

# TRANSCRIPT

## STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

### Inquiry into end-of-life choices

Geelong — 29 July 2015

#### Members

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Mr Daniel Mulino

Ms Nina Springle — Deputy Chair

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#### Witnesses

Ms Julie Jones, Chair, and

Ms Karlie Keck, Coordinator, Community Nursing and Support Program, and

Dr Peter Martin, Regional Director, Bellarine Palliative Care Services; and

Ms Jane Robertson, Community Nurse Manager, Colac Palliative Care Services.

**Necessary corrections to be notified to  
executive officer of committee**

**The CHAIR** — Thank you for being here this afternoon. I would like to welcome back Dr Peter Martin and express our gratitude to him and his colleagues for their hospitality today; Ms Julie Jones, the chair of Barwon South Western Region Palliative Care Consortium; Ms Jane Robertson, the community nurse manager of Colac Palliative Care Services; and Ms Karlie Keck, who is the coordinator community nursing and support program for the Bellarine Palliative Care Services.

Thank you for being here this afternoon. Just before we get underway, I caution that all evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to provisions of the Legislative Council standing orders. Therefore you are protected against any actions for what you say here today, but any comments made outside the hearing are not afforded such privilege. Today's evidence is being recorded. You will be provided with proof versions of the transcript in the next week or so. Transcripts will ultimately be made public and posted on the committee's website. I have allowed 45 minutes for this session, so I would invite you to make an opening statement and the committee will ask questions thereafter. Thanks again for being here this afternoon.

**Dr MARTIN** — I have been volunteered to present on behalf of my colleagues! I am sure they will interject, and I hope you will not get too sick of my accent.

### **Visual presentation.**

**Dr MARTIN** — The first slide is really talking about something we have covered already. I am conscious that some of this may be repetitious for you, but I will just say there is growth in our region, particularly a growth in the ageing demographic, therefore there are increasing demands for all of us, and certainly for particular places like the Bellarine, where the ageing demographic is a real issue.

If you are talking about access to specialist services, we will start with that. There are some issues about recruiting and retention in terms of regional areas as opposed to just in general. Some of the things I wanted to talk about were issues for solo specialists. We can talk about the wider region, and in fact I can compare it with my time in the UK where you are no longer allowed to be a solo specialist, because they recognise there are implications in terms of governance, safety, burnout and a whole bunch of other issues. I think when you look at this wider region, given this is south of the South Australian border as a region — I will just declare this; I know you have representatives here from the Bellarine and Colac, and I know you are seeing some of our colleagues tonight — there are issues about how we work across providing specialist care, when they might be quite professionally isolated. I guess that is one of the issues I wanted to highlight, and my colleagues may wish to chip in for others. We already know in certain areas the demographic of our key team members, obviously that is particularly nursing, and it can represent how we are going to get the next wave of suitably trained people.

One of the things for all of us in terms of the struggle regionally is that we might have some core disciplines of nursing and medicine, but when we look at getting access to allied health, particularly specialist psychology, counselling and bereavement support, there is a variation depending on where you are in this region and on what is available and whether that can be offered in a timely manner. I guess there are some implications again when we are looking at that holistic model of care that there is a variation between what you might get here and what you might get elsewhere. That is a little bit about those holistic goals, and it is not just about symptom control. It is not just about nursing care. It is wider.

In relation to the response to acute discharge, obviously our public hospitals are under enormous pressure. That reflects in people going home probably in a more complex state than certainly 5, 10 or 15 years ago. That has implications for people picking it up. I suspect some of my colleagues will want to say more about that in a second. It is really just to acknowledge that it is all very well to send them out, but it is also about what happens when you try to rapidly respond so that people are not left feeling vulnerable and you do not end up with that terrible sense of people having to come back to the emergency department, because it has not been set up with the right resources. It can often be provided, but it is also about the planning required and how rapidly we can pull it together.

