



LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON END OF LIFE CHOICES IN THE ACT

(Reference: [End of life choices in the ACT](#))

Members:

MS B CODY (Chair)
MRS V DUNNE (Deputy Chair)
MS T CHEYNE
MRS E KIKKERT
MS C LE COUTEUR

PROOF TRANSCRIPT OF EVIDENCE

CANBERRA

FRIDAY, 1 JUNE 2018

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Secretary to the committee:
Mr A Snedden (Ph: 620 50199)

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents, including requests for clarification of the transcript of evidence, relevant to this inquiry that have been authorised for publication by the committee may be obtained from the Legislative Assembly website.

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Amended 20 May 2013

The committee met at 10.16 am.

AGAR, PROFESSOR MEERA, President, Australian and New Zealand Society of Palliative Medicine

CHAPMAN, DR MICHAEL, Director of Palliative Care, Division of Cancer, Ambulatory and Community Health Support, Canberra Hospital and Health Services

THE CHAIR: Good morning and welcome. I declare open this sixth public hearing of the Select Committee on End of Life Choices in the ACT in its inquiry into the matters referred to the select committee by the Legislative Assembly on 30 November 2017. The hearing program for today, and the committee's terms of reference, are available from the table near the door. The proceedings are public, are being recorded by Hansard for transcription purposes and are being webstreamed and live broadcast.

I remind witnesses of the protections and obligations entailed by parliamentary privilege and draw your attention to the pink privilege statements which are set out on the table. I believe, Professor Agar, we emailed one to you.

Prof Agar: Yes; correct.

THE CHAIR: Could you both, for the record, confirm that you have read and understand those.

Dr Chapman: Yes.

Prof Agar: Yes; I confirm that I have read the privilege statement.

THE CHAIR: Thank you so much. Before the committee starts the hearing part of our program today, on behalf of the committee I acknowledge that we are meeting on the lands of the Ngunnawal people, the traditional custodians of this land. I pay my respects to their elders, past, present and emerging. We respect their continuing culture and the unique contribution they make to the life of this city, this region and this area.

I welcome today's first witness from the Australian and New Zealand Society of Palliative Medicine. Before we proceed to questions from the committee, would you like to make an opening statement?

Prof Agar: Yes, thank you. I am appearing before the committee today to represent the Australian and New Zealand Society of Palliative Medicine. I note that one of our ACT members, Dr Michael Chapman, who is also the director of the palliative care service at the Canberra Hospital, is in the room with you today.

I am a practising palliative medicine specialist with over 14 years of clinical experience in this field, but I am also a research academic, the primary focus of my research being approaches to increase the experience and quality of care for people approaching their end of life.

The Australian and New Zealand Society of Palliative Medicine is a not-for-profit

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medical society for medical practitioners. It provides care for people with life-limiting illness in both Australia and New Zealand. ANZSPM published physician statements on euthanasia and physician-assisted suicides infer that the discipline in palliative medicine does not include the practices of euthanasia or physician-assisted suicides, and it is in that background context that we make our statements today.

ANZSPM appreciates the opportunity to present to the Select Committee on End of Life Choices in the ACT today, and we appreciate your flexibility in allowing me to appear by telephone today.

ANZSPM would like to acknowledge the traditional owners of the land on which the select committee is meeting and the land from where I am speaking today, and pay our respects also to the elders past, present and future.

In our presentation today to the committee, we would like to focus our remarks and really highlight the critical points which were outlined in our written submission. We would then be very happy to answer any questions or clarify any specific aspects the committee would like to ask us to respond to.

Firstly, we would like to highlight what we see as non-negotiable optimal palliative care options which we really believe are essential to support all people in exercising their choice and preference at the end of life. One myth that we think it is really important to dispel is that palliative care involvement is the last days of one's life. As palliative medicine specialists, we support people with chronic and progressive illness over periods of time which often are the last months to years of life.

We also believe that people need timely, flexible and responsive access to interdisciplinary clinicians who have the necessary expertise to assess and address the symptoms and emotional and psychological needs that are occurring at any given point in time, but, even more critically, to clinicians who are proactively able to consider and plan for future scenarios to minimise impacts well before they occur. With the increasing clinical complexity which is now being seen, often because there are so many treatment choices and, in many cases, because people have more than one illness, this often requires specialist clinical expertise and an interdisciplinary team.

Good palliative care also involves people being warned about their condition and supports their involvement in shared decision-making and the communication of their preferences for care. This really requires a health workforce that is adequately equipped with the respect, confidence and communication skills to have these conversations.

We would also like to highlight the human workforce in Australia providing end of life care, often formal unpaid carers. We believe empowerment and support for caregivers is also a critical element, including quality respite services. For some people it is also important to specifically address the perception of being a burden on their carers and fear for the needs of ongoing care. To achieve this, we need a whole of health, whole of social services and whole of community response, and we know there are substantial deficiencies in all of these areas.

Many people see such cumulative deficiencies in the system as they traverse primary,

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community, acute and residential aged care. People often fall between the cracks due to the postcode in which they live, the time of day they present to hospital, the clinical diagnosis with which they present or a lack of knowledge or communication skills by the clinician they happen to meet, or are hindered from seeking services due to their misunderstanding or fear, or that of their family, about what palliative care is.

The analogy would be having a heart attack and not being offered evidence-based options for a coronary artery bypass or primary angioplasty either because there was not a clinician with skills to do the procedures or because no-one referred you to discuss these options.

In other jurisdictions, strong recommendations are being made about the steps which are needed to address current deficits in access to palliative care and quality care at the end of life. We are concerned that these have not received urgent or proactive action.

We would specifically recommend to the select committee that they pay attention to the larger problem with service gaps that will impact on all people in the ACT currently with a chronic progressive illness or those who provide their care, and for those who will develop such an illness in the future. This includes the whole breadth of services, both those delivered by specialist palliative care clinicians and those of health professionals already providing the care. Also, it needs to facilitate the person being in the location of their choosing.

We would like to specifically highlight our positive recommendations which we believe will address these deficits. Our focus on community awareness clearly addresses misconceptions and fears about dying and also facilitates knowledge of the extent of choice and engagement possible in decision-making in end of life care. We speak of remedying shortages in the specialist palliative care workforce and enabling early integration of palliative care clinical services in all healthcare settings. We recommend expanding palliative care programs for access that is equitable by location, setting and time, to include after-hours access.

We recommend mandating minimum competencies in end of life care and communications skills for tertiary education and vocational training for health professionals in the ACT which are updated regularly to ensure currency of practice. We recommend investing in carer support, including quality respite services, and ensuring that the policy and legislative framework allows advance care planning to be valued and have appropriate legal standing.

