

**St Giles’ Submission for the Consultation on the Quality and Safeguarding Framework for the NDIS**

St Giles provide services to over 5000 children, young people and adults with developmental difficulties and disability across Tasmania. We strongly support the implementation of the NDIS, and look forward to working with the NDIA to achieve true choice and control for people affected by disability.

St Giles appreciates the opportunity to provide input into the Quality and Safeguarding Framework for the National Disability Insurance Scheme. Our recommendations draw upon our experience as a large provider of a diverse range of programs from allied health services to community support, reflections on our involvement in the Tasmanian NDIS trial to date, and the organizational considerations and changes we’ve needed to make to adapt to an insurance driven scheme.

1. **What are the most important features of an NDIS information system for participants?**

The most important features of an NDIS information system is that it is accessible, i.e. easily accessed by people with a diverse range of disability and literacy, is up to date and provided by diverse sources.

To date, the NDIA have provided accessible information on websites and via state based offices across Tasmania. To our knowledge, the trial population of Participants have accessed information about the NDIA through multiple sources and are reporting that accessing this information has been a simple process. Where Participants have been confused about how to access the NDIS, St Giles have had adequate resources to be able to assist Participants to find information online, or provide contact details to state-based offices where Participants have been guided through the process. It is imperative that multiple mediums for communication are utilized to enable Participants ease of access to required information.

The type of information outlined in the framework ranges from process related eg knowing your rights and how to exercise them, to qualitative data, eg the quality of service provision that the Participant can expect. As this is a broad range of information, multiple approaches to how this information can be shared needs to be taken.

Straight forward Information about rights and responsibilities is an important role of the NDIA. At the point of planning Participants need to know their rights, their responsibilities and how to utilise their funds to achieve their goals. Planners and NDIA support staff are best placed to discuss this directly with Participants. This type of information also needs to be freely available online and via other mediums to ensure it is able to be shared widely and consistently.

‘Qualitative information’, such as the quality of a service provider or comparative differences between Providers, needs to be available away from the influence of the NDIA. Information of this nature needs to be available from a quantifiable, validated and reliable source that avoids subjective influences, and consumer driven sources that includes Participants in reviewing the quality of providers.

It is likely that consumer driven sources will emerge without any intervention from the Government. As has occurred in all markets, ‘reviews’ and ‘ratings’ of consumer products are readily available online. The positive element of this type of information is that it enables open consumer participation and provides an unregulated source of information in generally accessible formats. This type of approach provides Participants with information to enable greater choice, however it may not be the most valid form of information, as measurement is based on subjective feedback, and potentially inconsistent definition and application of ratings systems.

To provide an alternative and objective view of the ‘quality’ of a service provider there needs to be a source available that applies reliable measures and manages a system that provides validated data that is up to date and delivered in an accessible format.

Measures need to include areas such as: Participant satisfaction, outcome achievement, quality of the service’s facility, and staff training/skill levels. Measures need to be applied consistently to enable comparison between services, and Providers needs to be categorized to enable comparison. Data would need to be cleansed to ensure validity and interpreted to support consumer understanding. The information needs to readily available to the NDIA, however the process needs to be conducted and distributed by a source away from the Agency.

Initially the Federal Government could ‘tender’ for the development and application of a qualitative tool to measure effectiveness of Providers and manage the data that needs to be accessible to Participants, the NDIA and the broader community. The data could then be the responsibility of a regulative industry body, for whom registration and complaints processes could also be incorporated at a fee to Providers to enable sustainability.

**Recommendations:**

1.1 Information related to rights and responsibilities be available in all formats, as the NDIA has demonstrated through its website and location based offices.

1.2 Information about rights and responsibilities is the role of the NDIA, however data related to the quality of Providers needs to be managed externally.

1.3 Consumer driven sources of information on the quality of Providers is an inevitability and part of a ‘consumer’ driven market. This needs to occur without government intervention.

1.4 There needs to be a source of information that is reliable and valid, where measurement of quality is consistently applied. It is recommended that an external body be established who is responsible for developing a tool to measure quality and distributing information about the quality of Providers. This information needs to be readily available to Participants, NDIA and the broader community.

