15 December 2021

Committee Secretary
Health and Environment Committee
Parliament House
George Street
Brisbane QLD 4000

Via email: hec@parliament.qld.gov.au

Dear Committee Secretary

Thank you for the opportunity to provide input into the Committee's Inquiry into the Provision of Primary, Allied and Private Health Care, Aged Care and NDIS Care services and their impact on the Queensland Public Health System.

As members of the Committee may be aware, as the Public Advocate for Queensland, I undertake systemic advocacy to promote and protect the rights and interests of Queensland adults with impaired decision-making ability.[1] People with impaired decision-making ability encompass a broad and diverse group. This includes cohorts of direct relevance to this inquiry, specifically people with impaired decision-making ability who are receiving aged care services or are NDIS participants.

I acknowledge that the last decade has seen significant change occur in the health sector, including; the introduction of the NDIS by the Commonwealth Government, an ageing population which has placed increased pressure on health and aged services, the increasing cost of private health insurance, and medical advances and breakthroughs resulting in additional services and procedures being available to treat a range of conditions.

More recently, there has also been an increased focus on the quality and appropriateness of aged care and disability services, with the Royal Commission into Aged Care Quality and Safety completed in 2021, and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability currently underway.

The issue of interface

Issues that arise in the health sector, particularly for people with impaired decision-making ability, are primarily related to the current interfaces that exist between Commonwealth programs, like aged care and the NDIS, and state-based health services.

Too often, a lack of co-operation and collaboration between Commonwealth and state services mean that people with impaired decision-making ability remain in acute, sub-acute and rehabilitation health care environments (including authorised mental health units) as they are unable to access funding for the supports they require to maintain their health and wellbeing (eg. NDIS and aged care), or access appropriate accommodation in the community, which could include residential aged care and social housing adapted to their needs.

As the Committee was informed at the public briefing sessions held on 29 November and 8 December 2021, approximately 274 young people with disability medically ready for discharge remain in hospital or health care facilities, as do 320 older people.

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[1] *Guardianship and Administration Act 2000* (Qld) s209.

Level 7, 50 Ann Street | GPO Box 149, Brisbane QLD 4001 | 07 3738 9513| public.advocate@justice.qld.gov.au | publicadvocate.qld.gov.au

Some reasons for this backlog are attributed to long delays in people waiting for NDIS access decisions in the first instance, NDIS plans with appropriate supports not being in place, or an suitable residential aged care place not being available to which the person can be safely discharged.

While there is a wide-held perception that the backlog could be fixed with additional Commonwealth funding, this may over-simplify the situation and overlook issues, that if addressed, could improve the interface between the health system and these programs.

Looking at issues associated with aged care, older people are often admitted to hospital due to an infection (most commonly a urinary tract infection) or a fall in their home that involves a potentially serious break to a bone or bones, like a leg, hip, or shoulder blade, accompanied by, in some cases, concussion or a brain injury.

When entering a hospital care setting with these types of conditions or injuries, older people, being particularly unwell, can be disorientated and not able to respond to simple questions on topics including where they are, what day it is, and the details surrounding their admission to hospital.

Should, in these circumstances, an assessment of the person's decision-making capacity be undertaken at this time, there is a strong possibility that they will fail this assessment. This may then lead to either an attorney under an Enduring Power of Attorney assuming decision-making responsibility for the person or, if an enduring document is not in place, a guardianship order being made for a substitute decision-maker to make decisions related to the person's discharge from hospital.

Once this process is complete and a person is deemed not to have decision-making capacity, their likelihood of returning home (which may be their wish) does appear to be curtailed by a number of issues.

The first involves the provision of transition, restorative, or rehabilitative care. If a person is deemed to lack decision-making capacity, they are also unlikely to meet the eligibility criteria for rehabilitation or transition care services, meaning that their ability to regain movement and function, particularly after injuries like a broken hip, are restricted.

In terms of the availability of options for aged care services, once a person is in hospital, they are unable to be assessed for aged care services to be provided at home. Aged care assessment teams, who determine eligibility for aged care packages, will not assess a person's service requirements for in-home care in an environment outside of their home.

The culmination of these factors means that an older person wishing to be discharged to their own home, even if they regain their decision-making capacity as part of their recovery, is not able to return home. A lack of rehabilitation services limits their ability to regain the movement required to live independently and in-home aged care services are not available, as an assessment cannot be undertaken. Substitute decision makers may also decide that the person, although it is their wish to return home, should enter a residential aged care facility, often with the fear that they would be at risk if they returned home.

Hence, these people become members of the queue, medically ready for discharge (within the restrictions noted above) but waiting for the availability of a place in a residential aged care facility.

While the provision of additional residential aged care facility places funded by the Commonwealth government is always welcome, the information above illustrates that changes to the aged care assessment process and rehabilitation and transition services could also effectively provide another avenue through which older people could be discharged from hospital. This would need to be

coupled with a general increase in the availability of home care packages for eligible people, which is a Commonwealth responsibility. Some commitment has already been made to increasing the availability of home care packages as a component of the reforms recommended by the Royal Commission into Aged Care Quality and Safety. Issues similar to those described above may, however, be masking true levels of demand for home based aged care services.

The introduction of changes to rehabilitation services and aged care assessments are also supportive of a rights-based, person-centred approach to the provision of health-related services for older persons, which considers the person's wishes and preferences, in line with the general principles in the *Guardianship and Administration Act 2000*.

For people with disability medically ready for discharge from hospital, various interface issues are also apparent.

