provide the Health Conservation Zone and the Advocates. They're already doing most of the work already, they're just underfunded. Fund them properly, let them do the whole work.

So rather than setting up a new level of bureaucracy, rather than setting up a new level that the community's got to fight through, these are groups

that are already in contact with the community and already working with the community.

MR ROZEN: The second question that I had concerned the long-term health study, which is an issue that's come up for the Board, and particularly the scope of the health study and the focus in it on residents of Morwell rather than, as you explained, people who came into Morwell to work during the mine fire.

My question is this: you paused in your presentation to talk to us about that. Is that something that's been raised with council?

CR HARRIMAN: It is, it is a comment that continually comes up and it is something that is of major concern to the whole community. There's a lot of people that worked through the mine fire, in the Morwell area, in the Morwell South area; there's a lot of people outside the city that came to within the city and we need to look at those people as well, because their health has been affected majorly by the mine fire.

A prime example is, we had a lot of CFA volunteers came in, were doing a lot of 12, 14 hour shifts; they don't live in Morwell but they're in the mine fire fighting the fire and they're not included in the health study.

We had a lot of staff in Latrobe Valley, our office is in Morwell South, that came into every day doing 10, 12 hour shifts that were in amongst the mine fire smoke that lived outside the Valley.

We have a lot of business owners and a lot of people that come and work within Morwell in offices, in retail outlets, that work in Morwell that do 8-10 hour

days that aren't covered by the health study. So we think it's vitally important, not just for the people that had to put up with it 24 hours a day, but those that got high level exposure to it as well.

PROFESSOR CATFORD: May I thank you very much, you've made some very compelling recommendations; I counted 15, I don't know if my arithmetic is correct.

CR HARRIMAN: I only had 20 minutes to speak, sorry.

PROFESSOR CATFORD: I suppose my overarching question is about the council's commitment to advance any of those recommends. Perhaps you might couple that with your intended response to continuation of Healthy Together Victoria.

We've heard a lot of very good complimentary comments about the work the council's been doing through Healthy Together Victoria, but clearly there's some concerns about the continuity with that. So, would you like to make a comment about your commitment to investment in some of those measures?

CR HARRIMAN: Certainly, with Health Together Latrobe council is currently funding it with Latrobe Community Health Services. Government funding has dried up, we're continuing on with it. We believe funding will run out in December from the State Government, which will make it very hard for us to continue with it. Unfortunately, as a council we're constrained now with rate capping, which makes it very difficult to run a lot of these programs.

As a council, we voted in support, and written letters to the Ministers and to the State Government, extolling them, begging them to keep funding Healthy

Together Latrobe. It is vital to this community. There's so many health issues that we have in the community that were just exacerbated by the mine fire, and they continue to be issues that we're continuing to face.

We'll continue to lobby the State Government on that. I was in Melbourne, so was the CEO, last week and part of those discussions were with that particular issue.

With the recommendations, as a bare minimum, as a bare minimum, the State Government needs to fund a Health Conservation Zone and we need to be an exemplar program for the rest of the State, and we also need the Health Advocates as a bare minimum. To do less, in my opinion, would mean that the State is abrogating its responsibility to the community of Victoria.

We as a community have put up with decades of neglect, from both sides of politics; we've put up with mines surrounding our community; we've put up with the health issues of those mines for decades. We understand that they're vital to the rest of Victoria, because we'd have no manufacturing base in Victoria without them; Victoria wouldn't have had the cheap electrical supply it's had since 1949; it wouldn't have had the ability to build into the community it's got now. All we're saying is; we've worn a lot of that. We've now gone through a major, major health issue because of it; it's time that the State Government turned around and funded something back into this community.

The mine fire put the community on its knees.

Health wise, there's so many people that have developed asthma since the mine fire, didn't have it beforehand, have developed it since. There's a heap of people that can't live in their homes at the moment that we know have moved out because of the mine fire, there's a heap of people whose health has deteriorated. The least the State Government can do is to turn around and help those people. The least it can do for our kids coming through is to make sure that we're getting preventative health measures put in place so that they don't have to put up with what our parents and the generations before had to put up with.

So, yes, we will continue to fight for it every day; every day we're in contact with Ministers and State Government demanding that they do something for this community. I think every group within Latrobe City is doing the same. It's just, we're well aware of it; we know the Government's well aware of it and we're going to make sure they never forget it.

MR ROZEN: Thank you, Dale.

CR HARRIMAN: Sorry, I got a little bit off track there, John, I do apologise.

MR ROZEN: This time we will let you leave the stage, but only temporarily, because you'll be back after lunch. Thank you very much for your presentation.

Our next speaker is no stranger to the Inquiry, she's been present at a number of the previous seminars, it's Kellie O'Callaghan, who's the chair of the Board of the Latrobe Regional Hospital. Welcome, Kellie.

CR O'CALLAGHAN: Thank you so much for that warm welcome.

Thank you, Mr Mayor, you've saved me some talking points.

I apologise in advance in relation to the presentation, because as we've had our conversations this morning I've gone through and done a bit of a slash and burn, so you don't have to sit through the same information twice.

Also, I guess as much as possible I want to be able to take your questions so that it's relevant to what you would like to know and to give it some context. We'll see how we go in relation to the presentation and we'll try and keep up as we go through, then I will definitely jump off presentation and keep talking as we go.

I also would like to acknowledge that we are meeting here today on the traditional land of the Bratwoloong people of the GunaiKurnai clan, and I pay my respect to their elders past and any of those present.

I would also like to acknowledge the Inquiry Board and thank you for taking a genuine interest in our community and for facilitating a range of conversations that I strongly believe will result in longer term benefit for our community and for our people.

I would like to thank those members of our community and our partner agencies who have, through their discussions and interactions since the mine fire, informed my understanding and have patiently allowed me to question and explore in more detail their perspectives.

Whilst I speak to you today in my role as the

Board chair of Latrobe Regional Hospital, it would be impossible for me to separate my broader role within this vibrant and diverse community.

I was born and raised in Morwell and I hold a range of other roles within the local area. I was one of those kids that was brought up in a family who knew nothing but coal industry. My dad worked at the SEC, all of my uncles worked at the SEC, and we haven't known any different. This is our community, this is an industry that we have accepted, grown up alongside and had a significant role in.

I think it's important that I highlight the importance of the history in this community and the understanding of belonging in place and how this relates to health services.

The concept of the former Central Gippsland Hospital in Traralgon was conceived as a Rotary Club meeting in 1940. Historically hospital services in Yallourn and Moe were also community-driven and funded. This community has a strong and proud history of being directly engaged in the development and ongoing support for health services and I can assure you that that continues to this day.

Community partnership takes many forms at LRH and we have a dedicated team of volunteers who are invested in the positive outcomes of their community.

We are also generously supported by individuals, service clubs, businesses and larger corporations through our fundraising programs. Our Community Advisory Committee drive our initiatives to engage consumers within our service.

For more than 10 years LRH and many other health services, as Terry spoke of earlier - have embraced the philosophy of doing with us, not for us. This is not a new concept but one that is entrenched in many of our organisations. With us, not about us; with us, not for us.

We are the regional referral hospital and demand for our services continues to grow. We continue to strive to provide services that meet not only the needs of our local community, but also those members of the broader Gippsland area who require our services.

As our CEO Peter Craighead highlighted during previous health forum sessions, compared to Bendigo, Ballarat and Geelong, we are at a disadvantage. We are so far behind in regard to infrastructure investment that we are and will continue to play catch up.

We provide both inpatient and community-based mental health services and we continue to see increasing demand for services. That demand does not only relate to adults living with mental wellbeing challenges, but we are also seeing many children and young people in our community mental health facilities. I will present to you some of that data on the next slide, and these are referrals received each month to our small but dedicated team.

The data is overwhelming, but it can in no way give you an understanding of the individual stories and experiences of the children, young adults and families who live with mental health challenges within our community.

We are the largest employer in the Valley and, as

such, we are working in partnership with our partner agencies to improve the health of our staff.

We continue to experience increasing demand for chronic disease programs and, with this increased demand, we are experiencing waiting lists for services. The wait list for pulmonary and pain clinics are the longest, and you could anticipate a wait of approximately three months.

We are also seeing significant demand for our chronic disease management program, HARP, with a 27 per cent increase in 2014 and a projected rise of 14 per cent in 2015. We need to look at managing demand for our secondary and tertiary implications of chronic disease.

With those things in mind, what is the way forward? I've taken the opportunity to attend the community consultations and each of the health forums sitting days being held to date. I have listened to the information shared, discussed it in detail with my colleagues and community members, and we are to provide a response in regard to governance, sustainability and leadership.

We require a shared vision for health and wellbeing in Latrobe. We need a champion for change; someone to focus the community on our agreed vision for health and wellbeing; to support and encourage innovation, to engage community in conversation, projects, ideas and thinking that will inform service delivery in Latrobe and drive the further enhancement and development of natural patient pathways in health.

We need to have an advocate who can work alongside

our community and service agencies, and then engage with Government and corporate stakeholders about local opportunities.

We shouldn't just be focused on responses to health issues. We will build a more resilient community that is more able to actively engage in their own health and wellbeing with the support and encouragement they need at all levels of our community.

Our funding models currently see us segregated by silos; not as inclusive as we could be or should be. We can't do it effectively with the current organisational structure and there needs to be an advocate or a similar role in place.

We need to work together. What we do needs to be a reflection of our community's expectation.

The Health Advocate: our champion for change, the individual who would drive the innovation, breaking down the barriers and building up the relationships. The Health Advocate needs to be underpinned by a strong values base, with a focus on leadership, accountability and the capacity to report back to community, integration and collaboration across a broad range of stakeholders, and flexibility with the capacity to change and adapt approaches to ensure responsiveness.

The behaviours demonstrated by the advocate and their supporting board, council or officers, need to include respect for others, their experiences and perspectives; the desire to work as one in approaches to overcoming challenges relating to health and wellbeing; the focus on working with and in community; a willingness to listen and communicate effectively, no

matter how challenging the conversation. But also have the important focus on acknowledging those good things that are happening within our community and focus on new and emerging opportunities.

It is also important, as the Mayor has previously highlighted, that the advocate has a closely and clearly defined role in relation to emergency response. We need to be clear on how the role operates in parallel with Emergency Management Victoria.

The Board, or the council, as many of our previous speakers have alluded to, there is a very clear role highlighted in many of the discussions that have taken place at the health forums for a board or a council to support the work of the advocate.

But there is also an important requirement for an office of the advocate - and I know the Mayor has spoken to this as well. It will be established to underpin the work and the functions of the role.

Trusted local representatives, communities and organisations all working together to underpin the work of the advocate: they will provide the governance oversight, including strategy, compliance and risk assessment. As we've heard this morning, the Act clearly provides for the creation of councils.

The advocate needs to be a trusted and tested community leader; they also need to be prepared to work alongside the community to identify other trusted leaders and foster their development and roles to enhance a shared health and wellbeing message.

We also need community champions identified and supported to work within their own trusted networks to

further facilitate and engage a community-based and driven program that enhances sustainable health and wellbeing pathways and support.

Grassroots champions within communities: the unlikely leaders who will support and become the champions for their own community's change.

