Statement of Liz Cairns

Name: Liz Cairns
Address: 60 Brougham Street Geelong Victoria
Occupation: Head of Independence, Transport Accident Commission
Date: 26 August 2019

1. I make this statement in response to NTG-0421, exhibited hereto as Exhibit One.

2. This statement made by me accurately sets out the evidence that I am prepared to give to the Royal Commission into Aged Care Quality and Safety. This statement is true and correct to the best of my knowledge and belief.

3. I make this statement on behalf of the Transport Accident Commission (TAC) and I am authorised to do so.

4. I am currently the Head of Independence at the TAC. I have been in this role since November 2016. I am a qualified social worker (Bachelor of Social Work, Massey University, New Zealand), and I hold a Masters in Management – Personal Injury (Deakin University). I have 27 years’ experience in disability management, particularly in the context of social insurance schemes, in Australia and in New Zealand. I have also worked at a management level in publicly funded disability and aged care services in New Zealand.

5. Prior to working at the TAC, I worked for the National Disability Insurance Agency (NDIA). I was employed by the NDIA from 2012 – 2016, initially as the Barwon trial site manager and then as General Manager Operations. Prior to moving to Australia in 2012, I worked for many years for New Zealand’s Accident Compensation Corporation (ACC) in the area of serious injury management.

6. The TAC is a statutory corporation established under the Transport Accident Act 1986 (the Act). It administers Victoria’s compulsory third party (CTP) insurance scheme to provide no fault statutory benefits and common law damages for people who are injured or who died as a result of a transport accident within Victoria, or interstate if the accident involves a Victorian registered vehicle. The TAC also has a statutory responsibility to reduce the incidence of transport accidents through funding road safety initiatives.

7. As the Head of Independence, I am responsible for the operations and performance of the Independence Division. This division is one of three claims divisions at the TAC. The division supports the TAC clients who have sustained a significant and permanent impairment due to road traumas, and who are expected to require lifelong support at some level from the TAC. The impairments are moderate/severe acquired
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brain injuries; spinal cord injuries; and 'comparable' injuries such as multiple limb amputations, severe burns, and blindness.

ENTRY INTO AND SUPPORTS UNDER SCHEME

Question 1. Please describe the process by which a person enters the Scheme, including discharge and care planning following injury

8. For the purposes of the TAC's response, a reference to a participant in the Scheme is a reference to a client who is under the age of 65 years with a significant and permanent impairment directly caused by a transport accident and who requires supported accommodation.

Claims identification and lodgement

9. The Act requires that a person injured in a transport accident lodge a claim for compensation with the TAC within 12 months from the date of the accident. The TAC has a discretion to accept a claim up to three years from the date of the accident or when the injury first manifested.

10. TAC achieves early identification of people who have been seriously injured via road trauma via the information sharing protocol with Ambulance Victoria and a range of relationships with public and private hospitals.

11. The TAC has a formal Funding and Partnership Agreement with a number of hospitals including Alfred Health, Epworth, Healthscope Ltd and Healthcare Australia Pty Ltd.

12. TAC also has formal agreements with the health services listed below, called the Hospital Accreditation Program Agreement. The intent of this agreement is that the TAC provides the health services with an educational platform for hospital staff to assist them in understanding what the TAC does and how to lodge claims for our clients. As part of this program the TAC facilitates an electronic claims lodgement platform and pays a small incentive for hospital lodged claims:

12.1. Albury Wodonga Health
12.2. Bendigo Health
12.3. Central Gippsland Health
12.4. Eastern Health
12.5. Barwon Health
12.6. Goulburn Valley Health
12.7. Monash Health
12.8. Northern Hospital
12.9. Peninsula Health
12.10. Royal Melbourne Hospital
12.11. Western Health.
13. The TAC has established triage and transfer protocols which ensure trauma patients are admitted to designated trauma hospitals. Well-established relationships and existing partnership and/or contract arrangements with the major state trauma hospitals and Department of Health and Human Services (DHHS) ensure a smooth transition for clients.

14. The TAC has contractual relationships for inpatient rehabilitation, including public and private sector providers, including slow stream/transitional acquired brain injury (ABI) rehabilitation (such as that provided by Caulfield Hospital). These contractual arrangements outline terms, conditions and performance measures. This includes direct funding for rehabilitation beds (as occupied) with specific contractual inclusions and requirements of the providers that are focused on delivering effective and efficient rehabilitation outcomes.

