parent's confidence and self esteem, and other immediate priorities of the parent such as finding a job. QEII is aware of the need to be flexible given that the priorities for these families may be more about connecting with preschools and education, and not necessarily about early parenting matters.

The research also found that parents who had established connections to their broader communities through associations and support groups generally felt that these links were of significant value. Parenting education and family support, in its broadest sense, is needed in the general community due to the loss of extended family, the advents of smaller families, the greater mobility of the population and changes in family structure. For many families, the net effect of these phenomena is social isolation and lack of confidence. These things are perhaps even more apparent in CALD and new and emerging communities given smaller family and support networks whilst trying to integrate into and raise their families in new social and cultural systems.

5.4 Separation and divorce

CMS recognises that the rate of divorce and separation has stayed approximately the same according to the Australian Bureau of Statistics information even though the rate of marriage has increased. This has implications for children and their sense of safety and security. There is a real risk that "adults business" can become "children's business" and it is important that policies and practices focused on the best interests of the child and don't get caught up in this parental negotiation cycle.

There is an evidence base growing around the potential benefits to many separated parents of engaging in a focused dispute resolution forum that assists them to hear and consider their children's experiences and needs within a brief, therapeutic medication process [86]. A study [87] found that improving the mutual regard of both parents and their emotional availability to their children often resulted from the child inclusive intervention. This had important flow-on effects for the emotional wellbeing of their children up to one year after intervention.

5.5 Step families and blended families

The Australian Bureau of Statistics [88] defines stepfamilies as, ".....those formed when parents re-partner following separation, and where there is at least one step child of either member of the couple present".

This definition does not include families in which children reside in the household part-time, or stepfamilies where the non-resident parent has re-partnered [89]. The ABS also distinguishes between stepfamilies and blended families. A blended family contains a stepchild, but also a child born to both parents [88]. Stepfamilies are increasing in number with a corresponding rise in complexity of relationships when the family is formed. It is desirable that practitioners become familiar with stepfamily issues in order to facilitate adjustments in surviving loss and change the experience of stepfamily living [90].

5.6 Grandparents or alternative carers

While many grandparents provide temporary child care for grandchildren, some are the primary carers of their grandchildren. The reasons grandchildren come to live with their grandparents are varied, but often include trauma of some kind, such as a parent's drug or alcohol abuse, relationship breakdown, mental or physical illness, imprisonment or death [91 92 93]. As primary care providers, grandparents assume responsibility for their grandchildren's emotional, structural and financial support[91].

Grandparents differ from other adults caring for children. They are often retired or planning retirement, and, compared with younger parents, on average have lower financial resources and less physical stamina. They may face difficulties resuming parenting at an older age, difficulties accessing assistance, or legal costs. This situation, combined with their own ageing, can result in unexpected social, financial and health problems [94].

Grandparent families differ from other families in the domains of [95]:

- age (In 61% of grandparent families, the youngest grandparent was aged 55 years and over);
- family type (almost half (47%) of grandparent families were lone grandparent families, with (93%) of these lone grandmothers caring for grandchildren);
- Income and cost of living (the transition to being a grandparent primary carer may be sudden, and associated with high initial costs related to accommodating children. The ongoing cost may not have been planned for and may affect the sustainability of the grandparent's retirement income. In 2003, one or both grandparents were employed in only one third (34%) of grandparent families. In keeping with this, around two-thirds (63%) of grandparent families relied on a government pension, benefit or allowance as their main source of income); and
- area of usual living (Grandparent families tend to live in regional areas, more so than other families. In 2003, a similar proportion of grandparent families lived in the major cities of Australia as lived in regional areas of Australia (48% compared with 45%).

5.7 Parents affected by alcohol or other drugs

The negative health and social consequences of drug and alcohol use for individuals, communities and families are widely acknowledged. Drug and alcohol use does not occur in isolation and it has been linked to poor mental and physical health, social disadvantage such as lack of education, unemployment, homelessness, social exclusion and poverty. The link between social disadvantage and drug use, particularly alcohol is most evident within the Indigenous population [96]. One study [88] highlighted the use by parents of drugs and alcohol as a contributing factor in 57% of cases of care and

protection applications. Research shows that people aged 18-35 are the group most likely to be addicted to illicit drugs and also the most likely to bear children. Drug use has a significant negative impact on the ability of parents to be available to their children and provide safe care and an outcome of this is the entry of children into out-of-home care. The impact of parental drug use on the extended family can also not be overlooked, with many grandparents finding themselves raising their grandchildren at a time when their advancing age and declining health present its own challenges.

5.8 Families in rural and remote contexts

It is well documented that the health status of rural and remote Australian is an ongoing challenge [88]. Up to 36% of clients attending the QE II Family Centre come from the surrounding regions of rural and remote NSW [89]. Health outcomes, as exemplified by higher rates of death, tend to be poorer outside major cities. The main contributors to higher death rates in regional and remote areas are coronary heart disease, other circulatory diseases, chronic obstructive pulmonary disease, motor vehicle accidents, diabetes, suicide, other injuries and some cancers such as lung cancer. These higher death rates may relate to differences in access to services, risk factors and the regional/remote environment. This also reflects higher proportions in those areas who are Aboriginal or Torres Strait Islander. Overall, death rates for Indigenous people tend to be much higher than for non-indigenous people.

There are clear differences in health service usage between areas. There are, for example, lower rates of GP consultations and generally higher rates of hospital admission in regional and remote areas than in major cities. There are also inter-regional differences in risk factors: for example, people from regional and remote areas tend to be more likely than their major cities counterparts to smoke and drink alcohol in harmful or hazardous quantities. It is also likely that environmental issues such as more physically dangerous occupations and factors associated with driving play a part in elevating accident rates and related injury death in country areas.

Whilst there are positives in terms of lifestyle for people living in rural areas there can be difficulties for young families associated with rural and remote access to support services. Women now have to move out of smaller towns to either regional centres or Canberra to have their baby. This occurs at a stressful transition time for the family [88]. QEII is committed to achieving timely referral pathways for families and professionals residing in areas with limited support services available.

5.9 Partners working away from home

There are a number of occupations which take a parent away from their family for periods of time. Many of these occupations in the ACT are through the military, mining and government service industries and the increase in the fly-in-fly-out (FIFO) worker. There are a number of studies internationally which document the social impact of this, and particularly on the family [90]. A WA

study [91] revealed that the FIFO lifestyle for parents with children under 5 years was the greatest, particularly for the impact on their life and relationship. Another WA study interviewed FIFO families from a strengths based perspective to find out how they managed their parenting and concentrated work schedules. What became apparent as a result of the study was the importance of social supports the importance of negotiating parenting tasks and the ability to keep the emotional presence within the family unit of the parent that was away at work.

5.10 Parents with a disability or a child with a disability

About 1% of Australians have an intellectual disability. For those who are parents, it can be lack of suitable support services, rather than their disability, which make it hard to cope. It is thought that approximately 1-2% of families with children aged between 0-17 years include at least one parent with learning difficulties. People with an intellectual disability can have a lot more difficulty than others in understanding ideas, solving problems, concentrating, remembering and learning new things. Intellectual disability can result from damage to the brain before or after birth, through either genetic causes or by external (environmental) factors.

Parents with a physical disability often experience undue hardship because:

- there is not enough respite or home help and a lack of support services within the community to meet their day-to-day needs;
- people working in the care sector don't understand the needs of disabled parents; and
- family relationships are interrupted when children are removed or cared for by others when their parents are hospitalised, ill or having difficulty.

4% of Australian children aged 0-4 years have a disability including chronic illness, intellectual or physical disability. The percentage is higher in Indigenous communities. Most parents adapt successfully to parenting a child with a disability and see their child as a positive contributor to the family and a source of happiness. Depending on the severity of the disability, the pressure and the sense of isolation that can accompany high levels of care can place a lot of emotional stress on parents, and might affect the parental relationship or the family's ability to cope financially. Because of these stresses, emotional disturbances such as anxiety or depression are more common than usual among parents of children with disabilities.

