

# TRANSCRIPT

## STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

### Subcommittee

#### **Inquiry into end-of-life choices**

Warrnambool — 30 July 2015

#### Members

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#### Witnesses

Ms Usha Naidoo, Manager, Care Coordination,

Ms Jacquie Page, Palliative Care Consultant, and

Ms Judy Sommerville, Volunteer, Western District Health Service, Hamilton.

**The CHAIR** — I now welcome representatives from the Western District Health Service from Hamilton: Ms Jackie Page, the palliative care consultant; Ms Usha Naidoo, the manager of care coordination; and Ms Judy Sommerville, who is a volunteer. Thank you very much for being here. Before I invite you to make some opening comments, I will just caution that all evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Legislative Council standing orders. Therefore you are protected against any action 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 within the next week. The transcripts will ultimately be made public and posted on the committee's website.

We have allowed 45 minutes for our session this afternoon. I invite you to make some opening remarks, and we will have questions thereafter. Thanks again for being here.

**Ms PAGE** — We really appreciate the opportunity to talk to you. Palliative care is something for us that is — a consultant once told me it is in our DNA — who we are; it is what we do; it is what we are extremely passionate about. So thank you for this opportunity and for valuing us, because by hearing us we feel you are valuing us. Thank you for that.

Our palliative care service is based in Hamilton, Victoria, as part of Western District Health Service. Our main campus is in Hamilton Base Hospital; however, we also have campuses in Coleraine and Penshurst as a consult service. We also service Casterton Hospital and the surrounding area within the Glenelg shire.

We also attend residential care settings to give education to staff, as well as to review their patients. Currently we have six individual residential care settings that we go to. The population serviced by palliative care is 18 500. I have taken into account Casterton as well; which is not actually in the southern community district, but I have added it because we actually go there, so that is important. It covers an area of 6652 square kilometres. And I drive, and I do not have a plane, so that is quite a long way to go!

We receive referrals from any health professional, both within the region and externally from the larger metropolitan centres. Patients are also able to self-refer, and I love getting those self-referrals. I think they are pretty special. We have a service expectation, and it is a 100 per cent expectation. We fulfil this. We respond to every referral within 24 hours in the working week. Obviously, if we get it on a Friday evening that is going to be a bit tricky until the following Monday, but we pride ourselves on that. It is current, and it is 100 per cent fulfilled.

Palliative care services in Hamilton is a consult service, so that includes 70 hours of nursing. That can be a bit misleading: I am a clinical nurse consultant manager, and I work four days a week; there is a registered nurse working three days a week. It is my choice to work four days a week. I could have worked full-time, but I have children. District nursing support for after-hours calls is within that 70 hours, and we have our volunteer cohort who are pretty special and offer home respite on an as-required basis. They do quite a lot else for me too. And I have medical governance that is provided by our palliative care general practitioner, who is actually funded for approximately 4 hours per week. I tell you now she does a huge amount more than that.

We manage a community caseload of anything up to 40 patients at a time, all of whom are at varying points within their disease trajectory. We also consult and are sometimes called upon to manage our palliative inpatients as well. I was interested by the comments earlier, because we go there because of a lack of confidence of our nursing staff in giving out medications. So thank you for saying that, Fiona. This workload has increased tremendously since the appointment of the clinical nurse consultant, hence highlighting the need for specialist palliative care nursing. Palliative care nurses are a special breed. I do not know if you are getting that yet from your talk with everyone. We do this because it is what we, as I say, are very passionate about.

We work closely within the multidisciplinary team, consisting of a GP, palliative care nurses and a bereavement counsellor, travelling from Warrnambool once a fortnight. We routinely make referrals to occupational health, physiotherapy and shire home help services, so we can call on those sources of help. Patients are always placed at our centre. It is slightly different to patient-centred care. We firmly believe that they are at the centre of care, along with their carers.

