

# **Inquiry into the NDIS Quality and Safeguards Commission**

Submission to the Joint Standing Committee on the  
National Disability Insurance Scheme

**28 July 2020**



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## Who we are

The Australian Lawyers Alliance (ALA) is a national association of lawyers, academics and other professionals dedicated to protecting and promoting justice, freedom and the rights of the individual.

We estimate that our 1,500 members represent up to 200,000 people each year in Australia. We promote access to justice and equality before the law for all individuals regardless of their wealth, position, gender, age, race or religious belief.

The ALA is represented in every state and territory in Australia. More information about us is available on our website.<sup>1</sup>

The ALA office is located on the land of the Gadigal of the Eora Nation.

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<sup>1</sup> <[www.lawyersalliance.com.au](http://www.lawyersalliance.com.au)>.

## Introduction

1. The ALA welcomes the opportunity to have input into the Committee's examination of the operation of the NDIS Quality and Safeguards Commission (the Commission), as part of its role to inquire into the implementation, performance and governance of the National Disability Insurance Scheme (NDIS).
2. We understand that the Commission is an independent agency established to improve the quality and safety of NDIS supports and services.<sup>2</sup> In order to complete this role, the Commission regulates NDIS providers, provides national consistency, promotes safety and quality services, resolves problems and identifies areas for improvement.<sup>3</sup>
3. The ALA has been a regular contributor to inquiries by various state and federal agencies and parliamentary committees in relation to the ongoing issues associated with the establishment of the NDIS. We have had particular concerns in relation to the quality of planning,<sup>4</sup> the quality of NDIS review processes,<sup>5</sup> and the quality of workforce development initiatives.<sup>6</sup>
4. The ALA believes that the Commission has a vital role to play in overseeing how the NDIS/NDIA implement their responses to these challenging issues. To that end, we restrict our commentary around the success of the Commission to responding to three of the Terms of Reference, namely:
  - a. The monitoring, investigation and enforcement powers available to the Commission, and how those powers are exercised in practice;
  - b. The effectiveness of the Commission in responding to concerns, complaints and reportable incidents – including allegations of abuse and neglect of NDIS participants; and

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<sup>2</sup> <<https://www.ndiscommission.gov.au>>.

<sup>3</sup> Ibid.

<sup>4</sup> See for example: <<https://www.lawyersalliance.com.au/documents/item/1631>>.

<sup>5</sup> Ibid.

<sup>6</sup> See for example: <<https://www.lawyersalliance.com.au/documents/item/1854>>.

- d. The adequacy and effectiveness of provider registration and worker screening arrangements, including the level of transparency and public access to information regarding the decisions and actions taken by the Commission.

## **COVID-19 and the danger presented by reliance on insecure work for sub-contracted NDIS services**

5. Before addressing these Terms of Reference, the ALA draws the Committee's attention to an issue which we believe has the potential to become an imminent crisis for the NDIS, and thereby, the Commission.
6. It has been identified that the tendency for aged care workers to work across multiple aged care facilities has been a major contributor to the spread of COVID-19 in that industry. The Federal Government, in partnership with its Victorian counterparts, has identified a specific plan to address this issue. According to government announcements<sup>7</sup> this plan includes funding to:
  - Ensure that aged care employers can cover any additional entitlements to enable employees to work at a single site;
  - Engage and train additional staff where existing employees are unable to work due to self-isolation requirements and/or where a more intensive workforce mix is required;
  - Support aged care workers who are unable to work due to symptoms, self-isolation or travel restrictions, regardless of whether they would usually receive paid leave.
  - Provide alternative accommodation so that workers who live or work in hotspots can continue to work.
7. This plan operates in conjunction with Victorian Government initiatives designed to discourage employees from working when they feel unwell.<sup>8</sup>
8. At the core of this problem within aged care is the sector's reliance on insecure work including casual employment arrangements, sub-contracting arrangements and the like (see our response

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<sup>7</sup> See for example: <<https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/support-for-aged-care-residents-and-aged-care-workers-across-victoria>>.

