Disability Services Australia

# Response toNational Disability Insurance Scheme (NDIS) Costs – Productivity Commission Issues PaperFebruary 2017

## Purpose of Submission

Disability Services Australia (DSA) is a strong advocate for the rights of people with disability (PwD) to live a life of choice, inclusion and achievement. DSA is also a strong supporter of the National Disability Insurance Scheme (NDIS) and its objectives outlined in the National Disability Insurance Scheme (NDIS) Costs – Productivity Commission Issues Paper, February 2017, of:

- Improved wellbeing of people with disability, their families and carers
- Better options for PwD for education, employment, independent living and community participation
- Efficiency gains and cost savings in the disability support system and savings to other government services.

DSA makes this submission with the intent of contributing to the success of the NDIS, and the sustainability of the service market place that will be required to provide the quality outcomes and long term gains put forward in the original Productivity Commission Inquiry into the state of disability care and support services (2011).

## The National Disability Strategy and the NDIS

The National Disability Strategy 2010 – 2020 was intended to achieve the following outcomes:

1. PwD live in accessible and well designed communities with opportunity for full inclusion in social, economic, sporting and cultural life
2. PwD have their rights promoted, upheld and protected
3. PwD, their families and carers have economic security, enabling them to plan for the future and exercise choice and control over their lives
4. PwD, their families and carers have access to a range of supports to assist them to live independently and actively engage in their communities
5. PwD achieve their full potential through their participation in an inclusive high quality education system that is responsive to their needs. PwD have opportunities to continue learning throughout their lives.
6. PwD attain highest possible health and wellbeing outcomes throughout their lives.

Whilst some progress has been made in the implementation of this strategy, there are certain areas where insufficient progress is placing cost pressure on and threatens the future viability of the NDIS. DSA would like to specifically highlight areas of concern relating to Strategies 1 to 4.

**Strategy 1**

Strategy 1 included the practical requirements of:

- ***Improved accessibility of the built and natural environment through planning and regulatory systems, maximising the participation and inclusion of every member of the community.***
- ***Improved provision of accessible and well designed housing with choice for PwD about where they live***
- ***A public, private and community transport system that is accessible for the whole community***
- ***Communication and information systems to be accessible, reliable and responsive to the needs of PwD, their families and carers.***

***Accessible Community Facilities***

Very little headway has been made in this area, especially in established suburbs where little new development is taking place. Where a building is not being renovated or modified, there is no requirement for it to be retro-fitted to meet current standards for accessibility.

Many of our customers access our centre based services as a form of community participation, as the lack of accessible amenities within the community prohibits them spending extended periods of time outside these centres. For example, our very high support needs customers may need assistance of a hoist for toileting, and adult rated change tables if required. The example provided relates to specialised amenities, but even at more basic levels of accessibility, options are limited.

In addition, access standards have been developed based on physical requirements, and do not take in to consideration accessibility for people who have behavioural disabilities such as autism (over 28% of people accessing the NDIS). Again, many of our customers access our centres based services with specially designed sensory areas suitable for people with autism, as they struggle in many community based settings.

The NDIS efficient pricing model does not allow for funding of assets such as these purpose built centres, and the vision of the National Disability Strategy has not been realised in relation to accessible communities.

Under the current pricing regime, many service providers will be required to close centre based services, with the result being that PwD will be required to receive support in their homes and experience a reduction in community access.

This does not align with the intent of the National Disability Strategy, and could increase the cost of the scheme over the longer term. Carers will not receive adequate respite, and there could be an escalation of support requirements with a reduction in community access and the support that can be provided in a specialist facility for PwD.

There will be market failure in the area of service provision for people with complex behaviours and high levels of physical disability, with the closure of specialist centre based services.

### *Accommodation*

The Specialist Disability Accommodation (SDA) initiative within the NDIS Pricing and Payments framework will create an incentive for the development of new accessible housing stock. However, it will take some time before the new housing stock comes on line, and there is still a lack of clarity around the mechanisms relating to these payments.

In the short to medium term, a lack of affordable housing in metropolitan areas will increase the cost of care. People will be forced in to crisis accommodation  aged care facilities, will be required to live long distances from informal support networks, will be required to live in group situations with people they would not chose to live with, or live with aging carers who are struggling to cope with caring responsibilities.

As no viable strategy was put in place prior to the roll out of the NDIS to ensure available housing stock to meet the increased demand for supported independent living, it will be difficult for savings or efficiencies to be realised in the short to medium term under the NDIS model of funding, and little capacity for real innovation in this area.

### *Transport*

As a service provider based in NSW, with our customer base predominantly in Western Sydney, we can categorically say that very little progress has been made in the area of accessible transport. Whilst some existing infrastructure has been upgraded, this has not been consistent across the transport network, and the network itself provides poor coverage across the metropolitan areas.

Most of our customers are not able to use the existing public transport system to access services and the community, and have insufficient funding in their NDIS plans to access private accessible transport on a regular basis.

As a service provider, we are having to reduce our fleet of accessible vehicles due to the efficient pricing model not including an allowance for vehicles or infrastructure to support service delivery. The transport allowance provided to individual PwD does not cover the costs required to be recovered by a service provider for the use of accessible vehicles.

We are aware of many service providers down grading their accessible vehicle fleet.

The lack of accessible public transport will increase cost pressures on the NDIA. To avoid market failure pressure will be placed on the NDIA to fund accessible transport to avoid reduction in current service availability and access.

We are not aware of any government driven innovation to move toward a collaborative approach combining disruptive transport models (such as Uber) and the national or state wide pools of accessible vehicles. This type of strategy would need to be developed and coordinated at government level as opposed to the market presenting solutions, as there is no economic incentive to deliver innovation in the area of accessible transport.

### *Communication Systems*

Communication systems are inadequate, and information in relation to both community based and specialist disability support is fragmented and often not in accessible formats.

Information in relation to the NDIS is not well understood, and often conflicting depending upon the source. Service sectors such as Health, Education, Criminal Justice and Ageing are not sufficiently briefed on the NDIS access processes, and with the devolution of state funded services, the expectation that the market will move to fill in the referral pathways is unrealistic in such a complex and changing environment

Local Area Coordinators (LACs) are required to provide information and referral services as part of the contracted relationship with the NDIA. However, targets for plan approvals are preventing this additional work and at full scheme, with over 400,000 participants requiring an annual plan review, it is unlikely that this information and referral work will be done well unless the LAC network is significantly increased.

In addition LACs are not currently across the interfaces between different service systems. We have seen a specific example of a NSW Health Service Brain Injury Unit refer a patient to an LAC for an NDIS plan, when in fact they acquired the injury through a motor vehicle accident and should have been referred to iCare (Lifetime Care and Support). Neither the health system worker nor LAC were aware that this person had been referred to the incorrect funding source and the person was provided with an NDIS plan and funding.

The original ILC framework was intended to provide additional services in the area of information provision, linkages and referrals. However, a significant reduction in the funding for this activity also questions the effectiveness of this initiative.

DSA are unaware of initiatives to address the points raised above, so are not sure if these are "roll out" issues or if they will be long term issues without some adjustment to scheme design.

**Strategy 2 included:**

- ***More effective response from the criminal justice system to PwD who have complex needs and heightened vulnerabilities***.

DSA is a major provider of the Community Justice Programme (CJP)service, a service that has been funded by Ageing, Disability and Home Care (ADHC) since 2006. This service focuses on juveniles and adults with intellectual/cognitive disability who are exiting custodial settings. As part of this program DSA provides a team of forensic case work and clinical specialists who undertake comprehensive risks and needs assessments, post release planning, behavioural intervention and service co-ordination. This service extends to the provision of supported accommodation, in restrictive facilities for the most complex of customers, to drop in support to those considered least complex (although this setting can be more challenging in terms of the prevention of re-offending or self harm).

