
National Disability Insurance Scheme Consultations

Consultation 1 | Access and Eligibility Policy for independent assessments

Consultation 2 | Planning policy for personalised budgets and plan flexibility

Consultation 3 | Supporting young children and their families early, to reach their full potential

Submission by the
Australian Physiotherapy Association

February 2021

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Executive Summary

Introduction

The Australian Physiotherapy Association (APA) welcomes the opportunity to make a submission to the National Disability Insurance Agency (NDIA) against its most recent reform series and related suite of discussion papers in supporting the Government's efforts to making the National Disability Insurance Scheme (NDIS) simpler, faster, fairer and more flexible.

The NDIA's discussion papers provide important directions about independent assessments, planning and plan flexibility, and early intervention services. However, in realising its potential, it is our view that the three policy shifts outlined hold little promise in restoring the Scheme to its original policy intent. While important gains have been made, what is lacking in these proposals is empathy in policy design, and in truly valuing those for whom these policies are built. The core aim should be to build the connections to support people to grow and thrive.

Consultation 1 | Independent Assessment

In seeking to establish the best policy outcomes in regard to access and eligibility for Independent Assessment (IA) in Consultation 1, we must ensure the required clinical expertise is utilised in making assessments, including valuing the existing providers input. We must avoid narrowing policy aims to an extent that it disempowers and removes choice and control for the individual. The context-specific challenges need to be prioritised in policy to reflect the complexity, and changing and evolving nature of a person's functional impacts from their disability.

Overall, the policy directions as outlined lack empathy in policy design. The strong policy basis for person-centred approaches to care is lost in this approach. The further need to ensure a strong degree of social participation for people with disabilities and for giving them much greater capacity to exert power has been significantly diminished. Further, there is no evidence base for IA – it is an assessment that is not indicative of function over time, of disability history or nuanced to address fluctuations in daily needs.

The IA should be optional for access to the NDIS and not mandatory. Participants should have the right to choose. The IA tool is also somewhat of a blunt instrument. It lacks sensitivity about a participant's potential. We are concerned that it does not recognise future gains, prognosis and capacity building potential. We see capacity building, in building independence and skills, is where opportunities lie and where significant gains can be found through the right allied health inputs.

The experience of people with disabilities needs much more policy attention. Retelling stories and experiences, especially to strangers, can be traumatic. The IA potentially 'locks out' the trusted professional, such as the treating physiotherapist. An ongoing and trusting relationship with a physiotherapist (or other professional) is critical. The loss of trust and continuity is not in the patient/client's interest, or conducive to trusting, continuous care.

The workforce implications are also significant. The current provider market is 'thin', meaning that the IA workforce will likely be recruiting from an underskilled market. This will leave gaps in workforce cover in all locations, especially rural, regional and very remote.

Consultation 2 | Personalised budgets and plan flexibility

The reforms outlined to strengthen personalised budgets and plan flexibility in Consultation 2 also outlines some significant policy shifts. The NDIS needs to work for everyone now, and into the

future. Key to making this work is the need to ensure participants in the Scheme are able to use their funding more flexibly. Typically, support budgets are a retrograde measure that do not enhance choice and control for those in the NDIS, and their families. Individual needs should be funded as the Scheme intended.

The policy focus needs to be on ensuring the transparency of budget development and facilitating improved communication and interaction between planners, participants and providers. There are significant policy risks in an approach that allows a periodic release of funds in terms of ensuring policy responsiveness to the fluctuating needs of people with disability. Further, ensuring a skilled workforce with appropriate qualifications and training of planners will need to be prioritised and in place early to implement the new model.

Consultation 3 | Early Childhood Early Intervention (ECEI)

In response to the policies proposed in supporting young children and their families in Consultation 3, generally, our members support increasing the age of ECEI from under 7 to under 9. It is vital that supports are offered early and are specifically tailored to meet individual needs of children. However, a policy emphasis on an age point is inherently negative and serves only as a signal to families of a looming significant funding cut.

While it is acknowledged that the ECEI approach was designed to be a 'gateway' to the Scheme, we feel this weakens the policy intent. Specifically, it diminishes the core aim to ensure quick access to support that is tailored to their individual needs and circumstances. This requires some flexibility, particularly to ensure we can respond those children who actually warrant an increase in funding supports at those critical age points.

The APA does support a shift in the Early Childhood Early Intervention provider marketplace towards the use of registered providers. However, this will require significant reform to the *NDIS Practice Standards on Early Childhood Supports* to make this viable for the current provider marketplace. The APA supports a provider registration process which recognises the current requirements of allied health providers in maintaining their AHPRA registration and the professional Codes of Conduct by which we are bound.

It is important that the focus remains on a quality registration system which protects some of the most vulnerable people in Australia. This requires a commitment towards a stronger clinical framework and focus on the significant reform required to the current standards. It is vital that this reform includes the removal of the financial and resource barriers when becoming a Registered Provider to ensure marketplace viability.

