Stride Response

QPC Inquiry into the NDIS Market in Queensland

August 2020

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Preface

Stride Mental Health (Stride) is Australia's longest-established mental health charity and has provided specialist mental health services to people with persistent mental illness and complex needs since 1907.

Today Stride employs over 750 staff providing community outreach, residential and integrated mental health services for over 15,000 Australians in NSW, Qld and Vic. Half our income is derived from the NDIS. Our two key priorities are (i) services for people with persistent mental illness and complex needs and (ii) an increasing focus on early intervention with children, young people and families.

Our services encompass:

- **Community-based services** for people with persistent mental illness and complex needs –funded primarily through NDIS with additional grant funding support from Continuity of Support and National Psychosocial Measure programs (formerly PHaMs and PIR programs) in particular. We also provide community services under State grant programs.
- **Residential services:**
  - Under NDIS "Supported Independent Living" (SIL) funding, for adults
  - For young people – we operate a range of state-funded services including recovery-oriented services focused on social and emotional wellbeing, education and employment outcomes, and some services for complex cases involving the out-of-home-care system.
  - An acute Youth Step-Up Step-Down service in partnership with the Cairns and Hinterland Hospital and Health Service.
- **Integrated services:**
  - For young people: we operate six "headspace" centres – Stride is the largest operator of headspace centres in Australia
  - For adults: we operate four integrated mental health services centres – two in NSW (under State funding for "LikeMind") and two in Queensland (under our own name "Stride Hub").
  - For children and families: we operate two mental health centres in Ipswich and North Brisbane, called "Stride Kids".

We welcome this opportunity to contribute our views regarding the NDIS market in Qld. Our extensive history in the service provision of psychosocial supports and our breadth of services in Queensland means we have an extensive range of experiences and issues to draw from in our response.

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Summary

The QPC Inquiry Issues Paper is broad-ranging and poses many important questions. In our response we focus on four key areas:

1. **NDIS pricing** and the impact on the Provider market.
2. **Thin markets** – with a focus on the provision of psychosocial supports in regional/remote areas of Qld.
3. **Gaps and overlaps between the NDIS and other schemes** and psychosocial supports in Qld.
4. **Other NDIS issues with implications for Qld State services.**

Section	Situation	Recommendations
1. NDIS pricing and impact	The current approach to NDIS pricing for Core Supports and some other key service items is at best driving low cost-models not focused on Participant safety, quality supports and outcomes; it is unsustainable for real-world, enduring organisations employing permanent staff. This will have a real impact on the provider marketplace in coming years and particularly in "thin markets".	▪ An independent review of NDIS pricing should be commissioned. ▪ An independent NDIS Price Commissioner could be established, balancing the views and input from the NDIA, Providers and Participant, considering quality and safety among other factors.
2. Thin Markets	There are a wide range of barriers to adoption of NDIS packages and Provider sustainability in rural and remote communities, exacerbated by the NDIS pricing issues above.	▪ Integrate potential NDIS, state and federal funding to develop more coordinated and sustainable mental health support service strategies in remote (especially Aboriginal-and-Torres-Strait-Island) communities in Qld, engaging with local leaders. ▪ Review and redesign the NDIS service model for these communities with a focus on cultural appropriateness. Consider establishing more NDIA Access Clinics.
3. Gaps and overlaps	▪ There is a very significant gap between former Federal funding for mental health services (Day to Day Living, PIR and PHaMs) and future funding after accounting for NDIS transition. ▪ There is a lack of clarity about scope and boundaries for federally funded mental health services (including NDIS) and state funded services and in some cases a significant lack of collaboration and integration.	▪ Review the psychosocial service resourcing for those who do not qualify for the NDIS in future years; seek to understand the assumptions and modelling that has been used to determine the resource allocation quantum for the NPS measure – and make this transparent. ▪ Create models for better integration of funding sources to allow more effective, holistic and efficient provision of services for complex individuals and high-needs communities. ▪ Where it is necessary to limit duplication of services, create rules based on the specific service provided/funded through the NDIS rather than blocking Participants from whole services because they are an NDIS Participant.
4. Other issues with implications for Qld State services	See section 4 – topics covered include: ▪ The NDIS Quality and Safeguards Commission ▪ Specialist providers vs generalist providers for specific (complex) Participants/cohorts ▪ Restricted access to Supported Independent Living (SIL) ▪ "Thin markets" for some specialist providers including Mental Health Occupational Therapists and Behavioural Support Practitioners.	

