QPC Presentation - February 5, 2021 9~30

The purpose of this note is to outline a response to the QPC Draft Report 'The NDIS market in Queensland' 2020 specifically Chapter 9 and in particular Section 9.5 'Underlying problems' and section 9.6 'Addressing accomodation issues' as they relate to NDIS participants as long stay hospital patients.

Background:

I agree with the conclusions drawn by the draft report regarding the implementation of the NDIS in Qld and the resulting market failure. There are however specific cohorts of NDIS participants where market failure has had a disproportionate negative impact most notably long stay hospital patients with intellectual disability, those populations of participants with less severe intellectual disability in the correctional system and those participants younger than 65 in residential aged care. I propose to concentrate on on those participants who are long stay hospital patients.

At the end of 2019 there was considerable media coverage in Qld regarding the number of NDIS participants who despite being ready for discharge remained in hospital due to the lack of suitable support and accommodation despite funding from the NDIS. With the advent of COVID~19 there was a concerted effort by the NDIA and state health jurisdictions nationally to discharge these patients from hospital to free up beds in preparation for COVID~19 patients.

Despite these efforts there remains today a large indeterminate number of NDIS participants remaining in hospital because of a lack of suitable support and specialist disability accommodation. Whilst there were many short terms successes with the initiatives to prepare for COVID~19 many of these participants have returned to acute care settings because of inadequate supports and accommodation.

Despite the obvious inappropriateness of extended hospital stays for the participant and their families the Qld Government is incurring considerable financial and opportunity costs with large numbers of NDIS participants remaining in hospitals. This situation is exasperated by the availability of significant funding for both support and specialist accommodation for eligible participants of the NDIS.

This situation is an obvious and real example of NDIS market failure.

Issues:

The issue of market failure for the cohort of NDIS participants who typically becomes long stay hospital patients are complex and interrelated with no single 'silver bullet' solution. There are five key areas of concern:

Participant Need:

The needs of those participants that typically experience long stay hospital stays are: severe intellectually disability often with co morbidities such as mental health and chronic illness and demonstrate challenging behaviours that exclude them from long

term meaningful relationships. Evidence of trauma is often identified as a result of the challenges of providing suitable care and support.

The number of participants in this cohort in hospital at any one time are a representative portion of a much larger cohort of participants. This group is represents a major component of those patients referred to in the health sector as ‘frequent flyers’ or approximately 4 percent of the population who are high users of acute services.

Care and Support:

I have deliberately used term ‘care and support’ to reflect the case that many participants in this cohort experience chronic illness as well as disability. Accordingly, to provide appropriate care and support requires not only support from the NDIS but also from the health sector. Similarly, many participants demonstrate challenging behaviours often caused by a combination of intellectual disability and trauma that require specialised services from highly trained staff operating in a clinical team environment.

All of these factors as well as a lack of knowledge of these participants have made sourcing suitable care and support services from an NDIS market extremely challenging. It is important to note that there is no obligation on NDIS providers to provide services to these participants with acute hospital services assuming the role of provider of last resort. Government should consider as a priority the role of AS&RS being maintained as a funded NDIS to perform this role.

Accommodation:

The challenges of the provision of SDA under the NDIS are adequately addressed in the draft report except for a number of considerations. The provision of SDA should be as an integrated component of assessing the individuals needs of the participant, the provision of both care and support services as well as SDA. A key failure of SDA development to date has been the decision to invest without identifying the participant. Further, many of the participants in this cohort will require accommodation for themselves rather than with another participant.

A key component of any future initiatives to provide accommodation for participants of this cohort is facilitating the ability of the participant and/or their family to purchase the property. Preliminary discussions with QIC have occurred in this regard. Ownership of the property by the participant and/or their family removes much of the complexity associated with SDA provision.

Support Coordination:

Support coordination as funded by the NDIS is a particular challenge for NDIS long stay patients. Most examples of coordinating services or arranging discharge from hospital has been undertaken by hospital social workers or discharge planners from within the hospital. This situation has resulted in a number of complexities for the future sustainability of the participant living in the community. Examples include: hospital priorities primarily concerned with discharging the participant rather than organising long term accommodation and support, a general lack of understanding of the NDIS particularly the funding of the participant in preference to a provider and the blending of Support Coordination, SIL and SDA as an integrated service by the one provider.

Planning for discharge from the hospital in many ways circumvents and neutralises the need to build the social infrastructure required to facilitate discharge. For example, hospital social workers are not in a position to facilitate a market response from providers to facilitate discharge of long stay NDIS participants. A case in point is the relative lack of medium term accommodation in close proximity to major metropolitan and/or major regional hospitals to facilitate discharge.

Case Management:

The final point to raise is that of case management technologies to enable a participant to coordinate and manage both care and support to remain living in the community. As mentioned above this cohort of participants have complex needs that require a multitude of responses from multiple providers. Technology that is owned and managed by the participant and/or their family to manage and maintain individual case records will go along was to ensure that adequate care and support is provided. A common complaint of acute hospital services on re admission is the lack of notes on the care and support provided to the participant.

Similarly, a reassessment of the view that Support Coordination is a short term intervention be dependent on the needs of the participant concerned. Many of the participants in this cohort have chronic illness and disability that does not ameliorate with time or investment.

Recommendations:

Qld Government take a population health approach to identifying those NDIS participants that meet the criteria for being at risk of long stay hospital admissions and develop processes in partnership with NDIS providers to ensure adequate care and support is in place.

The role of the Qld Government in this regard is to provide stewardship to the market to respond to the needs of this cohort in a meaningful way. This is best achieved through the provision of information, facilitation of process and the development of partnerships with NDIS providers, the participant and their family.

As a priority the Qld Government should sponsor a demonstration project within a designated region of Qld to develop a strategy for the implementation of the NDIS stewardship model. A recommended region is Toowoomba.

It is important to note that it is not the role of the Qld Government to fund the provision of services for these participants as this is the role and responsibility of the NDIS. It is the role of the Qld government to ensure that Queenslanders are provided with every opportunity to access services they are eligible for and to ensure that the services are appropriate for the persons individual need.

Michael Harris Moodie
Adj Professor
University of the Sunshine Coast

February 1, 2021