Conclusion

The APA acknowledges the challenges and complexities in designing services to suit the diverse range of needs of those with disability. As you finalise and set the final design parameters on these important program parts, we would welcome the opportunity to meet with you to discuss our concerns.

A simpler, faster, fairer and more flexible Scheme cannot be realised through the measures proposed here. The policies, as outlined, hold the potential to undermine the achievements in getting to this critical point in the reform process. Unfortunately, from our profession's perspective, these latest policy parts do not provide the landmark reforms needed to deliver on the promise of Australia's NDIS.

Introduction

The Australian Physiotherapy Association (APA) welcomes this opportunity to make a submission to the National Disability Insurance Agency (NDIA), across the three consultation areas in setting policies about independent assessments, personalised budgets and plan flexibility, and Early Childhood Early Intervention, on behalf of the physiotherapy profession.

Physiotherapists are movement and participation experts in disability who specialise in improving function, participation and building capacity. Physiotherapists are committed to providing expert, evidence-based, safe and high-quality care to people with disability and contributing to an effective and equitable disability sector.

The APA has approached each of the consultation parts addressing the questions in the one submission.

Consultation Paper 1: Access and Eligibility Policy for independent assessments

APA Position

The APA **does not support** the parameters currently set against the access and eligibility policy for independent assessments.

Introduction

In the consultation paper, the drivers for change are outlined as a need to ensure transparency and further need to reduce the potential for “sympathy bias”. The complexities for the NDIA in terms of the variability of the information currently collected is well understood. However, this change represents a significant and unjustified policy shift.

A number of our concerns fall outside of the issues raised from within the consultation questions. In an effort to support the NDIA in its further policy development post-consultation, in shaping a more viable policy solution, we have offered additional advice against general comments subsections (i) to (vi) immediately below.

General comments

- Alternate policy choices

The APA considers a more viable and less costly policy solution to the NDIS employing their own “independent assessors” to complete standardised assessment would be to appropriately support existing processes. Efficiencies and improvements can be found through some simple policy fixes. The first relates to addressing the cost barriers for people with disability to access the Scheme. Eligibility has been difficult for many due to demand or cost barriers in relation to the functional assessments often requested by the Agency. Improvements can also be made through the redesign of templates to ensure ample space for an appropriately detailed response and the provision of clear guidance to what is required.

- Functional capacity and IA toolkit

A simple policy shift to provide a definition for “functional capacity” and guidance about making these judgements would help to address inconsistencies and issues of perceived or real bias. Further guidance to allied health professionals supporting people with assessments and reports

with what standardised tools and information are required. This is essential information and this detail has not been published until recently with the release of the IA toolkit in 2020.

It is also important to acknowledge the limitations of tools to measure functional capacity in a disability. There is no evidence to support the suite of assessments in the toolkit to provide the standardised assessment. WHODAS to assess functional disability has limitations in its single time lens and inability to capture capacity and fluctuations over time. It lacks detail on self-care and associated reliability issues of scores. It also lacks measurement around capacity or barriers to a number of tasks. In terms of psychosocial disability, the chosen tools have not been validated in these disability populations. For example, the Vineland assessment instrument has not been validated. A key concern is that the tools have assessment bias towards a “by proxy”.

- Valuing the individual

We consider the disruption imposed as significant for the individual. People with disability, and their families/carers need to continue to be treated and managed by their trusted health professional. This toolkit will allow a stranger, unknown to the person and their family, to take over, locking out their practitioner of choice. Challenging behaviours can be dangerous for new providers, as well as cause unnecessary anxiety and stress for those in the Scheme.

Access remains key as these changes will impose significant barriers for some, particularly in terms of pre-access where there are shifts in eligibility. Assessments used decisions for “access” and “planning” should be considered separately; and therefore different information provided for planning meetings, due to different requirements in the legislation (i.e. access criteria vs reasonable and necessary criteria for planning and funded supports).

- Valuing expertise

A key concern also relates to ensuring the required expertise in making assessments and the ability to further leveraging that expertise beyond the initial assessment. We note that the independent assessment will be completed by a qualified health professional. Given the responsibility of the task, it is essential that a qualified health profession is also AHPRA registered.

We support the policy shift in terms of the focus on function rather than diagnosis. However, we have concerns regarding the ability of the Independent Assessment (IA) to truly demonstrate the needs of a person with disability. In particular, we are concerned that the knowledge, expertise and experience of providers who may have worked with a participant for some time will not be taken into consideration when developing a plan. The continued use of IA for plan review rather than regular providers is also problematic.

- Workforce implications

In order to provide a meaningful assessment and information to NDIA delegate the IA will need to have extensive experience working with people with similar type of disability in the community and be familiar with common functional issues. As there are a wide range of disability types, it will be difficult to build a comprehensive workforce to meet this need in the geographical area. This workforce would compromise already thin markets and providers available to support people with their actual needs. This new system will undoubtedly take away from available therapists to support people with disability.