This service is being transitioned to the NDIS, and is being funded a the higher intensity rate of $45.17 per hour, a $2.38 premium on the standard 1:1 NDIS rate for self care and community participation of $42.79.

We have had significant success in the reduction of re-offending and self harm amongst the customers we support in this cohort. However, we are concerned that the way this service is being transition to the NDIS and the price for services will cause a decline in service level

and a loss of ground against gains previously made in this area of the National Disability Strategy.

The NDIS pricing for this cohort is insufficient to cover the level of staff, training, supervision and support required to safely deliver services and outcomes to this group. In addition, there is no funding for assets. Many of this cohort will not be eligible for an SDA payment, and are not in a position to make any contribution to rent over and above a portion of their DSP and commonwealth rental assistance. Long waiting lists for Community Housing is making it virtually impossible to expand drop in support services to these customers, or set up new shared accommodation models. Many of this cohort would not be deemed fit to hold a lease and service providers do not have sufficient funding to hold a lease on behalf the customers, when their DSP and rental assistance cannot meet a commercial rental.

DSA will need to put a hold on future growth in this service area, as we are unsure that there will be sufficient funding to cover the staffing resources required to deliver CJP services, and are unable to source appropriate accommodation for additional customers without additional funding for assets.

**Strategy 3 included:**

- ***Improved access to housing options that are affordable and provide security of tenure.***

The lack of access to affordable housing has been discussed previously. Further barriers exist in both the commercial rental market and even the affordable housing market, where landlords do not wish to have tenants with disability due to the potential for property damage and impact on neighbours.

Whilst this is discriminatory, in reality, it is a regular response we experience when we support our customers to secure housing.

**Strategy 4 included:**

- ***The disability support system to be responsive to the particular needs and circumstances of people with complex and high needs for support.***

As an organisation, DSA has traditionally supported customers with complex and high needs for support. However, the NDIS pricing and payments framework creates a disincentive for service providers to support customers with complex and high support needs.

The efficient pricing model, requiring 95% billable time, a supervision ratio of 1:15, and total organisational overhead of 9% does not allow for training of staff, and provides no allowance for facilities or accessible vehicles during service provision hours.

Centre based pricing assumes customers will be in groups with support levels of either 2 or 3 customers to 1 support worker. However, the reality is that customers that need to access a centre based rather than community based service setting usually have a 1:1 support ratio and at times require 2 support workers to assist with personal care.

Often facilities will need to be modified with sensory spaces, specialist amenities and allow for zoning to manage behavioural differences of customers.

DSA is reviewing centre based services, and is likely to significantly reduce the number of centres to mitigate the financial losses likely to be incurred through the delivery of this type of support to complex and high support needs customers.

Trauma based behavioural complexity has been discussed as a part of the CJP feedback – Strategy 2.

In summary, it is likely that the current NDIS approach to pricing for people with complex and high support needs will result in a reduction in service options for this group. This reduction in choice will effectively discriminate against this most vulnerable group.

## Responses to Specific Productivity Commission – Issues Paper Questions

### Plan Utilisation and Participant Numbers

- ***PWD and their carer's are not understanding their role as a "consumer"***
- ***Portal claiming issues are under stating plan utilisation rates***
- ***Fragmented approach to planning, support coordination and community linkages is problematic for NDIS participants and the sector as a whole***

The historical evolution of the disability service sector meant that there were capped "places" within pre-defined service models for PwD. People were deemed "lucky" to be able to access services, and had no real rights as a consumer when receiving these services. From the perspective of the PwD and their carer's, there were no financial transactions involved in accessing a service, and services were perceived as a type of welfare.

With the roll out of the NDIS, PwD and their carer's are required to behave as consumers and make "purchasing" decisions. This is a significant paradigm shift.

With intellectual disability and autism being the primary diagnosis for approximately 66% of NDIS participants, where participants do not have an engaged and well informed carer, they themselves and their carer's are struggling to understand their role as a consumer, engage service providers, and negotiate and understand the transactional arrangements.

Many service providers are delivering services to NDIS customers, but due to issues with the NDIS portal, errors in plans, the large number of plan review requests, and problems with claiming against a significant number of plan line items, plan utilisation rates will be appearing lower than they actually are. To this point, at the time of writing DSA had over $1,000,000 of outstanding revenue relating to rejected portal claims. DSA are struggling to find a reliable contact to engage with on a regular basis within the NDIA to resolve these issues.

The original Productivity Commission Inquiry Report – Disability Care and Support 2011, Overview and Recommendations, identifies Disability Support Organisations (DSOs) as essential to the design of the NDIS – refer Appendix I. The role of the DSO was to:

- Provide personal planning services and individual guidance
- Link people to the community
- Assemble "packages" of supports from specialist and mainstream providers
- Undertake administrative tasks for people using self-directed funding
- Provide data to the NDIA
- Innovate in coordinating services

The DSO concept was not included in the roll out of the NDIS in its original form, but in its place are LACs, Plan Managers, and the ILC framework. In addition, a significant amount of Support Coordination funding is being included in individual plans to support participants to select and engage with service providers, and in many instances, the Support Coordination is being delivered by service providers who are not independent of service provision. This is more fragmented than the original intent of the DSO model, and there is a lack of clarity and understanding around the concept of Plan Management.

DSA recommends that the concept of the DSO be revisited, as the fragmented approach to the delivery of the functions outline above will be adding cost to the NDIS, and reducing overall effectiveness.

DSA suggests that higher than anticipated scheme entrants would be due to an under-estimation of unmet need – a result of poor data quality. Participants are not exiting the scheme at the expected rate as there is an unrealistic expectation around "treatment" of disability and the time taken to increase a person's capacity, and consequently the cost of care. In addition, as a carry over from the historical model for disability service provision, carers would be concerned that they may lose the entitlement to support if they stop accessing services. People need confidence that they can easily re-access funding as it is required on a timely basis.

**Interface between NDIS and Other Service Sectors**

- ***Interface between NDIS and other mainstream service sectors is not working***
- ***LACs have insufficient training, and appear only to be trained in NDIS requirements/operational processes***
- ***NSW Health is struggling to discharge patients with a disability or acquired disability, where support services are not already in place***

DSA's experience is that the interface between mainstream services and those funded by the NDIS is not well understood by both mainstream and disability organisations, and even NDIS partners such as LACs.

We noted a previous example of the health system referring a patient to the NDIS as opposed to iCare, even though the injury was sustained through a motor vehicle accident.

Many of the mainstream service sectors, such as health and public education are experiencing cost pressures of their own. Support teachers in schools receive little training,

are often under resourced, and often there are more children requiring additional support than can be catered for. For example, DSA is aware of a primary school in Blackheath, NSW, that has funding for one support teacher, and there are close to 70 children within the school that have some level of disability, developmental delay or learning disorder. This creates an incentive for both the mainstream service sectors and the families/PwD to tap in to NDIS funding to access services that in theory should be available within the mainstream service sectors but are inadequately resourced.

DSA is also aware that many of the Local Health Districts (LHDs) within NSW are struggling to discharge patients who either have or have acquired a disability, and do not have suitable care arrangements in place. There are limited numbers of organisations with the capacity to deliver specialist support coordination, and due to the shortage of allied health professionals and the increased demand for allied health services with the roll out of the NDIS, few allied health professionals are focusing on this area of service delivery.

LACs will generally not have the skills to provide appropriate navigation and support services for someone with an acquired disability or existing disability with complex health needs, and standard support coordination may be insufficient in many instances.

Due to shortages of affordable and accessible housing, no centralised vacancy management system, and fragmented information on mainstream and disability services within various LGA's, it becomes very difficult to discharge someone from hospital within reasonable time frames and the default position is to move people to vacancies within aged care facilities irrespective of their age.