5.11 Family violence

Over the past thirty years there has been increasing recognition that domestic violence is a significant public issue, and not merely a 'domestic' or a private matter between two individuals. This shift in perception has, in turn, led to an

acknowledgement that the responsibility for addressing domestic violence belongs to the whole community. This includes employers and workplaces [91].

One of the most common forms of violence against women is that perpetrated by a husband or an intimate male partner [97]. Over three quarters (76%) of the violence against women is perpetrated by someone they know, with over one quarter (25%) of women reporting that the violence was perpetrated by a partner.

Partner violence can affect the physical, mental and reproductive health of those who experience it [97]. This impact can go beyond the wellbeing of individuals, affecting families, particular communities or society as a whole. Violence that occurs between partners may also affect children living with them [97]. 60% of women who had experienced partner violence in the last five years had children in their care. Just over two-thirds of these women said that the children had witnessed the violence. There is increasing concern about the impact of domestic violence on children and understanding of the frequent co-existence of domestic violence and child abuse [98, 99].

6.0 CMS' strategic focus and governance

6.1 Vision

Towards Healthy Families [103]

Ija Mulanggari, goodtha Mulanggari

Thriving Mothers, Thriving Babies

Ngunnawal meaning

6.2 Mission

The ACT community knows, values and supports CMS

Expand programs

Maintain and develop existing programs

Strengthen links with government/non-government sectors

6.3 Values

As a major stakeholder in child and family health for the ACT and surrounding region the Canberra Mothercraft Society at the Queen Elizabeth II Family Centre holds values and vision.

In relation to children and families we place a high value on:

- promoting the physical, emotional and psychosocial wellbeing of children and their families and strengthening family resilience;
- enhancing confidence and infant health; and
- achieving effective outcomes.

In relation to service provision we place a high value on providing a safe, caring and supportive environment that:

- respects individual and cultural differences;
- promotes equity, access and empowerment;
- enables staff to achieve the highest professional standards that reflect best practice and research;
- promotes cooperation and collaboration with other service providers; and

- advises government on health needs of families with young children.

6.4 CMS Board

The CMS Board is made up of eleven members[100] - ten members from the community and one honorary medical officer position. The Board consists of:

- the president and four office bearers;
- six ordinary Board members; and
- one Honorary Medical Officer.

6.5 Key result areas

To achieve their mission CMS aims for results in these areas[102]:

- program development;
- community and public relations;
- finance and audit; and
- governance.

6.5.1 Program Development

- service development;
- research; and
- staff development.

6.5.2 Community and Public Relations

- media relations;
- sponsorship; and
- involvement in community and government activities.

6.5.3 Finance and Audit

- short term viability; and
- long term viability.

6.5.4 Governance

- contemporary best practice governance;

- diverse membership base; and
- sound leadership by a skilled board.

6.6 Governance

6.6.1 The legal entity

The Canberra Mothercraft Society Inc. (CMS) is incorporated as an association membership based, not for profit non government organisation. CMS is a registered charity. The Society has a Constitution[100] in which the objects describe the purpose and role of the Society in the provision of primary health care and community development programs to families in the ACT and Greater Southern Region of NSW.

CMS has a Board of management whose powers are to control & manage the affairs of the Society & to govern in the best interest of CMS. The Board is comprised of members of the Society and is representative of the community it serves. The Office Bearers of the Board [100] are the:

President;

Vice-president;

Treasurer; and

Secretary.

In support of the effectiveness of the Board the backgrounds of Board members include expertise in: law; financial management; medicine; early childhood education; nursing; midwifery; health service management; speech pathology; textile art; counselling; parenting; & disability services.

6.6.2 Limitations model of governance

The Boards governance role is characterised by the processes and systems used by the Board to set organisation direction and priorities, identify risks and create policies to manage these, set management performance expectations and monitor achievements against these and to report to these. In 1999, CMS formally adopted a limitations model of governance with Governance Policies [101] that are annually reviewed and establish the criteria for delegations, accountability and performance of the Board and the Director of Nursing & Midwifery/Executive Officer (DON&M/EO). CMS has a DON&M/EO whose role it is to: lead in the operationalising of the strategic directions established by the Board; provide strategic advice and support to the Board; communicate its directions to staff; communicate on behalf of staff to the Board; and to represent the Board and CMS to government and other agencies [101].

The purpose of the governance model is so that the CMS Board can achieve enough control so that it can exercise its duty of care and enough freedom so that the DON&M can achieve the best possible outcomes. The Board add value to the operations of the Society by: helping the DON&M/EO and senior staff to: determine what matters most; bringing the wisdom of the Board members to organisational decision making; think strategically; monitor progress; and challenge assumptions and the value of achievements; and creating and modelling the desired culture. This occurs at Board Meetings, Committee Meetings and weekly meetings between the President and the DON&M/EO. The DON&M/EO is employed by the Board as a body. Aspects of the relationship between the Board and the DON&M/EO are delegated to the President who always acts in accordance with Board policy. The Board has no managerial relationship with the CMS staff, this being the sole preserve of the DON&M/EO.

6.6.3 Setting and monitoring the strategic direction

The Board is responsible for providing strategic leadership and determines CMS's strategic direction by developing the strategic results to be achieved[101]. The Board regularly monitors the achievement of the strategic results at its monthly meetings. CMS has a cyclical strategic planning process in place that is understood by staff and the Board. In the development of the 5 year Strategic Plan CMS is informed by: CMS Constitution; contracts with key stakeholders; ACT Health Strategic Plan; demographic data; feedback from clients; feedback from key stakeholders; service reviews; staff; research; contemporary thinking about practice; evaluation and achievements against the previous strategic plan. The intent of the plan is that identifies goals and priorities that are recognised and have meaning across the organisation and the plan is realistic in relation to available resources and it informs the way resources are allocated. The Strategic Plan is used to inform the Operational Plan.

6.6.4 Board committee structure

The Board has a committee structure [101] to support the work of the Society. The Board uses committees sparingly and only in response to its own job. The Board Committees do not conflict with the Boards delegation to the DON&M/EO. The Board Committees are:

Board

DON&M/EO Compliance Committee;

Finance & Audit Committee;

Community & Public Relations Committee;

Program Development Committee; and

Board Policy Making Committee.

All Committees have Terms of Reference and report to the Board. Key members of staff, including the: DON&M/EO; Clinical Manager; Operations Manager; Counsellor/Community Development Officer; and the Finance Officer, if members, are equal members of the Committees. The DON&M/EO, Finance Officer and Operations Manager also attend the Board meetings.

6.6.5 Compliance

On behalf of the Board the DON&M/EO ensures that CMS complies with all statutory requirements, its Constitution [100] and contractual agreements in relation to financial and performance reporting requirements with funding bodies. CMS is committed to transparency in all of its activities and publishes a comprehensive Annual Report [103], complete with a full copy of the Auditors Report, on its website and hard copy to all members, stakeholders and interested individuals and organizations.

6.6.6 Operationalising the Strategic Plan

Operational assessment, planning, implementation and evaluation are the responsibility of the DON&M/EO [101]. The DON&M/EO, in consultation with staff and the Board during planning sessions, develops biennial Operational Plans in order to achieve the Strategic Plan. Monitoring is evidenced by the monthly reports provided to the Board. Monthly reports are written against the strategic directions and performance outcomes identified in the Strategic Plan:

- program development;
- community and public relations;
- finance and audit; and
- governance

All staff participate in the Professional Development Evaluation Program where the achievements and the future needs of the individual and the organisation are discussed and an individual development plan made. Operational Policies are developed and regularly reviewed to inform and support staff. Policies [104, 105] reflect compliance with relevant legislation. To achieve the strategic directions the style of management is adaptive to meet the individual staff needs, the ever changing health care environment and the dynamic needs of CMS. The organisation has well prepared and well qualified leaders:

- DON&M/EO;
- Clinical Manager;
- Operations Manager;
- Counselor/Community Development Officer; &
- Educator.