- Addressing bias

The core issue around bias, perceived or otherwise, which is driving this change, lacks evidence. Registered providers have significant practice standards that they have to adhere to and be audited to. It is inappropriate to not consider registered providers of a standard to not be in a

position to conduct assessments and provide reports of a participants needs objectively, ethically and within and evidence based context.

While we understand IA may provide some protection from providers who are taking advantage of participants and acting unethically to promote excess therapy recommendations, we believe this group is the minority among our profession. Further, the APA is concerned that 'sympathy' bias stated in reports could be far outweighed by reporter bias of person or family desperate to access NDIS funding, with the possibility of false or misleading information being provided around functional capacity.

Consultation response

Policy directions | **Learning about the NDIS**

Q1. What will people who apply for the NDIS need to know about the independent assessments process? How this information is best provided?

It will be important to set out the basic process for applicants. This would need to include advice as to why the IA is necessary. Further detail would include who the assessor will be – their organisation and profession assigned. Further background, knowledge and skill areas as well as their baseline level of experience will be key.

Full disclosure around what information the assessor will take into account will be also be important. How other evidence from existing supports and providers will be considered. Information should be provided clearly and transparently in application process, website or Local Area Coordination (LAC) making the applicant aware of necessary information. Information will need to be provided in multiple formats – paper, electronic, briefing meeting.

From a process perspective, it is noted that Independent Assessment may deem no longer requires NDIS. Therefore, the frequency of the assessments and what triggers re-assessment should be disclosed. There is inherent risks if based on one assessment particularly in terms of negating symptom or disability emphasising as well as those who present of good or bad days.

Policy directions | **Accessing the NDIS**

Q2. What should we consider in removing the access lists?

Differentiating between primary and secondary disabilities is key. Education, experience and training of planners in regards to conditions. Removing lists may impair clarity of access for some. Perception of disability varies between public, health and medical professionals. There is risk that this will increase confusion as to who can access NDIS funding.

Q3. How can we clarify evidence requirements from health professionals about a person's disability and whether or not it is, or is likely to be, permanent and life long?

There will be a need for clear transparent information that is freely available and disseminated to health practitioners and updated regularly as necessary. This should include a list of health professionals able to make claims of permanence. To ensure consistency, there should be a form to complete which defines permanence, disability and functional impacts. Many conditions are lifelong or chronic, but function and disability can increase or decrease. For example, sometimes permanence is uncertain in the case of post-stroke. In this case, NDIS funding should be available in the sub-acute phase post stroke in the hope that reliance on support may reduce and cease all together depending on recovery.

Q4. How should we make the distinction between disability and chronic, acute or palliative health conditions clearer?

An important policy consideration would be to reconsider making the distinction of disability and chronic conditions. However, this is problematic as there is not always a clear distinction between some of these conditions as often disability and chronic and acute health conditions are interwoven and closely linked. There are many health conditions that cause disability and significant functional impairments and reliance on supports and services.

A lack of integration of the health system also has impacts; many people with chronic health conditions are unable to access the necessary supports. The distinction between health conditions and disability often results in people having to access a multitude of health professionals rather than being able to make the choice of one. Addressing services barriers and gaps is important in ensuring appropriate care. Utilisation of funds to access therapy services in particular that cannot be provided by the health system should be an option for participants. Service and deficits are unpacked further in Table 1 below.

There is enormous pressure of health professionals to make decisions on permanency of level of disability within the first six months of diagnosis. One of the bigger problems health care professionals face is determining what AT is required early into a person's recovery. As hiring equipment isn't deemed economically viable, we are faced with prognosticating recovery and forced into decisions around whether or not expensive AT is required. Efficiencies can be found by way of equipment loan, which occurs with the Medical Aids Subsidy Scheme (MASS) Palliative Care Equipment Program (PCEP) in Queensland. Equipment should be considered a loan and then returned to NDIS if no longer required.

Table 1 | Deficits in supports against condition

| | |
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| Cystic Fibrosis | Cystic Fibrosis requires significant amounts of physiotherapy and there is very limited funding for this population to access services outside of hospital services. |
| Ehlers Danlos | Ehlers Danlos is another condition that is permanent that is often not recognised as a disability. The impact of these conditions can vary significantly much the same as some of the conditions that are automatically assumed as eligible disabilities for NDIS. |
| Developmental Co-ordination | Developmental Co-ordination is not readily recognised by the NDIA as a lifelong condition, which is not in line with current evidence. |

Policy directions | **Undertaking an independent assessment**

Q5. What are the traits and skills that you most want in an assessor?

Specialist training and clinical experience working within the area of disability is key. In particular "health professionals" is a very wide term. It will be important to set parameters around how many years of training and experience will be required. The individual should be AHPRA registered of at least three years with continuing clinical experience.

Workforce supply issues remain a concern and we would recommend a transition period. The recruitment process will need time to recruit independent assessors who have the specialist skills to complete an independent assessment.