<sup>8</sup> <<https://www.dhhs.vic.gov.au/covid-19-worker-support-payment>>.

to Term of Reference (d) for more on this issue). The ALA is concerned that the same issue is likely to come to the fore in the disability support sector.

9. The preconditions of the COVID-19 crisis in aged care also exist in the disability sector, which has:
  - highly susceptible service recipients;
  - a highly mobile workforce; and
  - a workforce based on insecure work arrangements, mostly without sick pay, who are forced to choose between working when sick and not being able to financially support their families.
10. The ALA urges the Committee to consider an immediate response to this inevitable and impending crisis, and consider its expectations of the Federal Government, the NDIA and the Commission in ensuring participant safety.
11. The death toll in the aged care sector due to this issue is unnecessarily high. The Committee must act quickly to ensure that this is not replicated in the disability community.
12. Our submissions to the three nominated Terms of Reference (ref paragraph 6) appear below.

### **a. The monitoring, investigation and enforcement powers available to the Commission, and how those powers are exercised in practice**

13. The ALA applauds the Committee for giving particular focus in this inquiry to the effectiveness of the enforcement powers of the Commission. Since its establishment, the ALA has been concerned whether the Commission would have the legislative ‘teeth’ to have a positive impact on the quality of service provision.
14. Of particular concern is whether, once an adverse finding has been made against a service provider, adequate mechanisms exist to ensure that the actions or behaviours of that service provider change, and that this in turn leads to new expectations and norms of behaviour across the industry.
15. The specific difficulties in imposing behavioural change in an industry dominated by outsourced service provision are discussed more in our response to Term of Reference (d).

16. The ALA encourages the Committee to make specific recommendations on whether they believe the Commission has the mandated authority it needs to effect change, and is adequately resourced to ensure that happens.

## **b. The effectiveness of the Commission in responding to concerns, complaints and reportable incidents – including allegations of abuse and neglect of NDIS participants**

17. The ALA submits that central to the effectiveness of any complaints process is ensuring that the complainant has access to a range of support measures. This is particularly true of complaints by people with disability against their service providers or the NDIS.
18. The act of lodging a complaint can be a harrowing experience for a service recipient:
- The power asymmetry that exists in a complaints process is well-documented. The complainant can feel like they are in a 'David and Goliath' struggle to be heard, understood and believed. Often they come up against well-resourced departments or legal teams intent on defending the actions of those that the complaint is made against.
  - There can be a fear that a complaint will lead to worse service provision, as a result of retribution.
  - The act of making a complaint can be a source of retraumatisation.
19. Often, complainants engage in a complaints process unaware of their rights.
20. The ALA submits that the Commission has an important role to play in ensuring that complainants are well supported during this process. Proper support can help to ensure that the complaints process is fair, that all accessibility issues are considered, and that responses to the complaint are appropriate and timely.
21. The ALA urges the Committee to consider whether current requirements of the Commission, in processing complaints from NDIS participants, enable or hinder fair process.
22. The ALA believes that all complainants should have access to expert support mechanisms – this includes access to legal support, or the supports provided through independent advocacy agencies.



23. The ALA submits that there is a high level of legal need among people with disability. It agrees with the Law Council of Australia (LCA) that the legal system is largely inaccessible for many people with disability and can produce unjust outcomes.<sup>9</sup>
24. The ALA is concerned that specialist disability legal assistance services and other specialist critical support services are not adequately resourced to address this legal need. According to the LCA, specialist disability legal services face severe resource constraints and, as a consequence, are struggling to meet the growing demand and are having to turn large numbers of vulnerable people away.<sup>10</sup> According to a 2014 survey of 53 community legal centres across Australia, only half had processes in place to ensure that legal services were directed towards people with disability.<sup>11</sup>
25. The ALA strongly submits that specialist disability legal assistance services should be appropriately resourced and expanded. This includes increased funding for specialist community legal services and Legal Aid lawyers with expertise in disability to ensure that people with disability have affordable access to appropriate and effective legal representation. Further, the ALA submits that additional resourcing should be provided to other critical support services, such as disability advocates, mental health services, tailored accommodation, and rehabilitation and diversionary programs.
26. The ALA further submits that this additional resourcing should ensure that there is appropriate access to advocacy and legal services with disability expertise regardless of geographical location.
27. We believe it is vital that the complaints process is adequately resourced to allow for this support provision.

