Disability Services Commissioner

Joint Standing Committee on the National Disability Insurance Scheme
Inquiry into the NDIS Quality and Safeguards Commission

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1. Introduction

The Disability Services Commissioner (DSC) commenced on 1 July 2007 under the *Disability Act 2006* to improve disability services for people with a disability in Victoria. This independent statutory office works with people with disability and disability service providers in Victoria to resolve complaints and promote the right of people with disability to be free from abuse.

Our complaints resolution process is free, confidential and supportive and we encourage and assist the resolution of complaints in a variety of ways including informal approaches to resolution, conciliation processes, or under certain circumstances through investigations, including of deaths and major impact incidents of assault, injury and poor quality of care. Our person-centred approach aims to achieve improved service outcomes while actively supporting the rights of people with disability to live with dignity and respect.

The Commissioner's oversight jurisdiction of service providers is predicated on service providers being registered in Victoria, under the relevant Victorian Act. As more service providers transition to funding under the National Disability Insurance Scheme (the NDIS), the DSC's role will significantly decrease over 2020/2021. As our role decreases, we have been referring more matters to the NDIS Quality and Safeguards Commission (NDIS Commission). DSC's oversight role over the past 13 years uniquely positions us to comment on the operation of the NDIS Commission since it commenced.

The DSC would like to comment on the following terms of reference:

2. The monitoring, investigations and enforcement powers available to the Commission, and how those powers are exercised in practice

The DSC welcomes the monitoring, investigations and enforcement powers available to the NDIS Commission. The 2015 Victorian Ombudsman Investigation Report *Reporting and investigating allegations of abuse in the disability sector* and the 2016 Parliament of Victoria *Inquiry into Abuse in Disability Services* report both confirmed the importance of robust and broad investigative powers. The NDIS Commission powers are extensive, have the benefit of applying nationally, and offer the potential for addressing both provider and worker-related issues in the disability sector. An example of the strength of the powers is the ability to issue banning orders against service providers and workers. As Part 2 of the NDIS Provider Register indicates, the

NDIS Commission has already utilised this power to issue 21 banning orders against individual workers and service providers.

In relation to the exercising of its own powers, the DSC takes an Alternative Dispute Resolution approach to complaints resolution and has a strong capacity development and educational focus in order to empower people with disability to be involved in or lead their complaint processes where appropriate. DSC have found that if people are unable to speak up about the little things, they are even less likely to speak up about the big things. DSC found that it was essential to promote the message that "it's okay to complain" to people with disability while ensuring that proactive investigative and review powers are also utilised, at the same time, to ensure the full suite of regulatory mechanisms is being deployed for the benefit of people with disability. These processes ensure that providers are accountable and maintain continuous improvement. DSC has also played a strong role in educating staff and providers in better practice.

DSC considers that the monitoring, investigations, and enforcement powers available to the NDIS Commission are robust and extensive, and the NDIS Commission should use their powers to the fullest. The NDIS Commission should be proactive in looking for gaps or oversights that arise as the scheme proceeds, with an eye to filling those gaps or oversights. DSC also notes that, in its experience, investigations into abuse and neglect in provision of disability services can be time and labour intensive. This is because much abuse takes place in ‘closed environments’ that can be difficult to oversight. Investigations is an area of the NDIS Commission that should be well resourced.

3. The adequacy and effectiveness of the NDIS Code of Conduct and the NDIS Practice Standards.

The DSC considers the NDIS Code of Conduct, and the accompanying guidance, is a good high-level statement of national requirements for disability workers and service providers. We welcome the decision by the Victorian Disability Workers Commission, which has recently started operations in Victoria, to adopt the NDIS Code of Conduct as the Victorian Disability Service Safeguards Code of Conduct, setting out the obligations that all Victorian disability workers must abide by and providing a standard to protect people with disability from harm and abuse. From our experience, it is essential that quality and safeguarding frameworks are consistent and complimentary.

DSC also acknowledges the NDIS Worker Orientation Module 'Quality, Safety and You', which is an interactive online course that explains the obligations of workers under the NDIS Code of Conduct from the perspective of NDIS participants. The design and production of the module are of excellent quality, the module puts the voices of people with disability forward, and the national reach of this training module has been extensive. We encourage the NDIS Commission to continue to emphasise and develop these kinds of educative programs.

While regular audits of service providers are conducted by the NDIS Commission in order to ensure compliance with NDIS Practice Standards, in Victoria service providers have been required to undertake mandatory annual complaints reporting to the DSC. The mandatory complaints reporting process requires service providers to demonstrate feedback and complaints compliance on a 12 monthly basis and allows for a proactive response to potential risks or themes, rather than waiting for lengthier auditing timeframes. We recommend a similar scheme to the NDIS Commission.

4. The effectiveness of communication and engagement between the Commissioner and state and territory authorities.

As disability services transfer from states to the federal jurisdiction, DSC's oversight role has been decreasing. At the same time, the NDIS Commission's Victorian office, which opened on 1 July 2019, has seen its work increase. Confusion about who to raise complaints with has meant our office frequently receives complaints that are within the jurisdiction of the NDIS Commission. In the 2019-2020 year, DSC made 32 formal written referrals to the NDIS Commission and we had 199 inquiries where we provided the potential complainant with the NDIS Commission details. DSC has found that communications and engagement between our office and the Victorian office of the NDIS Commission has been very effective so far. The office is open to receiving referrals and collaborative in their approach to ascertaining which agency is best placed to deal with issues.

5. Related matters

Engagement and Complaints reporting: DSC's experience over 13 years has shown that having a localised team for sector/community outreach leads to positive outcomes for stakeholder engagement. We have found that it is important to have a presence and connection with stakeholders in order to promote our oversight work but also to build trust within the sector. At its peak, DSC interacted with 800 providers, and it took many years for those providers to build their feedback systems,

incorporate staff training about complaints into their programs, and actively work with their clients to encourage them to speak up. The NDIS Commission will have many more providers to interact with, and many of those providers will be new to the sector. We encourage the NDIS Commission to engage in localised community engagement programs.

Review of deaths: Since 2017 DSC has operated, under legislative request from the relevant state Minister, a death review function in which our office inquires into and investigates every death of a person who was receiving disability services at the time of their death. Each year we report to Victorian Parliament on our death reviews, and in so doing have discovered a number of key issues in the care of people with disability that may contribute to premature deaths. These issues include the failure of disability services to manage the risk of choking and aspiration, inadequate bowel management, and poor record keeping practices. We have also found that the risk of premature death increases if a person with complex communication needs is not supported to express their needs effectively. These insights have informed several better practice programs, and we have issued Notices To Take Action to service providers to improve staff training in a variety of areas including: duty of care responsibilities; the principles of person-centred active support; record keeping practices, particularly the need to maintain participant files for medication, specific health plans, and bowel and food/fluid charts; appropriate behaviour support strategies and recognising restrictive practices; how to provide appropriate mealtime supports; and recognising and responding to the signs of deteriorating health.

The NDIS Act mandates that all registered NDIS providers across Australia must notify the NDIS Commission of deaths of people that occurred, however the NDIS Commission has not yet committed to a national approach to reviewing all deaths of people with disability. While not all deaths need to be investigated by the NDIS Commission, we consider a robust approach similar to that of DSC is required if the sector is to identify and address the full range of contributors to the deaths of people with disability, especially in the context of the considerable rates of lower life expectancy for people with disability.