NSW Government Submission to the NDIS Review

25 May 2023

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**Introduction**

The NSW Government welcomes the opportunity to provide input to the Review of the National Disability Insurance Scheme (NDIS). The NDIS Independent Review Panel and the Secretariat supporting them have provided opportunities for input through mechanisms outside this submission in which NSW has participated. As the Review continues beyond the finalisation of this submission NSW will continue to contribute through mechanisms provided by the Review Panel and Secretariat.

This submission is an opportunity for the NSW Government to confirm our commitment to working collaboratively with all stakeholders to deliver an NDIS that is sustainable and puts people with disability at the centre of the scheme.

**NSW has a long-standing commitment to disability inclusion**

New South Wales is proud to have been the first state to sign up to the NDIS. With more than 170,000 active NDIS participants and an annual contribution of $3.75 billion to the NDIS in 2022-23, NSW has a large stake in its success.

Under the *Disability Inclusion Act 2014*, NSW has a statutory commitment to the inclusion of all people with disability into mainstream services and the broader life of the community. This is reflected in the overarching NSW Disability Inclusion Plan and made accountable in the Disability Inclusion Action Plans that each government public authority and the 128 local government Councils are responsible for developing and reporting against.

**Refocus the NDIS on its original vision and different levels of NDIS supports**

Recommitment to the NDIS as it was planned and envisaged, including returning the Information, Linkages and Capacity Building program and other Tier 2 supports to their original forms and purposes, will contribute to a system that is both sustainable and places people with disability at its centre.

**The NDIS is part of an ecosystem of services that support people with disability**

NSW funds mainstream government services that have important interfaces with the NDIS which also support people with disability. In line with its statutory disability inclusion commitment, NSW strives to ensure mainstream services are equipped to support people with disability as a part of their everyday business and their obligation to make reasonable adjustments.

A more clearly delineated set of roles and responsibilities, including those which are shared between the NDIS and mainstream services, could support all systems to deliver on their core business of supporting the people who use them.

**People with complex needs may require support to engage with all of the services they require**

People have complex lives, experiences, and disabilities. Some NDIS participants engage with multiple service systems, such as Justice, Child Protection, Health, Housing and Homelessness, and Education.

NSW is committed to working with all jurisdictions to ensure that people with complex needs receive all of the supports that they need individually, and will also receive the support they need to navigate the multiple service systems that deliver these services.

# Recommendations

**A note on NDIS Sustainability**

The NDIS Review aims to support the NDIS becoming a mature and sustainable program that gives people with disability the supports they need to participate fully in community life.

NSW supports the need for the scheme to be sustainable and available into the future.

Issues such as provider fraud and overcharging and staffing and process issues inside the NDIA are currently being addressed through a Federal budget commitment. Equally, National Cabinet has taken the lead on addressing hospital discharge delays for NDIS participants, and committing to an *NDIS Financial Sustainability Framework*.

The NSW Government recognises Australian governments will work together towards NDIS sustainability. As such, sustainability will not be explicitly addressed in this submission but we believe that the outcome of accepting these recommendations would contribute to sustainability.

The NSW Government’s recommendations in this submission are framed around a commitment to NSW citizens – a commitment that the NDIS be sustainable, equitable, and support all participants to meet their goals and aspirations through reasonable and necessary supports whilst NSW continues to deliver their mainstream supports.

**NSW’s recommendations to the Review Panel are organised under six themes[[1]](#footnote-2)**

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| * APTOS
 | * Workforce
 |
| * ILC and Tier 2
 | * People with complex needs
 |
| * Safeguarding
 | * Participant experience
 |

The themes have been selected following consultation with NSW Government agencies to identify their most pressing issues, many of which intersect with elements of the NDIS Review terms of reference.

All themes and examples focus on what people with disability need, in and outside the NDIS, to live their lives.

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| **Part 1:** | **APTOS** |
| **1.1**  | **The APTOS, roles and responsibilities of each jurisdiction.** |
| 1.1.1 | Refresh the APTOS to provide more direct guidance on roles and responsibilities of each jurisdiction. |
| 1.1.2 | Clarify governance arrangements to ensure priorities are met and work is not duplicated.  |
| 1.1.3 | Work to resolve the treatment of “in-kind supports” in NSW. |
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| **Part 2:**  | **ILC and Tier 2** |
| **2.1** | **Returning ILC and Tier 2 supports to their original purpose will create a more sustainable NDIS.** |
| 2.1.1 | Restore the focus of the Information Linkages and Capacity Building (ILC) Program to its original vision. |
| 2.1.2 | Strengthen Tier 2 supports to improve outcomes for participants and reduce long run scheme costs.  |
| 2.2 | **Returning Local Area Coordinators to their original functions will strengthen Tier 2 supports.** |
| 2.2.1 | Returning ILC and Tier 2 supports to their original purpose will create a more sustainable NDIS. |
| 2.2.2 | NDIA to differentiate and safeguard the Local Area Coordination function from other parts of the NDIS. |
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| **Part 3:**  | **Safeguarding** |
| **3.1** | **A robust and proportionate formal safeguarding system is critical.**  |
| 3.1.1 | Update the operating model of the Quality and Safeguarding Framework. |
| 3.1.2 | Resource and empower the NDIS Commission to adequately mitigate risks to participants. |
| 3.1.3 | Address growing self-management of NDIS plans to deliver more proportionate regulation to all providers. |
| 3.1.4 | Create nationally consistent principles for community visitor and oversight schemes to strengthen safeguarding. |
| **3.2** | **Service Agreements should be designed using Plain English and only used when warranted.** |
| 3.2.1 | Develop clearer guidelines for the use and implementation of service agreements. |
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| **Part 4:**  | **Workforce** |
| **4.1** | **A sufficient supply of well trained and well supported staff is essential for effective safeguarding.** |
| 4.1.1 | Explore options to improve access to professional development and clear career pathways for disability care sector workers. |
| 4.1.2 | Explore options for a portable entitlements and training scheme for disability care sector workers, and consider NSW as a possible trial site for such a scheme. |
| 4.2 | The lack of wage parity with equivalent work in other care sectors is a risk for a sustainable NDIS workforce. |
| 4.1.2 | Acknowledge potential wage disparities between the disability care workforce and the aged care workforce and possible staffing implications and impacts on the care workforce as a whole. |
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| **Part 5:**  | **Complex needs** |
| **5.1** | **A more responsive system for people with complex support needs.** |
| 5.1.1 | Include sufficient funding in support plans to ensure collaboration with multiple stakeholders. |
| 5.1.2 | Routinely fund support coordination for people with complex needs. |
| 5.1.3 | Introduce case management for participants with complex needs. |
| 5.1.4 | Manage NDIS eligible young people involved with Youth Justice through the Complex Support Needs pathway. |
| 5.2 | **Complex participants need the support of more highly trained staff when dealing with mainstream interfaces.** |
| 5.2.1 | Improve the capacity and quality of NDIS support coordinators, LACs, planners and other disability workers. |
| 5.3 | **An insufficient supply of high-quality behaviour support practitioners contributes to escalating behaviours of concern.** |
| 5.3.1 | Progress the National Action Plan for Developing the NDIS Specialist Behaviour Support Market. |
| 5.3.2 | Establish expected content and minimum standards for behaviour support plans. |
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| **Part 6:**  | **Participant Experience** |
| **6.1** | **Thin markets impact access to the NDIS** |
| 6.1.1 | Implement a sustainable strategy to effectively respond to thin markets. |
| **6.2** | **Access to the support system should be made less complicated.** |
| 6.2.1 | Trial other options that could support entry to the scheme for those that need it. |
| 6.2.2 | Develop a process for following up on dormant applications that require further information. |
| 6.2.3 | Reduce the age of access consent from 18 years old to align better with other Commonwealth-delivered systems, such as Medicare. |
| 6.2.4 | Develop a suite of documents for access requests and an online access request form to make applications easier. |
| **6.3** | **Beyond access to the scheme: participants may need ongoing supports with plan utilisation and review.** |
| 6.3.1 | Develop a process for checking that a support coordinator has been allocated and that the plan is being actioned/ utilised. |
| 6.3.2 | Provide written explanations, citing relevant information and evidence, as part of any plan reviews or funding changes. |

Additional Recommendations: Health Related

NSW Health has identified additional issues that have a direct impact on the capacity of NSW Health to deliver its core business, and have an impact on the safely and timely discharge of NDIS participants from NSW Health facilities. These can be found in the Annexe. A table of NSW Health’s proposed solutions can be found below.

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| **Annexe**  | **NSW Health proposed solutions** |
| 1 | The NDIA and the NDIS Quality and Safeguards Commission should address the risks associated with the delivery of Disability Related Health Supports (DRHS) through delegated care, revision of the NDIS’s DRHS operational guidelines, and establishment of a clinical governance mechanism for DRHS. |
| 2  | New Participant Service Guarantee (PSG) timeframes be developed for NDIS participants admitted to hospital requiring a change in circumstance plan reassessment or NDIS eligibility determination. NDIS funding short term accommodation rates for participants who are medically ready for discharge where there is a delay in identifying accommodation or supports.  |
| 3 | NDIA to establish a mechanism for informal supports to access a “one stop shop” for crisis support, including immediate access to NDIA funded case management, short-term accommodation, community engagement and liaison with other mainstream services to ensure the breakdown of supports does not result in relinquishment and social admission to hospital. |
| 4 | The NDIA should prepare for relinquishment of NDIS participants by some service providers. This should include a combination of short- and medium-term accommodation options, as well as support in engaging across mainstream and informal supports. |
| 5 | There are steps along the discharge pathway that require the NDIA to implement further change and develop processes to ensure a successful transition for participants. These include health liaison officers in all facilities that treat NDIS participants, implementing a vacancy management system, and specialist hospital discharge planners. |
| 6 | NDIS support workers should be able to stay with the participant in the emergency department without seeking prior approval from the NDIA. The APTOS should be reviewed for clarity around the role of Health and the role of the NDIA in funding support workers in the ED environment. |
| 7 | The APTOS should distinguish palliative care from end-of-life care and explain how palliative and disability supports can be provided concurrently. NDIA decisions should be consistent with this position, and result in funding of disability supports. Establish a shared-care approach for people with a life-limiting conditions.Ensure that there is a sufficient market of providers who can support NDIS participants with both life limiting conditions and disability care needs. |
| 8 | The NDIA should: Create consistent access and eligibility requirements for people with psychosocial disability.Adapt the planning process to meet the needs of people with psychosocial disability.Strengthen the registration requirements for behaviour support practitioners.Routinely build flexibility into plans to enable the dynamic support needs of a participants with psychosocial disability to be met. |

# APTOS

## 1.1 The APTOS, roles and responsibilities of each jurisdiction.

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|  | Recommendations | Review TOR # |
| 1.1.1 | Refresh the APTOS to provide more direct guidance on roles and responsibilities of each jurisdiction. | **1e** |
| 1.1.2 | Clarify governance arrangements with NDIS impact to ensure priorities are met and work is not duplicated.  | **1e** |

**The current APTOS does not effectively clarify responsibilities between the NDIS and mainstream services**

* The Applied Principles and Table of Supports to Determine the Responsibilities of the NDIS and other Service Systems (APTOS) identifies the roles and responsibilities of service systems for funding and delivery of supports for people with disability.

