NDIS Solutions Paper

This paper is to be read as Appendix 1 to ISSUES PAPER ON THE OBSERVED OUTCOMES OF THE NDIS by Alister Morton undated paper - file saved 21/3/2021. It should also be understood in the context of the cohort of people primarily with Intellectual Disability and who are accommodated in Supported Residential Facilities or Community Supported Housing with predominantly 24 hour supports.

KEY POINTS

1. Older persons in South Australia with congenital or life-long disability ARE the most vulnerable citizens as they are mostly without significant Advocacy support from family or significant others.
Solution – **Independent Advocacy provided routinely for persons who require nominee or legal guardian.**

2. NDIS funding is not objective and equal or consistent across Participants in the program.
Solution – **NDIS funding should be standardised and commensurate with diagnosis and objective functional status of the participant.**

3. NDIS funding is open to Political bias rather than individual Participant need.
Solution – **NDIS funding should not either require strong advocacy or action based on Political complaints or intervention – an agency separate from Government should administer the system**

4. NDIS has discrimination inbuilt at core – Agency Managed Participants DO NOT have access to providers of choice as Self and Plan Managed Participants do.
Solution – **All Participants should have equal freedom for Providers of choice. NDIS Quality and Safeguards and Provider Registration should be disbanded as had been ineffective and wasteful and obstructive.**

5. NDIS funding is determined by largely non-clinical NDIA Planners
Solution – **All determinations and assessments should be carried out or informed by Qualified Professionals with Specific Qualification in Disability or Health as situation requires.**

6. NDIS Planning Meetings are provided often without true Multi-disciplinary collaboration and meetings are not minuted – minutes are not provided to Participants / Nominees as a true record of Planning Meetings.
Solution – **All Planning Meetings or formal determination meetings should be minuted and accepted by all parties. Planning meetings should provide proper opportunity for Multidisciplinary input.**

7. NDIS Plans including Participant Profiles and Goals are quite often false or at least poor constituting effective fraud on behalf of a Commonwealth Officer.
Solution – **Plans should be developed by a person who has direct face to face knowledge of the individual and their circumstances and should reflect minuted Planning meeting minutes (currently none).**

8. Many Participants in SRF's have had effective funding reduction limiting access the same amounts of funding for Accommodation Support, Day Options / Programs and Therapy.
Solution – **Urgent review of pre-transition funding and services and comparison with current funding and services. Key funding areas must be reported if Plans are assessed year after year and cannot be reduced except for where a person's disability has improved. The system needs to**

properly understand the needs of the majority of it's population and not concentrate primarily on the younger developmental cohort.

9. Most Participants (almost all) have lost the standard yearly Respite / Holiday away from the SRF due to insufficient funding for specialling or respite staffing
Solution – **All participants should have adequate staffing SIL funding to enable individual activities on a weekly basis and at least yearly respite from the principal place of residence if appropriate.**

10. Participants in the Govt and NGO sector have had an effective cut in Support Coordination funding of about 75% per person as well as Service Coordinators being more disconnected.
Solution – **All participants who cannot act for themselves should have at least 12K Support Coordination – ideally this should be undertaken by a Key person acting as a Local Area Coordinator according to the original principal. This equates to only approx. 1 day of active coordination per month. This was the approximate level of Program Service Coordinator funding provided prior to transition in Govt and NGO Accommodation Services for this cohort.**

11. Govt Accommodation Services or NGO's who were primary advocates for many Participants are now reduced to a position of conflict of interest in being the 'Service Provider'
Solution – **Independent Advocate to be provided**

12. Participants do not have easy and User-friendly access to NDIA support – the LAC system that was meant to be incorporated into the NDIS seems to have diminished.
Solution – **LAC system rediscovered and reintroduced to deliver person-centred, direct, accountable, Case-management style coordination.**

13. Access is difficult and impersonal for contact with NDIA Agents (Planners etc.)
Solution – **Eliminate the Centrelink style Federal system and provide a Local, Accessible, Contactable scheme.**

