

CONSULTATION RESPONSE



National Disability Insurance Agency Independent Assessments – Access and Eligibility and Planning Policy

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Allied Health Professions Australia
Level 1, 530 Little Collins Street
Melbourne VIC 3000
Email: office@ahpa.com.au
Website: www.ahpa.com.au

Introduction

Allied Health Professions Australia (AHPA) thanks the National Disability Insurance Agency (NDIA or Agency) for the opportunity to provide feedback on its Independent Assessment consultation. AHPA is the recognised national peak association for Australia's allied health professions, collectively representing some 130,000 allied health professions. Allied health professionals are a critical part of the National Disability Insurance Scheme (NDIS), providing a wide range of supports and services to help participants maintain and improve function, build their capacity to participate in community life, education and employment, and to access vital assistive technology (AT).

We have welcomed the acknowledgement by the Agency that the expertise of the allied health sector is an important foundation for independent assessments, and we argue strongly that this clinical knowledge and experience will be equally important in assessments for the early childhood approach. AHPA's previous work with its members and the Agency to provide guidance in relation to the independent assessment workforce provides an important foundation for our input. Those activities focused not on the assessment process itself, but rather on the skills, expertise and required credentials of potential assessors, the training of that workforce, and guidance about potential quality assurance processes. There is a clear opportunity to build on this work, and the data from current pilot activities, through further targeted activities that will begin addressing key questions such as the impact of pre-access requirements, the efficacy of the current assessment toolkit, the appropriateness of the proposed assessment process and its adequacy in relation to other factors that impact participant needs, the use of independent rather than known allied health professionals, the impact of standardised budget setting with minimal capacity for variation, and the changed planning process.

In responding to the Independent Assessment consultation, AHPA has sought to highlight a range of issues and opportunities across both consultation papers. Despite this response approach, we continue to argue that combining access and eligibility with planning policy is increasing anxiety for participants and providers and we argue that a more constructive approach would be to initially separate the use of independent assessments for the purpose of initial scheme access from re-assessment and participant budget setting. Our view is that there is a strong argument for a no-cost, equitable entry point to the scheme for potential participants, and significant potential benefit in using an experienced allied health workforce to undertake those assessments. However, the use of independent assessments for the purposes of budget setting and setting constraints on the planning process is by no means supported by the sector without greater clarity about how this will operate and work to address key issues. Those include allowing significantly greater input from participants and allied health professionals into the budget setting process. It should also allow the use of practitioners with existing relationships with participants to carry out independent assessments for existing participants in the scheme. We call for the establishment of an expert advisory group consisting of allied health clinical experts and participant representatives to oversee implementation and evaluation of the program, regardless of its final form, and for additional work to be carried out in conjunction with a formal allied health working group.

In relation to the Independent Assessment workforce, we note ongoing concern in the sector about the capacity for assessor organisations that have tendered to provide independent assessments to attract sufficiently experienced allied health professionals to work as independent assessors under the current proposals. AHPA and its members have put forward clear advice to the Agency about minimum standards for the experience of assessors, as well as the mentoring and supervision requirements that are required to ensure quality and safety for participants and assessors. We argue strongly that the Agency should publish clear requirements for assessor organisations in relation to the workforce they employ, including requirements in relation to employment of more experienced

practitioners to provide supervision and mentoring for less experienced staff as part of quality assurance processes. We also argue strongly that similar requirements should be in place for assessors undertaking independent assessments for early childhood services under section 25 of the Act even if Early Childhood (EC) partners are the employers of that early childhood pathway assessment workforce.

As a final note, AHPA argues in the strongest possible terms for the establishment of an expert advisory group focused on supporting the development, implementation and monitoring of independent assessments. This will be an essential foundation for building confidence and trust among both participants and providers and will support the calls for greater co-design of this process. Membership of this expert advisory group would consist of participant representatives, allied health professionals and appropriate medical specialists. The group would be charged with monitoring data about access, including access for cohorts currently struggling to access the scheme, the effectiveness of independent assessments as a foundation for budget setting and planning policy, and other elements outlined in our responses below. Strong allied health representation will be particularly important given their key role in the planned assessor workforce, and as key providers of functional assessments outside of the scheme.

This submission has been developed in consultation with AHPA's allied health association members.

Recommendations

While AHPA has provided detailed responses to the individual consultation questions below, this list of recommendations is intended to summarise our overall proposals. We welcome further opportunities for discussion with the Agency to expand on these.

Our recommendations are:

1. Change the timeline and planned implementation from a national rollout to a staged rollout that will allow additional testing and refining of independent and other complementary assessment models outlined below.
2. Separate the use of independent assessments for Access and Eligibility purposes and Planning Policy to allow time to fully test the impact on scheme entry before planning processes are changed.
3. Establish an expert advisory group (EAG) consisting of participant representatives, allied health professionals and 1-2 medical specialists with appropriate disability expertise to support and oversee activities below and ongoing evaluation of the rollout of the new assessment process. Allied health representation should cover key clinical areas of focus including physical disability, communication and auditory disability, mental ill-health, developmental delay, Autism Spectrum Disorder (ASD), assistive technology (AT) and behaviour support.
4. Establish in parallel to the EAG a renewed working group of allied health profession representatives to provide guidance about the training, credentialing and quality assurance requirements for the assessor workforce, including the early childhood assessors, and assessors that are drawn from a participant's current team of supports.