15. The TAC has well-established relationships with the inpatient rehabilitation providers for all clients who sustain injuries resulting in permanent and significant disability. These relationships enable early and ongoing contact by a TAC Independence Coordinator with the treatment and rehabilitation teams, the client and their family. This includes early and active participation by TAC in the hospital discharge planning with the client, families and rehabilitation units. This process identifies the most appropriate discharge destination for all newly injured clients and the supports that the client will need. The early involvement by a TAC Independence Coordinator generally means that there is sufficient lead-in time to arrange the required supports for discharge.

Independence Division

16. The Independence Division at the TAC manages all life-long claims for the Commission. These include spinal cord injury, moderate and severe brain injury, multiple amputations, blindness and severe burns. The Independence Division funds about $280 million per year in supports and holds 70% of TAC's liabilities.

17. The service model of the Division has an Early Support Branch, which provides support co-ordination for clients from date of injury up to two years post injury. This enables active involvement with clients during the in-patient rehabilitation phase including discharge planning and integration back to community. This team engages early with other areas of the Division including the centralised Accommodation team and Home modifications team.

18. Once a client has been supported to integrate into their community and their intensive support needs have reduced the Independence Service model supports a transition from Early Support Co-ordination to Active Support Co-ordination (for longer term active planning). Where the client needs have stabilised and there is no further need for active planning, the claim is retained within the Independence Division for long-term support.

19. The Independence Division also has a specialist team of Intensive Support Co-ordinators who work with clients who present with high and complex needs, typically characterised by interfaces with multiple parts of the wider health and service systems, such as Justice, Mental Health, and Child Protection.
Question 2. Please identify the policies/procedures that govern the Scheme's provision of therapy, rehabilitation and functional independence services

20. All TAC's public policies are guided by the Act and are available online at http://www.tac.vic.gov.au/providers.

21. Also, in response to this question, TAC has identified internal policies relevant to clients who are under the age of 65 years, have a significant and permanent impairment and require supported accommodation. These documents are not publicly available and copies are exhibited hereto as Exhibit Two.

22. Confidentiality is claimed in relation to all of the documents contained in Exhibit Two and the TAC seeks a non-publication direction pursuant to s 6D(3)(b)(ii) of the Royal Commissions Act 1902 (Cth) in respect of these documents.

Question 3. Please provide any policy/care pathway documentation that describes the process of developing and activating a care plan for a participant, including decisions regarding accommodation and care. Provide any documentation that describes the process that would result in aged care placement for a Scheme participant.

23. The Independence Division introduced a client-centred planning approach in 2011, called Independence Planning.

24. The independence planning process supports clients to develop their own goals. The provision of services is then aligned to those goals.

25. The intent of the Independence plan was to:

25.1. place the client at the centre as they work towards maximising their independence;

25.2. work with the client to identify specific, measurable, achievable, relevant and timely goals (SMART). Services and treatment is then aligned to goal attainment;

25.3. focus on client outcomes and proactive management based on goal setting rather than client experience and reactive claims management;

25.4. work in partnership with clients, providers and their communities to support their goals;

25.5. develop and co-ordinate an agreed action plan for clients, TAC and providers.

26. Given the disability sector is currently experiencing significant reform, with the introduction of the National Disability Insurance Scheme, the TAC commenced an extensive review of the Independence planning process in 2017. This review has included feedback from clients, staff, and independent consultants and resulted in the identification of opportunities to improve the current Independence Planning to ensure the TAC is aligned to the principles of Contemporary Disability Practice and the reforms currently occurring in the disability sector.
Future Independence Service Model to align to Principles of Contemporary Disability Practice

Independence Service Model Transformation (SMT) underway

27. This review process resulted in the establishment of the Service Model Transformation (SMT) Program of work. As part of this program, an SMT planning pilot commenced in February 2019. The aim of the SMT Planning pilot as defined within the project scope is to “work with clients, families and providers to build capability for clients to live ordinary lives”.