The Health Conservation Zone: by placing an immediate focus on decision-making, resourcing and planning that focuses on the health and wellbeing of our local community; developing models and practices that are reflective of community expectation, working alongside community organisations and service agencies to identify current gaps, barriers and inhibitors to good outcomes for individuals and groups; and then implement pathways, processes and models in partnership with all stakeholders to ensure a strengthening of outcome for a local community.

There's been lot of discussion around the health forums around the name, labelling or impact of identifying the municipality of a Health Conservation Zone. Our priority needs to be for access and support for the Valley. We need to ensure that whatever we do does no harm but enhances the opportunities for our local community.

There are also other ways we can strengthen the representative role of our community. We also need to focus on the importance of local representation on our own boards. It sends a very strong message to the local community about the services within their own communities that they're not able to run if board appointments made at Regional Health Services are not

local community members.

I do not believe that there is a lack of skill, experience or willingness by members of our local community to run their own Regional Health Service.

In response to whether the Health Conservation Zone will in some way cause a detriment, and whether or not we should just embed this practice within our current bureaucracy and service provision network; doing more of the same isn't going to work. We're nearly two years down the track, at the rate we're going, if we don't make a change, there will be no change for this community.

I wanted to reflect on some of the work of Evelyne de Leeuw and Don Campbell - for those who have been in attendance at the previous sessions you'll be well aware of the conversations they've had with us. They've spoken at length about everything being health; about communities with chronic bad health and about providing the conditions for healthy communities, for communities to thrive, for a healthy economy and examples that we can learn from.

Evelyne spoke at length around Corio and Norlane and communities taking health and wellbeing into their own hands. When it comes to a question of cost - the question was asked at one of the sessions "can we afford it?" We can't afford not to.

If we don't make the changes now, not only will the health comes deteriorate further, but the cost of providing healthcare to a population and the increasing incidents of chronic and acute presentation will be a burden that we will not be able to carry.

Don Campbell spoke at length around the Atlanta Regional Collaborative Health Improvement Model - I tell you, I feel like I've been studying for VCE exams since the close of the last session. I have done my homework, not pretending to be at all academic because I'm not, I'm community focused. But I have gone and had some conversations, people like Wendy, and I know John and I have had some conversations throughout the sessions around the model.

I agree that the Atlanta Regional Collaborative Model for Health is one that is strong and is solid. The playbook that's available on the website gives some very clear examples of what we could implement within our own community; it's easy to understand and there's some real quick wins in that model.

The Stanford Model For Social Innovation, the collective impact approach and the five conditions of a common agenda, shared measurements, mutually reinforcing activities, continuous communication and the backbone organisations creating and managing collective impact could easily be implemented within our community with the commitment of organisations.

Working alongside community to assist them to overcome challenges and barriers to participate in their own healthcare should be our focus. We can actively encourage awareness and engagement for the broadest range of activities, supports and networks that will sustain and underpin an improved health outcome for our community.

We can create pathways to advantage by promoting healthy behaviour and preventing risky behaviours

through care coordination approaches, comprehensive care, patient-centered practice, coordinated care, accessible services, quality and safety, and we still have a lot of work to do on integrated information system and the formation of evidence-based strategies.

So, what might the specifics look like? Health Conservation Zone: we can look at creating bulk billing initiatives within our community. We can remove financial barriers to care.

Our system at the moment is not set up to take into account multiple presentations and multiple conditions. We need to build a focus on person-centered care. We need to treat the whole patient and make their journey seamless.

Chronic disease patients tend to be more responsible for their own care and conditions - how can we support them to do that better?

It's important for us to train more Allied Health professionals and create these education opportunities within our own community. We need to build our own local workforce. Amanda Cameron spoke at length about those opportunities when she presented.

We need to keep local. We need to grow, train and work in the Valley. Sustainability is something about us doing our own work, and working with us and not for us is so paramount.

The commitment of LRH as a Regional Hospital, in that very true sense of a regional provider, needs to include appropriate infrastructure. LRH needs to be brought up to the level of Bendigo, Ballarat and Geelong, and there is an importance for the Latrobe

Valley community and Gippsland more broadly to have the equity of access to services that exist in other regions.

This includes access to those services - and I know Wendy's spoken at length about access to specialist services, but also those issues of transport and other incidental support.

The broader availability of Gippsland Medical Students Program we've heard about in one of the other sessions, where they're mentoring high school students and creating pathways to education.

What use is it to treat people with presenting health problems if we're going to return them to circumstances that made them unwell to start with?

Proportional universalism - I hadn't heard of that before. But the interesting concept of the same for all but more for those who need it most. It's a way of thinking about how we work with our communities to ensure a focus on, those who need it, get it.

We can look at the Stamford model, we can look at the Dutch nursing model, we can look at concierge models - there are any number of opportunities available to us to learn and we can implement those learnings.

We can attach funding to a patient. Treat locally wherever possible. If the money is in the system, and that is a capacity of a local service provider to provide that service, you should not have to go to Melbourne for that treatment.

Evidence informed strategies together with innovation and community generated and owned

opportunities must be paramount. We've heard of many examples over the period of the Health Improvement Forum discussions about children being engaged in communities - doing our blood pressure checks; it's stuck in everyone's mind, it's simple. A lot of this stuff is simple concepts and just applying them.

John spoke of health screenings and the opportunity for health screening days hosted by service providers. They're quick wins, they're things we can do, we just need those resourcing and partnership opportunities to work together.

We heard of positive media messaging, sharing the community narrative. Our media outlets and community engagement professionals within all of our agencies that spoke at the forum said they're prepared to do it and they're doing it now. They started on Twitter that afternoon. They will do the work and we need to support them in taking that initiative.

Our focus needs to be on healthy behaviours, our smoking and tobacco interventions, diet, nutrition, exercise, physical activity, alcohol, drug, preventative care for physical and mental health problems. We need to create pathways to advantage for children in relation to family environment, communities, early education and maternal and child health; for our older learners through pathways to achievement, mentored learning and employment transition, and for all through employment and Government supported economic development, as the Mayor has spoken about earlier.

We are a very strong community. We have strong

community leaders, and they want to be part of returning this community and our people to a strong position of health and wellbeing. Thank you all very much for your time and I'm happy to take your questions.

MR ROZEN: Thank you, Kellie. Perhaps, if I could kick it off and ask you a question that relates specifically to your role with the hospital.

We had a session about recruitment and retention of the medical workforce and the particular challenges that that presents in the Valley, and I notice you mentioned earlier you were talking about Allied Health, and that was one area that was identified. Perhaps if you could expand on that and what the particular difficulties are and what you think needs to be done to address those particular problems.

CR O'CALLAGHAN: I think one of the opportunities for conversation that we had in the previous session, I know Amanda spoke to it at great length and I don't pretend to be an expert on this at all, but with some of the changes that have come about in terms of educational opportunities and the changes in relation to Monash University and Fed Uni, there hasn't necessarily been a re-population of training in formalised education for Allied Health professionals at a local level, and any opportunity where that could be provided will then create pathways for our own local students, not only to learn more about the job opportunities that might be available for them, but to stay within community, continue their education and then work in amongst - and not only our acute

facilities, but at our primary health networks and with Ben at LCHS and all these other places. There's lots of job opportunities out there for our Allied Health professionals.

But in a lot of ways we are having to go out and find them outside of community, and that's never going to be bringing strength to our own capacity to meet our own community's needs. Part of it's education based and creating pathways. The employment opportunities, I think given what we're presented with, are going to be there.

PROFESSOR CATFORD: Kellie, can I thank you very much for attending, I think, virtually all of the forums over the previous four days and for such an excellent summary of the outcomes, we've obviously got a record of all that so it will be very useful to us.

You've spoken very passionately, as has the Mayor, about the role of the Health Advocate. Do you have a view of how this actually works in practice, in terms of the advocate being sufficiently independent not to be captured by agencies but, I mean, how are they employed, whether they work, how is this office created?

CR O'CALLAGHAN: If I had to visualise it, I think it's a stand-alone office in downtown Morwell, it's got its own staff, it's got its own shop front, it's a walk-up facility, it's where community can go in and get information, support and advice on referral. It's a bit of a brains trust for the community to access information and create a bit of a pathway to get in touch with other things that you need.

In terms of working alongside the partner agencies, and I think it is that, it's not about another level above, it's about working alongside the other community agencies and service providers. One of the most important things coming out of the discussions we had, and the roundtable was referred to, and a number of attendees today were part of the roundtables for the service providers: all of the organisations in attendance agreed that this was an opportunity for them to further expand what they're able to do. One of the great difficulties you have as a service provider is, you're effectively delivering on either a statement of priorities or contracted service, you're lobbying for infrastructure and new opportunities and service delivery. To have someone to bring all of that together and to help work through the priorities, to talk about what the priorities are for all of those service providers, and then work alongside the community is really important.

For me, I think it connects everything up. It's all of those gaps that we've never been able to bridge as independent service providers, and it creates an opportunity there. I think the strength in it is that the agencies want it, they support it and they can see the benefit in it.

The independents: it's going to be a strength of personality thing, you can't have an advocate there that's going to be easily rolled or leant on to too heavily. You need someone who's got the strength of character to be able to stand there on their own merits, put a good argument and, above all else,

represent the view of the community, irrespective of lobbying that may come from service delivery agencies or bureaucracy.

MR ROZEN: Thank you, Kellie, we'll excuse you temporarily, if we may, and invite you back to join the panel discussion after lunch.

Our next speaker is John Guy. John is the chair of the Board of the Latrobe Community Health Service and John's also been present at previous sessions that we've run. Welcome, John.

MR GUY: Thank you, and thank you for the opportunity. I'm not going to talk specifically about the Latrobe Community Health Service, but rather talk about my experience with "health".

I've been involved with various aspects of health for the past 45 years. My involvement commenced with work in the safety programs with the former State Electricity Commission of Victoria, continued with an appointment as manager, occupational health and safety with the State Electricity Commission, and perhaps ends with my position as chair of the Latrobe Community Health Service Board.

No one can deny that the event of 9 February 2014 was unprecedented and severely impacted on the health of a section of our Latrobe Valley and Morwell community, and those who worked in Morwell during those 45 days.

I might also state that I've been a member of the recover committee since its inception and I represent the Latrobe Community Health Service on the Hazelwood Mine Fire health study.

On the question of the ongoing long-term effect of this event on the population of Latrobe City, I think that's best left to the Hazelwood Mine Fire health study.

Another fact that cannot be denied is that the health of the Latrobe City community was well below Australian standards before the fire occurred, and this situation has existed for many years.

As the saying goes, there is nothing new under the sun. In 1991 I was involved with others in this community in the planning and implementation of the Latrobe Valley Better Health Program funded by the Victorian Health Promotion Foundation.

At that time, there was a concern that coal dust was having a detrimental effect on the population of the Latrobe Valley and it was the cause of a higher than average incidence of deaths.

The release of the Latrobe Valley Health Study in August 1990, led by Dr Jonathan Streeton, highlighted community concerns about the health of our residents.

An analysis of the death rates between 1969 and 1983 revealed higher death rates than the rest of Victoria for in doctrine (sic), nutritional disease and from accidents. Dr Streeton identified contributing factors as alcohol, nutrition, smoking and lack of exercise.