Detailed Responses

1. NDIS pricing and the impact on the Provider market

Context

The NDIS price limits for Core Supports are based on its Cost Model, published in 2019 and updated in June 2020 as a result of its 2020-21 Price Review (see https://www.ndis.gov.au/Providers/price-guides-and-pricing/annual-price-review).

The NDIA Cost Model depends on about five key parameters which in turn are based on a survey of Providers called the Temporary Transformation Payment (TTP) Survey. The NDIA methodology uses the 25th percentile for each of the key parameters, aiming to calculate the cost of an "efficient Provider", meaning a Provider at the 25th percentile of cost. This means that if the NDIA's methodology is *correctly* applied, 75 percent of current Providers are not sustainable at the NDIA's price limit.

In practice the NDIA has chosen to ignore some of its own survey data and set lower prices, and has also made mistakes in its calculations, resulting in even less sustainable pricing.

The Key Issue

In simple terms the NDIA price limit approach benefits and incentivises Providers to aim for *lowest cost.* There is a very significant risk that this comes at the cost of client outcomes, quality and safety. Providers do not believe that the NDIS pricing for Core Supports (and now some other items also based on the Cost Model methodology) is sustainable.

It is Stride's submission that an independent review of NDIS pricing should be commissioned.

An independent NDIS Price Commissioner could be established, balancing the views and input from the NDIA, Providers and Participant, considering quality and safety among other factors. This mirrors arrangements in place for aged care pricing (http://www.acpc.gov.au/internet/acpc/publishing.nsf/Content/about).

The State of Queensland has a significant interest in the NDIS price approach and its long-term consequences; decisions made now will determine the nature of service provision in the future (reduced quality and safety), exacerbate thin markets, and result in increasing load for State services.

Cost Model Parameters, Price Implications and Comment

The NDIA has acknowledged overwhelming Provider sector feedback that its Cost Model does not reflect true costs but has not increased prices in its recent review. The NDIA is also aware of errors made in its recent Cost Model calculations but has chosen not to address these.

The first table below summarises some of the key parameters in the NDIS Cost Model used to determine price limits, with comments about the basis of these assumptions and issues arising.

Table 1: NDIA Cost Model Key Parameters

Parameter	NDIA Cost Model Assumption	NDIA Cost Model Basis	Issue/Comment
Span of Control (ratio of support workers per Supervisor)	1:15	The Span of Control parameter was increased for 1:11 (2019) to 1:15 (2020-21) on the basis of the 2020 TTP Provider Survey, which resulted in a calculation of 1:15 at the 25th percentile for this metric	The TTP survey question asked about *headcount* but the result has been used to calculate span of control in *Full-Time-Equivalents (FTE)*. A team with 15 headcount probably has about ten FTE (on the NDIA's own data). This is a simple error. The NDIA has been made aware of this but has not amended its cost model calculation.
Utilisation (percentage of a support worker's time that is billable)	92% (low intensity) to 87.7% (high intensity)	The Utilisation assumption for low intensity core supports is based on (slightly higher than) the TTP Provider survey (90% at the 25th percentile)	The NDIA has received consistent feedback from the Provider sector that the Utilisation rate is unsustainable for organisations that employ permanent (rather than casual) staff. Stride (and many others) believe the Utilisation assumption is even more unsustainable in high intensity supports where support workers are dealing with highly complex Participant and risks.
Overhead (in the NDIA's definition, this means all costs other than the support worker and supervisor salaries)	12%	The TTP Provider survey showed that "overhead" (by the NDIA definition) is 19.8% at the 25th percentile and 28.1% at the median. The NDIA chose to ignore the survey data for this parameter on the basis that some Providers did not complete the survey and "probably have lower costs"	As the NDIA Price Review Report states; *"Submissions from Providers indicated widespread dissatisfaction with respect to the level of overheads allowed for by the cost model . . . the vast majority indicated that their actual level of overheads considerably exceeded . . ."*. The NDIA decision to set prices below levels that its provider survey dictates will drive Providers to a highly casualised workforce and will reduce focus on client safety, quality and outcomes.