To summarise, we know that palliative care, and more specifically access to palliative medicine specialists or medical teams who have specific palliative care expertise which is timely, responsive and tailored to the individual's wishes and preferences, makes a real difference, supporting people to live well until the end of life. We argue that the pressing priority to provide optimal end of life choices requires people to have real access to quality palliative care, which is currently not the case for many, who receive too little too late or no services at all.

THE CHAIR: Thank you, Professor Agar.

THE CHAIR: My first question is to either or both of you. Professor Agar, you are the president of the Society of Palliative Medicine. We have heard a lot of evidence that palliative care in aged care, particularly in the ACT but possibly across other jurisdictions as well, is limited. I guess that might be a nice way—

MRS DUNNE: Sub-optimal.

THE CHAIR: Sub-optimal is possibly a better word to use. I note in your opening statement you also mentioned that being able to offer palliative care to people in nursing homes is of paramount importance. Could you expand on whether there is possibly not as much understanding of, or not as much access to, palliative care in residential aged care?

Prof Agar: Yes, I think that increasingly the population of people in residential aged care who will have complex palliative care needs is increasing. The scope of practice of people providing care in residential care without support from people with more specialist skills, or who can support the training and education that those staff need to be able to provide palliative care, is where we see there is a really critical gap.

Importantly, I think the large number of people with dementia as their primary diagnosis in residential care requires really specific clinical expertise from specialist palliative care providers, the residential aged-care facility and also people who provide specialist dementia care. That is an area where we feel that there is a significant gap. Dr Chapman, who is also dual trained as a geriatrician, might like to elaborate more specifically on that issue.

Dr Chapman: Yes. I completely agree with the comments. I think the palliative needs of the community of ACT residents living in aged care are a paramount need. There are absolutely gaps. Carers are most likely not the way that we would prefer it, I think. Having said that, I think it also raises a really important opportunity for us to think creatively about how we are going to meet these needs.

An example case in point is an ACT government sponsored trial, the INSPIRED trial, which you may or may not be aware of. It was a randomised controlled trial looking at a novel approach to offering proactive integrated early access to indirect specialist palliative care support—that is, a palliative care clinician being involved to provide support to care workers within the aged-care context to be able to help them provide palliative care better for the residents they are looking after and to help identify residents who may need specialist palliative care input as early as possible. That is a novel way to provide specialist palliative care.

It is a new technique. I think that one of the things the ANZSPM submission and Professor Agar have so well articulated is that, while there are gaps and there is a need to be able to meet those gaps, there is also a need to recognise that the traditional way that palliative care has been provided up until today is probably unable to meet those needs without some creative thinking and new approaches. This is one example of a new approach to how to meet those gaps.

THE CHAIR: I note that recommendation 5 of your submission talks about mandating training and minimum competencies in end of life care management and

communication skills. Do you think that that is another area for health professionals across the board—aged-care workers, nurses, nurse practitioners, doctors, GPs—across the whole gamut?

Dr Chapman: Meera, are you happy for me to talk to this point first?

Prof Agar: Yes.

Dr Chapman: I could not agree more. I think it is an absolutely critical need for focus. A lot of the points that we have identified in terms of the clinical difficulties in identifying patients who might have palliative needs and determining exactly what their preferences and values may be as their illness advance relate to, we believe, the difficulties that many clinicians have with actually communicating in these kinds of spaces. These are difficult conversations to have. Without having the adequate training, competency and confidence to be able to have these conversations, they often do not happen.

I personally have been involved in attempts at Canberra Hospital, which is the place where I work, to build communication education interventions to try and help upskill our workforce in learning how to have these conversations, to have the kind of confidence to be able to take that first step. But, while there is a general recognition that this is an important thing, at the moment there is not a lot of resourcing, support and attention. This is a critical area for us as a healthcare community to really focus on to meet the needs of the community.

THE CHAIR: This will be my last question. We have heard from witnesses talking about death in general and that end of life choices and end of life care choices are things that are difficult for families to do, for people to do. But we have also heard evidence that it can be difficult to have conversations about advance care planning or advance care directives with health practitioners, mainly GPs, because of time factors and being unsure about how to have those conversations. Would you tend to agree with those contentions?

Dr Chapman: Yes, all true comments.

Prof Agar: I think it is not only time. I think sometimes people and their families put out a feeler and are really saying, “We would like to talk about this.” Clinicians who are not confident will either not see that flag or will actively shut down that line of conversation.

I think a lot of the evidence suggests that these things take a bit of time up-front. It is not an exorbitant amount of time, but that investment up-front has so many flow-on effects, both in terms of the efficiency of matching care with exactly what the person is wanting and needing but also that that early timely conversation saves a huge amount of crisis—saves very highly distressing conversations down the track. We would see communication skills as similar to a surgical skill. Maintaining currency is something that is really critical for all sorts of care professions.

Dr Chapman: I completely agree with that. I guess the other comment I would make refers back to your reference to the community’s difficulty in having this discussion.

That is another thing that Professor Agar mentioned in her opening address and in the submission. It is this increasing recognition from within palliative care, but I think within the community at large as well, that we as a society have a lot of work to do in recognising that death is actually a natural part of our living. If we as a community—to our point of comfort—can embrace that or at least recognise it and discuss it with the people who are dear to us, some of the things that are currently considered healthcare problems may actually not necessarily need a healthcare solution.

The increasing focus for many specialist palliative care providers and people who are interested in this area is on looking at how we can make our communities more compassionate, how we can improve our death literacy as a community. It is actually a way of moving some of these issues away from the healthcare space and improving the way that we are supporting each other as human citizens in our journey towards dying.

MRS DUNNE: There are so many questions I would like to ask, but I will start with a workforce issue. In your recommendations you touched on what I suppose we call palliative care literacy for the wider health community. How many palliative care specialists are there operating in the ACT?

Dr Chapman: It is a good question. I have to take this on notice because this is my sort of guesstimate. I run the Canberra Hospital service. I am the chair of the Palliative Care Network, but I do not work for Calvary Healthcare, which runs the bigger palliative care service. My understanding is that in terms of palliative medicine specialist FTEs there are around four FTE in the ACT at the moment, which is—

MRS DUNNE: And people in training?

Dr Chapman: There are two advanced trainees in palliative care at the moment. Notably, there are not any roles for those people to step into, were they to complete training. There are about four FTE-available palliative medicine specialists in the ACT at the moment. It is important to note that that is notably less than the prediction in the palliative care planning services plan in the ACT for 2013 to 2017. It predicted that there would be a requirement for eight FTE by 2017. This is just for palliative medicine specialists. Obviously, it does not include nurses and allied health—

MRS DUNNE: Yes. I was going to move on to that as well.