On 31 August 1990, in the Medical Observer, an article appeared, "Latrobe Valley Tries Healthy Experiment. Victoria's Latrobe Valley could be the site for one of Australia's biggest experiments in

preventative health following the release of a study which found lifestyle was the main cause of high death rate in the area. Alcohol, motor accidents, poor nutrition were major contributors to the higher than average death rates for Latrobe Valley.

"The study found that air pollution from the coal mines and power stations which dot the valley about 70 kilometres east of Melbourne was not the cause of the high death rates. Health and Local Government authorities in the region are preparing to embark on a major preventative health campaign targeting the primarily blue collar industrial workers who make up a large proportion of the Valley's population." It goes on to talk about the project.

The Latrobe Valley Better Health Project involved participants from community health, Local Government, hospital, unions, employees, health organisations, the Aboriginal community and migrants. Two project officers were employed to raise awareness in the Latrobe Valley community.

The project involved a number of projects: a food service improvement program, food as a fundraiser, a point of sale program, growing your own vegetables, breastfeeding, workplace health promotion, injury surveillance system, youth and alcohol safety house, reducing back injuries and reducing sporting injuries. All projects had listed goals, activities, settings, participants, research systems and evaluations.

In relation to the injury surveillance system, The Express of 10 July 1992 carried a headline, "Better Health Project Labelled One Of The World's Best. A

Swedish health expert has labelled the Latrobe Valley Better Health Project as one of the best in the world. The director of the Stockholm County Council Health Promotion Program, and an internationally recognised leader in the field of injury prevention, was in Morwell on Wednesday at the invitation of the Latrobe Valley Better Health Program, VicRoads and the Monash Health Accident Prevention Centre.

"The Stockholm Health Promotion Program has operated successfully since 1983, improving community awareness of accident prevention." It goes on to talk about the success of the program in the Latrobe Valley.

Over the years we've seen a pattern of the introduction of health programs funded by Government, and then, for various reasons, including change of governments, the recent phenomena of one term governments and other additions, these programs have been abandoned.

The latest victim of change in Government funding policy is the Healthy Together Latrobe project which commenced in July 2014 and was jointly managed by Latrobe City and the Latrobe Community Health Service. The program was funded by Federal and State Governments and recently abandoned by the Federal Government, with the State Government indicating it will not fund the program into the future.

Turning to the information gathered from the consultations on health at Morwell, Moe and Traralgon, I find it difficult to draw conclusions from numerous dot points based on opinions which would require further investigation as to their veracity. In some of

the responses to question 2, with regard to health services in the Latrobe Valley, it appears to contradict the responses to question (1), what are the health challenges in the Latrobe Valley? So, there's a lot of work, I think, that needs to go into analysing some of those responses.

There is no doubt that, as mentioned in this feedback, there is a problem in the Latrobe Valley with long-term unemployment and the consequences that this has had on the health of this population.

The Latrobe Valley Health Conservation Zone: I agree with the concept of a Health Conservation Zone but disagree with the name. I've attended two sessions where this concept has been discussed and I'm a little frustrated about the fact that the project is not progressing, or not progressing as fast as I would like it to progress.

I also agree with some of the comments made by people who attended the community consultation, in that, a Health Improvement Zone would have some positives in that it would be based in the Latrobe community, be resourced and focused on services; it would have common priorities and have people working together. It's important to bring together with a united focus for a long-term measurement improvement. The Latrobe communities need to be seen as a whole, not individually.

It would be a good platform to have a conversation, and something that was ongoing particularly around the schools.

The mine fire has resulted in an upsurge of

pressure to close the Hazelwood Power Station which, if not managed correctly, will add to the already serious unemployment situation that will lead to further health problems in this community.

While the future changes to the power industry are certain, it requires an orderly and considered transition that ensures that the Latrobe Valley can bring in new industry, together with job replacement and re-skilling in order to address the socio-economic status of this community.

What is needed is a program that is focused on Latrobe City population funded on an ongoing basis, managed by local people and directed at measuring the improvement in the health of our citizens over a five to 10 year program.

The program should focus on lifestyle issues as evidenced by the 1990 findings of the Latrobe Valley Better Health Study, lifestyles affecting the population of the Latrobe Valley residents as, in my opinion and evidenced by recent articles in the press, these factors are still very much evident in our community and indeed across Victoria and the nation.

In the short-to-medium term the State Government should agree to the ongoing funding of Healthy Latrobe project and do further research to test the validity of the determinants of ill-health in the Latrobe Valley population.

We should use the definition of Professors Campbell and Clarke, that health is a state of complete physical and mental well-being, not merely the absence of disease and health, and that the

environment are interrelated.

I believe we should take a lesson from the Latrobe Valley Better Health Program and form a local Management Committee to manage the Healthy Together Latrobe program. This group should be made of community representatives from council, community health, unions, industry and the migrant community.

Again, as Campbell and Clarke state, placing the consumer's perspective relentlessly at the centre of the process of health improvement will be critical to success. In the long-term the proposed Health Improvement Zone should assume responsibility for the ongoing programs designed to improve and sustain the health of the La Trobe Valley residents. Thank you.

MR ROZEN: Thank you very much, John, for that historically informed presentation, I think very valuable for the Board to, as you say, recognise that there's nothing new under the sun and things have been tried before and we can obviously learn from that.

A question I have for you concerns the Health Advocate, which I don't think was something you mentioned in your presentation but certainly featured in a lot of our fora and the consultations we've had.

Do you have a view on whether or not that would be a valuable addition to the landscape?

MR GUY: I think it would be, and I think, as outlined by Kellie, it needs to be an independent position, placed in its own office in the Latrobe Valley where people have access to it from the street.

MR ROZEN: Thank you. Members of the Board.

PROFESSOR CATFORD: John, thank you very much, and also for

attending some of the other forums.

I wondered if you just might talk a little bit about the interface with the primary health network and the community health service, and how do you see that working in practice?

MR GUY: Probably, that's a difficult question, because I think there's always been problems between the various health functions. As somebody said, I think earlier, we tend to operate in silos. I have, in my role, tried to advocate connections between the Latrobe Community Health Service and the hospital. I think there should be a closer liaison there and closer communication to make the transition of people who are in that primary health area to the acute area a lot more seamless. Likewise, when they come out of the acute area, that they're looked after into the ongoing treatment in the primary healthcare sector. I don't know whether that answers your question.

PROFESSOR CATFORD: Just take it another way: what do you feel about the future of primary care partnerships, particularly in the Latrobe Valley and Gippsland?

MR GUY: They've certainly operated in the past and had limited success. I suppose what I'm promoting is that people from the community come together and form a partnership, probably with the Health Improvement Advocate, to look after the health of the Latrobe Valley people, rather than have bureaucratic organisations do that function.

MR ROZEN: Thank you, John. We might temporarily excuse you, if we may, and we'll invite you back to join our panel discussion.

Our last individual speaker today before we have a break for lunch is Nola Maxfield. Nola is the chair of the Board of the Gippsland Primary Health Network. Thank you, Nola.

DR MAXFIELD: Thank you. Before I start, I'd like to acknowledge the traditional owners of the land, the GunaiKurnai people, and acknowledge their elders past and any who may be present.

Thank you to the panel for inviting me to speak, and you will be pleased to know that there's actually some synergy between what's already been said this morning and what we would suggest we will be doing and the panel can also look at for the short, medium and longer term in this field.

Can I start by just talking about Gippsland Primary Health Network. There are some people here who have been intricately involved, and I acknowledge my fellow board members and CEO. There are others to whom we are a relatively new organisation. We only started on 1 July. We are funded primarily by the Federal Government and we are there to be a primary healthcare organisation with a focus on supporting primary care, so general practice, Allied Health. We're there to do health planning, health system integration and commissioning of services in line with national and local priorities.

We haven't come absolutely out of nowhere. There were the Medicare Locals prior to this, and in Gippsland we were fortunate that our boundaries remained the same and we have the same board who is ongoing. There's been some staff changes, but we've

been able to build on what was already there but to be able to put a new focus into the organisation and what we're planning to do.

Our objectives are to increase the efficiency and effectiveness of medical services for patients, and in particular those at risk of poor health outcomes, and to improve the coordination of care so that patients are going to get the right care in the right place at the right time.

Our mission previously was to work for a measurably healthier Gippsland, and we're going to continue to do that. As I'll mention later, we will use data to be able to try and measure that and then to utilise that data to improve healthcare for people. Our mission aligns very well with what's trying to be achieved for improving the health outcomes of the people in the Latrobe Valley.

The mine fire, as has already been mentioned, did demonstrate a need for more cohesion among health service and community support providers with regard to both a coordinated response and support to the community. It's been very encouraging to hear the incredible passion and willingness expressed by the community and the service providers to learn from the events and to improve the capacity to, not only respond to the situation, but also to address the underpinning health and economic disadvantage of the people of Morwell, the Valley and of greater Gippsland.

There's many social determinants of health that have already been mentioned that have contributed to the poor health of the Valley. Unfortunately, coming

from a lower socio-economic status, those people tend to make more of the unfortunate lifestyle choices - the rates, as already have been mentioned, of smoking and obesity are much higher. There's lower education and employment opportunities and then, added to that, we've got the risk of the environmental exposure to burning of coal and the long-term exposure of asbestos for the people of the Latrobe Valley who are now exhibiting symptoms of that.

So Gippsland Primary Health Network has both a mandate and an opportunity to contribute to a collaborative governance system and leadership that's going to create a sustainable response and support to grow the health of the Valley community.

Chronic disease management: unfortunately, all health indicators are more pronounced in the Valley, reflecting the lower health status and greater disadvantage. Chronic disease management is becoming more complex. So, general practice, Allied Health, are seeing people with larger numbers of comorbidities - they've got more chronic health problems and the impact of lifestyle choices and also of ageing.

We need to see better coordination and integration of the care and increased access to secondary and specialist care.

In primary care, we need to have the nurse educators who are embedded within primary care; the care coordinators, the Allied Health and shared care approaches with specialists. We need to build community health literacy to increase the timeliness of service access and integration, to maintain people in

the community and support their journey of care, and we've already heard about that from other people.

We also need to develop secondary specialist clinics as a shared care model across primary and hospital care sites, to increase access for the community and to help reduce unnecessary hospital attendances. I think it is vital that the primary and the secondary systems are working together to develop those.

Health workforce development, we've already heard about. We know that between the hospital and the community and primary care providers health is going to be the largest employer in the Valley, and yet, it still seems inadequate to meet the health needs of the community.

As has already been said, we need to attract and retain health workforce to the area, and that's vital, and we need to replenish the ageing workforce as well.

We need to develop health workforce capacity to share the workload and encourage generalists and proceduralists to expand the specialisation that's available, shared care, advanced practice and skilled substitution. We need to make sure that we have people here who can work across a variety of fields and not just very narrow specialities.

We also need to attract investment to build an infrastructure for health and also for the economy.

Care pathways have been mentioned, and this is a constant message about improving evidence-based care and increasing both provider and community knowledge about service options. We need a model of community

care where GPs and specialists together adopt and promote care pathways.