1.5 Quality service information be managed by an external body who is also responsible for registration and complaints handling (see below).

**2. How can the information system be designed to ensure accessibility?**

There will need to be multiple information systems to deliver the type of data recommended above. It will need to be available online and as paper based options to ensure that all Participants can access the information. A strong advertising campaign will be required during the roll out and onwards to ensure that all eligible Participants know where and how to access information on the NDIS and Providers.

**Recommendations:**

2.1 Information needs to be distributed in multiple formats to ensure all potential Participants can access required information.

2.2 There needs to be a large and far reaching advertising campaign on the NDIS, how to access information on the NDIS processes and the quality of Providers.

**3. What would be the benefits and risks of enabling participants to share information, for example, through online forums, consumer ratings of providers and other means?**

It is inevitable that consumer driven quality and rating systems will occur. Participants are already doing this through their own networks and online groups. It is not the role of Government to intervene in this area, however it is important that an alternative be available to Participants such as suggested above (see Recommendation 1.4).

Consumer based rating systems generally occur in the public domain, and as such, Providers may be able to use these ratings as part of their marketing strategy. There are inevitable risks, such as a Provider being “trolled” (negatively represented by a large group of people online) by a group of unhappy consumers, however this risk is a potential for any company, and as such, emphasizes the need for Providers to have responsive complaints processes and embrace continuous quality improvement practices.

**Recommendation:**

See 1.3

**4. Are there additional ways of building natural safeguards that the NDIS should be considering?**

As noted in the Framework paper, there are many programs already working closely with business and the broader community to build natural safeguards. The Information, Linkages and Capacity Building framework also emphasises this approach, and is an important element of the future success of the NDIS.

The ILC Framework points to the importance of Local Area Coordinators (LACs), the role of advocacy groups and potentially funded projects to build the capacity of the mainstream sector to provide a strong base of support to people with disability, enabling greater access to mainstream services, employment opportunities and social connectedness. In both the Quality and Safeguarding Framework and the ILC Framework the document makes reference to the NDIA building ‘partnerships’ with community organisations to improve the practices of mainstream services to better enable the support and inclusion of people with disability. Partnering with a community organization could imply the NDIA has a stake hold, an invested interest, in the success of that organization, putting the agency at risk of bias when assisting clients to choose providers.

The function of the NDIA is clearly outlined on the NDIA website and does not describe the agency as a provider of services (<http://www.ndis.gov.au/about-us/functions-ndia-including-decision-making-powers>). If the NDIA was to engage in community based partnerships, their role becomes blurred. Does this mean the Agency must go through Provider registration requirements, are they subject to quality assurance assessments, will the NDIA show preference to “partner” organisations over non-partner organisations, does this reduce their ability to support clients to choose? It is imperative that this line be clear to ensure the Agency does not take on more than it can manage, and not confuse the role of funds distributor verses service provider.

To use an example the Health Insurance sector provides an appropriate comparison. Health insurers don’t provide surgery. Their role is to ensure that the patient’s policy allows them to pay for the required surgery and if so, the health provider is paid once the surgery has been conducted.

This should be the extent of the involvement with the NDIA in “building natural safeguards”. The NDIA needs to identify areas of need (see ILC Framework) and tender out funds to provide these services. They should not participate or “partner” with community organizations to deliver these programs. Again, a comparison with the health insurance sector can be drawn. Private health insurers pay for preventative health services such as dental checks or massage in the hope that these smaller cost interventions will minimize or avoid larger cost interventions in the future.

For the purposes of minimizing reliance on individual funding packages, the NDIS has a responsibility to fund appropriate community programs to strengthen community and social inclusion for people with disability, however they do not have a role in delivering or partnering with providers to deliver these services. The NDIA needs to have a hands off approach, keeping focused on its role as an insurance agent and not a service provider.

