Submission No 112

INQUIRY INTO IMPLEMENTATION OF THE NATIONAL DISABILITY INSURANCE SCHEME AND THE PROVISION OF DISABILITY SERVICES IN NEW SOUTH WALES

Name: Name suppressed

Date Received: 1 August 2018

Partially Confidential

Dear Sir Madam

This is a PRIVATE submission.

I am a fulltime carer of my daughter who receives NDIS support. I not only have experience in disability as a parent, but have worked in the industry and still maintain contact with former colleagues in the industry, both in residential and day support.

We are very grateful for the support we receive, as it is much better than under the old system. It has allowed me to take the difficult step of removing my child from supported accommodation, back into my fulltime care. Unfortunately, however, I had to do this due to issues of neglect and bullying by staff, particularly a seeming lack of supervision or re-education of these staff members by management. There is also a lack of disciplinary action or even dismissal for quite serious breaches. Example: 'delusional' behaviour by the client actually due to bullying and 'gaslighting' by staff, leading to prescribing of higher dose of antipsychotic medication.

Systemic issues:

1. Casualisation of employment of support staff, as encouraged by the NDIS: Paradoxically, because of the high demand for staff, many unsuitable people are being employed. This compromises the quality of care of particularly high-support clients. It also encourages a high staff turnover because
* Employers are deliberately ignoring WHS considerations, knowing their constant recruitment of new staff will replace experienced staff moving on due to poor WHS compliance, in particular manual handling.
* Employers are reducing working conditions, leading to older or more experienced staff (especially permanent employees) exiting the industry. In many cases employee protest results in lightning audits or unjustified harrassment by management. Example: withdrawal of salary packaging for permanent employees even though the administrative costs are mostly borne by the employee.
* Employers are 'cherry picking' support packages to concentrate on packages with lower overheads. Example: clients with only 2 hours per day support cannot find a service provider.
* Employers overload casual staff with shifts, as they are less likely to protest at the overwork.

2. Service providers purportedly unable to provide better quality of care because they are underfunded for their administrative costs. Example: case managers' higher workloads, leading to inadequate staff supervision or training; as well as having no practical knowledge of the client because the case manager never works face-to-face shifts.

3. Lack of timely payments by NDIS to providers of equipment or consumables. Example: funding approved for incontinence products cannot be spent because of such tardiness in payment by the NDIS to the vendor that the vendor won't accept further orders before the funding period expires.

4. The current complaint system to the Ombudsman is so inadequate and overloaded that only the most serious complaints are investigated. The NDIS still has not taken on this role. The rate of complaints itself is an indication of systemic problems within the disability sector.

5. Plan renewal appointments are always overdue, making service providers reluctant to continue support beyond the cutoff date due to funding uncertainty. Example: respite care cannot be accessed when service provider does not have confidence in prompt payment. This delay will flow on to reduce the amount of respite care that can be accessed.

6. Not enough detail in plans once approved, particularly inexplicable when detailed costings were provided by the applicants. Planners specifically advise plans have been approved in full when the plan was actually reduced.

7. Huge delays (months) in review of plans, thus discouraging applicants from requesting a review. Example: respite funding inexplicably reduced when the carer had already indicated a lengthy hospital stay was anticipated later in the year.

8. Removing ancillary health providers from the system, instead relying on the client accessing an inadequate number of GP referrals (5) under the Enhanced Primary Health Care system, which also often sees 'gaps' being charged to the client. Example: unable to access sufficient podiatrist, physiotherapist and dietician services.

9. Refusal to fund equipment specific to the needs of the client's syndrome, e.g. glasses for severe myopia, orthotics, specialised hearing aids, custom shoes.

Policy issues

Supported Work
A better policy is needed, recognising the desirability for expansion of Supported Work opportunities, to improve both community engagement and emotional wellbeing of people with a disability. It would also improve the mainstream public's perception/acceptance of funding people with a disability when reciprocity can be demonstrated. This enhanced Supported Work participation would also allow government to better justify to the public the need for an adequate funding model for the NDIS.

Self-managing
The NDIA has until recently encouraged families to self-manage, apparently in an effort to reduce fraud. This is a flawed policy because there is little recognition of the difficulties families experience in their caring role, which often preclude them from taking on this additional task. These difficulties are emotional, physical and financial.

Regards