Care pathways I'm still explaining to GPs, so apologies if you don't actually know what we're talking about here, but it's a model which is developed for specific diseases. You sit down, the GPs and the specialists together, and work out what needs to be done. There are a couple of generic models out there, so there's a basis, but the important thing is about, if a specialist is receiving a referral from a GP, what information needs to go with the patient, what do they need to know, rather than have the person turn up and then they're sent off because they haven't got the right test, they haven't got the x-ray with them. Then the GP also needs to know what's required back to them in order to be able to continue to care for that person in the community.

Part of the value of that is also sitting down those groups together and having the discussion, about what does it mean for that place. So it would be for the Latrobe Valley, how does that work there, and then that is available as a web-based system for the health providers to use. That work will need to be informed by clinical councils and community groups.

E-health connectivity, care coordination - we've heard about that as well. We need timely access to information and it needs to be sensible information, it needs to be legible if it's handwritten. People in the community need to be able to know about waiting times and options for treatment.

In Gippsland, we have S2/SE referrals, which

enables encrypted communication between GPs, community health, hospitals, councils, and that should allow for good feedback and it needs to be a system that actually is easily able to be used or else it doesn't get used.

Any developments in E-health will pave the way for increased electronic literacy for providers. For example, there's telehealth as has already been mentioned. I know that I find it valuable, because I'm a GP and working in general practice, that if the telehealth consultation is occurring in my clinic, and I have the patient beside me, and we have the specialist who we can see on the screen there, that both of us are getting the same information at the same time, and I'm able to, actually later on, decode some of that information from the specialist with the patient as well. But I know what to watch out for, what the specialist wants me to be looking for, if there's any problems to send back, at the same time as the patient is finding this information out.

This is particularly helpful in the Latrobe Valley, but also in more remote communities, but it should not be seen as a substitute for providing health services on the ground, it should be in addition and supporting those health services.

The My Health Record is the latest iteration of the Commonwealth Government's personal controlled electronic health record, and the Commonwealth Government is currently debating how that will roll out and there may well be some trials on people having to opt out of that system, rather than everyone having to opt in. If we have more people utilising that, if

there's more information populating those records, then it will be useful and people will want to use it.

Again, the State is also looking at more systematic approaches to E-referral and investment in a Statewide approach for consistency and access across primary care and hospital settings, and the Valley is well placed to embrace these more durable systems.

Collaborative population health planning is another thing that the primary health network is working on. We will need to know the community health needs and identify the people at risk at an early stage, and that's then the starting point for health improvements.

As we've heard, both Local Government and primary health networks have a mandate for population health planning and we need to make sure that they align.

We need to work together to plan the approach, particularly including hospitals, community health, the primary care partnerships, the Department of Health and Human Services, our regional office. These will improve access to diverse sources of information, and in particular we'll look at bringing general practice information into that as well to aid our understanding and interpretation of the social and health challenges and to develop a shared action plan that addresses the needs and appropriately leverages the respected organisational mandates and resources.

So we do need data, data and more data. We need to develop a data warehouse that enables interpretation of the information, and that's whether it's clinical, social, environmental. We need to look at cross-data

analysis or even linked data that helps to understand the journey of the consumers and the carers, and then to be able to identify the gaps and where the care coordination is needed.

There's a lot of data held in general practice and that can be extracted by the Gippsland Primary Health Network to report back to the GPs so that they can identify and target population health issues in their local community. If they see a value in that data being able to be interpreted back to them, then we're going to get even more involvement of them in the data collection.

We've got Statewide health data, episodic hospital data, but often what it's missing is the reasons and to be able to predict when people are going to actually start to become frequent attenders in Emergency Departments or into hospitals.

The GP data is actually more granular and can tell a longitudinal health story, and so, we think that the GP data, when we can utilise some systems that are out there and hopefully more that will be developed, can fill some of the information gaps and be of use to planning secondary and tertiary specialist services. It can also help to determine social and lifestyle drivers that can cause health disadvantage and inequities.

So, about addressing gaps and building capacity and service availability: lack of service access has been frequently mentioned during the mine fire forums.

The primary health network has a mandate for commissioning services to address service gaps, to

build organisational capacity to meet community needs and to encourage employment investment.

We're not competitive with other service providers. We have inherited very few action direct service provision and we are in line with Commonwealth Government expectation, moving out of those fields completely.

We don't want to be competitive with the other service providers; we want to work with them to procure and tender services from existing providers and as well as attracting new business investment to the area.

We not only tender for service delivery, but we prioritise models that embed care coordination. Essentially, we purchase health outcomes and integration of care.

We want to create and participate in community-based collective impacts, so we want to restore and grow health that will take more than individual service development; it will take a co-ordinated and long-term investment in health outcomes by all parts of the health, social and economic systems, which is what we've heard about today.

We have a focused commitment by a network of health and community leaders to assist in building community trust and sustainable health and wellbeing solutions, and we need to leverage our respective skills and expertise to build that capacity and to augment the finite resources.

We need shared measurement and tracking outcomes for accountability to help to attract economic and

social investment.

Health advocacy needs both leadership and intuition and effective social entrepreneurs, effective start up engineers and community engagement individuals. But sustainability comes from building community ownership and trust and an enduring institution of shared commitment.

So, what is the best way forward to improve the health of the community? From our perspective, short-term, 6-12 months, creation of a collaborative network of community and health leaders to drive commitment to action and collective impact for population health improvement.

To develop the role of a Health Advocate and entrepreneurial, individual or a group, who will be engaged with or have a mandate for developing a sustainable institution.

To help employers focus on the health and wellbeing of employees who in turn become informal local community advocates.

Gippsland primary network will embed clinical councils and community advisory councils. The Commonwealth Government require us to set up clinical councils, and in Gippsland, recognising that there are a number of subregions - we will have three. Each of those will cover two Local Government areas and for here it will be Latrobe City and Baw Baw. Those clinical councils are required to be GP led and we have in place GP chairs for each of those councils and we are about, in the next short week or two, to ask for expressions of interest for other clinicians to be

involved in each of those, so that will shortly be available to people of this area.

We're also required to have a community advisory council and we are keen not to duplicate. There are already a lot of advisory councils across the community, and in particular also in the Latrobe Valley, the Latrobe Regional Health and other organisations. We're investigating how we can utilise all those community advisory groups that are out there and look at, do we target for particular issues particular groups. We're keen not to just set up something that is very small and duplicates what's going on.

The care pathway system that I've mentioned will be developed to guide evidence-based practice and provide a one-stop-shop for access to clinical and referral information. Data warehouse capacity will be developed to enable GP and other data sources to be used for collaborative health planning amongst agencies and to inform system procurement.

Looking at the medium term, one to two years, the primary health network commissioning of increased access to services with coordinated and integrated models of care will develop.

There should be investment in primary, secondary and tertiary services to augment chronic disease management and access to specialists and Allied Health support.

We need to advance E-health and workforce support through clinical placements, and we need to develop commitment to measurably improved health outcomes

through shared data and feedback accountability to the community.

For the longer term, three to five years, we acknowledge that continuous reform causes change fatigue and a bit of political distrust amongst health providers in the community, but we do need coordinated and long-term investment in health outcomes for all parts of the health, social and economic systems essential in building trust and community resilience.

To conclude, Gippsland Primary Health Network is committed to working collaboratively to achieve all of these objectives. Thank you.

MR ROZEN: Thank you very much, Nola, for that presentation. As I think has been remarked in a number of the forums, the recent introduction of the PHN is timely in many ways; it sort of dovetails quite nicely with the work of this Inquiry.

One of the issues that have been discussed and that I'd just like you to comment on is, the PHN is unique in the organisations we've heard from today because it plays that coordinating rather than service provision role, and so, it raises the question of how, if there was to be some designation of the Latrobe Valley as a health conservation or improvement zone and a Health Advocate introduced, which is certainly something that people seem to be supporting, how would those concepts work alongside the PHN in your view? Is there scope for collaboration between them?

DR MAXFIELD: I think there's definitely scope for collaboration, and our role would be to assist in coordinating their work and linking them to the

providers who are already out there. So, general practice/Allied Health. The person who's out there is going to need to know what's available and they may also be able to help guide system redevelopment or even service redevelopment; it's not just the public system, but also, the private providers out there who need to also be aware of what's needed and how they can change what they do in order to better serve the community.

MR ROZEN: Thank you. John.

PROFESSOR CATFORD: Nola, thank you very much. You're really quite a different organisation compared to the others because you're a creature of the Australian Department of Health and Ageing and the others are essentially creatures of the Victorian Government and Parliament, and so the interface is really important.

To what extent will we be able to determine your own future, do you think? Will you have sufficient autonomy and flexibility to join what could be a very exciting development down here?

DR MAXFIELD: I think that, certainly from talking to Minister Ley recently, if we can actually show that we've used our data, that we've done our population health planning, and that certain services are needed, and we can be the Commissioners of those services to improve the health of the community, then they're prepared to look at that.

Now, everybody's constrained by money, but we're there to present what the needs are, and it may be that we're actually not just going to the Federal Government for money, but we're also saying to the other providers - so the state of the private providers,

look, this is what we need and this is how we can do it and everybody needs to put in. I'm not sure if that answers your question, but if we can see what the need is, then I think we have opportunity.

PROFESSOR CATFORD: Certainly, some of the earlier presentations looked towards potentially some new funded models, or pooling funds and so on, and if the State were joined with the Commonwealth on this, that could be very exciting. Would your PHN be happy, do you think, to participate in those?

DR MAXFIELD: We'd certainly be happy to look at it. Certainly the Federal Government is looking at other models of service, and I think that's already been alluded to. How do you pay for things differently rather than just rewarding people for doing - in consultation, as the Medicare system currently does, how can we change that.

I think that part of our role will be to take our private providers along for the discussion on that. It's certainly asking them to do things differently, but I think we've certainly got a core group out there who, provided that they were engaged in the discussion in the right way, would be amenable to looking at other ways of achieving better health outcomes.

PROFESSOR CATFORD: So, innovation is very much part of the work you want to do?

DR MAXFIELD: Certainly for us, and I think Gippsland actually has a bit of a reputation for being prepared to embrace those things.

PROFESSOR CATFORD: The Latrobe Valley is just one part of your total patch. Could this cause tensions or

difficulties if there's a lot happening here and perhaps less in other parts of your area?

DR MAXFIELD: We've always had to manage that since we've become Gippsland, because it's always felt that, if you're in the Latrobe Valley and if you stood on your chair and you looked east, well maybe you could get to Sale or Bairnsdale but you couldn't see further than that, and you couldn't really see over the Strzelecki, so we've always had to be mindful that there's other parts of Gippsland that need to be considered, and again, I think we need to make sure that we consider all of our parts, but there's obviously a particular focus happening in this way in the Latrobe Valley, we'll look at what needs to be done in the other parts of our community.

PROFESSOR CATFORD: Just a final question. You presumably have core funding from the department?

DR MAXFIELD: Yes.

PROFESSOR CATFORD: Do you have provision to bid for innovation funds in the way that we're sort of hearing in Victoria may well be occurring?

DR MAXFIELD: There may well be some coming up in the future from the Commonwealth Government.

PROFESSOR CATFORD: Thank you very much.

MR ROZEN: Can I just ask you about one expression you used, which we've heard mention on previous occasions, that's "social entrepreneur". I just want to get some understanding of what you mean by that term and how it might relate to the work of the Inquiry.