All staff members qualifications are published in the Annual Report[103]. The organisational structure and position descriptions devolve responsibility and

authority. Staffing levels are continually monitored and remain adequate to meets the needs of both clients and staff. All staff are supported with study leave and financial support to obtain appropriate qualifications and continuing professional development to suit this scope of practice.

Staff are encouraged and supported to be active participants as the organisation evolves to meet contemporary needs of our clients. Clinical staff have also been supported to develop coding skills and analyse that data for service improvements.

6.6.7 Financial management

CMS has a budget that reflects the priorities of the Strategic Plan and financial performance is closely monitored and analysed at monthly Board meetings where the Board is provided with detailed financial reports with an analysis of key trends and issues. Budgets are developed for specific programs or projects. In its Strategic Planning CMS considers long term financial viability and sources of income. All long term liabilities are fully covered by contractual arrangements and in reserves. The DON&M/EO works within clear financial delegations and authority. The organisation utilises accrual accounting system and the annual audit[103] reflects that financial management systems meet accepted accounting standards. Members of the Finance & Audit Committee undertake internal controls and checks and this is reported to the Board. The entity is a going concern.

7.0 Scope of care and linkages

7.1 An integrated approach

Services need to be effective and efficient and aimed at improving outcomes for the whole population, as well as addressing those most in need. An important consideration is to ensure that children and families have timely access to the types of services they need.

Universal approaches aim to target the whole population of births in ACT. Research[33] from Canada describes services being available and accessible to all children. The research validates a population approach because the vast majority of children up to age 6 that are considered at risk of not reaching their full potential fall in two-parent, middle-income families. Programs need to focus on all children, not just those in poverty or with special needs. The report emphasizes that programs must incorporate early identification of problems and has the capacity to adapt the setting to meet the individual needs of the child. This requires specialized expertise and resources and good links with specialized services and the health care system.

Providing a universal service for child health and wellbeing means that an early coordinated response can occur for those children with risk factors and those referrals and interventions can be commenced prior to entering the school system. Offering universal programs to all families is essential so that families who are vulnerable or at risk are not stigmatized. Preventative strategies at the earliest stages of life are more likely to be most effective and successful than later stage interventions when family issues have escalated. Studies [106] have shown that investing resources into the early years is both cost effective and can have significant health and wellbeing outcomes into adulthood.

Primary health care services are the first point of contact for families in the ACT and surrounding regions of NSW service systems. QEII is committed to developing key local contact points for families with young children in the ACT and surrounding regional and rural areas. Often services provided locally operate in isolation from each other. QEII seeks to improve interagency collaboration by recognizing that for a coordination infrastructure it requires specific resourcing independent from service delivery. This role includes setting up consultation processes with the community about the changing needs of families with young children, encouraging families to participate in programs to support them in their parenting role and assessing the barriers to service accessibility. A flexible developmental approach is required locally which demands rigour and accountability.

The universal primary and secondary primary health care services are provided by ACT Government Health Directorate Women, Youth & Children Health Program. Through their commitment to primary health care principles and practices and an experience for clients of seamless services ACT Government Health Directorate and CMS have since 1997, provided an integrated Primary Health Care Service. QE II is the tertiary Primary Health Care service in the ACT and is integrated with the WY&CP in the provision of

those services. This creates for the client continuity of care and a single entry point for referral providers such as GP's, mental health, community allied health and child protection, alcohol and drug services, maternity hospitals and a range of non government organisation or referral providers.

The tertiary primary health care service at QEII is specifically targeted at early intervention provided for complex health and behavioural issues that cannot be resolved by community based services and parents with increased vulnerability. This service is able to be targeted because there is a universal system already in place which acts as a springboard by which at risk and vulnerable individuals and families are identified as requiring targeted services.

A number of collaborative strategies, entrenched in the CMS Agreement with ACT Government Health Directorate, and partnerships exist to assist work with the primary and secondary care systems. The ACT primary health care services of the WY&CH Program and CMS provide direct community and residential services to children and families with challenges and conditions that are mild or moderate or chronic, complex and severe. An integrated approach has the capacity to respond to emerging problems and conditions, rather than waiting until problems become so entrenched and severe that they require attention in the acute care sector [107].

Particular efforts need to be made to develop ways of engaging and retaining contact with the most marginalized and vulnerable families, and making all aspects of the service system more equitable and inclusive [108, 109, 110]. Through the single client intake system offered by ACT Health QE II clients move from one contact point to the next without repeated registration procedures. This seamlessness is enabled by an inter-disciplinary service focus where the client's needs are assessed in totality and holistically. There are waiting periods for QE II services, and a triaging system is in place to ensure timely access according to clients needs.

Integration for QEII has four essential components:

1. professional staff from QE II and the WY&CHP are enabled and encouraged to work together in an integrated way built around the needs of children and families;

2. within QEII there are common processes which are designed to create and underpin joint working';

3. a framework exists which brings together ACT Health WY&CHP and CMS, supported by the pooling of resources as appropriate, and ensures key priorities are identified and addressed; and

4. a strong interagency governance arrangement, in which shared ownership is coupled with clear accountability [111].

7.2 Partnerships

Community and intersectoral partnerships, are seen to be an effective way for a range of stakeholders in any given community, to come together and work towards achieving common goals, using the strategies that are most appropriate to their local contexts. A strong motivating factor for adopting a partnerships approach for the delivery of services is recognized because the environment in which we live is a challenging and rapidly changing one, and this is creating a need for new ways to engage and families with their transitions through life, learning and work roles. It also found that delivering this support requires a co-ordinated response, which is able to address the unique needs of families, in the specific settings and circumstances in which they live.

Another driving force in developing strong effective partnerships is the financial reality of funding resource restraints. When looking at partnership approaches there are some key messages:

- all stakeholders in the community are responsible for working in partnership to support young families to make decisions about their futures, and in their specific life transition;
- local solutions to local problems are effective because they can be designed to suit the local context. Local ownership of initiatives also encourages participation and commitment;
- partnerships work best if they have clearly stated, shared and agreed goals, strategies, outcomes and accountability requirements, with all stakeholders working together to achieve common objectives;
- bringing about change at the local level requires flexible guidelines in government-funded initiatives, with the provision of assistance, support and ideas for those communities that need it; and
- effective partnerships include families and children in decision-making processes [112].

Working with other sectors to improve health and wellbeing is not always straightforward; it can be complex, difficult and takes time. Strategies must be guided by strong leadership and supported by varied collaborative efforts across all relevant sectors in order for progress to be made[113]. Planning time is needed for new partnerships to develop relationships with services/organisations that will enhance sustainability. Collaboration will guarantee the establishment of priorities and also ensure diverse and innovative approaches. A structured approach with adequate management support is needed.

Stehlick [114] considers the mutual benefits of partnering with industry. In the development of partnerships that build social capital, the activities themselves become part of the process of trust building. The industry's investment in this

proves is then viewed as a positive commitment by the community, which in turn leads to potential social capital growth, both within the community and with the industry partner. CMS' clinical and community development services work in partnership with a diverse range of health, social service and educational agencies.

8.0 Organisation of Services

8.1 Program areas

Program areas are clustered into two service program areas and one for operational services and one for people development:

QE II Family Centre Residential;

Community Development;

Corporate Services; and

People Development.

Each program area delivers a specific service or services and manages the different projects QEII has received from different funding sources. As program areas expand and additional projects are added, there is flexibility to adapt the programs areas based on best fit and workload of the area manager.

Program sustainability is an important consideration at the beginning of any new project. Some programs may not be designed to continue past the funding time limit. Best practice is to fund new initiatives into existing service budgets with recurrent funding. This practice supports the sustainability of the initiative and associated activities. However, many factors, such as the extent of community involvement, training, health providers and community member, implementing the new program as a health service activity and not as a vertical program, change management strategies and evaluation processes contribute to sustainability. Evaluation focus' on the effectiveness of interventions for individuals and families and of the community development strategies; the service's processes be monitored and the quality audited against agreed standards; client satisfaction; and short-term outcome measures.