5. Publish pilot results to show outcomes of current expanded independent assessment trials and identify areas where additional testing is required.
 6. Work with EAG, allied health working group, and participant sector to identify gaps in current assessment proposals, based on pilot outcomes and consultation input, to find and test solutions as part of staged rollouts or additional pilots. These include:
 - a. Reviewing the impact of pre-access requirements, particularly for cohorts that may have issues establishing eligibility, and options to increase access to funded allied health and medical assessments focused on establishing permanence and/or diagnosis as part of a more equitable and streamlined entry.
 - b. Additional information needs, including environmental factors and the capacity of family or informal supports, that are needed as part of independent assessments if these are to support accurate budget setting process and the process by which allied health assessors gather this information.
 - c. Identifying additional assessments, including communication assessments, that may be required and how these inform access and plan budget setting.
 - d. Identifying the circumstances in which individual allied health professions or professionals with areas of specific clinical experience such as psychosocial disability or communication disorders may be more suited to carrying out assessments for particular cohorts of people with disability.
 - e. Development of a complementary model that uses allied health professionals with existing relationships with participants or applicants to the scheme with existing health professional support to undertake independent assessments, using the standardised toolkit, and whether additional training, credentialing and quality requirements would be necessary.
 - f. Identifying how goal-setting and differences in individual aims can be built into the budget setting process to support a more appropriate planning process.
7. Work with EAG to establish mechanisms to monitor, report on and advise on potential incremental changes to independent assessments during staged rollout including:
 - a. Impact on scheme access, particularly for underrepresented cohorts such as people from Aboriginal and Torres Strait Islander communities and those with psychosocial disability.
 - b. Effectiveness of using independent assessments for budget setting and overall impact on size of plan budgets and access to services using both scheme data and participant feedback mechanisms.
 - c. Performance of independent assessor organisations through comparative benchmarking including benchmarking of independent assessors with assessments carried out by non-independent assessors.
 - d. Effectiveness of current assessment toolkit and benchmarking with alternative tools identified by clinical experts during consultation.
8. Undertake further consideration of the role of the NDIS Commission in relation to the registration of independent assessor organisations and the quality assurance.

Responses to the consultation questions

Access and eligibility

AHPA is cautiously supportive of proposed reforms to the access process, based on a more equitable and nationally consistent assessment process. We very much welcome the introduction of qualified allied health professionals as part of that process and argue that there are opportunities to make more effective use of that clinical knowledge within the framework of a consistent assessment process. We argue that changes are needed to ensure that the process can gain the confidence and trust of participants and providers, and we have outlined a number of recommendations that could form the foundation for an enhanced, national assessment process.

Question 1

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

While the focus of this question appears to be information for scheme applicants, we argue that there is a need for focus not only on information for potential participants, but also for those that are likely to provide support to those people in the lead up to seeking access to the NDIS. AHPA argues strongly for an increased focus on improving understanding of the NDIS within mainstream health and other non-NDIS systems, with a particular focus on the pathways into the NDIS. This is particularly relevant in relation to new scheme pre-access eligibility requirements, where clear information to providers and participants about mainstream systems may support pre-access is essential.

We note that with the increasing maturity of the NDIS, and the high current participant numbers, new applications to the scheme are likely to consist primarily of families with young children with disability, adults who have become disabled as a result of an accident or illness, or those with psychosocial illness. We argue that each group requires a slightly different approach, focused on the likely referral pathway and the intersection with mainstream services that is likely to pre-empt an application to the scheme. We argue that the Agency should seek to develop consistent approaches that include improved mapping of the intersections between the disability system and adjacent systems such as health and mental health. On the basis of this work, the Agency and other government bodies should work to develop guidance for practitioners, including resources and templates focused around supporting people with disability to demonstrate eligibility and meet pre-access requirements. We also argue strongly for a focus on developing easily accessed and shared resources that practitioners can provide to families to help them understand the range of NDIS and other supports and services available to them and the pathways to access for these.

For younger cohorts, the focus will need to be on streamlining the intersection between mainstream services, particularly maternal and child health nurses, as well as educators, and EC partners. Given the greater capacity for flexibility due to the proposal around Short Term Early Intervention, and the focus on access under Section 25 of the Act, families are likely to require less information from those referrers though we encourage work to provide clearer guidance about the NDIS and the early childhood approach. We also argue that there is a need to address issues of stigma in relation to disability that may prevent families from accessing services that their children may need. There is significant potential to look at how the EC pathway is branded and communicated that may help reduce some of those concerns, particularly through an emphasis on not requiring the formal label of a disability diagnosis.

For those whose disability is the result of illness or accident, the roles of health professionals working in acute and rehabilitation settings are important to consider as referrers and information sources for people with disability, particularly in relation to the access process. Current proposals around pre-access criteria outline clear requirements from medical and allied health providers. Streamlining information for those practitioners that will provide information, as well as for the people with disability that will require their support at the pre-access stage is essential. This information should focus primarily on access processes and information inputs, though there is also a need to increase understanding in the mainstream system about the role of the NDIS and the differences between what participants can access from the NDIS versus what might be provided through the health system.