Dr Chapman: Also, as Professor Agar was updating me in our discussion yesterday, the current peak body recommendation from Palliative Care Australia for 2018—this is a January document entitled the *Palliative care service delivery national plan*—now suggests that in fact there should be two FTE per 100,000 of population for palliative medicine specialists to be able to provide best care.

MS CHEYNE: Two per thousand?

Dr Chapman: Two per 100,000.

MRS DUNNE: That would be eight in the ACT.

Dr Chapman: Or perhaps more if you consider that in fact we treat many more people than just from the ACT.

MRS DUNNE: That is right. We take in the region, yes.

Dr Chapman: I guess a summary of that blurb would be to say that we are on all counts under-resourced for palliative medicine specialists in the ACT.

MS CHEYNE: By at least half.

Dr Chapman: By at least half, yes.

MRS DUNNE: Would that translate into the nursing and allied health professionals who work in palliative care as well?

Dr Chapman: Yes; I think that is a fair comment. Traditionally, there is a stronger workforce for palliative care nurses, often in many jurisdictions, compared to palliative medicine specialists and allied health workers working in palliative care contexts.

The most recent update from Palliative Care Australia around this issue does not give a clear recommendation on the number of nurses, although based on the 2003 recommendations from Palliative Care Australia again, we are very likely, in the ACT, well below the recommended numbers and likewise within the allied health context.

MRS DUNNE: And moving on from that to the number of available beds in hospital, in hospice, in the community, can you comment on the supply of beds versus the demand?

Dr Chapman: It is a very complicated issue from a specialist palliative care perspective because some of the need is invisible. Some of the people who probably should be getting access to specialist palliative care services due to the reasons we have already discussed probably are not getting access to them. So it is likely that the need is much greater than we recognise.

Having said that, we are unable to meet need currently for a couple of different reasons. Home-based services, community services, are stretched and are not able to provide best care. The inpatient palliative care beds at the moment are only available as an off-site facility at Clare Holland House. Whether those beds are available depends a little on when you ask. Sometimes the needs are greater and sometimes the needs are less. But I understand that the occupancy rate of that service is often around 80 per cent, so there often is capacity within that service in terms of physical beds, although staffing for those beds is perhaps more of an issue.

An even more pressing issue is the availability of palliative care beds within an acute hospital context. In the ACT at the moment there is no provision for palliative care. There are consultation palliative care services, which I run at Canberra Hospital, but there is no availability for a person who has acute needs who also needs specialist palliative care needs to be in a palliative care bed in the acute hospital.

MRS DUNNE: There is no palliative care ward in the hospital?

Dr Chapman: No. This has been an ongoing point of discussion and something that has certainly been talked and thought about. It is not that it is a completely novel idea. There has been a sort of draft plan for how that might look and how that might work and the resources required for that circulating within ACT Health, but there are no actual beds at the moment.

MRS DUNNE: Are you aware of the Productivity Commission report on human services and their commentary on palliative care which came out in March or April?

Dr Chapman: I am aware of it but not in detail.

Prof Agar: Yes, I am aware. ANZSPM presented to the Productivity Commission whilst that was in draft.

MRS DUNNE: Are you yet able to respond to the recommendations or is that a work in progress?

Prof Agar: Was there a specific recommendation that you—

MRS DUNNE: No. There were half a dozen fairly general ones, but I was wondering what your organisation's initial response to those recommendations would be?

Prof Agar: Our view is that to get flexibility, responsiveness and integration, you need a critical mass of services to start off with to drive that sort of innovation and capacity to enhance palliative care services. Our view is that we need to get the critical mass issues sorted. Some of the Productivity Commission's deliberations are very aspirational, but there are some really critical issues we have to put in place to be able to then project to some future models that will be very innovative and able to deliver the things we are aiming to do for people at the end of life.

MS CHEYNE: Dr Chapman, I am not sure if you are aware but previous witnesses have praised your work, so it is very useful for us to now have you here, to talk to you directly.

Dr Chapman: Thank you.

MS CHEYNE: We have heard some examples from previous witnesses where they have had a relative who has been in the hospital and then has been moved to Clare Holland House. We heard from some witnesses yesterday about a delay in that happening or even being refused by a social worker until the chaplain rang up and intervened. Although I am not asking you to comment on that specific case, can you paint the picture of the journey people have had in the hospital system, including if they then get referred to Clare Holland House, so that we can see it from your perspective?

Dr Chapman: That is a good question. There are lots of different journeys that might result in a person being referred to and accepted at Clare Holland House. Traditionally the usual reasons for a person to go to Clare Holland House from a clinical

perspective are that a person might be approaching the end of life context and might be coming close to dying and Clare Holland House is their preferred place to die. And so they are accepted to Clare Holland House for that purpose—to be able to care for them as they are dying.

It might be because the complexity of their needs, their palliative needs, is such that having round-the-clock specialist palliative care input is really critical, and that might be because of their physical needs, their psychological needs, their spiritual needs or some other kind of need that is best provided in that context. Sometimes people go there for respite care, although that is a less frequent thing just because of capacity and usually not from the context where a person is coming from hospital, for instance, as raised in your comment.

Part of the difficulty for Clare Holland House, though, in negotiating when a person is offered care and how that care is offered is because it is a small facility. It is 19 beds and, like the acute hospitals, it is a short-term facility. It is not a place a person can go to for a long, long time. That often puts people in the unenviable situation of recognising that they would like to be at Clare Holland House and they would like to be as soon as they can be and yet, because of the context of the needs they have or the uncertainty of exactly how long they might need that bed for, it is difficult to determine exactly when would be the right time for them to go. Does that make sense?

MS CHEYNE: Yes, it does.

Dr Chapman: It is a vexed situation because all the clinicians involved would clearly identify that if a person's preference is to be there, obviously that is a priority. It is really important that that is a priority that is balanced against others, but there are lots of priorities at play. Having access, having the availability for someone else to get care in that context who may not necessarily have that specialist care support if they were not at Clare Holland House is also an important thing to balance against it. Does that make sense?

MS CHEYNE: Yes, it does make sense. Death and dying is quite inexact. We constantly hear how difficult it is to predict someone's death even in a six or 12-month period. I think Clare Holland House on some level is a victim of its own success.

Dr Chapman: Absolutely.

MS CHEYNE: It is widely and highly regarded and I think a lot of people just want to go there without necessarily understanding when is the right time for them to go there.

Dr Chapman: I think that is absolutely true, and one of the things that makes that so much harder is that, if we recognise that Clare Holland House is this gold standard of care that provides an excellent service—just about everyone I have ever spoken to thinks that the care is excellent—lots of people want to go there. And yet if, for instance, a person's care needs are such that they do not necessarily need to be at Clare Holland House anymore because their needs have changed, there is no good

next step available.