8.1.1 QE II Family Centre clinical programs

CMS offers clinical residential primary health care programs provided from QE II, a public hospital, located in Curtin, Canberra. All families, who meet the admission criteria as identified in the service Agreement[115] with ACT Health, with children up to 3 years of age are welcome at QEII. Clients admitted to the Centre must have already accessed primary or secondary primary health care services or other relevant social services and the issue remained unresolved before being admitted to QE II. The scope of care articulated in the CMS contract with ACT Health includes the provision of tertiary level Primary Health Care for clients experiencing one or more of the following:

- complex lactation and other feeding problems;
- failure to thrive;
- unsettled baby;

- mood disorders;
- child at risk;
- special needs families;
- parenting support; and
- behavioural problems.

The QE II Family Centre is integrated into the ACT Government primary health program – the Women, Youth & Children Health Program [115]. As an integrated service the single Community Health Intake system is utilised for all referrals to QE II and from QE II for continuing community based care. This creates for clients from the ACT a seamless service and for other clients a single point of entry into ACT primary health services. CMS is committed to this model of integrated services that stay focused on the needs of clients.

8.1.2 Community development

Community development is the process of increasing the capacity of a community, strengthening and developing towards its full potential through identifying their own solutions to their own needs and priorities. It involves the principles of collaborative, collective action, participation, empowerment, equity and social justice. As facilitators, CMS through its community development programs works in partnership with local people, communities and organisations to meet identified needs [116]. CMS' purpose in community development is holistic people centered development.

Parenting skills are a major tool people use in meeting the needs of their children CMS' approach to community development is based upon identifying people's strengths and enhancing their capacity to parent effectively [117]. Thus, parenting projects are foundational development projects wherever CMS partners with communities and other agencies [118]. Responding to the specific needs of a community results in capacity building projects such as health promotion, strengthening relationships at the individual, family, community and intersectoral levels.

The process in community development is crucial to the project outcome. We seek to follow an ecological and incremental process through which individuals, families and communities gain power, insight and resources to make decisions and take action regarding their well being as they work together toward a common goal. In that process we have formulated ten key principles:

- start where the people are;
- build relationships, then introduce new ideas, showing how they may meet identified needs;
- keep projects simple;

- involve as many community people as possible in all activities from the start – consult and collaborative ;
- run programs as close as possible to peoples homes, and;
- run programs in ways acceptable to the participants – act locally;
- develop staff to educated others train trainers who can train others;
- work in partnership/s wherever possible;
- cooperate with government and other non government agencies – think globally; and
- encourage interdependent relationships from an individual to public policy level.

8.1.3 Corporate services

Corporate services provides function to the Organisation in the five key areas of:

- business development;
- finance;
- human resources;
- quality improvement and data management; and
- administrative support for service delivery (operations).

In the delivery of our corporate services CMS is particularly mindful of the profile and specific needs of our workforce [119]. As the complexion of the workforce changes we must learn more about each other so that a receptive work culture is maintained. The rapidity of change is another crucial force which we recognise. We are committed to understanding, accommodating and using change through continuous quality improvement principles and practices in order to improve corporate services [120].

8.1.4 Organisational development

CMS is committed to an appropriately qualified and competent workforce that demonstrate the traits of a learning organisation [121]. It is important that QEII staff acquire the knowledge, skill and attitude [122] required to address the complex, extensive range and ever-changing needs of clients/communities.

The provision of effective orientation, support and supervision for new staff to assist the transition from the familiar to a new or changing work environment will be provided to ensure quality services. QEII staff induction program provides a framework to ensure every new staff member becomes a fully

integrated and effective member of our organisation. Opportunities for continuing professional development will be continually explored and provided that meet the individual development needs of staff and those of the organisation in order that we meet our contractual service requirements and Strategic Plan.

9.0 Administration and operations management

9.1 Senior management team

The Director of Nursing & Midwifery/Executive Officer, together with Operations Manger, Clinical Nursing & Midwifery Manager, Operations Manager; Community Development Officer and Staff Development Officer are responsible for: implementing CMS' Strategic Plan by developing and achieving the Business and Risk Management Plans; and formulating and monitoring the budget.

The team, led the Director of Nursing & Midwifery/Executive Officer, ensure:

- effective management with focused leadership and commitment for supporting QEII activities particularly through: advocacy for the importance of the work, the strategies used, the resource needs and workforce issues; facilitation of partnership building; and sharing decision-making with key stakeholders and the needs identified within communities; and
- they are able to: manage workers of all disciplines; manage material and financial resources; participate in health service management and planning; develop operational plans; develop and maintain partnerships; and organise services to meet client/community needs.

The quality of work-life and subsequent attraction and retention of staff is affected by workforce management practices. Realistic workloads, appropriate staffing levels and supportive management are crucial elements of successful service delivery.

9.2 Services, systems, partners and sustainability

The service and development program have been designed to provide an overarching function for QEII, guiding the senior management team to facilitate:

- a single service delivery model across services;
- consistency of practice;
- planning/coordination of services from initiation of projects to completion and integration;
- quality services;
- practice support and education individuals and teams;
- evidence-based approaches to service development and practice; and
- strong external links and partnerships.

In relation to our services, systems, partners and sustainability we are committed to:

- effective coordination with clear role definitions are developed between paid employees and volunteers. Volunteers are provided with training and supervision;
- multi-disciplinary teams that work with an interdisciplinary approach;
- formal partnerships and agreements will be developed within the system of service provision and communities so that collectively, they can address the issues in the community;
- policy and policy development, planning, information requirements, research (qualitative and quantitative), service support will support the implementation and infrastructure required by services;
- changing service patterns that require new initiatives and specified outputs will be built from existing service;
- change management strategies will be implemented to ensure organisational actual change occurs; and
- continuous quality improvement and risk management practices will be inherent within all of our systems and services.

10. Research and practice development

Research can and does play an important role in services and decision-making at QEII. The trend toward greater research use has been attributed to: pressure for evidence concerning 'what works'; the need to justify funding for the implementation and continuation of programs and initiatives; and the need to make informed decisions to safeguard the safety of children where there is the potential for harm [123].

A number of factors which may inhibit the use of research by practitioners in the social services, such as: limited access to research; an organisational or workplace environment that does not encourage continued learning and personal or individual factors, including one's own values, beliefs and assumptions, and a lack of individual motivation. Barriers to research use appeared to relate to workload and workplace issues. Most respondents stressed the importance of reading and research as being legitimate forms of professional development. They also emphasised the need for management and colleagues to be supportive of research use, in order for their workplace to be conducive to accessing and applying research.

QEII is committed to exploring ways to contribute to bridging the research and policy/practice gap and finding ways to encourage practitioners to be involved in research activities. Planning will be done in partnership with key university faculties to increase the capacity of interdisciplinary research in early parenting and early childhood.

11.0 Continuous improvement

CMS is committed to continuous improvement in service delivery and management practices. Our approach to quality improvement is:

- based upon the participation of the Board and staff;
- aimed at long term success through client and staff satisfaction; and
- benefits both society and the organisation.

Programs and processes are constantly evaluated and improved in the light of their efficiency, effectiveness and flexibility. It is important for CMS to consider and determine whether or not the services being offered are actually achieving better outcomes for children and their families. It is essential to have a clear understanding at all levels of the organisation on the outcomes that are to be achieved.

Informed by The National Safety and Quality Health Service Standards (NSQHS)[126] and using the Quality Improvement Council *Plan, Do, Check, Act* cycle feedback from clients, staff and systems are evaluated against organisational goals and evidence based practice. The purpose of the cycle is the identification, reduction and elimination of suboptimal practices and process through the use of reflection and the implementation of best practice through continuous evolution of our systems and practices. The emphasis of our evolutionary approach is on incremental and continuous steps.