28. The new SMT planning approach involves:

28.1. using new conversational tools to develop a deep understanding of our clients; their wishes, preferences and needs and tailoring our approach based on this;

28.2. administering new planning tools to focus on participation in valued life roles, personal wellbeing and to identify & mitigate risk;
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28.3. new self-direction tools aimed at building capability of clients and families to lead the planning process and make choices around the types of support they receive and who delivers this;

28.4. a new digital planning platform used by staff that supports a more flexible approach to planning and reduces administration for staff;

28.5. implementation of a hierarchy of supports to improve uptake of informal and community supports aimed at reducing isolation and building sustainability;

28.6. new decision making principles that guide the critical thinking of staff in considering TAC funded supports.

29. An extensive evaluation framework underpins the SMT Pilot with outcomes of that evaluation to inform broader implementation for all severely injured clients from June 2020 onwards.

Question 4. How does the Scheme determine what supports a Scheme participant is eligible for? In what ways is this a determination of whether the supports are reasonable and necessary? What is the Scheme's approach to this determination? What, if any, limitations apply to this determination?

30. A client's (participant's) entitlement to supports are initially determined by the provisions of the Act which provide a comprehensive range of statutory no-fault benefits including medical and rehabilitation services, income support, home and vehicle modifications.

31. If a client or their treating practitioner has requested a service that is payable under the Act, the TAC will then determine whether the service is reasonable in the context of the nature of the injury, the cost of service having regard to the service actually rendered and its necessity in the circumstances.

32. Regard is also had to the Clinical Framework for the Delivery of Health Services,¹ which is produced by TAC / WorkSafe Victoria (WSV), to ensure that any service funded is evidence based, able to measure and demonstrate effectiveness of the treatment, empower the injured person to manage their injury and achieve their functional goals. The Clinical Framework is exhibited hereto as Exhibit Three.

33. As outlined above Independence clients are involved in a planning approach which identifies their goals and then reasonable supports are aligned to the goals. The supports include contributions from the client, their family/informal support networks, what is available in the community, the responsibilities of mainstream services systems, and what is reasonable for the TAC to fund. Contributions in this context are not necessarily limited to financial contributions.

Question 5. For Scheme participants under the age of 65 years requiring supported accommodation and care, how is this provided?

34. 97% of TAC clients with permanent and significant impairment are able to be supported to return to their own home. Typical supports required are home modifications, motor vehicle purchase and modification, equipment, attendant care.

(paid and gratuitous), domestic assistance, child-care (where needed), vocational rehabilitation, community access, therapies.

35. For clients who are unable to return to their home or have no home to return to TAC works with clients, their families and treating teams to determine the most appropriate alternative housing option.

36. The TAC regards a Residential Aged Care (RAC) placement as the least preferred option. The process by which all other alternatives are considered are discussed in the response to question 9. Where RAC is being considered, the determination of the client's suitability for RAC is determined through the My Aged care processes, which is progressed by the client's treatment team. Once determined as suitable, the appropriate level of care is determined through the Aged Care Assessment Service. The TAC can then fund the relevant government fees, as residential aged care is recognised as supported accommodation under the Act. The TAC can also fund a specialised Residential Aged Care Placement Provider to assist clients and families in finding an appropriate RAC facility. Additional supports that are needed to assist the client maximise their independence and achieve their goals in RAC can also be funded by the TAC.

37. The TAC has a centralised team of Support Co-ordinators who work with clients who are living in any supported accommodation setting (including RAC, Shared Supported Accommodation (SSAs) and Supported Residential Services (SRSs)). This ensures that the TAC has staff who have a detailed understanding of the challenges for clients in such environments and who are well positioned to support clients to explore alternative housing options if so desired by the client. This team also actively plan with clients to ensure TAC can support them in achieving their individual goals. In addition to support provided as part of the Government RAC fees, the TAC will fund reasonable supports to assist client in RAC to achieve their goals. This could include medical and like services, Attendant Care for community access and therapy support, individual specialised equipment, and therapies.

38. The TAC has a zero tolerance of abuse for clients. A team of Safeguarding Specialists provides proactive and reactive support to clients, families, service providers and TAC staff where issues of abuse, neglect or exploitation have been identified as potential or actual risks. The Safeguarding Specialists work with clients to build their capacity, voice and enablement to take action. The team also work with providers to enhance their knowledge of both service quality and safeguarding expectations, and manage provider compliance to service expectations.