**The APTOS is a high-level principles-based statement**

* There is no shared statement by the Commonwealth and state and territory governments on the operational interpretation of the APTOS, and there has been ongoing disagreement between state and territory jurisdictions and the NDIA over the interpretation of the APTOS.
* There is no mechanism in place to resolve disagreements in the interpretation of APTOS funding responsibility for certain supports. This contributes to gaps and delays in service provision which may result in poorer outcomes.
* There is scope for the governance element of the review to consider how disagreements of this nature could be resolved.

**NSW has identified a number of examples where unclear APTOS rules are leading to suboptimal outcomes**

* There are a number of examples from mainstream interfaces where misinterpretation of the APTOS is leading to decisions that are inconsistent with policy intentions and causing poorer outcomes for NDIS participants. Examples of this include:
	+ **Provision of concurrent supports.** NSW Health makes reasonable adjustments so that people with disability are appropriately supported while they are in hospital, but a small minority of patients will also need access to one or more disability specific supports (concurrent supports). Under the APTOS, the NDIS is responsible for providing concurrent supports to participants who require disability specific supports during hospital stays, however the criteria for approval of concurrent supports are not clear.
	+ **Intersections of disability with mental health, justice or aged care** are also currently open to misinterpretation and participants can risk losing or missing out on services, which can lead to escalating behaviours of concern or deteriorating mental health.

**Improving communication and information sharing between Ministerial Councils will better align priorities and avoid duplication in work**

* The National Housing and Homelessness Ministerial Council and Disability Reform Ministerial Council have both committed to priority actions to improve data sharing and housing outcomes amongst people with disability.
* Improving communication between the Ministerial Councils and Senior Officials will limit the duplication of ongoing work and improve outcomes for people with disability.

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|  | Recommendation  | Review TOR # |
| 1.1.3 | Work to resolve the treatment of “in-kind supports” in NSW. | **1a** |

**In NSW, In-kind supports have been operating as an interim measure since the NDIS commenced**

* The respective bilateral agreements for the NDIS launch acknowledged the need for continuing in-kind arrangements for both Commonwealth and state and territory services until such time as agreed.
* The APTOS subsequently agreed by governments in 2015 and appended to the respective bilateral agreements for NDIS transition, included supports such as specialist school transport, personal care in schools, and the taxi subsidy scheme as responsibilities of the NDIS.
* The respective bilateral full scheme agreements specified commitments to in-kind phase-out, with interim arrangements while discussions continued in the Ministerial Council about how these services would be delivered as part of the NDIS.

**There is still no resolution around funding arrangements for providing these ‘in-kind’ supports into the future.**

* This issue should be resolved promptly, noting the limitations in-kind arrangements place on reform. In 2017 the Productivity Commission noted that in-kind supports can hinder market development and reduce choice and control for participants. It suggested that careful, cooperative and consistent approaches between the NDIA and governments are needed to end in-kind services as quickly as practicable.[[2]](#footnote-3)

# ILC and Tier 2 supports

## 2.1 Returning ILC and Tier 2 supports to their original purpose will create a more sustainable NDIS

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|  | Recommendations Review TOR # |
| 2.1.1 | Restore the focus of the Information Linkages and Capacity Building (ILC) Program to its original vision. | **1b** |
| 2.1.2 | Strengthen Tier 2 supports to improve outcomes for participants and reduce long run scheme costs. | **1b** |

**The Information, Linkages and Capacity Building Program has not been implemented as intended**

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| * Critical Tier 2 supports, envisaged by the Productivity Commission and agreed by governments, including the Information, Linkages and Capacity Building (ILC) Policy Framework, have largely been neglected to date, despite being vital to scheme sustainability.
* As the Productivity Commission noted in 2017, the interface between the NDIS and other disability and mainstream services is critical for participant outcomes and the financial sustainability of the scheme.[[3]](#footnote-4) Tier 2 supports should exist and help people at this interface with other mainstream services.

**NSW has previously run programs that have delivered Tier 2 supports*** These include:
	+ The NSW Ability Links program, where “linkers” with detailed local knowledge and community links, worked closely with people to provide support to access community and mainstream services. The economic and social benefits were noted in its evaluation with a cost-benefit ratio of 3:1. NSW ceased to deliver this program on the understanding that these outcomes would be captured as part of Tier 2 and LAC functions[[4]](#footnote-5). NSW has provided the NDIS Review Secretariat with information on the Ability Links program.
	+ The Integrated Service Response (ISR) program for people with complex needs who are relinquished or at risk of relinquishment. Sometimes when informal supports breakdown, care is relinquished by taking the NDIS participant to the emergency department, resulting in a hospital social admission. This program facilitated a co-ordinated approach between the NDIS and the other NSW funded supports to address the complex needs of this group.

**NSW welcomes the opportunity to work with the Commonwealth to identify local solutions that address the intentions of Tier 2*** With the full establishment of the NDIS, these types of Tier 2 supports are critical elements of the original scheme. Addressing the shortcomings of the current Tier 2 arrangements will provide important and impactful supports to vulnerable and marginalised people with a disability. A fully functional Tier 2 may assist in limiting growth in participant numbers.
* Tier 2 was intended for all people with disability – the NSW mainstream supports are available however Tier 2 investment (which is an element of the NSW NDIS contribution) has not yet been delivered in the intended manner. By investing in early identification of vulnerable families and /or preventive interventions, the scheme will be able to return to its original vision.
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## 2.2 Returning Local Area Coordinators to their original functions will strengthen Tier 2 supports

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|  | Recommendation | Review TOR # |
| 2.2.1 | Returning ILC and Tier 2 supports to their original purpose will create a more sustainable NDIS. |  |
| 2.2.2 | The NDIA differentiates and safeguards the Local Area Coordination function from other parts of the NDIS.*[[5]](#footnote-6)* | **1b** |

**During the NDIS implementation phase, Local Area Coordinators became de facto NDIS planners**

* In the implementation and subsequent phases of the NDIS, the original Local Area Coordinator (LAC) function was diverted into a planning function, leading to fewer resources to connect people with disability to mainstream services.

**The role of LACs can be shifted to strengthen the connections between the NDIS and mainstream services**

* Now the NDIS is a mature program, strategies should be adopted to strengthen the role of Local Area Coordination (LAC) and restore the ILC component of the scheme. This could include:
	+ Support to gather and submit sufficient information for the access application should be more consistently provided to potential applicants by Local Area Coordinators, and others who are familiar with the NDIS application process and requirements.
	+ The Review could consider the use of the NSW Connection Model, or a similar model, to improve plan utilisation when plans are not being used. This model has successfully operated across NSW public schools. NDIS Connection desks involve one-on-one meetings arranged in the school or community setting with the local NDIS partner to support families to understand and navigate the NDIS. Schools promote the Connection Desks within their community. Benefits from this model include parent/carer questions being answered in a timely manner, strengthened relationships between the school and NDIS partner, and allowing the NDIS partner to provide ‘just in time’ support.

**The recommendations of the NDIS Independent Advisory Council report provide a scaffolding for these improvements**

* In its February 2021 Report, *Supporting LACs to be LACs*, the Council wrote:
	+ It is the view of Council that as the NDIS pivots in its post transition phase, the NDIA must look to the Local Area Coordination function for more than assisting participants to implement their plans. Framed correctly, the Local Area Coordination function can be pivotal to meeting legislative objectives related to supporting social and economic participation and facilitating greater community inclusion, neither of which cannot be achieved without building community capability[[6]](#footnote-7).

The Council also recommended that “in reconfiguring the Local Area Coordination function, the NDIA differentiates and safeguards the Local Area Coordination function from other parts of the NDIS”. The NSW Government supports this recommendation.

# Safeguarding

## 3.1 A robust and proportionate formal safeguarding system is critical

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|  | Recommendations Review TOR # |
| 3.1.1 | Update the operating model of the Quality and Safeguarding Framework. | **1d** |
| 3.1.2 | Resource and empower the NDIS Commission to adequately mitigate risks to participants. | **1d** |

**A revised Quality and Safeguarding Framework is urgently needed**

* The NDIS Quality and Safeguarding Framework is a critical element of NDIS safeguarding and the current (2016) iteration does not deliver the safeguarding elements that it was intended to deliver.
* The 2016 Framework was written to address a projected future state where participants would be sufficiently supported to manage their services and providers to the full extent of their capabilities.
* It did not anticipate immature markets, the number of participants choosing not to have their services managed by the NDIA, or the ILC program not being implemented as envisaged by the Productivity Commission and as agreed by governments.

**Everybody’s business is nobody’s business: A more precise safeguarding framework would clearly indicate where accountability lies**

* While safeguarding should be embedded in the roles of everybody who work in the broader disability space and is key to the provider code of conduct, a revised Quality and Safeguarding Framework would be strengthened by a clear identification of roles and responsibilities with regard to NDIS participants. Without this, vulnerable participants risk “slipping through the cracks”.
* Under the original Quality and Safeguarding Framework, the ILC program had an implied responsibility for safeguarding through its role in building participants’ capacity to make decisions and self-advocate. However, as noted above, this part of the scheme has not been implemented as intended, with the result being that these critical safeguarding elements are missing.
* A revised Framework could address the actual circumstances of the scheme and give contemporary examples of best practice for all parties.

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|  | Recommendation | Review TOR # |
| 3.1.3 | Address growing self-management of NDIS plans to deliver more proportionate regulation to all providers. | **2g** |

**Growing numbers of participants are self-managing their NDIS plans and using unregistered providers to deliver their services**

* Also of concern is the ability of participants under plan management to engage unregistered providers. While plan managers are required to be registered, participants using plan managers are not required to engage registered providers, except for some key support types such as SIL.
* There is a case for further limiting the support types and situations where plan managed participants can engage unregistered providers.
* Unregistered providers are not regulated to the same extent as registered providers, which exposes NDIS participants to greater risks, as their providers have not undertaken an independent audit process to verify or certify the quality of their services.
* Because lack of registration is not seen as a barrier to growing their businesses, and registration itself is expensive and time consuming, there are diminishing incentives for providers to seek registration, thus increasing the prevalence and use of unregistered providers.
* The NDIS Quality and Safeguards Commission does not have the ability to oversee and regulate unregistered providers to the same extent, which leads to a two-tiered system where some providers have fewer checks and balances on their actions while others maintain expensive registration systems and are subject to more onerous oversight. This can be compounded in remote and underserviced communities, where unregistered providers are more prevalent.