For people with psychosocial disability, access is particularly difficult and there is a clear need to continue improving understanding of access for this cohort and the mental health organisations and allied health professionals that may be providing supports outside the NDIS. AHPA notes the significant challenges that this cohort of people has in accessing the scheme and flags our significant concerns about the pre-access requirements that they will need to meet in order to access the independent assessment process. AHPA argues that it will be critical to ensure that people with psychosocial disability, their informal supports, and the mainstream mental health providers that are likely to be referring those people to the NDIS, to have a clear understanding of the access pathway including requirements relating to establishing eligibility including diagnostic information and information about permanence. It is also important to establish with both potential participants and mainstream providers how pre-access requirements might be supported without depending on the person to be able to fund a range of assessments and reports. We have argued below for an Agency-funded access pathway for some cohorts and encourage careful consideration of this approach.

Question 2

What should we consider in removing the access lists?

The Agency has argued that a key focus for the introduction of independent assessments is to increase equity and to provide a more streamlined and consistent process for seeking access. We note that concurrent work focusing on early childhood intervention proposes a range of reforms to improve the timeliness of access for potential participants. AHPA argues that the removal of access lists stands in stark contrast to this, adding additional requirements on people with disability that have previously been recognised as clearly eligible. AHPA recognises that the use of access lists has been imperfect and that particularly those that fall into category 2 or List B (<https://www.ndis.gov.au/about-us/operational-guidelines/access-ndis-operational-guideline/list-b-permanent-conditions-which-functional-capacity-are-variable-and-further-assessment-functional-capacity-generally-required>), have had unnecessary challenges demonstrating the impact of their disability on their daily life at the point of seeking access.

This process can be both expensive and traumatic for people with disability. It can also have the effect of turning away people who should be accessing the scheme, particularly if they are still at a stage where they require only minimal supports. For example, those with degenerative conditions such as Parkinson's disease or multiple sclerosis will almost certainly become participants in the scheme. Yet many report being rejected rather than being enrolled as participants with limited or no active funds in place. We note in this context our strong view that the scheme would be significantly improved by greater capacity to enrol people with disability as participants even if they do not have an active plan. Instead, the focus would be on providing access to appropriate Agency-funded assessments at appropriate times, as well as support from LACs or other similar Agency-funded supports to provide assistance to access non-Agency services. As the person's needs increase,

instead of needing to seek access, assessments are scheduled and subsequent planning then provides the person with access to a plan and budget appropriate to their needs.

The independent assessment, provided it is working as intended, provides significant scope to address some of these challenges in relation to demonstrating the impact of a disability and the functional needs that a person may require assistance with from the scheme. As such, we take the view that for a range of cohorts, the access lists may no longer be required and could instead be addressed by the information and coordination strategies outlined above to improve intersections with mainstream health and medical supports.

Yet AHPA also argues that the intention of the access lists remains as a means of streamlining access for both participants and the Agency that would otherwise be unfairly burdened and have inappropriate barriers to entry. Instead of focusing on those disabilities that are clearly recognised as permanent, AHPA argues that there is significant potential to achieve improve the accessibility of the scheme for a range of cohorts that have been shown to struggle to gain access and for whom the costs of demonstrating eligibility are highest. This includes people on the autism spectrum, people with psychosocial illness, people with single-domain disabilities such as auditory or speech conditions, and those with less well understood conditions that can be difficult to diagnose. Rather than requiring detailed pre-access evidence from these groups, AHPA argues that the independent assessment process could be expanded to include funded support to gather information and evidence, through the independent assessment and the clinical input of that allied health assessor, and through potential additional assessments that the independent assessor identifies as necessary.

In this way, a standardised process is introduced that focuses on equitable access for those conditions that are most struggling to access the scheme. It may also be appropriate to have similar streamlined access for cohorts such as Aboriginal and Torres Strait Islander people, and people from Culturally and Linguistically Diverse (CALD) communities. We recommend the establishment of an expert advisory group consisting of participants, allied health professionals and appropriate medical specialists to develop and monitor this list in conjunction with the Agency.

Question 3

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?

AHPA recognises the importance of increasing awareness among mainstream health and mental health professionals about the requirements of the scheme in relation to supporting participants to demonstrate eligibility. Our previous response has noted our view that there is significant potential to improve coordination between the disability system and other adjacent systems, particularly in relation to supporting streamlined access to the most appropriate NDIS and mainstream services. Better planning and coordination with other funders and state- and territory-based systems through increased information and resources, including reporting templates for health professionals, will improve the process for many participants. A key focus should be helping clarify any differences between standard reporting that may take a more medical or clinical focus, and the requirements of the NDIS Act.

AHPA also argues strongly that the Agency needs to consider carefully the impact on equitable access that arise from the proposed pre-access eligibility requirements. We argue strongly that further work is required to determine where barriers to entry may exist and how the scheme may address those.

AHPA has undertaken significant consultation with its broader membership in relation to independent assessments, particularly in relation to the challenges associated with demonstrating permanence for a range of conditions. We note strong concern in the sector about this requirement in relation to access to the scheme for a range of cohorts who are currently struggling to access the scheme. A range of cohorts, outlined in the previous response, have been shown to have greater barriers to access and to be underrepresented in the scheme. This must be addressed as part of the introduction of an improved access process.

