CONSULTATION RESPONSE

Allied Health Professions Australia

Joint Standing Committee on the National Disability Insurance Scheme Inquiry into NDIS Planning

September 2019

Allied Health Professions Australia (AHPA) welcomes the opportunity to provide feedback to the Joint Standing Committee on the National Disability Insurance Scheme (NDIS) inquiry into NDIS Planning. We represent 20 national allied health associations and collectively work on behalf of their 120,000 allied health profession members. Many of those allied health professionals are involved in providing services to people with disability, people who may or may not be participants in the National Disability Insurance Scheme (NDIS). AHPA and its member associations are committed to ensuring that all Australians, regardless of disability, can access safe, evidence-based services to assist them to realise their potential for physical, social, emotional and intellectual development.

This submission has been developed in consultation with AHPA's allied health association members. We encourage the Committee to carefully review individual responses from AHPA members for more specific examples and profession-specific feedback.

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Introduction

Allied Health Professions Australia (AHPA) and its member associations represent an important part of the workforce involved in providing support to people with disability in Australia. That workforce has experienced significant challenges as a result of the introduction of the National Disability Insurance Scheme (NDIS), many of which relate to the planning process. While the sector has welcomed the introduction of the scheme and seen significant improvements for many participants, the planning process remains an area of significant anxiety and is the greatest contributor to negative views of the scheme for participants and providers.

AHPA and its members recognise that the NDIS is still maturing and that the rapid pace of change is a major challenge for the NDIA and its planner workforce. Individual allied health providers and the allied health peak associations have consistently sought to understand the planning process and how best to engage with it in a constructive and collaborative manner. However, these efforts have been hampered by a seeming lack of transparency in terms of NDIA processes as they relate to the planning process and the training and guidance provided to planners as well as a general lack of willingness to engage with the sector formally around planning issues.

The combination of significant variation in the training and experience of different planners, as well as a lack of clarity about the position taken by the NDIA on some issues, means identifying causes can be very difficult. Feedback from members suggests that the planning process can work very effectively with genuine participant-driven planning, strong provider involvement, and plans that accurately reflect the choices and needs of the participant. Unfortunately, feedback suggests the converse is also often true and it is difficult to determine which factors contribute to that variance. The impact of staffing caps has been highlighted by numerous commentators and almost certainly plays a significant role in putting pressure on the planning workforce. Similarly, the role of experience and knowledge of the disability sector cannot be understated. But it also appears clear that the NDIA is at times implementing policy decisions in the background, which play out through the planning process, without communicating to the sector about those or how they might impact on planning processes and outcomes.

AHPA and its members have sought to engage with the NDIA to better understand and contribute to improvements in the planning process. However, despite meetings with senior executives and with the Technical Advisory Team, there has been no constructive engagement with the allied health sector in relation to planning. This stands in stark contrast to the approach taken by other parts of the NDIA in engaging with AHPA and its members in a range of areas such as pricing and provider policy. That engagement has been a major factor in easing concerns and smoothing the transition in those areas for providers. AHPA strongly argues that the NDIA's planning division will not achieve significant improvements without a more transparent and collaborative approach to working with consumers and providers.

Commentary to the terms of reference

AHPA has sought to keep its responses to this round of consultation short but encourages the Committee to engage with AHPA and AHPA's member associations further on any of the issues outlined in this submission or those provided individually by member associations.

a. the experience, expertise and qualifications of planners;

AHPA understands from ongoing member feedback that there is significant variation in the experience, expertise and qualifications of planners. It is clear from the reported experience of allied health disability providers that there are very real differences in how well individual planners are able to understand the needs of individual participants. It is also clear that the extent to which planners sufficiently understand the disability sector and the individual roles and contributions of different allied health professions varies with direct consequences to the accessibility of those services in participant plans. It is our understanding that these knowledge and experience issues are further exacerbated by significant turnover in the planning space. If there is indeed a lack of stability in the workforce, then this significantly impacts the ability of planners to gain knowledge and experience on the job and the likelihood of a maturing workforce that will have the necessary experience and knowledge to support a rigorous planning process. AHPA also understands from meetings with the NDIA that the training provided to planners on commencement of their roles has varied significantly over time. While we welcome work to improve planner training, we're not aware of specific measures to address differences in training and drive greater consistency across the workforce. Nor is it clear that issues that are reported up via various mechanisms are translating into upskilling of the planning workforce.

