Quality Lifestyle Support

Enhancing the Lives of Individuals

8 January 2016

Your ref : 11.1.09

Communities, Disability Services and Domestic and Family Violence
Prevention Committee
Parliament House
George Street
Brisbane QLD 4000 email cdsdfvpc@parliament.qld.gov.

Attention : Research Director
Attention : Karl Holden

Dear Sir

Further to our conversation yesterday I have listed below some matters that I view as relevant for the committee consideration.

I have worked within the Human Service sector for the better part of 30 years with 25 years in senior management roles, the last 16 years as Director of Quality Lifestyle support. Within these roles I have regularly been engaged to provide Medico Legal Reports to the court with regard to the cost and design of service responses to those impacted by disability.

Primarily I have been engaged by respondents, but have provided reports for plaintiffs.

Legal firms such as MacDonnells Law, Shine Lawyers, Jensen McConaghy, Moray & Agnew, Workcover Qld, McInnes Wilson and Broadley Rees Hogan to name a few who have utilised my expertise in establishing commercial cost of care provision and recommended service models aligned to community standards.

QLS has also, "as an accredited provider", been utilised by the following insurers to meet the needs of numerous clients awaiting settlement of claims

- RACQ
- Suncorp/AAMI
- QBE Insurance
- Allianz

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QLS is also used by the Public Trustee and by other Trustee companies such as Perpetual Trustee, post settlement in providing services.

Key areas where I believe the committee may have some interest in my submission at hearing.

1. Areas of difference in approach to service delivery by Medical professionals and the Human Service Sector. This area alone has considerable impact upon not only the cost of service delivery, but on the manner in which services are applied. Medical services, being diagnostic and rehabilitation primarily, whereas the Human service sector is significantly more holistic, taking into account the overall environment and networks available to a supported individual.

2. Profiteering of service providers overstating need. I have personally witnessed service provision being applied at over 400% greater than what would be acceptable within government funded situations.

3. The belief of some Nursing professionals and their associations that they are the only qualified support appropriate to meet the needs of those with complex support needs. I have strongly stated to the court on many occasions that medical models, as promoted by these individuals, are not currently accepted by the greater community here and internationally. Submissions to the courts by some of these professionals at best have been misleading and overstating the educational requirement of care providers. I have seen suggested models that basically place Registered nurses in supervisory roles 24 7 in wait of the possibility of a catheter being dislodged that an untrained support worker cannot reinsert. The failure to mention to the court that this is a routine non immediate life threatening event that is easily taken care of by a visiting district nurse or a trip to an ER grossly overstates the level of support required and in turn compounds costs.

4. Service provision not meeting currently accepted human service standards due to it falling outside the Disability Services Act. This area is particularly disturbing, as I recently viewed a situation being funded by WorkCover that was instituting restrictive practices that would be considered illegal if applied to a government funded arrangement. The lack of oversight from such programs as the Community Visitor Scheme or having an appointed independent Public Guardian where needed, places individuals without intellectual capacity in very vulnerable situations. Again, some of these types of situations have been led by Medical professionals unskilled in community service delivery. I should also add that although I have the highest respect for General Practitioners, I have personally come across many situations where strong beliefs in institutional models are present. Even to the point of migrant Doctors (not realising Queensland has closed institutions for people with Disabilities) stating to me that clients I support require institutionalization. I am still asked to report on the availability of institutional placements at times when preparing reports for the court, thus indicating to me that there is still a clear lack of knowledge re contemporary models of support to individuals impacted by disability.

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As to the areas identified in your letter of the 23 November 2015

1. *The most suitable model for implementing the National Injury Insurance Scheme (NIIS) for 1 July 2016 as entered into by Queensland in a Heads of Agreement with the Commonwealth in May 2013 with options including:*

   a. a no-fault lifetime care scheme; or

   b. a hybrid common law and no-fault care and support arrangement.

2. *In undertaking its inquiry, the Committee should consider:*

   a. How the government can sustainably and affordably meet the NIIS minimum benchmarks for motor vehicle accidents;
   b. Affordability for Queensland taxpayers and motorists;

   c. The long term nature of liabilities in a NIIS; and

   d. The desire to target full funding of long term liabilities in accordance with actuarial advice.

As explained yesterday, my personal time constraints have not allowed me to formulate an extensive response to the matters but the below are a few thoughts that have come to mind.

- A hybrid common law scheme I believe would be best suited given appropriate safeguards.
- Independent but challengeable assessment.
- Mechanisms to ensure that gratuitous support is compensated adequately. If this is overlooked, greater costs will be created due to abandonment in high support needs situations. as well as increasing vulnerability to those already at risk. Automatic consideration for respite of gratuitous carers in 24 7 situations to assist in preventing abandonment issues.
- Direct involvement at a case management level pre discharge from hospital where applicable.

- Preferred provider status for accredited providers. Although some variation of cost, a set maximum unit charge to be negotiated.

- Service provider options and choice to be granted to service recipients without designated boundaries or regions which exist in other government funded schemes within communities.

- As to the manner of funding, this is an area for the insurers to examine, however, given the expense of much of the legal process and the evidence gathering basis of many of these cases, an appropriately established Multidisciplinary assessment team incorporating such members as a consulting Medical Professional, Occupational Therapist, Physiotherapist, Service provider with sound knowledge of the Human service sector to establish the representative support need and assist in the transition to a support model, will I feel, reduce overall costs.

I hope the above is of assistance and I am more than willing to assist the committee further in this matter if requested.

Regards

[redacted]

JOHN HART
DIRECTOR