**Empowering the NDIS Commission to address these issues of proportional regulation will allow markets to develop more naturally whilst safeguarding NDIS participants**

* Registration of all providers (with limited exceptions) in a way that is proportionate to the risks of the services they provide will allow the NDIS Commission to deliver greater oversight of the provider market.
* NSW understands that the NDIS Commissioner is already examining ways to adopt a more unified and consistent regulation of all providers.
* To deliver these changes and improve participant safeguarding, the NDIS Commission needs to be adequately resourced and empowered. NSW notes the commitment in the Federal budget for additional funds to the Commission.

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|  | Recommendation | Review TOR # |
| 3.1.4 | Create nationally consistent principles for community visitor and oversight schemes to strengthen safeguarding. | **2g** |

**Community Visitor Schemes do not provide a consistent level of oversight nationally**

* Many States and Territories, including NSW, have Community Visitors Schemes (CVS), which play an important role in safeguarding vulnerable NDIS participants, but the way they are managed and remunerated, and what falls within their remit, varies widely between jurisdictions.
* There is an opportunity to adopt nationally consistent principles to CVSs, which would strengthen safeguarding.

**Implementing WestWood Spice’s recommendations for a nationally consistent approach to CVSs would strengthen safeguarding**

* In 2018, the Department of Social Services commissioned WestWood Spice to conduct a review of Community Visitor Schemes.[[7]](#footnote-8) The final report recommended the Commonwealth, states and territories should work towards national consistency around key aspects including reporting, standards for review, scope and interfacing with the NDIS Commission to define minimum consistency necessary.
* Under nationally consistent principles for an oversight scheme, there could be an opportunity to increase the capacity of Official Community Visitors to provide greater oversight of SIL properties and to provide an impartial voice/advocate for participants.

## 3.2 Service Agreements should be designed using Plain English and only used when warranted

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|  | Recommendation | Review TOR # |
| 3.2.1 | Develop clearer guidelines for the use and implementation of service agreements. | **2f** |

**Service Agreements are being more widely used by participants, leading to increased use of Guardianship Orders in NSW**

* Service agreements may be useful in safeguarding NDIS participants from fraud and funds mismanagement.
* They are not explicitly required for most NDIS services, but have been widely used in the NDIS for most of the scheme’s life.
* Use of service agreements has not been regulated, leading to diverging quality of agreements and lack of clarity for participants as to what they are agreeing and whether it is beneficial to them.
* There is also no regulation of how the participant is supported to understand the agreement they are being asked to enter into.

**The NSW Public Guardian reports an 83% increase in guardianship decisions on implementation of the NDIS**

* In NSW, as at 19 May 2023, the NSW Public Guardian’s data indicates a 367% increase in the number of guardianship applications between 2018 and 2022 indicating the NDIS as the primary reason for the application. Their data also shows that in the period 1 July 2021 – 30 June 2022, 8176 decisions were made in relation to a represented person’s participation in the NDIS. This is an 83% increase since the period of 1 July 2018 – 30 June 2019.
* The wide use of service agreements and the requirement by many service providers to have these signed is a contributing factor to the need for guardianship orders being made and orders remaining in place for some participants. For participants with a cognitive disability or who are vulnerable with few supports, the complexity of agreements, number of forms and need for consent is driving the need for a substitute decision maker to be appointed where they would not otherwise need to be.

**Clearer guidelines for the use and implementation of service agreements could lead to fewer guardianship orders and more empowered NDIS participants**

* NSW acknowledges the release of the NDIS Supported Decision Making Policy. Greater emphasis on providing supported decision making will help to ensure that participants are capable of more independence in the long run.

# Workforce

## A sufficient supply of well trained and well supported staff is essential for effective safeguarding

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|  | Recommendation | Review TOR # |
| 4.1.1 | Explore options to improve access to professional development and clear career pathways for disability care sector workers. | **2d** |
| 4.1.2 | Explore options for a portable entitlements and training scheme for disability care sector workers, and consider NSW as a possible trial site for such a scheme. | **2d** |
| **Attrition and turnover rates for the disability care workforce have been increasing*** The yearly turnover rate across the NDIS workforce ranges from 17 to 25%, based on taxation data from 2015-16–2017-18, significantly higher than the economy average of 12%.[[8]](#footnote-9)
* There are considerable risks of burnout and psychological injury amongst disability care workers, particularly when working in isolated workplaces or resource-constrained scenarios. The Behavioural Economics Team of the Australian Government (BETA) found that ‘high workload’ was the most common reason for leaving a position as a disability care worker, according to a survey of 768 workers.
* The National Skills Commission found high rates of employee turnover for aged and disability carers, particularly among workers under the age of 44, with 24% of young workers spending just one year in the role. This could be a particular risk for vulnerable workers and CALD groups, who often make up a large percentage of the gig economy and contractor workforce.

**Attracting and retaining disability sector workers is critical to delivering quality services*** In June 2021, Disability Ministers endorsed the National NDIS Workforce Plan 2021 to 2025. The Plan contains 16 initiatives to retain and grow the skilled workforce that is required for the NDIS and related care sectors.
* The NSW Government implemented the More Jobs More Care (MJMC) program in 2020-22 to attract more workers to the disability workforce in thin market areas in NSW.
* The next step is creating genuine pathways towards career progression and opportunities to increase skill and experience.

**NSW welcomes the Commonwealth Government’s acknowledgement that the need to grow the Care and Support workforce is a key structural shift facing the economy[[9]](#footnote-10)*** NSW has provided fee-free training places for Disability and Social Care diplomas since 2020.
* A national approach to working with TAFEs, Registered Training Organisation and Disability providers may help to address worker shortages.

**Consideration should be given to re-examining information sharing protocols, to ensure States and Territories can appropriately regulate disability sector workplaces** * Disability support workers face a variety of risks in the workplace, including manual handling injuries and psychosocial injuries. Safety in all NSW workplaces is regulated by SafeWork NSW.
* Currently, it is an offence under the *National Disability Insurances Scheme (NDIS) Act 2013* to solicit protected information from the National Disability Insurance Agency, the NDIS Quality and Safeguards Commission and other persons, whether or not the information is actually disclosed. This extends to the WHS regulators and impacts how they undertake compliance and enforcement activities.
* Regulators cannot ask for information to undertake an investigation that is information about a person such as an NDIS participant. This includes serving notices and asking questions.
* Currently this information can only be provided via a request to the Commissioner of the NDIS Quality and Safeguards Commission from the Secretary of the relevant NSW Department under section 66 of the *NDIS Act 2013*. Disclosing the information is at the discretion of the Commissioner or CEO based on whether it is reasonably in the public interest.
 |

## The lack of wage parity with equivalent work in other care sectors is a risk for a sustainable NDIS workforce

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|  | Recommendation | Review TOR # |
| 4.2.1 | Acknowledge potential wage disparities between the disability care workforce and the aged care workforce and possible staffing implications and impacts on the care workforce as a whole. | **2d** |

**Aged care workers are now paid substantially more than disability care workers on the same Award**

* The 2022 Fair Work Commission (FWC) decision to increase wages for aged care workers places upward pressure on disability sector wages.
* Support workers who were paid the same hourly rate under the Social, Community, Home Care and Disability Services (SCHADS) Industry Award are now being paid more if they work in the aged care sector than the disability sector, despite the skills required being the same in both cases.
* In making its decision to increase the wages of aged care workers on the grounds of both work value and equal remuneration for gendered work, the FWC considered the impact on disability support workers of the increase sought for aged care workers covered by the SCHADS Award, but decided that funding arrangements “are a matter for government”[[10]](#footnote-11).

**To avoid the risk of even greater workforce attrition, governments should commit to considering how wage parity can be achieved across the care sector**

* Given the projected increasing demands on the care and support sector as a whole, Award differences between different elements of the sector are likely to create further imbalances of supply and demand.
* Creating wage parity between comparable jobs and skillsets remove perverse incentives for workers to move between care settings, which will benefit the care sector as a whole.

# Complex support needs

## A more responsive system for people with complex support needs

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|  | Recommendations | Review TOR # |
| 5.1.1 | Include sufficient funding in support plans to ensure collaboration with multiple stakeholders. | **1a** |
| 5.1.2 | Routinely fund support coordination for people with complex needs in recognition of the difficulties navigating the NDIS and its interface with mainstream service systems. | **1a** |
| 5.1.3 | Introduce case management for participants with complex needs to facilitate coordinated supports, and better outcomes for vulnerable people. | **1b** |

**The current scheme arrangements can be difficult to navigate for people with complex needs**

* NDIS processes rely on people to be able to self-initiate, self-manage, self-govern, self-advocate or have an informal support person (family or friend) do this on their behalf. This may be unrealistic though for some people with complex needs.
* The system, as it is currently arranged, does not pay sufficient attention to the complicating personal circumstances people in this cohort may face, such as trauma, interaction with other complex interfaces such as Health, Justice, or Out of Home Care, or participants’ lack of informal supports like friends or family.

**NSW mainstream services report that there is an underestimation in the scheme of the resources needed to support people with complex needs**

* Across NSW Government mainstream services, the experience is that there is an inadequate consideration within the NDIS system of how to support people with disability that have the most complex support needs.
* In particular, there is an underestimation of the resources needed to adequately support people with complex mental illnesses, psychosocial disability, or behavioural support needs. See NSW Health issues paper 8 below for further explanation.

**NSW Government analysis indicates significant NDIS funding underspends for children in OOHC**

* High level data analysis indicates that the average utilisation of NDIS plans for children in Out of Home Care (OOHC) in NSW is lower (56%) than for non-OOHC participants (63%). Some children also have no spends against their plans, many do not have support coordination, and many have significant underspends (20% underspend or more) at least four months into their plan. The total estimated unused value of the funding available in these plans in FY2021-22 was $17.4 million [[11]](#footnote-12)
* Additional funding in support plans for collaboration with key stakeholders such as family and mainstream supports could also help ensure people with complex needs get access to the right supports at the right time.

**Case management may be the best way to ensure good outcomes for some participants with complex support needs**

* As acknowledged in the NDIS Review *Participant Safety Proposals Paper*, a number of reviews into the NDIS have called for a case management type of approach for some vulnerable participants with particularly complex needs.
* The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability has also raised questions in some hearings[[12]](#footnote-13) about the provision of case management for vulnerable participants within the NDIS.
* Consideration should be given to introducing case management for select participants in acute or complex circumstances in acknowledgement of their additional safeguarding needs.
* Allowing for the adoption of a more bespoke approach in limited circumstances is likely to prevent crisis interventions and other escalations that create poorer outcomes for individuals, place pressure on systems at all levels of government in the long term, and ultimately also have an economic cost.