Patients are always asked — pretty much fairly early when they meet me — where they ideally would wish to die. What would that choice be? The majority will say at home. However, very quickly, often in the same

breath, they will say to me, 'Only if my family can cope'. For some elderly clients the thought of caring for a partner, especially if they have little or no extended family, is daunting in the extreme. Many patients will say from the outset that dying at home is not an option for them, and that is okay, especially, strangely, the more rural of our clients, because they have lived on the farm all their life and they know what infrastructure is available. They know it is not out there for them, so straightaway they will say, 'I can't die on the farm'.

We offer a bereavement service. Carers have a visit from a clinician after the loved one's death. This is often a time of reflection, and I spend my time talking about the death and what came up to it, and they want to relive it. A visit is then performed after the funeral. All the time the clinician is assessing for signs of abnormal grief behaviours. If there are none, the family are then contacted three-monthly, six-monthly and yearly by our volunteers.

If the clinician is concerned, then referrals are made for ongoing support, and I think something I heard very recently was that there is a high percentage of carers who actually suffer a post-traumatic stress disorder post bereavement. That just blew my mind. We sent fighters over to fight for our country and they came back with post-traumatic stress, but we are asking our carers to care for someone they dearly love in the home, and they are experiencing the same syndrome. That is just huge for me.

It is very easy for me to stand, or sit, here and tell you that we require further assistance to help our clients at the end of life, but in order to give you some context I am going to tell you a story. It is a true story, and it is about something that is happening right now to one of our clients, a few kilometres down the road. I am going to tell you of my thought processes as well, as I was caring for that lady, so you can decide and see for yourselves the challenges we face. The story is not yet complete, because the final chapter has not been written.

This story was given to me and it is given to you as a gift. It is from the lady herself, and it is given with her permission for me to tell it. I have a 47-year-old lady admitted to our service within the last month, who is dying of widespread metastatic cancer. She lives on a farm, some 30 kilometres outside of Hamilton, and has four primary school-aged children. A clinician went out to visit the client the day following receipt of the referral. During the initial telephone call to the client she sounded strained, although she did not want to elaborate on the phone. The visit was on a Friday afternoon. The clinician was met at the door by the client, limping and in tears. She had been in horrible pain in her left leg for a week, and she described the pain as 10 out of 10 and like someone had taken a burning hot poker and shoved it from her hip to her knee. We set aside the assessment and called the oncologist straight away, who suggested admission for pain control and X-rays to rule out fracture. This lady absolutely refused to go to hospital, as the children were soon coming back from school, and she wanted to spend as little time as possible in a hospital. She also works in the local hospital, and she does not want the staff knowing or being involved in her business. You see, this lady is a nurse.

We liaised with her GP, who wrote instructions for an X-ray. We contacted the X-ray department, which worked late that evening to accommodate my lady, and organised an appointment for her the following day with her GP to review her X-ray. You see, our GPs do not do home visits, so she could not be seen at night. Her daughter was actually playing in a netball match that night and she was going to get to that netball match come hell or high water. What she said to me was, 'I will put up with it. I will just chew through the painkillers'. Within a week her pain was better controlled. We have actually put in measures, and she now describes her pain as 2 out of 10 — and for a palliative care nurse that is the goal, that is a win.

We then set about sorting out her priorities of care. She had been the main bread-earner for her family and was living on food parcels donated from the Lions Club. Her response was, 'They are good, because they fill my children's lunchboxes'. We spent time assisting her to complete a Centrelink form for financial assistance. She had actually been eligible for that assistance the November before, but she did not know, so she had been struggling all this time. We have no social worker linked with our community program, so we do that.

We discussed how we can best support her children in preparing for their mum's death. We offer her our counselling service. We have a visiting bereavement counselling support worker who comes once a fortnight, who is fantastic; however, she comes once a fortnight and she can probably only fit in four clients at a time. So space is at a premium, and it was going through my head, 'Gosh, I hope they have space for this lady soon'. She has asked to die at home, but I have no district nurse to provide personal care this far out, so it would be nearly impossible. I do not tell her that. If she lived within the Hamilton boundary, she would be able to access three-days-a-week personal care. Even for those people within that boundary with little family support, that is inadequate for someone dying who is bedbound. For those families who do support people for home death, not

all the family members can cope with washing their mother or father. And really why should they have to? They are doing the loving bit, shouldn't we be doing the caring?

