Queensland Nurses & Midwives' Union

Submission to

Queensland Productivity Commission

The NDIS market in Queensland draft report

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submission

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Introduction

The Queensland Nurses and Midwives' Union (QNMU) thanks the Queensland Productivity Commission for the opportunity to comment on the *NDIS market in Queensland draft report* (the 'Report').

Nursing and midwifery is the largest occupational group in Queensland Health (QH) and one of the largest across the Queensland government. The QNMU is the principal health union in Queensland covering all classifications of workers that make up the nursing and midwifery workforce including registered nurses (RN), midwives (RM), nurse practitioners (NP) enrolled nurses (EN) and assistants in nursing (AIN) who are employed in the public, private and not-for-profit health sectors including aged care.

Our 65,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The QNMU represents members who are employed by NDIS providers or are sole practitioners for the NDIS market, and the issues raised in the Report have a significant impact on the livelihood of those members. It is therefore disappointing that the critical role of nurses has been overlooked in the Report, especially as disability and health care (physical and mental) often go hand-in-hand.

There is potential for increased collaboration and integration between disability and health care, such as community health services in general and Primary Health Networks, led by the nursing workforce and our professional values of holistic care. Nurses have the skills, expertise, and qualifications to perform roles that support participant empowerment and self-sufficiency.

There is also a need for enhanced collaboration and integration between the acute health care sector and community-based disability support services. The QNMU is particularly concerned about increasing anecdotal evidence of inappropriate long-term length of stays for people with complex health or behavioural issues arising from the lack of community-based services that meet the needs of these people. Data on this problem is patchy because of the decentralised organisation of health and community-based services, so this problem is currently somewhat hidden and, as a result, is not requiring adequate attention. This results in sub-optimal outcomes for people with a disability who are effectively "falling between the cracks" in the system and significant additional costs for the acute care sector that are too often the only available care option.

The Nursing and Midwifery Board of Australia (NMBA) certainly supports the role of registered nurses in the disability sector. The introduction to the NMBA's Registered Nurse Standards for Practice states:

Registered nurse (RN) practice is person-centred and evidence-based with preventative, curative, formative, supportive, restorative and palliative elements. RNs work in therapeutic and professional relationships with individuals, as well as with families, groups and communities. These people may be healthy and with a range of abilities or have health issues related to physical or mental illness and/or health challenges. These challenges may be posed by physical, psychiatric, developmental and/or intellectual disabilities.

The NDIS must enable nurses to work to their full scope of practice and recognise the specialised and vital role of nurses in the assessment, education, and capacity building of participants with complex disability needs. For example, the proposed Allied Health Assistants could be named Health Assistants and also come under the supervision of a registered nurse when performing nursing activities to broaden their scope of activity and employment.

In this submission, the QNMU will address the relevant Information Requests and some of the draft Recommendations proposed by the Report.

Recommendations

The QNMU recommends:

- Regulatory frameworks that protect workers by committing to minimum qualification requirements, mandatory ongoing training and supervision, and fair working conditions.
- Specifically, the requirement that all disability support workers who are employed by a registered NDIS provider have attained a Certificate III in Individual support as a minimum.
- Governments to take decisive action on tackling precarious employment and job insecurity to incentivise and maintain the disability sector workforce.
- Removal or review of *Draft Recommendation 9.*
- Review of *Draft Recommendation 19.*
- Increased collaboration with other sectors, such as health centres, Aboriginal and Torres Strait Islander health services, and local government initiatives such as community/neighbourhood centres in rural and remote areas.
- Action on those effectively "trapped" in acute care facilities inappropriately due to lack of appropriate services in the community for people with complex health or behavioural needs, by addressing gaps and shortages in specialist disability accommodation provider services and in building and incentivising the specialist clinician workforce.
- Forming NDIS partnerships and ensuring consultation with Aboriginal and Torres Strait Islander organisations, nurses and midwives where possible for a more inclusive and equitable NDIS.
- Governments to take a proactive and central role in workforce planning, specifically in facilitating and driving the training and development of a qualified and work-ready workforce.
- Robust and comprehensive research into the impact of job quality of disability sector workers on the quality of service provided.

Supply side issues

The QNMU acknowledges the concerns raised in the Report regarding the role and impact of the NDIS regulatory framework. As a public service, the NDIS requires government intervention and regulation to ensure the safety and quality of the services it provides. Regulation is not only required to safeguard that participants' health and wellbeing is not placed at risk from questionable business practices, but also to ensure that the disability workforce is not financially or professionally disadvantaged by unscrupulous providers or by the NDIS system itself.

Our QNMU members who work for an NDIS provider or as sole practitioners for the NDIS have reported issues such as:

- Lack of clarity or consistency around award entitlements, appropriate financial remuneration, and job security.
- Challenges with clinical decision-making as a result of unclear clinical governance pathways and lack of clinical supervision and/or mentorship.
- Lack of guidance around scope of practice for nurses and the overlap in scope of work/tasks for support and care workers.