Table 2 (next page) compares the NDIA's Cost Model result with real-world costs for an organisation like Stride, for a Level 3 (high intensity) Support Worker. The figures presented for Stride Mental Health are in conservative (lower than actual current costs).

On this basis Stride's cost per Support Worker is about $13,000 (14.5%) per worker per annum higher than the NDIA's model.

Table 2: NDIA Cost Model vs Stride Mental Health for a Level 3 Disability Support Worker

Table Notes are on the following page.

	NDIA Cost Model		Stride Mental Health		
Cost	**$/hr[1]**	**$ pa per SW**	**$ pa per SW**	**Calculation**	**Comment**
Salary and Oncosts - Support Worker	$49.28	$72,267	$72,267	Calculation based on SCHADS level 3.2 and allows for leave, super and other entitlements	
Salary and Oncosts – Supervisor	(1:15) $3.76	$5,520	(1:10) $8,279	Stride's average span of control ratio is not yet 1:11 (i.e. our cost is higher than indicated) but we are working towards this target	The NDIA basis for amending the *Span of Control* ratio to 1:15 is in error[5]. We believe 1:10 (FTE) is a reasonable efficient organisation target; higher risks safety and quality
Local training costs	nil[2]	$0	$805	Training cost included at 1% of S&W costs (a low benchmark)	The NDIA cost model provides for support worker time for training, but not for the direct costs of training
Other S&W Allowances	$1.01	$1,486	$1,486	Assumption unchanged from NDIA cost model	
Sub-Total Salaries/Oncosts	**$54.06**	**$79,272**	**$80,547**		
Local oncosts – office, utilities, consumables	nil[2]	$0	$3,500	A small shared office (rent $25k pa; utilities $5k pa; consumables $5k pa) divided by ten support workers = $3.5k pa per SW	Stride's true local office costs are significantly higher than this; we are working to reduce this cost over time (eg through shared offices)
Service quality, safety and governance overhead	nil	$0	$1,990	Service Quality team: 2.0 FTE in an organisation of 500 frontline staff; Supervisor's supervisor at a ratio of 1:10	The Service Quality team is responsible for policies and procedures, compliance, accreditation, complaints, investigations and more, as well as for reporting and communication to the NDIS QSC
Depreciation	Omitted[3]	$0	$884	Stride's depreciation (excluding motor vehicles) is 1.3% of services expenditure but we have used a conservative 1% in this model	The NDIA excluded depreciation "on the basis that it's a financing cost" but in practice depreciation includes for systems (to deal with the NDIS) and other relevant costs which must be funded
Corporate overhead (finance, IT, HR, marketing, risk, CEO & governance)	(12%) $6.49	$9,513	$12,374	We have costed Corporate Overhead at 14% of other costs; this is our strategic target (current costs are about 20% above this)	There are benchmarked for corporate overhead that indicate costs are above the NDIA's 12% figure – for example, in the NDIA's own price review report which quotes a Nous Consulting study showing a median cost of 10.2% for finance, IT and HR functions alone
Cost of Capital	(2%) $1.21	$1,776	$2,033	Assumption unchanged from NDIA cost model	
Total "overhead"	**$6.76**	**$11,289**	**$20,781**		
Total	**$61.76[4]**	**$90,561**	**$103,679**		

Table Notes

1. This column replicates the NDIA Cost Model and is expressed as $ per billable Support Worker hour (the final total is the NDIS Price so calculated).
2. The NDIA Cost Model does not include any provision for local direct costs including training, rent, utilities or consumables. These costs are either funded out of the NDIA's "overhead" provision (later in the model) or not at all.
3. The Deloitte report on the NDIS TTP Provider Survey (see https://www.ndis.gov.au/Providers/price-guides-and-pricing/benchmarking-surveys-and-reports) reported that the analysis of overhead excluded depreciation on the basis it is "typically considered capitalisation and finance expenses" (p16).
4. $61.76 is the NDIA Cost Model price for the 2020-21 year.
5. The NDIA's TTP Provider survey asked for a ratio in headcount, but the cost model has applied the ratio in FTE terms. Based on the NDIA's own data on the proportion of casual workers, a team of 15 Support Workers likely has FTE of about 10.

