



Joint Standing Committee Inquiry into the NDIS Quality and Safeguards Commission

NDS has supported for some time the establishment of the NDIS Commission to replace the patchwork of quality and safeguarding systems around the country. These legacy systems were of varying sophistication and effectiveness, and were onerous for providers operating in more than one state or territory. In our view, NDIS participants should be protected by the same quality and safeguarding system, and be able to expect the same quality of supports, regardless of where they live.

The work required to implement a national regulatory system for quality and safeguards has been immense. Difficulties have been exacerbated by the substantially different starting points across the country. Negotiating the legislation—including the practice standards, worker clearances and processes for approving the use of restrictive practices—was complex, not least because states and territories had very varied practices and expectations in place, with some jurisdictions having more developed requirements than others. Providers across the country had varying understandings of the requirements for operating in a modern regulatory system, and very different levels of preparedness.

The following comments are made with a view to improving how providers can be assisted to meet the requirements of the NDIS Commission and implement processes to continually improve the quality and safety of the supports they provide NDIS participants.

Monitoring, investigation and enforcement powers

The legislation gives the Commission appropriately broad monitoring, investigation and enforcement powers, however NDS has limited information on how these powers are being used.

Compliance and enforcement actions that result in a penalty are summarised on the Commission's website however the information is too brief in our view to help drive improvements in practice. More information on breaches, and trends, would give providers information they could use to improve their practices.

A regular summary of audit findings, including a focus on what types of non-compliances were being identified, would be particularly useful to the sector. Knowledge will help improve practice.

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Provider experiences of complaints made to the Commission by participants

Complaints are critical to a good regulatory system. They are to be encouraged and used to drive quality improvements. The process needs to be well managed and timely.

Building on provider feedback, NDS urges the Commission, when responding to a complaint, to initially approach relevant staff by email, wherever possible, so there is a record of the engagements between parties. Phone calls to frontline staff may be made at an unsuitable time and may be confusing to the individual (the complaint may have been submitted by the provider's complaints officer). Staff can also be confused about whether they are under investigation for a serious matter or whether the inquiry is more exploratory in nature. Additionally, if the employing organisation has no knowledge of the contact, they are not in a position to support the staff member being questioned.

As is their right, some participants don't raise a complaint directly with the provider but lodge it directly with the Commission. Unfortunately, providers may not be contacted by the Commission until some months have passed, making it difficult to investigate what happened to generate the complaint.

Timeliness of complaint notification can be slow; for example, a provider has reported to NDS that a complaint made in January was only notified to the provider in September. The provider was unaware there was a complaint for this duration and was providing service throughout this time.

A complaint should be lodged with the Commission by a behaviour support practitioner who believes the implementing provider is not implementing a Behaviour Support Plan (BSP) appropriately. Currently, they are not provided information about the resolution, missing an opportunity to improve practice and understanding.

As the Commission is still consolidating its processes, it is to be expected that these concerns will moderate over time.

Adequacy and effectiveness of the NDIS Code of Conduct and the NDIS Practice Standards

The NDIS Code of Conduct is a clear and sound document that guides staff and organisations on expectations about how they will work with and support NDIS participants. It has a strong education and expectation role in driving the delivery of high quality and safe supports to people with disability.

During development of the legislation to establish the Commission and its powers, NDS raised concerns about the inadequacy of the Code as an enforcement tool. Our concerns remain. The absence of a requirement for worker clearances for all workers supporting NDIS participants—workers engaged by non-registered providers and self-managed participants are not required to hold a worker clearance—places even more weight on the Code to deliver appropriate supports. NDS believes all workers delivering face-to-face supports to NDIS participants should be required to hold a worker clearance, including workers associated with registered and non-registered providers and workers who are engaged directly by

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participants. The current requirement that staff who have more than incidental contact with participants should have a worker clearance is appropriate.