Equipment can be sourced through palliative care, such as a hospital bed. We have a palliative care after-hours service and we encouraged her to ring if she had pain for support. She will get phone advice, but she lived too far out for a visiting nurse. There is not any other option really. Realistically she may be admitted to our one designated palliative care bed. We do have one, but that is in high demand and often there is a waiting list as there has been for the last two months. Hopefully it will be available for her, but it is located within an aged-care facility. My lady is 47, with four primary school children, so we have questioned whether that is the right place for my lady, and it is just not. So where am I going to put her? She is not at that stage yet and she is not dying yet, but I need to have a plan and I have nowhere to put her. I have no care to offer her to fulfil her wish.

The goal for many Australians is to die at home, as illustrated by the Grattan report in 2014. The burden on our inpatient beds will and is going to increase. We are, as a society, filling our acute facilities with dying people who do not wish to be there. We have to resource our palliative care community services appropriately. So how can you help me? I have a wish list, and I am not going to give it all to you. Which bedbound, incontinent, dying patient wants to be washed and made comfortable three times a week? How many times a week do you wash when you are able-bodied? I suggest you wash every day. Give me more patient support workers out in the community to offer patient care. These do a fantastic job and they cost less than a registered nurse.

The Silver Chain after-hours care model and the HammondCare model, which I have had personal experience with in New South Wales last year, do exactly that. A hospital bed costs you \$14 000 at least per night. I think that can go up to \$17 000, although please do not quote me. If you fund me and fully fund our community support, I am so much cheaper. I can do the care so much cheaper for you. We currently work within a consultancy model. Would a care support model work better? I suggest it would. Allow me to do what I do best. I am an excellent symptom-control clinician, I had been doing it a long time. I am good at assessment and coordinating care. That is what you pay me to do as a clinical nurse consultant. I could see more people per day if you funded support workers to help me. Give me a family support worker to assist the family and focus completely on the carer's needs, because if you look after the carer then the carer can look after the patient. Once the carer goes down then everything goes down.

That view applies to the Shepparton model. They use a family support worker three times a week, and it works really well. If the carer has more focus, you will empower them and keep their loved one at home. In terms of more options for respite, if the patient does not want to stay at home there must be more respite options and inpatient facilities to care for patients. Please do not quote me on this, I know you said you quote things, but this is something I worked out at Cabrini. The insurance companies are now recognising — —

**The CHAIR** — We actually are recording so — —

**Ms PAGE** — I know. I will say it, and then if I am wrong, you can shoot me.

**Ms PATTEN** — We understand that you are estimating — —

**Ms PAGE** — I am estimating, yes.

**Ms PATTEN** — And that this is an estimation.

**Ms PAGE** — Yes. The insurance companies are now recognising palliative care and will fund private patients to stay in facilities. However, we do not have the infrastructure to support that. That is my quote. The FTE in my department is not sufficient to cover the area we do and service the clients we see. Working long hours is a characteristic of the palliative care nurse and doctor. So is a high attrition rate, burnout and psychological damage. We are crying out for help. Help us to help the community. We see their suffering every day. Palliative care means so much to every life it touches because in the end it is about time. Time to share in the comfort and company of loved ones, time to die with dignity and care, and yet time to truly be alive for the last time possible. Palliative care patients are not dying, they are living; and while they live they are suffering. As they die their family members remember it, and those memories will converge on a similar truth: palliative care is wonderful, but there is just not enough of it in Western District Health Service. I will hand you over to Judy.

**Ms SOMMERVILLE** — Thank you very much. My name is Judy, and I have worked as a palliative care volunteer in Hamilton for the past 23 years. I have also worked in the funeral industry, working with families' funeral arranging and embalming, and in my own natural therapy business with massage, acupuncture and lymphoedema, and lymphoedema was primarily what I used with palliative clients as a volunteer.