Impact of Utilisation

The comparison above shows that Stride's cost per Support Worker is about $13,000 (14.5%) per worker per annum higher than the NDIA's model.

There is one more key NDIA assumption that effects price, and therefore Provider income – the assumed Utilisation rate (the percentage of a Support Worker's paid hours that is billable to the NDIS). This assumption determines the rate the Provider is paid per billable hour.

The NDIA's Cost Model Assumption for a Level 3 (high intensity) Support Worker is a Utilisation rate of 87.7%. We believe that this is significantly too high for high intensity supports where the workforce is permanently employed (not casuals). The impact of this assumption is also significant; if, for example, a Utilisation rate of 80% us applied instead of 87.7%, the gap between Stride's cost and the NDIS price increase from 14.5% (calculated above) to 24%.

Summary of Pricing Impact

As illustrated in our analysis several of the costs that are not included or inadequately covered in the NDIS' pricing model are directly quality related, including the true cost of staff supervision at a reasonable management ratio and the cost of safety and quality, including costs of NDIS accreditation and reporting.

In addition, driving for unreasonably high utilisation rates when working with complex Participant adds significant risks both to client safety and to worker wellbeing.

The NDIA pricing approach is driving the sector towards a highly casual workforce with less supervision, reduced training, and reduced quality and safety support systems. This poses a key risk across NDIS services but especially in support of Participant with complex needs.

In Stride's opinion the NDIA pricing approach has an even greater impact on regional areas and other "thin markets".

Recommendation/s

- An independent review of NDIS pricing should be commissioned.
- An independent NDIS Price Commissioner could be established, balancing the views and input from the NDIA, Providers and Participant, considering quality and safety among other factors.

2. Thin markets – with a focus on the provision of psychosocial supports in regional/remote areas of Qld

Stride Mental Health provides mental health services in the Torres Strait and in the South-Western Qld (Roma/Cunnamulla/St George) region, with funding from the Queensland Health Mental Health branch, as well as some NDIS funding.

In our experience there are very significant barriers to sustainable NDIS service delivery in these (and similar) areas, most notably:

- Significant cultural barriers: individuals not willing to apply for NDIS packages as it is not an appropriate cultural fit e.g., they do not want to be labelled as having a disability or for their small community to know they have a disability; the access process is overwhelming and support from allied health providers is often scarce in regional/remote locations or the expense of accessing allied health providers in a barrier.
- Very small markets: even if most eligible people take up NDIS packages the total value of these in some areas is insufficient to support a sustainable team (eg of 3-4 workers including service leader). This is the same for specialist allied health supports e.g. providers of therapeutic supports.
- In some cases, difficulties in recruiting qualified staff with experience in complex psychosocial health supports.
- Higher costs (travel and distance), lower productivity of workforce.
- More complex community and social issues e.g. very high rates of unemployment
- Long timeframes (to build community relationships and trust) – measured in years.

Moreover, we do not believe that an individualised funding model is the right methodological approach to improving mental health (and other) outcomes in remote communities – rather, a whole-of-community approach including engagement with local leaders is necessary to be effective and meet the cultural needs of many remote/rural communities.

NDIA Access Clinics can help support those who need it to successfully transition into the Scheme. This would support those who are hard to engage including Indigenous communities.

Recommendations

- Integrate potential NDIS, state and federal funding to develop more coordinated and sustainable mental health support service strategies in remote (especially Aboriginal-and-Torres-Strait-Island) communities in Qld, engaging with local leaders.
- Review and redesign the NDIS service model for these communities with a focus on cultural appropriateness. Consider establishing more NDIA Access Clinics.

3. Gaps between NDIS and other schemes in psychosocial supports in Qld

Funding Gap (between former Federally Funded-services and the NDIS)

We believe there will be enormous gaps for people with psychosocial disabilities not qualifying for the NDIS or unwilling to attempt the access process.