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Canberra Mothercraft
Queen Elizabeth II Family Centre
Society Inc

Attachment B

Estimated Transition Out at 30 June 2019 Budget

Category	Item	All staff redundant	Continuing Employment clinical and Front Line	Variance
Staff Payouts	Severance	1,230,000	313,163	+ or - 20%
	Long service leave	661,000	450,000	+ or - 20%
	Annual leave	362,000	362,000	+ or - 20%
	Accrued personal leave		264,150	+ or – 20%
Staffing – Transition Out	Staff 3 FTE equivalent for 5 months	210,000	89,000	+ or - 20%
	Project Officer - .5 FTE for 17 months	210,000	89,000	+ or - 20%
	Contractors – accountancy	50,000	50,000	+ or - 20%
Contracts	Eziway Contract	6,563	6,563	+ or - 20%
	Suez Contract	7,114	7,114	+ or - 20%
Advertising	Newspapers	2,000	2,000	+ or - 20%
Legal	Fees	100,000	100,000	+ or - 20%
Removalist	Fees & disposal	100,000	100,000	+ or - 20%
	Tip Fees	2,000	2,000	
Insurance	Runoff	60,000	60,000	+ or - 20%
	Business including Public Liability	3,000	3,000	+ or - 20%
Records - Clinical	Electronic retention, retrieval and destruction	105,994	105,994	+ or - 20%
Records - Finance	Electronic retention, retrieval and destruction	5,000	5,000	+ or - 20%
Records - Admin	Electronic retention, retrieval and destruction	5,000	5,000	+ or - 20%
Records - Employee	Electronic retention, retrieval and destruction	5,000	5,000	+ or - 20%
Office +	Space for 5 months	17,500	17,500	+ or - 20%
Software	Attache HRM Software	1,960	1,960	+ or - 20%
	Scanning Software	300	300	
	Office Software	200	200	+ or - 20%
Office Fitout	• Table • Desk and Chair x 3 • Filing Cabinets • Shelving • Mobile phones x 3 • Laptops x 3 • Printer x 1 • Multifunction Printer Scanner	7,500	7,500	+ or - 20%
	Office Consumables	500	500	+ or - 20%
	Post Box	65	65	+ or - 20%
	IT Support	500	500	+ or - 20%
	Computer Security	170	170	+ or - 20%
	Internet Fee – 5 months	500	500	+ or - 20%
	Telephone Pay as you go x 3	240	240	+ or - 20%
Banking	Fees	250	250	+ or - 20%
Total		**3,154,356**	**2,048,669**	+ or - 20%

CANBERRA MOTHERCRAFT
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Mr Michael De'ath
Interim Director General
ACT Health
GPO Box 825
CANBERRA ACT 2601

Dear Mr De'Ath

ACT Health Canberra Mothercraft Society Agreement

I refer to your letter dated 25 July 2018 and **attach** the following information requested in that letter:

- Financial, staffing and service information
- Queen Elizabeth II Family Centre Service Delivery Model
- Estimate transition out budget

I will provide the end of year financial statement and staff leave liabilities for 2018 after the end of year adjustments have been completed as the calculations for accrued leave liabilities as at 31 July can only be finalised after the end of the pay period on 5 August 2018. The QEII accountant has also been in communication with the CMS auditors in an effort to bring the audit forward.

In your letter dated 31 July 2018 you ask for CMS to clarify whether it intends to continue negotiations in good faith over the next month based on statements made by Ashurst in relation to CMS preparing to cease delivery of the services to address the risk of not being able to agree a Funding Agreement before 31 August 2018.

CMS' intention has always been, and will continue to be, to negotiate in good faith. Whilst it may appear to current negotiators from ACT Health that these negotiations have been for a short period only, for CMS negotiations have been protracted (continuing for over two years) and expensive. From CMS' perspective negotiations have been compounded by new complexities being introduced by ACT Health at each meeting, as well as ACT Health stepping back from previously agreed positions. Accordingly, CMS is seeking to finalise the terms of the new Agreement before 31 August 2018 to ensure negotiations do not continue to incur cost and time, with no resolution. Clearly, in light of the protracted negotiations to date, CMS must be in a position to cease delivery of the Services if it concludes that, after more than two years of negotiation, agreement is not possible.

CMS will continue to seek a meeting with the Minister. However, in light of your comments concerning her availability, CMS agrees to continue negotiations with ACT Health. To this end, could you please provide:

- ACT Health's response to CMS' negotiation positions as soon as you have reviewed the attached information; and
- a proposed negotiation timetable.

Yours sincerely

[redacted]

2 August 2018

Attachment C

1.0 Financial information

Agreement Schedule 3 Item 2 (2) (a) & (b)

The organisation will provide the Territory with:

(2) financial report by 30 November in each year of the Agreement period and by 30 November of the first year after the end of the Agreement period, comprising:

(a) A cash/financial statement as at the end of the Agreement period providing full details of expenditure of the funding amount; and

(b) A disaggregated audit report, prepared pursuant to section 74 of the Associations Incorporations Act 1991 (ACT)*, which audit report will include an opinion as to whether the Funding Amount has been expended in the manner required by this Agreement and be accompanied by a certification from the person preparing the report, that the report has been prepared in compliance with section 74 of the* Associations Incorporations Act 1991 (ACT) *and which specifies the relevant section of the Act.*

1.1 Profit and loss statement 2017/2018

1.1.1 CMS as an entity

Unrelated CMS activities do not form part of the Services under the Agreement. There is no provision in the Agreement that calls for CMS to subsidise the Service neither has the expectation been raised in previous Agreement negotiations.

CMS makes the full auditors report on CMS and QEII activities publicly available on its web site after the Annual General Meeting. CMS provides a full copy of the auditor's report to the Australian Charities and Not for Profit Commission. CMS will provide a disaggregated audit report to ACT Health after the CMS Annual General Meeting in November.

1.1.2 QEII Family Centre

End of year adjustments are in progress. Unaudited cash/financial statements as at the end of the Agreement period for 2017-2018 will be available to ACT Health by 20 August 2018. providing full details of expenditure of the funding amount, will be provided when the audit is complete and released by the Board (Schedule 3 Item 2 (2) (a)). In light of current negotiations, CMS is negotiating with the auditor to bring the audit forward to ensure the timely provision of accurate and audited information to the Territory. It is anticipated that unaudited statements for 2017 – 2018.

The auditor was appraised of the protracted negotiations with ACT Health in 2017 as an unusual event that was highly abnormal in relation to the typical operating activities. Audited reports were prepared on the basis that issues related to funding were reasonably expected to be resolved. The current status of Agreement negotiations will be reported to the auditor for inclusion in the 2017–2018 report.

Agreement negotiations for the 2016 – 2019 Agreement by CMS were based on the assumption that the Territory understood and valued the Services that is described in and provided by CMS under the Agreement. Through current negotiations, CMS reasonably expected that the funding amount for the provision of the Services would be adequate for CMS to provide a responsive, accessible, acceptable and quality service, as well as acknowledge the Territory initiated change in the operating environment and would cover the costs of the agreed Services provided by CMS on behalf of the Territory (Agreement Schedule 2; Schedule 3; Schedule 4; Schedule 5; & 7 Schedule 6).