DR MAXFIELD: I think it's about people who actually do have a vision about things being able to be done differently

and looking at the point of view of having communities and what are the needs of the community, and how can we develop systems within the community to improve. I'm not sure if that - but, yeah.

MR ROZEN: That's very helpful, thank you. Any other questions? No.

Thank you very much, Nola, for your time and we'll excuse you for the moment and ask you to join us in our panel discussion at 1.30.

Thanks, once again, to all the speakers that we've heard from this morning, it's been very valuable for the Board to hear the views of such a group of community leaders in the health area.

We'll now break for lunch till 1.30 and then we will reconvene for a one hour panel discussion. Thank you.

LUNCHEON ADJOURNMENT

MR ROZEN: Thanks very much everyone and, as you can all see, the six panelists who presented this morning have been kind enough to come together as a group for what we anticipate will be up to an hour now where they're available - some are looking a bit concerned at the thought of that - an hour where they're available. It's a format that we have used, as I know some of you will be aware from previous forums.

We're going to do it slightly differently today and that is that, in addition to questions the Board may have and questions that I may have of you, we thought, given that this is a culmination of a five day process and we've had a number of members of the local community who have come along to some or all of those

five days, that we thought we would give members of the community an opportunity to ask you questions now.

I should say, to preface a couple of remarks about that, firstly if anyone does have a question to ask of anyone on the panel, we would ask that they wait until the microphone comes around to them so that they can be recorded for the transcript, and also, that they identify themselves by name, and if they're here representing an organisation, that they identify the organisation.

The second thing I would say is that, I'm sure people in the audience would understand that some members of the panel, and I'm thinking particularly of people who work for the Department of Health and Human Services, may be somewhat restricted in what they can say, particularly about questions of likely future Government policy, and so we just ask that people respect that. I'm sure that it won't be that they're avoiding answering questions, but rather, that it goes with the territory that they occupy that they may not be able to be as fulsome in their answers as they otherwise would want to be.

So, rather than me starting the questioning, perhaps if could invite people, perhaps by raising their hand, if they have a question for anyone on the panel, and we'll take it from there.

CR HARRIMAN: No questions, thanks for that. Thanks.

MR ROZEN: Come on Dale, you'll be used to being asked questions in a community forum, I'm sure.

We've got one here. I'd just ask you to identify yourself for the transcript.

MR ARKINSTALL: John Arkinstall, I'm a member of the Voices of the Valley. I'd like to ask the panel what they saw as the role of the Health Advocate or the community more generally in concierging to assist people to make use of services more effectively.

MR ROZEN: Kellie looks like she wants to go first.

CR O'CALLAGHAN: Thanks for the question, John. I think one of the potential opportunities for a health concierge model, particularly for those members of our community living with chronic illness, is we can break down some of the barriers of access, and also, just break down some of that level of disadvantage that we know exists in terms of getting access to services, but also connecting up all of those incidental and Allied Health related opportunities for care that could exist within the community, but it's also the other social supports and networking opportunities.

I think what we do know, for people living with a chronic condition, that any opportunity to form a relationship with a trusted individual who can help you guide your way through care is going to add some advantage.

I know I had a conversation with some clinicians at the VHA conference last week, and we were comparing the differences between models of care for different types of illnesses, and the example I gave in my instance was having lived with a chronic condition for 14 years, the complexity of having to work through that pathway as opposed to having a recent breast cancer diagnosis, where you effectively get on the train and it just follows through. So there's a natural pathway:

I didn't have to think about my treatment for breast cancer, yet I still have to on a daily basis think about my treatment for my chronic condition. The reality; the chronic condition is actually probably more potentially threatening than the breast cancer diagnosis, so it actually doesn't fit in terms of access.

I think that concierge style of approach, no matter whether that looks at individual support or a community nursing model like the Dutch model, would actually provide some advantage to community.

DR MAXFIELD: There may also be some advantage in looking at things in a different way and, if the Commonwealth Government is prepared to look at different ways to funding chronic disease management in general practice, part of what that will fund would be a nurse or somebody within the practice who would actually be facilitating people's journey through management of their conditions.

MR ROZEN: Thank you. I don't know if anyone else wants to add anything there. Looks like, no. Do we have any other questions from the audience? No, looks like back to me. Anita?

MRS ROPER: If there are no questions, sorry, Dale, but this is directed to you. It was a question I wanted to ask earlier, and then Kellie referred to it in her presentation as well.

More clarification: when we were talking about the Health Advocate, you talked about, as it currently stands and implies in the future, that the Health Advocate could not get involved in any emergency

situation until the end. So, what are the barriers?

CR HARRIMAN: Just under current legislation, the current legislation states who can be involved in an emergency situation. So, it would need to be put in that the Health Advocate becomes part of that Emergency Management process.

We have an Emergency Management Plan for the region and there's a State Emergency Management Protocol, about who can be involved, when they become involved and what obligations they have or what responsibilities they have, and a Health Advocate's not in there from the start, and I think we need to look at that; that when we have an emergency situation, particularly like the mine fire, that there is a Health Advocate and a health person in there from a local point of view, not coming from Spring Street, but a local person that knows the region and can advocate on behalf of the locals so we don't end up with the situation we had with the mine fire last year.

MR ROZEN: I was wondering if we could return to the three themes that we are focusing on today, and just to remind everyone the three themes are governance, leadership and sustainability.

I thought what I'd like to do is open it up to the panel, and this may stimulate some questions from the audience as well, to consider each of those issues, and I want to ask some fairly broad open-ended questions rather than trying to focus in on specific areas of the presentations because I think we've already done that.

In relation to governance, I want to open up to the panel to ask the broad question about what can be

done, either by existing institutions or by way of recommendations by the Inquiry, what can be done to improve governance in relation to health in the Latrobe Valley?

MS PEAKE: I'm happy to start. I think when we talk about governance, we're talking about three things: we're firstly talking about, how do we bring people together to plan and how do we make sure that, in planning, there is better access to data so that we're really focusing our plans from a population perspective, what are the issues that are most relevant to this community. I think a lot of what we've heard today is the opportunities that exist, in large part with what might be the future directions of the PHNs, but also through the goodwill of the leaders from the different parts of the health service to really combine their data to understand health issues for this region.

So, bringing that together into a health plan which really focuses on the priorities and the measures of success, I think, is incredibly important, and that enables you to have an evidence based approach, but drawn from the community and connected to the community.

The second element of governance is then how services work together to provide more integrated care. That is really about the operating model for how services function. I think we've heard a lot today and over the last five days about the ways in which funding models and organisational models either help or impede different ways of working together, and so, I think there's some really fruitful discussions to be had

about what pooled funding models might look like, what outcomes based fundings might look like, how we can have some local flexibility to really not have the stop-start programs we've seen in the past, but instead have sustainable leveraging of existing resources on evidence-informed approaches to delivering better care.

Then the third level of governance recognises the discussion we've had over the morning that health is not just about health services. Better health, better wellbeing is about a whole-of-community approach to how communities work, about how people get access to opportunity.

I think the discussion we had earlier about how regional strategic planning can be informed by public health policy and practice is the third opportunity for strengthening governance in the region. What comes out of the review that's happening at the moment of regional governance structures is one opportunity, but it's also about how local leaders in the private sector, the community sector and Government, keep working together to be thinking about healthy workplaces, to be thinking about, with local council, how town planning is occurring, how land use planning is occurring, how our schools are promoting healthy behaviours and pathways for kids, and how our various services are really creating those opportunities for community participation and community inclusion.

I think in each of those domains of how health services plan, how we organise ourselves to deliver more patient-centered, joined-up integrated services, informed by the sort of technology which helps with

care pathways, and then thirdly how we think as a community as a whole about building a stronger community and opportunities for participation, all comes back at the end of the day to good use of data and strong community leadership, good ways of engaging the community so the community has a voice and good use of evidence for where we put our effort.

MR ROZEN: Thank you, Kym. Can I invite anyone else to add to those observations.

DR MAXFIELD: The primary health network's been mentioned, and I think this is what makes it so exciting to me to be involved in the Gippsland Primary Health Network at this stage, is that we've got the opportunity to use data and to be able to get more data than we've had before. And we also have a structure that's going to be in place shortly with our clinical councils for people to be able to look at that data and then to use all our networks and our relationships with the public and the private providers to then utilise that for the good of the community.

MR GUY: A lot of people talk about, for the good of the community. I think where we fall down is our process of connecting with the community to find out what they want. So we really need to concentrate on that area, I think, about how we can interact with all sections of the community and find out what the needs of the community are.

MR ROZEN: Just picking up on that, is that something that a Health Advocate might be able to assist with, do you think?

MR GUY: I think it could play a major part in that process,

yes, and particularly as Kellie mentioned before, if it was set up with a shop front in a town somewhere, where people have easy access.

Because a lot of people, with formal communication set-ups won't attend those, but if it was somewhere where they could walk in off the street, maybe that could make it more accessible.

MR ROZEN: Are there existing barriers, do you think, to understanding community wishes and wants?

MR GUY: I believe there are, yes.

MR ROZEN: What are they?

MR GUY: I think probably education is one of them. We've talked about the socio-economic situation that exists in the Valley, and that's a factor. People being perhaps a little bit put off by formal structures. There's probably a multitude. I think there's a lot of comment in some of the sessions that have been held, with some input from people about some of those obstructions too.

MR ROZEN: Yes, I think so.

CR O'CALLAGHAN: I think one of the interesting points, and John's highlighted some barriers there, but there's also an opportunity for us as providers in setting up a governance structure to ensure that it is a transparent process and that there's an availability for community to learn about those structures of governance that exist and learn about the setting of strategies and learn about how compliance and risk and all of those resource allocation issues, how they actually operate.

I think we often talk a lot in governance about the rules of governance and we forget who our

stakeholder is. So, in terms of setting up a governance structure in this particular scenario, our primary stakeholder is the community. If we think of them as the company we're operating for, then we need to get their best outcome, then we would apply our strategy and our compliance structure and our risk framework to meet their need. But if we're not talking to them about how that works and what that means, then why we're operating in that way, we're immediately going to have a disenfranchised community anyway.

Part of it is about breaking down some fairly complex concepts into a level of understanding from community, and then also mirroring back and making sure that it's understood, not just assuming that when we're talking about governance everyone knows what we're talking about.

I think we are all within organisations where it works very well, but we need to be a bit better at explaining that and ensuring that we're creating opportunities for our community to ask questions so that the governance process is operating in their best interest.

MR ROZEN: Just reflecting, as you were saying that, on some of what we've heard in some of the other sessions, one of the things that comes back to me in relation to community engagement is that one size doesn't necessarily fit all. And we talk about community, but the community is actually quite diverse - we've got an indigenous community, we've got a non-English speaking background community. These must be things that council faces on a day-to-day basis, Dale; are there

lessons from that experience?

CR HARRIMAN: I think part of what we do is go out and engage with a variety of the community, and I think part of good governance is that it's not just the same group that you go to every time; it has to be a broad spectrum. We have one of the largest populations of indigenous culture in Latrobe City. We have, I think, 55 per cent of our population has a parent, either one or both parents born overseas, so we have a huge multi-cultural population.