We also argue that a number of cohorts will continue to be disadvantaged if the proposed pre-access requirements remain in place. Instead, we argue strongly for the introduction of a process such as the streamlined approach outlined above in our response to the previous question. This would allow the agency to identify cohorts experiencing additional barriers to entry as able to access an enhanced independent assessments process, without first having to demonstrate more than minimal information such as diagnosis. One of the advantages of this approach is that rather than relying on mainstream health professionals to develop increased understanding of scheme requirements, independent and other assessors providing input into this process, could develop enhanced expertise in relation to assessing and reporting on the functional needs of people in these cohorts.

Question 4

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

AHPA disagrees with the premise of this question, arguing that it suggests a means of delineating or rejecting responsibility and ensuring that people are not inadvertently seeking assistance from the scheme for services that the Agency considers the responsibility of other systems. While AHPA recognises the need to establish boundaries in relation to what is funded by the NDIS, and what is not, we also argue strongly that issues around eligibility and definition of disability continue to result in people falling through the gaps in services. More importantly, we argue for a greater focus on support for those that need it.

AHPA argues that the scheme should be taking a more significant role in providing national leadership to identify interface issues and areas where definitions may be less clear with a view to also identifying barriers to access, and gaps in, non-disability services for both scheme participants and those outside the scheme. An approach based on a 'no wrong door' and supported referral process would help to ensure the scheme better enables people with disability to access services even when ineligible for the NDIS. The current work to develop a new National Disability Strategy is likely to provide a foundation for this work but AHPA argues that with the increasing shift of resources into the NDIS, states and territories are increasingly limited in the range of services that they offer. As such, the NDIS and the Department of Social Services (DSS) must seek to lead.

Question 5

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

AHPA and its members have undertaken significant work to identify the experience and credentialling requirements for the allied health professionals working as independent assessors. We've also undertaken work to map out the support and supervision needs of that workforce, as a means of ensuring quality and appropriate clinical oversight. The latter is an important means of supporting participants and the assessor workforce. We direct the Agency to the report submitted in 2020 and propose that additional work to refine and enhance this advice will be required, based on the findings of current pilot programs and changes to the independent assessment proposals arising

from this consultation process. We welcome the opportunity to provide that support and input as a means of ensuring the highest quality workforce is available to support participants during the assessment process.

AHPA also notes that other allied health professions are likely to be appropriate as providers of independent assessments, noting that the key requirement for participation appears to be a combination of allied health qualification and meeting the Level B assessor requirements of Pearson Clinical, the developer of the Vineland 3 assessment tool. We very much support additional work to identify other professions that may be relevant as potential assessors, either in an independent capacity or as existing supports for participants that could provide assessment services. Engagement with Pearson suggests that other professions may well meet these requirements and we encourage a process that allows other professions to be included in the pool of potential assessors.

In some cases, assessors will require specific expertise that will supplement the standardised independent assessment process. Our previous work with the Agency in relation to independent assessments suggests that there are areas of additional input likely to be required for some participant cohorts and that additional assessments by appropriate allied health professionals will be required in areas such as communication disability. Further work will be required to identify these and to monitor the overall effectiveness of the assessment process both during current pilots and during a staged rollout. We note that there are already provisions for the use of additional assessments in the proposed process in relation to assistive technology and specialist disability accommodation.

Question 6

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

Ongoing consultation with practitioners, participants, and peak associations suggests that the most accessible way of providing independent assessments will be a flexible approach to the assessment that includes the accessible and tailored options outlined in 3.5.2 of the Access and Eligibility consultation document. It will also seek to utilise allied health professionals with existing relationships with the participant wherever possible, subject to participant choice, and appropriate expertise and experience. It is very clear from discussions with participants and providers that the most important foundations for assessments are the trust and confidence of the participant, and that there is great value in drawing on the existing knowledge and expertise that the practitioner has developed by working with the participant and their family or other informal supports. The very strong view from both participants and providers is that it is not possible for practitioners that do not have an existing relationship with the participant to be able to deliver an assessment of the same quality and we argue in the strongest possible terms for trialling the use of the standardised toolkit by a participant's chosen health professional.

AHPA recognises that some people with disability, particularly those accessing the scheme for the first time such as younger people with disability or developmental delay, are unlikely to have existing relationships with appropriate allied health professionals and that there will be a need for a workforce that could be considered independent of the participant. In this case it will be important to ensure that the accessible and tailored options outlined by the Agency are available to participants and communicated effectively and that the assessors are experienced, well-trained allied health professionals. It will also be important to ensure that there is ongoing engagement with participants to review the accessibility of the process, with oversight by the proposed expert advisory committee.

AHPA also notes that for the assessment process to be accessible to participants, there is a strong need to ensure that the process continues to feel inclusive and based on the individual wishes of the participant. The current proposals for a highly standardised assessment, and a highly standardised draft budget with limited scope for adjustment during planning, is one that does not meet with our understanding of accessibility and does not support participant inclusion. We argue that further work will be required to ensure that this process is more flexible and able to receive appropriate input from participants and allied health professionals to support a more individually appropriate outcome and plan.

Question 7

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

While AHPA defers to our colleagues in organisations such as Indigenous Allied Health Australia (IAHA) with greater expertise in cultural safety and inclusion, we note strong evidence for the value of investing in building the Aboriginal and Torres Strait Islander allied health workforce with a view to increasing the availability of assessments undertaken by people from within indigenous communities rather than outside of them.