With the growth in funding for services for people with disability, new ideas and approaches will emerge. Rather than controlling what emerges, the NDIA need to support sector development by funding programs that can demonstrate successful models of support and intervention that achieve the goal of a more inclusive society, and minimise reliance on government support.

**Recommendations:**

4.1 The NDIA to distribute funds to appropriate providers to deliver programs that will enhance and build the broader community to enable better natural safeguards, community inclusion and participation for people with disability.

4.2 The NDIA should not have a role in delivering services through ‘partnerships’, but rather through fair tendering processes that identify best practice and funds programs that meet the objectives of building the mainstream sector, reducing reliance on government support and enhancing opportunities to build a more inclusive community.

**5. What can be done to support people with a limited number of family and friends?**

As suggested above, there are many programs already successfully linking people to broader community activities that enable greater social inclusion. It is important that these programs continue to be funded under the ILC component of the NDIS (previously known as Tier 2). Identification of successful programs could be done through a review of services focused on building social opportunities, with funding being provided to those delivering a successful models, and expansion of successful models into communities that do not have access to these programs. The ILC provides a framework for this type of capacity building.

**Recommendations:**

5.1 A review be conducted to identify programs delivering successful strategies that build social inclusion, based on the Framework for Information, Linkages and Capacity Building.

5.2 These programs be expanded into communities where they are not being delivered.

5.3 Programs need to be evaluated as per Recommendation 1.4

**6. What kind of support would providers need to deliver high-quality supports?**

Quality will be defined by what participants want, the outcomes achieved by a particular provider, and how this approach is marketed, including the use of structured measurement tools (as outlined above) or consumer feedback.

Commonwealth, state and territory governments have a role to support providers to transition to the full role out of the NDIS, and have been doing so through peak industry bodies, the sector development fund projects and state based support, such as the NDIS Implementation team in Tasmania. This support has been greatly appreciated, however ultimately it is up to the Provider to determine how to deliver high quality supports.

Services have access to the latest research and practice based evidence on what constitutes high quality support in their various areas. It is the responsibility of any ‘business’ to determine what makes them a quality or desirable service, and demonstrating and promoting how they do this to potential consumers.

If the NDIS or government bodies are too involved in defining or developing what a high quality support looks like, the industry is at risk of becoming homogenous, impacting on the capacity for Providers to deliver variety to the market and the choices available to Participants.

If an external source develops a quality measurement tool, Providers will adapt to ensure they meet the appropriate standards. This should be seen as a guide. How Providers achieves quality may vary, and this should be supported to enable market diversity.

**Recommendations:**

6.1 Providers are responsible for how they wish to pursue a quality approach to their support practices.

6.2 An independent body should be engaged in measuring quality to support Participants in choosing a Provider that meets their needs.

**7. Should there be an independent oversight body for the NDIS? What functions and powers should an oversight body have?**

An independent oversight body would enable the NDIA to focus on their task of distributing funds to people with disability to enable them to receive reasonable and necessary support, while another body, ideally industry based, focusses on sector compliance and supporting complaints.

Drawing on the health sector again, health professionals are overseen by the Australian Health Practitioners Regulation Agency (AHPRA) that is comprised of industry specific Boards whose responsibility is to oversee the registration of health professionals and complaints handling. They describe that their role is to “protect the public” (<http://www.ahpra.gov.au/About-AHPRA.aspx>), ensuring that if someone calls themselves a pharmacist, for example, that there are certain standards of practice that individual is engaged in to ensure they are qualified to deliver the services they purport to be able to deliver.

In the context of the NDIA, an external body, guided by relevant industry leaders, could oversee the role of registration and quality assurance practices of providers and individual practitioners, manage complaints and monitor market development to ensure the sector is meeting the needs of people with disability. This “one stop shop” could be a point of contact for Participants, Providers and the NDIA.

Similar to AHPRA, an independent body would have the power to “de-register” a Provider for malpractice; measure, support and monitor quality practices and improvement, handle complaints (when other statutory bodies are not appropriate), manage market data and be empowered to highlight unmet need to assist the market to develop and grow.

The federal government could provide seed funding for the establishment of this type of Agent, with the intention of reducing funds once registration and compliance fees enable sustainability.