Again there is that issue that occasionally for all of us in the community we get a call. At times now we want everything in now. We become very reactive rather than proactive, so that is these late and complex referrals. I think we talked this morning about late referrals in general. That is equally true for community services — the pressure it puts on our teams for people to be able to rapidly redeploy their whole plan of care.

In relation to the out-of-hours services, there are two large things. Obviously I was listening to my general practice colleagues, and we have the special interest group of which Ric is part. I think the issue for us is the variability. There are some people who provide all the out-of-hours service, but there is a significant proportion who do not. So primary care is there in terms of general practice, but for a large proportion it is a locum service, and that completely changes the dynamic. Increasingly the calls I am getting are that there could be someone here in eight hours or in four hours, but that is not going to fix the problem. What can we do and how do I support my colleagues in the community around that issue?

There is out of hours, and then there is out-of-hours nursing, and there is a variation. At some places you will get a community nurse who can rapidly respond. In other areas there will be no community nursing available, and the only alternative is if we cannot fix it up by remote control, they will have to do attend an emergency department, which is often what nobody wants — the patient, the carer or the health service.

In relation to eHealth, I am talking in very broad terms. Luckily in our region we have got a united kind of approach for specialist palliative care, but how that links with general health care, and how it grows if you can move between the private and the public sector is yet to be seen. I think you have heard a lot about that so I just reinforce the point that I have heard others make. We have talked about the capacity of palliative care beds, but I suspect it would be potentially useful to hear from others what it is like when they are the ones trying to deal with what happens when there is not a bed, and the pressure and the dilemmas that that puts them under as well. I will stop at that point.

In relation to generalist care, I talked about the skills for a generalist feeling they can have the tough conversations. Some of them can, but many do not feel skilled to do that. I talked about the generalist out-of-hours provision — for instance, just up the road here there is a pocket where there is no after-hours care and we have to completely plan differently for that person rather than for somebody 10 or 15 kilometres down the road. ‘There are pockets’, we will say to such and such patient, ‘which means we are not going to be able to rely on after-hours general care.’

In relation to medication management, I heard you asking some questions around this issue of getting access to drugs. We know from the evidence that the single biggest reason people end up in ED that is preventable is having drugs that they need for the common symptoms that arise out of the blue. How we would make that happen in terms of our general practice colleagues and ourselves is overly complex, and so we have this kind of different view, but it is not as easy as it should be and the legislation does not reflect that.

We have had to do some workarounds when people run out of a key medication as to how they get it from one part of the system to another. It is very complicated and a very long policy, and I am not sure that is in anybody’s interests. That is just simply to provide an obvious medication for somebody’s care. We have done a workaround for that regionally, but it might mean a relative driving up to our palliative care unit, picking up a box of drugs and driving them back. I think sometimes the nurses do feel somewhat exposed. I have interpreted that policy, and that is something that would be very well placed to review.

I have mentioned locum GPs. As I said, in-hours care, whilst there is variation, in general, if anything, in the region it is better than from what I can see from my metropolitan colleagues, but out of hours is still hugely variable. As I said, some go above and beyond the call, giving their mobiles or attending, but others say, ‘We need to get a locum in’ and that can be a massive delay. There are also home visits, including residential aged care.

In relation to supports, I talked about respite, particularly for people who are elderly and frail. In fact it is the carers who are typically elderly and frail and maybe their nearest family member maybe 2 or 3 hours away.

In relation to carer education, we have in fact looked to pilot how we can formalise carer education, because the problem is they need to be freed up to attend the education because they are caring. There is an issue of how you get them respites so that they can come and find the information they need to look after their loved ones. Medication management is a particular issue in residential care, whether they are getting the care they need, but then when they need to get a drug, they have to be able to give it to themselves, and if they are frail the person in the residential facility is not legislatively entitled to give them that painkiller which would easily keep them in that facility.