We also note the value of increasing cultural awareness within the Agency. We argue strongly that improved access to indigenous practitioners should be a key focus of the scheme and other government initiatives and call for increased coordination between all governments, in the form of a national allied health workforce strategy, with targeted initiatives focused on issues and opportunities to build the Aboriginal and Torres Strait Islander allied health workforce.

AHPA recognises that cultural safety and inclusion also impacts heavily on Australians with a CALD background and we recommend increased engagement with organisations representing CALD communities for further advice and input. AHPA is aware that a key factor for consideration is recognising potential stigma and cultural factors that may impact on how participants and their families or informal supports may report on their own capacity and needs.

AHPA welcomes the opportunity to consider with the Agency how to develop training of assessors and the broader allied health disability workforce in relation to cultural safety.

Question 8

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

AHPA recognises the value of a consistent assessment process and takes the view that it is more appropriate to design a process that works for all Australians with disability with only limited exceptions to the use of a standardised set of assessment tools. We do consider that if a person has existing assessment information sufficient to demonstrate their functional needs, and meet the information requirements of the assessment with the information already gathered by health professionals, they should not need to undertake an additional independent assessment. It may be viable in such a case to have an assessor review evidence that has been provided and to complete a ‘desktop independent assessment’.

However, AHPA considers it essential to provide scope for a less formal assessment process, most likely comprising a flexible degree of interaction between the potential or current participant, and their existing health professionals and other supports, potentially with additional support from an appropriately qualified assessor where existing supports may not be qualified allied health

professionals. The intention of this less formal process will be to gather the information required for an assessment through other means that may be less intrusive for the person and may be based on the knowledge and expertise of others. We note examples provided by allied health professionals of people that have experienced trauma or have complex psychosocial or other disabilities that mean the person is unlikely to be able to participate in an assessment, particularly if they do not know that assessor. While section 3.5.2 of the document refers to the possibility of significant aspects of the assessment being completed by ‘a person who knows them well’, we argue that with appropriate safeguards in place, this should be expanded to also include formal and informal supports involved in their life, potentially without their direct involvement.

Question 9

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

AHPA argues that a range of mechanisms will be necessary to ensure that independent assessments are of a consistent level of quality, and are meeting both participant and scheme needs. We have argued strongly in previous work with the Agency for the need to have robust quality assurance measures in place that consist of a range of key strategies:

- Consistent clinical supervision and mentoring requirements for any employers of independent assessors to ensure that those assessors are able to access peer support and clinical oversight from highly experienced practitioners.
- Regular audits of independent assessment reports by the Agency or an independent agency to ensure that there is consistency across assessment providers and that the assessments are meeting quality requirements.
- A proportion of audits should involve participant feedback to ensure that there is consistent input from participants into the reviews.
- Monitoring and reporting on scheme data in relation to scheme access with particular emphasis on key cohorts currently experiencing additional access barriers. Reporting on scheme data in relation to overall plan values, utilisation and plan reviews to establish quantitative measures to report on success of plan budget measures.
- Establishment of dedicated feedback mechanisms (see response to Question 10 below) to allow participants to contribute feedback or seek additional reviews of their assessments where they feel these have not accurately represented their experiences.
- Establishment of an independent assessment expert advisory group consisting of participants, allied health practitioners and appropriate medical specialists.

AHPA refers the Agency to the report provided as part of work relating to the independent assessment workforce conducted in 2020 as well as the submissions of a number of AHPA member associations. We also reiterate our view that further work is required to refine those recommendations and offer our support for working with participants and the Agency to co-develop robust quality assurance mechanisms in relation to the workforce. We also offer our assistance in identifying appropriately qualified and experienced allied health professionals to provide representation in the proposed expert advisory group.

Question 10

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

AHPA does not have a view on the most effective way of providing assessment results to the person applying for the NDIS, provided the information is provided in an accessible way. We defer to the

participant community as the most appropriate source of guidance on how results should be presented.

However, AHPA notes our strong view that it will be essential to ensure that assessment results are also accompanied with information about how a participant may flag concerns, raise questions, and provide feedback about the process. We acknowledge that the Agency has determined that the assessment results themselves do not comprise a reviewable decision and guidance about accessing formal review processes will not be appropriate.

While there may not be a formal administrative law review requirement, AHPA takes the view that the Agency should be seeking to build confidence with the participant sector, and providers, and to learn and iteratively improve, any new assessment process. We argue strongly that this cannot be achieved without a review process that allows participants to retain a degree of control in relation to the outcomes of the independent assessment process. Building in systems that allow participants to engage with the outcomes of assessments should be an essential foundation for these reforms. That feedback and engagement system should be clearly articulated as part of the assessment results. There should also be options for participants to provide anonymous feedback, outside of a review process, to ensure that the participant community feels confident in providing detailed feedback without fear of repercussions.

The Agency should develop a formal public reporting process outlining participant feedback on the independent assessment process. It may be appropriate for reporting to be first provided to the expert advisory group as part of regular reviews of participant experiences with a view to ongoing evaluation of the assessment process and as a precursor to proposing potential improvements. In this case, the expert advisory group may also publish actions being proposed on the basis of that participant feedback.