The consequences of these gaps have been well-identified through a range of reviews and inquiries, namely significant inconsistency in plan budgets, interpretation of eligibility guidelines, decisions about levels and types of service to fund, decisions about appropriate assistive technology to fund and more. AHPA members report significant variability even within individual regions with NDIS providers having widely varying outcomes for participant clients with similar needs and goals. Issues are often exacerbated during times of change such as when new price guides come into effect, suggesting that internal change management processes are not yet working effectively enough.

From our perspective, the planning role is one that requires not only a sophisticated understanding of the needs of the person with disability but also a strong understanding of the broader disability sector. This includes a strong understanding of the roles and potential contributions of a broad range of supports such as allied health professionals, the impact of different types of intervention, the role of assistive technology and more.

We argue that it will be difficult for any planner to have sufficient knowledge and experience across all areas of disability but that a strong foundation of appropriate experience, or appropriate clinical expertise through an allied health or other appropriate health qualification, provides the necessary basis for planners to build on. One of our key concerns is ensuring that planners can recognise the gaps in their own knowledge and know when they need to seek additional information through

more collaborative engagement with participants and providers, and through engagement with internal support structures such as the NDIA's Technical Advisory Team. AHPA argues that there needs to be a consistent minimum requirement of qualification or appropriate experience in disability and/or allied health.

AHPA also argues that with the complexity of different types of disability, different support types, and areas such as assistive technology it may be most appropriate to develop greater specialisation within planner teams and to allocate planning work based on that expertise. AHPA argues that the Technical Advisory Team does not adequately address gaps in planner knowledge, particularly given that use of the service is voluntary. While specialisation of planners alone won't address all issues, and while it may be more difficult for regional teams to build expertise across different areas, it would potentially be a means of supporting planners to develop appropriate expertise.

One of the greatest areas of concern for AHPA and its members is what we understand to be a deliberate intention to close off the planner workforce from engagement with the allied health sector. From our perspective, there could be major benefits to more systematic engagement with providers, both on an individual level by planners, but also on a system level in terms of the NDIA working with the provider sector on opportunities to skill up the planner workforce. While the NDIA has clearly recognised the need to provide more rigorous training to planners, and has expanded the introductory training it provides, it is not yet clear that this will address knowledge gaps sufficiently, nor how current planners with lesser training will be brought up to an equivalent level of knowledge. A range of AHPA member associations have approached the NDIA with the offer of providing webinars or other written information about their individual profession and their role in supporting people with disability. This has so far not been taken up by the NDIA, despite being a significant opportunity to work more collaboratively. Instead feedback has stated that NDIA policy is that planners can only utilise resources developed internally.

Recommendations:

1. **Set minimum standards for disability experience for planner roles either based on relevant allied health qualifications or other health qualifications or equivalent work experience in the sector.**
2. **Increase planner specialisation within planning teams to allow for subject experts.**
3. **Work with allied health and other professional groups to develop co-designed training and support resources.**

b. the ability of planners to understand and address complex needs;

AHPA argues that planners do not consistently have the experience and expertise to understand and address complex needs. AHPA has noted above the challenge of ensuring planners have sufficient experience and knowledge to deal with the broad range of support needs that they may encounter. This is exacerbated where planners are working in smaller teams and more regional locations, where there may be less capacity for particular planners to develop additional expertise in particular areas and to either take the lead on planning where that expertise is needed or act as a support and mentor for other planners. As a result, the issues experienced by participants and providers are magnified where participants have more complex needs.

From the perspective of AHPA and its members, there are a range of factors that might contribute to the complexity of an individual participant's needs. These may include more complex disabilities and co-morbidities, complex assistive technology, or the need to understand the intersections with other systems and supports, including mental health issues and psychosocial disorders. AHPA recognises that planners are unlikely to be able to build sufficient expertise in all areas to make the necessary decisions regarding eligibility and supports, particularly where participants have complex needs. While we argue above for greater specialisation, we also argue for processes and guidelines that seek to help planners access professional input and advice when required. We argue that a major missed opportunity is the use of more collaborative processes that draw in participants, planners, and providers. While there are already numerous examples of collaboration between planners, participants and providers, and strong feedback suggesting the benefit of this approach, many planners still reject any involvement of providers or communicate only limited or no information to providers.

The consequence of this gap can be significant for families and participants and may result in lack of access. For example, the distinction between developmental delay and disability in early childhood is clinically complex and not straightforward even for clinicians. The ECEI criteria and its application does not reflect this complexity and requires more sophisticated understanding of early childhood delay and disability than currently exists by those making eligibility decisions.

The current inability of planners to understand and address complex needs is causing delays for participants to access the scheme as their eligibility is being queried and more information is sought, often at the cost of the participant. It may also result in inappropriate levels and types of support being approved. Not only are these consequences stressful for participants and their families but also results in unnecessary appeals.