There is this terrible thing of if we just had someone who could give them their as-needed medication they could stay there, but because they are not entitled in terms of the qualifications the whole system falls apart. We might have somebody who needs painkillers once or twice a night. If it works, they can stay where they want to be, but the system does not enable that through some of the issues — for example, if they are a patient care worker they are not medication endorsed, so there are some real issues around that. Some of my colleagues have much more experience in the kind of everyday living that than I do.

In relation to discharge and community services, there is a sense of ‘Okay, we have done what we need to in hospital, but what is that gap now when we start to get them home?’.

Our next acronym is our community palliative care services. How can we extend them to have that extra flex to say they need to go home, but actually have somebody for the first 48 hours, 24 hours a day. At the minute we have some work and workarounds with a local charity we have partnered, and I think you may be meeting them.

**Ms JONES** — Already done.

**Dr MARTIN** — Already done. That has been fantastic, but that is limited by the philanthropy that supports it and those kinds of flexible support packages. I want to come back to one of the things I heard you ask earlier about the aspiration of 10 per cent dying at home versus 70 per cent. I think we can narrow that gap — 70 per cent. I am not sure that we know, but I think we need drivers both of the policy and the funding and other levels that drive us towards it. I do not think that it is the number that is so important. It is the fact that we are driving towards doing better than we are. We do record a preference of place of care and place of death in our services at the minute to try and get a sense of what that looks like. The research is a little bit short on how it changes over time. A lot of people say, ‘I want to die at home’ at the start, but as it starts getting more difficult and there definitely are some issues about feeling secure and what access they have, I think it changes over time and we probably need some more data. But I think no matter what we might find, more people want to be at home than we are managing to deliver at present.

I think we have already talked about some clinical cohorts that are not well served by current models. I heard Chris and Mark talk a little of this earlier today. People with primary brain tumours are going to have extended periods of being very disabled, often at a younger age; Often they are dependent children and are ending up looking at residential aged care. We have tried to look for a workaround where we have targeted one residential service that Barwon Health runs and how we can support that, but even then there is some stressful hoops for them to get through into that system. With the means testing that has come with the aged-care services now that it is even more stressful for the carers to say, ‘I now have to go and get my finances assessed’. It is just at a very stressful time. That is incredibly difficult. So that is one group.

Some of our neurodegenerative patients can again be very disabled. Another thing is that it is not static, so you cannot set up a package that fixes it because it is going to change from one week to the next. I think you heard about the people who are paralysed as a result of damage to their spine. It is the same thing — they are disabled, they often have complex symptoms that can often change over time — but in fact this may go on for many months. As I mentioned to you, our average stay is a couple of weeks. That does not mean we cannot change it a bit, but it would mean that our capacity to respond to emergencies becomes limited.

The private sector links are very variable. Some private sectors invested quite a lot into integrating palliative care. We have done that from the start. In a sense even though there is probably not a lot of incentive to do that, we did that simply because we wanted to provide that and to make sure that discharge planning was good. They welcomed it, but how do you do that as well as our current core business in the public health centres? So I think there is a variation.

And lastly, there is veterans affairs. I think we have got some very complicated situations with one provider being the preferred provider but not actually being palliative care-specific, yet it is the palliative care provider. So there are some very bizarre and complex things. As soon as we have a vet, we think, ‘Oh my goodness, it is going to get complicated’. That to me was clearly not the objective. The objective was to give them, if you like, some extra flexibility to recognise their service. Down here that is very messy indeed. That is probably enough. I think inside Julie’s album there is a bit more obviously.

**Ms JONES** — I might just comment on the feedback there. I do not know if you will get a chance to read it. It is fairly lengthy and wordy, but we have had several reviews over the last 18 months to get a fair amount of consumer feedback. These are just two comments from carers, and I think they just kind of illustrate some of the things that have already come up in terms of themes around having the gap between the hospital and community services. For a carer overnight I think it is a very lonely place at night when you are looking after a loved one who is terminally ill. For this particular carer — I spoke to her on the phone — 18 months after the patient had died it was still very much in the forefront of her mind about the stress and the chaos that she felt inside at the time, which she felt was conveyed to her husband. There was an element of her being a clinician rather than being a wife because she was administrating the medication et cetera. That was trying to keep husband out of pain et cetera. It was not at the forefront that she was actually there to comfort him as a wife. I just thought that was a particularly pertinent kind of quote to have there because, as I say, it has got long-lasting effects and there were a range of issues that came out of that one.