1.2 Breakdown of cost structure for patients admitted to QEII

	Cost structure	2017-2018* $	2016-2017 $
Day patients~	Nil	0	0
Overnight patients	ACT Govt funding	3,467,100	3,467,100
	Private health insurance	*695,294*	822,045
	Non eligible Service User	*6007*	0
	Reports		64,000
	Accommodation fees	TBA	63,326
	Other		34,856
Other consultations	Nil	0	0
TOTAL			**4,451,327**

~ No day patients are admitted as per Agreement Schedule 2 Item 1 (2) (a) & Schedule 6 Item 11

* 2017-2018 data, apart from Act Government funding will be finalised when end of year adjustments are finalised

*1.3 Information on costs claimed**

	2018* $	2017 $	2016 $
Private patient			
Per patient (average)	*1,366*	1,374	1,371
Whole of revenue	*695,294*	822,045	814,206
Medicare			
Per patient (average)	Nil	Nil	Nil
Whole of revenue	Nil	Nil	Nil
Fee for service	Nil	Nil	Nil
Diplomatic corps	6,007	Nil	Nil
Foreign nationals	Nil	Nil	Nil
Other	Nil	Nil	Nil

* Figures for 2017–2018 are estimates only until end of year adjustments are finalised

1.4 Schedule of fees 2017-2018

Category	Fee
Borders – bed & breakfast 1 person 2 persons	 $35 per night $45 per night
Breast – supply line	$7.00
Consumer provision health record <50 pages Per page thereafter	$41.70 $0.35
Consumer – view health record	$15.20
Consumer - view and have health record explained	$41.70
Health record provided to insurer	$209.00
Health record provided to patients solicitor	$209.00
Hospital accommodation Single room (not at private patients request) Single room (at private patients request)	 $350.00 $609.00
Non eligible patient	$2051.00 per day
Parenting observation & report	$4000
Refugees	No charge
Search fee (other than for continuing treatment)	$57.75
Summary of health record	$86.90

1.5 Cost modelling outlining how ACT Government funding is apportioned across the Service User base

The ACT Government funding is block funding and is combined with revenue from all other sources gained in the provision of services at QEII. ACT Government funding and other funding is applied to the entire Service User base.

Using the public other sources of revenue split of 72:28 for 2017, the breakdown of funding source for accumulated provisions of $1,762,515 at 30 June 2017 is:

- ACT Government revenue $1,269,011
- Other revenue $493,504

Revenue from other sources meant that CMS did not call on supplementation under the Agreement in 2017 (Schedule 4 Item 1, 1.2 (1) (2) (3)).

2.0 Service model and patient breakdown

Service model

Agreement Schedule 2 Item 1 (2) (a)

Provide primary health care residential services (Service) to families of young children experiencing health and behavioural difficulties in the post natal and early childhood period. These Services will be delivered from the Queen Elizabeth II Family Centre.

Agreement Schedule 2 Item 3

The service will be managed in such a way as to provide an integrated approach to Service User care through cooperative and collaborative policies, procedures and communications with the Division of Women, Youth and Children, Health Directorate and other service providers and agencies.

Note: the Service will be linked to the single point of entry/intake for the Division of Women, Youth and Children's Community Health Programs. Service Users will be referred to the service through the single point of entry/intake.

Agreement Schedule 6 Item 11

The following admission criteria relate to a number of issues and problems which, in many circumstances can be managed by secondary level services. The prime factors which differentiate between secondary and tertiary level support relate to the complexity and severity of the problem, the frequency of the interventions, and the extent to which that support needs to be intensive and continuous. An assessment must be made that an admission to the residential services is the most appropriate for the client/s and that community based care is not adequate or appropriate for the effective management of the difficulties being experienced.

(1) Complex lactation and other feeding problems

(a) requiring support for mother and baby on a feed-by-feed basis over a 24-hour period or longer to ensure that lactation or a suitable feeding regime is established and/or continued.

(2) Failure to thrive

(a) following lack of success in ensuring that adequate caloric intake is being achieved and that further and closer observations, interventions and investigations are required

(3) Unsettled baby

(a) following lack of success of the interventions of secondary level service providers and where closer observation and investigation, and more intensive therapy and/or trialling of a range of strategies is warranted;

(b) for support for parent/s and family who have become very stressed by this experience; and

(c) when the parent/s require more intensive support and education about parenting skills.

(4) Mood Disorders

(a) for women experiencing Mood Disorders such that normal coping mechanisms have been assessed as being compromised and more intensive support and counselling is needed in order to regain strength and confidence in parenting abilities;

(b) for women and partners when the problem is severely affecting the family dynamics and functioning and where both partners need support and counselling; and

(c) when the care of the baby is of concern.

Note: *Women experiencing a severe psychosis or other acute and serious mental illness should be cared for in an appropriate psychiatric unit. The tertiary service is appropriate for the admission of these clients once the acute episode has been treated and where the client/s requires additional close parenting support and/or to aid in establishing or improving the relationship (bonding) between baby and mother/parents, and prior to discharge or transfer back to secondary supports.*

(5) Child at risk

(a) when risk of harm or neglect of baby/child is a concern, and when the provision of intensive parenting support, education and implementation of suitable strategies is assessed as being necessary for the improvement of family functioning and the well-being of the child; and

(b) on request from Child Protection Agencies when further assessment, support and education is needed.

(6) Special need families

(a) Where multiple babies are born or one or both parents have a physical or intellectual disability and require considerable supervision, information and practical support in establishing and maintaining parenting roles and skills.

(7) Primary carer support

(a) When a parent/s requires close and intensive support and encouragement in the acquisition of basic parenting skills, and/or a supportive environment in which to develop and gain confidence in parenting.

(8) Behavioural problems in children/families

(a) When an infant or child to 3 years is exhibiting disruptive and distressing behaviour and the family requires intensive assessment in determining, and support in implementing strategies aimed at managing this behaviour; and

(b) For families with infants or young children, where one or more members are displaying abnormal behaviour which is having a detrimental effect on the other family members, and where a planned and intensive program to modify such behaviour and/or improve family dynamics will be beneficial.

In response to the Agreement provision for a primary health care model the *QEII Model of Care* has been developed, implemented and undergone evaluation at each renewal period (Attachment A).

Patient breakdown

2.1 How patients are identified as either private or public patients

Until the 2013 Agreement, as part of the base funding, QEII was expected to make net savings to the Territory with revenue raised from 250 private Service Users per annum. This provision was removed in the 2013-2016 Agreement. CMS have advised at each Agreement Management meeting with ACT Health that the percentage of net savings against the total grant was decreasing.

On admission, Service Users are offered the opportunity to use their private health insurance and advised that any gaps will be waived. All eligible Service Users and refugees who either choose not to use their private health insurance or who are not privately insured are admitted as public patients.

Public/private mix

Year	Public patients	Private patients	Public/Private split
*2017-2018**	*1527*	*509*	*75:25*
2016-2017	1427	593	70:30
2015-2016~	1223	573	68:32

~ In November 2015 QEII capacity increased from 20 to 26 Service Users.

*Estimate only and cannot be finalised until end of year adjustments have been made.

The net savings in private revenue (potential cost to the Territory if all eligible Service Users were public patients and no other revenue gained) has steadily declined from its peak in 2011 (equivalent to 40% of the ACT Government funding) to its anticipated 2018 level of equivalent to 25% of the ACT Government funding amount. ACT Health has been repeatedly advised that the increase in Government funding is not keeping pace with the decrease in net savings in private health insurance revenue and subsequent increase in public patients. The capacity of the organisation to absorb the gap is not sustainable.

2.2 Programs operated from QEII

Programs operated at QEII utilising ACT Government funds.

Agreement Schedule 2 Item 1 (2) (a)

*Provide primary health care **residential services** (Service) to families of young children experiencing health and behavioural difficulties in the postnatal and early childhood period. These Services will be delivered from the Queen Elizabeth II Family Centre.*

Agreement Schedule 6 Item 11

"..... An assessment must be made that an admission to the residential services is the most appropriate for the client/s and that community based care is not adequate or appropriate for the effective management of the difficulties being experienced."