If a person acquires disability as a result of an accident or life changing health event (eg. a stroke) their sustainable discharge from hospital often relies on a successful application to the NDIS for the development of a disability supports plan.

Several interface issues contribute to making this process difficult, which are exacerbated when the person does not have a strong family or supporter-based network. From a hospital bed, it is difficult to know who to contact and how the process works in terms of determining eligibility to access the NDIS, and then developing a plan including the necessary disability supports to enable the person to maintain their health and wellbeing in the community. Just being provided with the paperwork is often not enough to facilitate this process, as a person with a newly assessed and life-changing disability will already be potentially overwhelmed, and not emotionally ready to take on the process themselves.

Once initial eligibility has been determined, potential participants then need to undertake a series of functional assessments involving a range of medical professionals. Facilitating access to these professionals for assessments from hospital can be difficult, particularly if the professional is not based or attached to that hospital or health service. Often there can be problems associated with perceived risk, particularly if a medical professional from outside of the hospital needs to have the person perform basic functions that require movement or mobility.

Once an NDIS plan is developed and approved, additional issues can arise that delay discharge from hospital. Many of these issues relate to things like available public housing suitable to the person's needs or a requirement for guardianship and administration appointments, which are state based responsibilities that can take many months to secure. For some participants, modifications to their residence may be required, or if they live in rental accommodation where these modifications are not possible (including public housing) there may be a need for new accommodation to be found that is suitable or could be made suitable with modification.

For some participants, finding suitable accommodation is even more complicated. If, for example, they require 24-hour support services then a larger residence may be required, or if they have certain behavioural needs that require the provision of more robust accommodation then further delays may occur.

The issues noted above can be exacerbated when a person has a psychosocial disability and is receiving treatment in an authorised mental health facility. All authorised mental health facilities across Queensland are locked, making the access required to facilitate engagement with the NDIS more difficult than in a general hospital environment. Patients in these units can also see the difficulties associated with accessing the NDIS become an issue for the Mental Health Review Tribunal in terms of a decision regarding the person's step-down program from involuntary treatment. I am also not aware if patients in authorised mental health facilities who are medically ready for discharge

are included in the data currently collected by Queensland Health, which may mean that the numbers are under-estimated.

While a number of Hospital and Health Services (HHSs) now employ NDIS and/or disability nurse navigators to assist patients with accessing the NDIS and other health related services (like GPs), the service is not available in all hospitals and the extent to which HHSs are committed to a wrap around process, including the engagement of state-based services to assist the person, varies. I am also not aware (as noted) if these services extend to authorised mental health units to assist people with psychosocial disabilities.

I understand that the Metropolitan South Hospital and Health Service (MSHHS) does provide a strong example of the disability/NDIS nurse navigation service working well, which could provide additional information for the Committee to consider in forming its recommendations for this inquiry.

The information above describes the processes and issues for people in initially accessing the NDIS and being discharged from a health care facility. However, existing NDIS participants can also be in hospital and medically ready for discharge.

In some circumstances, people with existing NDIS plans are admitted to hospital as a service provider of last resort, when their care relationship with a support provider has broken down, their service provider is not able to provide the level of supports required to maintain their health and wellbeing, or they can no longer remain at their existing place of residence and no other suitable accommodation can be found.

While for some people this may occur throughout their time as an NDIS participant, it can also occur in the initial stages, as a result of a hurried discharge from hospital into the community, where inappropriate accommodation or disability supports were provided.

Often more intensive work is required with these participants, as they are more likely to have complex health and disability related needs. Again, the provision of collaborative and co-ordinated wrap-around services, involving state and Commonwealth partners, is required in these circumstances. Work is also required with the NDIA to establish service providers and accommodation of last resort (so that people do not end up in hospital by default), particularly in thin NDIS markets in regional, rural, and remote areas of Queensland.

I present this information to the Committee anecdotally and for further investigation. The Committee may wish to gather additional information and data in relation to the issues raised in this submission.

What does appear to be obvious is the need for the interface between state and Commonwealth systems to be improved, with a collaborative approach and services to enable people with impaired decision-making ability to be sustainably discharged from hospital and other health settings into community settings, without jeopardising their health and wellbeing.

Additional funding to achieve this goal is always welcome, however this may need to be accompanied by increased coordination and collaboration between state and Commonwealth agencies. This would include, at a state level, hospital and health services, Queensland Health (as a policy driver), housing, community services and Queensland's guardianship and administration agencies, including the Queensland Civil and Administrative Tribunal (QCAT), the Public Guardian and the Public Trustee.

A potential opportunity for the Queensland Government, as least in the shorter term, may be the development or conversion of existing facilities to provide transitional accommodation for people finalising the details of their NDIS plan or waiting to enter residential aged care. This accommodation could also include rehabilitation and re-ablement services for those people who are not eligible to receive these services in hospital. The provision of these services may assist people to transition back

into a residential setting, as well as building the self-confidence and strengths necessary to prevent re-admission to hospital. Transitional accommodation may also be able to facilitate older people returning to their home for a period of time to be assessed for in-home care services, as opposed to residential aged care.

In addition, the development or formalisation (if already in place) of discharge teams, consisting of representatives from health, housing, and community services, as well as NDIS support coordinators and aged care finders (introduced by the Commonwealth government recently) and nurse navigators may also assist in addressing the interface issues and barriers that currently exist.

Thank you for the opportunity to contribute to this inquiry. Should you require any clarification on the issues raised in this submission, or would like to discuss any of them further, please do not hesitate to contact my office on Ph: 3738 9513.

Yours sincerely

John Chesterman (Dr)
Public Advocate