On a personal level I have worked with several family members. I have helped my sister, in a dual role with palliative care, look after my brother-in-law at his home. It was his wish to stay home and we had an amazing system at the time — an arrangement with his doctor, palliative care and district nurses. I was able to help him with all his requests as he was dying, so it was peaceful. He lived in Hamilton so it was much easier to access the services. Last year my sister and I nursed my father at home. It was his wish to die in hospital. He requested that because he did not want us to have to deal with it. However, dad deteriorated very fast and I made the decision to keep him at home. Again, we had access to palliative care and district nurses, but I could not get over the difference in the changes to the services in six years.

My mother was in a nursing home, so it made things much better as we had the chance to set up her room and she felt like it belonged to her. The ambience was so beautiful, and we had access to everything there — all the nurses. Working in the community with palliative clients, I can safely say that of all the people that I have worked with in palliative care, as well as my own clients in my natural therapy business, a good 78 per cent or more of these people stated that they wanted to die at home. If the client lived more than the 10 kilometre-radius of Hamilton and needed help after hours, they would have to be transported to Hamilton or the nearest hospital. It is very stressful for a family member to have to drive a sick loved one, at night, for help if people were not covered by ambulance. Some people needed to travel over 30, 60, or 80 kilometres. If the person transporting was elderly or if the client could possibly die in a car, stress levels were through the roof, risking a serious accident, not just to that group but to others as well. Often in the country the weather is not totally kind to us. One week we had 11 inches of rain and consequently it shut off roadways everywhere and clients were just not accessed in the remote rural areas. Clients constantly say, 'if anything is going to go wrong, it will happen after 4.30 when the staff finish, or a weekend'. When you live in the bush and have never dealt with death or the dying of a family member, without face-to-face support, it is hard to know if you are panicking or you are scared of what could be happening and what to do.

Medication was often brought up, and as a volunteer you would hear this. Some fear giving the wrong amount or the wrong medicine. They fear killing the person. If the patient is still in pain, the family would ring for help but often they had no idea of what they were being told because they were in a total state of stress. So they really need that one-on-one contact. The nurses themselves are absolutely amazing. They go out and they set up everything for them and explain it, but when you are in those final stages of dying, people just panic for some reason. I saw it in my own family with my own sister, so I knew. She has been a funeral director for years and years, and it was just incredible to see her reaction, and that really brought it home to me.

People really do not have any idea of the stages of dying. The family want to nurse loved ones at home, but they really do not understand the process of dying. The palliative team do explain all this to them in stages, but of course it is a terrifying experience for some people, and not everybody dies by just going to sleep or going into a coma. From my experiences anyway, it can be quite stressful for a lot of people.

If the dying person has to be taken to hospital at night, family are left in limbo, particularly deep rural country people. They are just left in limbo. If they have got small children, they have just got to pack them up and take them. Not all rural farmers or remote farmers have access to the next-door neighbour. The next-door neighbour may not want to be involved in it. They have got to pack the family up and take them. Some hospitals will offer help to the family, and others will not. If the family lives way out of town — like, very remote — they have to travel 60 or 80 miles a day back and forth to see their loved one, because farming does not wait. Their loved one misses out on seeing them, and they miss out on seeing their loved one. Quite often if that loved one passes away during that transitional stage, it is quite heart-wrenching from what I can see. It really changes grieving processes.

Rural country people really do want to be in their own home environment to die. If I may, I will give you a scenario of what a rural farmer said to me about dying on a farm in a remote area. This man was a salt-of-the-earth farmer. This man was dying. He said, 'You know, dude, I was born on the land, grew up on the land and bought up a family on this land. I have battled the pests and the elements, and I have managed to grow

food for my country, but here I am dying and there is no guaranteed support system available for me to die on my land should my family require help’.