Due to the immaturity of the audit process (with a large proportion of providers still to have completed the first full round of an audit cycle) it is difficult to provide an assessment of how well they are working to drive quality improvements across the sector. Knowledge from aggregated audit findings is limited. NDS urges the Commission to release this type of information as it would help providers improve their practices.

One Module does, however, need amendment: Supplementary Module 1, High Intensity Daily Personal Activities. Providers of psychosocial support must be assessed against this module but it is not fit for purpose for this group. The Module has largely been designed for providers of supports for participants with complex medical conditions such as:

- Complex bowel care
- Enteral (nasogastric tube-jejunum or duodenum) feeding and management
- Tracheostomy management
- Urinary catheter management (in-dwelling urinary catheter, in-out catheter and suprapubic catheter)
- Ventilator management
- Subcutaneous injections
- Complex wound management

This list doesn't relate to the competencies required to support participants with psychosocial disability.

It would be appropriate to review the practice standards as soon as most transferring providers (that have operated under systems managed by state and territory governments) are operating under the new system.

Adequacy and effectiveness of provider registration and worker screening arrangements

Providers, particularly those that are smaller (including small therapy providers) and operating in rural and regional areas, continue to report that the cost of audit causes them to refrain from registration. An analysis of this issue is warranted.

The Registrar has confirmed that finalisation of Registration occurs quickly after receipt of the audit report. Unfortunately, there can be lengthy delays between the completion of audit and the lodging of the report, and then again until the Commission finalises Registration. Providers most impacted are those seeking registration for the first time or seeking to register for new registration groups. In a recent meeting of 19 NSW-based providers, none had received notification of their registration renewal despite audits having been conducted up to six months previously.

Providers are concerned about the skills and expertise of some auditors. For example, Registered Nurses have undertaken audits on Supplementary Module 2

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Specialist Behaviour Support and 2A Implementing Behaviour Support Plans without having experience of behaviour support practices.

Management of the transition period, including impacts on other oversight, safeguarding and community engagement programs

Providers transitioning from state and territory quality systems have had very varied levels of knowledge and experience of the requirements to operate under the NDIS Commission. Greater assistance to those transitioning from less sophisticated systems, particularly early on, would have eased the process.

During the early transition, of providers in NSW and SA, information and advice was lacking. Over time, the resources provided by the Commission have increased.

The issue that caused the most difficulty during transition was the management, and resulting reporting, of BSPs. Definitions of restrictive practices, or what required reporting, changed in some jurisdictions as they transitioned to the Commission's jurisdiction. For instance, a practice that had not required reporting under a state-managed system immediately required reporting after every instance of its use, until such time as a new BSP was in place (which could require making multiple reports per day on just one participant). A shortage of behaviour support practitioners—who develop such plans—meant that the total wait for a new BSP could be many months.

The administrative burden on providers during this period was substantially increased. The sector still reports significant wait periods for appointments with a behaviour support practitioner.

The establishment of new workforces is never easy. Providers report receiving inconsistent messages from Commission staff, noting variations between what they receive verbally and what is available in writing.

NDS suggests consideration be given to allocating 'case contact' staff from within the Commission to providers supporting more than a defined number of participants. A similar structure is used by the NDIA and has proved to be useful.

The NDIS Commission has responded to the need to build capacity among providers, including through two grants rounds. The first provided grants to numerous organisations to undertake projects; NDS was awarded a grant to improve knowledge about the Code of Conduct and in positive behaviour support. Recent grant funding to NDS has been directed to developing resources to assist sole practitioners, and small to medium-sized providers to understand and implement requirements associated with the reporting of complaints and incidents, and with risk management.

Targeted grants rounds help deliver resources to address gaps in knowledge; they are a valuable support to providers as they understand and work under a more sophisticated quality and safeguards system. They are highly appreciated by the sector.

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Other comments

- **Behaviour Support Practitioners**

As noted above, there is a shortage of behaviour support practitioners to meet the demand for their critical services.