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|  | Recommendation | Review TOR # |
| 5.1.5 | Manage young people involved with Youth Justice who are eligible for NDIS support through the Complex Support Needs pathway | **1a** |

**National Disability Data Asset pilot test case findings show that young people in NSW with disability were more likely to re-offend within two years than young people without disability[[13]](#footnote-14)**

* Access for this cohort is often significantly delayed due to the need to re-stream access through the Complex Support Needs Branch. As a result, young people leave custody without an NDIS package in place, and their application is only re-commenced if they re-enter custody.
* Additional targeted supports while NDIS participants are in contact with Youth Justice, including in the lead up to release, are likely to reduce reoffending and redirect young people with disability to more productive pathways.

**Better identification and supports are needed to reduce the risk of people with disability coming into contact with the justice system[[14]](#footnote-15)**

* Findings from the National Disability Data Asset (NDDA) Justice test case showed that NSW people with disability are particularly over-represented in custody. Data showed 1 in 10 had a cognitive disability and nearly 4 in 10 had a psychosocial disability.

## Complex participants need the support of more highly trained staff when dealing with mainstream interfaces

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|  | Recommendation | Review TOR # |
| 5.2.1 | Improve the capacity and quality of NDIS support coordination, LACs, planners, behavioural support workers and disability workers. | **1b** |

**Capability and knowledge deficits among providers can lead to inadequate use of NDIS plans**

* Providers may lack the knowledge about various types of disabilities, for example intellectual disability compared to behavioural issues, speech disorders, or the impact of childhood trauma on brain development and its impact on people’s perception of the outside world and motivation to engage. Providers may also lack knowledge of the appropriate interventions to help with these conditions.
* This can lead to underutilisation of NDIS plans and participants not receiving the supports and services they are eligible for.

**Thin markets for allied health professionals and a lack of specialist training for support staff are leading to poor outcomes**

* There are a number of examples where a lack of support, due to either thin markets for skilled support staff or a lack of specialist training for existing staff, result in poorer outcomes for NDIS participants.
* For example, the NDIS market does not have consistent quality of Support Coordination staff. The experience of NSW Out of Home Care and Youth Justice systems is that often young people do not receive the quality of support coordination that they need. Delays are common, particularly in regional areas. This is a common experience for Health also. Frequently hospital staff take are required to take on a support coordination role, due to lack of availability or skill of the support coordinator, in order to progress hospital discharge.
* Further work needs to be done to support the growth of the Support Coordination market and to build specialist expertise of Support Coordination providers to work with cohorts of participants with complex needs.

## An insufficient supply of high-quality behaviour support practitioners contributes to escalating behaviours of concern

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|  | Recommendations | Review TOR # |
| 5.3.1 | Progress the National Action Plan for Developing the NDIS Specialist Behaviour Support Market. | **2d** |
| 5.3.2 | Establish expected content and minimum standards for behaviour support plans. | **2d** |

**Access to appropriate positive behaviour support remains a challenge for many NDIS participants with complex needs.**

* NSW mainstream services such as Health, Education, Justice, Child Protection, and the NSW Trustee and Guardian often find that the quality and content of behaviour support plans varies markedly, as do the skills and knowledge of Behaviour Support Practitioners.
* Many plans have inadequate funding for behaviour supports. Available funding may only support a few hours of supports, which is focused on development of a behaviour support plan.

**Large numbers of unauthorised restrictive practices have been reported to the NDIS Commission for NSW** **and 80% of behaviour support in NSW is delivered by just 74 providers**

* The average utilisation of behaviour support funding in FY22 was 50%. This indicates a lack of qualified behaviour support practitioners. Behaviour Support Practitioner shortages, contributes to increased use of unauthorised restrictive practices.

**Implementing standards for behaviour support practitioners and for the content of behaviour support plans could, over time, lead to reduced behaviours of concern**

* Renewed commitment to The National Action Plan for Developing the NDIS Specialist Behaviour Support Market is called for.
* NSW acknowledges that this is not quickly or easily addressed, but the benefits over the longer term for both NDIS participants with complex behaviours and scheme sustainability will be considerable.

# Participant experience

## Thin markets impact access to the NDIS

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|  | Recommendation | Review TOR # |
| 6.1.1 | Implement a sustainable strategy to effectively respond to thin markets, including:* + More use of Coordinated Funding Proposals such as bundling and pooling.
	+ Use of alternative commissioning models e.g. direct commissioning, government provided services.
	+ Building upon existing initiatives, programs, and governance arrangements in engaging with networks of Aboriginal community-controlled organisations.
 | **2c** |

**Thin markets are a key driver for some of the worst outcomes for participants**

* When people cannot access the support that they have funded in their NDIS plan they rely on other service systems or informal supports to meet their needs, or their needs and associated costs escalate. In some cases, they don’t receive the supports that have been deemed to be reasonable and necessary to them.
* Thin markets are a key driver for some of the worst outcomes for participants, including breakdowns in informal supports, avoidable hospital presentations, long stays in hospital or mental health units, or homelessness. The people most affected are those with complex support needs, further contributing to marginalisation of vulnerable people.

**NSW has identified a number of thin markets with critical risks to service delivery**

* Thin markets are generally experienced even more severely in regional areas. Identified thin markets include:
	+ **Thin Markets in Western NSW which disproportionately affect Aboriginal communities.** NSW and the NDIA have identified that there is persistent low plan utilisation in Western NSW[[15]](#footnote-16). For example, the NDIS Thin Markets project has identified that in Walgett and Wentworth LGAs in NSW average plan utilisation hovered between 41 and 51 per cent in 2019-20.
	+ **Behaviour Support Practitioner shortages, causing increased use of unauthorised restrictive practices.** The behaviour support practitioner market in NSW is extremely concentrated, with 80% of behaviour support funding in NSW going to just 74 providers. A National Plan for addressing the thin market in qualified behaviour support practitioners has been developed,[[16]](#footnote-17) but progress has not been reported since 2022.
	+ **Lack of early intervention supports and allied health services in rural and regional areas.** There are insufficient supports in rural and regional NSW for children with developmental delay, disability, or additional needs.

**NSW is committed to working with other jurisdictions to develop practical means of addressing thin markets and improving plan utilisation**

* NSW notes the recent Commonwealth budget NDIA package, which included funding for $7.6 million over two years from 2023–24 to partner with communities to pilot alternative commissioning approaches to improve access to supports in remote and First Nations communities.
* NSW looks forward to working with the Australian Government to develop an approach to workforce training and development, including the provision of suitable accommodation for NDIS workers. Coordination between Commonwealth and State governments to address resource gaps and capacity constraints would deliver better participant outcomes and improved value for money at the community and scheme level.

## Access to the support system should be made less complicated

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|  | Recommendations | Review TOR # |
| 6.2.1 | Trial other options that could support entry to the scheme for those that need it, such as the establishment of walk-in services, or allowing NDIS reports/application supports to be billed by GP’s and private practitioners. | **1a** |
| 6.2.2 | Develop a process for following up on dormant applications that require further information. | **1a** |
| 6.2.3 | Reduce the age of access consent from 18 years old to align better with other Commonwealth-delivered systems, such as Medicare. | **1a** |
| 6.2.4 | Develop a suite of documents for access requests and an online access request form to make applications easier. | **1a** |

**The NDIS should be easily accessible and interact productively and constructively with other mainstream interfaces.**

* NSW mainstream agencies, as well as disability stakeholders, report that the NDIS is difficult to navigate, lacks transparency around its decision making, and does not operate in tandem with mainstream interfaces.
* This is frustrating for participants, their families, and mainstream services alike. It also leads to missed opportunities for early interventions that would benefit the scheme and participants, and it diverts the resources of mainstream services away from their core business. For example, when the caseworker for a child in out-of-home care changes, there is no mechanism for altering the child’s NDIS record automatically to reflect this. Each new caseworker is required to provide substantial evidence of meeting the threshold of parental responsibility for NDIS purposes.
* Real time access to NDIS plans must be provided to caseworkers who have parental responsibility for children in out of home care. This has been a known issue since the implementation of the NDIS and a solution has not yet been achieved. Lack of access impacts on plan utilisation and outcomes for the children in care.
* More opportunities to support entry into the scheme for eligible people (“no wrong door” approach) would improve the application and assessment process.
* This would be complemented by support to access available pathways to mainstream supports for people who are not eligible for an individual funding package under the more robust Tier 2 and ILC supports described above.

**Dormant applications may be a sign that scheme applicants need more support, not less**

* For example, the NSW Health system sees people present to hospital, often with no medical need, who have a history of unsuccessful NDIS application requests. While these people ultimately benefit from multidisciplinary teams in hospital, it shifts responsibility to the NSW health system.

**Applications from young people in out of home care or the juvenile justice system can be delayed due to the need for parental approval for the application to proceed**

* This could be addressed by reducing the age for independently seeking NDIS support in line with Medicare or Youth Allowance.
* People over 15 can apply for their own Medicare card and there are circumstances where they can accept their own medical treatment, such as when it is in their best interests.

**There are a number of ways that processes could be improved to enhance the scheme and how it interacts with participants and mainstream interfaces**

* For example, an online access request form could be developed with pop-outs/links from within the form for key information such as describing functional capacity, treatments trialled evidence of disability, with translated and easy read versions available.

## Beyond access to the scheme: participants may need ongoing supports with plan utilisation and review

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|  | Recommendations | Review TOR # |
| 6.3.1 | Develop a process for checking that a support coordinator has been allocated and that the plan is being actioned/ utilised. | **1a** |
| 6.2.2 | Provide written explanations, citing relevant information and evidence, as part of any plan reviews or funding changes. | **1a** |

**Monitoring allocation and utilisation of supports and support coordination is good practice**

* Support coordinator allocation and plan utilisation are critical metrics for success of NDIS supports. When a support coordinator is funded in a plan and the participant cannot self-select, the planner sends a request for service. However, a request may or may not be accepted, it may be put on hold, or further information requested. A follow up system should be put in place to ensure plans are actioned and progressed.