14. NDIS Satisfaction rating is possibly skewed toward those who have capacity to provide feedback. Experience and dialogue with participants would suggest that the advertised satisfaction rate is highly inflated either by demographic, method, or reporting. An overall satisfaction rate approaching 90% seems incredulous and inconsistent with participant feedback.
Solution – **Urgent review of data collection and reporting. Equal weighting for participants without ability to feedback, and review with professionals how to reasonably gain true feedback about the system where a person cannot do this themselves. Ensure a method for staff to make confidential complaints about loss of services or treatment for participants.**

15. NDIA Quality and Safeguards has failed to provide reasonable outcomes and has not faced any known consequences in the wake of the Annie Smith affair.
Solution – **Disband Quality and Safeguarding as stands as it has failed to provide. It has to my knowledge not sought to measure or appreciate any loss in Quality or safety in the provision of services. Community Visitor Scheme should be massively upgraded and States (or perhaps even local Councils) should be funded to monitor and report on the performance of the Commonwealth (if it is to remain a federal system).**

16. Govt COS Program Participants have extreme limitation with services only able to be delivered by one specific provider under agreement with SA Govt. The COS unit is somewhat obscure with very limited ease of contact and information to Participants.

Solution – **All Participants irrespective of funding relationship should be provided with equal access to personal choice and freedom of provider in a truly ethical fair system.**

17. NDIS Finance Committee has failed to appreciate market forces in relation to Therapy and the function and efficacy of Allied Health Assistants.
Solution – **Allied Health Assistant rates should be dramatically increased to reflect the real cost of delivery of these services and to appreciate the benefit of delivering more services for less. Why not motivate a market that looks for more cost effective options rather than providing incentive for increased professional and more expensive input. This also helps to increase employment and status of lowest paid workers (essentially paid commensurate with Personal Support Workers). An Allied Health Assist may cost $55/hr to retain their services and NDIS funds at $48 if under AHP direct supervision and $86 if under indirect supervision. Employees may make 70% billable KPI which means there is a slimmest of margins even for an AHA level 2. An AHP (PT) may cost $75 /hr to retain and NDIS funds at $224 / hr. Once billable potential taken into account the margin here might be 50% ($112 / hr). Why would an employer faced with this reality look at increasing it's workforce / capacity with a larger number of personnel that bring little or no margin? AHA level 1 rates should be deleted as the same skill set and employee cost is most often required whether the Physiotherapist is providing direct supervision or not and the Assistant is paid no less because they are assisting the Therapist directly with a complex participant. AHA rates should be increased to $120 / hr. Higher PT rates should be reviewed as this causes market forces that may alter preference for therapist for similar work e.g. AT provision by OT rather than PT.**

18. NDIS has failed to recognise the benefit of Govt and large NGO Agencies in promoting the rights and programs for people with a disability, for developing links and providing opportunities for tertiary education and research in disability, and for the progression of ethic driven behaviours, education and training in the disability sector.
Solution – **NDIS Price Catalogue should be reviewed with better appreciation of market forces and Larger Organisations should be provided with a surcharge ability or receive some bulk / … funding to appreciate that they carry larger overheads. The current model is selective for the benefit of sole traders or smaller businesses with few overheads.**

19. NDIS' fiscal focus has resulted in wholescale changes and loss of morale and ethic across the disability sector where it was understood the objective was to provide a Person-Centred Approach rather than a fiscal centred approach.
Solution – **Unsure of a solution – a personalised funding model will inevitably force it to be about the money and not about the person. The previous Block funding model meant that finance wasn't necessarily individualised or decisions of support were not based on this but on need and clinical priority. Some people simply missed out on services as others presented with higher priority. Now what determines service is funding not need or priority and sometimes funding is mismatched with need and priority and requires too much bureaucracy to administer making it untimely, inefficient and poor. Except for removing the funding based model unsure of how to solve this tendency.**