DSA recommends the development of a "gateway" service model that can potentially sit between service sectors such as Health, Criminal Justice and Out of Home Care, and effectively "triage" people to the appropriate funding source, assist them with an access request, support them with their first plan, and provide timely specialist and standard support coordination. This would be similar to the DSO concept, but could potentially refer to the future NIIS (state funded equivalents in the interim), the NDIS, Consumer Directed Aged Care (CDC) funding and other appropriate agencies, and provide a level of planning and support coordination for all these agencies/schemes.

This "gateway" approach would simplify the participant journey, reduce duplication of process, mitigate the risk of cost shifting or a person accessing incorrect funding, reduce costs associated with extended hospital stays (or custodial settings) or sustaining people in residential aged care, and improve outcomes through better quality planning and service sector knowledge within the gateway service.

DSA would be interested in setting up an independent entity to trial a "gateway" concept in partnership with DSS and DOH.

### ILC and LAC Programs

- ***ILC Program is underfunded***
- ***LACs will need to be adequately resourced to review 2,000 plans per day post full roll out, plus meet requirements for linkage and navigation support for people to access mainstream and specialist services***
- ***Will be difficult to recruit, train and retain quality LACs in a competitive market place at the required rate***

In a letter to Christian Porter in December 2016, the exiting Chairman of the NDIA Bruce Bonyhady stated that the ILC program was a cornerstone of the NDIS, and that $132 million was insufficient to adequately fund this program.

If the ILC is underfunded, those that fall in to "Tier II" will receive insufficient support or direction to access mainstream and community supports. This could encourage PwD and their carers to overstate support requirements to access NDIS funding and move themselves in to "Tier III".

Bruce Bonyhady also raised the following points:

- During the final year of NDIS roll out – 2018-19, the NDIA/LACs will approve 850 plans per day and review 1,100 plans per day
- During the first year of full NDIS operation – 2019-20, the NDIA/LACs will be reviewing 2,000 plans per day.

The concept of the LAC role could make sense if it were sufficiently funded and resourced to deliver the 2,000 plans per day, have the appropriate skills and knowledge of their local communities to provide quality linkage and navigation support, and have sufficient knowledge of other mainstream and support service sectors to ensure people are accessing appropriate supports.

However, DSA's observation to date is that there is a high level of turnover within the LAC organisations in the greater Sydney region, resulting in inexperienced and often poorly trained LACs. We understand that the LAC organisations are struggling to recruit in a competitive disability market, and are recruiting from outside the sector. It can be positive to recruit from outside the sector, but DSA would suggest that insufficient training and support is being delivered to get these LACs up to speed in the knowledge required to navigate a complex and changing sector, and to deal with and understand the requirements of people with often complex behaviours.

We do not believe this to be a roll out issue, but that it will be an ongoing issue due to the number of plan reviews that will be required post full roll out, and the increasing level of competition for skilled workers.

**Workforce**

- ***Supply and demand factors differ between metropolitan and regional areas, with recruitment being most difficult in regional areas***
- ***Difficult to recruit skilled workers for complex PwD***
- ***Allied Health workers are difficult to recruit***
- ***The modern award, the Fair Work Act and NDIS pricing will make recruitment of 60,000 – 70,000 disability support workers difficult***
- ***Disruptive labour hire platforms are suited to high functioning PwD, or those with engaged and skilled carers. This cohort represents a minority of NDIS participants.***

The supply and demand for labour is directly related to the underlying economic conditions at any given time, and these can very between City and Regional locations. The key economic factors that affect labour across our geographic landscape are industry growth rates, inflation rates, localised unemployment rates, wages growth and localised worker participation rates. Additionally, localised competition from like industries plays a key role in the availability of labour.

DSA currently has over 70 vacant Support Worker positions across NSW. Our vacancy rate at any given time over the last 2 years has varied between 30 and 90 positions. DSA has a headcount of 400+ Support Workers.

DSA regularly tracks a number of key factors in regards to acquisition of labour. The most critical of these factors that we track is the 'time to fill' (a vacancy) rate. Our average time to fill in city areas is currently 15 working days. However in Regional areas it averages at around 50+ days with an extreme case of 60+ in Southern NSW i.e. South Coast, Goulburn and Queanbeyan.

Additionally, there are also variances in hiring for 'disability type' with a noticeable degree of difficulty in obtaining Support Workers for our Criminal Justice Program – our most complex customer cohort.

Professional staff, in particular Psychologists and Speech Pathologists are generally difficult to attract (especially in Regional areas) in a very competitive marketplace. This has driven the need to implement creative sourcing strategies such as the hiring of interns for a short term solution. We have also seen significant wages growth in the allied health professions due to labour shortages.

There is no doubt that as Baby Boomers retire from full time work there will be an overall impact on a range of employment sectors. Whilst there may be some potential for retirees to take on casual disability support or mentoring roles, the aging population will also create an increase in demand for aged care workers, in direct competition with the recruitment for workers in to disability roles.

Ageing carers will also mean a reduction in the ability to deliver informal supports, and will increase the requirement for paid supports.

The modern award, NDIS pricing and the requirement for an NDIS workforce of 60,000 – 70,000 are all in direct conflict. The modern award is restrictive and coupled with the requirements of the Fair Work Act, do not allow organisations with award employees to meet the requirements for choice, control and flexibility, a promise made by the NDIS to PwD.

NDIS pricing is unsustainable for most organisations, even paying the basic award wage. There is no capacity for organisations to pay above the award to attract employees to work for the organisation as disability support workers, and then deliver financially sustainable services.

A number of labour hire models based on web platforms have been developed to create a "disruptive" and low cost labour hire market place for disability and aged care. These platforms definitely have a place in the NDIS and aged care market, but can only cater for those PwD who have a high level of capacity to organise, train and direct their own staff, or who have a highly engaged and capable carer. People with high support needs, challenging behaviours and a low level of informal support are not in a position to utilise this type of labour.

Historically DSA has transitioned casual workers to permanent part time or full time workers as a retention strategy. However, the requirement for flexibility from our customers under the NDIS model, and the ease with which customers can change providers or alter their service arrangements is creating a disincentive for organisations to increase the permanent workforce. The risks associated with paying workers for "non-billable" hours or having to pay redundancies are high in this new environment.

Developments in technology may increase efficiencies in care provisions in some areas. However, where the cohort of PwD has a behavioural disability, face to face supports are essential. This accounts for the majority of people accessing the NDIS.

**NDIS Pricing, Provider Readiness and Potential for Market Failure**

- ***NDIS pricing is unsustainable for service providers***
- ***The premium for complexity is insufficient, and there is a strong risk of market failure in the area of service delivery for complex customers – this includes those with challenging behaviours, and those that require centre based services***
- ***Lack of NDIA consultation with service providers has impeded the ability of service providers to be ready with business systems and processes for the NDIS transition***
- ***Current NDIS pricing will prevent new players entering the market place, other than for allied health services.***

DSA believes that current NDIS pricing is unsustainable for service providers. The base 1:1 rate of $42.79 is built up from a SCHADs award grade 2 year 3 support worker, who has 95% of their time as billable to a customer, has a supervision ratio of 1:15 (FTE) and moving to 1:18 as organisations make "efficiency gains", and allows 9% for all organisational overhead.

The principles under pinning the NDIA are built on participant choice and control, and participants are advised that they should be able to direct when, where, how, for how long and with who their services should be delivered.

To be responsive to these requirements, organisations will need a truly flexible work force with a high ratio of casuals to permanent staff. However, growing competition for workers is seeing workers choose organisations that are prepared to offer permanent roles (understandably, workers want a level of security, may be looking to obtain finance etc.). With a permanent workforce and a customer base seeking flexibility, it is virtually impossible to achieve a workforce utilisation of close to 95%. In addition, a utilisation rate of 95% allows no time for training, staff development and supervision.