And the second one, again around about that time, was from a carer who was living with someone with an aggressive neurodegenerative disease who was getting to the end of their physical ability to do it. They were not necessarily old and frail, but they had been caring for a loved one with a disability for a long time. They were getting to the point where the carer distress was really, really kicking in, and they felt that there needed to be some more supports. Respite might have helped. It might have been more longer term, but certainly something that would actually help them to, I guess, recharge and be able to continue in that carer role.

**The CHAIR** — Any other comments, ladies, before we proceed to questions?

**Ms KECK** — No, I think we are happy to answer questions.

**The CHAIR** — Dr Martin, if I could just pick up on your point about bereavement support. I would just like to learn more about what exactly that entails, and perhaps where that is lacking at the moment.

**Dr MARTIN** — There have been some standards, which I think have brought more commonality to how we deliver bereavement supports. I think that at least if you make it into a specialist palliative care program, you will get bereavement support and an offer of bereavement support usually over the next 13 to 18 months. The challenge with that is if you are not known to a specialist palliative carer, the variation in what you may or may not be offered is enormous. I do wonder what the burden on our general community is outside of that. I know from speaking to my colleagues in the grief and bereavement world that they are conscious of that as well. That is one issue.

I think the other issue is when you combine grief and bereavement with the likes of mental health and complex social situations, I am not sure the services are as well joined up. We have evolved a psycho-oncology service here where we can look at joining it up a bit better between what might be mental health or psychiatry, and we have very good links with our mental health colleagues, but it is not always joined up. There are some real specialty niches for those people who are grieving who may have chronic mental health issues for instance. So that is what I would say. I am not sure how my regional colleagues would see their access to such services.

**Ms KECK** — Our access is a secondary consult. We do not have those support services in our organisation at Bellarine Community Health, so our access to the psychosocial team and other bereavement-associated teams is limited. That support regionally is not as great as it would be in the Geelong area. Do you reckon, Jane?

**Ms ROBERTSON** — Absolutely. We are in a similar situation. We have limited access, limited support, and if we can link them up, then you have got the problem of the waiting time. They might not get in for weeks sometimes, or if it is an urgent situation, we might have to look at giving them physical support to get down to, say, an area like Barwon.

**Ms KECK** — So transport is also a huge issue in the regional areas in getting the clients into these services. Also, a lot of them are from the lower socio-economic cohort, so just trying to be able to provide them with the finances to actually get them into the appointments is often a challenge as well. We use some things like taxi vouchers, or we have volunteers that would perhaps go and assist them to present to these appointments if they get one in a timely manner.

**Ms JONES** — Even in Barwon Health there are bereavement standards that we have tried to adhere to, and we have had to develop a program which is quite a successful program in terms of volunteers doing some of our

bereavement follow-up. They have a longer term, over 12 months after death, connection to the primary carer, and if there are any complex grief issues, they are the flag to talk to our psychologist, and grief and bereavement counsellor around addressing those. But again, in terms of resources, that is the thing we have had to put in place to be able to maximise what we have got. The volunteers doing it are absolutely fantastic. They get really good training. They get debriefing sessions, and all of that kind of thing. They are very well supported, but that is how we have done it at Barwon.