PARTICIPANTS WITH SIGNIFICANT AND PERMANENT DISABILITY

Question 6. How many active participants in the Scheme have significant and permanent disability? Of those, how many are under the age of 65?

39. The table below sets out how many active participants in the Scheme have significant and permanent disability.*
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TAC Claims

<table>
<thead>
<tr>
<th>Category</th>
<th>&lt;65</th>
<th>&gt;=65</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active</td>
<td>2449</td>
<td>412</td>
<td>2861</td>
</tr>
<tr>
<td>Inactive</td>
<td>2270</td>
<td>771</td>
<td>3041</td>
</tr>
<tr>
<td>Total</td>
<td>4719</td>
<td>1183</td>
<td>5902</td>
</tr>
</tbody>
</table>

*There are another 105 Motor Accident Board (a predecessor of the TAC) claims that are active, of which 83 are under 65.

Question 7. What are the disability/diagnostic profiles of those under the age of 65?

40. The diagram below sets out the active independence claims under 65 years of age, by injury.

Active Independence Claims under 65 by injury

<table>
<thead>
<tr>
<th>Category</th>
<th>Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non Catastrophic</td>
<td>Above elbow/knee amputation</td>
</tr>
<tr>
<td></td>
<td>Blindness (due to nerve severance)</td>
</tr>
<tr>
<td></td>
<td>Severe burns</td>
</tr>
<tr>
<td>Mild ABI*</td>
<td>*Mild ABI defined as either:</td>
</tr>
<tr>
<td></td>
<td>a) Glasgow Coma Scale =&gt; 7 and Post Traumatic Amnesia =&gt; 7 days but less than 21 OR</td>
</tr>
<tr>
<td></td>
<td>b) Glasgow Coma Scale &lt;= 7 and Post Traumatic Amnesia up to 7 days</td>
</tr>
<tr>
<td>Severe ABI*</td>
<td>*Severe ABI defined as either:</td>
</tr>
<tr>
<td></td>
<td>a) Glasgow Coma Scale &lt;= 8 and Post Traumatic Amnesia =&gt; 7 days OR</td>
</tr>
<tr>
<td></td>
<td>b) Post Traumatic Amnesia &gt; 21 days</td>
</tr>
<tr>
<td></td>
<td>Quadriplegia</td>
</tr>
<tr>
<td></td>
<td>Paraplegia</td>
</tr>
</tbody>
</table>

Question 8. What, if any, interaction does the Scheme and Scheme participants have with the National Disability Insurance Scheme (NDIS)?

41. An individual may be both a participant of the National Disability Insurance Scheme (NDIS) and a client of the TAC provided they:

41.1. meet the access and disability requirements of the NDIS and

2 National Disability Insurance Scheme Act 2013, section 24 'Disability requirements' provides:

1. A person meets the disability requirements if:

Signature

Witness
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41.2. have been injured as a result of a transport accident.

42. Decisions regarding which scheme funds what supports is noted in the respective legislations of the National Disability Insurance Scheme Act 2013 and the Act.

43. Individuals with permanent injuries (as is the requirement of the NDIS) particularly those requiring 24 hour care and/or residing in supported living such as disability shared supported accommodation and younger people in residential aged care most likely to be eligible to receive supports from both schemes.

44. The TAC and the NDIA currently have a Memorandum of Understanding (MOU) for information exchange. This information exchange is in relation to participants or clients of the NDIA and the TAC. The TAC also has a process for supporting internal claims managers to work with mutual participants and ensure privacy of information.

45. The relationship between the two organisations is managed with a central point of contact being the Director of Compensation, NDIA, and the Senior Manager Performance and Innovation, TAC.

46. The National Disability Insurance Agency has advised the TAC that in the context of the respective statutes, the National Disability Insurance Scheme Act 2013 and the Transport Accident Act 1986, TAC funded individuals who also meet the requirements for Specialist Disability Accommodation (SDA) funding are eligible to receive SDA funding from the NDIS as this is a service which cannot funded by the TAC under its legislation. Letter from Michael Francis, Deputy Chief Executive Officer, NDIA, to me dated 20 July 2019, is exhibited hereto as Exhibit Four.