With complex customers, a supervision ratio of 1:15 is generally too high, staff require more training and support, and staff generally need to be on a higher grade than grade 2 year 3. The price of $45.17, a $2.38 premium on standard support, is insufficient to cover the cost of supporting complex PwD.

As previously mentioned, DSA believes this pricing will create a disincentive for organisations to provide support to complex PwD, and there will be market failure in this area. DSA believes there is a strong possibility that this will drive increasing cost to the NDIA as crisis services are put in place or the NDIA has to become "provider" to complex customers, effectively reverting back to the previous state funded model.

DSA has provided feedback on pricing to the NDIA on a number of occasions and has included these submissions for Productivity Commission review at Appendix II. These include detailed cost analysis of our centre based service for complex customers, and clearly demonstrate that the current NDIS centre based prices will not sustain centre based services. This analysis demonstrates the requirement for DSA to close most of its centre based services due to financial unsustainability.

Once again DSA believes there will be market failure in the area of centre based services, disadvantaging PwD who generally have few other options due to the extent of their disabilities.

Provider readiness to transition to the NDIS has been mixed. However, DSA has been pro-actively preparing for the transition for some time but has still struggled with the transactional and business process issues associated with the transition. NDIA portal issues, lack of responsiveness of the NDIA to respond to queries, ongoing issues with the portal booking process, poor LAC understanding of the process and plan errors are just some of the issues that have resulted in DSA, at the time of writing this document, having over $1million of rejected NDIA claims they are trying to resolve.

The NDIA failed to consult with the disability service sector prior to the cut over to the new ICT platform, and failed to provide any information to providers as to how this platform would operate and the booking processes so that providers could train their own staff and prepare business processes prior to the cut over. This would have been completely unacceptable within any commercial sector, and the disregard for the impact on the disability services sector has been astounding.

It is likely that the way this process has been managed, and the ongoing issues (often played down by the NDIA) coupled with unsustainable pricing are likely to cause further market failure within the existing disability services sector, especially where service providers have insufficient working capital to see them through this period.

Current NDIS pricing is creating a disincentive for new players to enter the market, with the exclusion of allied health services. There has been some movement in the labour hire space where staff can be hired by those with disability that have the capacity to supervise and direct their own staff at low cost. However, for the more complex customers, and the significant NDIS cohort with intellectual disability or autism as their primary diagnosis, there have been no new players entering the market place.

**Quality and Safeguards Framework**

- ***It is unclear how unregistered providers will know of, and be compliant with, the quality and safeguards "Code of Conduct"***
- ***As most NDIS customers will be able to purchase from unregistered providers, there is a disincentive for service providers to meet compliance and third party verification costs, and register as providers with the NDIA.***

The release of the quality and safeguards framework highlights the requirement for registered providers to comply with the framework, and for unregistered providers to comply with a "Code of Conduct".

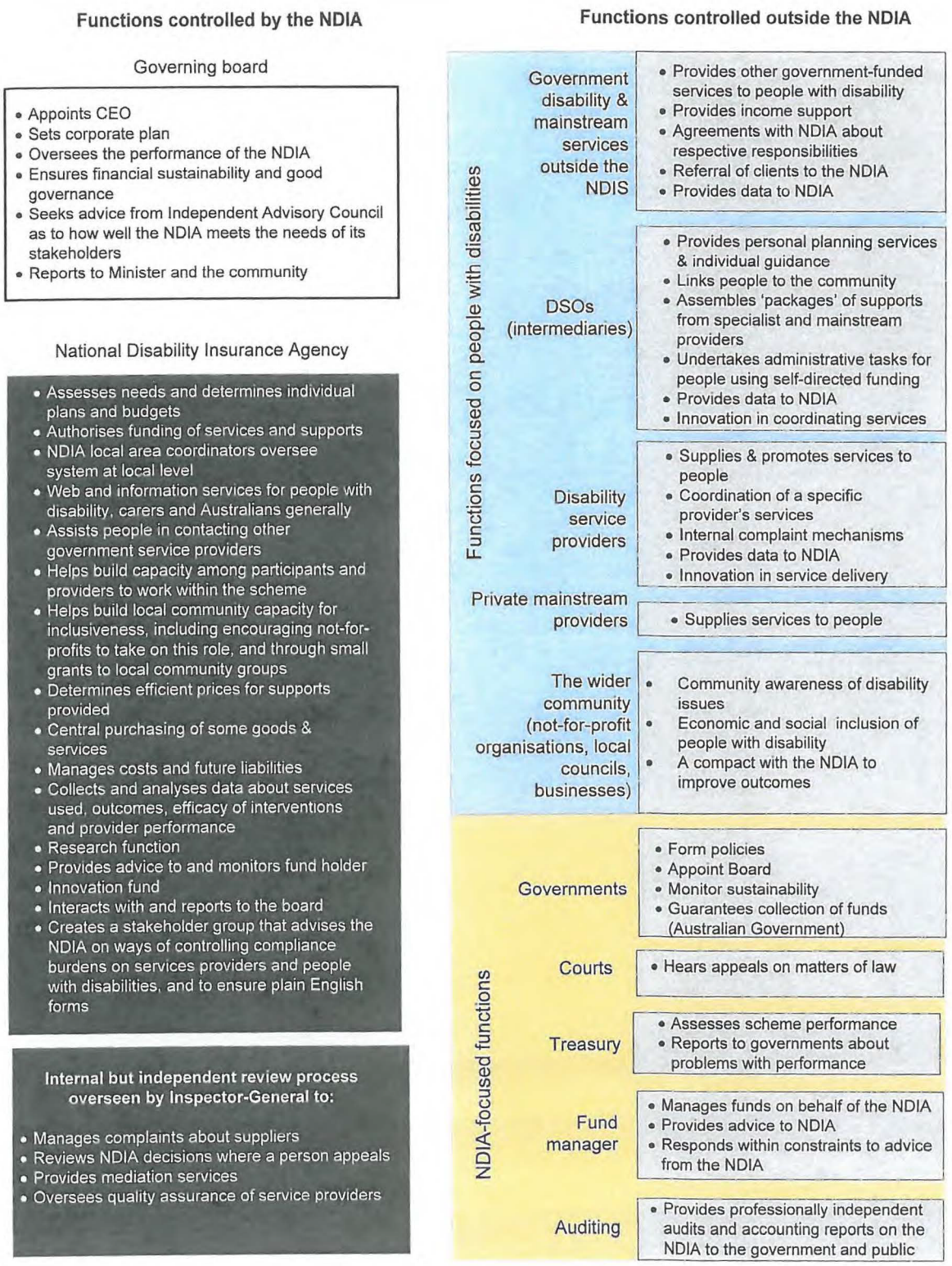
DSA understands that the NDIA's goal post full roll out is to have the majority of plans either self managed or plan managed, with a smaller percentage of plans being managed by the NDIA. This would mean that a majority of participants would be able to purchase services from unregistered providers.

DSA questions where a person is self managing and is able to access any provider as long as the support is deemed reasonable and necessary, how will the provider know they need to comply with the "Code of Conduct" when they may not be regular participants in the disability market place? Will the PwD need to ensure the provider is compliant? What skills will they need to make this assessment?

DSA also questions what the future incentive will be for service providers to register with the NDIA, where there will be an increased cost to comply with the quality and safeguards framework and have third party verification? When the majority of participants in the NDIS will be able to access services from unregistered providers, why would a service provider register with the NDIA?