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<sup>9</sup> Law Council of Australia (LCA) (2018), *The Justice Project Final Report – Part 1 – People with Disability*, August 2018, 13.

<sup>10</sup> Ibid, 56.

<sup>11</sup> Productivity Commission (2018), *Access to Justice Arrangements*, 720 (see figure 21.1).

28. This Committee has received a great deal of information about the NDIA's capacities in responding to complaints. For example, the Committee's interim report on the planning process<sup>12</sup> noted that:

*'The committee is also concerned that significant delays in the plan review process, as well as delays in conducting internal reviews of decisions, are causing undue burden and distress for participants, limiting participants' ability to access supports (including disrupting continuity of supports), and undermining effective administration of the NDIS.'*

Against this backdrop, it is vital that the Commission's complaint handling processes are more client-focused than those of the NDIA.

#### **d. The adequacy and effectiveness of provider registration and worker screening arrangements, including the level of transparency and public access to information regarding the decisions and actions taken by the Commission**

29. The ALA recognises that the Commission has a difficult task in ensuring the accountability and quality control of work standards, and that this is made more difficult when dealing with outsourced, contracted-out service provision.

30. The traditional model of full-time employment with the one employer for the course of a career began to shift in the 1970s and 1980s as businesses embraced a process of cutting labour costs.

31. Boston University Economics Professor David Weill coined the term 'the fissured workplace'<sup>13</sup> to describe how businesses and departments were walking away from directly employing staff to utilising a range of other mechanisms to source labour. These mechanisms include franchise models, labour hire firms, employment agencies, subcontracting arrangements and the like.

32. The desire for a more flexible workforce has in turn created significant issues for those seeking to ensure quality and safety. The fissured workplace has created several tiers of accountability

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<sup>12</sup> <[https://parlinfo.aph.gov.au/parlInfo/download/committees/reportjnt/024350/toc\\_pdf/NDISPlanningInterimReport.pdf;fileType=application%2Fpdf](https://parlinfo.aph.gov.au/parlInfo/download/committees/reportjnt/024350/toc_pdf/NDISPlanningInterimReport.pdf;fileType=application%2Fpdf)>; para 3.92.

<sup>13</sup> *The Fissured Workplace: Why Work Became So Bad For So Many and What Can Be Done to Improve it* (2014).

between those who want the work done, and those who provide the work. For example, where a hotel chain may have, in the past, directly employed cleaners to do the work, they may now tender out the cleaning services and award the tender to the cheapest supplier – a contracting or labour hire company. Under the traditional employment model, the hotel would:

- control the tasks of the cleaners;
- direct the work of the cleaners;
- accept responsibility for upholding the employment relationship with the cleaners, including ensuring compliance with workplace laws and employee entitlements; and
- accept responsibility for the provision of a safe environment in which the cleaners can work.

33. Under the fissured workplace model, the hotel may contract a services company to provide the cleaning services, following a competitive tendering process. The successful tenderer may then may engage a labour hire firm to source independent contractors to do the work. In this situation, there are several tiers separating the work of the cleaners from those that benefit from the work performed.

34. The ALA submits that there needs to be a more streamlined and direct accountability structure between the entity that wants the work done (in this case the NDIS and the NDIS participant) and those who do the work. This accountability structure needs to include responsibility for the quality of service provision, the health and well-being of the workers, and responsibility for ensuring that workers are receiving their full entitlements.