20. Clinical Funding was previously prioritised by therapists familiar with the participant who would determine hours provided according to need at the time. Now Clinical prioritising is effectively approved by an NDIS Planner without Clinical registration (AHPRA) who in many cases has never met the Participant, and through a process that creates delay and increased risk to the Participant.
Solution – **Clinical decisions should be made by a Clinician with direct assessment of the Participant. Funding in many cases is a Clinical decision – not an administrative one.**

21. Rather than 1 CSTDSA battle per year and Each Provider battle with Disability Services for block funding each year the NDIS has reduced funding to thousands of individual battles with each Participant or their nominees
Solution – **Disband the NDIA as a scheme which has failed to realise the expected efficiencies of the 2008 DIG Report. Go back to a sustainable model before all the Providers have been irreversibly damaged. This may already be too late. The only other option is a funding model that is decided through true independent assessment – not assessment tendered and responsible to the NDIA. Then again, the relevance of having an NDIA is the question.**

22. NDIS has increased the stress and understanding of many families, carers, nominees of people with a Disability who are mostly themselves limited or tired. It creates a system which is complicated and uses terminology and processes that is often confusing. It would be worth looking at family separation rates in this cohort.
Solution – **The system needs to be Objective, Determinable, Consistent, Stable and non-adversarial. It must provide a reliable and ongoing source of funding without constant review for those whose disability does not significantly change and there needs to be again a personable, local, direct assessment process by suitable person who is also responsible for the outcomes. Research should be conducted into the stress for families and relationship to the NDIS.**

23. NDIS has resulted in an overall decline of Lifestyle Planning, Care, and Support for many across the sector, especially those who lack advocacy.
Solution – **Proper Local Area Coordination to deliver fully funded effective Support Coordination / case Management. Independent Advocacy and Community Visitors to check on care.**

24. The OPA in South Australia fails to appreciate in writing in its Annual report the overall negative impact of the NDIS and although listing concerns provides descriptions that are slightly misleading and not clearly representing the issues.
Solution – **the OPA should not report findings of the NDIS but should make their own assessments about the effectiveness and safety of the Scheme. The OPA should understand that the cohort of currently between 900 – 1200 individuals they hold in cases reflects only a small portion of the number of people who cannot advocate for themselves in South Australia. The OPA should seek to find information about unmet advocacy need in South Australia.**

25. The Majority of younger Participants have nominees that are dissatisfied with the processes and inconsistencies or injustices of the system. Some have seen significant increase in support however acknowledge that the process creates considerable increase in stress in families where there is already considerable pressure.
Solution – **The scheme needs to be adjusted so that it is more standardised and less subjectively inconsistent. It should not be as is commonly stated whether you get a good Planner or not.**

26. The NDIS has failed to enable the full utilisation of allocated funds resulting in $6B returned to Treasury and not utilised where it was assessed that it was needed in the last financial year.
Solution – **All unallocated funds for the scheme should be returned to the scheme in Capital funding type projects or business supplement projects as unallocated funds usually occurs because there was insufficient providers or resources. There should not be an incentive to Government to not spend the NDIS allocated funding.**

27. Many Disability Organisations both GOVT and NGO have lost asset base / income and suffered significant financial pressure as direct result of overall decreased funding through NDIS compared with the previous Block funding. This has resulted in significant

rationalisation of services and training resulting in decreased quality of services and also increased risk to Participants.
Solution – **Some form of business surcharge or block funding for large providers to enable competing with small concerns with few overheads.**

28. Financial pressures on larger organisations have resulted in staff pressure and turnover, and specifically professionals leaving and operating as sole traders and managing the overheads that larger organisations can not mange.
Solution – **As for 27**

