

**Feedback on the Consultation Paper:  
Proposal for a National Disability Insurance  
Scheme Quality and Safeguarding  
Framework**

**Presented to the**

**Department of Social Services**

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**Authorised by:**

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## About the APA

The Australian Physiotherapy Association (APA) is the peak body representing the interests of over 17,000 physiotherapists and their patients. APA members are registered with the Physiotherapy Board of Australia, have undertaken to meet the APA Code of Conduct, are expected to use the latest research in practice and often have further and/or expert qualifications.

The APA sets a high standard for professional competence and behaviour and advocates best practice care for clients. It is our belief that all Australians should have access to high quality physiotherapy to optimise health and wellbeing.

## Vision

That the whole community recognises the full benefit of physiotherapy

## Belief

That all Australians should have access to high quality physiotherapy to optimise health and wellbeing

## Purpose

To leverage our global leadership position for the benefit of physiotherapy and consumers

Updated APA statement

## The Consultation Paper: Proposal for a National Disability Insurance Scheme Quality and Safeguarding Framework

We have organised feedback according to the questions posed in the consultation paper.

### Consultation questions

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

An NDIS information system should:

- provide information about functions of the NDIS, NDIA or monitoring body
- help participants understand which questions to ask when they are looking for a physiotherapist to support them
- provide information about the providers available
- be accurate and concise and accessible in a number of formats including for people with sensory issues and complex communication needs
- convey what evidence there is for the interventions that physiotherapists are offering, and help participants understand evidence based practice.

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

The information system can enhance accessibility by ensuring multimodal communication which is responsive to the disability community.

Information can be disseminated through existing networks e.g. Mid Coast Communities, SARRAH, Allied to Kids, Yammer, FACS Newsletter, local NDS and other websites, and should allow the service user to select a preferred method for receiving or accessing information. E.g. by text, email, post, and in different formats suited to the service user.

#### 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?

The APA supports the principle of informing consumers so they can make the right decisions for their care. While consumer ratings and similar forums may be useful for consumers in some circumstances, it is important to consider the implications of such forums for consumers and registered practitioners, like physiotherapists, who are subject to the National Law.

The National Law strictly controls registered practitioners' advertising and prohibits the use of testimonials. Other professions are not required to meet these higher standards and so there is not a 'level playing field' amongst health professionals. Such forums would not necessarily allow the consumer to make an informed decision between a physiotherapist and an exercise physiologist, for example, who is not registered and not subject to the National Law. Such forums, while well intentioned, could unwittingly contravene the National Law, disadvantage registered practitioners and not support informed decision making.

The development of this type of forum should not compromise registered practitioners' legal obligations, provide a level playing field between providers and ensure fair, balanced and accurate comment. Information about practitioners should have to meet the higher standards required of registered practitioners.

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

The NDIS should allow for additional access to consistent & ongoing case management and social support, if required. Participants should also be helped to develop person centred tools such as One Page Profile & Communication profiles to ensure that support people have a rounded understanding of the participant.

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

The NDIA focuses on the needs of the participant, and like others, participants may not want lots of people interfering in their lives. That said, the overall well-being of a participant may identify the need for interventions that may promote improved overall function. There should be capacity to help the participant identify goals that promote additional goals and skills that support natural safeguards, like peer and companion networks.

The establishment of forums for planners and carers to discuss such topics may help identify participants who might benefit from the identification of these goals.

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

NDIA should consider providing governance, policies and procedures and simple measures to guide other agencies in developing consistent approaches and frameworks against which providers can model practices and measure outcomes, and participants can compare providers.

Members also identified the need to access professional supervision for physiotherapy staff and students, ongoing professional development for physiotherapists, access to literature and time for staff to attend community of practice forums.

**7. Should there be an independent oversight body for the NDIS? Why or why not?**

The APA supports the establishment of an independent oversight body that is part of the framework that provides assurance of safety, quality and achieving outcomes.

**8. What functions and powers should an oversight body have?**

Such a body should be represented locally, for example represented in each Centrelink or organised similar to the Mandatory Hotline system, and allow people to speak to someone in person.

The body should hear complaints against the NDIA and providers, provide a mediation service, and have powers to investigate and take compliance action, as necessary.

Any person, including a practitioner, should be eligible to make a complaint.

**9. Considering the options described above, which option would provide the best assurance for (a) providers? (b) participants?**

“Option 4: Mandated participation in an external quality assurance system for certain providers of supports” provides a risk based assurance framework for participants and providers. Accreditation and registration of providers would establish a set of performance standards and outcomes for providers and participants, yet be flexible enough to allow new entrants to the market to establish themselves, with other specific safeguards in place.