Planning policy

AHPA broadly supports the work of the Agency in relation to increasing the flexibility of plan budgets. We agree that in many cases, ‘participants, their families and carers are best placed to make decisions about the kinds of supports they need to pursue their goals’. However, we note that this will not always be the case and that there should be appropriate recognition of the formal and informal supports that participants may wish or need to draw on to make decisions about services and services. We also argue that there is a real risk that flexibility will be used as the basis for restricting funding and requiring participants to prioritise or choose one goal over another with potential consequences in relation to the intentions of the scheme. The proposal to publish best practice evidence about choosing supports will be problematic if not undertaken with independent clinical oversight that addresses potential conflicts the Agency may have in relation to discouraging use of supports for the purpose of cost minimization rather than clinical outcomes.

Question 1

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?

AHPA notes consistent feedback from providers working in the sector, and those seeking to enter the scheme as providers, about the complexity of plans for those that are new to the scheme or less

experienced. We strongly encourage an approach that seeks to work with participants and providers to re-design plans from the ground up in a way that is easier to understand and provides an appropriate foundation for plan budgets.

In addition to work on the structuring of plans, AHPA argues that it will be important to carefully design and test via pilot projects how best to structure and communicate information about flexible budgets to ensure that participants are exerting choice and control through enhanced flexibility, while not inadvertently losing out on services that they may be appropriate and required. This is particularly important given the stated intention to have budgets remain flexible across core and capacity building supports. We note the example provided in section 3.5 which refers to a participant undertaking an activity on the weekend with the support of a disability support worker, at the cost of other supports which may include longer-term capacity building activities with greater overall outcomes for the participant. For example, a range of behavioural interventions can require regular, ongoing interventions but which may not provide the same immediacy of impact as a more short-term focused activity.

While we note that the Agency is seeking to minimise the risk of participants running out of funding by adjusting payment schedules, we argue that additional measures will need to be included to ensure that participants are able to make informed decisions about making use of flexibility and understand potential risks. It may also be necessary to provide additional guidance and governance in relation to providers arguing for greater use of plan funds. For example, it may be appropriate to structure plans, and to provide accompanying information, that helps participants understand where there may be more aligned areas of supports that might be appropriately swapped with one another and where there may be quite different supports and potential impacts arising from reducing their use.

Question 2

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

AHPA has significant concerns about the proposals to provide participants with only limited scope to impact on the draft budgets that are set on the basis of the proposed independent assessment process. Our understanding of the current proposals is that this will be a highly standardised budget based on a participant's functional capacity rather than their individual circumstances, goals and aims. If this remains the case as the planning policy proposals are rolled out, AHPA calls for the provision of accessible tools for participants, and any supports or advocates they may have, that can support them to undertake initial planning and budgeting and determine whether the proposed budget is likely to meet their needs. In addition, participants should be provided with clear guidance about what evidence or information they might need to bring to the planning meeting to substantiate the case for budget changes.

Question 3

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

AHPA takes the strong view that participants should be empowered to manage their budgets whenever possible. We note our own engagement with many participants in the scheme, suggests that there are a large number of participants who have the knowledge, experience and understanding of their own needs to make appropriate decisions about the supports and services.

This should be supported and enabled with minimal use of fixed budgets and an emphasis on participant control and flexibility.

However, AHPA also notes that many participants and their informal support networks will not have the same level of decision-making capacity and knowledge of disability supports. This may mean that a high degree of flexibility creates additional risks. AHPA does not consider itself to have appropriate expertise to assert when this should be the case. Instead, we propose that the proposed expert advisory group, with participant and clinical representation, works with the Agency to set out principles relating to individual capacity and budget flexibility. This will form the basis for decisions about how flexible to make individual budgets and may outline processes to fix more of a budget where a participant may be experiencing issues.

AHPA notes its support for fixing budgets for capital expenditure for high-cost assistive technology, home modifications and accommodation. We also note our strong view that all participants should be supported to build the capacity to flexibly manage their own budgets and that this could be a focus for capacity building supports where participants are identified as not initially having that capacity or knowledge.

Question 4

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)

The impact of independent assessments on plan budgets is one of the greatest sources of anxiety for both participants and providers, particularly in light of the proposals by the Agency to largely lock in the draft budget prior to planning meetings and to limit opportunities to adjust budgets based on the planning process. It appears clear that the new process will significantly impact the ability for participants to have budgets that meet their individual needs rather than a standardised profile, based on functional assessment results determined by the Agency. The consultation documents (section 3.2 and 3.3) state that "*a personalised budget will be informed by the participant's individual circumstances, such as their age and where they live, and their functional capacity, including any relevant environmental factors, such as available informal supports*". While AHPA recognises the value of using an assessment of functional capacity, informal supports, and geographic factors as the foundation for a draft budget, we strongly argue that it should not be more than a foundation and that there must be appropriate input from participants and appropriate allied health professionals to address other areas not picked up in the assessment process.

Participants may vary enormously in their individual circumstances and goals, despite otherwise fitting an Agency-generated functional capacity profile, with potentially significant differences in the level of funding that they may require. For example, several participants may all have similar levels of visual impairment, similar family and community supports, and also live in similar metropolitan environments. Yet one may be seeking to enter the workforce for the first time, another may want to learn how to use a guide dog, and another may wish to improve their physical capacity to ambulate safely in the community after a fall. Each of these is likely to require a significantly different range of supports and services with different costs associated with each. It is not at all clear how the proposed process will in any way engage with the individual goals of the participant, or how standardised budgets will accommodate this variation. It is also not clear at all how individual assessments will reflect changes in circumstances such as a child starting school or an adult moving from supported into open employment. This lack of clarity around how independent assessments

will account for critical factors in a participant's life and circumstances must be addressed to help the sector understand and have confidence in the proposed process.