29. NDIS focuses on the younger cohort and with the term 'Maintenance' not being supported in essence. NDIS considers it's role is to increase function rather than maintain it. Clinicians with long term experience in the disability sector acknowledge that the majority of Therapy in the older person's context is about maintaining function and capability not about "Capacity Building'. This leads to a 'disingenuous' attempt for Professionals to have to build programs and reports around the construct of development rather than maintenance. NDIS must recognise the concept of maintenance.
Solution – **NDIS must recognise and support the notion of "maintenance therapy". Every person in society can help maintain their fitness, well-being, and function and so Participants must be provided with reasonable and necessary supports to maintain their Capacity. Capacity Building Supports to be renamed simply Capacity Supports – if we must retain categories!**

30. NDIS had failed to understand the intersect with Health. It is important that significant health and Rehabilitation supports can be provided by disability specific and experienced providers rather than that provided through normal SA Health programs.
Solution – **Additional funding should be provided for Health-related Incidents and Rehabilitation for a person with a disability to be provided by people who are trained in Disability. It is unreasonable to expect that a person suffering a health related issue such as an ankle fracture cannot be supported by their principal provider / therapist who knows the person best. Again a true Local Area Coordinator should be accessible and able to assess the persons immediate need and respond with delegated authority to approve additional funding. NOTE – This would also solve the current SA issue of hospital beds being held by NDIS particpants awaiting accommodation or change of circumstance funding processes and stop the building of hospital wards to fill with people who are not truly SA health patients but find themselves in SA Health system as a 'service of last resort'.**

Additional points from consultations with other Providers

31. Experienced provider estimates that split families rate is higher (potentially double normal statistic) in the disability sector and this raises issues for "duplication of supports". NDIS needs to understand that equipment may need to be provided for multiple residences for a child participant and also modifications to vehicles may be required to more than one vehicle as it unreasonable to expect that one guardian would have to take all transport responsibility.
Solution – **Assess causes of stress for families supporting people with a disability. NDIS to appreciate living arrangements of the individual and that duplication of supports may be reasonable and necessary.**

32. Previous system was a "wrap around" system which meant that family issues were addressed with Social work and Psych. Current system is participant / child focussed and can ignore the needs of families / parents.

Solution – **A true Local Area Coordinator Model like a Case Worker or Key Worker with adequate funding to properly engage a multidisciplinary team. NDIS and States need to assess what was provided prior to NDIS transition and compare with what is provided now and test whether it meets the "no worse off" clause of the Act.**

33. Interface with Health has been stated as an issue but also the interface with education and DCP and Housing has ongoing and exacerbated issues as a result of the NDIS.
Solution – **NDIA need to review issues of responsibility and barriers created by jurisdiction arguments and eliminate these through proper agreement and management.**

34. Old systems created Capacity Building – NDIS creates Dependence. One provider feels that limitations in funding previously promoted maximising building capacity around the person whereas a fiscal system flooding the market in some areas creates dependence and increased use of therapy hours.
Solution – **Unsure – NDIA have been fiscally reckless in many cases potentially in order to help transition and acceptance of the scheme and then have to find ways to limit funding in subsequent plans. Research of overall Plan trends for cohorts should be published.**

35. State V Federal funding responsibility conflicts. Example Housing HSA refuses to do home mods as "it is a disability issue". Before NDIS some mods ok but now it is a problem with changes noted 6-12 months ago. Provider believes that HSA has obligation as does Education DECD to provide Disability specific access / needs and it is not necessarily a NDIS responsibility.

Solution – **Age old problem when more than one person responsible – similar is happening even within people's Plans with lots of inefficiencies and duplication of roles with Support Coordinators, Plan managers, Planners, LAC's, SSC's, Therapists, Nominees, Providers. Often lots of talk and no action. Key solution is accountability and responsibility – a team decision and action list that is minuted. A Key person (LAC) who holds responsibility.**

NDIS should not continue to state its goal is to make Disability Funding Affordable or the Scheme affordable. The NDIS Act should be ensure that a Reasonable and Necessary Support system is fully Funded.

Alister Morton

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