We have identified that, for instance, the aged-care sector unfortunately, despite many best efforts, does not necessarily provide the level of palliative care we would ideally provide, and resourcing for community home-based palliative care is such that being able to replicate best care is not always easy to achieve either. Therefore, there is some difficulty for people who might have a short-term requirement at Clare Holland House. They might need or wish for the care in Clare Holland House in the shorter term but are not necessarily close to dying. It is not easy to figure out what is the appropriate and wished-for preferred next step for them. The lack of availability of those next steps makes it then more difficult to get people into Clare Holland House because it is only 19 beds.

MS CHEYNE: Are there situations where people, like you were saying, go into Clare Holland House and then perhaps their needs are not as great anymore? When that occurs do they normally stay at Clare Holland House because moving them out is logistically more complex than it is worth or are there situations where they come back to a hospital setting or a home setting?

Dr Chapman: There are absolutely contexts and situations where people go home from Clare Holland House, go to aged-care facilities and come back to acute hospitals. All of those things happen. Perhaps they could even happen more if there were more robust services available in those other contexts to be able to continue that care.

The more that we are able to get people into Clare Holland House in a streamlined, flexible and immediate way, but then also be able to move them to somewhere else appropriate for them when their needs have changed, the easier it would be to get the next person into Clare Holland House because the bed would be available. Does that make sense?

MS CHEYNE: Absolutely. That is the crux of some of the evidence we heard yesterday.

Prof Agar: Australia-wide there are some innovative models to try and address that group of people who have intermediate needs in terms of complexity but not the duration of needs. It is a group of people, especially some who are younger—people with brain tumours are a good example—who have very high level physical care needs and are young. Residential aged care is not necessarily designed to meet that context of need. That is really highlighted by palliative care services. There is a significant gap, and there are models in Australia which are trying to tackle that.

MS CHEYNE: Do you have examples of models we could look at?

Prof Agar: There is a hospital in Victoria—I would have to check exactly which one—that is looking at a step-down model within its acute-care service and looking at the economic framework for how that compares to both the acute unit and the palliative care unit. In south-west Sydney we developed a palliative care suite within a residential aged-care facility where we partnered with the specialist palliative care service and provided proactive assessment and care planning on a weekly basis. We partnered with GPs on a regular basis to upskill their confidence.

We work through things like pharmacy and a medication licence and all the practical infrastructure things that a palliative care unit has that residential aged care does not have. There are intermediary solutions in terms of equipping a residential care facility or an acute-care facility with some of the additional things. But it is really about thinking what those elements are, articulating processes by which they can enhance that model of care, and putting in structures and relationships and partnerships to make that happen. I think there is a practitioner model in the ACT which is working in partnership with residential aged care. That is another good example of trying to bridge that specific gap.

MS LE COUTEUR: Continuing from that question, what do you think could be done to improve palliative care in aged care, given that for many people that is going to be their last place of residence?

Dr Chapman: Thank you for the question. I guess—and I am sure Professor Agar will want to speak to this point as well, because it is a very clear area of focus from her research as well—for us, there are a couple of key things that can be done and that should be done: empowering and educating the workforce within an aged-care context to be able to provide palliative care to residents, to identify the needs that they are unable to meet themselves, and to recognise and to know what the pathways are to be able to get support; and to be able to provide in-reach care support options through specialist palliative care services to help to articulate these needs, provide that education and provide the extra care when it is required.

Also, one of the many complexities within aged care is that, given the care capacity limitations of aged-care workers, if something happens that is unexpected, is unpredicted or does not have a clear plan, the immediate response tends to be referral to an emergency department. Obviously that has potentially huge, and sometimes really tragic, implications for the resident and the family involved in that referral if it is avoidable or preventable. There is a need for working with aged-care facilities to put in the best plans that we can through advance care planning mechanisms and improving palliative care plans for residents and families to make sure that we are avoiding unnecessary hospitalisations and clinical interventions when they are unwanted or inappropriate.

MRS DUNNE: On that, is there much recognition, in your experience, amongst aged-care providers in the ACT that they need to lift their game?

Dr Chapman: That is a very complicated question to answer. I think a lot of care workers and people involved in aged care recognise that the care that they provide is not what they would wish in a perfect world. I think, also, that a lot of staff are very passionate about doing the absolute best with what they have got and doing the best for their residents. I would hate the implication from this discussion to be that the aged-care sector is not doing enough and is not recognising that there are actually issues. I think they do try very hard. Many of them try very hard and very creatively to do their best.

There is a program that is working that is underway at the moment which I have been a bit distant from because I am on leave at the moment, with ACT Health, Canberra

Hospital health services and a lot of the local aged-care facilities, in trying to get into the same room and talk about care needs, transitions, palliative needs, advance care planning and these sorts of things, and actually trying to work out, as a care community, how we can do this better and how we can do it more transparently and systematically. So there certainly are steps, even within the current resourcing, to try and improve our game. But there is a lot of work to do.

MRS DUNNE: I might be a cynical old legislator, but what you are saying is that there is creativity within the current resourcing. For me, it is not even really code; there is just not enough money being spent in the aged-care sector for them to actually meet needs.

Dr Chapman: I think that is undeniably true.

MRS DUNNE: Let us not do it by code.

Dr Chapman: The reason I keep coming back to creativity is that my suspicion is also that if we just spent more money doing exactly what we are doing at the moment, it still would not meet needs.

THE CHAIR: It still would not make any difference.

MRS DUNNE: Yes.

Dr Chapman: And actually we need to both resource things appropriately and think really deeply about how we are going to use those resources better than we are using them at the moment. I think that is probably required.

MRS DUNNE: Okay. It is not just more of the same.

Prof Agar: I think probably the other thing to say is that access to our facilities is quite a critical element, but in terms of actually maintaining good system controls, the role of the registered nurse in residential aged care becomes quite critical in that practices are really important. That is often missing or you have one registered nurse who is trying to provide palliative care for a large number of residents, which becomes impractical if we are actually trying to have timely and responsive responses to inadequately controlled situations.

MRS KIKKERT: I am quite keen on dignity therapy. We heard about it the other day, and we found out that it is not available here in the ACT. Could you tell us which jurisdiction provides this dignity therapy and how we can implement that in the ACT?

Dr Chapman: That is a really good question. Again, Meera, jump in at any stage if you want to. I am aware of providers within South Australia and Victoria, and I am sure in New South Wales as well, who provide dignity therapy as it was described by Harvey Chochinov in his initial descriptions.