Physiotherapists are registered nationally by the Physiotherapy Board of Australia and regulated by the National Law which is enforced by the Allied Health Practitioner Regulation Agency (AHPRA). They are subject to AHPRA’s Codes of Conduct, and governance frameworks, workplace rules and guidelines, and members of the APA are also subject to the rules and codes of membership. Physiotherapists are also subject to the criminal and civil legal system.

Recognition of physiotherapists’ registration would reduce administrative duplication and cost.

**10. Should the approach to registration depend on the nature of the service?**

All services providing care should be required to comply with basic standards quality assurance and safety. The registration process should also take risk and context, e.g. working with children, or

clinical condition into account, and, for example, speciality or expert scope of practice. This provides proportionate assurances and information that can best guide decision making about services.

**11. How can the right balance be reached between providing assurance and letting people make their own choices?**

The NDIS should build natural supports for each person in the community wherever possible which integrate continuous dialogue and evaluation that include providers and participants and the wider community.

**12. How important is it to have an NDIS complaints system that is independent from providers of supports?**

An independent complaints system will ensure transparency, accountability and assurance for persons accessing services

**13. 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?**

The complaints system should work with the existing systems for registered health professions, and should take complaints for all funded supports.

**14. What powers should a complaints body have?**

The complaints body should provide a conciliation service, have investigative powers including powers to compel evidence, and should have a range of compliance and enforcement tools, including NDIS de-registration, referring matters to AHPRA, or other relevant regulatory agency and determining compensation.

**15. Should there be community visitor schemes in the NDIS and, if so, what should their role be?**

Community visitor schemes should be available in the NDIS if participants identify a need for them.

**16. Who should make the decision about whether employees are safe to work with people with disability?**

The registering body should be competent to decide about a person's suitability to work with people with disability. That body should require risk-based checks and oversights to ensure that the person they are employing has the necessary skills, knowledge and character requirements for their role.

**17. How much information about a person's history is required to ensure they are safe to work with people with disability?**

This should be based on risk. Typically however, we expect positive vetting to be carried out by a screening agency.

**18. Of the options described which option, or combination of options, do you prefer?**

We prefer a risk based approach with comprehensive checking. This role could reasonably be carried out by existing screening agencies to reduce cost and duplication of functions, and produce a single card, nationally recognised, or exchangeable from state to state, like a driving licence or airport employee card, that clearly endorses a worker, for working with NDIS participants, or vulnerable people, for example.

**19. 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?**

The NDIS has a duty of care to ensure that all providers are safe and competent.

**20. What kind of assistance would be most valuable for people wanting to manage their own supports?**

Participants may require training or more tailored resources about workplace health and safety, business practice and requirements e.g. ABN, employer/employee relationships, information on the differences between registered and non-registered providers, case management support, cultural competency and language access, and support setting SMART goals and assessing costs and benefits

**21. Who should decide when restrictive practices can be used?**

The person's legally nominated carer or advocate should decide when restrictive practices can be used. The carer or advocate should be required to seek relevant advice and should also involve or be informed by an independent panel/organisation authorised by the NDIS, when necessary. Restrictive practices should only be implemented after alternative strategies have been exhausted, and only when there are imminent safety risks that cannot be met in any other way, including more support.

**22. What processes or systems might be needed to ensure decisions to use restrictive practices in a behaviour support plan are right for the person concerned?**

Processes should be based on best practice. Any process should involve consultation with persons with disabilities and health/disability professionals, recording behaviours that have caused the issue of restrictive practice to be raised, evidence that alternative strategies have not been successful and the monitoring, reporting and reassessment of the restrictive practices

**23. Are there safeguards that we should consider that have not been proposed in these options?**

The consultation might consider decision-making agreements or communication charts which help minimise behavioural issues. Restrictive Practice Authorisation Panels, although administratively cumbersome, are successful in considering the individual and how to enhance their life. We suggest an environment scan to identify relevant trials and practices.

**24. For providers, what kinds of support are you receiving now from state and territory departments that you think would be helpful if it was available under the NDIS?**

Workshops on the Disability Inclusion Act, Enablement training

**25. Would you support mandatory reporting on the use of restrictive practices? Why/Why not?**

Yes. Mandatory reporting would support participants who are at risk.

**26. If you support mandatory reporting on the use of restrictive practices, what level of reporting do you believe should occur?**

Option 3 pg85 provides the highest level of safeguards for participants and providers.

In Option 3, providers must report on each occasion where a restrictive practice is used (for physical, chemical, mechanical restraint and seclusion) In addition to the reporting requirements set out in Option 2, this option would require providers of supports to regularly report on each use of chemical, physical and mechanical restraint and seclusion (as per agreed definitions in the National Framework). This information could be reported by providers via an electronic online system which could be automated as much as possible to reduce the administrative burden on providers. This approach could be similar to the Restrictive Intervention Data System currently used in Victoria to enable providers to report on restrictive practices.