It is important to acknowledge the specialised skillsets required. This is a difficult and complex decision that will have a significant impact on people's lives. For example, a musculoskeletal physiotherapist who has multiple years of experience working within their field but has limited experience of clients who might have mental health or neurological conditions may not be appropriate for assessing clients with these conditions. In order to obtain fairness, we would recommend that the NDIA considers the use of a panel of assessors to bring the required skill depth to each issue.

In terms of practical skills, familiarity and training with tools and extensive training in application of assessments will be important. The ability to implement a standardised assessment tool and adapt this to a person with disability without compromising the assessment results is essential.

Q6. What makes this process the most accessible that it can be? For example, is it by holding the assessment in your home?

At home or in local community. This depends on the area and region that a client lives, services available and what is the most efficient way of completing the assessments. Telehealth options or remote access may need to be considered. It would be preferable for the assessment to be provided by a local organisation.

Q7. How can we ensure independent assessments are delivered in a way that considers and promotes cultural safety and inclusion?

Assessors should be trained in culturally safe practices. Interpreters must be available, and allow for advocates to be present. Feedback from participants can assess the delivery of culturally safe practices.

Policy directions | **Exemptions**

Q8. What are the limited circumstances which may lead to a person not needing to complete an independent assessment?

The IA should be optional for access to the NDIS and not mandatory. Participants should have the right to choose which access path they would like to undertake. The choice for IA or provision of evidence from their regular providers must be made clear. Further, where participants have had strong relationships and evidence of quality outcomes in the past with regular providers, then these assessments should be considered as an alternative to an assessment.

In addition to the above terms of broader exemptions, while we emphasise IA should not be mandatory, we consider that if the assessor has the appropriate skillset, there shouldn't be many circumstances that a person will not be able to complete the assessment. However, areas that could encompass "limited circumstances" could include psychosocial disability that makes the process a significant burden/ stress to the participant.

Policy directions | **Quality assurance**

Q9. How can we best monitor the quality of independent assessments being delivered and ensure the process is meeting participant expectations?

Using registered NDIS providers that are accountable to the NDIS commission would be the key requirement. Regular audit and consultation with participants and care providers is required. This would include regular assessments with two assessors to check inter-rater reliability as well as indicators for assessors to escalate to a panel to discuss more complex cases. Ensuring robust quality assurance mechanisms internally within the IA organisation to

measure their staff performance and provide ongoing support in regards to professional development.

Policy directions | **Communications and accessibility of information**

Q10. How should we provide the assessment results to the person applying for the NDIS?

Multiple modes. Verbal communication in form of a summary assessment. Provide written summary assessment to the participant/family and support team.

Consultation Paper 2: Planning Policy for Personalised Budgets and Plan Flexibility

APA Position

The APA **does not support** the parameters currently set against the planning policy for personalised budgets and plan flexibility.

Introduction

In the consultation paper, the drivers for change are outlined as a need to improve equity and consistency in planning decisions and provide more choice and control for participants. A core objective is to provide for more transparency and address inconsistent and inequitable plan budgeting decisions.

The APA does not consider these proposals will achieve these outcomes. Instead, we see policy design that will remove choice and control as dismissive of the goals and desires of the participant. The NDIS was previously based on individualised funding that was based on the specific support needs of the participants to meet their chosen individualised goals, with a plan customised to meet their needs.

The NDIA proposes typical support packages based on impairments and standardised assessments. The Australian NDIS system was a world leading contemporary funding system designed to empower people to live the lives they choose. This is a significant backwards step, people will now need to modify their supports to fit a standardised amount of funding.

Consultation response

Q1. How should a participant's plan be set out so it's easier to understand? How can we make it easy for participants to understand how their funding can be spent?

Clearer explanations of reasonable and necessary supports that were considered when developing the plan. Breakdown of what decisions have been made in regards to funding allocation. Separation of flexible and fixed with a simplified definition of what that means providing some examples from the IA embedded in the plan.

Q2. How can we support participants to prepare for a planning meeting? What might be needed to support participant decision-making?

Participants should be provided as much notice as possible so that their healthcare providers can provide supporting documentation. We would recommend one month minimum notice as the reports are lengthy and complicated. These would need to be available for a pre-planning meeting. It is important to provide flexibility acknowledging that AT forms may not be completed by time of planning meeting, particularly in the hospital setting, so to allow for estimate around AT cost.

A goal review meeting prior to planning meeting – including helping the clients to problem solve why they did or didn't achieve their goals. The pre-planning meeting might also include discussions around working through how they use their funds, level of supporting documentation, allocation into different pools, unrealistic goal setting – may need more achievable short-term goals toward the longer-term ones. In addition, presenting their challenges and considerations such as what supports may assist them, what are their aspirations, what has worked in the past, what equipment they may need, and any barriers to accessing supports that may affect plan utilisation.

Q3. Which supports should always be in the fixed budget? What principles should apply in determining when supports should be included in the fixed budget?