Programs	Number	Hours of operation	Clinical staff:client ratio for each program
Day programs*	Nil	Nil	Nil
Overnight programs	1	24 hours per day 7 days per week (Schedule 2 Item 4 (3) (a))	Morning 4:26 Evening 4:26 Night 3:26 Supporting staff: • Clinical manager 1.2 FTE • Medical officer 0.65 FTE • Client counsellor 0.5 FTE • Clinical development nurse 0.2 FTE • Staff development officer 0.7
Other service types	Nil	Nil	Nil

*No day programs have been provided since 1997under Agreement Schedule 2 Item 1 (2) (a) & Schedule 6 Item 11

2.3 Breakdown of number of patients admitted

Length of stay	2017-2018	2016-2017
Day treatment only	Nil	Nil
Overnight (single night)	Nil	Nil
Overnight (two nights)	Nil	Nil
Overnight (three nights)	Nil	Nil
Overnight (greater than three nights)	2036 (100%)	2020 (100%)

2.4 Breakdown of whole of organisation staffing levels

Permanent staff complement

Category	FTE
GSO Grade 2 Year 5	4.1
ASO Grade 2 Year 5	0.2
ASO Grade 3 Year 4	2.4
ASO Grade 4 Year	0.7
ASO Grade 5 Year 5	0.2
ASO Grade 5 Year 2	1.2
SOG B	1.0
Clinical Coder Year	0.5
EN L1 Y5	2.5
RN/RM L1 Year 1 Year 2 Year 3 Year 4 Year 5 Year 6 Year 7 Year 8	 1.8 1.0 O.7 1.3 1.0 1.0 0.6 1.8
RN/RM L2 Year 1 Year 2 Year 3 Year 4	 0 2.2 0 7.7
RN/RM L3.1 Y3	0.7
RN/RM L 3.2	0.5
RN/RM Level 4 Grade 2	1.2
RN/RM Level 5 Grade 6	1.2

Contracted staff

Category	FTE
Accountant	0.3
Career Medical Officer 2	0.65
Professional Officer C Y2	0.6

2.5 Wait list

As at 31 July 2018

Days waiting for admission	Number clients day program*	Number of clients overnight program	Days waiting for admission	Number of clients day program*	Number of clients overnight program
1	0	6	17	0	6
2	0	4	18	0	4
3	0	6	19	0	4
4	0	2	20	0	4
5	0	4	21	0	4
6	0	4	22	0	4
7	0	4	23	0	4
8	0	4	24	0	4
9	0	6	25	0	4
10	0	4	26	0	4
11	0	6	27	0	4
12	0	4	28	0	4
13	0	6	29	0	4
14	0	4	30	0	2
15	0	4	31	0	0
16	0	4	32	0	4
TOTAL				**0**	**132**

*No day programs have been provided since 1997 as per Agreement Schedule 2 Item 1 (2) (a) & Schedule 6 Item 11

2.6 Users from vulnerable groups

At QEII it is recognised that interventions to support the physical and cognitive development of vulnerable young children during the early years of life are critical to improving their educational, social and economic outcomes in the longer term. The early years of life – especially the first three years – are now recognised as having a critical influence on a child's long-term health and development.

As major physical and brain development takes place before the age of three, the early childhood years can be either a window of opportunity (for enriching human development) or a window of vulnerability, where social stressors such as poverty or family dysfunction contribute to developmental delay. The provision of support to all children and their families, and especially vulnerable children and their families, during the first years of life is increasingly recognised as crucial to increasing parental competence and reducing the social and environmental risks to vulnerable children's development.

At QEII we recognise that the risk factors most commonly associated with the occurrence of child abuse and neglect include but are not limited to: domestic violence; parental substance use and abuse; parental mental health problems; prematurity; and parental disability (physical/intellectual). These issues often occur within a wider context of economic and social disadvantage and become part of a complex inter-related group of problems. At QEII Service Users from vulnerable groups are prioritised (CMS Service Delivery Model 4.1). Some families undergo an extensive parenting observation and families may be offered a series of subsequent admissions at the child's developmental milestones until the age of three.

Vulnerability category	Clinical codes	Number
Acculturation difficulty	Z60.3	5
ATSI descent		61
Child at risk	Z61.1; Z61.8; Z61.9; Z61.4; Z61.5; Z62.0; Z62.4; Z62.5; Z62.8; Z65.3; Z65.8; R46.0; T74.1; T74.2;	52
Complex social issues	Z59.6; Z60.1; Z63.2; Z63.4; Z63.5; Z63.79;Z63.9;	92
Domestic violence & relationship issues	Z63.0; Z63.8;	27
Feeding mismanagement & mild, moderate and severe faltering growth	R63.3; E43.0; E44.0; E44.1	130
Parental disability	Z92.8; F81.09	12
Parental mental health issue	Z13.3;Z86.5; F31.9; F32.0; F32.1; F41.2; F41.9; F42.9; F43.1; F43.2; F53.0; F60.31; R45.0; R45.1; R45.4	477
Prematurity issues	O71.88; P07.31; P07.32; P59.0; P92.2; P92.5; P92.8	274
Primary carer born overseas		186
Substance use & abuse	Z72.0; Z86.4; P96.1; Z63.71; Z63.72	23
TOTAL		**1,339**

3.0 Transitional costing and staffing liability

3.1 Transitional costing

See Attachment B

3.2 Staffing liability

See Attachment B

Emerson, Marc (Health)

From: Dal Molin, Vanessa (Health) on behalf of DGACTHealth
Sent: Wednesday, 1 August 2018 4:36 PM
To: [redacted] (Health)
Subject: Correspondence to Canberra Mothercraft Society.pdf [DLM=For-Official-Use-Only]
Attachments: Correspondence to Canberra Mothercraft Society.pdf

Dear [redacted]
Please find attached correspondence from the Interim Director General, ACT Health for your consideration.

Kind regards,
Vanessa

Vanessa Dal Molin | Business Manager
Office of the Director General, ACT Health
Ph: (02) 6207 9532 | M[redacted] **Email:** vanessa.dalmolin@act.gov.au
ealth.act.gov.au

Care ▲ Excellence ▲ Collaboration ▲ Integrity

ACT Government
Health

Office of the Director-General

[redacted]
Canberra Mothercraft Society

Dea[redacted]

ACT Health Funding Offer for the Canberra Mothercraft Society.

I would like to thank you for your letter dated 26 July 2018 and your communication of 31 July 2018 through your legal representatives[redacted]

I would like to start by stating that whilst the negotiations to date have been complex, I understand it is your intention to reach agreement in order to provide certainty for CMS. I can confirm that ACT Health is committed to these negotiations in good faith and that we are continuing work as necessary to ensure they progress in line with our previous discussions.

ACT Health is currently awaiting information from CMS which was discussed at our meeting on 23 July 2018 and set out in my letter of 25 July 2018. This information is required to enable ACT Health to properly assess the request for additional funding in compliance with its legislative obligations.

I consider that the current timeframe proposed by CMS may place unnecessary burdens on your organisation to provide the information requested to support your request for additional funding and continue our negotiations.

I am committed to working with your organisation to reach a robust and effective agreement that provides funding certainty for CMS and delivers services that are valuable, effective and efficient for the Canberra community. However, such agreement must reflect the Territory's compliance with ACT legislation and policy.

I refer to your statement that CMS will not provide a response to my request of 25 July 2018 until one or more members of the Board have met with the Minister for Health and Wellbeing and note that accordingly, the progress of negotiations currently sits entirely with CMS.

I can advise that I have discussed your request with the Minister for Health and Wellbeing, and the Minister has agreed, as a gesture of good faith, to meet with representatives of CMS. I can also advise that as the Interim Director-General Health, I am the delegate for all negotiations and, representatives of ACT Health including myself will be attending this meeting as is considered appropriate by the Territory.

GPO Box 825 Canberra ACT 2601 | Ph: 6205 0823 | Email: DGACTHealth@act.gov.au I www.act.gov.au

The Minister has advised she is unable to meet with CMS prior to 14 August 2018 and that her office will inform ACT Health of potential suitable times following this date. Once this information is received, ACT Health will liaise with CMS to support the meeting taking place.

As there is a delay in meeting with the Minister due to her availability, I invite you again to provide the information requested in my letter of 25 July 2018 to assist in quantifying the claims made by CMS as part of continued progress in the ongoing negotiations.

As a separate issue, while the Territory is committed to continuing its negotiations with CMS, as outlined above, I am perplexed by the statement in the email to the ACT Government Solicitor from Ashurst dated 31 July 2018 that *"CMS will shortly commence its preparations to be in a position to cease delivery of the services at that time. CMS considers that this preparatory action is required to address the risk of not being able to agree an acceptable new services funding agreement with the Territory before 31 August 2018."*

I understand your statement to mean that CMS will not agree to any further extensions of the SFA post 31 August 2018 and that you are formally indicating that if agreement cannot be reached prior to this date that CMS will cease service delivery irrespective of the existing proposal and ongoing negotiations of a four-year funding agreement.