APPENDIX 1

## Figure 4 Who does what in the NDIS?




They would also develop linkages with mainstream local community groups (such as Scouts or Rotary) so that these were receptive to the inclusion of people with

II

"Commercial in Confidence"

## Disability Services Australia
## Bankstown Profitability Analysis
## Current vs NDIS Funding

| | Current Funding | % Funding | 100% Attendance Level NDIS Funding | % Funding | % Var. to Current | 85% Attendance Level NDIS Funding | % Funding | % Var. to Current | Notes |
|---|---|---|---|---|---|---|---|---|---|
| **Funding:** | | | | | | | | | |
| ADHC Individual Funding Allocation | 838,000 | | 681,756 | | | 579,492 | | | |
| ADHC Block Funding Subsidy | 524,607 | | | | | | | | |
| **Total Funding** | **1,362,607** | | **681,756** | | **-50.0%** | **579,492** | | **-57.5%** | |
| Direct Labour | 647,845 | 47.5% | 480,647 | 70.5% | -25.8% | 480,647 | 82.9% | -25.8% | NDIS FTE 7.7 |
| **Gross Contribution** | **714,762** | **52.5%** | **201,108** | **29.5%** | **-71.9%** | **98,845** | **17.1%** | **-86.2%** | |
| Less Labour Overheads: | | | | | | | | | |
| | 125,399 | 9.2% | 102,215 | 15.0% | -18.5% | 102,215 | 17.6% | -18.5% | |
| Total Labour Costs | 773,244 | 56.7% | 582,862 | 85.5% | | 582,862 | 100.6% | | |
| **Site Contribution after Total Labour Costs** | **589,363** | **43.3%** | **98,894** | **14.5%** | **-83.2%** | **-3,370** | **-0.6%** | **-100.6%** | |
| Total Site Overhead | 232,028 | 17.0% | 232,028 | 34.0% | 0.0% | 232,028 | 40.0% | 0.0% | |
| **Net Site Contribution** | **357,335** | **26.2%** | **-133,134** | **-19.5%** | | **-235,398** | **-40.6%** | | |
| Corporate Overhead - Current | 199,505 | 14.6% | | | | | | | |
| Corporate Overhead - Efficient Pricing Model | | | 61,358 | 9.0% | -69.2% | 52,154 | 9.0% | -73.9% | |
| Specialist Psychologist Support | 80,765 | 5.9% | 80,765 | 11.8% | | 80,765 | 13.9% | | $ 168.26 NDIS price per hour |
| **Net Profit** | **77,065** | **5.7%** | **-275,257** | **-40.4%** | | **-368,317** | **-63.6%** | | |
| Meet 5% Sustainability Benchmark? | | Yes | | <5% | | | <5% | | |

**Key Assumptions:**

| | | | |
|---|---|---|---|
| Attendance Rate | | 100% | 85% |
| Support Worker Billable Hours | | 95% | 95% |
| Breakeven Hourly Rate (Customer Facing Average) | $88.39 | $65.80 | $76.67 |
| | | N.B. NDIS 1:2 Rate currently $52.60 on this basis | |

**Restatement of Data for Sensitivity Analysis on Cost Savings**

| | | |
|---|---|---|
| Direct Labour | 480,647 | -25.8% |
| Supervision & Training etc | 102,215 | |
| Site Overhead | 232,028 | |
| Corporate Overhead | 52,154 | -73.9% |
| Specialist Psychologist Support | 80,765 | |
| Total Costs | 947,809 | |
| Total Attended Hours | 12,362 | |
| Breakeven Hourly Rate (Customer Facing Average) | $76.67 | |

**Profit Result Under NDIS Funding:**

| Attendance Rate \ Billable Hours | -275,257 | 80% | 85% | 90% | 95% |
|---|---|---|---|---|---|
| 75% | | -430,356 | -430,356 | -430,356 | -430,356 |
| 85% | | -368,317 | -368,317 | -368,317 | -368,317 |
| 95% | | -306,277 | -306,277 | -306,277 | -306,277 |
| 100% | | -275,257 | -275,257 | -275,257 | -275,257 |

| Corporate Overhead Savings \ Direct Labour Savings | | -5.0% | -10.0% | -15.0% | -25.8% |
|---|---|---|---|---|---|
| | -10.0% | $97.88 | $95.26 | $92.64 | $86.97 |
| | -20.0% | $96.26 | $93.64 | $91.02 | $85.36 |
| | -30.0% | $94.65 | $92.03 | $89.41 | $83.75 |
| | -73.9% | $87.57 | $84.95 | $82.33 | $76.67 |

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# Disability Services Australia
## East Hills Profitability Analysis
## Current vs NDIS Funding

| | Current Funding | % Funding | 100% Attendance Level NDIS Funding | % Funding | % Var. to Current | 85% Attendance Level NDIS Funding | % Funding | % Var. to Current |
|---|---|---|---|---|---|---|---|---|
| **Funding:** | | | | | | | | |
| ADHC Individual Funding Allocation | 1,166,000 | | 824,510 | | | 700,834 | | |
| ADHC Block Funding Subsidy | | | | | | | | |
| **Total Funding** | **1,166,000** | | **824,510** | | **-29.3%** | **700,834** | | **-39.9%** |
| Direct Labour | 657,428 | 56.4% | 547,926 | 66.5% | -16.7% | 547,926 | 78.2% | -16.7% |
| **Gross Contribution** | **508,572** | **43.6%** | **276,584** | **33.5%** | **-45.6%** | **152,908** | **21.8%** | **-69.9%** |
| Less Labour Overheads: | | | | | | | | |
| | 110,756 | 9.5% | 102,119 | 12.4% | -7.8% | 102,119 | 14.6% | -7.8% |
| Total Labour Costs | 768,184 | 65.9% | 650,045 | 78.8% | | 650,045 | 92.8% | |
| **Site Contribution after Total Labour Costs** | **397,816** | **34.1%** | **174,465** | **21.2%** | **-56.1%** | **50,788** | **7.2%** | **-87.2%** |
| Total Site Overhead | 202,899 | 17.4% | 202,899 | 24.6% | 0.0% | 202,899 | 29.0% | 0.0% |
| **Net Site Contribution** | **194,917** | **16.7%** | **-28,434** | **-3.4%** | | **-152,111** | **-21.7%** | |
| Corporate Overhead - Current | 171,177 | 14.7% | | | | | | |
| Corporate Overhead - Efficient Pricing Model | | | 74,206 | 9.0% | -56.6% | 63,075 | 9.0% | -63.2% |
| Specialist Psychologist Support | 40,382 | 3.5% | 40,382 | 4.9% | | 40,382 | 5.8% | |
| **Net Profit** | **-16,643** | **-1.4%** | **-143,022** | **-17.3%** | | **-255,568** | **-36.5%** | |
| Meet 5% Sustainability Benchmark? | | <5% | | <5% | | | <5% | |

| Notes | |
|---|---|
| NDIS FTE | 8.8 |
| $ 168.26 | NDIS price per hour |

**Key Assumptions:**

| | | | |
|---|---|---|---|
| Attendance Rate | | 100% | 85% |
| Support Worker Billable Hours | | 95% | 95% |
| Breakeven Hourly Rate (Customer Facing Average) | $71.42 | $58.43 | $67.95 |

N.B. NDIS 1:2 Rate currently $52.60 on this basis

**Restatement of Data for Sensitivity Analysis on Cost Savings**

| | | |
|---|---|---|
| Direct Labour | 547,926 | -16.7% |
| Supervision & Training etc | 102,119 | |
| Site Overhead | 202,899 | |
| Corporate Overhead | 63,075 | -63.2% |
| Specialist Psychologist Support | 40,382 | |
| Total Costs | 956,402 | |
| Total Attended Hours | 14,076 | |
| Breakeven Hourly Rate (Customer Facing Average) | $67.95 | |

**Profit Result Under NDIS Funding:**

| Attendance Rate \ Billable Hours | -143,022 | 80% | 85% | 90% | 95% |
|---|---|---|---|---|---|
| 75% | | -143,022 | -143,022 | -143,022 | -143,022 |
| 85% | | -143,022 | -143,022 | -143,022 | -143,022 |
| 95% | | -143,022 | -143,022 | -143,022 | -143,022 |
| 100% | | -143,022 | -143,022 | -143,022 | -143,022 |

| Corporate Overhead Savings \ Direct Labour Savings | -5.0% | -10.0% | -16.7% | -20.0% |
|---|---|---|---|---|
| -10.0% | $79.85 | $77.52 | $74.41 | $72.85 |
| -20.0% | $78.64 | $76.30 | $73.19 | $71.63 |
| -30.0% | $77.42 | $75.09 | $71.98 | $70.42 |
| -63.2% | $73.39 | $71.05 | $67.95 | $66.38 |

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## Short Case Study # 1

| **Background Information** | Consider including factors such as client's age, gender, family relationships, and relevant history. |
|---|---|

Xx is a 31yr old male who resides in DSA supported accommodation with three other males at Ruse. Xx has lived in several accommodation sites over the years but living at Ruse since 2008 is his longest, unbroken tenancy.