Dignity therapy is a particular approach, one of many, in how to embrace and regard our sort of narrative experience of our life; to have that be recognised and honoured; and to have—I am searching for the right word—the impact of that both received and

understood by the person who has lived that life and also shared with those around them, their community, their network, their family. While it is an undeniably powerful mechanism to do that, it is only one way of doing it.

Certainly a focus on providing interventions that honour the individual and their life experience and also supports to enable that legacy to continue into their death and dying, including really robust bereavement supports, are absolutely required in the ACT, and there is no distinct, discrete funding or resources for those things really at the moment.

MRS KIKKERT: Do the people that provide that service go through a special type of training?

Dr Chapman: Yes. Yet again, Meera, jump in at any point if you wish to. I have not been specifically trained in providing dignity therapy myself, but I understand that there is a described training program to be able to provide that therapeutic approach. As mentioned, it is a very important intervention, one of a number of different ways of recognising the individual and honouring them, but it is something that requires particular training.

MRS KIKKERT: Is it offered by palliative nurses or by a special person who has that training?

Dr Chapman: Usually by a special person who has had that training. The vocation of that person is not specific, from my understanding of it. You could be a person who has a spiritual care or pastoral care background, a psychologist, a nurse, a doctor—many different types of clinical background—to be able to provide that particular intervention. But you do need some training to be able to do it.

Prof Agar: Critically, it needs to be available at a particular time. It is something that is worked through with the person over a period of time, and so again there is a need for that early intervention and rating these sorts of options. Allowing someone some time to think about whether that is for them so that they can engage truly through that process over a period of time is, I think, one of the issues. Even in places where it is available, if you do not have it offered at the right time, it is also problematic.

Dr Chapman: That is a good point, Meera. Adding to that, coming off the points we made previously, at the moment, as we have identified, while palliative care resources of a variety of different types are under-resourced, there is probably also much greater need, because these conversations are not being had and people are not being offered even what is available.

It is quite probable that even if we had dignity therapy available in the ACT, there might be many people who would benefit from it who would never even know about it, because there is not enough comfort in actually having these conversations with people raising these issues. Specific resources such as dignity therapy may be a really important part of the puzzle, but without us actually making sure we are doing the work to make everybody realise that it is everybody's business to talk about palliative care and to talk about death and dying, the right people will not actually get access to it.

PROOF

THE CHAIR: Thank you for appearing today for the committee. It was insightful. I am sure we could have spent hours talking more, but unfortunately we are out of time. There will be a proof transcript provided to you once it is available, to provide an opportunity for you to check the transcript and suggest any questions, should they be required.

FITZHARRIS, MS MEEGAN, Minister for Health and Wellbeing, Minister for Transport and City Services and Minister for Higher Education, Training and Research

DE'ATH, MR MICHAEL, Interim Director-General, ACT Health

BONE, MR CHRIS, Deputy Director-General, Canberra Hospital and Health Services, ACT Health

LAMB, MS DENISE, Executive Director, Cancer, Ambulatory and Community Health Support, Canberra Hospital and Health Services, ACT Health

THE CHAIR: Welcome to our final witnesses for today's hearings. Minister, before we get started could you confirm for the record that you understand the privilege implications of the statement there. And could all the officials also confirm for the record that you understand the privilege implications of the statement.

Ms Fitzharris: I do, thank you.

Mr De'Ath: I do.

Mr Bone: I do.

Ms Lamb: I do.

THE CHAIR: Minister, would you like to make a brief opening statement?

Ms Fitzharris: Thank you, madam chair. I will be very brief, because I know time is precious and you probably want to ask a lot of questions of the people beside me. I want to note that I am here in my capacity as Minister for Health and Wellbeing, but the government's submission obviously raises a range of issues across other directorates, particularly legal issues. I have with me members of ACT Health who can talk to specific issues.

The government warmly welcomes this inquiry and the way that the committee has conducted the inquiry, and the range of submissions it has received, which the government is very pleased to see. Obviously there are matters of substantive importance but there is also the democratic imperative for the ACT to be able to have a democratic debate and for the Assembly to make its own judgements and laws about what is right for our community.

There are a range of issues covered. We have ACT Health staff with us today and we are very keen to answer your questions and particularly to follow up on any further questions around health service provision, particularly palliative care.

THE CHAIR: Minister, we have been hearing a lot of evidence over the last five hearings and today, the sixth hearing, about some of lack of understanding, possibly, or lack of delivery, of palliative care service in aged care. I know aged care is a federal matter, but do you hear much about that as minister for health? Do officials hear much about that through their roles, working in the ACT health area?

Ms Fitzharris: I will let others respond, but although it is often presented that aged care is a federal matter, from my point of view as minister for health, residents in

ACT aged-care facilities are ACT residents and need to receive the highest quality care. It will be the case that many of those residents may find themselves receiving treatment from ACT Health staff in ACT health facilities. In many instances, whether it is regarding palliative care or other health services, it is possible that they did not need to end up in a hospital. They may have been able to receive better treatment if we had worked more closely.

That goes to issues that we are discussing more broadly at the moment about the stewardship of the health system in the ACT, but that is probably a broader comment. I will ask either Chris Bone or Denise Lamb to talk specifically about it.

Mr Bone: We do not get a lot of feedback about palliative care services or a lack of palliative care services in the broader community, in residential aged-care facilities and in people's homes. We get feedback through complaints, phone calls or whatever; it is not something that comes up on a regular basis.

THE CHAIR: That is very interesting. We have heard a lot in relation to both palliative care in particular, as you suggested, and at home, in hospital or in residential aged care. That is quite interesting; thank you for that.

Mr Bone: In relation to formal feedback, we do not get a lot of feedback.

Ms Fitzharris: Could I add to that. The ACT quality in health care awards are held every year. This year the award was won by a team at Clare Holland House. The work that they do—I think there may have been a submission reflecting on this either through a professional association—

MS CHEYNE: Was this the INSPIRED trial?

Ms Fitzharris: Yes.

MS CHEYNE: It has been mentioned a few times.

Ms Fitzharris: That sort of work is underway and effectively is funded by ACT taxpayers, as we fund the provision of services both at Calvary Public Hospital and at Clare Holland House. Those are the sorts of areas where I am keen to learn how they are going. They are obviously going very well. If you have had even a five-minute conversation with the team that provides these services, you will know that they are very inspiring and dedicated professionals.

MRS DUNNE: I would like to reflect a little on the palliative care services plan, which is mentioned in your submission, which expired in 2017. It was for 2013 to 2017. Firstly, what is the status of that plan? Is there a replacement plan? And you set forward six goals in that. Have those goals been reviewed? My reading of those goals, in the context of the evidence that I have heard and this committee has heard, would be that we probably have not met any of those goals. I would like some general background on the status of the palliative care services plan and general commentary on your assessment of the last plan: whether it worked, and what needs to be done if it did not.