**Ms PATTEN** — Thank you for the presentations. There were two areas that were of interest particularly. I guess keeping people in their homes for as long as possible is not only the most compassionate thing but economically is probably a better solution. We were hearing earlier from the hospice and MACS, which sound like they doing some really great, innovative work, but they have these limitations, as you touched on, about being able to provide drugs to the patient — that the family will be sitting at the home, the family has access to them, but they have to wake the family member up. Is there a simple solution to that that you are aware of? Is it simply a matter of training them or giving them some sort of certification to be able to administer those substances or is it a whole legislative change?

**Ms JONES** — I am not sure what the official requirements are. I know with MACS they looked into actually being medically endorsed, so even though they are not a qualified nurse, they can actually have some sort of certification to be able to say that they could administer it. There is that element to it. I am not a clinician, so forgive me for this, but the syringe driver and access to longer-term medications that way I guess is part of the solution as well, but I am not sure.

**Dr MARTIN** — I am not sure if my colleagues want to answer before I do — I am really conscious of the limelight.

I think there are three issues. There is the legislative lack of clarity, so I think there is no reason that I can see frankly why it makes sense that a patient care worker should not be giving a medication that a family member can. It seems very odd to me, and it seems odd that we would be putting that sort of pressure on giving the correct medication to the right person. I think that could be made clearer, and would probably enhance patient care.

Then I think the second issue to talk about is that for some carers they are very confident and capable of doing exactly that, but they need time to be educated, and how we do that when they are not providing that caring role is something we need to work on. How do we incentivise the system to allow them to be freed up to be taught how to do it, because I think there is a cohort that would gladly take that on and be able to do it.

As I said, the other issue I think is how we enable those very good workers to be able to do something that I think in general they would be very capable of doing.

**Ms PATTEN** — Yes.

**Ms ROBERTSON** — I would share a similar opinion, as I was going to say. I think it is twofold: is legislative, but it is also as Peter just outlined. It is about empowerment, being a carer and being able to provide support, especially overnight, and we can build up the confidence. It is incredible that they feel like they are being part of that journey, and it is that long-term memory of what they have been able to provide. But I think it is a grey area too, and the guidelines on what they can do and what they cannot do. If we are not 100 per cent clear, then again we have to also be mindful of health registrations.

**Ms KECK** — That is right, and making sure that the carers are competent. How do we know that they are competent? So for the registered nurse training a carer to administer medication, do we have a set of guidelines around that? What makes someone competent?

**Ms PATTEN** — What do we do for families doing it?

**Ms ROBERTSON** — Exactly.

**Ms PATTEN** — Is that a practical solution that would meet some of the problems that you have raised today?

**Ms KECK** — With regard to after-hours provision it would. For our service, we have an on-call overnight service they can call, and a nurse will go and visit after doing a triage process. If they need to have medication, the medication is stored in the home, so there are out-of-hours medications that may be used for pain, nausea, those sorts of things. But if we had extra resources for and guidelines around the carers being able to carry that out, it would be less of a cost than having a registered nurse perhaps going out to do it.

**Ms PATTEN** — Having to travel.

**Ms KECK** — For the smaller organisations from a budgetary point of view.

**Ms ROBERTSON** — I know also that we sometimes just do not have the capacity or the resources to be able to provide that service overnight. We try to where we can, but again we are limited. We cannot always guarantee that there will be someone on call overnight, and it is heartbreaking. There has got to be some more work done definitely around that, and funding is another issue to be able to provide that.

**The CHAIR** — Can I ask: what is your work around that sort of situation? And can I perhaps invite either of you to comment more generally about some of the issues you see and experience — being a bit more remote than Geelong or Melbourne for other services?

**Ms KECK** — I think, no. 1, to recruit and retain clinical staff who will want to work in the evening and then be on call overnight is an issue. In the regional areas it is harder to recruit those specifically trained staff. Do you find the same, Jane?