Xx has Down Syndrome, Moderate Intellectual Disability, Obsessive Compulsive Disorder, Autistic Tendencies, Hearing Impairment, Partial Transient Paralysis (Left Side), is Short Sighted and has ongoing skin conditions.

Xx has regular contact with his family, who he visits every second weekend. He does not call his family members family, he calls them his friends. He is fixated on fantasy characters and engages in roleplay when visiting his mother. He also portrays these characters and will escalate quickly if they are not acknowledged.

Xx has a history of aggressive challenging behaviours which impact on his day to day life. He can become demanding, controlling towards, and may attempt to intimidate other people (housemates, family, staff and members of the public), He frequently seeks acknowledgement and invades the personal space of others. He can become unresponsive with increased agitation both verbally and physically.

Other challenging behaviours include

- Repetitive questions
- Delusion/false beliefs (e.g. believing others to be his mother)
- Teasing
- Non-compliance (e.g. sitting on the floor and refusing to leave)
- Property damage (e.g. throwing objects, upending furniture and smashing windows)
- Leaving without support
- Inappropriate social behaviour e.g. being overly affectionate to others
- Xx has a history of removing his clothes in public when his needs are not met.

| **Goals** | The client's identified goals over the course of the case study period. |
|---|---|

To communicate effectively with staff and others to ensure that my needs and wants are being met without anger, frustration or agitation.

- Exercise & Healthy Choices
- Capacity building e.g. living skills
- Acting appropriately when out in the community.
- Continuing to attend Day programme to assist me to foster and maintain relationships

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| | |
|---|---|
| **Intervention** | This section is what we did to assist the client achieve their goals. Include factors such as the duration of our engagement with the client, other services involved, theoretical approach(s) used. |

- Extensive ongoing support from ADHC Senior Psychologist as well as from DSA Allied Health Services. Xx received a six week intensive programme "Old Me/New Me". This gave him coping strategies and the ability to make appropriate choices regarding behaviours.
- Visual communication alongside social stories when accessing the community.
- Daily activity planner which assists routine as Xx responses well to structure.
- One on one support from staff at his day programme which he attends three days per week. This gives Xx the support he requires to maintain programmes in place.
- One on one support at home with activities of his choice which includes physical Friday and community activities.

| | |
|---|---|
| **Outcomes** | What was the end result? Did we make a difference? |

Applying person centred approaches and engagement strategies has made a significant difference to Xx's life.

Xx attends his day programme three times per week which he really enjoys. This enables him to form friendships and to interact appropriately with his peers. It also allows social interaction.

Due to Xx's challenging behaviours, staff are providing consistent support strategies and following the intervention strategies outlined in his behaviour support plan.

Xx benefits from having clear boundaries set for him but will escalate if these are not maintained. Strategies must be implemented according to the intensity of his behaviour.

| | |
|---|---|
| **Reflection** | Why was our intervention effective? How could the outcomes have been better? What systemic barriers did we identify the impacted on the outcomes? |

- Creating personalised intervention with measurable outcomes.
- Consistency in following strategies and programmes implemented.
- Providing one on one support has minimised behaviours as Xx appears to respond to this type of support.
- Informing Xx of staff support the next day as unexpected staff changes impact on his outcomes.

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## Short Case Study # 2

| **Background Information** | Consider including factors such as client's age, gender, family relationships, and relevant history. |
|---|---|
| • Male, late thirties, autism spectrum disorder and intellectual disability. Lives at home with mother and father. Mother has chronic stress/ depression<br>• Parents have no other supports either formal or informal in place other than DSA<br>• Alleged sexual abuse by member of community in mid-2014 led to dramatic increase and escalation of challenging behaviours – physical violence against parents, staff and peers, verbal assault, threats to self-harm and kill others which led to him being sectioned under mental health act numerous times. Combination of above led to the family being in crisis<br>• Previously supported 1:3 but was increasingly requiring 1:1 support | |
| **Goals** | The client's identified goals over the course of the case study period. |
| • Take part in meditation classes and learn techniques for self-soothing, relaxation<br>• Communication – customer self-identified that he talks too fast which causes communication issues leading to frustration and anxiety.<br>• Travel independently on public transport from Camperdown to Bulli (trip approx.. 1 ¾ hrs) | |
| **Intervention** | This section is what we did to assist the client achieve their goals. Include factors such as the duration of our engagement with the client, other services involved, theoretical approach(s) used. |
| • Techniques learnt at meditation class transferable to centre based support where staff are able to reinforce and model<br>• Specialist Intervention therapeutic services enlisted to provide counselling , behaviour intervention and speech therapy<br>• 'Zoning' at site allowed us to provide 1:1 support as needed without reducing number of support hours or days which would have had significant impact on family who were in crisis | |
| **Outcomes** | What was the end result? Did we make a difference? |
| • Having a high number of staff familiar and trained to follow BISP with this person allowed us to identify variations from baseline behaviour and implement strategies that reduced severity and frequency of challenging behaviours and intervention of police / sectioning.<br>• Reduced risk of self-harm, whilst still increasing social interaction with peers<br>• Shared approaches with family giving them strategies and techniques where previously they had none. Also allowed for consistency across home and day program environments.<br>• Person who was placed on priority list for accommodation services due to threat of abandonment from parents is still living at home<br>• Development of meditation and self-soothing skills gave customer, family and staff confidence to implement travel training in an environment full of potential triggers. Customer is now successfully completing journey independently without incident. | |
| **Reflection** | Why was our intervention effective? How could the outcomes have been better? What systemic barriers did we identify the impacted on the outcomes? |
| • Ability and flexibility to increase staffing ratio as needed immediately<br>• Working closely with Specialist Intervention Services through providing reporting and ongoing monitoring<br>• Health system unable to provide any support. Family were bounced from sexual health to mental health without ever being properly supported as his abuse, mental health issues and disability did not fit into one category. | |

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## Short Case Study # 3

| **Background Information** | Consider including factors such as client's age, gender, family relationships, and relevant history. |
|---|---|

- Male, early 20's. Cerebral Palsy, Profound hearing impairment, nonverbal, wheelchair user. Requires 1:1 support for almost all aspects of life e.g. scratching nose, feeding.
- Lives at home with mother and step-father.
- Wheelchair user, weight approx. 120kg. Requires 3:1 support for personal care.
- No in home care received or other formal supports. This places huge burden physically, mentally and emotionally on parents.

| **Goals** | The client's identified goals over the course of the case study period. |
|---|---|

- Develop skills using Assisted Augmentative Communication
- Develop friendships
- Regularly access the community for meals, shopping and site seeing.
- Have my personal care needs met

| **Intervention** | This section is what we did to assist the client achieve their goals. Include factors such as the duration of our engagement with the client, other services involved, theoretical approach(s) used. |
|---|---|

- Use of head switch allows person to access Facebook. Photos taken and uploaded by staff give him a presence in social media where he is able to interact with friends.
- Interaction and engagement with peers
- Transportation to access community, and adequate staffing to assist with supports whilst in the community.

| **Outcomes** | What was the end result? Did we make a difference? |
|---|---|

- Capacity to provide 3:1 personal care each day removes huge burden placed on parents who receive no in home care or other support at home.
- Family are able to have an opportunity to have sustainable employment to continue with their caring role
- Customer has personal care needs met with dignity, and adequate support.
- Customer has developed friendships independent of family relationships with peers

| **Reflection** | Why was our intervention effective? How could the outcomes have been better? What systemic barriers did we identify the impacted on the outcomes? |
|---|---|

- Accessibility of modified vehicle
- Flexibility and capacity to have trained, qualified staff to meet needs
- Financial costs to family to continue support and provide equipment, and the need to maintain employment.
- The need for expensive personal care equipment that is maintained to provide effective personal care, which cannot be transferred to community use.