**Recommendations:**

7.1 An independent oversight body be established to oversee registration of both Providers and individual practitioners, similar to the role AHPRA plays

7.2 The oversight body to have the power to ‘de-register’ a Provider or individual practitioner who does not comply to agreed conditions

7.3 The Federal Government to seed fund an oversight body to be a ‘one stop shop’ for Participants, Providers and the NDIA in all matters relating to: registration, quality assurance, complaints handling and market development.

**NDIS Provider Registration**

**8. Which ‘option’ would provide the best assurance for providers and participants? Should the approach to registration depend on the nature of the service? How can the right balance be reached between providing assurance & letting people make their own choices?**

If the sector is unnecessarily regulated, this will potentially lead to the withdrawal of providers from the market, reducing choice for participants.

A range of registration levels need to be available depending on the complexity and risk of the supports being provided. A risk matrix could be developed to assist with identifying services that are high risk (eg intimate contact with the person) and high level of complexity (eg tube feeding) to low risk (no physical contact required, other people present) and low level of complexity (eg gardening, maintenance). Once risk level is identified, a range of registration levels can be applied, from Option 1 for low risk providers, to option 4 for high risk providers.

To minimize duplication, if a Provider is subject to other forms of registration and compliance, such as registration with AHPRA, then the above should not apply. Providers with other regulatory processes in place should still be required to provide evidence of their compliance and be subject to low level NDIS registration (eg option 1).

**Recommendations:**

8.1 A range of registration levels need to be available depending on the complexity and risk of the supports being provided, avoiding duplication when providers are subject to other compliance systems.

**Systems for handling complaints**

**9. How important is it to have an NDIS complaints system that is independent from providers of supports? Should an NDIS complaints system apply only to disability-related supports funded by the NDIS, to all funded supports, or to all disability services regardless of whether they are funded by the NDIS? What powers should a complaints body have? Should there be community visitor schemes in the NDIS and , if so, what should their role be?**

The NDIA must remain focused on delivering support to Participants to develop goals, and provide necessary funding to achieve said goals. It should not be involved in managing Providers or being responsible for resolving complaints about providers or for Participants. Complaints handling must be separated from the NDIA.

The NDIA are responsible for identifying supports and distributing fund to Participants. There is a risk that Planners involved in this process may favour organisations, or supports that are delivered by a specific organization, because of reputation, that may or may not be a true representation of a Provider.

Should the NDIA oversee complaints processes, there is an inherent risk of the Agency being deemed bias, particular when the Agency may in the future commission particular support in thin markets, or identify specific providers to deliver services under the Information, Linkages and Capacity Building Framework.

An open competitive market will give participants greater choice and control over who they engage to provide their support. If the market is managed by the government body that distributes the funds, how is this any different to the system we have in place now? Are we at risk of homogenizing the market place?

An independent body that oversees registration and accreditation; removed from Providers and the NDIA, could manage all aspects of compliance, including complaints handling.

Complaints systems should only apply to providers for whom there isn’t already an established process, such as the ACCC. Generally this would be current providers of specialist disability services or new providers wishing to work within this sector. Participants should be encouraged to use mainstream complaints systems first.

An oversight body would need to identify Providers who were subject to other complaints processes and/or their own complaints system and provide information to Participants about where to complain, should there be another avenue available.

In responding to complaints that are applicable to an independent body a system could be developed similar to the notification process of AHPRA (<http://www.ahpra.gov.au/Notifications/The-notifications-process.aspx>). AHPRA publish notification results on their website and are empowered to ‘de-register’ a health professional, should the severity of their action deem it necessary.

A community visitor could be used as on the ground agents for a registration and accreditation scheme, however they need to be focused on high risk, high level of complexity type of supports such as supported accommodation.

**Recommendations:**

9.1 Complaints processes need to be overseen by an independent body that is responsible for all compliance facets, including complaints handling.