Ms Lamb: I am the Executive Director for Cancer, Ambulatory and Community Health within Canberra Hospital and Health Services. The palliative care plan for the ACT was written to cover the period from 2013 to 2017. What occurred during that period of time was the move to work towards a territory-wide services plan. The palliative care territory-wide services plan was how we were moving forward. A consultant was contracted to develop a plan into the future. We are now working on the implementation of that plan, which will cover off and take the place of the previous palliative care plan.

MRS DUNNE: Is the substitute plan published? Is it available for the committee?

Ms Lamb: The implementation plan and the model of care have been. Yes, they can be made available to the committee.

MRS DUNNE: Are they currently being implemented?

Ms Lamb: Work has commenced on the implementation of that plan, yes.

MRS DUNNE: You said you had a consultant. Who did the consultant consult with to devise the plan?

Ms Lamb: Communio were the consultancy group. They worked with all services within the ACT. They consulted widely within services and also consumers of palliative care to develop this model of care and implementation plan to move forward.

MRS DUNNE: When did it start to be operational?

Ms Lamb: It has not been made operational at this point in time. There is a process where, over 12 months, it will be implemented. The first component of it is looking at the governance of services across the ACT and how to improve that networking of services to ensure that there are a range of people working to provide that front-line service to the community. That acknowledges that it is made up of GP services, community services, hospital-based services, and palliative care through Calvary. It is about really focusing on a holistic approach to palliative care.

MRS DUNNE: Has there been a review of the 2013-17 palliative care services plan?

Ms Lamb: As part of the development of the new model of care and implementation plan, that previous plan was reviewed, and discussions were held with a range of stakeholders as to whether or not it achieved its aims and objectives, and how to move forward to progress those.

MRS DUNNE: What was the assessment about the effectiveness of the 2013-17 plan?

Ms Lamb: My understanding is that there was acknowledgement that there had been progress from the beginning of that plan; however, there was still a long way to go in how we can best provide those services across the ACT as a networked service, rather than individual services working on their own.

MRS DUNNE: Minister, could the committee see those papers?

Ms Fitzharris: Yes, we can provide those.

MRS DUNNE: Thank you.

MS LE COUTEUR: I am glad to see that there are people who can answer questions apart from health ones, because I was surprised that we are only having Health coming. My question is about elder abuse and the capacity to make decisions, given that most of the people for whom end of life is an issue are older, and some of them have lost capacity or may be excessively influenced by people around them. What do you see that we can do to reduce that problem? This is basically a legal question.

Ms Fitzharris: At the outset, let me say that the staff with me today are all from ACT Health, but the submission that the ACT government put in covers a whole range of areas. There are some things within that in relation to which, if I could suggest it, those are follow-up questions for other ministers and other officials.

MS LE COUTEUR: Okay.

Ms Fitzharris: Particularly on elder abuse, I know that Minister Ramsay is leading a piece of work on that, including with the ministerial council on ageing. It is a priority for him to talk through that, and Health will have involvement in that broader piece of work.

MS LE COUTEUR: Okay. I thought from your remarks at the beginning that you were going to be able to cover everything, despite only being the minister for health.

MS CHEYNE: No; she said the opposite.

MS LE COUTEUR: Sorry; I interpreted it that way. I was a bit disappointed that it was only a submission from the Health Directorate, because I think this issue is vastly bigger than health.

MS CHEYNE: Her submission is a government submission that includes comments from the attorney.

MS LE COUTEUR: I have actually read the submission.

MS CHEYNE: Yes. I think we asked them to appear and they said no, but perhaps we need to revisit that.

THE CHAIR: Yes.

MS LE COUTEUR: My understanding was that we had asked the attorney to appear and he had refrained. Being the government representative, you are the one. I misheard your earlier comments to understand that you would be able to talk about the whole submission, because you had other people who would be able to help you.

Ms Fitzharris: These are wonderful people from ACT Health. I am happy to follow

up on that or let the committee do that on its own.

THE CHAIR: The committee will follow up with other ministers; thank you.

MS LE COUTEUR: I will leave that one then.

Ms Fitzharris: I am sure they are listening, by the way.

MRS DUNNE: I hope so.

MS LE COUTEUR: Hopefully, they are listening and quickly writing that they would love to appear.

Ms Fitzharris: Yes, I understand.

MS LE COUTEUR: I can approach it from a health angle, because advance care directives are used in the health system, and we have heard evidence, firstly, about whether people have the capacity to make them and, secondly, possibly an even more difficult issue, about whether they have the capacity to amend them. People may have an advance care directive for some time in the future, but if their world has clearly changed or it would appear that possibly their desires may have changed, how do you go about looking at capacity? We had some discussion from someone earlier about supported decision-making rather than substitute decision-making.

Mr Bone: I would need to get full advice. This is a discussion between the clinician, the patient and the carer or the relative, but everybody is assessed on their capacity to give informed consent. Where that capacity is diminished, there are processes in place where we support the individual through the administrative tribunal process for guardianship to oversee. So there is an independent body looking at how we protect the rights of an individual who maybe does not have the full capacity to make an informed decision. That process is well legislated and stepped out. And we provide safety and protection for patients while that process goes through.

We can only do so much once the patient comes to us. If there is a clinical judgement that the person does not have the capacity to make an informed decision, we put those safety procedures in place so that we protect the safety of the patient.

MS LE COUTEUR: We heard evidence before, as I said, about supported decision-making, where people were talking about someone who might have 30 per cent capacity—I do not know how you measure it—but with support was able to make decisions about their care which reflected the state they were in at that time, as distinct from the state they may have been in 10 years previously when they quite possibly would have had different views on life. That is not something that is available—

Mr Bone: I cannot comment on that. I do not have the information.

THE CHAIR: That is probably something for the Attorney-General, for the legal people.

MS LE COUTEUR: But it would be clearly implemented within—

MRS DUNNE: Yes, but it needs a legal framework. I do not think that the Health staff are qualified, and the health minister has made it clear that they are not qualified to make these comments. Is that right?

Ms Fitzharris: I think you will get a fuller answer from potentially Justice and Community Safety officials, yes.

MRS DUNNE: Sorry, when I say that you are not qualified, I do not mean that disparagingly.

Ms Fitzharris: I am not a lawyer.

MRS DUNNE: I do not mean that disparagingly, but it is not your area.

Ms Fitzharris: I did understand that; I did appreciate the distinction. It is genuinely something where it is a whole-of-government issue. A lot of people contributed to the government submission; I think it would be an opportunity for you to hear from the legal experts inside the ACT government.

Mr De'Ath: We acknowledge the concern and appreciate the issue, but we are not able to comment further beyond that at this time.