Problems associated with BSPs are exacerbated by NDIA processes. If a provider has to use a restrictive practice on a participant who does not have a BSP in place, the development of one is initiated. This requires an allocation of funding in a plan. The participant will, in this instance, need to request a plan review, which involves a delay. Once funding has been secured, there will be another delay while waiting for an appointment with a behaviour support practitioner and the development of a BSP (which may then require the training of the staff who will implement it). Until this happens, every single use of a restrictive practice must be reported (once a BSP is in place, the use of authorised restrictive practices is done monthly).

A process to fast track and streamline a plan review to have funds made available for the development of a BSP needs to be implemented.

- **Inadequate supports funded in NDIS participant plans**

The Joint Standing Committee has often considered problems associated with planning and knows the issues. Inadequate plans, particularly for participants with complex needs, can impact on the quality and safety of supports provided.

Charges have been laid in relation to the horrific death of Ann Marie Smith, an NDIS participant, and other reviews are underway. To help prevent similar events in the future, NDIS planning must identify what safeguards are available to an NDIS participant (formal and informal), and where there are gaps take measures to address them—through measures such as providing adequate support coordination and/or ensuring an advocacy service is in regular contact.

NDS urges further work be undertaken by relevant parties on how the planning for participants with complex needs and for those with little informal support is undertaken and funding decisions made. Where a participant lives in quite isolated circumstances, a formal, independent advocacy arrangement should be in place.

- **Decreasing supervision in NDIS funding**

The price cap for support from a disability support worker is calculated by the NDIA's Cost Model for Disability Support Workers.

In 2019–2020, the allowance for supervision of these workers was based on one supervisor to 11 FTE workers (the part-time nature of the workforce means this generally equates to a headcount of between 20 and 30 workers).

For this current year, the NDIA has made the unjustifiable decision to reduce the allowance for supervision based on the assumption of there being one supervisor to 15 FTE workers (likely to be between 30 and 40 workers). This decision should be overturned urgently. Adequate supervision and support of this workforce is essential to the delivery of high quality and safe supports.

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- **Compatibility of residents in shared living arrangements**

Violence does occur in some shared living arrangements. It needs to be of concern to providers, the NDIA and the NDIS Commission.

In some cases, the NDIS Specialist Disability Accommodation (SDA) framework has the potential to encourage poor practice. Properties categorised as 'robust' are generally used as homes for people with challenging behaviour and can continue to be built to accommodate up to five people. As the property owner will be interested in maximising the return on their investment, they are likely to want all residents to attract the (higher) robust build SDA funding level. This is contrary to research which indicates that outcomes are better when people with behaviours of concern are not co-residents with one another.¹⁴

This hints at another problem which will emerge. Because the SDA framework has been designed around tenancy, the ultimate decision about which residents can/will live together sits with the SDA provider. Increasingly, we can expect a property owner to have very limited knowledge of people with disability. While there is an expectation that participants can choose with whom they live and that a SIL provider is consulted, there is nothing to mandate that either of these occur.

Incompatibility of residents of group homes is a significant factor in violence that occurs between residents.¹ The NDIA plays no role in considering compatibility of people living in SDA (previously this was done by some state and territory governments through their vacancy management processes). Providers of SIL, who are working in the dwellings providing support, may or may not be involved in discussions about the suitability of participants to live together. To believe the market will drive good decisions about who can live together is, in our view, naively optimistic. Similarly, the NDIS Commission has no involvement in living arrangements but will be receiving the incident reports that indicate violence is occurring.

As noted above, reducing violence and abuse of participants is a concern of providers, the NDIA and the NDIS Commission. Efforts need to be directed at relying on this shared concern to improve the decisions about who lives together in a shared support arrangement and how we can drive ongoing improvements to the quality and safety of supports received.

- **Gaps between responsibilities of the Commission and NDIA need review**

During the COVID-19 pandemic, disability service providers have been beset by both a paucity of information about how to keep the people they support, as well as their workers, safe, and by contradictions in the advice provided by numerous government departments and agencies.