These issues also impact providers. While the participant is the key focus and their experience is the highest priority, provider sustainability is also crucial and the NDIS should seek to address the significant additional work many providers put in, unfunded, to support participants to access the scheme and to get fit-for-purpose plans as a result of planner issues.

Recommendation:

1. **Develop formal collaborative planning processes that guide planners in how they work with participants and providers as part of the planning process for participants with complex needs.**

c. the ongoing training and professional development of planners;

AHPA argues that a rigorous process of ongoing training and professional development is essential for planners. The planning role itself is critical to the structure and function of the NDIS and as part of a scheme that is still maturing and experiencing significant change, will need to continue to evolve and take on board changes to both policy and other structural changes.

Planners must be up to date with the latest information and interpretations of policy in order to perform their role correctly. This requires a strong internal focus within the NDIA on managing change and continuously re-training planners in response to change and the identification of issues.

This process is currently not working effectively and AHPA members report significant delays in planners understanding the implications of changes, such as changes to price guides and access to Assistive Technology (AT). While some delay is perhaps understandable due to the rate of change in the scheme, reports from members that engagement with the NDIA around incorrect decisions and interpretations is dismissed is extremely concerning. It is not clear that the NDIA has appropriate change management processes or sees that issues areas need to be addressed across its planner workforce.

AHPA argues for the need to build mechanisms to allow participants and providers to flag issues they are seeing with planner knowledge and understanding and for this to be addressed by ongoing training and development. This should not be seen as a formal complaint or means of sanctioning a planner, but rather a means of helping to address the high level of inconsistency that providers experience. For the allied health sector, there are numerous examples of ongoing issues related to incomplete planner knowledge. AHPA members consistently report uncertainty about the role of different allied health professions with the consequence that participants may have requested supports rejected despite those supports being reasonable and necessary.

This particularly impacts professions such as art and music therapy. Issues also frequently arise in relation to provision of assistive technology. Orthotist/prosthetists also frequently report issues whereby some planners do not sufficiently understand the funding of this role and the need to include funding for both the assistive technology and for the clinical work involved in assessing, fitting and reviewing a prosthesis.

A mechanism for providers to flag these issues and internal mechanisms to determine whether further training is required, and if this is individual training or an issue that applies to a larger cohort of trainers, would allow the NDIA to more effectively address issues in the planning process and reduce future unscheduled plan reviews. Making this a more transparent process with reporting on the issues that are raised, and the mitigation strategies being applied by the NDIA, would go a long way to increasing confidence in the planner workforce and the NDIA's commitment to an effective, consistent, equitable planning process. AHPA notes that this should not necessarily require participant involvement as it is not about the content of a particular plan, but rather a means of addressing what have been identified as knowledge and expertise gaps.

We argue that ongoing training and development should not only be seen from the perspective of maturing the workforce and managing change, but also as a means of addressing gaps in the existing workforce including differences in the level of training provided. The planner workforce should be nationally consistent and this requires a range of strategies including retention strategies. The workforce must be as stable as possible and effort should be made to ensure not only that the right staff are hired, but also that the right systems and supports are in place to support staff retention. Our view is that a stable workforce is needed to ensure that knowledge and expertise are developed through on the job experience.

Recommendation:

1. **Training and professional development must be a key aspect of employment for planners and should be nationally consistent.**

2. **Training and development should be more collaborative with stakeholders outside the NDIA including participants and peak associations.**
3. **Systems should be developed to allow planner issues to be reported and translated into training and development.**

d. the overall number of planners relative to the demand for plans;

AHPA does not have sufficient knowledge of workforce numbers or ratios to comment on the number of planners relative to demand. However, we are aware of long delays experienced by many participants both at the planning stage, and at the plan review stage. This suggests that there may be staffing issues impacting the planning process. AHPA is also aware that, at least in some regions, local area coordinators (LACs) are taking on an expanded role to address what appears to be lack of access to planners. Feedback from members suggests that there are cases where the pressure on planners is resulting in LACs taking on much of the planning role and planners being relegated to a rubber-stamping role. This appears to have the effect of exacerbating issues around planner knowledge and consistency.