MS CHEYNE: I am sorry I had to dash out before. I think these are Health questions, but tell me if they are not. I note your earlier comment that you do not get a lot of feedback about palliative care services, but in our last five days of hearings we have had a lot of feedback. I am not sure how closely you have been following our hearings, but some of the things we have heard are that we need better training of doctors in terms of their, for lack of a better word, bedside manner in explaining palliative care and what it looks like, and what to expect in dying, both to the patient and the family, and when that is available.

The need for more palliative care services, particularly home-based services, has been a theme right throughout from the professionals that we have heard from. We have also heard that there is a need for more support for the acute staff in the hospital and, I think, that there is a lack of debriefing opportunities for some staff. And resourcing has come up quite a lot. We heard some figures earlier today that the ideal standard is to have two FTE per 100,000 head of population and that at the moment in the ACT we have a total of four FTE palliative care specialists.

That is a bit of a summary, but I just wanted to see whether those things were on ACT Health's radar and—this is a bit of a follow-on from Mrs Dunne's questioning—whether there is work being done in any of these areas. Something else we have heard about is whether there should be a specialist palliative care ward within Canberra Hospital, and whether that is in the works.

Ms Fitzharris: Just as a broad comment, I think the original question was around residential aged care and palliative care. That was the original question as opposed to feedback on palliative care in general. Chris might be able to talk further to that.

MS CHEYNE: Sure, yes. Yes, sorry.

MRS DUNNE: I did not pick up that distinction before. I thought that when Mr Bone spoke before, it was about feedback on palliative care simpliciter.

Mr Bone: My feedback was just on palliative care generally, but with a little focus on residential aged-care facilities.

MS CHEYNE: Thank you for making that distinction.

Ms Fitzharris: In a broad comment, all of those things are being considered in various different ways as well. A really important point that Denise spoke to earlier is a territory-wide approach. There is often discussion about what happens in ACT Health being only about the hospital. As has been discussed, it can be the hospital, Calvary hospital and maybe our community health centres, our walk-in centres and Clare Holland House. And it invariably involves primary care, which is GPs, as well, and then the community sector organisations that deliver health.

The health system in the ACT is not just about one location; it is about a patient receiving care from a range of different health specialists. That connection and territory-wide approach are something that we are extremely committed to, because the feedback that patients and members of our community always provide consistently is that we should be navigating the system for them; they should not be having to do it themselves.

In terms of location, that is feedback that I have received in broad terms around where care is provided. People often want to be in their own home or closer to their own home, for example, receiving some level of care at a community health centre, at their local GP. Only when they become very unwell might they wish or need to be in an acute hospital, and they may need to be in respite care as well. All of those matters are important around a whole range of things that are happening in health at the moment, but that is something more broad.

MS CHEYNE: Not exclusive to palliative care.

Ms Fitzharris: No, but palliative care is another example of where people may choose to die or wish to die and whether they are able to do that. When that time comes, if they are able to do that in a place of their original choosing, or whether they and their families may seek to do something else, it is a very difficult sort of discussion.

THE CHAIR: Along that line, minister, are there any recent initiatives that are happening in palliative care?

Ms Fitzharris: One that is fairly close to my heart is one that was funded recently around paediatric palliative care.

THE CHAIR: I read that in the submission.

Ms Fitzharris: We did not have specialist paediatric palliative care support. That was funded two budgets ago, after feedback from families who had lost children, around their experience in palliative care—a couple of families in particular, who also then contributed to some of the design work around what that service might look like and the recruitment of new staff to that area. There were also discussions with Clare Holland House. Generally, it is for adults, but occasionally they do have children there with their families. It is about being able to be sensitive to a family's experience, particularly when there is a child involved. So that is one, but there are a range of others. I can let Denise and Chris talk in more detail around the original question.

Ms Lamb: In relation to the point you raised in regard to the training of health professionals, that is an important area that is starting to have focus put onto it. A lot of health professionals go in to save people. To work well with someone, accepting something around death and dying, to ensure that they have a good death is a skill that we need to support our health professionals with.

One of the initiatives that has been commenced is some specific training that is being led by Dr Michael Chapman in regard to those crucial conversations that need to be had with the individual person, and their family and carers, about what their wishes are and how to explore what is their pathway of care, so that doctors, nurses and other health professionals can have those discussions in a respectful way, acknowledging the wishes of an individual person. We need to continue that work around supporting our health professionals to be able to have those conversations.

That also comes into supporting the acute care staff, when they are working with somebody who is dying, in how to best manage their own feelings and the issues that that may raise for them. As to the area in regard to the specialist ward, we are exploring what that might look like from the perspective of a palliative care ward or end of life ward.

MS CHEYNE: So it is a live issue or live consideration?

Ms Lamb: It has been explored, yes. And there is the need for people to be able to come in and have an acute episode of care. They may be a palliative care patient and require some changes in their treatment to allow them to go back home and be cared for, to live their life at home. There is that acute episode; then there is also that end of life care where you have someone who has those specialist skills and there is the environment to ensure a good death within a hospital.

MS CHEYNE: Has ACT Health got anything specific underway to try to increase the resources of palliative care or the numbers of palliative care specialists in the ACT?

Ms Fitzharris: We currently have the figure around the numbers of specialist physicians. My advice is that we are currently at 1.9 per 100,000 population and also have the second highest rate of clinical palliative care nurses, at 14.9 per 100,000. The figure is around two; my advice is that we are at 1.9.

MRS DUNNE: We have heard that we have four palliative care specialists and two in training but there is no career structure for the ones who are in training.

Ms Fitzharris: Mrs Dunne, when you say “we”, you mean—

MRS DUNNE: This committee.

Ms Fitzharris: When you say that “we have four”, do you mean ACT Health?

MRS DUNNE: ACT.

Ms Fitzharris: The ACT as a whole?

MRS DUNNE: Across the ACT there are four as a whole and two in training. The palliative care services plan says that in 2012 there were 5.8 medical staff, and the projection was that by 2017 there would be eight. It would be useful for the committee to be able to reconcile those figures, because the ones in the plan do not marry with the evidence that we have heard.

Ms Fitzharris: Okay.

MRS DUNNE: On notice, could we have a breakdown of what those figures looked like in 2012 and what they actually look like today.

Ms Fitzharris: Yes. If the committee secretariat could point us to the evidence that you have had so we can also get the context, that would be really helpful.

MRS DUNNE: Yes, sure. Thanks.

Ms Fitzharris: And that was provided as ACT Health staff or across the ACT?

MRS DUNNE: Across the palliative care service panoply.

Ms Fitzharris: For the ACT?

MRS DUNNE: For the ACT.

Ms Fitzharris: We will take that on notice.