Based on this statement of CMS' position, I seek urgent clarification of whether CMS intends to continue negotiations in good faith over the next month. If not, then I propose that we discuss that directly and that it may be in the best interests of both parties to commence transition planning as soon as possible to ensure appropriate measures are in place to provide certainty for staff and patients of CMS. Please let me know as soon as possible whether I have accurately reflected CMS' position.

If you have further questions regarding this matter, please contact my office on (02) 6205 0823.

Yours sincerely

Michael De'Ath
Interim Director-General
31 July 2018

emailed 28/09/2017.

ACT Government
Health

[redacted]
Queen Elizabeth II Family Centre
129 Carruthers Street
CURTIN ACT 2605

Dea[redacted]

Extension of Service Funding Agreement 2013 – 2016 between ACT Health and Canberra Mothercraft Society (CMS) contract number 2013.21920.450

I refer to the Agreement dated 31 October 2013 between the Australian Capital Territory, represented by ACT Health (the 'Territory') and Canberra Mothercraft Society Incorporated trading as Queen Elizabeth II Family Centre ('Organisation').

During a recent meeting with officers from ACT Health, it was agreed to extend the current Agreement to 30 June 2018 to allow sufficient time to finalise the new Agreement.

Therefore, in accordance with clause 12 of your existing Agreement, the Agreement Period will be extended for a further period of nine (9) months up to and ending 30 June 2018.

An email confirming your acceptance (or otherwise) to vary the existing Agreement for a further period of nine (9) months up to and ending 30 June 2018, is to be forwarded via email to matthew.richter@act.gov.au with a cc to marilynne.read@act.gov.au before 29 September 2017.

Yours sincerely

Mary Wood

Ms Mary Wood
A/g Deputy Director-General
Innovation

September 2017

Read, Marilynne (Health)

From: [redacted](Health)
Sent: Wednesday, 21 June 2017 9:25 PM
To: mathew.richter@act.gov.au
Cc: Read, Marilynne (Health); Jacqueline.larkham@act.gov.au
Subject: RE: Letter of extension

Dear Mathew,

Thank you for your letter confirming the extension to the 2013-2016 ACT Health & Canberra Mothercraft Society Agreement until 30 September. As requested in your letter this email denotes CMS' acceptance of this offer to extend.

Regards,

[redacted]

From: Read, Marilynne (Health)
Sent: Wednesday 21 June 2017 10:48
To: [redacted]ealth)
Subject: Letter of extension

Hell[redacted]

Please find attached a copy of the letter that has been sent to you in today's mail.

Thanks.

Kind regards
Marilynne

Marilynne Read | Senior Policy Officer | Women, Youth and Child Health Policy Unit Phone (02) 6207 4440 | Email Marilynne.Read@act.gov.au Policy and Stakeholder Relations | ACT Health | ACT Government
2-6 Bowes Street Woden | GPO Box 825 CANBERRA ACT 2601 | www.act.gov.au

CANBERRA MOTHERCRAFT
Queen Elizabeth II Family Centre
SOCIETY INC

129 Carruthers Street
Curtin ACT 2605
Email: info@cmsinc.org.au
Tel: (02) 6205 2333

PO Box 126
Curtin ACT 2605
www.cmsinc.org.au
Fax: (02) 6205 2344

Ms M Read
Senior Policy Officer
Stakeholder Relations
Women Youth & Child Health Policy Unit
ACT Health
GPO Box 825
Canberra City ACT 2601

Dear Ms Read, Maylynne

Re: Draft Service Funding Agreement 2016 – 2019

Thank you for meeting with us on 16 May and your email of 19 May with the Draft 2016-2019 Agreement. In response to those specific items you raised:

- Item 4 Schedule 2: updated - noted;
- Item 5 Schedule 2: the correct accreditation provider is Quality Improvement Performance and the relevant standards are National Safety & Quality Health Service Standards – Guide for Small Hospitals;
- Item 3 Schedule 3: NMDS reporting - noted; and
- Item 1 Schedule 4: funding amount to be advised – noted.

On preliminary review of the Draft Agreement there are serious matters that remain outstanding. A comprehensive response will be provided following the CMS Board meeting on 28 June, in the interim and on behalf of CMS I specifically draw your attention to:

- confirmation from ACTH on 16 August 2016 that QEII was exempt from an open tender process until 2022 (Clause 13 and Schedule 6 indicate a handover of the service to ACTH or another provider at the conclusion of this Draft Agreement);
- there is no provision in the Draft Agreement to the specific proposal for continuing employment and/or redundancy arrangements for staff should CMS cease to be the provider of the service (as provided for the ACT's other NGO provider of public hospital services); and
- Schedule 4 Funding Amount: Item 1, 1.2 Supplementation 1-3 from the 2013 – 2016 and previous Agreements is missing from this Schedule 4 in this Draft Agreement and must be replaced.

Under Clause 5.9 (2) of the current Agreement *CMS is obliged to notify the Territory in writing of any other event or circumstances which might reasonably affect the provision of the Services in accordance with this Agreement.* Advising the service will go to open tender the Territory has created an operating environment that might reasonably affect the provision of services. The Territory has placed the service at reasonable risk of not being a preferred employer. The due diligence exercise undertaken by CMS in 2016 confirms this concern - *the greatest risk to the provision of a quality service is the capacity to attract and retain through continuing employment an appropriately qualified workforce.* The Draft Agreement does not ameliorate this risk by providing surety for continuing employment and/or redundancy in line with CMS' proposal in August 2016.

CMS had understood that negotiations had been underway since the annual Agreement meeting in May 2016 and each Agreement extension was under the guise of the new Agreement being finalised. We were concerned at being advised that negotiations are only now 'beginning' and advised at the meeting on 16 May that CMS had agreed in good faith and at short notice on five occasions to extend the 2013 – 2016 Agreement. CMS sought reciprocity from ACTH at the meeting for a further extension until at least mid August in order to allow CMS time to consider and take advice if necessary on any offer made by the Territory. Your email was silent on this matter and I therefore seek confirmation for this extension.

CMS looks forward to a mutually agreeable solution to these issues and would appreciate your earliest response.

Yours sincerely,

[redacted]

23 May 2017

Cc Anthony Butler

ACT Government
Health

[redacted]
Queen Elizabeth II Family Centre
129 Carruthers Street
CURTIN ACT 2605

Dear [redacted]

Extension of Service Funding Agreement 2013 – 2016 between ACT Health and Canberra Mothercraft Society (CMS) contract number 2013.21920.450

I refer to the Agreement dated 31 October 2013 between the Australian Capital Territory, represented by ACT Health (the 'Territory') and Canberra Mothercraft Society Incorporated trading as Queen Elizabeth II Family Centre ('Organisation').

During your meeting with officers from ACT Health, you requested an extension on your current Agreement to 30 September 2017. This is to allow sufficient time for negotiation on the new Agreement following yours and the President's return from leave.

Therefore, in accordance with clause 12 of your existing Agreement, the Agreement Period will be extended for a further period of three (3) months up to and ending 30 September 2017.

An email confirming your acceptance (or otherwise) to vary the existing Agreement for a further period of three (3) months up to and ending 30 September 2017, is to be forwarded via email to matthew.richter@act.gov.au with a cc to marilynne.read@act.gov.au before 28 June 2017.

Yours sincerely

Mr Matthew Richter
A/g Executive Director
Policy and Stakeholder Relations

16 June 2017

ACT Government
Health

E-MAILED
1/8/18 10am

Office of the Director-General

[redacted]
Canberra Mothercraft Society

Dear [redacted]

ACT Health Funding Offer for the Canberra Mothercraft Society.

I would like to thank you for your letter dated 26 July 2018 and your communication of 31 July 2018 through your legal representatives, Ashurst.

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If you have further questions regarding this matter, please contact my office on (02) 6205 0823.

Yours sincerely

Michael De'Ath
Interim Director-General
31 July 2018