- Before transition to the NDIS, Stride was a very significant Personal Helpers and Mentors Service (PHaMs) and Partners in Recovery (PIR) provider with a total of about 25 service sites across these federally funded programs (nearly half of these services in Qld).
- Based on our transition, we estimate:
  - Over 40% of PHaMs clients were ineligible or were refused for NDIS (including a small percentage declining to apply);
  - Between 30% and 40% of PIR clients were ineligible or were refused for NDIS support.
- The National Psychosocial Support measure (for "future" clients not eligible for NDIS) is funded to about 5% (order of magnitude) of the previous federal measures[1]. We anticipate that this funding will prove greatly inadequate over time – in simple terms, 35%-40% of community members that may have been supported in the past by PIR or PHaMs will be supported through 5% of the previous funding.
- The burden of this shortfall at a macro level will fall on State services including hospitals, emergency services and emergency departments.
- There is a risk that this unmet need with contribute to a rise in adverse outcomes for this vulnerable populations including suicide attempts, suicide, homelessness and unemployment. These outcomes will be exacerbated for people in regional/remote areas with access to even fewer state funded supports.

Integrated Service Hubs vs NDIS

- Stride Mental Health operates several "integrated service hubs" providing a range of mental health and related services to the community. These services aim to provide a one-stop-shop addressing multiple needs of service users.
- In some of these cases our funding contract (PHN and/or Q Health) stipulates that NDIS Participants cannot be supported through the integrated service.
- However, there are commonly periods (for example in a time of escalation for a Participant with episodic mental health issues) where it would be in the Participant's best interests if we accessed additional services from the Hub; in some other cases there are services provided to the Hub that may be complementary to services funded through the Participant's NDIS plan (but not funded through the plan).
- We believe that there should be more focus on seamless service provision to meet the needs of and facilitate positive outcomes for the Participant. We understand that different funders also want to limit duplication of service delivery.

[1]We note that the NPS measure was to be "matched" by State funding – we believe that much of the "matching" is existing rather than new funding to address the gaps outlined here.

Overlap Between/Lack of Integration of Federal and State Funded Services

More generally, we think there is a lack of clarity about the scope and limits of federally funded (including NDIS) and state-funded services in mental health. For example:

- (In another state) we operate a State-funded integrated service hub and the PHN recently announced the same suburb would be the local site for a new federally funded integrated service, almost identical in purpose.
- We have several experiences (some in Qld) where there is limited collaboration between PHN and HHS on mental health strategy or services, including examples where we have part-funding from both State and Federal sources, but a lack of ownership of the issues that fall between the two funders.
- NDIS planners are making it difficult for Participants to access Therapeutic Supports, asking Participants to utilise Medicare (MBS) funding instead; however, we believe that there is a difference between MBS-funded supports and maintenance Therapeutic Supports funded through the NDIS.
- In all these cases we think there is a great opportunity to conceptualise more integrated models of service delivery that deal more holistically with the needs of individuals and of the local community and deliver better outcomes for a given investment. This includes improving the extent to which NDIS funding for some service users can more seamlessly be incorporated into an overall integrated service strategy.

Recommendations

- Review the psychosocial service resourcing for those who do not qualify for the NDIS in future years; seek to understand the assumptions and modelling that has been used to determine the resource allocation quantum for the NPS measure – and make this transparent.
- Create models for better integration of funding sources to allow more effective, holistic and efficient provision of services for complex individuals and high-needs communities.
- Where it is necessary to limit duplication of services, create rules based on the specific service provided/funded through the NDIS rather than blocking Participants from whole services because they are an NDIS Participant.

4. Other NDIS issues with implications for Queensland State services

NDIS Quality and Safeguards Commission

The QPC Inquiry issues paper posed questions relating to the NDIS Quality and Safeguards Commission (p35-36). Stride also made a response to the recent Joint Standing Committee inquiry into the NDIS QSC, available on request; much may be relevant to the QPC questions on this subject.

Our Joint Standing Committee submission summary and recommendations are included below for the information of the QPC.