**Ms ROBERTSON** — Absolutely. I think to be able to attract them, to gain the qualifications. It is such a specialised area that the cost — a lot of these people that we have in our area I know have young families — of doing the training is astronomical. At the end, the difference in pay sometimes to what they are currently doing — we are only talking about 2 or 3 hours more — but they could be thousands out of pocket. As you say, with recruitment but also around retaining good staff, things change, situations change. I find that we get a lot of people who come in and float out. Sometimes you get families that have been in the region for a very long time, and those staff are fantastic and they are the ones that bend over backwards, but then I worry about their work-life balance and their wellbeing because they are going above and beyond and they are multi-hatting. You will find that in a rural area. I am sitting in three roles at the moment, so we just stretch and stretch and stretch. It is difficult. Because it is such a highly specialised area we need to be able to not only recruit them and retain them but we also need to make it very attractive and worthwhile. How do we do that? It is a challenge.

**Ms PATTEN** — From a government perspective, it would still be cheaper to do that than to have those people be in hospitals.

**Ms ROBERTSON** — Absolutely.

**Ms KECK** — Definitely, and I think we also have to look at the self-care of the staff. My staff are also doing overtime, with multiple hats in different roles, and they are burning out. It is an issue also. For our clients definitely and the carer support, there is not enough resources there at all. But for the staff, as their manager, we have to look at that as well.

**Ms FITZHERBERT** — You mentioned earlier, Dr Martin, that you have a very long policy on transferring drugs. I was just wondering: would it be possible for the committee to see that? Not right now but — —

**Dr MARTIN** — Of course. I cannot see any reason why it would not be available, and it might give you a sense of the kind of work-around that we have tried to do to do the right thing for the patient while not exposing our staff to having something misinterpreted. It came out of a clinical need; people were running out of medication and that was stressful for everybody concerned. We wanted to do the right thing but not expose somebody where something with the legislation maybe was not clear. I would be very surprised if the organisation was not keen to share it.

**Ms FITZHERBERT** — That would be great, thank you.

**Dr MARTIN** — As long as you realise that the messiness of it probably reflects how we have tried to do the work-around.

**Ms FITZHERBERT** — Yes. No problem, that makes sense. The other thing is that the presentation earlier said there was limited access to palliative care unit beds. I am just wondering roughly how many palliative care beds would there be in the region?

**Dr MARTIN** — You mean including South West? I am not sure. The designation that the department did some time ago was on their level 3 beds, level 2 and level 1. I just want to be clear. Even though there will be a total, it will not be apples and apples. Some of them will have a designated bed with the environment suited to families and patients. Some of them will have a single room with space for carers, but there would not be a specialist palliative care team wrapped around that, because they only use one or two beds. South West would have level 2 beds where there would be, if you like, some in-reach support and expertise but not a specialist palliative care bed. Then we would be the level 3, which can do the extras in terms of interventions and things. If I recall correctly — I know it flexes up and down a bit — there would be something like six in Warrnambool. Correct me when you see them later on. And then they would have maybe a bed or two at Portland and the same at Hamilton, which they will probably flex, depending on the client need at the time. So you have 16 here, 16 there and then a couple more — you are kind of looking at 24 for the whole Barwon South West, which would go out to the border with South Australia.

**Ms FITZHERBERT** — That does not include, does it, the 24 palliative care beds that are due to open at Geelong but are not open because that ward is not open?

**Dr MARTIN** — Correct. The 24 are just the 16 that you saw today — the south west and their integrated level 2 model — and then the model to support local care at Hamilton and Portland. The idea was to get this tiered approach which we talked about in general terms this morning. We are obviously trying to work out how we achieve the funding for that. It has been designed, but at the minute that is the total for the region.

**Ms FITZHERBERT** — If those extra 24 beds came on, if they were funded, that would be a significant increase in the number of palliative care beds.

**Dr MARTIN** — Yes, so proportionately it would be a very large increase. The idea is that we think that there are some people who need to have their care in the acute sector and who could not come out here, even if we did have extra capacity out here. It is about shifting what type of care they get within the same campus, because they need diagnostics or they are having radiotherapy et cetera. In some wards we could not do it, even if we had more beds here, because it needs to be in a specific place, and some of it is just a share capacity. For other patients who might come in with a catastrophic stroke, the idea is that they are just not well enough to be transported, so they could get the right care, but in the main campus.