The palliative staff say that the majority of people wish to die at home as a testament to honour the person’s life and wishes. Most families facilitate their needs. It is not everyone’s wish to die at home. Since I began as a volunteer with palliative care 23 years ago, staff have halved and services have halved, and it really does make life difficult because there are more people dying, particularly in rural country areas. In all my years of working with the Hamilton palliative care unit I have never heard a bad word spoken about the palliative or district nursing staff. It makes me feel very humble and proud to be able to work alongside these professional, loving, caring, kind and compassionate people.

The demographic area that needs to be covered by the Hamilton palliative care team is enormous. It is physically impossible to cover the area required to help keep people in their homes with loved ones at all times. Things can change in a day with a dying person. We have one palliative bed, as Jacquie said before, in the whole of Hamilton. Only a month ago there was a record number of palliative people requiring beds for various legitimate reasons. The palliative nurses spend hours helping families set up what is required to nurse a loved one at home. The district and palliative nurses do this with love and dignity, but they are hours away from getting to the next person. In our volunteer group in Hamilton we have a few volunteers assisting with filing and brief cards because that is what suits them, and others working with clients. The ones working with clients give the palliative staff peace of mind knowing that the family has the help needed for a break. If the volunteer sees that help is needed in a specific area, they can and do report back to the staff to get what is required to help the family.

Staff are travelling to remote areas after hours voluntarily to make sure remote clients are getting the services that they need. The staff are breaking their backs to see that remote families are supported in nursing their loved ones at home, particularly in the last stages, to help fulfil that dying person’s wish.

This has come from the people too. They say, ‘If you want us to be taken out of our homes to hospital to die, we need help and support with where we are to be placed’, so the dying person has an understanding of where they are going and families are familiar with surroundings. Not doing that can change the dying person’s grief and dying process, because they may in their heart not want to be shifted, but they may see that the person caring for them is not coping and may not want to place any further burden on them. If they have an understanding of where they may be going, it may help with the transition.

This comes back to where families are placed in remote areas where district nurses do not go. In a perfect world it would be wonderful to have a hospice or even a wing of our own in our palliative area. I thought I should add that.

**Ms PATTEN** — Of course.

**Ms PAGE** — Okay, some questions please.

**The CHAIR** — First of all, can I just say on behalf of all of us, thanks so much for such a passionate presentation and such a personal presentation as well. We sincerely appreciate it. Ms Page, I am interested in the Shepparton model that you described. I am not familiar with that, so can you perhaps talk in more detail about that?

**Ms PAGE** — I have not worked there myself. It is only from what you hear on the grapevine and what you hear when you go to conferences and things and talk to people. They are known as the Rolls-Royce service of palliative care in Victoria. I guess for numerous reasons they are well staffed, they are well funded and they are well resourced. They have their own after-hours service — they man it themselves — so they do not need to be ringing out to metropolitan areas. Their staff know their patients. They get called out, and they go out and see their patients at any time of the night as far as I am aware. They also fundraise. Their community fundraises a huge amount of money for them and supports them. I believe their family support worker was actually funded through their hospice shop. They are known as the service to be in. If you are going to die, die in Shepparton, because they are the ones that look after you well in that area. That is the consensus.

**The CHAIR** — Ms Sommerville, how many volunteers are part of the volunteer team?

**Ms SOMMERVILLE** — It varies sometimes. Have we got about 10 to 12 at the moment?

**Ms PAGE** — Yes.

**Ms SOMMERVILLE** — That varies, of course. People come to town, and they leave town. It is a specific area. Not everybody wants to or feels comfortable working in that area. But we do have that, and they are a great team. We really enjoy working with these girls as well as the clients. It is a really close-knit little organisation.

**Ms PATTEN** — Again, thank you very much for your presentations. I think it is really striking home that, as the Grattan Institute is saying, 70 per cent of people would like to die at home. However, the reality of that, looking at the districts that you are trying to cover, the remoteness of them and how this would apply in other parts of Victoria, I think rural people are pretty practical about this, as I have been hearing over the past couple of days, as well and recognise the limitations because of the life choices they have made for where they live. We are going to have to find a happy medium, and what that looks like is something I hope this committee can discover and recommend. So what does this look like? It seems it is not all medical, as you were saying; it is home care and family care workers. In the perfect coordination of your group, do you have a concept of how many home care workers you would need?