- At a high level we have found the NDIS Quality and Safeguards Commission to be sometimes slow to respond (for example, we lodged an extremely positive external audit report in December 2019 but in spite of many follow-ups we still do not have confirmation of our registration), and in some cases inconsistent and unclear in communication (a variety of examples are given in this submission).
- Stride recognises that more recently the Commission's responsiveness to critical matters has improved, as evidenced by recent advice and recommendations as COVID-19 continues to challenge Australia.
- We add that the Commission's core aim – quality and safety – is fundamentally undermined by the NDIA pricing approach which we believe fails to consider quality or safety. In Stride's case our quality and safety practices are funded out of our own pockets and are not subsidised by NDIS income (with the result that we are making unsustainable losses).
- Stride acknowledges the size of the role the Commission fulfils and the scale of the Commission's functions across Australia. The Commission has established itself during a time of rapid change and turbulence for Participant, carers and Providers. Stride looks forward to continuing to support the Commission to ensure the provision of quality and safe supports for all Participant and welcomes any requests for further information on the contents of this Submission.

Section	Recommendation
NDIS Pricing	▪ The Quality and Safeguards Commission should play an explicit and significant role in price-setting for the NDIS, expressing its opinion on key parameters underpinning the NDIA Cost Model. ▪ An independent NDIS Price Commissioner could be established, balancing the views and input from the NDIA, Providers and Participant, considering quality and safety among other factors.
Monitoring, investigation and enforcement	▪ The Commission should clarify the definition of "in connection with" and broaden reporting requirements to include all Participant deaths. ▪ The Reportable Incident process should include unregistered Providers.
Responsiveness to concerns and complaints	▪ The Commission should improve response times for review and feedback of all reportable incidents, including the process and communication with Providers. ▪ The investigation process including requests for further information should be streamlined in the best interests of Participant and Providers. ▪ Conflicting information on the criteria for a Reportable Incident should be removed and information be made available consistent within guidance material and Commission feedback to Providers. ▪ Participant should continue to be encouraged and supported to make complaints.
Code of conduct and practice standards	▪ Review of the Code of Conduct and consider mechanisms such as application of the Code of Conduct to unregistered Providers to ensure accountability for the provision of safe and quality supports. ▪ Reflect the costs of accreditation, quality and safety in NDIS pricing.
Provider registration and worker screening	▪ Access to worker and Provider information, including the Worker Screening process, should be expedited and enhanced. ▪ The Commission should consider the impacts on Providers of undertaking registration and how it might engage with Providers to make the process and communication from the Commission more efficient and cost-effective.
Communication between Commission and state and territory authorities	▪ Improve collaboration between The Commission and state and territory authorities to reduce administrative costs for the NDIS and Providers.
Commission resources	▪ Improve or redeploy Commission resources to improve effectiveness and timeliness of communication and key processes like accreditation.

Specialist Providers vs Generalist Providers for Complex Participant Cohorts

- The NDIS does not generally distinguish between generic and specialist providers (for particular cohorts). We see people with complex mental health needs referred to non-specialist support providers with poor outcomes including increased presentation to State hospitals and other services.

Restricted Access to Supported Independent Living (SIL)

- We are seeing the NDIS increasingly restrict access to SIL funding for potential participants, with the outcome that there is increased use of State health services where it is not warranted:
    - We have concerns about lack of acceptance of allied health recommendations including from Queensland Health practitioners; for example, cases where Q Health specified that a client requires SIL but the NDIS Planner determined that the client does not need 24/7 care with the end result that the client ends up in (State-funded) CCU anyway as they are not able to live independently. In our opinion the Q Health practitioners making the recommendations are better qualified than the NDIS planner.
    - Most participants leaving long stay health facilities need a transition back into the community but the NDIA appears to feel that if they are eligible to leave health care they can go into their own home. In these cases, SIL is a needed option (even if for a transitional period).

Lack of Specialists

- We are experiencing difficulties in gathering evidence needed for Participant plan approvals, and difficulties accessing specialist providers, with respect to some specialised roles.
    - We are finding it difficult to access Mental Health Occupational Therapists. Their reports are vital to some Participant applications, including for SIL.
    - Behaviour Support Practitioners often have quite a large waiting period and require additional funding to ensure that the participants support network are all adequately trained to implement the behaviour support plans correctly.