Recommendation:

1. **That government review NDIA data to determine if there are staffing issues limiting the number of planners relative to the demand for plans. If this is the case, we argue that government should relax staffing caps.**

e. participant involvement in planning processes and the efficacy of introducing draft plans;

AHPA strongly argues for greater involvement of participants in the planning process, noting the need to ensure participants and families have the skills, knowledge, and access to information, to do so effectively. AHPA recognises the key role that participant support organisations and advocates need to play. However we also argue that provider involvement should be considered on a more formal basis, noting the significant role providers can play in supporting participants and planners to develop the most appropriate plans. AHPA argues that a more in-depth planning process, with greater participant involvement, may address some of the issues participants experience with first plans including underutilisation of supports. More participant involvement in the development of the plan, with a greater focus on supporting the participant and any family supports to understand the planning process and the options available to them, could improve the quality of those plans.

AHPA members report that the planning process is undermined by significant communication issues between participants, providers and the NDIA that result in poorer outcomes for participants and increased work for providers. The current process appears to somewhat artificially separate the provider from the planning process, despite the role they may play in supporting families to understand and navigate the system. While it may not be appropriate to involve every provider, and there is some need to ensure that there are appropriate checks and balances to address conflicts of

interest, the involvement of allied health professionals in collaborative planning with participants and planners is something that should be sought wherever possible and appropriate.

AHPA strongly supports the re-introduction of draft plans. AHPA is aware of numerous examples of errors in plans that resulted in the need for plan reviews and which could have been more effectively addressed through the use of draft plans. This could significantly reduce the volume of plan reviews resulting from plans not resembling the identified needs of participants and their families. AHPA also argues that it would be appropriate to allow participants to nominate a support person, including a provider, as not every participant is able to review a plan appropriately. We also note that a more collaborative process may involve providers having a role in reviewing draft plans, particularly in more complex areas such as in relation to assistive technology with significant benefits in reducing the incidence of planning errors.

Recommendation:

1. **Increase participant involvement in planning processes with a focus on increasing knowledge and understanding of participants and their family members.**
2. **Introduce more collaborative planning processes that involve appropriate providers.**
3. **Re-introduce draft plans.**

f. the incidence, severity and impact of plan gaps;

While AHPA does not have quantitative data on the incidence and severity of plan gaps, we frequently receive feedback from members about situations where this is occurring. That feedback seems to suggest that these are occurring through the decision-making of individual planners, without a clear foundation, and which appear to be avoidable by putting in place more rigorous, and transparent, decision-making processes. AHPA members frequently report instances where services requested by participants, and supported by providers as necessary, are either knocked back entirely or only partially funded.

This is highly concerning because it appears to be done on what seems to be an arbitrary basis, in some cases only on the opinion of the planner, and in clear contradiction of what we consider to be expert recommendation. We also note that these issues have been reported by other organisations and groups such as the Office of the Public Advocate's 2018 'Illusion of choice and control' report. These types of gaps between what is requested and what is provided can occur in a broad range of ways. Some of the key examples encountered most frequently are:

- Replacement of one type of service with a lower-priced version. Examples may be choosing to fund personal training services rather than exercise physiology, or choosing group art or music classes over music or art therapy provided by a qualified therapist.
- Partial funding or funding of lower-priced assistive technology.

While AHPA acknowledges that there may be situations where a second opinion is appropriate if the planner has concerns about the recommendation of a provider, we do not believe that a planner should override expert recommendations without the necessary knowledge and expertise to do so.

These issues appear to be driven primarily by a focus on cost-cutting and AHPA questions whether planners are too focused on scheme sustainability and not sufficiently on the needs of participants.

Recommendation:

1. **Review the basis on which planners can reject participant and provider recommendations and develop more transparent and rigorous decision-making processes. These should include the requirement for clear advice from planners as to why a request has been rejected.**

g. the reassessment process, including the incidence and impact of funding changes;

AHPA understands that the reassessment process primarily applies to children as they shift from being eligible for ECEI services to being assessed for access to the mainstream NDIS. Those with developmental delay often must go through a reassessment process to, in effect, 'prove' that they have a long term/permanent disability. This is an unnecessary and stressful process as families face the possibility of being told that their child is ineligible for the scheme and that their funding and support will therefore cease. It is a similar situation for children who have been given an initial short-term NDIS plan for six months, as the NDIA effectively waits to see if the child is still considered eligible (i.e. they 'still have a disability') six months later.

The impact of funding changes can be significant for families deemed ineligible for mainstream NDIS funding. The transition to the NDIS has had a major impact on the availability of services outside the scheme and families may no longer have the same access to services that they previously did under states and territory funding. The loss of services can have a significant detrimental impact on families as well as impacting the development of their children with disability. AHPA argues that further work should be undertaken to identify better processes for assessing and discharging participants from the scheme, with a focus on connecting participants and their families to other services and support mechanisms.