**Greater consistency and transparency are required when a plan is reviewed and altered**

* The NSW Trustee and Guardian reports that when enquiries are made with the NDIA about decisions that have led to dramatically changed supports in plans, the response is often that the decision is based on what is deemed ‘reasonable and necessary’. In most of these cases, the participant has unchanged diagnosis and support requirements. This is a common experience for NSW Health also, where requested supports for hospital discharge are declined as not deemed ‘reasonable and necessary’ without any additional information provided.
* For people with disability multiple pieces of evidence are required to prove eligibility and the amount of support required. However, when a plan is reviewed and altered, there is no requirement for the NDIA to provide evidence or a written explanation of their rationale. Likewise, the interpretation and required standard of evidence for decisions, reviews and outcomes of s100 internal reviews need to be more consistent and transparent for all involved.

**Addressing these issues as they arise will lead to a clearer understanding of the scheme by participants and service providers**

* This should lead to greater participant satisfaction and fewer appeals against plan review decisions.

# Looking Forward

**The NDIS is an unprecedented reform that was implemented in unprecedented times**

The NDIS represents collaboration and good will between all levels of government. It is a once in a lifetime reform that is making real improvements in the lives of participants and in the systems that support them.

In the decade since the scheme started rolling out in trial sites, including the site in NSW’s Hunter region, unparalleled events have taken place in Australia and the world.

Floods, bushfires, and a global pandemic have tested our systems and our resolve. We have a renewed understanding of the value of the ability to live an ordinary life within our communities. This brings with it a commitment to ensuring that people with disability, who need the support of the NDIS, can fully participate in community life.

To this end, the NSW Government is continuing to make its mainstream service system more accessible and inclusive, exemplified most recently by its submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability[[17]](#footnote-18).

**The Review is an opportunity to reflect on the progress that has been made since the NDIS was designed and implemented**

The focus of this submission has been on identifying ways to strengthen the NDIS, based on the experience of NSW mainstream agencies and with a view to providing practical and constructive recommendations to improve the scheme.

Sustainability is not explicitly addressed in this submission, but we believe its recommendations will contribute to the sustainability of the scheme.

While the NDIS has made a positive and profound impact for people with a disability, parts of it have diverged from the original intentions of Australian governments. The ILC, LAC and Tier 2 functions need to be recalibrated, so they deliver according to their originally intended purpose.

But an over-adherence to original scheme principles has not always worked either. Over reliance on a market model to meet the needs of *all* participants across all service types and locations has meant poorer services and supports for *some*.

This Review, and the NSW Government’s submission to it, is an opportunity to consider what has worked and what hasn’t. It is an opportunity for Australian governments to reflect, to work together, and to recommit to people with disability, and their friends, families and communities across Australia.

**Now the issues have been identified, the work on developing solutions can begin**

It is critical that the Review does not stop at identifying areas for improvement in the NDIS. For real change to be made, we need concrete, achievable, and person-centred solutions.

As with the implementation of the NDIS, planning, collaboration and good will between all levels of government are needed.

NSW is committed to the work of developing and implementing meaningful solutions that will produce real and measurable improvements for all participants and deliver a sustainable and enduring NDIS into the future.

# Annexe: NSW Health issues papers

NSW Health 1

## Disability Related Health Supports (DRHS)

On 28 June 2019, the Council of Australian Government’s (COAG) Disability Reform Council (DRC) issued a [Communique](https://www.ndis.gov.au/news/3033-disability-reform-council-update) confirming that the National Disability Insurance Scheme (NDIS) will fund a range of disability related health supports (DRHS) for participants where the need for these supports is part of the participant’s daily life and directly related to their disability. Accompanying the Communique was a of supports to be funded, including those associated with continence, respiratory care, nutrition, wound and pressure care, dysphagia, diabetes, podiatry and epilepsy.

**Description**

NDIS funding for DRHS is a key factor for people with complex needs being able to remain safe and secure at home and avoid unnecessary hospital admissions. As per the NDIS Operational Guidelines[[18]](#footnote-19), “*disability-related health supports are health supports that relate directly to the functional impact of your disability. If you need help to manage a health condition because of your disability, we may fund disability-related health supports to help you manage that condition”.* DRHS supports are health supports that a person without a disability would be able to manage themselves or not require if they did not have a disability. These are therefore considered to be disability related supports and therefore the NDIS has funding responsibility.

The administration and management of DRHS needs to be provided by suitably qualified providers, and appropriately monitored. There has been a lack of clinical oversight for decision making about inclusion of DRHS in participant plans as well as clinical governance and oversight of delivery of NDIS funded DRHS. This presents a risk to participants, which can lead to increases in discharge delay or readmission due to breakdown in supports.

There doesn’t appear to be a requirement for providers to report or provide clinical governance information to the NDIA or Quality and Safeguards Commission on the delivery of these supports. Many of the DRHS are delegated to Disability Support Workers and not provided by Registered Nurses or other qualified health professionals. The lack of clinical governance oversight in the delivery of these services has the potential to significantly impact on preventable hospital admissions. This often leads to the view that people require overnight supports or 24/7 supports to facilitate the delivery of DRHS, which is often not the case – it’s more of a matter of delivering the services in the community in a way that was intended and with robust clinical oversight / practices and procedures.

Current issues are being experienced in relation to:

* Diabetes management
* Continence
* Wound care
* Podiatry
* Epilepsy
* Nutrition
* Dysphagia.

For these supports, there is a lack of consistent application of funding and ongoing questions around:

* what supports are covered
* what evidence is required to “prove” a DRHS should be a NDIS funded support?

It should be noted that respiratory supports were previously included in the agreed DRHS list. This has been removed from the NDIS webpage[[19]](#footnote-20). There is a lack of clarity around what respiratory supports the NDIS will fund. This includes provision of equipment such as BiPAP and CPAP machines.

**Proposed solution**

The NDIA and the NDIS Quality and Safeguards Commission should address the risks associated with the delivery of DRHS through the following actions:

* Provide funding for allied health professionals to prescribe the DRHS for the participant, for example speech pathologist to prescribe nutritional products for management of dysphagia
* Fund supports provided through a delegated care model. For some disability-related health supports, for example, “a registered nurse may be able to train and delegate key tasks to a support worker or enrolled nurse. This trained worker would directly provide …the support where they are competent in the task. This is called ‘delegation and supervision of care’. It allows a registered nurse to delegate nursing tasks to the most appropriately qualified person.”[[20]](#footnote-21)
* If the NDIS decline DRHS that have been recommended by a person’s treating team, they should provide full decision-making justification and advise as to clinical guidance sought in making the decision to decline supports recommended by other clinicians.
* An independent advisory panel, made up of clinicians, should be created to revise the NDIA operational guidelines that should govern the funding and delivery of DRHS in NDIS plans.
* The staff profile of the Technical Advisory Branch (TAB) should be made available to show level of clinical expertise utilised in making clinical decisions.
* The NDIS Quality & Safeguards Commission, in conjunction with the NDIA, should establish an appropriate clinical governance mechanism to ensure critical safeguards are in place for the delivery of DRHS. These safeguards should include:
* Monitoring/oversight of service providers to ensure appropriate management of DRHS supports is in place.
* Training requirements to appropriately manage DRHS are mandated for non-health professionals and disability support workers.

**Justification for solution**

DRHS are supports that require clinical guidance and training for delivery. Prescribers of DRHS are best positioned to inform the health care needs of a NDIS participant. Declining DRHS supports in a participant’s plan creates avoidable health risks to the individual and avoidable hospital admissions.

**Summary statement**

NDIS funding for DRHS is one of the key factors for people with complex needs being able to transition safely from hospital to the community and remain safe and secure at home. Inclusion of DRHS in participant plans avoids risk to participants who require DRHS and avoids increases in discharge delay or readmission due to breakdown in supports.

NSW Health 2

## Participant Service Guarantee (PSG) timeframes

The NDIS Participant Service Guarantee (PSG) sets timeframes for the NDIA to make decisions about things such as access, plan approvals and plan reviews/ reassessments. The NDIA has performance targets for meeting these timeframes. In many instances, these timeframes are cumulative, based on the stage of the NDIS journey. They include:

* 21 days for access decisions
* 28 days to change a plan to implement AAT decisions
* 60 days to review decisions
* 21 days to decide to do a plan reassessment (change of circumstances), followed by 28 days to do the plan reassessment.

**Description**

The PSG timeframes and the NDIA processes put in place to meet the PSG are appropriate for people living in the community but are not appropriate to facilitate timely decisions for NDIS participants or potential participants relying on a NDIS decision to leave hospital. The PSG should specify the maximum number of days a NDIS participant who is medically ready for hospital discharge should remain in hospital because one or more NDIS funded supports cannot be provided.

**Proposed solution**

The PSG should identify timeframes specific to participants admitted to hospital requiring a change in circumstance plan reassessment or NDIS eligibility determination.

In accordance with standard practice in Queensland, if the PSG timeframes are applied to inpatients, the NDIS could fund Short Term Accommodation rates for the participant to remain in hospital when the person is medically ready for discharge and requires disability supports and disability specific accommodation. .

**Justification for solution**

The PSG should be used to drive new process improvements that achieve timely and safe hospital discharge for all NDIS participants. Discharge delayed participants face risks of hospital acquired infections, institutionalisation, loss of functional capacity and risk of exacerbation of behaviours of concern. Hospital bed days are a very costly accommodation alternative for people who do not have a medical reason for being in hospital. Discharge delays also place a cost burden on the health system and contribute to system blockages when people with acute medical needs need to wait longer for a hospital admission.

**Summary statement**

The PSG timeframes are not appropriate for inpatients who are discharge delayed and require expedited planning or decision making to allow them to be safely and timely discharged to community living. Discharge delays place additional strain on the health system and carry risks to patients.

NSW Health 3

## Social admissions- family/ informal support relinquishment

There are many factors that impact the ability of informal supports to continue to support a person with disability. Informal support breakdowns may occur at transitional life stages, such as a person with disability transitioning from primary to high school; child to teenage years; ageing parents; change in family composition; siblings moving away from home, etc. When a person’s life situation changes and informal supports cannot be maintained, families often feel isolated and unable to continue to support their loved one. The emergency department is one of the places families/ informal supports leave a NDIS participant they can no longer care for.

**Description**

Sometimes when informal supports breakdown, care is relinquished by taking the NDIS participant to the emergency department, resulting in a hospital social admission. A social admission is the term used when the person is not admitted for a medical reason. In these instances, the health system is seen as an alternative care provider. Often the person relinquished, and the health system rely on a timely response by the NDIS to fund and secure an appropriate community accommodation, including supporting access to social housing.

**Proposed solution**

The NDIA should establish a mechanism for informal supports to access a “one stop shop” for crisis support, including immediate access to NDIA funded case management, short-term accommodation, community engagement and liaison with other mainstream services to ensure the breakdown of supports does not result in relinquishment and social admission. Where possible, the proximity of the crisis supports to the existing informal supports should be considered for people that live in regional and remote areas.

The Integrated Service Response (ISR) program could be used by the NDIA as an exemplar model of support for people with complex needs who are relinquished or at risk of relinquishment.