Part of what we do as a council, and I think a lot of groups in the area, when they go out and engaging, it's engaging on six or seven or eight different fronts with people so that you're getting a wide range. You're getting your multi-cultural groups, but you're also getting your different sporting groups, you're getting your disabled, you're getting your carers, you're getting the broad spectrum.

Part of what has been done at a couple of councils, I know the City of Yarra has done it, is actually put out an application for the community to be involved in a community input session. They got 200 applications, short-listed it down to 60, by having who's in our community, age group, nationality and got the whole spectrum covered, and I think that's part of what we probably need to do. That's something new that's been done; they've only done it this year, but it's worked exceptionally well in them getting feedback from their community, so that you're not getting the same voices, you're getting different voices and you're getting the whole community involved in it.

MR ROZEN: Terry, I wonder if I could bring you in here if I could because, when you presented earlier to us, I think it was either you or Kym told us, there was a new community engagement section within the area that you're responsible for. Perhaps if you could tell us a little about that please and how that's intended to work.

MR SYMONDS: I guess there's probably three things I'd mention. I might say as an overarching comment that, although it's a branch within the Department, I don't think it's only focused on how the Department directly engages with communities. I think one of the questions for the Department is, when is it appropriate and useful for the Department to engage directly with communities, and when is it our job to support other organisations who are in communities and on the frontline to engage better with their communities and give them tools and resources to do that, and that's an interesting question.

For example, how do we understand the views and the needs of populations? One is by directly engaging with them in their local community, but there are other sources of intelligence about this; they occasionally fill out surveys, they occasionally provide information to others. The ABS regularly surveys people about barriers to healthcare, about their views on access to healthcare, about priorities and so on. We get that information. How well do we share it with local organisations? We survey populations ourselves. How much do we break that into local cohorts and share it with organisations at a local level so they can see the

intelligence that we've got?

We now have for the first time access, not only to the hospital statistics that were talked about before, but access to MBS data from the Commonwealth is being shared, which is a really welcome contribution I might add from the Commonwealth. So, have we started to analyse that and break that down into bundles of information that we can share in the way that Kym talked about and give resources to other organisations, so I just make that comment at the beginning.

I suppose there's three issues: one is about the Department's relationship with other organisations, so sector engagement, how well are we talking to other service providers, making sure we know the issues they're seeing on the frontline; the kind of issues reported today from these organisations or others, how well we are building that into our own policy.

The other is a direct engagement with communities - I've said that's not only our focus, but occasionally that is important. When do we engage the communities about priorities for Government, what's their view on what our policies should be? What's their view on priorities for State Government?

The third is clients and patients. I think it's important that we also run processes to make sure that we're directly engaging with the clients and users of services that we fund.

For example, we fund a survey of patients that leave hospital, it's done on a Statewide base, I know that service providers do that for themselves, but we also do it Statewide and we get some benefits from

doing that on a large scale across the State and then report those results back. That tells us, for instance, about whether people leaving hospital feel they've got adequate support from the community to help manage their care at home. Do they feel their GP was adequately engaged by the hospital? We can now see that information at a local level, and we report it back publicly as well as to local organisations.

I suppose I'm giving you a feel for some of the work that our branch is going to do. There's one another, I might add, which is the use of new technologies. We have a significant investment in digital technology in the Department - it's traditionally thought of as the good looking websites department, but I think we have to think about the fact that the internet and accessing the web is only one means for transmitting information - let's think about technology as a way to actually get advice and feedback from communities. You know, young people don't mostly sit on a PC and use the internet and browse public websites, they're going to use their phone, and so, what can we put on their phones that means they can give us feedback about things? Is it possibly to poll users of services?

I don't expect lots of service providers to be able to do that within their own scarce resources, that's something that we can do at a Statewide level and put those tools back in the hands of other organisations. So that's some of our early thinking.

MR ROZEN: Kym, I wonder if I can bring you in here. In relation to the new position for which recruitment is,

I think, presently ongoing, the role, is it a Morwell-specific role?

MS PEAKE: It is.

MR ROZEN: How is that expected to work?

MS PEAKE: It's absolutely a Morwell-specific position that is intended to be really from community, within community, deeply engaged, particularly around any emergency events, but there as a resource ongoingly to be working with agencies but also working with the EPA, to be tapped into what are the concerns, the questions from members of the community which can then be fed back in - very much the role that I know many people today here have played, but in an ongoing supported way.

The key to its success is going to be that it's someone who is trusted and who is very open and listening, and that there is follow up. I think, really to John's point, one of the critical things in how you have an authentic approach to engagement with the community is that it's not simply going out and surveying and talking to people and then there's no follow-up. We also, through this position, are looking to have really good processes where it's not always going to be possible to do everything everyone would like us to do, but being able to explain what is possible, what's being done and what's the process going forward.

MR ROZEN: If I could raise the question of sustainability because, if there's one theme that has come through a lot of the work that the Inquiry has done in the previous four days of Health Improvement seminars, it's

the frustration people feel with this stop-start aspect of Government programs. We heard quite a bit about Healthy Together, and that's an example that's been used on a number of occasions.

How can that be overcome, I suppose, is the question? In particular, I'd ask the panel to reflect on the role that the community itself can play in trying to mitigate against that occurring in the future with any new initiatives that are put in place.

CR HARRIMAN: I'll start, if you like.

MR ROZEN: Thanks, Dale.

CR HARRIMAN: That's all right. I think John mentioned a similar program started in 1990, and there was one in 1983, I believe, before that. I think from my point of view, the outcomes could have been achieved if the money put into re-running the program in 1983 had have been put into actually funding the necessary outcomes and recommendations, I'd be about 5 kilos later, looking more like John, fit and healthy, and I think a lot of the community would be a lot better off. I think part of it has to come down to, if we can get that enhancement region, or a health enhancement region organised, then we can see the benefits because the Government would have to make a long-term commitment. I think we really need to force the Government into picking an area, and I think this is a great area to do it, and making a long-term commitment to the health and wellbeing of those residents, and having a bipartisan approach where what works in this region is then rolled out to the rest of Victoria.

I think that's important, I think there has to be

a commitment to funding it through one particular region and seeing what works and it has to be bipartisan. It's great to have all these programs coming out every five or six years, keeps a lot of people employed, but leaves a lot of people unhealthy.

We had 500 people come in with Healthy Together, went through the Jamie Oliver school, did the cooking, had a huge impact on the schools. I know a lot of the schools are involved with the kitchen garden and they're producing salads, and kids normally that don't see vegetables are actually eating fruit and vegetables, which is great, it's a great outcome. But that's while they're in primary school. Once they hit secondary school, 2-3 years in the message is lost if there's no constant reinforcement, and I think that's where we need to have that bipartisan approach and a commitment that we're not going to fund a program for four years or the term of this Government; it needs to be, we will fund it, but then there is going to be money set aside for any recommendations that come out of it, particularly in regard to health.

MR ROZEN: Thank you, Dale.

MR GUY: I agree with that, I think it's got to be a whole-of-Government approach, it's got to be probably a five year plan which gives time to set the process up and go through to an evaluation stage so that you can see the benefit of the program. Otherwise, we're not going to get anywhere.

MR ROZEN: Kellie.

CR O'CALLAGHAN: I think, having the ongoing Government commitment is the first step. I think the other thing

you need is for everyone to agree what the principles of the measures of success for the programs will be so that there is that quite clear and measurable indicator of whether or not something is working.

I think we see a lot of seed funding, we see a lot of initial program commencements, but then when it comes to the actual, did it work, how do we measure it, we don't necessarily agree the principles for success up front. I think, if we do that, it's easier to defend - so I put the political hat on, sorry about that, Mr Mayor.

CR HARRIMAN: That's all right, go for it.

CR O'CALLAGHAN: Easier to defend something from the political perspective if you know you've got the measures to back it up.

The other thing is, if we have flexible and responsive program models, you allow the programs to adapt and you allow a service provider to be more flexible in their approach, be more responsive. So, if there's a deficit that starts to show in the program, they can pick up the slack and be more attentive to the need of the community and, therefore, get greater engagement.

So, sometimes we give these program models out as, it's like this and you've got to deliver it this way and you can't step outside the bounds. So, if you give a much more flexible and responsive framework setting you're likely to get a few more measures of success.

So put in formal evaluation models, but I think the other thing, we've been talking about it a lot over each of the five days, is having community ownership of

the programs. Because, once you give something to a community that's working and you try and take it away - you know, good luck with that. So, there's some work there that can be done on ensuring that in the first instance the programs that we get are appropriate and relevant, that they're measurable and we're evaluating them in an effective way, and then they're defensible because the community owns them and wants them and sees the inherent value in them.

I think some of that sustainability model is around ensuring that it's appropriate in the first instance, and then has a level of solid service delivery ownership and community attachment as well.

MR ROZEN: Thank you. Nola, I wonder if I can just bring you in on this question, because I recall from your presentation earlier you talked about measurable improvement in health as being one of the key components of the PHN. I just wondered, what does that mean in practice? How is it envisaged that you'll measure improvements in health?

DR MAXFIELD: It was also the vision for our Medicare Local, and I don't think we actually came to grips with how we were going to measure that. I think that now we're actually going to be able to get a bit more data and be able to work out - start to look at some dashboard reporting and look at what are the important areas, and then to be able to monitor that over time. We're going to have to be informed by our clinical councils and our community reference groups as to what are the important issues for those communities to start with.

We will also be judged by the Government and they

will also use some of their data, so things like immunisation rates, chronic disease management, screening of various things, whether it be perhaps new breast screening, bowel cancer screening, so we are going to be held to account by them in providing some of the data and we'll use that as a starting point.

MR ROZEN: Thank you. Kym.

MS PEAKE: I was just going to add, slightly cheekily, that I think we're really talking about prevention and primary prevention initiatives and how do we sustain those when we ask the question about sustainability.

It's interesting, when we think about road safety, the role that the research partners have played in really, not only evaluating what's been done, but giving good advice to both the transport authorities and the justice authorities about where to put the next lot of effort in campaigns.

I think one of the really valuable contributions that VicHealth makes, and I think they do make this really well and we've got to keep leveraging that, is to play that role in giving advice about, what are the health promotion and prevention activities that have the most affect and how, both at a local level and at a Statewide level, do we take account of that in where we're putting our next lot of effort. That was one point I just wanted to make about sustainability, that the link with research and evaluation is, I agree with Kellie, is critically important.

The second point I guess I just wanted to make is that, in our approaches we also want to leave a little bit of room for experimentation as well and we want to

make sure that it's okay to try things and they don't work, and that they do stop, and that we're adaptable in that way.

I think we just want to be careful that, in promoting sustainability and adaptability, that we don't cool the ability to experiment, innovate, and actually put our hands up and say, actually that didn't work, we're going to try something else.

MR ROZEN: Any questions from any of the board members - John.

PROFESSOR CATFORD: I wondered if I could continue the theme of resourcing, and clearly, some of the local agencies are very clear that they need some additional help from Government to advance their cause.

But, of course, there are a range of resources available. We've heard I suppose predominantly looking at Victorian Government resources, but there's obviously Federal Government resources, and potentially the PHN can tap into that.