Flexibility of funds has merit but the measure brings with it uncertainty. There are concerns of moving therapy funding into flexible funding as participants may not understand the importance of capacity building supports and use this funding for other purposes.

Large AT items should sit within fixed funding but there should be enough funding for sufficient modifications to the clients environment, for the client to be as independent (up to fully independent) as they chose to be. This should be put in place regardless of cost, if the Scheme is truly about maximising participation in the community.

Q4. How can we assure participants that their plan budgets are at the right level? (e.g. panels of the Independent Advisory Council that meet every six-months to review learnings and suggest improvements)

A key policy shift is to ensure the continued measurement of plan utilisation and assessment of the barriers to this. Understanding that poor plan utilisation is not indicative of a reduction in budget amount. Having more measurable goals as part of a participants NDIS plan is important. This would be reliant on planners having the skills to be able to set goals with participants. At the moment the qualifications and training of planners is not sufficient to do with people with disability.

Further practical policy considerations in terms of testing plan budgets could include providing a break down example (week or fortnight) demonstrating how the funds within the plan could be used for the recommended supports. This could then be extrapolated for the life of the plan to fully demonstrate or test that the funding is sufficient.

A more sustainable policy option, while difficult to implement initially, would be the trialling of equipment in home environment. For example, test equipment for a period (one month) to ensure scripting is at the correct level. It is challenging for health professionals early in a patients disability journey to prescribe the correct equipment. These are expensive items and currently what is scripted cannot be returned. The MASS system in Queensland is based on equipment loans, this model would work well within the NDIS.

Q5. What new tools and resources should we provide to support people using their plan and new plan flexibilities?

Education relevant to the supports and services that were considered when developing the plan. Use multiple accessible formats for learning including written, animation, short-form, long-form. Ensuring the use of appropriate language resources, such as Auslan, and that content is culturally sensitive.

Q6. What do we need to consider for children aged 7 and above in the new planning process?

Understanding that there can be times of increased needs in and around significant life transitions and development through childhood and adolescents and into adulthood. Having an increased ability to review and adjust support provision.

Q7. What ideas do you have for how people can use their plan more innovatively?

Each patient is unique and individual innovations will factor in a wide range of ways. Flexible funding will help facilitate this, but standardising the level of flexible funding per plan will be the challenge. Price deregulation may increase the ability to access innovation. Promotion of various types of services that can assist people with disability may inspire more innovative approaches.

Q8. How best to handle the timing of the release of funds into plans and rollover of un-used funds?

A percentage base release system could be explored but there are limitations to this approach. The release of funds should be done on an individual basis and similarly for unused funds. A maximum set limit should be implemented to avoid funds being spent in one transaction. This would avoid funds being expended on expensive AT that has not been recommended by a health professional.

There also needs to be a threshold at which more money is released – not a point in time – as needs vary in intensity throughout a plan. Needs can vary throughout the year for children and families may choose certain times of the year to focus on interventions. Families may choose to conduct intensive therapies over school holidays which would make it difficult to manage with a constant flow of funds rather than being able to draw down on a needs basis.

Q9. How should check-ins be undertaken? Under what circumstances is a check-in needed? Who should be involved in a check-in?

Some participants may not feel the need for a check-in, therefore these should be optional and driven at the participant's request (after discharge from hospital/change in medical status or change in social status i.e. lost job, break/ new partner). Mandatory check-ins at certain times will ensure consistent communications with the option for more as deemed fit by the participant or the planner.

Triggers for check-ins might include increased monetary value, multiple occasions of purchase when not indicated or for the independent assessor. These arrangements should be defined and provided to participant when a plan is approved. Options to include family, support workers, providers in check-in should be available. These could be one face-to-face or over an appropriate video software.

Q10. How often should we check-in with participants in different circumstances?

The frequency of check-in would vary. More frequent for those with complex needs including for young children, those with variable psychosocial disabilities, and children within child protection services. Frequency will differ for vulnerable groups including Aboriginal and Torres Strait Islander peoples, and those from culturally and linguistically diverse backgrounds.

For those new to a plan, we would recommend that these occur within the first 3 months. This would ensure that vital checks can occur including that there is not a large gap in their services and that they understand how to use their funds to maximize their supports and independence. Beyond this period, a review, short-form, between 6 and 12 months would be sufficient. Longer-term and for more stable plans we would suggest review 12 monthly.

Q11. How can the NDIS ensure positive relationships between participants and planners?

Trust comes from knowing that participants of the NDIS are doing the right thing. It is important to approach the discussions around goals and effective use of their plan – working through issues in a supportive manner to instill trust. Transparency during the application process and approval process is key. Linking what the IA has deemed against how a plan is managed with fixed and flexible funding. Ensuring the availability of planners will also be important and assurance around their abilities including qualifications, training and education to ensure they are people with a high level of understanding of disability.

Q12. How can we best support participants to transition to this new planning model?