**Ms PAGE** — I worked in New South Wales last year, and I was part of the team that implemented the Silver Chain model throughout regional New South Wales. I ran three teams. They won the tender. It was government funded. Purely for the last terminal phase or the last week of life — obviously it did go on longer than that sometimes — we had patient support workers going in in the morning to do personal care. It was not just personal care; it was whatever the family needed to keep that person at home. One of my personal care workers baked a cake. The reason she baked a cake was not so that the dying person could eat it, because they could not, it was because the dying person wanted the smell of the cake in the house. For them that was huge.

That is what I told my support workers to do. I said, ‘You are there to do whatever the family needs for that time’. The district nurses from the local health district then went in to change syringe drivers. We then had a palliative care nurse that was funded by Silver Chain who went in in the evening to settle patients. They are as rural and remote as you are. I would have my nurses and support workers travelling up to an hour out of the metropolitan area to go to a patient. They kept 78 per cent of their palliative care patients, known to their palliative care team, at home — 78 per cent. We did not have one presentation to the A and E department through that terminal phase, with that support. So they are achieving — —

**Ms PATTEN** — Where was this?

**Ms PAGE** — This was in regional New South Wales. My teams ran from northern New South Wales, based in Lismore — covering that area — then down to the mid north coast going out towards Bellingen and all the area around that.

**Ms PATTEN** — Yes, I know the area well.

**Ms PAGE** — And then going down — we were based in Singleton — around Hunter New England. That was a huge win to keep that many people at home.

**Ms PATTEN** — Do you think that is a model that could be replicated in the Hamilton area?

**Ms PAGE** — I do not see why not.

**Ms NAIDOO** — The challenge for us as managers is we cannot recruit people like Jacquie all the time. We had not had a consultant for eight months while we were recruiting, and we paid a huge amount of money to get Jacquie to come from New South Wales to Hamilton. We do not know how long Jacquie is going to be there, so we could be in a predicament very soon. The salary is not the same as New South Wales. We had challenges because we have to recruit and retain them, and we do not have anything attractive to keep them there. Apart from the sheep and the country air, what else do we provide?

**Ms PATTEN** — The cheese is very good.

**Ms NAIDOO** — You get limited funding. You have to use the funding for patient care, and you have to keep your clinicians there, so it is a huge challenge.

**Mr MULINO** — Ms Page, if you have any additional information you can send us about that project, I think that would be really useful. You can send it through to the secretariat.

**Ms PAGE** — Yes, I can.

**Ms SPRINGLE** — You have talked about two different models here: the one that you are working on in New South Wales and the Shepparton model. Very quickly, could you give me an idea of what the differences are between those two models?

**Ms PAGE** — It is going to be difficult, because I have not worked in Shepparton. This is all on hearsay. The palliative care community is a very incestuous one — we all talk to each other, we all support each other — but I have not worked there. I have worked in New South Wales, so I know that model much better. But I think with Shepparton — and again I could be wrong — they are better resourced financially, and their community resources them as well, so that is the shire, I guess.

**Ms SPRINGLE** — Is that predominantly why they are better resourced, because they have got that community groundswell of fundraising behind them?

**Ms PAGE** — Probably, but they are funded from you guys too. They just seem to have done very well.

**Ms NAIDOO** — And it is a bigger area than Hamilton. If you are only looking at the population size — and that is how we are funded — we are 4.8, but we see a lot more patients and when we do have a good consultant we seem to have more referrals, because patients tend to come for services. Apart from that, most of them do not, because they need to build that trust as well and knowing that they are going to get the services.

**Mr MULINO** — Thanks again for your evidence. It does strike me that there are a lot of areas that we can look at in this space. One of them is people's capacity to stay at home and die the way they would prefer to, but also it is particularly challenging in the rural setting, as you have all talked about. Again, as a number of people have talked about, both in the sector but also beyond such as the Grattan Institute, there seem to be potential savings here where we could actually get a better outcome for less money.