But there are also resources coming from outside Government, and I was wondering if the panel might just comment on this: whether large employers or businesses might be a source of resourcing, or indeed philanthropy. There are examples in other parts of Australia where philanthropy has also played a really good role at levering further investments from Government.

So, I really wanted to address the question of resourcing, and also just of course make the point that we are already spending significant resources already in the Valley; to what extent can we lever or use our

resources that we have got at the moment more effectively?

Can we think in innovative ways about finding new resources, but could we also use our existing resources more effectively? I wonder if you could help ask the panel that question.

MR ROZEN: Sure. You don't need me to repeat it, I'm sure. Kellie.

CR O'CALLAGHAN: Happy to jump in. I think, what we don't acknowledge sometimes is that the corporate entities within our community are willing to be engaged and be involved.

MR GUY: And are engaged.

CR O'CALLAGHAN: Absolutely. I think a lot of the time we don't necessarily make it easy for them to do that. We can get very focused on our core business arrangements and delivering on our departmental obligations and contracts, and don't think about innovative approaches to engaging organisations and entities.

I know I've had lots of conversations - and often it's come about since the mine fire - around the old days of the SEC where if you wanted something done at a primary school, you'd ring up and the works guys would come out and they'd build a new library at a primary school or they'd paint something for you, or if a community agency wanted something, you'd engage with the corporate who would come out and offer some kind of in-kind support.

The other thing that I think's happening a little bit, and it certainly has happened since the mine fire itself, is that, for some of that Industry Group

they're almost a bit bashful about getting out on the front foot and then offering up some of those opportunities in case they are in some way criticised for coming into that arena for the wrong reasons.

I think there's a time and a place for us to sort of open that discussion again around what that can look like. The other thing is, it doesn't need to be big cheques. I think we always had this idea that someone's got to write a cheque and buy something or give something.

There's quite a lot of value in having corporates engaged in assisting organisations, whether it be with skills resourcing or in-kind contributions or other levels of value-added within organisations. So I think we can probably be a bit more creative about how we do that and formalise some of those opportunities.

Look, it's another thing that the Health Advocate can do, partner up and actually help organisations match up and share skills and share resources, so that they're not having to spend money on things that can be provided by a corporate who's happy to support them, so I think the opportunity's there.

The other thing is, philanthropic organisations have a very strong history within the Valley. I know my initial experience was through Good Beginnings, when it lost its Federal funding, I was a coordinator there for a while and it was the SIBEK(?) Trust that stepped in and funded it for two years after seeing an article in the paper, and Roger Eden stepped into that space and said, "You know what, I'll pay for it; it's an important program". So philanthropy is well entrenched

in a lot of the organisations that we work within and there are good, solid relationships.

But one of the difficulties is for smaller community-based organisations and health services to know how to gather that money, to know how to get out there for themselves and attract those sorts of partnerships. I think there's almost an introduction relationship building connecting up space, where if we had this central point where all that information came into, you could start to share it out across the network a little more equitably, and having said that, obviously across the paddock, we don't have too much trouble getting people engaged, because it's a hospital, and people say, "Great, I'll give the money to the hospital".

But it might be more appropriate that they are providing money to a program that John's doing at LCHS. You know, who's not to say that we shouldn't be sitting down and working out how we best use our community resources through corporates and philanthropy. So, I think we've got to start having those conversations and planning more effectively as a community.

MR GUY: I think a lot of that sponsorship has occurred over a number of years; we just haven't thought about applying that to health. It doesn't matter where you go in the Latrobe Valley, you will see, if you go to a concert, you will see sponsorship from a power company. The hospital ball that's coming up, sponsored by a whole lot of organisations in the town. We just haven't thought of that angle of asking for sponsorship for health programs.

MR SYMONDS: If I can just comment, I think there are some communities and health services that have done very well with that, and I think one of the things we should do is make sure we spread good practice around that kind of stuff.

I think support for philanthropics is also something which the engagement branch of the Department is looking to do. They've pointed out that in the past State governments have done a bit more to marshal some of that support and brief philanthropics, make sure there's good connections between the donors and the other organisations, that's something we can do a bit more of at Statewide level without getting under the feet of local organisations.

In terms of leveraging existing funding and John's questioning about that, I completely agree, I think there's a significant amount of money invested by State Government in acute health services for instance, and our funding model has strong positive incentives for that money to be spent efficiently, but it's kind of agnostic about whether that money is spent well to avoid people having to come to hospital.

In fact, if hospitals spend that money efficiently, they get to keep the difference between what it costs for them and what an efficient price might be. But, if they don't spend that money on admitting patients, we take it back, and so, you could argue that it acts as a kind of perverse incentive to a certain degree.

One of the things for us to think about in terms of leveraging existing investment, and this gets back

to a governance investment, is how to make sure that acute health services share accountability for prevention of avoidable admissions and chronic disease driving admissions and, if we do that and tie that to funding, then the funding we've got is working harder for overall health, not just for activity, and it's balancing that investment being for what gets done, which is what it does now, versus what is needed, and I think the investment has to work a little harder for what is needed, not just what gets done. I think that's a change to make in funding models I think.

MR ROZEN: Sorry, Kym, just before you start, I'm just reminded of something you said earlier, Terry, about the difference between outcomes and outputs and I wondered what you meant, but I think I've just learnt, have I? Is that what you're - - -

MR SYMONDS: That's exactly what I meant.

MR ROZEN: So an outcome would be better health, and output would be treating people.

MR SYMONDS: We fund Latrobe Regional Hospital something approaching $200 million a year for hospital services. That's a not insignificant investment by the State Government in the health of the Latrobe Valley. But that money is tied to outputs, like treating an orthopaedic patient and them leaving hospital. Now, there's plenty of orthopaedic surgery needed in the Valley, I have no problem with that at all, but I think, in line with earlier comments, we should also be giving Latrobe Regional Hospital and the community some flexibility, to say that, on balance, if that funding could also meet other needs and be deployed or pooled

with other things to achieve better outcomes, providing we agree on how that's measured and understood, perhaps that's a model we should be thinking about, and that's exactly what we are starting to toy with, and I think, if that fits in line with the Inquiry, then it has relevance.

MR ROZEN: Sorry, Kym, I think you were about to say something?

MS PEAKE: I was just going to make a small point that there's also the broader determinants of health where all employers and a whole range of other actors within the community play such an important role - whether we're talking about sporting clubs and how they maximise participation or we're talking about attitudes to women and violence and how employers model expectations and support, people who might be finding themselves having the experience of exposure to family violence. So, if we actually gathered up all of the indirect ways through some quite deliberate activity, that a whole lot of different institutions and places in communities could contribute to reducing the burden of disease and promoting healthier communities, we can also have conversations within communities that not only are about providing sponsorship, but making a contribution in a different kind of way.

MR ROZEN: I'll just check if there are any other questions that the Board has of the panel.

PROFESSOR CATFORD: Could I ask now about community engagement and this whole question about co-design or co-ownership and really partnering with communities.

I think all of you have commented on that in some

way but, I mean, do you think there's an opportunity in the Valley to actually do something which is quite remarkable in terms of linking with organisations - we have Voices of the Valley here with us today, and there are other organisations. Could you do something that sets you apart in terms of a new way of governing and leading?

CR HARRIMAN: I'll jump in on that one. I believe we already are. I believe the basis for it is already there, the community groups are there, the community input is there, the willingness is there, it just needs to be harnessed. I think that's where, from this panel, that might be the harnessing, that the people are there - as you've seen, the people are there, they're willing, they want to be involved, and I think it's just a matter of harnessing that. I think it can be something that can be modelled and rolled out across the rest of Australia.

I work with a local charity that are working with carers that are doing a similar thing - it's the carers at a ground level enhancement, and I think that's what we need here. It has to be, not a top -down, but it has to be the community driving this, it has to be the community from the ground up building the system. I think we've got the people who are willing to do it, we've got the people with the qualifications to do it, we've got the people with the drive to do it long-term and I think that's important. It's not going to be something that the community is going to run out of puff within six months; I think we've proven that we've got people that are willing to stay the long-term, so

I believe it's something that just has to be harnessed.

CR O'CALLAGHAN: I think community engagement really is just about facilitating an understanding, and I think we over-complicate it. We like to over-egg it because it makes us feel important.

There's nothing that I do in my job that someone else couldn't do. There's no process within an organisation that someone couldn't understand if given the respect and the time and the consideration and the genuine goodwill to share that understanding.

I think that's where we're at; it's about acknowledging that there are differences in the way that we see things, that there are learnings that can be had and, if we just accept that facilitating that process of sharing information and being transparent, and agreeing to disagree. Like, Wendy will tell you, we don't always necessarily agree about everything, but we can have a robust conversation about those things which we may not share an agreed position on and get to a point where we can move forward with some understandings.

I think that's probably what we're doing, and also looking at how do we help community to actively participate in their own engagement, not just telling them that they need to participate in community engagement, but helping them to do it themselves and in bringing those ideas to the table.

Some of the frustrations that I know Wendy and Marianne and John will probably tell you about is, in the initial stages trying to be heard, trying to get credibility, trying to have some champions for either

their message or understanding what it is that they're trying to question.

Some of those conversations were quite accidental; we ended up sitting at tables in other forums and learning from each other that way. I think we just need to formalise some of that, so we force ourselves into conversations that may be uncomfortable, that we don't want to have. It doesn't need to be easy, it doesn't need to be comfortable, but if we can't even get to the point of having conversations and working out what we are trying to achieve - I think part of it is handing over to the community that engagement. What would you want it to look like? How would you do this? We can't always assume it's the providers or administrators or counsellors or whatever we are at the time, that we know better, and we've got to stop telling communities what we're going to do for them and let them tell us how they would like to be engaged with and facilitate that understanding.

MR ROZEN: What I'd like to do now is bring this session to a conclusion in this way - we've done this with each of the previous panel sessions that we've had - sorry, is there a question on my left?

MS ROBINSON: I did have a question.

MR ROZEN: Sorry, there's a microphone coming your way.

Would you please identify yourself for the transcript?

MS ROBINSON: Marianne Robinson, I'm a member of Voices of Valley. In some respects this is a follow-up to what Kellie has just said, but it's something I've been thinking about all the way through the presentations, about leadership and governance.

The question is to all members of the panel, what would need to happen to make it possible that we can make decisions about resources and programs at a local level? Various people have spoken about what a Health Advocate could do, and you're expecting a super human person perhaps, but also, what we've learnt over the last year, 18 months is, quite often get a response when we suggest something, "We don't need to do that, somebody else is doing it. We don't need to suggest this line of operation, somebody else has already got that under control." That is, I think, one of the significant barriers to greater community participation, and it's a barrier in two ways: one is a perception that it's not the community's job, it's the agency, the Government, whatever it might be - that's the perception from the community side.

There's also the acceptance, which I think we've heard quite a lot - that whatever we want to do is subject to what the Federal Government decides, what the State Government decides; we have to get permission to do what we need to do.

So, what sorts of things do you think need to happen, need to change for us to be able to do what we want to do?

MR ROZEN: It's a big question. Dale.

CR HARRIMAN: I'll jump in on part of it, I don't think I can answer all of it, Marianne, but I'll get part of it.