Early consultation and less jargon with more education and reassurance. "Fixed and Flexible" still does not outline what it can be used for very clearly. There is a need to ensure real world examples are given as to what each could be used for i.e. Fixed for Car Modifications, Flexible for Physiotherapy Assessments and Travel.

Consultation Paper 3: Supporting young children and their families early, to reach their full potential

APA Position

The APA **strongly supports** the NDIS progressing policy solutions that will ensure children get faster access to NDIS supports. However, the APA does not support all aspects of new early childhood approach as outlined in the consultation summary.

Introduction

In the consultation paper, the drivers for change was to address issues around children receiving the right support in the NDIA. This follows the NDIA's review, in May 2020, of the implementation approach for the Early Childhood Early Intervention (ECEI) pathway. The APA notes the reset objectives are to: improve outcomes for young children and their families/carers; ensure the right children receive the right support at the right time; and develop short- and long-term solutions for pain points, challenges and gaps.

We acknowledge that it can be very difficult to target vulnerable children and get them to transition to the Scheme. A key access concern relates to perceived stigma which continues to deter families from registering for ECEI. This stems from concerns that their child may be disadvantaged later in life – impacting on job prospects, insurance eligibility and on broader life milestones. While a national public information campaign is required to address community attitudes through the new National Disability Strategy, the APA welcomes the NDIA's emphasis on ensuring targeted education so that families are aware of the benefits of becoming a participant of the Scheme.

The APA supports the policy objective to create a distinct ECEI implementation model, differentiated from the adult-centric Scheme. We support the core aim to ensure the right level and mix of support at the right time (including more pre-access assistance and transition support) through a family-centred approach aligned with best practice. While we support the exclusive use of registered providers to facilitate access to ECEI services, we believe significant reform will be needed to remove the current policy barriers. This includes supporting the current workforce by removing excessive red tape impacting on provider participation and ultimately market growth.

Consultation response

General questions

Q1. Do you have any specific feedback in relation to:

- (i) the increased focus on STEI outside of access to the Scheme
- (ii) the proposed increase in age range for the EC Approach from under 7 to under 9 years of age,
- (iii) the desire to see more successful transitions from the Scheme to the next state of life.

- (i) Focus on STEI outside of access to Scheme

Improving identification processes and improving access to services is supported (Recommendation 10, 11). A delay of 3 or even 6 months to receiving input can make a significant impact on the developmental trajectory of a child. Therefore, containing and/or extending Short Term Early Intervention (STEI) (recommendation 12) to the ECEI Community Partners should be considered carefully. This would diminish choice and control to the participants who should be able to engage with and build early critical relationships with providers in their community.

The APA supports the exclusive use of registered providers to facilitate access to ECEI services. However, this would require significant reform to remove some of the barriers of becoming a registered provider. Leveraging the skillsets and existing expertise will be important. There are excellent clinicians in the community who are well-positioned to provide best practice EI care.

Enabling access should guide all policy decisions. If there are providers available in the community, they should be used. If access to community base providers is challenging then accessing services through ECEI partners should be an option but also strategies to increase the market workforce must be considered.

There are concerns of conflict of interest if all STEI was to be provided by ECEI partners. This approach would also affect the community workforce as it removes that EI role of the community therapist and it also impacts on continuity of care. If a child can engage with a community therapist as early as possible, they should be able to continue to work with them through their development as their therapist has a better understanding of their background.

Developing and providing clarity in regard to the interpretation of developmental delay under section 25 of the NDIS Act (2013) (recommendation 13) would be supported by the profession. Currently it is difficult to ascertain when to begin a conversation with families about the ECEI/NDIS and when a referral is appropriate. Lack of clarity can lead to delays in referral and therefor delay in accessing adequate supports.

(ii) Increase in ECEI age range

Generally, there is support from our member base to increase the age of ECEI from under 7 to under 9 (recommendation 13). Whilst the neurodevelopment may have slowed in comparison to the first 5 years there is still significant changes throughout the primary years and shift to increase community participation expectations (as opposed to a more protected or supported family dominant environment). Shifting to under 9 does allow for more of a transition and “settling in” to school and understanding the challenges a child may have in the school environment.

Another concern to our membership lies in policy intent that diminishes quality by enacting a trigger at a specific age point for a significant funding cut. The whole intent of the NDIS is to provide individualised plans and this shift does not enable the required flexibility to support those that may require increase supports (at various age points). A policy alternative would be to remove the emphasis on age and instead implement a 5-year post diagnosis review. This could enable access to services such as those offered to adults who acquire a disability such a traumatic brain injury (TBI) or spinal cord injury (SCI) which require intensive supports for a period of time after diagnosis or onset of disability.

A policy shift of this nature must also consider the likely implications across certain populations groups. Some key concerns of our membership include:

- Those children who may have flown under the radar of diagnosis and it is not until they are in a school environment that significant need for support is identified;
- Young children who acquire a disability at between 5-7 or with the new age 7-9 that may not receive the same amount of funding as if they were being assessed through the ECEI lens;
- Increase needs at different times throughout childhood including transition to high school and then the final years of high school to ensure an optimal transition to post school life; and
- Children who have progressive disabilities where the need for support may increase across these timeframes.