In some jurisdictions providers were urged to cease some disability supports (such as centre-based programs in Victoria) while in others there was a strong expectation they would continue to operate these services, even when providers were concerned they would not be able to enforce social distancing and effective infection control

¹ See <https://www.publicadvocate.vic.gov.au/media-centre/377-violence-by-co-residents-in-group-homes>

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measures. While the NDIA acknowledged the innovative ways some supports were continuing to be delivered, and supported online delivery by assisting many participants to purchase devices in order to receive support online, the regulator of the sector, the NDIS Commission, has adopted a less proactive approach.

There are considerable differences of opinion across government departments, agencies, providers and people with disability about what constitutes an 'essential service'. Over recent weeks, the term is sometimes used to describe those activities of daily living supports required by a person with disability (such as assistance to get up, personal care, meals, and transport); but on other occasions it is used for any support a person may want (such as to participate in social activities).

Participants and providers need to be involved in discussions on how to determine which supports are or are not essential for an individual during a pandemic or other emergency. The different approaches taken during the COVID-19 pandemic have sometimes been inadequate and at other times have undermined the importance of attempts to minimise its impact on people with disability and the workers who support them.

Information to providers on how to implement measures to try to prevent COVID-19 outbreaks among the people they support has been inadequate. For example, material about the use of PPE by the disability sector was released by the NDIS Commission on 24 March but lacked the detail required to be useful. Additional information was—belatedly—released by the Department of Health on 19 May, but was not customised for the sector (for example, it does not mention that a person with disability may demand all staff wear full PPE; does not provide material to help explain to a person when it is or is not required; does not mention that some people with disability may not wear PPE even if requested; or how to implement good infection control in settings where a person does not understand or does not follow what is required).

For most of April, providers were told to contact the National Stockpile if they could not obtain PPE elsewhere; when they did, they were denied supply.

For a considerable time—generally weeks—after the pandemic response began, providers lacked information about how to respond to a positive diagnosis (or the need to isolate a person) in someone who lives in shared accommodation with other people with disability. The majority of houses used for this accommodation have shared bathrooms and living areas thus making isolation of an individual who has a positive diagnosis (or is required to isolate) impossible. Even today, the knowledge and advice about what to do in such an emergency is not clear in all jurisdictions (particularly if alternative accommodation is required; and particularly if there is a substantial outbreak of COVID-19 within the sector).

Varying advice within the Public Health Orders issued by state and territory governments has added to the confusion.

As disability service providers and their staff have navigated the labyrinth of ambiguity that sees them responsible for their clients' wellbeing, but also the health and safety of frontline staff, the information and guidance available to them has been

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inadequate, confusing and at times voluminous, particularly for those providers working in multiple states and territories.

The COVID-19 pandemic has exposed weaknesses in planning for emergencies in the disability sector. Gaps in the design of the new support system, often falling between the areas of responsibility of the NDIA and the NDIS Commission, have been exposed.

The NDIA is largely responsible for providing funding to eligible people with disability and supporting them in their decisions about how to spend it; while the NDIS Commission regulates providers. The pandemic has revealed an information and decision gap between these bodies which needs to be filled in emergencies. Clear and consistent advice, built upon the health-related advice being provided to all other Australians, is what has been required but has been inadequate. The recently developed Management and Operational Plan for People with Disability is useful but needs reviewing to ensure it is fit for responding to all community-wide emergencies that impact on people with disability.

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National Disability Services is the peak industry body for non-government disability services. It represents service providers across Australia in their work to deliver high-quality supports and life opportunities for people with disability. Its Australia-wide membership includes more than 1180 non-government organisations which support people with all forms of disability. Its members collectively provide the full range of disability services—from accommodation support, respite and therapy to community access and employment. NDS provides information and networking opportunities to its members and policy advice to State, Territory and Federal governments.