I think some of it is about capacity building, and some of it is about a cohort that are in various parts of our acute system that could be brought to the same area and have that kind of concurrent management that I mentioned to some of you this morning.

**Ms JONES** — I am manager for the Barwon Health palliative care program as well. When we put the proposal together for the new beds back last year, we talked about a flexible model. Where you have got funding or resources for 24 beds, if that could actually be flexed so that if you need to add more resources into the community because X number of patients are going out and need X amount of care or equipment or whatever it might be, we could flex in and out and up and down in that way as well, rather than being restricted by the silos of beds in the community. The whole model of care that we put forward was around being able to change with the patient demographics cohort needs that were in the palliative care program at that time.

**Ms FITZHERBERT** — That makes sense, but in terms of the 24 beds and the 8 acute beds that are attached in that ward that has been built and, I understand according to the Addy, is finished but not yet funded, is there any sense of when that will be funded?

**Dr MARTIN** — Not yet. The other part of the flex is that we talked about people maybe needing to come in to be stabilised but still being able to go home, so they are not just in a traditional inpatient bed. I think the other thing that we have all recognised is that at the minute we are not really able to offer any of our clients respite where we can say, 'If you take them home for a week, they can come back for a respite'. I have been here for nine years and we have not ever truly been able to say as a discharge plan, 'If you are able to do this, this is the respite we can offer you'. We just cannot, because it is always full of emergencies. I think that is something that

would really change the landscape, whether it is our colleagues down at Colac or at Bellarine who are able to say, 'We can give you regular respite'. It has just not been available.

**Ms FITZHERBERT** — Just one last question: when was that new ward actually completed? My understanding is that it is completed, but it is just that beds are not funded, so it cannot be used. When was it completed?

**Dr MARTIN** — At the end of May.

**Ms FITZHERBERT** — Okay. Thank you.

**Ms PATTEN** — Following through with looking at the respite as well, thinking back to MACS and to the Hospice Foundation and appreciating how difficult it is to recruit in regional areas the highly qualified staff that ideally would be working in this area, is there a role for more of a trained certificate III home-care worker with a palliative care certification on that and possibly a medical endorsement on top of that? You might be able to find more local people who are happy to take that on. Could that fit in to your care structure?

**Ms KECK** — Yes, absolutely. That, I could see, would work and be effective.

**Ms PATTEN** — And then you could have specialist services — —

**Ms KECK** — Tapping in.

**Ms PATTEN** — Tapping in.

**Ms KECK** — Coordinating, directing.

**Dr MARTIN** — That might need to come from a large pool because if we only have one or two, obviously they cannot be on call all the time. It is really out of hours so there would need to be some thought about what the pool would be and what the critical mass of that pool would look like, but I absolutely think it would allow us to deliver more people who wish to stay at home. Just even the pilot alone — we have been running it for a few months — has given us the ability to say to somebody, 'We can put somebody in to help you out' just transforms the landscape in terms of them saying, 'Okay, I'll take that on. I'll try and stay a bit longer'. It is usually at that last critical period where they can almost just fall before they go over the line. absolutely.

**Ms PATTEN** — It does not necessarily need to be that nurse. It needs to be someone with the compassion and the skills.

**Dr MARTIN** — And so that we can offer clear support them as well. They can lift the phone and get the advice and support they need.

**The CHAIR** — Dr Martin, can you clarify from whom you are seeking the funding for those beds that are not yet funded?

**Dr MARTIN** — The state government.

**Ms JONES** — We put a proposal in in September last year.

**The CHAIR** — I would like to thank Dr Martin, Ms Jones, Ms Robertson and Ms Keck for the presentation of their evidence this afternoon. The committee very much appreciates your contribution.

**Witnesses withdrew.**