**Justification for solution**

NSW Health is not the most appropriate agency to provide crisis accommodation, or disability specific support services needed by people who are relinquished by their carers.. Disability related supports are the responsibility of the NDIS. The provision of these supports or case management to link people with these supports diverts resources away from health’s core business.

**Summary statement**

In times of crisis or when caring arrangement breakdown families/ carers/ informal supports can choose to relinquish care of a NDIS participant. Often, they choose to relinquish care at an emergency department, so the participant’s health and care needs are met while a new accommodation option is sourced. This leads to social admission of people with a disability when they have no acute medical care need. Sometimes these are lengthy admissions while service systems determine the participant’s eligibility for their services and supports. More appropriate short term accommodation options need to be available for participants who are relinquished.

NSW Health 4

## Social admissions- provider relinquishment

The NDIA has commissioned Marathon Health services to provide an After Hours Crisis Referral Service for crisis situations that require a disability sector response. This service is for approved referrers only such as emergency service organisations (police, ambulance, public and private hospitals), acute state mental health services, federal police and state justice officers. Crisis referrals may occur where the participant's disability related supports suddenly become ineffective or inadequate.[[21]](#footnote-22)

**Description**

This service, however, does not provide any actual supports and is purely a referral service. People with complex physical, intellectual and behavioural support needs or who require medical support units because of comorbid disability and health related issues are not adequately supported. In times of crisis, since the transition to the NDIS, there is no crisis disability accommodation provider or co-ordinator. Often when there is an immediate need to change accommodation service provider, the NDIS participant is taken to the emergency department. If no alternative accommodation option can be secured, usually they are admitted as a social admission. Reliance on hospitals as alternative providers of accommodation is inappropriate and costly. A social admission for a person with complex behaviours can be traumatic and harmful to themselves and other patients. Disability service providers need to be able to raise their concerns with the NDIA earlier about continuing to support the participant and are considering ceasing service provision. The NDIS should fund support for service providers who are finding it difficult to continue to support a participant to live safely in the community.

**Proposed solution**

The NDIA should prepare for relinquishment of NDIS participants by some service providers. This should include a combination of short- and medium-term accommodation options, as well as support in engaging across mainstream and informal supports- a similar role to that of the former NSW Health Integrated Service Response (ISR) project.

The NDIA should aim for there to be no social admissions because of provider relinquishment.

The NDIA should address market gaps in specific service delivery areas such as housing and behaviour support.

**Justification for solution**

NSW Health is not the most appropriate agency to provide crisis accommodation disability specific support services needed by people who are relinquished by their carers. Disability related supports are the responsibility of the NDIS. The provision of these supports or case management to link people with these supports diverts resources away from health’s core business.

**Summary statement**

The NDIS should be able to support accommodation placement stability as well as orderly changes in providers of accommodation support. Social admission of participants due to provider relinquishment should not occur.

NSW Health 5

## Discharge pathway process improvements

In June 2022, the NDIA developed the *NDIA Hospital Discharge Operational Plan* (the Plan). The Plan included a range of actions for the NDIA to implement, to achieve their discharge targets. Many of these actions are reliant on the health system for implementation and achievement of intended outcomes. When people cannot access the disability supports that they require, they may rely on the health system to meet their needs while the NDIA prepares a NDIS Plan to support their transition from hospital to community.

**Description**

The implementation of the Plan has led to cost shift and an increase in work for Health, including increased:

* Governance and oversight for implementation of processes
* Co-ordination of care of NDIS participants. Discharge planning in the context of NDIS involves many stakeholders requiring increased resources and time to communicate and co-ordinate with the disability sector and NDIA
* Medical, nursing and allied health time to undertake all NDIA Hospital Discharge Assessments (previously some assessments were undertaken by NDIS funded allied health staff) and associated plans.

Whilst NSW Health has been working collaboratively with the NDIA to implement the Plan, there are steps along the discharge pathway that require the NDIA to implement further change and develop processes to ensure a successful transition for participants.

**Proposed solutions and justifications**

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| --- | --- | --- |
| **Issue**  | **Solution**  | **Justification**  |
| 1. Nomination and appointment of Support Coordinators
 | Consider alternative ways to work with the NDIA so Support Coordinators with the appropriate skill set, and availability, to support discharge delayed participants can be appointed. | The current system of participants sourcing own Support Coordinators can be cumbersome. It is challenging for participants to find Support Coordinators with availability as well as with the appropriate skillset and/or local knowledge to support safe and timely discharge.  |
| 1. Nomination and appointment of a Behaviour Support Clinician where a Behaviour Support Plan (BSP) is required to facilitate discharge
 | The NDIA should recommend appropriately qualified and available BSP clinicians to support discharge delayed participants, where the BSP clinician is known to have the appropriate skill set and availability to support the participant. Alternatively, the NDIA should implement an interim approach to behaviour support whilst a BSP and, where appropriate, restrictive practice authorisations, are developed. | The current system of participants sourcing own BSP clinicians can be slow and complicated. It is challenging for participants to find BSP clinicians with availability as well as with the appropriate skillset which can contribute to discharge delay. |
| 1. Availability of Health Liaison Officers
 | The NDIA should ensure that every NSW Health facility providing service to a NDIS participant is engaged with an assigned Health Liaison Officer. Where their regular HLO is unavailable or one has not been assigned, a process of assigning the service to an alternate HLO needs to be developed.  | There is current inequity in facilities being able to access the support of a dedicated HLO. There are also challenges when HLOs are on leave or uncontactable and no alternate source of support is identified.  |
| 1. Involvement of clinicians or suitably trained and briefed planners in planning meetings to address complexity of supports required
 | The NDIA should ensure that, for patients who are discharge delayed and have complex presentations, the participant is supported/ encouraged to invite their NSW Health representative to their planning meeting. Where an NSW Health representative is not in attendance at planning meetings, the NDIA planner should be sufficiently trained in the person’s disabilities, and the complexity of their support needs  | Plans with insufficient disability supports can result in a breakdown of supports and avoidable readmissions. Having clinicians available to explain the complexities of disability support required, as well as discuss the discharge assessment as developed by hospital clinicians, during the planning meeting, will allow the planner to build appropriate supports into the plan in the first instance.  |
| 1. Identification and management of disability accommodation vacancies
 | The NDIA should implement a vacancy management system for known disability accommodation vacancies, similar to that formerly provided by states and territories.  | The current system of Support Coordinators or hospital staff contacting multiple providers to seek appropriate short term, medium term, SDA or SIL accommodation is resource intensive and often contributes to discharge delays. Having a register of vacancies maintained by the NDIA or the NDIS Quality and Safeguards Commission would reduce use of plan funding in searching for appropriate placements and assist in expediting discharge from hospital.  |
| 1. Vetting of suitability of providers to deliver appropriate support services, particularly for complex participants
 | The NDIA, through the NDIS Quality and Safeguards Commission, should ensure that providers demonstrate that their staff have a suitable skill set to support people with complex health and disability support needs, such as psychosocial disability. This could include introduction of a Commonwealth system like the NSW Community Visitors Scheme[[22]](#footnote-23), allowing unannounced service visits to ensure the participant feels appropriately supported and is receiving the supports they have entered into an agreement to receive.  | Provider registration is currently a paper-based exercise with no requirement to provide evidence that staff are suitably trained to support participants, particularly those with complex support needs. Introducing a system of provider accreditation and supervision could provide more targeted services to be provided that meet individual needs.  |
| 1. Provision of concurrent supports whilst participants are inpatients
 | The NDIA should allow a participant to use their funded supports flexibly whilst they are in hospital, to support their disability related needs. This includes for behaviour management, social and community participation, and communication assistance. This should not require case by case approval and is an agreed support as per the APTOS.1[[23]](#footnote-24) | When NDIS participants cannot access needed concurrent supports, their health and treatment can be compromised, and/ or this can put the NDIS participants, other patients and hospital staff at risk. This can also contribute to delayed hospital discharge and limit community transition options because of a more complex presentation. |
| 1. Consistency in planning and decision making
 | The NDIA should identify appropriately trained/ qualified hospital discharge planners, with experience in complex health and disability related supports, to deliver consistent planning and decision making to all NDIS participants who are discharge delayed. The clinical advice provided as part of the Hospital Discharge Assessment template should be acknowledged and incorporated into planning decisions.  | Good decision making should be underpinned by a relevant level of expertise and accompanied by explanations of how and why decisions are made. Without clinical background, decisions can be made that do not address the disability related supports of the individual and result in insufficient supports being provided. The provision of appropriate disability support funding should be seen as a risk mitigation factor in preventing breakdown of supports and inappropriate readmissions.  |

**Summary statement**

Existing and stringent discharge pathway processes result in NDIS participants potentially being discharge delayed whilst waiting to access disability supports. The NDIA needs to improve discharge pathway processes and timelines to allow participants to receive appropriately funded NDIS plans to allow for safe and timely discharge.

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## NDIS Support in the Emergency Department

Emergency Departments (ED) can be a challenging environment due to the high volume of activity and the physical environment, including noise levels, foot traffic, lighting, announcements and equipment. Participants with disability may experience heightened stress and anxiety in the ED and require support, guidance, and assistance from a familiar support person. This is a crucial time that both NDIS and health services intersect and requires collaboration and integrated care co-ordination to support the participant’s journey either through to admission or discharge home. An ED is considered an outpatient area of the hospital until a person has been admitted.

**Description**

For many health consumers with a complex presentation, an ED management plan is developed (collaborative approach between the patient/ consumer, community mental health, ED staff, police, ambulance, clinical directors, family and/or carers, and any relevant support providers or other representatives). The goal of most ED management plans is to support the person in ED and ideally transition them to the most suitable environment in a timely way. Often the plans include a requirement for NDIS funded support staff to remain in attendance for the following reasons:

* ED presentation can be a quick encounter.
* Consumers are often required to remain in the ED waiting room for extended periods, which can also be an area of high activity.
* The NDIS funded support worker supports the person’s engagement with ED services.
* The NDIS funded support worker is there to provide disability related support which can assist the participant to remain calm and feel safe and secure. This may include assistance with communication and emotion regulation.

When a NDIS funded support worker is requested to remain with the person in the ED, negotiation is often required with providers and/or the NDIA as to whether the support is a health reasonable adjustment or disability related support (NDIS funded) responsibility. Providers may also leave people at ED unaccompanied as they are not aware that a person’s funding can be used to provide support in this environment.

**Proposed solution**

All agencies should view the ED as a collaborative space where health is responsible for providing the treatment, and the NDIA is responsible to fund the disability support required for the person to attend and engage in this environment. This ideally means the NDIS funded support worker staying with the participant, as they do when attending other medical appointments.