The QNMU suggests these concerns can be addressed through regulatory frameworks that protect workers by committing to minimum qualification requirements, mandatory ongoing training and supervision, secure employment arrangements and fair working conditions. Moreover, the government should bear the primary responsibility for developing and growing the disability workforce by recognising the expertise required to work in the disability sector and ensuring appropriate financial remuneration.

There are strong parallels between the disability sector and the aged care sector, in terms of how service quality and delivery is currently subjected to market forces. In learning the lessons from the aged care sector however, it would be prudent to consider tighter regulation to avoid competitive cost-cutting to the detriment of participants and the workforce. Other factors to consider include:

- More streamlined regulatory oversight, including enforceable penalties for failure to comply.
- Regular review of the NDIS system and post-evaluation quality improvement measures.
- The dangers of a fully privatised system.
- Regulation of the workforce, specifically the requirement that all disability support workers who are employed by a registered NDIS provider have attained a Certificate III in Individual support as a minimum.

Improving market coordination and supply

The most critical issue facing the disability workforce is precarious employment and job insecurity. Creation of the “flexible labour market” has led to the financial exploitation of workers and the dangerous proliferation of casualisation of the workforce.

In a recent 2020 survey by the QNMU, an overwhelming majority (96.3%) of members indicated that job security was *important* or *very important* when looking for work (Queensland Nurses and Midwives' Union, 2020). Moreover, two-thirds of members reported that *having a permanent job* was the most important factor in job security. The second most important factor was *having security against unemployment*.

The precarity of current employment opportunities available in the NDIS is well-known and a significant barrier for potential workers (Baines, et al., 2019). The devastating impact of job insecurity has become apparent in the post-pandemic climate, where two-thirds of those who lost their job during the COVID-19 pandemic were casual workers (Australian Bureau of Statistics, 2020). This is significant because 31.7% of carers and aides are employed on a casual basis (Gilfillan, 2020), suggesting greater risk of job insecurity in this sector. Because of the gender make-up of the Health Care and Social Assistance sector, women are disproportionately disadvantaged by these precarious employment arrangements.

According to our survey, half of the QNMU members on casual or temporary contracts reported that they had only accepted casual or temporary contracts due *to limited opportunities for a permanent role*, and 96% of members on temporary contracts indicated that they would *prefer to become a permanent employee* if the opportunity arose.

To encourage workers into the sector, the government must take decisive action on tackling precarious employment and job insecurity. This means:

- Secure working arrangements, including security of hours, wages, and employment status.
- Supporting conversion of casual or temporary contracts into permanent positions.
- Fair and respectable wages.
- Good, safe working conditions, including physically and psychologically safe working environments.

Regarding Draft Recommendation 9

The QNMU does not support the proposal to develop an Application Programming Interface (API). There are several issues regarding the proposed participant-to-provider digital "competitive tendering" marketplace:

- Participants already indicate an overwhelming, difficult and time-consuming experience engaging with an NDIS provider. A digital marketplace will only further add to an already complex experience.
- A digital marketplace will place significant burden of resources on providers, who already cite extensive administrative requirements associated with running a business. The resources required to constantly check and respond to "posts" will disproportionately disadvantage smaller businesses and sole practitioners.
- Should providers opt out of participating in this digital marketplace, they are likely to be missing out on opportunities to provide services.
- NDIS providers are unlikely to individually tailor their "tenders" due to resource constraints, potentially leading to further misinformation and confusion.

Improving price regulation

Regarding Draft Recommendation 19

The QNMU considers revision of the existing caps to be reasonable, however cautions that a complete roll-back of all the price caps could be problematic. It is necessary to retain some drivers of efficiency through price capping in order to operate within a finite budget and reduce the risk of financial exploitation, especially in areas with reduced service provision.

NDIS accommodation issues

The QNMU is very concerned that insufficient resources in the NDIS sector for community-based care is leading to excessive burden on the acute care sector. The government must invest in implementing strategies for participants who are essentially "trapped" in acute care facilities inappropriately due to the lack of more appropriate services in the community that can address complex health or behavioural needs.

The following case studies are clear examples of the impact of such a phenomenon:

Case study 1 – Medical unit
A young woman receiving NDIS support was admitted to a busy acute care medical ward, where she was successfully treated for a medical issue. However, the lack of

appropriate post-discharge accommodation options suitable for her disability-related needs resulted in an inappropriately long length of stay on the ward.

Without appropriate community-based services, she became “trapped” in the acute care sector despite no medical requirement for the patient to remain in hospital. She began to exhibit several behavioural issues during the admission.