AHPA argues strongly that allied health professionals, and the clinical assessment and planning that they undertake with participants, are an important source of input into the planning and budget-setting process. That expertise should be drawn in both through initial input as part of the independent assessment that provides context about a person's individual circumstances and the capacity of their family or informal supports, as well as their overall environment. There should also be capacity for participants to begin identifying goals, and to seek additional input from allied health professionals and other service providers, in order to provide input about potential plan needs before draft budgets are set.

AHPA is pleased to see that the Agency has recognised the importance of not only setting appropriate budgets, but also of assuring participants and the sector that these budgets are at appropriate levels. We also support the broad proposal to have participants review learnings and suggest improvements as part of a formal evaluation process. We argue that it will be essential to ensure strong participant representation in the evaluation process, and take the view that the Independent Advisory Council should provide input into the evaluation and quality improvement process.

However, AHPA argues strongly that the level of complexity and clinical input required to inform the independent assessment process, and its translation into plan budgets, means that a dedicated expert advisory group is essential. This group should have very strong participant representation and interaction with the Independent Advisory Council. It should also consist of a broad range of relevant allied health professionals with appropriate expertise and experience. These allied health professionals will not directly represent their professions, but rather provide an independent, clinical input and oversight role, covering an appropriate range of clinical areas of operation including mental health and behavioural supports, intellectual disability, communication, auditory and hearing disability, and physical disability.

We have argued above in our response to question 9 from the Access and Eligibility consultation document, that it will be important for the Agency to collect and share both quantitative and qualitative data about plan budgets. This should include data on average plan budgets before and after the introduction of independent assessments, utilisation of plans, applications for plan review, and reporting on issues relating to expenditure of plan funds such as participants expending all plan funds significantly before the end of that payment period. In addition, we have argued strongly for the need to build in a review and feedback process that allows participants to provide input on independent assessments. We include in this feedback on the adequacy of the draft plan budgets that are supplied to them as part of the assessment and planning process.

This information should be formally reviewed and responded to by the expert advisory group with reports to be published by the Agency on their website.

Question 5

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

AHPA has argued above for the need to consider varying capacity to manage flexible budgets and the need to focus on improving capacity where it may be determined that a greater proportion of fixed items is required. AHPA has also argued for structuring budgets and accompanying information

in a way to provide a degree of guidance to participants about where it may be appropriate to move funds from one type of supports to another, and where not.

In addition, AHPA also argues that there would be significant value in supporting participants to make decisions about utilising funds, particularly where they or the Agency may feel that they do not yet have full capacity to manage a fully flexible budget independently. In such a case it may be appropriate to provide some support coordinator or plan manager supports that can be accessed for advice on potential impacts of utilising funds differently than initially planned.

Question 6

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

AHPA members have argued strongly that children are subject to potentially rapid changes in their requirements due to the speed at which they may be developing. As such the planning process needs to be flexible and responsive enough to allow families to access more frequent planning processes and greater flexibility in relation to goal-setting and prioritising of funds. It may be sufficient to schedule more frequent check-ins, and to provide increased flexibility in relation to drawing on plan funds, than may be needed for adults with disability.

Question 7

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

AHPA argues strongly that the most effective way to ensure plans can be used innovatively is to allow participants to choose the services they want without the Agency seeking to define what allowable services are, subject to broad governance such as regulation of professions providing services and limits on access to services that have been deemed risky or low value by an independent clinical panel.

AHPA and its members have noted with some concern the range of references in the consultation documents in relation to advising participants on best practice and evidence-based interventions. We have noted in detail in our response to the early childhood the challenges that exist in gathering research data in the disability sector and the potential risk of conflating gaps in research data, particularly at the highest levels of research reliability, with lack of effectiveness. AHPA and its members have also frequently reported to the Agency the experiences of participants and their families being told that they can no longer access supports such as those provided by creative arts therapists or registered music therapists.

We argue in the strongest possible terms that the Agency should take an enabling approach that supports participants to identify services and supports that may meet their needs, including from areas of clinical intervention with a lesser evidence base, provided these are subject to overall safety and quality requirements. The Agency should seek to address misinformation provided by Agency planners, or Local Area Coordinators (LACs) and support coordinators funded by the Agency. The Agency should also seek to support increased research and less formal identification of effective and innovative approaches and communicate these to participants and providers as a means of supporting continual quality improvement in the sector.

Question 8

How best to handle the timing of the release of funds into plans and rollover of unused funds?

AHPA recognises the need to manage risks in relation to the release of funds in order to ensure that participants are able to continue accessing funds throughout the year to access services that have been determined to be reasonable and necessary. As such, we are broadly supportive of more frequent releases of smaller amounts of funding. However, AHPA understands from discussions with the Agency and participants that there is an intention to proscribe participants from drawing down funds from their budgets. While this may be seen as necessary, it contradicts the intention of greater flexibility and control for families as well as potentially impacting access to intensive therapy packages, a common intervention type utilised by allied health practitioners and supported by strong research for some intervention types.