I think part of what needs to happen is that we need a change of view from State, Federal and even Local Government. We've always gone top-down, and

we've just seen that works in some instances, but there's cases where it doesn't work. I think part of what we need to do is start looking at building those community-up sounding boards. We need to have that community-up input. As Kellie said before, rather than telling the community how we're going to do something, asking the community, how do you want it done, and having those community groups in place, similar to what the City of Yarra have done, they've done it with planning, they're now rolling it out across a whole range of issues, asking the community, how do you want it done, what do you see as the future, how do you want us to go about it, and having that input from the community, from a range across the community, and it just gives you that better understanding of what's actually needed; because, if the Government imposes something that the community doesn't want, we've seen it before, it fails and it falls over in a very short time; the Government will drive it for six months, fund it for 12; 13 months in it no longer exists or no longer relevant.

MR GUY: An interesting question. It's interesting when you talk about community, isn't it, because a lot of the things I do, I'm doing as part of the community; or all the things Kellie does is for the community, the same as Dale. What we've got to do is, I think, think about how we can bring other people into that, and a lot of people don't want to get involved in committees, they don't want to take on jobs.

If you advertise, and some of the organisations I'm in, if we advertise we're having an annual meeting,

people won't come because they know there's a danger they're going to get tapped on the shoulder to take on a position. If you advertise it just as a meeting where you're going to discuss something, people will come along.

So, I really don't know what the answer is, but somehow or other we've got to try and involve a lot more people in the discussion.

MR ROZEN: Kellie?

CR O'CALLAGHAN: I'm happy to jump in. I think we start at, yes, and we work out the how. I think we immediately take a defensive position of not enough and insufficient resourcing and it's all too hard. I think the other thing; we take it personally, and I know, gee, I've done it on more than one occasion; you immediately take the question or the suggestion as an attack on the basis of what you're doing now as being inadequate, so therefore you jump to the no.

I think if we start at the yes, but I don't know how, and then have that conversation and work out the how from that, we're probably going to be communicating a little bit more effectively. So, I think rather than discouraging people from bringing ideas to the table, start at yes, acknowledge I'm hearing you; all right, now how are we going to do this, because I'm not really clear of how we're going to make that happen.

The other thing I think we need to do is understand we're just the custodians of the health services we're operating, and we need to be respectful of that. We are here effectively for a very short period of time and we'll make certain changes and we'll

instigate certain systems and practices, but we are only the custodians of the system, and these systems will have had history before us and will continue far beyond us. And, if we keep operating on the basis that it's just ours and it's all closed and we say no to anybody making changes to it, then it will never evolve. So we need to be considering that as well.

I think one of the most important things that we've experienced, particularly within this local community, is that acknowledgment is key, but action is essential. We need to be listening to our community, acknowledging that we're listening to what it is that they are concerned about and fearful of, but we also need to be instigating some action so that they can see that they've been heard and there's been an outcome from it. I think, yes, start with a yes, and then work out the how from there.

MR ROZEN: Thank you. Wendy.

MS FARMER: Two questions - Wendy Farmer from Voices of the Valley. The first one's to Kym. Kym, you said there's a recruiting position at the moment for a community engagement for Morwell. Can that be broadened to be for Latrobe Valley?

One of the things - and I know you can't answer me on this one straight away because you have other people to go to - one of the things that we saw right through all the forums that we've had is, by dividing the Latrobe Valley into separate areas, you know, Moe, Morwell, Traralgon and surrounding areas, we have a real divide. I believe, and I'm pretty sure Dale and Kellie being on council also believe, that we need to

start working to build Latrobe Valley together, each town, each little area supporting each other, so we really need to start looking at these agencies that come into Latrobe Valley on how they can build this area as Latrobe Valley rather than as four or five different separate areas.

MS PEAKE: Thank you. So look, I'm really, really happy to take the feedback and go back and talk to the team about what's possible.

MS FARMER: The other question/statement that I probably have is, we just touched on funding, and we know that the coal companies pay a lot of Crown royalties. None of that money actually comes back to Latrobe Valley. You know, is there a way of saying, okay, you've been working in our backyards for the last 90 years, that it's time that some of that Crown money be handed back to the Latrobe Valley to improve Latrobe Valley? That's all.

CR HARRIMAN: I'm probably the one that's going to handle the coal royalties, quite happily, quite happily. This council actually wrote a letter to the State Government, there was a notice of motion put forward at a council meeting calling on the State Government to pay part of the royalties it receives from the three mines to the council or into a fund for development of Latrobe City, within Latrobe City.

To paraphrase the response, "It's ours, go away" was the response from the State Government. It is State Government money that they put into general revenue and it won't be coming back here.

As a council, we fully believe that our residents

have put up with the mines being here for the betterment of the whole of Victoria, and that part of that should come back - we know it happens in other states. We know in WA in particular that part of those royalties are dedicated to the communities that that money comes from, and we believe, whatever Government's in play, that that needs to be what's done here; that part of those royalties is put back in - doesn't have to come to council, I'm quite happy if it doesn't come to council, if there's an independent body that's set up that says for the development of Latrobe City, Latrobe Valley, this is what we're going to do - whether it be better roads, whether it be bridges, whether it be pools, whether it be sporting facilities, whether it be paying businesses to come down and set up here so we can transition, happy for it to be spent by an independent body, this council has gone out and chased it, the State Government has said no, that doesn't mean we've given up.

MR ROZEN: Thanks, Dale. What we've done with previous panels is asked a final question to see if each member of the panel had one message, if you are able to give one message to the Board, and specifically focusing on today's topics of governance, leadership and sustainability. So, if you could leave the Board with one message about those topics and about improving health in the Latrobe Valley, now's your chance. I'm happy to start anywhere.

CR HARRIMAN: I'll jump in first, always happy to ask for money. With sustainability, we have the systems basically ready to go here already, we have the people

ready to go, we've run a number of programs in the past - make them sustainable. Don't give us something for two years, don't give us something for three years; look at what we're already doing, look at what's making a difference already, and make sure that we've got it for 10, 15 years. We're doing a health study for 10 years; anything that we do needs to be modelled on that 10 year guideline, because we need to see at the end of 10 years how it's gone, if it's made a difference or not. So, with sustainability, 10 years is our guideline if we can ask for it.

MR ROZEN: Thank you, Dale. Terry?

MR SYMONDS: I suppose, picking up on some of the themes around sustainability that's come up in this session, one thing to leave the Board with I suppose from my point of view would be to focus on the infrastructure of the system. There is a significant investment already at play, there are bodies and structures and relationships already in place. How could the accountability and the performance measurement and the governance around those structures serve the interests and meet the needs that the Board's identified?

I think it's easy to identify, in every situation, not just here, it's easy to identify new things we can do and new investments, I think those are always at risk by their nature. Whereas, I think if we can get at modifying the DNA of what's already at play in primary care, acute health, the governance of those arrangements, it's already here, then I think we're talking immediately about something that by its nature is more sustainable. That is an historic opportunity

that I think is in front of us because of the timing of the board's Inquiry. There is a constellation coming together around the way in which primary and acute care providers work together for population health, and there is a convergence of interest across Government, through things like family violence, in the way that health and social care come together; I think that's an opportunity that I think I'd be very interested to see how the Board considers that as you form your own recommendations.

MR ROZEN: Thanks, Terry. Kellie, one last thought to leave the Board with?

CR O'CALLAGHAN: I think we just need to trust that this community has its own inherent strengths and that we should build upon those as much as possible.

I understand that we want to be to build a future for our children and that, as leaders within the community, we are genuinely interested in ensuring the sustainable health outcomes for our own community and, given the appropriate support and commitment, we can do that.

MR GUY: As I said earlier, I think we should push ahead with the Health Advocate role. There certainly are a number of organisations that are working in the health area, they tend to work in silos, so we need to pool some of that together, I think the Health Advocate can do that. We need to look at ways of empowering the community at all levels to be involved in that.

MR ROZEN: Thank you. Nola?

DR MAXFIELD: I think the primary health network is here and raring to go and to take on some challenges, and I

think we'd welcome being asked to bring our various providers together and the community, with some funding, to look at different ways of doing things.

MR ROZEN: Thank you. Last, I hope not least.

MS PEAKE: I would really welcome and encourage an engagement with the Family Violence Royal Commission. I think that they will be making recommendations at a pretty similar time about how - very similar conversations about different funding models and governance models and operating models to integrate social care, so looking at how their work interfaces with the very same things in health. So that, picking up on Terry's point, there is an opportunity for the Latrobe Valley to be building on all the leadership resources that are very clearly on display, demonstrating new ways of working, getting new investment to have those new ways of working as trials for the rest of the State, and in fact the rest of the country. I think there's such an exceptional opportunity and there is a strong both need and case, because of the leadership capability here, to be positioned in that way.

MR ROZEN: On that very positive and inspiring note, it just remains for me to sincerely thank each member of our panel. We're very grateful for the time that you've all made available today, and I think the Board has benefitted greatly from hearing your views about the various topics that we've discussed, so thank you very much.

PROFESSOR CATFORD: It's up to me, I think, to close the afternoon.

We heard a little bit about some of the history here in the Valley, and I think perhaps when the next history book of health in the Valley is written there will be the time before this meeting and the time after this meeting.

Because, for our part, we think it's been quite a remarkable roundtable and, if you just reflect that we have the leaders of the principal health agencies coming together and discussing, giving up your very precious time to come together to discuss the future of health in the Valley, and you have been amazingly generous not only in your time but your ideas and your thoughts and your energy. I think you've been extremely open and constructive, you've presented a willingness to work together co-operatively between agencies and partner with the community, and for that reason I think it has been really quite a remarkable roundtable, so thank you all very much indeed on behalf of the board.

I'd also like to pay our thanks and respect to all the other members of previous forums, and there have been 12 before you, that have also given very generously of their time and they have also presented a wide array of suggestions and ideas.

I think what you've embodied today we saw previously at the other forums about spirit of cooperation and thinking very positively and constructively as you move forward.

As Anita mentioned, our time as an Inquiry is really very limited and it will be up to those of you and your organisations to move forward, but I think we

have a lot of confidence that that will occur.

So, thank you very much indeed. I'm reminded to say that transcripts of today's discussions will be available on our website overnight and, if people would like to send a further submission, this is your very last chance of saying anything further to the Inquiry, those submissions need to be in by this Thursday, 22 October and thereafter hold your peace, certainly in terms of the work of the Inquiry.

We will be putting our heads to the grindstone, which is no mean feat, because there's been such a rich array of ideas and suggestions. Anyway, our intent is to bring together a report that respects the various contributions that have been made and comes forward with recommendations that will help the Government and you, the agencies and the community, take forward a brighter future for the Latrobe Valley.

So again, on behalf of the Board, thank you all very much for coming, and for all the various people who have been supporting us, members of the community, support teams from the various agencies, our own Inquiry team led by Genelle Ryan, who's just standing at the back door behind me, it's been a fantastic effort and not without a considerable amount of organisation and skill.

I'd particularly like to thank our audio-visual assistant, John, our media communications support person, Spencer Mitten, and particularly the health lead, Monica Kelly, who's done so much to put all these forums together.

So, I wish you a very good day and we look forward

to seeing you in another capacity on another occasion.

Thank you very much.

FORUM CONCLUDED