35. The ALA draws the Committee’s attention to the current trend toward the ‘Uberisation’ of the disability workforce. It is important that the Commission, in overseeing the provider registration and worker screening arrangements, recognises that:

- a. The disability workforce is made up of some of the most vulnerable worker cohorts in Australia;
- b. These vulnerable cohorts of workers are particularly susceptible to the actions of unscrupulous employers;
- c. Sham contracting is rife, with workers told they must be independent contractors rather than traditional employees. These workers are then missing out on

superannuation, insurance, workers' compensation, award protections and the other workplace benefits Australian workers have come to expect;

- d. Technology-based employment matching services that actually employ their staff, rather than merely connect contractors to clients, need to be rewarded; and
- e. In order to compete with other care sectors (including health and aged care), the employment conditions within organisations registered to provide NDIS services must be first-rate.

36. In Appendix 1 to this submission, the ALA presents a number of case studies where the employment processes of attendant care agencies have led to poor care outcomes for participants.

37. However, the alternative to using agency staff – that is, engaging support staff directly – is complex and fraught, and may not be the optimal model for many people with complex care needs.

38. The 2019 report *Growing the NDIS Market and Workforce Strategy* tells us that:

*'The scale at which the workforce needs to grow in a short period is significant. It is estimated that the NDIS workforce will need to increase by up to 90,000 full-time equivalent (FTE) employees over the next five years.'*<sup>14</sup>

39. The *Australian Disability Workforce Report*, produced by National Disability Services, reveals a number of interesting facts about the disability care workforce:

- a. Around 70% of disability support workers are women, compared to a figure of 46% in the wider Australian workforce;
- b. Disability support workers are slightly older than the Australian workforce: 44% are aged 45 years or more, compared to a figure of 39% in the workforce more generally;
- c. Most disability support workers are employed as permanent (55%) or casual workers (42%). Very few are fixed-term workers (3%). The number and rate of casual workers is the fastest growing employment type in the sector;

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<sup>14</sup> <<https://www.dss.gov.au/disability-and-carers-programs-services-for-people-with-disability-national-disability-insurance-scheme/growing-the-ndis-market-and-workforce-strategy>>; p10.

- d. Small and medium-sized organisations/employers engage more casuals;
- e. Organisations with higher female-to-male ratios have higher levels of casual employment and lower levels of permanent employment. In organisations with a majority male workforce, the proportion of permanent employees in those organisations is 74% and the proportion of casuals is just 22%; and
- f. The turnover rate for casuals has averaged around 1.6 times as high as the permanent rate and appears to be increasing.<sup>15</sup>

40. The NDIS has become the main supplier of funds for the employment of disability care professionals. The ALA believes that the Commission has an important role to play in recognising that the NDIA's procurement processes for service provision should have far higher expectations on the credentials of the applicant firm as an employer of choice. If a firm cannot provide details of their success as a quality employer, they should not be funded by the NDIS to provide services to people with disability.

## Conclusion

41. The Australian Lawyers Alliance (ALA) welcomes the opportunity to have input into the Joint Standing Committee on the NDIS's inquiry into the operation of the NDIS Quality and Safeguards Commission. The ALA is available to further assist the Committee in its consideration of these important issues.

**Graham Droppert**

**President**

**Australian Lawyers Alliance**

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<sup>15</sup> <<https://www.nds.org.au/policy/australian-disability-workforce-report-second-edition-highlights-workforce-risks1>>.

## Appendix 1

### Attendant care agency worker case examples

The attendant care industry has grown sustainably since the NDIS was brought in and expanded over recent years. Evidently, what has not increased is the quality of care, knowledge and training of some of the support workers.

Below we have provided a few examples that highlight this lack of care and training. These have been drawn from the experiences of occupational therapists and other allied health providers who work closely with ALA members.

It is notable that attendant care agencies are now receiving a much higher rate for people who are deemed 'complex care', and in many cases it is primarily the agency who decides who is complex care and who is not.

There is a perception among health professionals that attendant care agencies are often benefitting the most out of the NDIS funding – not the clients who need the care and support.

The most startling and shocking example of this has been the tragic death of Anne-Marie Smith in Adelaide.<sup>16</sup> Where was the agency in all of this, why weren't there 'quality of care' checks by the agency, and why was this allowed to happen?

This case calls into question the quality control processes of the NDIS.