A likely contributing factor in the distress and agitation of the patient was that she had been admitted to a ward that was not appropriate for her support needs. The confusion and frustration with the lack of community-based services for discharge are also likely to have influenced her distress.

This resulted in significant resource demands on the ward, with nursing staff under additional workload pressures and demands to manage the complex and challenging behaviours of the patient. The nursing staff were also subjected to near-daily assaults by the patient, some resulting in serious injury. Additional security and staff had to be rostered on to manage the increased acuity of the ward.

Case study 2 – Mental health unit

A young man with a severe disability had been raised by his grandparents for the majority of his childhood. When his grandparents eventually moved into a residential aged care facility, there were no other family members who were able to provide care. In the ensuing stress and trauma directly related to the loss of his primary carers, and without adequate supports in the community, the man exhibited extremely challenging behaviours that resulted in an admission to a mental health unit. The treating team concluded that he required 24/7 care from experienced clinicians with a specialist qualification in his particular area of disability.

While he had an NDIS package, it was insufficient to cover the cost of providing specialist services for the management of his behaviours. The consumer remained on the mental health unit for over 12 months due to the lack of appropriate discharge options available for his disability care needs. It is also important to note that the consumer did not have a mental health diagnosis and that all behavioural concerns were related to his disability.

Case study 3 – Rehabilitation unit

A random audit of a single day in a highly specialised rehabilitation unit in a tertiary hospital revealed that on that day, there were at least 15 patients who were experiencing delayed discharges from hospital due to the lack of appropriate NDIS community-based services. Sourcing residential services and in-house care was challenging for the level of disability support and assistance required.

The knock-on effect of this meant substantial delays for people who were on the waiting list to be admitted, many of whom had already been waiting several months, as the rehabilitation unit is the only one of its kind in Queensland. This is particularly concerning as delays to healthcare access is known to potentially lead to poorer treatment outcomes.

Three main issues emerge from all of the case studies illustrated above, namely:

- Inappropriate admissions of NDIS participants into acute care facilities, despite resolution of their acute care needs.
- Lack of specialist disability accommodation available in the community.
- Urgent need of a specialist clinical workforce with the skills, training and education to manage specific types of disability. Such highly specialised level of care cannot be provided by disability support workers.

The result of such incidents are poorer outcomes for the NDIS participants who are "trapped" in acute care facilities, their families and/or carers, other patients in the acute care system, the staff involved, and the Hospital and Health Services who must bear the burden of these significant costs.

From a resource and funding allocation perspective, this trend effectively shifts the costs from the federal government (NDIS) to the state government (Hospital and Health Services).

The QNMU recommends urgently addressing the gaps and shortages in specialist disability accommodation provider services and in building and incentivising the specialist clinician workforce to meet this demand.

The NDIS in rural and remote areas

The QNMU believes that increased collaboration with other sectors, such as health centres, Aboriginal and Torres Strait Islander health services, and local government initiatives such as community/neighbourhood centres, would be beneficial in supporting greater coverage and accessibility of services for NDIS participants living in rural and remote areas.

Aboriginal and Torres Strait Islander people and the NDIS

The QNMU notes QAIHC's public submission from the Interim Report and supports the concerns raised regarding Aboriginal and Torres Strait Islander access and participation in the NDIS. Collaboration with organisations such as QAIHC may be beneficial to identifying eligible participants who are yet to access NDIS services.

Forming NDIS partnerships and ensuring consultation with Aboriginal and Torres Strait Islander organisations, nurses and midwives where possible is integral to a more inclusive and equitable NDIS.

Regarding the employment of close contacts of Aboriginal and Torres Strait Islander people in NDIS provider roles

The QNMU considers that any review of the NDIS rules regarding conflicts of interest in the employment of informal supports is careful to avoid a "one size fits all" approach. It is vital that while balancing consistency of approach does not disadvantage participants and their ability to access services, due to their personal circumstances, local community engagement, and geographical location, caution is also applied to reduce the risk of exploitation and financial abuse of participants. For example, the QNMU suggests that the proposed NDIS provider should not be the participant's primary carer or someone who lives in the same household.

Queensland Government roles and interventions

The Queensland government must take a proactive and central role in workforce planning, specifically in facilitating and driving the training and development of a qualified and work-ready workforce. Planning of this workforce should be at both the commonwealth and state level to account for localised issues in Queensland such as the large disparity of service access across regionality (Joint Standing Committee on the National Disability Insurance Scheme, 2020). Funding and financial incentives should also take a target approach to accurately reflect the regionality-based needs of the state.

Secondly, the Queensland government also has an important role in investing in robust research into the impact of job quality on service quality in the NDIS. The QNMU welcomes the establishment of the National Disability Research Partnership (NDIS, 2020) and anticipates further insight into the impact of job quality of Disability workers on the quality of service provided.

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