(iii) Transition into the full scheme

The transition phase into the full scheme should not be perceived by both participants, providers and workers at the agency as a hurdle, a leap, a cliff, or a line in the sand. There is already considerable concern that funding will be dramatically reduced at this point in time which is leading to a reactive response from providers and participants to advocate “hard” for their levels of funding to remain.

A system that supports individual need regardless of age is what the agency should be striving for. A phased transition out of the Scheme for children who have good outcomes from ECEI should be supported. Children who have received ECEI should have access to “touch base” supports for quite some time, even indefinitely. It is important to acknowledge that some of these children may do well without supports during middle to upper primary but the changing stages, requirements or demands of their childhood could see a need to reintroduce supports. This may not be in the form of a plan but an allocation of funding throughout childhood for intermittent check-ins with their therapists.

Q2. How can we help families and carers better understand some of the terms the NDIA, and Early Childhood partners use such as: best practice; capacity building; natural settings, and/or evidence.

Education is the key to enabling families and carers to make informed decisions about the supports they access. This can be achieved through the provision of education packs, information sessions and family support groups facilitated by workers with suitable qualification and training in regards to best practice. These need to be delivered regularly. Further consideration would include making elements of these tools mandatory or having a points system of a form of family PD that they must reach each year. Ensuring support with achieving goals is also key. Supporting the NDIS provider market to ensure they are delivering supports under these principles would assist.

Policy directions | **Support with achieving goals**

Q3. What is the best way for us to check in with families and carers on how their child is tracking to meet the goals for their child?

The APA supports the NDIA’s objective to improve review and to support families to celebrate goals achieved (recommendation 21). However, the emphasis around the need to show or prove their (families) need for ongoing support does not align with this. There is a need to find a balance between celebrating the achievements and gaining the supports they require. The policy should not be skewed towards finding cost efficiencies and instead be directed towards ensuring adequate supports. The goal of the planning meeting should be to come away with the supports they require against the challenges faced. Families should be empowered to work through the supports they feel are working and should be ongoing.

In terms of tracking goals, it is our view that planners should be trained in how to develop more specific and measurable goals. The goals that are set within the plan are vague, broad and are extremely difficult to measure. Training planners to use a tool such as the Canadian Occupational Performance Measure (COPM) to set specific goals that sit underneath the broader goals may be one option. The other is to rely on providers. Good therapists will be developing these specific goals and measuring these against their support plans.

Q4. Would a mandatory early childhood provider report developed between families and their provider be useful for tracking against their goals?

The APA has concerns about the implementation of a mandatory tool (as per recommendation 22) as these tools are often not compatible with the varying practice management systems in place. Having a template or a list of mandatory requirements for

reports would be a more reasonable expectation. Currently, clinicians reconcile the report template against their own report which is in built to our practice management system.

It is important to clarify an issue presented during the consultation information session in relation to the report template, where it was inferred that the template would be shared between providers. The APA reiterates its concerns with any practice that involves sharing an editable document to external providers.

Q5. How can we better support families to connect with services that are either funded or available to everyone in the community?

The APA recommends a stronger funding commitment towards targeted community campaigns. This is currently difficult as the person trying to enable the family or participant needs to be knowledgeable of the specific community. One way of supporting this is directing families to the resources of information for community programs and events such as city council websites, community or neighbourhood groups.

Q6. How can we make the process of transitioning out of the NDIS something to celebrate?

A guiding principle in facilitating change should be to ensure choice and empowerment, and capacity to exercise choice for the individual. These core values need to be consistently communicated to families and providers (Recommendation 1 and 2). Our members have advised that they work with families within the ECEI with a clear goal of not needing to transition to the full scheme or hoping to not need supports in the future. Further, they ensure that when working with families of children with developmental delay they use language to support a goal of reduced or minimal funding.

The APA sees the transition-out plan for up to 3 months (as stated in recommendation 22) is grossly insufficient. A child who has been receiving supports for many years should not transition out of supports in 3 months. There needs to be timely check-in with the relevant therapist throughout development to ensure the developmental trajectory maintains on path. For some children, not having the check-in funded could mean a delay in the recognition of supports required and increased need of support into older years and potentially adulthood.

The APA would like to see a more appropriate policy response that allows a certain number of assessments/ check-ins per year. This would be a more appropriate spend to enable the NDIA to monitor children who required early intervention supports. Our members report many instances where the young children they have supported early in life reappear for support later.

Policy directions | Targeted support

Q7. If you live in a remote or very remote part of Australia, what are some ideas you have on how we can get early childhood supports to work in your community or communities like yours?

