

**Submission
No 186**

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

Organisation: Rehab Health and Fitness Australia

Date Received: 9 August 2018

I am writing this submission to add evidence into our journey through to our business to becoming a registered provider and our subsequent work within the National Disability Insurance Scheme.

We need to work towards a system that highlights investment in capacity building supports.

We need to work together to develop a scheme which maximises participation, is flexible to support participants changing needs, allows access to experienced therapists and allows us to provide evidence-based care in a timely manner.

We first registered our business in Feb 2017, following the transition of some of our existing clients and increasing enquiries to our service. We employ 30 allied health professionals in Sydney and have clinical interests in working with clients with both a disability and in aged care. We are registered for Early Intervention and Therapeutic Supports and a myriad of assistive technology categories. We have been providing allied health services now for 10 years, having run a successful and growing private practice during this time.

We have approximately supported 280 participants since the roll out of the scheme. With 75% of the participants being agency managed.

Our experience within the scheme has been amazing, disappointing, frustrating and all the emotions in between. We have emotionally supported the families we are providing capacity building supports for. They have all had varying journeys through the scheme to date and at times have experienced stress, dismay, joy and frustration. Most of the time this is because it feels like a scheme with no rules.

When the scheme works well it is wonderful to be a provider. Some examples of this are: -

- A participant who sustained a traumatic amputation being approved for a powered wheelchair. On discharge from rehab 5 years ago they were provided with a second-hand manual wheelchair from a friend. This was in disrepair and incorrectly sized which had caused pressure areas and multiple hospital admissions. To see her approved for a new wheelchair, fully funded by the scheme is amazing.
- Providing respiratory management advice for a young lady with Level V Cerebral Palsy and her family. Being able to educate her support staff and family on techniques to prevent respiratory infections. She has just made it through 10 months without a hospitalisation. Prior to this she had 4-5 admissions to hospital per year

There are many ways in which NDIS is NOT working well. There is the feeling as a provider that we aren't respected or listened to. That we are constantly being asked to provide more and more services for less and less due to plans and funding limitations. The extended delays for essential equipment that our experienced staff have determined as clinically necessary are not considered, reviewed and if they are, are stuck in long long delays. That families and participants safety is being compromised during these delays. When a participant is unsafe in their environment due to lack of Assistive Technology or Home Modifications there is no one to call that can address the issue with our team. If you contact the 1800 call centre they can send an email to escalate it. I think after escalating over 50 issues I have heard from staff on 2 or 3 occasions.

Frustrations arise when there is no consistency between decisions made across the scheme. And decisions are finite with no further provider input considered or discussed. A prescription for a piece of Assistive Technology or service is denied without engagement of the Allied Health Professional.

Communications from the Agency are in poor quality, lack details and often delayed. The Independent Pricing Review was release after business hours on a Friday afternoon, followed by endorsement from the Board of NDIA on Saturday morning. This was despite the fact there was no consultation with the relevant Peak Bodies, despite their reports in the media to the contrary. At the most recent Senate Estimates Hearing on NDIS services Mr De Luca announced that the Agency had implemented a nationwide change to the assistive technology pathway, aimed to reduce delays in the provision and the cost of supplier for Level 1 and 2 assistive technology items. As a provider we have received a fact sheet from one support co-ordinator in recent months about these changes. However, this fact sheet is undated, and we are unaware of the currency of the communique. We are yet to receive any formal information, training or even an email to providers to highlight what would be monumental changes.

Payments for services are frustrating. An example being a participant's plan is reviewed with no notice and we lose funds from service booking that we may not have yet to claim for services. I have sent over 40 emails to the provider payments team since it was launched in Feb/March 2018 on different issues and had a response on 5-6 occasions. As a business we currently have over \$10,000 in written off work and at present upward of \$20 000 I am chasing with provider payments and plan management agencies for payment.

Early intervention has its own problems. We are aware of children who received their diagnosis following the cut off dates for Better Start funding and are yet to be provided with their planning meetings. There are plan gaps.

Some considerations we have given to simple ways to improve the scheme.

1. Provide us as therapist's, guidelines on what will and will not be funded. Assist with developing a robust and all-encompassing document of the different Levels of Assistive Technology so we aren't all guessing and interpreting it differently. No point in providing hours of therapy and training and AT request forms for iPads, for example, if they won't be funded. I understand there are certain circumstances where these will be funded but provide us with a guide. It helps us manage family's expectations as well.
2. Improve access o Assistive Technology Department or Home Modifications assessor so we can raise direct questions about approvals or whether to proceed with a recommendation and request, so we can get specific advice from a suitably qualified person in a position to give such advice
3. Better total plan governance - cease spending on Chiro and Acupuncture. Have ways of enforcing your own rules
4. Ask providers to use Easy English, not professional jargon, on how Capacity Building expenditure will impact on the participant, their care needs and their family. For example – give us the opportunity to say, "this piece of equipment will allow the participant to wipe their own bottoms."
5. Improve payments and response by finance or provider payment
6. Minimise the time we spend on hold. You are being billed for it on most occasions.

7. Stop double and triple handling applications. If you are rejecting my request for something call me. Maybe that will provide further information for the planner to make a decision or provide me with more information on why it was rejected and we all learn for the next time
8. Where is all the spending? The IPR feels like you are trying to claw back on Capacity Building funds – we IMPROVE participants lives. But across the scheme this only represents 12% of the total expenditure.
9. Plan governance – decision makers need clinical training to determine what is and what isn't reasonable and necessary
10. Acknowledge that poor determination and expenditure within core budget is where most funds are expended. Allow the allied health therapists to be more directly able to assist with core support structures.