Recommendation:

1. **Review assessment and discharge processes and mechanisms for smoothing the transition from NDIS funding to non-NDIS services.**

h. the review process and means to streamline it;

AHPA argues that the review process is currently not working well. Scheduled reviews are not being held on time and a number of members have reported that review meetings are being held much earlier than appropriate. This can have a significant impact on the effectiveness of reviews as interventions may not be far enough progressed to allow appropriate planning decisions to be made. The variable timing of review meetings suggests that there may be staffing or other issues impacting this process.

AHPA argues that there may be a benefit in reviewing whether all plans require the same review process and whether plans with only minimal or no changes could go through a lower level review process. AHPA also argues that it may be appropriate to consider certain appeals as higher priority and develop a process for these plans. A key example of this is the impact of the new NDIS Quality and Safeguarding Commission registration process. Under the new Commission rules, some practices are now identified as restrictive and require changes to be made and positive behaviour support plans developed. These need to be undertaken quickly to support the wellbeing of both the participant and the providers supporting them, however the current review process is slow and unwieldy.

Recommendation:

1. **Undertake work to test the feasibility of multiple plan review processes based on a risk stratification of plans.**

i. the incidence of appeals to the AAT and possible measures to reduce the number;

AHPA recognises that some Administrative Appeals Tribunal appeals are necessary and part of interpreting the boundaries of the NDIS. However, we argue that the largest driver of appeals is a planning process that is insufficiently collaborative and subject to the gaps in knowledge and expertise of planners as well as an unhealthy focus at planner level on scheme sustainability. We argue that the strategies outlined previously are likely to have a significant impact on rates of appeals, however we also argue that a cultural shift is required that starts with the needs of participants and prioritises this over sustainability concerns. While we recognise and support the need for the NDIS to be managed sustainably, we are concerned that if the focus is on cost minimisation over achievement of goals, it will reduce opportunities to improve the lives of people with disability and their ability to access and participate in the community and in employment. It may also miss opportunities to reduce longer-term scheme costs through increased independence.

j. the circumstances in which plans could be automatically rolled over k. the circumstances in which longer plans could be introduced

AHPA argues that for many people with disability, significant aspects of their support needs are likely to remain largely stable. We also argue that it is possible to identify key points at which changes are likely to be required—for example at key developmental stages, when assistive technology needs replacement, or when there are significant changes in functionality. AHPA argues that work should be undertaken by the NDIA to identify participants profiles where plans changes are minimal from year to year and to test whether an automatic rollover or longer plan could be implemented. As an alternative to a full roll-over process, the 'light-touch' planning process, where it is being used is an alternative that is significantly speeding up throughput and reducing the need for full planning meeting.

In either case, AHPA argues that it will be necessary to allow plan review processes to be triggered in a timely fashion by participants if needed. This is essential to ensure that as the scheme becomes more efficient, this process does not result in participants being restricted by plans that no longer meet their needs or if there are unexpected changes in their function or equipment needs. A streamlined plan rollover/longer plan approach and/or light touch planning process should free up resources to ensure more timely plan reviews.

Recommendations:

1. **Undertake a review of the extent to which current participant plans are changing year on year to determine where there may be participants whose needs remain consistent.**
2. **Pilot automatic rollover and longer plan approaches for willing participants to determine the viability of this approach.**

l. the adequacy of the planning process for rural and regional participants;

AHPA understands that the issues experienced by rural and regional participants largely reflect the issues experienced by participants more broadly. However, in many cases they are exacerbated through issues such as smaller and less experienced planner teams. In addition, feedback from members suggests that rural and regional participants are far more likely to be dependent on phone-based planning. The issues with this approach have been previously identified and AHPA argues that strategies should be introduced to reduce reliance on phone-based interviews.

AHPA has also had feedback to suggest that planning processes for rural and regional participants are sometimes based on available services rather than participants needs and goals. While we understand the need for a pragmatic approach, we also argue for the need to develop service offerings in regional and remote regions. If these service needs are not identified by the planning process, then it is difficult to build the case for market development.

AHPA also notes that access to the NDIS may be dependent on assessments from a range of health professionals and this is likely to be self-funded by the participant and their family. While this issue is one experienced by participants regardless of where they live, it is exacerbated in areas where incomes are likely to be lower and where access to services is both more limited and more expensive due to the need to travel to find appropriate practitioners.

Recommendation:

1. **Review if rural participants are more likely to depend on phone-based planning and if there are alternative approaches that could be implemented.**
2. **Undertake benchmarking of plans for similar participant profiles across different Modified Monash regions to better understand the impact of existing markets and service access on planning.**