47. The TAC and NDIA are currently working through the implementation of this eligibility for funding for specific TAC clients.

48. There are likely to be other funding differences between the two schemes that may enable TAC clients to access funded supports from the NDIA. These have yet to be explored.

YOUNGER PEOPLE

Question 9. Is residential aged care considered a viable placement option for Scheme participants under 65 years? Why or why not?

49. Residential aged care is recognised as supported accommodation under the Act.

(a) the person has a disability that is attributable to one or more intellectual, cognitive, neurological, sensory or physical impairments or to one or more impairments attributable to a psychiatric condition; and

(b) the impairment or impairments are, or are likely to be, permanent; and

(c) the impairment or impairments result in substantially reduced functional capacity to undertake, or psychosocial functioning in undertaking, one or more of the following activities:

(i) communication;

(ii) social interaction;

(iii) learning;

(iv) mobility;

(v) self-care;

(vi) self-management; and

(d) the impairment or impairments affect the person's capacity for social and economic participation; and

(e) the person is likely to require support under the National Disability Insurance Scheme for the person's lifetime.
50. However, it is the least preferred option for the TAC. Every attempt will be made to find alternative supported accommodation for an injured person.

51. To ensure there is sufficient scrutiny before any client under 65 years is supported to move into RAC the TAC has implemented a number of processes:

51.1. Centralisation of all Independence clients who are living in any supported accommodation (including RAC, SSAs and SRSSs) to ensure these claims are managed consistently and active planning is implemented where appropriate.

51.2. An Accommodation Advisory Panel was implemented by this team in July 2018 as part of the TAC Client Housing strategy. This panel is available to whole of TAC business. Claims managers from across the business are required to come to this panel for case planning for any client who is needing to explore accommodation options. Since inception in July 2018, 152 reviews have been completed by this panel. This panel explores all available options before an entry to RAC or SSA is able to be endorsed. The panel supports claims staff to understand what the client wants to do and ensure the client has a voice about where they want to live. If all options have been considered, and RAC is the only option, the TAC can fund a specialised Residential Aged Care Placement Provider to assist clients and families in finding an appropriate RAC facility. Over the last 12 months there has only been one client under the age of 65 years admitted to a RAC. This client’s complex family dynamic resulted in RAC being the only viable housing option. Alternatives are continuing to be explored with client and family. A case study of this complex circumstance is exhibited hereto as Exhibit Five.

51.3. Any TAC supported entry into RAC for a client under 65 or into SSA requires approval from a Senior Manager. The Accommodation Panel members are also well known to the rehabilitation hospitals and are regularly contacted by hospital staff to explore suitable discharge options for clients who do not have a home to return to. One new solution being developed will assist clients to seek access to NDIS and to establish their eligibility for SDA, which will open up a greater range of additional and contemporary housing solutions, particularly in regional areas.

52. Where no alternative is available a participant may reside in a residential age care facility on a temporary basis until more appropriate accommodation becomes available. Sometimes a participant may reside in residential aged care by choice given the proximity of the facility to their family, especially in regional or rural areas.

Question 10. Under what circumstances would a participant who is under the age of 65 years be offered or placed in residential aged care?

53. When no other suitable accommodation option is available or where the client or their family express a preference. In these circumstances, the TAC Support Coordinator would continue to work with clients and families to continue to explore alternative housing opportunities, as appropriate.
Question 11. How many active Scheme participants under the age of 65 years are currently in residential aged care?

54. There are currently 67 clients funded by TAC for residence in RAC. These comprise 60 TAC clients and 7 WorkSafe Victoria clients that are managed by TAC. 54 (81%) of these clients are aged over 65 years of age.

55. There are 13 clients aged under 65 years in RAC (19%). 12 of these are aged 45-65 years and one is under 45 years old. For this client, it is the family’s preference to have their family member in RAC to maintain proximity. There is active planning with that client that focuses on continuing to explore and identify more appropriate housing options.

56. Of the 12 older clients, 8 are actively planning with TAC support co-ordinators to achieve personal goals. This may or may not include a goal to seek alternative accommodation. Four clients/families having chosen not to actively plan at this time.

57. Exhibit Six contains a table which sets out de-identified details of current TAC clients, under the age of 65 years, in residential aged care.