MRS DUNNE: Could we also reflect on whether—if we are approaching 1.9 when the gold star figure is 2, that is fantastic—that takes into account the wider regional population that we might service through palliative care? I do not know how much regional support we give for palliative care.

Ms Fitzharris: We will take that on notice too.

MRS DUNNE: Thanks.

Ms Fitzharris: I have had some conversations at Clare Holland House around that very issue. Some of the services that we provide to regional patients are indeed some of the more acute services, but their capacity to provide community-based palliative care, particularly quite close over the border, for example in Queanbeyan, is something I have had discussions with them about. We will take that on notice too.

MRS DUNNE: Thank you; that is great.

Ms Fitzharris: It might be hard to pinpoint exactly that.

MRS DUNNE: Yes, but it is just to get a feel for what is actually happening.

Ms Fitzharris: A sense, yes.

MS CHEYNE: I have a final question on this line of questioning, if that is all right.

THE CHAIR: We have Mrs Kikkert still to go.

MS CHEYNE: It is short, and maybe the answer is, “I just do not know.” We have heard a few times that there is contention around whether Clare Holland House has enough beds or not. Some of the feedback that we have had is that there are enough beds but it is about the move-through of patients and also the staffing coming on and off. I do not know what my question is; I am just wondering if ACT Health has something that they can help clarify.

MRS DUNNE: Do you have a view about whether we have enough hospice beds and hospice staff?

MS CHEYNE: Yes.

Ms Fitzharris: Do you want to talk to that specifically?

Mr Bone: We do not have oversight of Clare Holland House and its occupancy and its throughput. I am happy to take it on notice and come back.

MS CHEYNE: Thank you.

Ms Fitzharris: I have had some discussions, and perhaps we could put it in writing to you, around the range of factors, whether it is a bed, the admission thresholds or the desire to have community-based palliative care as opposed to hospice-based care and a range of issues around that. We could take that on notice and provide some commentary and figures around that.

MS CHEYNE: Yes, and we completely appreciate—we were talking about it before—how inexact death and dying are, and that that does not help in terms of staffing and resourcing. But we have heard quite a variety of evidence saying that there are enough beds or not enough beds and enough staff or not enough staff. Getting to the “what is it” would help.

Ms Fitzharris: Is Calvary appearing?

THE CHAIR: They have already appeared.

Ms Fitzharris: And you did not ask then.

THE CHAIR: We asked a range of questions. I have also put 17 questions on notice to them, including some which you have just covered off, minister, and some which Ms Cheyne has just raised.

MS CHEYNE: They were one of the first to appear.

THE CHAIR: They sent us a whole bunch of extra bits of information.

Ms Fitzharris: You have learned a lot since then, yes. We will go back and see. Those services are funded by the ACT government, so we will go back and talk with them. They receive some funding from federal sources as well.

MS CHEYNE: If the answer is that we need to get them to appear again, just let us know.

Ms Fitzharris: Yes.

MRS KIKKERT: To follow up on that, we have heard many people talking about a second Clare Holland House down south or wherever. Is that something that you have discussed before or considered?

Ms Fitzharris: No.

MRS KIKKERT: That has been one of the recommendations from the submissions that we have received.

Ms Fitzharris: Right.

MRS KIKKERT: My question is in relation to page 11. You mention that various groups, including advocacy groups, will be able to participate in the SSP development process for palliative care and that there is a consultation period planned for late April 2018. Has this consultation commenced? And if so, what advocacy groups will be invited to participate in the process?

Ms Lamb: That component is part of the implementation plan that I was speaking to earlier. That consultation group is being set up as part of the governance structure for the implementation of the plan. The invitations will be going out to a forum for all stakeholders, and part of that will be the advocacy groups. Anyone that is identified as having a role within palliative care in the ACT will be invited to those, invited to be part of those consultation processes and forums.

MS LE COUTEUR: Will that include the aged-care sector?

Ms Lamb: Certainly, yes.

MRS DUNNE: I have a couple of quick questions. What support is provided to staff who are working in palliative care? And I have a question that relates specifically to ACT Health staff; I do not expect you to answer this for Calvary. In terms of their capacity to debrief professionally and to have professional assistance through the program that provides psychological assistance—

THE CHAIR: The EAP.

MRS DUNNE: The EAP, yes.

Ms Fitzharris: Employee assistance.

MRS DUNNE: Yes, the employee assistance program. Is there an employee assistance program? Do palliative care staff have access to that? And to what extent do you know that they make use of it?

Ms Lamb: I can make comment on the palliative care team that is based at Canberra Hospital. There is a program of supervision that is in place for all staff within that team where they are able to debrief and discuss any issues that they may have or anything that arises for them as part of the care of people that they are looking after.

MRS DUNNE: Do you have records of whether staff avail themselves of that? Or is it just available and it is between them and the provider as to whether they avail themselves of it?

Ms Lamb: I am talking about peer supervision that is part of their team management. There are regular meetings where staff are able to talk in relation to the cases that they are working on. They then also have the availability of the EAP, which is an external provider. We do not have information on their accessing of that service; it is a private arrangement that they can access.

MRS DUNNE: That is what I thought the arrangements would be, but there is professional assistance within the structure as well as through the EAP?

Ms Lamb: Certainly, yes.

Mr Bone: There is also an option—and I have used this—for staff to access psychological support through their GP, through the Medicare scheme, if they are not interested in using the EAP or our general sources. It is actually getting people engaged in dealing with the psychology of end of life care and death and dying in a manner that meets their needs, as opposed to anything else.

MRS DUNNE: One final question from me, if I might. I have asked a lot of people about this. Is ACT Health aware of the Productivity Commission report on integrated human services that came out in October, and the 60 or so pages in that that relate to palliative care?

Ms Fitzharris: I am only very broadly aware of it.

MRS DUNNE: There are recommendations there, and it would be useful to have some idea about ACT Health's thinking on how it will respond to that.

Ms Fitzharris: We will take that on notice. That is a good prompt; thanks.

Ms Lamb: I can say that that report is being taken into account as part of the

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implementation plan for palliative care. The commentary and recommendations that came out of that are being incorporated into the consideration of the implementation plan.

MRS DUNNE: I would love to see how that is being done, because it is quite an interesting piece of work. Thank you.

THE CHAIR: I thank the minister and officials for appearing here today. When available, a proof transcript will be forwarded to you to provide an opportunity to check the transcript and suggest any corrections. If witnesses undertook to provide further information or took questions on notice during the hearing, the committee is requesting that all questions taken on notice be responded to within 14 days of receipt of the proof *Hansard*. The committee has now completed its first hearing program. The committee will announce its future programs when available.

The committee adjourned at 11.44 am.