Of particular concern are those clients living in rural and remote areas where there may be only one or two agencies to choose from. Far too often clients and their families have to settle for a lower standard of care, where the agency 'holds the purse strings' and determines who provides care and when.

Consider the follow case studies:

#### **Case Study #1**

Client: 32-year-old man, severely and multiply disabled, non-speaking, PEG feed and incontinent. He communicates via facial expression and vocalisations. He requires maximal levels of assistance for all activities of daily living. He requires 24-hour care with two people for transfers. He has a history of pressure areas, so daily skin checks must be undertaken.

His therapy team has provided a comprehensive manual, inclusive of videos and step-by-step instructions for his daily care and exercises.

There has been difficulty sourcing consistent carers for this man. However, the agency has consistently sent carers who:

- Have not worked with people with severe physical disability;
- Do not know how to use, or have even seen, a hoist;

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<sup>16</sup> See for example: <<https://www.theguardian.com/australia-news/2020/may/31/the-death-of-ann-marie-smith-a-shocking-case-of-neglect-or-a-failure-of-the-system>>.

- Do not know how to use a slide sheet or complete manual handling (i.e. re-positioning in bed or rolling to change continence pads);
- Do not change his pads when necessary, resulting in him lying in soiled pads for hours;
- Do not know how to communicate with this man and/or interpret his communication (even though it is written down and included in a video);
- Did not routinely check his skin – and he ended up with severe pressure areas on his heels – which took in excess of eight months to heal and were painful;
- Did not read or follow the manual;
- Did not talk to him or let him know when they were going to touch him, which resulted in him becoming frightened and going into muscle spasm, which is extremely painful for him; and
- Had no training on how to recognise when he was having a seizure, which resulted in him having multiple seizures before someone noticed and he was given his medication.

This situation was repeated on many occasions for this client. In the end there was a change of carer agency and although the next agencies were better, the agency insisted on the therapist providing the training, which used up all of the therapist's allocated hours. Therefore, there were no or very little therapy hours left for the therapists to implement their programs with this young man.

### ***Case Study #2***

Client: 54-year-old woman with post acquired head injury. Able to walk with a wheelie walker, significant cognitive/memory issues. She requires 24-hour care, living in her own home. She requires assistance with all activities of daily living (including personal care). She prefers females to complete her personal care and likes getting up early to shower (i.e. 7:00am).

Carer agency sends in males for the early shift as they claim that all female cares are not available (as they are at home caring for their children).

Issues:

- Lack of female carers to complete personal care routine;
- Carer agency sets the hours and shift times to suit their carers;
- No carers have had training in cognitive/memory disorders and some yell at the client for 'not remembering', client becomes upset and distraught. Client's family come in to care for her due to her distress;
- Carer agency dictates who she can see and when (i.e. friends);
- Carer agency over-utilises the transport allocation – taking the client 'for drives' so that they can complete their own shopping and community chores;
- Client has to stay in bed until the carer is ready to complete her personal care; and
- Carer agency dictates how the client spends her money – i.e. does not 'approve' her to go to physio.

As this client lives in a regional area and she and her family live on farms, the client (and her family) have settled for care and carers that are not suitable for her.

### ***Case Study #3***

Client: 54-year-old man living in a RAC neurobehavioural unit (due to acquired brain injury 20 years ago). The client has daily care to take him off the unit and participate in community groups. The client prefers female, middle-aged carers.

The client has a receptive communication disorder – so language is paramount for him to be able to understand what is said to him. He prefers Anglo-Saxon carers, as he can understand these the best. Carers need to have some understanding (i.e. basic) of cognitive disorders and have a good command of English.

Issues:

- Agency sent in carers who had no experience working with people with cognitive/behavioural disorders;
- Agency sent in carers who did not have a good command of English;
- Carers continually on their phones;
- Carers who were not Anglo-Saxon – which caused the client to become aggressive towards the carer, resulting in the client being medicated; and
- The Agency would send carers who did not have driver's licence – which was a stated need for the carers – so the carer and the client would have to get a taxi to community group, at the client's expense.