Implementing tailored methods of delivery is necessary (Recommendation 8). Incentives are needed for providers to move and operate in these regions similar to those provided for the medical workforce in addressing rural and remote service deficits. The promotion of a fly-in, fly-out workforce has certain pros and cons to this, and COVID remains a barrier. Building capacity of your existing rural and remote workforce should remain the key policy aim. Exploring further supports by way of intensive or camp style supports for intervention could work.

Q8. How can our Early Childhood partners and mainstream services best support peer-to-peer connections?

There is a need for NDIA-led policy guidance in facilitating peer-to-peer connections between partners and mainstream services. There are inherent clinician risks in situations where the connection is not positive. Significant safety measures need to be put in place to protect young people from harm with the development of such an approach.

Q9. Are you interested in helping us co-design an approach that would make peer-to-peer networks easier to find and join for people?

The APA would welcome the opportunity to support the NDIA in working through solutions to enable peer-to-peer connections.

Q10. How can we better reach and get support to young children and families who experience vulnerability and remove barriers so they can receive outcomes in line with other children and families?

It is vital that the Scheme can respond to a broad range of needs and circumstances. A key imperative is that there are supports for people who are not eligible for the NDIS and for those transitioning between the NDIS and other systems. It is those that are currently left behind, often with complex needs and significant barriers to access, that the NDIA together with the lead Department, the Commonwealth Department of Social Services need to prioritise. This needs to be progressed through the new National Disability Strategy in terms of capturing and supporting those most vulnerable in our community.

Policy directions | **Tailored Independent Assessments (IAs) approach**

Q11. [The expanded text summary is not captured here, due to length, please refer to consultation paper for full information.] Do you have any feedback on this recommendation and/or any suggestions on how this proposed approach would work best for young children and their families/carers?

Please also refer to Consultation 1 for the APA's position on IAs. Further ECEI specific comments offered below.

As the proposal is for ECEI partners to implement a full assessment of a child, the APA is concerned that this may lead to increase costs and time burdens for families. Policy success is reliant on the ECEI partner to have a workforce conducting intake assessments with the appropriate skills to determine if and when further assessments are required (on top of those received by existing therapists, doctors and specialists).

The assessment tools do provide an overall picture of development but do not necessarily provide the specific details of impairment that can be shown from more discipline specific measures. With this in mind, the recognition and inclusion of external assessments and or reports from existing providers should be included in the budget development and planning process.

Policy directions | **Greater transparency on providers of best practice**

Q12. What mechanisms do you think could help achieve this?

The APA supports the need to ensure providers are delivering quality supports that are best practice. The APA would support the use of registered providers only in ECEI but to do this there needs to be significant reform in the registration process to remove the financial, administrative, time and resource burdens to businesses to attain and maintain registration.

There are so many excellent providers out there that are choosing not to become registered because of this. There are also many unregistered providers offering supports that are not aligned with the practice standards.

Q13. Who would be best placed to lead the development of, and manage, any additional complementary mechanisms?

The APA would support the established of an industry-led 'best practice accreditation system'. The development of a system to offer ECEI accreditation that requires a level of accountability in regards to quality and safety of providers of ECEI is a sound consideration. This could be in the form of mandatory training based on the ECEI NDIS practice standards. The NDIS Quality and Safeguards Commission, in its current form, is only serving to protect 20 per cent of ECEI participants (i.e. those that are agency managed). The other 80 per cent have no protection in place other than general AHPRA registration which does not provide specific regulation of EC practices.

Q14. What do you think of the following ideas for potential mechanisms? What are the benefits or concerns with these potential mechanisms?

The APA does not support any informal rating scale, feedback forums, customer review forums as where these have been used in health care they have proven to be problematic. In terms of the policy tools developed, the APA would recommend these encompass continuous monitoring and regulation involved. An "assess and forget" tool is not appropriate and will not serve to protect participants or hold providers accountable.

The APA recommends that registration with the NDIS Commission be made mandatory for all providers operating in the EC space. Further, we recommend that all self and plan-managed participants in the new Early Childhood approach to use only registered providers.

Other related recommendations comments

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| Recommendation 3 and 4 | Developing OG may provide some clarity and distinction but it comes back to the planner understanding and implementing this guideline. Concerns have been raised in the past in regards to planner/ delegate qualifications and training requirements in general and certainly within EC these qualifications, experience and training need to be specific to the young child. |
| Recommendation 15 | This relates to existing legislation that should be adhered to and therefore should not be explored further through this consultation. |
| Recommendation 18 | Significant concern been expressed by physiotherapist and other allied health peak body representative in regards to the CRC report on Assessment and Diagnosis on Autism including the lack of consultation in the development of the National Guidelines. A proposal of an opportunity to provide feedback on the guidelines has been suggested at meetings with other peak bodies including Speech, Occupational Therapy, Psych and AHPA. |
| Recommendation 19 | Understanding how the agency is looking to empower EC partners to provide clear information in regards to the best provider available (recommendation 19) will need careful management in regards to conflict of interest (COI) and personal biases. |

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