If having a NDIS funded support worker present is the most effective way to offer a NDIS participant comfort and support within the ED, the worker should be able to stay without seeking prior approval from the NDIA, particularly for participants with an ED management plan. The APTOS should be reviewed for clarity around the role of Health and the role of the NDIA in funding support workers in the ED environment.

This may also assist in preventing “relinquishment” scenarios from service providers. When service providers feel that the funded supports are breaking down, they often turn to the ED as their first and only option. If the NDIS funded support workers were able to stay with the participant, this could prevent inappropriate admissions, as well as offer an opportunity for the hospital, the NDIA and the service provider to work together in a crisis situation to ensure the participant’s supports don’t break down.

**Justification for solution**

Clarity regarding the roles of all involved would allow for decisions to be made quickly in a high-pressure environment and reduce the stress on all involved, particularly the NDIS participant. It would also allow for the participant to be supported in this environment by someone who is familiar with their disability support needs.

**Summary statement**

Emergency Departments should be viewed as a collaborative space where health is responsible for treatment and NDIS funded support workers, where appropriate, are responsible for the participants disability related supports.

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## Palliative and end of life care and system interface

People under 65 with life-limiting conditions that cause significant functional impairments may have trouble accessing appropriate disability support in a timely manner. The APTOS determines that palliative care is the responsibility of the health system. There is no agreed or shared definition of palliative care or of end-of-life care used by the NDIS and the health system.

Palliative care can help “people live as fully and comfortably as possible with a life-limiting or terminal illness. […] It is not the same as end-of-life care […] Having palliative care doesn’t necessarily mean that you’re likely to die soon. […] You can receive palliative care for years if needed”[[24]](#footnote-25). End-of-life care supports the person’s physical, emotional, social and spiritual/existential needs as they approach death[[25]](#footnote-26).

**Description**

Palliative and end-of-life care provided by the health system and disability-related supports provided under the NDIS are not mutually exclusive and can be provided concurrently. Person-centred palliative care may be delivered by a combination of health, cultural, religious, residential aged care and disability providers in a range of settings, including the home, hospital, palliative care units/hospices, residential aged care, or SDA/SIL[[26]](#footnote-27).

In many cases, palliative patients will require a mix of clinical and non-clinical supports to maximise their quality of life and allow them to remain at home for as long as possible, if that is their wish.

While Health provides clinical supports, palliative patients often require significant functional and social supports. Palliative care provided by the health system does not include provision of disability support for people who are medically stable or experiencing functional decline.

Admission to a palliative care unit or hospice is typically a short-term option to help with complex symptom management, or at the very end of a person’s life[[27]](#footnote-28) when a person is likely to die in the near future. Palliative care units are not a suitable accommodation model for people who are likely to need care for an extended period. NSW Health emphasises its role for making the clinical determination as to when a patient becomes palliative.

People who are approaching end of life may require a high level of nursing care and additional disability related supports for several weeks or months in a home like environment. Lengthy hospital admissions can put these patients at risk and lead to de-conditioning, which can impact their quality of life.

People with a palliative diagnosis may have an additional barrier to securing approved accommodation supports due to provider hesitancy in delivering disability supports to people with palliative care needs.

People who are medically ready for discharge frequently remain in hospital for lengthy periods while moving through the NDIS pathway. Some die in hospital waiting to access the NDIS funded, disability related, functional and social supports needed to spend the remainder of their life at home or in a non-hospital setting.

**Proposed solutions**

The APTOS should distinguish palliative care from end-of-life care and explain how palliative and disability supports can be provided concurrently. NDIA decisions should be consistent with this position, and result in funding of disability supports.

The NDIA should work with disability providers to develop their capacity to deliver disability care to people with a palliative condition. This should be developed in partnership with health-based palliative services. The NDIA needs to support the establishment of a shared-care approach for people with a life-limiting condition.

The NDIS should ensure that there is a sufficient market of providers who can support NDIS participants with life limiting conditions and disability care needs.

**Justification for solution**

The proposed solutions support the delivery of holistic palliative care across multiple service systems and support timely access to care which improves quality of life for people with life limiting conditions.

**Summary statement**

People under 65 years, with life-limiting conditions that cause significant functional impairments, have trouble accessing appropriate disability supports in a timely manner. The APTOS does not provide sufficient guidance on the responsibility to fund disability support for people accessing palliative care. The pathway to access supports required because of functional decline in a person identified as palliative, is too complex and lengthy.

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## Systemic misunderstanding of psychosocial disability and support needs

**Summary description**

There appears to be a systemic lack of understanding within the NDIA of complex mental illness and the nuances of supporting people with psychosocial disability. Additionally, NDIS processes tend to rely on people to be able to self-initiate, self-manage, self-govern, self-advocate or have a support person (family or friend) to do this on their behalf.

A psychosocial disability may restrict a person’s ability to concentrate, complete tasks, comprehend instructions, cope with time pressures and multiple tasks, interact with others, be in certain environments, manage stress, problem solve, make decisions, or understand their illness and resulting disability. These factors may all affect a person with psychosocial disability from being able to engage in NDIS processes.

People with psychosocial disability may need additional assistance to be able to access and utilise the NDIS. They require everyone who they interact with to have some level of knowledge and understanding of their disability type and what adaptations can be made to mitigate the barriers to successful engagement.

People with a disability are often vulnerable and marginalised, and this is often amplified for people with psychosocial disability. Relevant adaptations should be made at each stage within the NDIS pathway to ensure that people with a psychosocial disability have equity of access, feel valued and respected and receive support that is tailored to their individual needs.

**Pre-Access**

People with a psychosocial disability who are eligible for the NDIS may require assistance and/or advocacy to access the scheme. The more vulnerable a person is, such as someone with a psychosocial disability and who is CALD/NESB/homeless/ Aboriginal/ lives remotely / illiterate, the harder it is to access the scheme independently.

**Description**

Services that can assist people with psychosocial disability through the application process are not easily accessible.

Obtaining evidence required can be difficult, especially for someone who has poor health literacy and/or has limited or no connection with a GP or other medical practitioners. Some GP’s and medical practitioners are not willing or do not have the knowledge of NDIS processes to assist a person with psychosocial disability to make an access application. Private practitioners require payment for reports to assist with the NDIS application. Additionally, some people with psychosocial disability have no identification documents and no means of acquiring any.

Eligibility for people with a psychosocial disability is not consistent. There are no clear eligibility guidelines to prevent inappropriate NDIS applications where it is evident the application will be unsuccessful.

**Proposed solution**

The NDIA should:

* more clearly define eligibility criteria regarding psychosocial disability
* be involved in planning discussions early or prior to application, to promote a better understanding of eligibility and potentially reduce applications for ineligible people
* increase access to and promote walk-in services where people can receive assistance to gather information and apply
* advocate for Medicare claimable items to be established to allow GPs and private practitioners to bill for preparation of NDIS reports/application support. This may encourage more GP’s and private practitioners to assist with the preparation of reports.

**Justification for solution**

Systems and processes that can assist people with psychosocial disability to apply for access to the NDIS should be put in place to ensure that there is equity of access for all people with disability.

**Summary statement**

People with psychosocial disability can be vulnerable and sometimes not have the capacity to apply for the NDIS independently. The NDIS should be able to assist people with psychosocial disability to assess their eligibility and apply for support.

**Access**

Many people with psychosocial disability experience barriers completing NDIS access requests and meeting the eligibility threshold within the current NDIS system and processes.

**Description**

There appears to be no consistency in people meeting the access criteria for psychosocial disability.

Requirements for specific professional reports are too high, especially in the rural regions. In some locations, applicants don’t have access to specific allied health disciplines to complete reports e.g. OT or psychology. In some instances, the NDIA has questioned the validity of reports prepared by Mental Health Clinician and nurse practitioners, when a psychiatrist is not available to complete.

Verbal access requests are difficult for some people with psychosocial disability who often misunderstand the significance of their impairment and are unable to convey the impact of their disability and their support needs. At times, Health clinicians assist with verbal applications for people who are unable to answer the questions due to their disability. The fluctuating/ episodic nature of a person’s psychosocial disability may result in them being deemed ineligible for the scheme.

Following submission of access requests, where all information is not provided within the NDIA set timeframe (90 days from when they ask for more information), the participant is notified that the application won’t proceed. No further contact occurs after this step.

**Proposed solution**

The NDIA should:

* develop access eligibility requirements for people with a psychosocial disability and a process to ensure that these are applied to support consistency of response
* accept reports from an agreed range of clinicians, including mental health clinicians and nurse practitioners
* routinely follow up with participants to advise that the period for provision of additional information to support their application is closing and discuss whether they wish to continue.

**Justification for solution**

Clinicians are registered health professionals who are held accountable for their reports and clinical judgement by their registration body. The NDIA should accept the validity of clinical reports submitted for access applications and from a broader range of clinicians. Consistency of response would lead to less rejected applications and less need for the appeals process**.**

**Summary statement**

A consistent eligibility criteria and process for people with psychosocial disability is essential to enable people to gather evidence required to apply for access to the scheme.

**Planning**

A person with a psychosocial disability without adequate disability related support can experience negative impacts on their mental health. The planning process should be a positive experience to assist the participant to achieve appropriate outcomes.

**Description**

The current planning process is reliant on the participant’s ability to articulate their goals, aspirations and support needs. A person with a psychosocial disability can have difficulty articulating these, especially with someone they have never met and have no trust in. When a person is unable or unwilling to participate in the planning process, they may be deemed ineligible, receive an inadequate plan or have the planning process delayed, thereby leaving them without support for a longer period.

In some settings, the only planning meeting option offered by the NDIA is to have the planning meeting over the telephone, for example justice and rural settings. This often exacerbates the barriers noted above which leads to poor experiences and outcomes.

NDIS planning usually occurs at a single meeting. Often this is not enough time for the planner to build rapport with and understand the needs of someone with a psychosocial disability.

Many planners have limited experience in psychosocial disability and at times can use leading questions and jargon that a participant doesn’t understand or comprehend the consequence of their answer. A person with a psychosocial disability may require the assistance of a support person during planning meetings.

It is at the discretion of the participant whether Health is notified of the planning meeting and whether Health representatives attend. The current practice is that Health representatives attend where the participant requests this (they are not asked if they would like to invite a Health representative).

When planning decisions are challenged, the NDIA do not provide clear rationale which makes it difficult to know what evidence is required to appeal the decision.