**Ms PAGE** — Absolutely.

**Mr MULINO** — One of the challenges with actually assessing this is that I imagine in order to actually quantify that, it is going to be necessary to measure the impacts of any policy reweighting across the whole sector. Quite often it is tricky to do that when there are so many different moving parts. We have already asked for any additional information you are aware of. I would be fascinated if there were any, for example, quantitative studies on Silver Chair, for example, by the New South Wales government.

**Ms PAGE** — We only started in November of last year, so they are still in their evaluation phase — they are still evaluating. But we are seeing on the ground, so we are just talking about our local results, which is what we were seeing. I think it was a consultant up there who suddenly said, 'I haven't had a presentation to A and E. What's going on? No-one's turned up'. That was huge, because they had had loads of influx. So it was then that we went back and looked at it, and actually we have not had a single one — not a single one since she started.

When I left they were doing some sort of evaluation. They were doing an evaluation program with the school of economics, I think, in Sydney, so they were doing something, but they did not have anything formalised as yet. It was just local data that we were seeing.

**Mr MULINO** — We can certainly hunt around for any other evaluations globally, because this is an issue beyond Australia —

**Ms PAGE** — Absolutely it is. As far as I am aware, Silver Chain was the only one; there was nothing like it in the world. There was not anything that covered the patient through that area. It was a not-for-profit working with an LHD, which created a huge amount of angst. It took a lot of time for us to sit down and talk to these people and a lot of people were worried and saying, 'Are they going to take my job?'. There was lots of angst. If

you get the right people driving it and sit down and say, 'That is not what it is about; it is about the patient', it works. We were very picky about who we recruited. I will certainly send you everything I have got.

**Mr MULINO** — That would be great. Aside from the evaluation, my sense is that if progress is going to be made in this space, it is going to be necessary for different parts of the health sector, if you will, to jointly submit how it could work. In a sense obviously palliative care could justly put in a submission that, 'We could do with more resources', particularly in rural areas — —

**Ms PAGE** — And everyone else does it.

**Mr MULINO** — But in a sense it is going to be more powerful if some of the more institutional parts of the sector could at the same time jointly say, 'And this will actually alleviate pressure on certain wards', for example. We are hearing lots of compelling evidence, which I think is all consistent, but ultimately it is going to be more compelling if it is kind of a joint view as to how this could all work better.

**Ms PAGE** — I agree totally.

**Ms NAIDOO** — I think Palliative Care Victoria has done quite a bit of work as well in their submission, and we endorse what they have submitted as well.

**Ms PATTEN** — I believe they have surveyed all their members. We are waiting to receive that. Just going back to the mix. Again, it is just flowing on from what Mr Mulino was saying. It is probably the shifting of money, but I am still going back to the ratio of non-medical care, that support staff — —

**Ms NAIDOO** — We do not have them.

**Ms PAGE** — We do not have them. That is what we want, but we do not have it.

**Ms PATTEN** — At all? You do not have any at all?

**Ms NAIDOO** — No, we use volunteers quite a bit, and we use district nurses.

**Ms PAGE** — And we pay district nurses to do personal care for our patients, so that comes out of my budget.

**Ms PATTEN** — So a cert III home carer would — —

**Ms PAGE** — Exactly right. It would cost, I think, \$22.50 per hour, and they are wonderful — —

**Ms SPRINGLE** — But you cannot recruit them.

**Ms PAGE** — As opposed to \$39.

**Ms NAIDOO** — And we have to train them and make sure that they are — —

**Ms PATTEN** — Yes, I appreciate that.

**Ms NAIDOO** — And it is a high burnout area, so people do not stay in there for a long time.

**The CHAIR** — Ladies, thank you so much for being here. It was such an insightful, personal presentation about the challenges you are facing. We appreciate it.

**Witnesses withdrew.**