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### 1.7.1 Supported Independent Living

- *To what extent do existing definitions, descriptions and rules for Supported Independent Living align with current practices in the disability services sector?*
    - The two dimensional matrix fails to recognise the impact of different combinations of individuals/complexity. Whilst the combining of people with similar needs in a house is desirable for personal comfort and development it has been our experience to date that the state of housing supply and the urgency of individual need regularly drives a less than desirable matching. This, in turn, impacts the way in which a house must be managed and the costs that are incurred in the process. In practice, the costs of a facility may be driven entirely by the highest needs individual whilst, under the NDIS, the funding is provided at the average needs level.
    - Whilst the definitions acknowledge the need for behaviour management plans and an appropriate level of need assignment, they fail to adequately address the nature of episodic needs. Customers with episodic mental health issues can effectively move back and forth between the existing service definitions.
    - Current definitions and rules present the risk that complex customers who are difficult to match in a group living arrangement may be turned away by service providers. The two dimensional assessment framework does not cater for individual needs in a group.
    - Complex customers are often not readily accepted by neighbours. Providers may be motivated to turn these customers away due to the higher cost of managing community relationships not necessarily catered for in accommodation pricing.

      Case Study # 1 provided is an example of person who could fall in to this category.
- *Could they be improved or refined, and if so, in what form?*
    - The definitions need to take in to account the complexity associated with more than one person in a group living arrangement. Where one customer's behaviours trigger those of another, the complexity of the group may be greater than the sum of individual complexities.
    - An acknowledgement of the impact of episodic needs and a mechanism for adequately addressing them would be welcome. A contingency fund accessed quickly with appropriate evidence would allow support providers to adequately support customers through these times of need whilst avoiding financial stress for the provider organisation. This is particularly pertinent for people with a history of mental health and cyclic behaviours.

- *Can you provide examples of how existing descriptions, definitions and/or implementation rules are having a negative impact on your organisation?*
    - We can cite a recent case where a new customer with mental health issues was transitioning into support and our organisation had to fund 2 weeks of awake shifts and crisis day support. Support providers often find themselves in a position where they must incur these additional costs to mitigate risk for the customer and for the other customers and staff in a home. Whilst ultimately reimbursed in this case, these costs do place a financial strain on support providers.

- *Can you identify and/or describe the expected benefits to your organisation if your proposed changes were implemented?*
    - We expect to experience increasing difficulty in the "cash flowing" of these episodic behaviours as we transition to the NIDS pricing and business model. Without an effective means of funding these episodic behaviours organisations may choose not to support people with cyclic or fluctuating support needs.

- *Does the existing description of SIL present barriers to innovation? If so, are there specific examples that you can point to?*
    - The existing description limits the options to shared living arrangements. Presumably, truly independent living arrangements will be supported via the Assistance with Daily Life at Home s but we feel there are gaps in the price list with respect to the establishment of the living arrangement e.g.
        - assistance with financial arrangements with respect to purchase/construction of a home. We believe that the single item in the Improved Living Arrangements support category does not adequately describe this need and that the hourly rate provided therein may not be adequate for specialist advice with respect to setting up legal arrangements etc;
        - assistance with establishing family or other governance arrangements;
        - assistance with respect to planning and execution of home modifications;
        - assistance with screening and selection of flatmates, with or without disability;
        - assistance with setting up informal supports specific to the individual and their living arrangement i.e. arrangements integral to the success

of an innovative model that need to be established, monitored and maintained. As these needs are specific to the individual and their living arrangement, they will not be adequately catered for under the ILC framework;

- assistance with oversight of ongoing arrangements and stepping in as required;
- we note that, in the establishment of innovative SIL arrangements, the customer may benefit from Support Coordination and that the entity best placed to provide this support may often be the existing SIL provider. As we understand it, the current rules surrounding Coordination of Supports prohibit the current provider from providing this service.

- *Do NDIA implementation rules present barriers to providing innovative SIL supports? If so, in what ways?*
  - The existing rules do not appear to specifically address situations where individuals are living in separate accommodation in close proximity to each other (e.g. units scattered throughout a complex or villas/houses near to each other) or where individuals are living alone or with an able-bodied flatmate.

- *Would there be benefit from the NDIA explicitly stating assumed staff to participant ratios, rostering practices, shift lengths etc for each indicative price point? If so, how would you use the information?*
  - No. As stated above, the two dimensional price matrix fails to reflect the combination of customers in a house. Whilst customer plans must necessarily be individual, the rostering of staff in a house will be driven by the combination of customer needs e.g. whilst 3 standard needs people in a house may not need active overnight support, a 4th high needs customer may necessitate this arrangement.

- *Can you quantify by how much per-participant costs change as the number of participants sharing accommodation increases?*
  - No. Again this depends on the combination of customers in a house. Whilst the combining of people with similar needs in a house is desirable for personal comfort and development, as well as from a cost sharing perspective, it has been our experience to date that the state of housing supply and the urgency of individual need regularly drives a less than desirable matching.

### 1.7.2 Group-based activities

- *To what extent do existing definitions, descriptions and implementation rules align with current practices in the disability support services sector?*
    - The alignment is poor.
    - The current definitions and rules assume that centre-based activities will always be group based. This is not the case. Our highest support customers require 1:1 or even 2:1 support in a centre regardless of whether the supports are delivered in a group or individual setting. The requirement for a centre is generally driven by complex behavioural and/or physical disabilities, often requiring more than 1 staff member to support the customer for specific activities. A customer may require 1:1 support for some of the time, but require 3 staff members to assist with personal care activities. These staff are then taken away from other customers, so we need to have greater than the funded number of staff for general activities to allow for specific personal care or behavioural interventions.

  We have provided 3 case studies (case studies 2 – 4) for participants who at times require greater than 1:1 support in a centre. These have been provided to the NDIA previously with detailed costings (commercial in confidence) for the centres attended by these participants. We have re-attached this information for your review.

- *Could they be improved or refined, and if so, in what form?*
    - They need to reflect the different support needs of different individuals, particularly those more complex customers being supported in a centre. We understand that the NDIA has at times approved additional line items in a customer's plan in an attempt to address this problem (e.g. provision of 1:1 support hours at $41.18 plus Centre-based activities hours at $18.64 co-delivered for a total remuneration of $59.82 per hour). However, we believe this acknowledgement of higher complexity customers in a centre should be acknowledged with additional line items in the price list that allow for staff ratios higher than 1:1. When assessing the appropriate rate of payment it should be acknowledged that periods of high intensity care (e.g. personal care and hygiene activities) may drive higher manning in the centre as a whole.
    - Customers accessing a centre generally do so because of complex behavioural and or physical support requirements. This includes the requirement for "zoning" within a centre to allow for multiple customers with complex behaviours (meaning additional space per person), sensory spaces particularly for people at the severe end of the autism spectrum, special structural modifications such as hoists and change tables to assist with

individual personal needs where a person has a physical disability. These costs are not accounted for within the pricing framework.