9.2 Complaints systems should only apply to Providers for whom there isn’t already an established process.

9.3 An independent body responsible for handling complaints needs to establish a notification system, similar to AHPRA and including the capacity to ‘de-register’ a Provider should it be deemed necessary.

9.4 A Community Visitors Scheme may be appropriate for high risk/highly complex supports only.

**Ensuring staff are safe to work with participants**

**10. Who should make the decision about whether employees are safe to work with people with disability? How much information about a person’s history is required to ensure they are safe to work with people with disability? Of the options described above, which option, or combination of options, do you prefer?**

There is a demand for more workers in the disability sector, particularly when the NDIS is at full scheme (see National Workforce Strategy, NDS). If the safety processes are expensive to potential employees or onerous to Providers, it will form a barrier for the acquisition of new employees or Providers and puts the Scheme at risk of supply not meeting demand.

The degree of employee background checking needs to be commensurate with the level of risk; high risk & high level of complexity = high level of compliance to safety checks.

Safety compliance could be managed as part of the registration requirements of a Provider. Depending on the level of risk a support presents, option 1 – 3 could be applied. Option 4: a barred persons list, would need to be carefully considered, as there may be a risk of discrimination. A barred person’s ‘list’ would need to apply a strict criteria for a person to be placed on the ‘list’, and a review process of individuals would have to be imbedded in the system, to enable employees to change their practice.

Another option would be to institute individual registration, similar to health professionals subject to AHPRA. Anyone wishing to work with people in supports that are deemed high risk would need to register with an independent body and meet specific criteria such as a clear criminal record, pass a working with vulnerable people or working with children check. This body could oversee police checking and legal screening, and provide assurance to Participants and Providers. This takes the burden off Providers and provides assurance to Participants who self-manage. An independent compliance body could be responsible for overseeing this process.

Providers could choose to have their own employee checks in place, however if an individual registration system is adopted there is less of a need for this additional check. This reduces costs and time for Providers who are needing to reduce back office activity to maintain competitiveness in an open market.

Employees wishing to work across Providers would also have their costs reduced, as obtaining a National Police Check for every employer can become expensive. This way if they obtain registration they can demonstrate proof to potential employers of their safety status without incurring recurrent costs.

**Recommendations:**

10.1 The degree of employee background checking needs to be commensurate with the level of risk; high risk & high level of complexity = high level of compliance to safety checks.

10.2 Safety compliance could be managed as part of the registration requirements of a Provider.

10.3 A barred persons list would have to apply strict criteria for inclusion on the list, and capacity for an employee to redeem themselves.

10.4 Consider developing an individual registration system for employees wishing to work with people in supports that are high risk.

**Safeguards for participants who manage their own plans**

**11. Should people who manage their own plans be able to choose unregistered providers of supports on an ‘at your own risk’ basis (Option 1) or does the NDIS have a duty of care to ensure that all providers are safe and competent? What kind of assistance would be most valuable for people wanting to manage their own supports?**

If an individual accreditation process is developed, as discussed above, self-managed participants could have a choice of employing someone who is credentialed, or take the risk of employing someone who is not. In the context of choice and control, people who are assessed by the NDIA as being able to self-manage should be able to do so. The level of risk is then at the discretion of the Participant.

**Recommendations:**

11.1 Participants assessed as being able to self-manage should have the choice of who they employee, with the level of risk being at the discretion of the Participant.

11.2 If an individual registration system is adopted, self-managing Participants could have a choice of employing a credentialed employee, without incurring the cost of safety checks.

**12. Reducing and eliminating restrictive practices in NDIS funded supports**

Participants requiring this type of intervention will be the most vulnerable people involved in the NDIS. It is imperative that these people are protected. The approach developed in Victoria and Tasmania, as noted in the consultation paper, represent the highest level of oversight in Australia and should be seen as best practice.

Support provided by the Victorian and Tasmanian state governments enabling the implementation of these approaches could be replicated nationally.

**Recommendations:**

12.1 The systems in Victoria and Tasmania are best practice and should be adopted nationally.

12.2 Support to implement this process should be provided by the NDIS.

For follow up, or further information regarding this feedback please contact:

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