The Public Advocate
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25 October 2021

Parliamentary Joint Standing Committee on the National Disability Insurance Scheme (NDIS)
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New inquiry – current Scheme implementation and forecasting for the NDIS

Thank you for the opportunity to provide feedback to this inquiry.

As the Public Advocate for Queensland, I undertake systemic advocacy to promote and protect the rights and interests of Queensland adults with impaired decision-making ability.[1]

I provide the Joint Standing Committee with this letter for consideration in the interim report and will be preparing a more detailed submission prior to the completion of the inquiry in February 2022.

Considering the terms of reference for this review, there are two principal areas on which I would like to make preliminary comments.

1. **The interfaces of NDIS service provision with other non-NDIS services provided by the States, Territories and Commonwealth, particularly aged care, health, education, and justice services**

The interface of NDIS service provision with other systems has been a major concern of this office since the initial roll out of the NDIS across the country. Interface issues affect NDIS service providers and participants, as described briefly below.

NDIS Service Providers
The *NDIS Act 2013* has added to existing requirements under state and territory legislation, which creates issues for service providers, in terms of understanding, compliance, and reporting.

In areas including, but not limited to, legislation for the authorisation of restrictive practices, worker clearances, the reporting of deaths in care, and initiatives like community visitor programs, service providers need to understand and accommodate the requirements of both state/territory and Commonwealth legislation. This can include; being aware of the different definitions applying to certain activities, different reporting and recording keeping structures, and any audits or other associated compliance related activities.

The legislative requirements under the *NDIS Act 2013* can also conflict with other Commonwealth legislation, including the *Aged Care Act 1997*. These conflicts can make the transition for NDIS participants to different types of care and accommodation settings difficult. In the circumstance of an NDIS participant moving into residential aged care (which will become more prevalent as NDIS participants age), a provider is currently required to be an accredited aged care provider and an NDIS registered service provider. This means that the provider has to accommodate staff within the same facility operating under different legislative structures, including applicable codes of conduct and other standards. Worker clearances for aged care in comparison with NDIS staff also differ,

[1] *Guardianship and Administration Act 2000* (Qld) s209.

meaning that the ability of staff to care for different types of residents within a facility may be limited. Different legislative frameworks for the authorisation of the use of restrictive practices also apply to NDIS participants (under the *Disability Services Act 2006* in Queensland) in comparison with aged care residents (the *Quality of Care Principles 2014* under the *Aged Care Act 1997*), which again further complicates operations.

All of these issues are compounded in rural, regional, and remote areas of Queensland (and it is assumed other areas across the country) where multi-purpose services operate. These facilities incorporate NDIS, aged care and health services, provided from one core facility. In these circumstances, the *NDIS Act 2013*, the *Aged Care Act 1997* and the *Public Health Act 2005 (Qld)* operate simultaneously, along with associated national standards, codes of conduct and other regulations, which differ and sometimes conflict.

It is understood that it is a difficult process to achieve harmonisation and consistency across the country in relation to applicable legislation and policy, however the issues created for service providers cannot be underestimated.

NDIS Participants
For NDIS participants, issues associated with the interface between NDIS service provision and other service systems occur on two levels. The first is the service gaps that regularly exist for NDIS participants. A participant may have a robust plan however there may be a lack of appropriate service provision or wrap around services. The second involves NDIS supports not always being able to "follow" participants into other system environments including to places like hospitals or prisons.

These problems are particularly apparent in the health system-NDIS interface, with numerous examples of NDIS participants not attending specialist appointments to monitor known conditions, or not even visiting their general practitioner on a regular basis, as the necessary supports are either not supplied or have not been co-ordinated. This can create serious issues, including the late diagnosis and treatment of terminal conditions like certain types of cancer or other diseases.

When NDIS participants do visit a hospital or other health care facility for a medical procedure (like day surgery or a more complicated operation that requires a stay in hospital), significant problems can arise when support staff are not able to attend to assist them. This can be further complicated by the potential for disputes between health care and disability support workers as to roles and responsibilities, which means that the quality of care received by the participant may be jeopardised.

A critical example of this may occur in the area of restrictive practices, where emergency restrictive practices may be used on an NDIS participant in hospital who displays significant behavioural responses to a change of environment or support people. This need for emergency restraints and restrictions on the person's movement could potentially have been alleviated or eliminated if either the medical professionals associated with the participant's care, or a disability support worker, was able to proactively initiate elements of the participant's individual behaviour support plan, which identifies known behavioural responses displayed by a person to particular environments, and provides for less restrictive and often preventative methods of behaviour management.

I am aware that a practice direction has recently been issued in this area by the NDIS Quality and Safeguards Commission. This initiative is welcomed, and may assist in addressing some identified issues, however it is yet to be tested operationally. If the approach is successful it may also be required to guide interactions and necessary supports when participants are dealing with other service systems at a state and territory level.

More detailed examples of interface issues, and their impact on service providers and participants, will be provided in my subsequent submission to this inquiry.

Many NDIS-system interface issues have also been recounted in the public hearings conducted by the Royal Commission into Violence, Neglect, Abuse and Exploitation of People with Disability, which may contribute to the evidence base being developed as part of this inquiry.

2. The need for a pool of reserve funding for the Scheme

While a pool of reserve funding for the NDIS may be required in many areas, one of importance to NDIS participants, and particularly those with impaired decision-making ability, is reserve funding for providers of "last resort" to assume care and support functions.

Providers of last resort can be required in areas where there are particularly thin markets (like regional, rural, and remote Queensland) that lead to market failure (ie. no or very limited availability of required support services). Alternatively, they may be required when supplier-provider relationships fail, often for a variety of reasons, including things like the NDIS participant having exceptionally complex health and support needs.

In these circumstances, there is the potential for an NDIS participant to be placed back into institutional care (eg. residential aged care facility, hospital, or mental health facility), in very temporary accommodation (like an Air B&B or other holiday type accommodation), or with family members or other supporters who do not have either the facilities or expertise to provide the necessary supports that will maintain the participant's health and wellbeing. These outcomes are neither an appropriate nor acceptable solution for an NDIS participant, even on a temporary basis.

A pool of reserve funding would allow for an organisation, at very short notice, to provide emergency accommodation, care and supports appropriate to the person's needs and in accordance with their NDIS plan. This would provide the time necessary for alternative providers to be located and assessed for suitability, as well as for participants to consider the options available to them (in terms of alternate service providers or methods of service delivery) from a position of relative safety and security, where immediate needs are being catered for adequately.

The inquiry may also need to consider, in areas where markets are expected to remain particularly thin long term, the permanent contracting of last resort providers to be available and ready to assume responsibility for NDIS participants, particularly those with complex health conditions or very high support needs, as and when required.

As for the interface issues noted above, I will provide more detailed examples of these issues, including reference to the conclusions and recommendations from the Queensland Productivity Commission's inquiry into the NDIS market in Queensland, in my later submission to this inquiry.

Thank you for the opportunity to provide this initial feedback to the inquiry. Should you require clarification of any of the issues raised in this letter please contact my office

Yours sincerely

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Public Advocate