- *If relevant, can you provide examples of how existing definitions and descriptions are having a negative impact on your organisation?*

    - Beyond the issues described above, the current definitions and prices are unfairly prejudicing our organisation by not recognising the costs of centre facilities including rental costs and utilities. When combined with the cost of specialist equipment and higher staff ratios the current pricing regime makes ongoing support of our most vulnerable customers in a centre untenable. Our most vulnerable customers would be limited to 1:1 support in their homes, reducing their opportunity for social engagement, a change in environment, and participation in new activities. *Can you identify and/or describe the expected benefits to your organisation if your proposed changes were implemented?*
    - With adequate funding for appropriate staffing ratios and facilities costs, we would be able to maintain appropriate facilities required by complex customers to access a level of social interaction. Without these facilities, a large cohort of customers would need to stay in their homes as they would not be able to cope with a significant portion of their support hours being provided in community settings due to the level of personal care and behavioural support required.

- *Are existing support definitions a barrier to providing innovative group-based activity supports?*

    - Group based activities could be delivered in a centre or in the community, and centre based activities could be individual or in a group. These definitions could be improved to reflect the actual service provision. However, it should still be noted that sometimes a centre based activity will access the community and community based activities may access a centre for periods of time.
    - Tying a rate to a staffing ratio and then this ratio to an individual will limit choice. Customers will have to follow the consensus of the funded group as to what activities should take place. This will stifle customer driven innovation.
    - Whilst this is a discussion on definitions, with pricing set for a grade 2 worker with 95% of their time involved in direct service delivery, with a 1:15 supervision ratio (initially) and then a lean corporate overhead, it is unclear to us at which level innovation will take place, if not purely driven by customer preferences.

- *For Group based activity supports outside of a centre, current pricing arrangements implicitly assume that providers incur constant per-participant costs for staff ratios of 1 to 3 or greater. Can you provide input on whether this arrangement is reflective of the cost structure faced by your organisation?*
    - No, this is not reflective. Our costs are driven by customer need and by the market. If an appropriate level of support is 1:3 for a group of customers but we have 4 in a group on a given day then 2 staff will most likely be required – our effective staff ratio will then be 1:2. Similarly, if customers are funded at the 1:3 level but the market provides only 2 customers at this time then we are faced with the decision of refusing to supply or supplying at a loss due to an effective staff ratio of 1:2. Furthermore, saffing ratios often increase for certain activities such as transport or personal care for periods of time during the total activity time.

- *There is currently a single, per participant price for the provision of group-based activity supports in a centre. Can you provide input on whether this arrangement is reflective of the cost structure faced by your organisation?*
    - No, it is not reflective. This rate fails to reflect the fact that complex customers may require higher staffing ratios in a centre whether the activity is being delivered 1:1 or in a group. It also fails to acknowledge the costs of the facility and the specialist equipment and spaces contained therein..

- *Would there be benefit from the NDIA explicitly stating assumed staff to participant ratios in the NDIA Price Guide?*
    - No. There would be greater benefit in recognising that the costs of service provision are driven by the customer and market demands. It would be preferable if customers were given a blanket line item value for supports of this nature and given the option to accept billing at whatever rate can be supported by the provider's operation on the day i.e. if a provider has 3 participants wanting a similar service on a given day the service would be billed at a 1:3 rate; if there were only 2 customers wanting service the charge would be at the higher rate; if a customer's individual needs demand a 2:1 staffing ratio the service would be charged accordingly.

- *Are group-based supports typically provided on public holidays?*
    - Not currently, as we cannot provide this support within current funding. However, customers frequently request group based supports for weekends and public holidays.

### 1.7.3 Measures to reflect higher intensity and complex needs

- *What are the pros and cons of the NDIA making an allowance for relatively more complex needs?*
    - Pros
        - Risk mitigation – unrecognised/unfunded complexity may pose risks:
            - To the customer, where their needs cannot be adequately met or, worse still, where market failure causes a complete lack of supply;
            - To the support workers where under-funding promotes unsafe work practices in an attempt to cut costs;
            - Tothe community where a failure to meet the needs of our most complex customers leads to very challenging behaviours in a community setting.
        - Recognition that higher intensity people with complex needs may have episodes that require greater levels of support, and the satisfaction of this need.
        - Recognition that some customers require greater than 1:1 support some or all of the time and the satisfaction of this need.
    - Cons
        - Possible price list complexity – though, in many case, there may be scope to provide additional units of support rather than new line items.

- *Thinking about complexity, what are the factors (if any) that cause relatively higher costs for providers?*
    - Physical disability necessitating higher staff ratios and/or specialist equipment for health and safety reasons (customer and staff)
    - Challenging Behaviours necessitating higher staffing ratios and/or specialist intervention
    - Combinations of people with challenging behaviours in group settings such as a group home or centre based activity, where the behaviours aggravate the dynamic of the group – removing people from the group even for limited periods of time upset sustainable staffing ratios
    - Challenging behaviours necessitating building and other modifications e.g. furniture and appliances resistant to wilful damage.
    - Specific diagnoses benefitting from specific facilities (e.g. sensory rooms or quiet zones)
    - Management of community impact e.g. challenging behaviours impacting neighbours
    - Lack of informal supports ie. disengaged family members, parents who also have an intellectual disability, cultural barriers to accessing community supports, inability to access transport and community services
    - Complex mental health issues often associated with past trauma, resulting in potential risk to the person with disability and to the community – note: this cohort generally will not chose to engage with the NDIS or service provision and may be released in to the community after a period of incarceration. We would need to better understand the NDIS Assessment Tool to determine whether it adequately identifies the support requirements for this group. Cost for this group, in addition to personal and behavioural supports, will include strategies to minimize harm to the individual, staff and community. An example of this group would be those currently funded under the NSW Community Justice Program.

Many of these comments apply in centres, in homes or in the community.

- *If the NDIA was to implement an allowance for complexity, can you describe how this would benefit your organisation?*
    - It would remove uncertainty around our ability to provide supports for more complex customers. Currently we do not think the current pricing regime will allow us to maintain the more skilled workforce require for this cohort, staffing at the required ratios (not reflected in the funding line items for this group), or the facilities with special modifications previously discussed.
    - For customers who are assessed with highly complex behaviours, they require ongoing specialist support from our team of psychologists to provide behavioural support, training to staff, and support to families. Our experience

to date is that this support generally exceeds the levels funded in early NDIS plans in the Hunter trial site. We cannot sustain this skilled team over the longer term without adequate funding for complexity

- *What would be the pros and cons of the NDIA making a separate allowance for relatively more complex needs?*
    - We would see benefits in a separate allowance both for those customers who have ongoing complex needs and those who suffer episodic events. The allowance would ideally have two separate possible structures as follows:
        - An allowance for complexity in an individual's plan that is flexible, and could be used at the discretion of the individual/carer/support provider (in consultation with individual and carer) for the most beneficial type of additional support – eg. behavioural support, therapeutic support, other capacity building activities or even respite for the individual or family;
        - A pool of hours available at a provider organisation level and at a rate appropriate to the supports provided. These hours would be utilised by the provider organisation to provide crisis support immediately it is required to a person in the complex category who may experience an escalation of behaviours. A lack of such funding could create a disincentive in a consumer driven market for organisations to provide the necessary crisis support. An approval process could delay the provision of appropriate supports, so clear guidelines for accessing this funding would need to be put in place

- If *you are proposing changes to existing intensity mechanisms for SIL and group-based activities, should they also apply to the provision of Personal Care supports?*
    - Yes. Irrespective of the title of the support, the complexity of the individual does not change and the same challenges will present