AHPA argues strongly that there will need to be a process in place to identify if funding needs to be differentially spread out across the year, with flexibility to vary this timing where needed. I.e. a family may receive quarterly payments for their child with disability and may have planned with one of their child's therapists to start a program of intensive therapy focused around capacity building so that the child can travel to their school independently. In this case it may be appropriate to draw down 30 or 35 percent of the total plan budget in the first quarter with smaller amounts in following quarters. However, there may also be circumstances in which the timing for plans change and so there should be capacity to vary when funds are released.

AHPA also notes that there are a range of circumstances in which it may be appropriate to draw down on a plan due to temporary changes in circumstances such as family carer experiencing illness and requiring additional support worker supports. Many of these situations may not require an overall change in the size of the total budget but rather a process that enables families to access some flexibility in the timing of funds being released.

AHPA argues that it would likely be appropriate to have varying processes to vary funding access, including automatic releases or light-touch review processes for small amounts of funds where a participant or their family has not otherwise had to draw down on funds. However, there should also be responsive processes that allow timely access to a more comprehensive review where a larger envelope of additional funding is required. We also argue that there should be automatic triggers for check-ins with families where these are having to draw down significantly on funds or are not expending funds and rolling over a larger than expected portion of funds. This aligns with the Agency proposals in the consultation document.

We note that the Agency proposal appears to be that where a more significant change in funding is sought, this will trigger an additional independent assessment. AHPA wishes to flag the strong uncertainty in the sector about what value such an independent assessment would have in any circumstances other than a significant change in functional capacity or environmental factors. If these are the only factors the Agency is proposing to consider for the purposes of budget changes, then we have very significant concerns about the degree to which a participant's individual needs are reflected in the budget.

Question 9

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

AHPA supports a flexible approach to check-ins, based on the preferences of the participant. This should include telephone and online check-ins, as well as in-person check-ins. Participants should also have capacity to ask for informal or formal supports to be involved in check-ins. For example, a family may wish to have a therapist present to provide information and guidance about the need for

additional funding to help a participant achieve a particular goal. It may also be appropriate in some cases for check-ins to be conducted by a therapist rather than a delegate.

In relation to the circumstances in which a check-in is needed, AHPA supports the proposals in section 3.6.2, noting that the Agency will need to have robust notification mechanisms in place to monitor participant spending of funds to allow timely check-ins to occur. There will also need to be mechanisms to allow participants and their families to advise the Agency about upcoming milestones and significant events that may be coming up, ideally through an easily accessible function in the Myplace Portal. This would be separate to voluntary requests for check-ins with the intention for these to be mapped out proactively and able to be adjusted as needed.

Question 10

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

AHPA argues that check-ins should only be initiated when needed. We argue that in the absence of other triggers for check-ins, these would likely only be required on an annual basis. We propose that while the delegate may set the schedule for planned check-ins, there should be clear guidance on appropriate frequency. This framework or guidance would align closely with the development of guidance and parameters by the EAG focused on the flexibility and fixing of plan budgets for different participant cohorts.

Question 11

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

AHPA argues strongly that the proposal to largely lock in draft plans before planning sessions is likely to result in an unnecessarily combative environment. We hold the strong view that the process of budget setting should include an additional step to identify key goals and outcomes a participant may be seeking for inclusion in budgets as part of an additional level of individualisation. This could be built into the assessment process itself, though if the AHPA recommendation to use allied health professionals with existing relationships with participants is accepted it may be more appropriate to provide a degree of distance and independence by expanding the planning process to address issues around lack of flexibility and individualisation in the setting of draft budgets.

AHPA also notes the importance of clear and transparent frameworks or guidelines, co-designed with participants and clinicians as outlined above to guide planners in their decision-making. Planners are in many respects the public face of the Agency and the likely recipient of concerns from participants and families about any aspects of concern including draft budgets, check-in and payment release schedules and how fixed or flexible individual budgets are.

Finally, AHPA notes a strong view that there is a need to continue upskilling the planning workforce as well as resourcing more time for the planning process. By ensuring that planners have a better and more appropriate understanding of disability and disability supports, and that planners are able to invest an appropriate amount of time with participants and their families, AHPA believes that participants will have more trust and confidence in planners.

Question 12

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

AHPA argues in the strongest possible terms that supporting participants, and the allied health providers that support them, to transition to the new planning model requires careful and genuine engagement with the concerns and proposals put forward as part of this consultation process. We

argue strongly for a process of genuine co-design with both participants and the allied health sector, through mechanisms such as the proposed expert advisory group and involvement of the Independent Advisory Council.

AHPA also argues that there are unrealised opportunities for the Agency to bring together participants and the allied health sector as part of the design, implementation and evaluation of the new independent assessment process. While the Agency has undertaken some engagement with AHPA in early 2020 as part of the independent assessor workforce project, engagement with the Agency since then has been limited. Instead, the Agency has focused on direct engagement with participant representative organisations through regular meetings and the Agency CEO Forum.

AHPA and its members have engaged directly with participant representative bodies to support improved understanding of challenges and opportunities but argue for the benefit of greater interaction in conjunction with the Agency. We note also that the allied health sector is not represented in the CEO Forum, despite the involvement of other provider peaks and our role as the national peak association for allied health professions. Addressing this oversight may be an effective opportunity to support a more coordinated and co-designed approach.