**Proposed solutions**

The NDIA should:

* when booking planning meetings for people with psychosocial disability, routinely ask participants if they would like to have a Health representative at their planning meeting
* support the right of a NDIS applicant to have a family member/ advocate/ support worker/ clinician present throughout the planning process
* ensure adaptations to the planning process are applied where appropriate. For example, if it is apparent during the meeting that the person is unable to articulate their thoughts or answer the questions and no support person is present, they should discontinue the meeting and reschedule when the applicant is comfortable to continue and has support available. This may require more time for planning and multiple meetings enabling the participant to develop some rapport with the planner
* ensure interim plans are provided where appropriate to allow for temporary supports to commence while further planning is undertaken
* train specialist planners for people with psychosocial disability to support a better understanding of the considerations or adaptations that may be required.

**Justification for solution**

People with a psychosocial disability will not always be able to participate in the standard NDIS planning process and may require alternate processes to be developed.

**Summary statement**

People with psychosocial disability may experience additional barriers during the planning process and require access to additional supports. This may include adaptations to the planning process and further time.

**Plan implementation- choosing a provider**

Without adequate and appropriate disability support, a person’s psychosocial disability can exacerbate mental health conditions and cause a range of negative flow-on effects.

**Description**

There is no current regulation or minimum standard for providers to claim they have the capability to provide psychosocial disability supports. Engaging providers who are not skilled in the nuances of delivering psychosocial support can lead to poor outcomes for participants and can put participants and staff at risk. There are often multiple stakeholders involved in supporting a participant, with no clear lead agency.

People with psychosocial disability often experience amotivation, ambivalence, and/or poor decision making as part of their disability. They may require support providers who understand this and will support them, when required, to make decisions and encourage them to participate.

There is no process for monitoring of service delivery. For example, if a participant is ambivalent about engaging and asks the provider to leave during a planned service support period, the total booked hours of support are correctly still billed to the participants plan, as per NDIS guidelines. This makes it appear that the plan is being used but the participant isn’t actually receiving support,, making it appear that the person is receiving adequate levels of support.

People with psychosocial disability may require a Behaviour Support Plan (BSP). The quality and content of BSPs varies greatly. The skills and knowledge of Behaviour Support Practitioners also varies.

For people with a psychosocial disability, an escalation or demonstration of a behaviour of concern does not mean that there is an acute mental health issue or that the person is in crisis. Skilled and educated providers should be able to manage escalations that are directly related to the person’s disability. This should not be transferred to Health as a default mental health position. Trust and respect will continue to develop if the providers can support someone through times of increased need, which in turn assists with preventing future occurrences.

**Proposed solutions**

The NDIA should:

* work with the NDIS Quality and Safeguards Commission (QSGC) to strengthen the registration process for providers who are supporting people with a psychosocial disability and developing BSPs
* work with the QSGC to educate the sector around the purpose and use of BSPs and provide training to BSP practitioners on minimum standards
* encourage support coordinators, LACs or recovery coaches to monitor plan utilisation and rates of participant declined supports
* ensure providers are aware that participant core funds can be used to attend participant and stakeholder meetings.

**Justification for solution**

Appropriately skilled and registered providers, who have knowledge and understanding of psychosocial disability could enhance the quality of support provided, facilitate stakeholder collaboration and contribute to appropriate plan utilisation.

**Summary statement**

The quality of the support provider and the support being provided is integral to the ongoing wellbeing of participants. There should be a mechanism to ensure that providers are skilled and capable of providing quality psychosocial support and that the support provided is adequately captured in the participants plan.

**Plans and Plan Review**

**Description**

For people with a psychosocial disability, flexibility in support provision is often required. The episodic nature of psychosocial disability and mental health issues means that the intensity of support needed is not static. If a participant has a fluctuation in their support needs, the plan should be flexible to allow a change in supports to occur in a timely and responsive way.

People with psychosocial disability may require capacity building funding included in their plan to support their fluctuating disability support needs. Examples of capacity building interventions to assist people in the community might be:

* graded activities for skill development
* evaluating and providing adaptive strategies for task completion
* graded exposure to activities.

When a plan review/ reassessment (change of circumstances) is required, there is no process or system for review requests from participants in the community to be flagged as urgent or be fast tracked. This may lead to breakdown of supports and inappropriate hospital admission.

**Proposed solutions**

The NDIA should:

* Routinely build flexibility into plans to enable the dynamic support needs of a participant to be met
* establish Community Liaison Officer roles for community participants for when an urgent review/ reassessment (change of circumstances) or access request is required. Alternatively, increase the scope of practice of Health Liaison Officers to community participants at risk of inappropriate hospital admission or breakdown in supports.

**Justification for solutions**

Support needs for people with a psychosocial disability fluctuate. To effectively manage this and provide best practice support, the support plan should be flexible to meet this need.

**Summary statement**

The intent of NDIS plans is to fund the disability support needs of a participant. These plans need to be able to match a participant’s changing needs in a timely way.

1. The recommendations under each theme have been matched back to the Review’s terms of reference [↑](#footnote-ref-2)
2. Productivity Commission 2017, NDIS costs study report, Page 263, <https://www.pc.gov.au/inquiries/completed/ndis-costs/report/ndis-costs.pdf> [↑](#footnote-ref-3)
3. PC Review of scheme costs, 2017, page 2 [↑](#footnote-ref-4)
4. The NDIS Review secretariat has been provided with a range of information on Ability Links – including Aboriginal Ability Links and Early Linkers. This model is an exemplar for the positive role that LACs could play. [↑](#footnote-ref-5)
5. [https://static1.squarespace.com/static/5898f042a5790ab2e0e2056c/t/60540a713025687587aff5dc/1616120438947/Advice+-+Supporting+LACs+to+be+LACs+-+Final+-+2021-02-04.pdf](https://static1.squarespace.com/static/5898f042a5790ab2e0e2056c/t/60540a713025687587aff5dc/1616120438947/Advice%2B-%2BSupporting%2BLACs%2Bto%2Bbe%2BLACs%2B-%2BFinal%2B-%2B2021-02-04.pdf) [↑](#footnote-ref-6)
6. [https://static1.squarespace.com/static/5898f042a5790ab2e0e2056c/t/60540a713025687587aff5dc/1616120438947/Advice+-+Supporting+LACs+to+be+LACs+-+Final+-+2021-02-04.pdf](https://static1.squarespace.com/static/5898f042a5790ab2e0e2056c/t/60540a713025687587aff5dc/1616120438947/Advice%2B-%2BSupporting%2BLACs%2Bto%2Bbe%2BLACs%2B-%2BFinal%2B-%2B2021-02-04.pdf) page 3 [↑](#footnote-ref-7)
7. <https://www.dss.gov.au/sites/default/files/documents/02_2020/pdf-version-community-visitors-review_0.pdf> [↑](#footnote-ref-8)
8. Care Workforce Labour Market Study (nationalskillscommission.gov.au) [↑](#footnote-ref-9)
9. Budget Paper number 4, <https://budget.gov.au/content/bp1/download/bp1_bs-4.pdf> [↑](#footnote-ref-10)
10. <https://www.fwc.gov.au/documents/sites/work-value-aged-care/decisions-statements/2022fwcfb200.pdf> page 250 [↑](#footnote-ref-11)
11. DCJ analysis of matched NDIS-OOHC data. [↑](#footnote-ref-12)
12. For example, Public Hearing 13, Disability services (a Case Study), held in Sydney from 24-28 May 2021. [↑](#footnote-ref-13)
13. Source: Summary findings: Justice test case, page 11, <https://ndda.dss.gov.au/wp-content/uploads/2022/09/11-Summary-of-NDDA-Pilot-findings-Justice.pdf> [↑](#footnote-ref-14)
14. Source: Summary findings: Justice test case, page 10, <https://ndda.dss.gov.au/wp-content/uploads/2022/09/11-Summary-of-NDDA-Pilot-findings-Justice.pdf> [↑](#footnote-ref-15)
15. NDIS thin markets project report to Disability Reform Ministerial Council October 2022 [↑](#footnote-ref-16)
16. National Action Plan Developing the NDIS Specialist Behaviour Support Market <https://disability.royalcommission.gov.au/system/files/exhibit/CTD.8000.0013.1435.pdf> [↑](#footnote-ref-17)
17. <https://dcj.nsw.gov.au/documents/community-inclusion/disability-inclusion/royal-commission-into-violence-abuse-neglect-and-exploitation-of-people-with-disability/DCJ_Royal_Commission_into_Violence_Abuse_Neglect_and_Exploitation_of_People_with_Disability_report_FA2_web.pdf> [↑](#footnote-ref-18)
18. [Disability-related health supports | NDIS](https://ourguidelines.ndis.gov.au/supports-you-can-access-menu/disability-related-health-supports#:~:text=Disability-related%20health%20supports%20are%20health%20supports%20that%20relate,expert%20training%20for%20you%20or%20your%20support%20providers.) [↑](#footnote-ref-19)
19. [What do we mean by disability-related health supports? | NDIS](https://ourguidelines.ndis.gov.au/supports-you-can-access-menu/disability-related-health-supports/what-do-we-mean-disability-related-health-supports#:~:text=Disability-related%20health%20supports%20may%20include%3A%201%20funding%20for,products%20like%20catheter%20bags%2C%20pads%2C%20bottles%20and%20straps.) [↑](#footnote-ref-20)
20. [NDIS- DRHS Operational Guideline](file:///C%3A%5CUsers%5C60198986%5CDownloads%5COG%20-%20Disability-related%20health%20supports%20v2.0%20APPROVED%20-%20EXTERNAL%202022-06-21%281%29_0%20%282%29.pdf) [↑](#footnote-ref-21)
21. [NDIS After Hours Crisis Referral Service | Marathon Health](https://www.marathonhealth.com.au/ahcrs) [↑](#footnote-ref-22)
22. [Official Community Visitors (nsw.gov.au)](https://ageingdisabilitycommission.nsw.gov.au/about-us/official-community-visitors.html) [↑](#footnote-ref-23)
23. [The Applied Principles and Tables of Support to Determine Responsibilities NDIS](https://www.dss.gov.au/disability-and-carers-programs-services-government-international-disability-reform-ministerial-council-reports-and-publications/the-applied-principles-and-tables-of-support-to-determine-responsibilities-ndis-and-other-service)  [↑](#footnote-ref-24)
24. <https://www.health.gov.au/topics/palliative-care/about-palliative-care/what-is-palliative-care> [↑](#footnote-ref-25)
25. <https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/silver-book/part-a/palliative-care#:~:text=A%20palliative%20approach%20shifts%20the,issues%20as%20they%20approach%20death>. [↑](#footnote-ref-26)
26. <https://www.betterhealth.vic.gov.au/health/servicesandsupport/end-of-life-and-palliative-care-explained> [↑](#footnote-ref-27)
27. <https://www.health.gov.au/topics/palliative-care/about-palliative-care/where-is-palliative-care-provided#hospice-care> [↑](#footnote-ref-28)